State of Tennessee
Health Facilities Commission
502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 hsda.staff@tn.gov

CERTIFICATE OF NEED APPLICATION

1A. Name of Facility, Agency, or Institution

TriStar Southern Hills Medical Center – Nolensville Freestanding Emergency Department
Name

Unaddressed site on Ava Place near the intersection of Burkitt Place Drive and Nolensville Road
Street or Route

Williamson
County

Nolensville
City

Tennessee
State

37135
Zip

https://www.tristarhealth.com/locations/tristar-southern-hills-medical-center
Website Address

Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.

2A. Contact Person Available for Responses to Questions

Drew Tyrer
Name

Chief Executive Officer
Title

TriStar Southern Hills Medical Center
Company Name

Andrew.Tyrer@hcahealthcare.com
Email Address

391 Wallace Road
Street or Route

Nashville
City

Tennessee
State

37211
Zip

Executive
Association with Owner

615-781-4000
Phone Number

3A. Proof of Publication

Attach the full page of newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent. (Attachment 3A)

Date LOI was Submitted: 4/6/2023

Date LOI was Published: 4/6/2023

4A. Purpose of Review *(Check appropriate box(es) – more than one response may apply)*

- ☐ Establish New Health Care Institution
- ☐ Addition of a Specialty to an Ambulatory Surgical Treatment Center (ASTC)
- ☐ Change in Bed Complement
- ☐ Initiation of Health Care Service as Defined in §TCA 68-11-1607(3) Specify: ____________
- ☐ Relocation
- ☐ Initiation of MRI Service
- ☐ MRI Unit Increase
- ☑ Satellite Emergency Department
- ☐ Addition of ASTC Specialty
- ☐ Initiation of Cardiac Catheterization
- ☐ Addition of Therapeutic Catheterization
- ☐ Establishment/Initiation of a Non-Residential Substitution Based Opioid Treatment Center
- ☐ Linear Accelerator Service
- ☐ Positron Emission Tomography (PET) Service

Please answer all questions on letter size, white paper, clearly typed and spaced, single sided, in order and sequentially numbered. In answering, please type the question and the response. All questions must be answered. If an item does not apply, please indicate “N/A” (not applicable). Attach appropriate documentationas an Appendix at the end of the application and reference the applicable item Number on the attachment, i.e., Attachment 1A, 2A, etc. The last page of the application should be a completed signed and notarized affidavit.

5A. Type of Institution *(Check all appropriate boxes – more than one response may apply)*

- ☐ Hospital (Specify): ________________________________
- ☐ Ambulatory Surgical Treatment Center (ASTC) – Multi-Specialty
- ☐ Ambulatory Surgical Treatment Center (ASTC) – Single Specialty
- ☐ Home Health
- ☐ Hospice
- ☐ Intellectual Disability Institutional Habilitation Facility (ICF/IID)
- ☐ Nursing Home
- ☐ Outpatient Diagnostic Center
- ☐ Rehabilitation Facility
- ☐ Residential Hospice
- ☐ Nonresidential Substitution Based Treatment Center of Opiate Addiction
- ☑ Other (Specify): Freestanding Emergency Department

6A. Name of Owner of the Facility, Agency, or Institution

HCA Health Services of Tennessee, Inc.
Name

c/o TriStar Southern Hills Medical Center, 391 Wallace Road
Street or Route

615-781-4150
Phone Number

Nashville
City

TN
State

37211
Zip

7A. Type of Ownership of Control *(Check One)*

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Limited Partnership
- ☑ Corporation (For Profit)
- ☐ Corporation (Not-for-Profit)
- ☐ Government (State of TN or Political Subdivision)
- ☐ Joint Venture
- ☐ Limited Liability Company
- ☐ Other (Specify):_______________________________

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's website at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. If the proposed owner of the facility is government owned must attach the relevant enabling legislation that established the facility. (Attachment 7A)

Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.

RESPONSE:
TriStar Southern Hills Medical Center ("Southern Hills" or "TriStar Southern Hills") is owned by HCA Health Services of Tennessee, Inc., which is owned by HCA Healthcare, Inc. through several wholly owned subsidiary corporations. Please see **Attachments 7A-1**, **7A-2**, **7A-3,** and **7A-4** for Southern Hills' corporate status from the Tennessee Division of Business Services Department of State, Certificate and Charter, Organizational Chart, and Ownership Structure, respectively.

8A. Name of Management/Operating Entity *(If Applicable)*

Not Applicable.
Name

Street or Route **County**

City **State** **Zip**

Website Address

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract. (Attachment 8A)

RESPONSE: Not applicable. The proposed FSED will be managed and operated as a department of TriStar Southern Hills, the applicant.

9A. Legal Interest in the Site

Check the appropriate box and submit the following documentation. (Attachment 9A)

The legal interest described below must be valid on the date of the Agency consideration of the Certificate of Need application.

- ☐ Ownership (Applicant or applicant's parent company/owner) – Attach a copy of the title/deed.
- ☐ Lease (Applicant or applicant's parent company/owner) – Attach a fully executed lease that includes the terms of the lease and the actual lease expense.
- ☐ Option to Purchase - Attach a fully executed Option that includes the anticipated purchase price.
- ☐ Option to Lease - Attach a fully executed Option that includes the anticipated terms of the Option and anticipated lease expense.
- ☑ Other (Specify) Purchase and Sale Agreement

RESPONSE: Please see **Attachment 9A.**

10A. Floor Plan

If the facility has multiple floors, submit one page per floor. If more than one page is needed, label each page. (Attachment 10A)

- Patient care rooms (Private or Semi-private)
- Ancillary areas
- Other (Specify)

RESPONSE: See **Attachment 10A** for a copy of the floor plan.

11A. Public Transportation Route

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. (Attachment 11A)

RESPONSE: See **Attachment 11A.** The site is located in Nolensville, TN, on the Nashville/Davidson County-Williamson County border on Ava Place near the intersection of Burkitt Place Drive and Nolensville Road, easily accessible by car, ambulance, and other ground transportations. The plan for signage of the proposed FSED will be located at the intersection of Addy Way and Nolensville Road. There are no major bus routes that serve the proposed service area. Thus, access to emergency services in much of the service area is limited to personal transportation or EMS confirming the need for accessible emergency services in the service area. **Attachment 11A** shows the We Go Transit Nashville System Map bus routes that extend a little further south than intersection of US-31 ALT S/US-41A S/Nolensville Road/Nolensville Pk and Old Hickory Road but not all the way south to the proposed FSED. The service area is covered by Uber and Lyft services.

12A. Plot Plan

Unless relating to home care organization, briefly describe the following and attach the requested documentation on a letter size sheet of white paper, legibly labeling all requested information. It **must** include:

- Size of site (in acres);
- Location of structure on the site;
- Location of the proposed construction/renovation; and
- Names of streets, roads, or highways that cross or border the site.

(Attachment 12A)

RESPONSE: The size of site is approximately 2.8 acres located on Ava Place near the intersection of Burkitt Place Drive and Nolensville Road. Please see the plot plan included in **Attachment 12A** for the location of the

structure on the site, the location of the proposed construction, and the names of all adjacent roads. The signage of the proposed FSED is planned to be located at the intersection of Addy Way and Nolensville Road subject to applicant gaining either ownership of that property or the right to place a sign there or both and subject to local government approval.

13A. Notification Requirements

- TCA §68-11-1607(c)(9)(B) states that "… If an application involves a healthcare facility in which a county or municipality is the lessor of the facility or real property on which it sits, then within ten (10) days of filing the application, the applicant shall notify the chief executive officer of the county or municipality of the filing, by certified mail, return receipt requested." Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

  ☐ Notification Attached ☑Not Applicable

- TCA §68-11-1607(c)(9)(A) states that "… Within ten (10) days of the filing of an application for a nonresidential substitution based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of the municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

  ☐ Notification Attached ☑Not Applicable

EXECUTIVE SUMMARY

1E. Overview

Please provide an overview not to exceed **ONE PAGE** (for 1E only) in total explaining each item point below.

- **Description: Address the establishment of a health care institution, initiation of health services, and/or bed complement changes.**

  TriStar Southern Hills proposes to establish a FSED to provide needed emergency care in the proposed service area, which is centered in Nolensville, Williamson County, Tennessee, and is contained within ZIP Codes 37135, 37027, 37013 and 37211. The FSED will be located on the Nashville/Davidson County-Williamson County border, on Ava Place near the intersection of Burkitt Place and Nolensville Road. Southern Hills is the largest provider of ED services to residents of this area and has another FSED located in Antioch known as the Century Farms FSED. The proposed FSED in Nolensville is needed:

  - **To Enhance Access:** While there are two EDs in two of the ZIP Codes in the proposed service area, TriStar Southern Hills and Century Farms FSED (both in Nashville/Davidson County), the neighborhoods and communities south of those facilities do not have ready access to emergency services. Currently, the proposed service area emergency patients either go to Southern Hills, Nashville hospitals further north, or the hospital in Franklin (Williamson County) to the southwest, or hospitals in Rutherford County to the east/southeast. Southern Hills sees the most patients from the service area. A portion of the service area is geographically isolated due to significant traffic congestion delaying travel to emergency care and lack of an ED in ZIP Codes 37135 and 37027, creating access challenges for proposed service area residents needing emergency care (See **Exhibit 2**). In addition, many of the core Nashville hospitals outside the service area have long ED wait times and are frequently on diversion, further limiting access to ED services. The proposed FSED will provide emergency services in the community to be served and closer to where service area residents live.

  - **To Address Population Growth:** The proposed service area is experiencing a rapidly growing and aging population. Nolensville's population increased by 145 percent from 2010 to 2022 and shows no sign of slowing.[1] In addition, significant new development is planned in this area, including residential and commercial growth. From 2023 to 2028, the incremental population growth in the service area is expected to grow at a 4.6 percent annual rate, plus the new planned developments will increase demand for ED services and exacerbate traffic congestion to reach existing EDs.

  - **To Address ED Demands at Southern Hills:** The Southern Hills' ED and Century Farms FSED are highly utilized. Combined, Southern Hills and the Century Farms FSED, which opened in 2021, have experienced almost a 40 percent increase in utilization from 2020 to 2022. Some of the proposed service area emergency patients will choose the new FSED based on proximity, and thus reduce somewhat the patient traffic at the highly utilized ED at Southern Hills, which will help alleviate capacity constraints at the Southern Hills ED and Century Farms FSED.

  The Nolensville FSED will be a full-service hospital emergency department with the capability to care for all acuity levels of ED patients. The proposed 11,900 square foot freestanding ED will include 12 treatment/exam rooms, including one trauma room and one triage room, a lab, an imaging department (e.g., CT, X-ray, and Ultrasound), pharmacy support equipment, a nurse station, and associated support space. All equipment will be available 24/7. Please see the major equipment list provided in **Attachment 4E-1**. Also see page 28 for an image and equipment list for each treatment room.

- **Ownership structure -** The Nolensville FSED will be a satellite of Southern Hills, which is owned by HCA Health Services of Tennessee Inc. and whose ultimate parent company is HCA Healthcare, Inc. ("HCA Healthcare"). Please see the response to Question 7A and **Attachment 7A**. Southern Hills is part of the TriStar Health network, which operates 5 FSEDs, and HCA Healthcare, which operates 130 FSEDs.

- **Service Area -** The service area is contained within ZIP Codes 37135, 37027, 37013 and 37211. Applicant recognizes that portions of ZIP Codes 37211 and 37013 are outside the anticipated service area as shown in **Exhibit 2**.

- **Existing similar service providers -** The only existing EDs in the service area are Southern Hills and its FSED in Antioch (Century Farms), which serve the most service area patients. Service area patients also use Nashville hospitals further north, or the hospital in Franklin (Williamson County) to the southwest, or TriStar StoneCrest Medical Center in Rutherford County to the east. See the response to **Question 5N** for a list of these providers and their operating statistics.

- **Project Cost -** The estimated capital cost of the project is $16,995,153.

- **Staffing -** The proposed FSED will be staffed by approximately 31.8 FTEs, consisting of physicians, RNs, EMT/Paramedics, radiology, and lab tech, as well as nonclinical support staff to meet all acuity levels of ED services.

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[1] https://tennessee.hometownlocator.com/zip-codes/data,zipcode,37135.cfm and www.zipdatamaps.com/37135

2E. Rationale for Approval

A Certificate of Need can only be granted when a project is necessary to provide needed health care in the area to be served, will provide health care that meets appropriate quality standards, and the effects attributed to competition or duplication would be positive for consumers.

Provide a brief description not to exceed **ONE PAGE** (for 2E only) of how the project meets the criteria necessary for granting a CON using the data and information points provided in criteria sections that follow.

- **Need**

  The proposed FSED is needed because there are no EDs in the rapidly growing Nolensville/South Nashville/Brentioch area and the only two ED providers in the ZIP Code service area face capacity constraints. The significant distance to existing EDs outside the service area and traffic congestion create physical and practical barriers to accessing ED services. As a result, portions of service area residents face geographic isolation from access to emergency services (See **Exhibit 2**). The proposed service area is within Southern Hills' existing service area, and Southern Hills is the primary provider of ED services to service area residents. Other ED providers outside the service area are often on ED diversion and/or have long ED wait times. The proposed project will serve as an ED access point for service area residents much closer to home.

  The Southern Hills ED and Century Farms FSED are highly utilized and face significant constraints. The proposed service area is anticipated to grow and age significantly over the next several years, which will place additional demands on these highly utilized EDs. Because some proposed service area emergency patients will choose the new FSED based on proximity, the new FSED will help meet the emergency needs of the growing community as well as help alleviate capacity constraints at the highly utilized Southern Hills and Century Farms EDs. As an accredited Chest Pain Center and Primary Stroke Center by The Joint Commission and being located in densely populated urban areas, reducing capacity constraints at the main Southern Hills ED and Century Farms FSED will be beneficial to the consumers of its ED.

- **Quality Standards**

  The proposed FSED will serve all ED acuity levels and operate under the same quality standards as the Southern Hills' main campus ED. The proposed Nolensville FSED will provide high quality care that is accessible for all patients in the service area. As part of Southern Hills, the FSED will be accredited by The Joint Commission. The FSED will be part of Southern Hills' robust Quality Assurance and Performance Improvement ("QAPI") and Utilization Review Program to ensure quality of care and patient safety. Southern Hills has achieved an "A" rating by Leapfrog for the past six years (12 reporting periods).

- **Consumer Advantage – The community supports the proposed project based on:**
  - **Choice -** The proposed FSED will provide consumers with a choice of local access to ED services versus facing high traffic volume and long wait times at the other EDs outside the service area. Southern Hills and the Century Farms FSED, the only EDs in service area ZIP Codes, are historically highly utilized and face capacity constraints. FSEDs differentiate themselves from on-campus hospital EDs in terms of patient experience; hospital EDs routinely have long wait times, busy staff, crowded waiting rooms, and frequent diversion status. National studies reflect an average of 3-hour wait times in the nation's hospital-based EDs, whereas FSEDs see patients quickly and focus on getting patients out within 60 to 90 minutes.[2]
  - **Improved access/availability to health care service(s) -** The proposed FSED will improve access to care by bringing ED services geographically closer to patients' homes without facing the traffic congestion present along the limited routes to existing EDs outside the service area as well as alleviating capacity constraints at the Southern Hills ED and the Century Farms FSED. Improved ED operational efficiencies and access to timely emergency care are positively associated with enhanced quality of care, patient safety, and patient satisfaction.
  - **Affordability -** The Nolensville FSED will be highly accessible just like the Southern Hills and Century Farms EDs. The Nolensville FSED will accept all government payors, including Medicare and TennCare, and will treat all patients regardless of their ability to pay. The Nolensville FSED will adhere to Non-Discrimination and Charity/Indigent Care policies, which ensure access by treating all patients regardless of race, ethnicity, or socioeconomic status. The Nolensville FSED is required to adhere to HCA Healthcare's financial assistance policies, which aim to reduce cost of care or provide free care to eligible patients. See **Attachment 4N-1** for a copy of Uninsured Discount and Charity Write-Off Policies.

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[2] https://www.jucm.com/understanding-the-freestanding-emergency-department-phenomenon/

3E. Consent Calendar Justification

☐ Consent Calendar Requested (Attach rationale)

If Consent Calendar is requested, please attach the rationale for an expedited review in terms of Need, Quality Standards, and Consumer Advantage as a written communication to the Agency's Executive Director at the time the application is filed.

☑Consent Calendar **NOT** Requested

4E. PROJECT COST CHART

A.	Construction and equipment acquired by purchase:		
	1	Architectural and Engineering Fees	$426,000
	2	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$150,000
	3	Acquisition of Site	$3,290,000
	4	Preparation of Site	$650,000
	5	Total Construction Costs	$7,304,000
	6	Contingency Fund	$243,000
	7	Fixed Equipment (Not included in Construction Contract)	
	8	Moveable Equipment (List all equipment over $50,000 as separate attachments)	$3,205,000
	9	Other (Testing, Inspection, Escalation, & Building Fees)	$1,399,000
B.	Acquisition by gift, donation, or lease:		
	1	Facility (inclusive of building and land)	-
	2	Building only	-
	3	Land only	
	4	Equipment (Specify)______________	-
	5	Other (Specify) __________________	-
C.	Financing Costs and Fees:		
	1	Interim Financing	$290,000
	2	Underwriting Costs	-
	3	Reserve for One Year's Debt Service	-
	4	Other (Specify) __________________	-
			-
D.	Estimated Project Cost (A+B+C)		$16,957,000
E.	CON Filing Fee		$38,153
F.	Total Estimated Project Cost (D+E)	**TOTAL**	$16,995,153

RESPONSE: See **Attachment 4E-1** for a list of equipment over $50,000. See **Attachment 4E-2 for** the funding letter signed by Wes Fountain, CFO TriStar Division, attesting to the availability of funds through Southern Hills' ultimate parent organization, HCA Healthcare. See also **Attachment 4E-3** for HCA Healthcare's 2022 Annual Report documenting its ability to fund the proposed project through cash reserves.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with TCA §68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, will provide health care that meets appropriate quality standards, and the effect attributed to competition or duplication would be positive for consumers." In making determinations, the Agency uses as guidelines the goals, objectives, criteria, and standards adopted to guide the agency in issuing certificates of need. Until the agency adopts its own criteria and standards by rule, those in the state health plan apply.

Additional criteria for review are prescribed in Chapter 11 of the Agency Rules, Tennessee Rules, and Regulations 01730-11.

The following questions are listed according to the three criteria: (1) Need, (2) the effects attributed to competition or duplication would be positive for consumers (Consumer Advantage), and (3) Quality Standards.

NEED

The responses to this section of the application will help determine whether the project will provide needed health care facilities or services in the area to be served.

1N. Provide responses as an attachment to the applicable criteria and standards for the type of institution or service requested. A word version and pdf version for each reviewable type of institution or service are located at the following website. https://www.tn.gov/hsda/hsda-criteria-and-standards.html (Attachment1N)

See **Attachment 1N** for detailed responses to applicable criteria and standards applicable to the proposal in this application. As will be shown in **Attachment 1N**, the proposed Nolensville FSED meets all applicable state health plan criteria.

2N. Identify the proposed service area and provide justification for its reasonableness. Submit a county level map for the Tennessee portion and counties boarding the state of the service area using the supplemental map, clearly marked, and shaded to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. (Attachment 2N)

Service Area Definition

See **Attachment 2N** for the proposed county level service area map. The proposal in this application seeks to develop a new FSED to provide improved access to ED services in the service area – which the Applicant defines as much less than any one full county -- and to alleviate the operational and capacity constraints at Southern Hills. In this regard, the applicant has identified the ZIP Codes found in **Exhibit 1** as the ZIP Codes in which the service area for the proposed Nolensville FSED is located. Southern Hills identifies portions of this ZIP Codes service area as geographically isolated and lacking ready access to emergency services, as shown in **Exhibit 2**.

Exhibit 1
Proposed Service Area

ZIP Code	City	County	State
37013	Antioch	Davidson	TN
37027	Brentwood	Williamson	TN
37135	Nolensville	Williamson	TN
37211	Nashville	Davidson	TN

Southern Hills considered the following factors in its determination of the proposed service area:

- Geographic proximity to the proposed FSED
- Drive times and traffic congestion for service area residents to travel to existing EDs.

- Southern Hills' historical patient origin by ZIP Code
- The location of existing hospital EDs and FSEDs
- The fact that FSEDs often pull from a narrower service area than on-campus hospital EDs

As described in detail in **Attachment 1N – FSED Guidelines**, portions of this ZIP Code service area are geographically isolated. **Exhibit 2** provides a map of the service area ZIP Codes, the existing hospital based EDs and FSEDs around the service area as well as major travel routes in Nashville/Davidson and Williamson Counties. **Exhibit 2** also shows the portions of the ZIP Code area ("non-crosshatched") representing the area of geographic isolation as determined by drive time analyses as discussed in **Attachment 1N**.

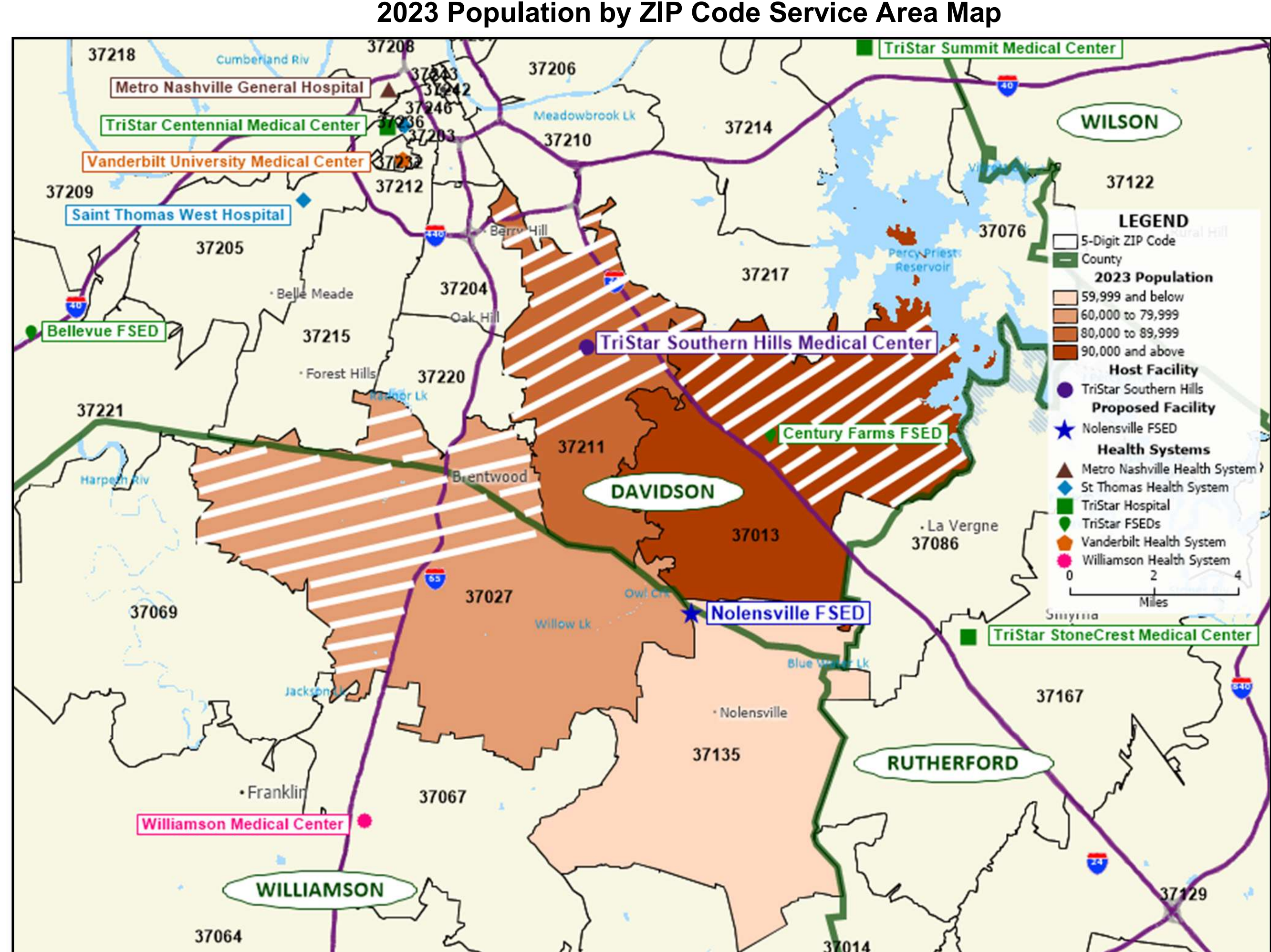
Southern Hills and Century Farms FSED are the only EDs in ZIP Codes in the proposed service area. Residents in ZIP Codes 37135 and 37027 do not have a local ED, and residents' drive times to existing EDs are often lengthy and unpredictable due to heavy traffic. The routes from Nolensville to any of the most proximate EDs are via 2 lane roads, through neighborhoods, commercial areas, and school zones, which particularly are impacted during peak traffic times. As a result, service area residents rely most heavily on Southern Hills and Century Farms, the most proximal EDs, for their emergency care. As such, both Southern Hills and Century Farms are highly utilized. The proposed FSED will bring needed access to ED services to ZIP Codes 37135 and 37027. It will also help alleviate the high utilization of Southern Hills and Century Farms by providing an alternative ED for patients in the southern parts of ZIP Codes 37013 and 37211.

Exhibit 2
Service Area Map with Geographically Isolated Area (Non-crosshatched)

Source: Maptitude
Note: TriStar StoneCrest is included because it is a nearby hospital to the proposed service area. Rutherford County is NOT a part of the proposed service area.

Exhibit 3 shows the 2023 service area population by ZIP Code obtained from Claritas Spotlight. ZIP Code 37013, where Century Farms FSED is located, has the most populous of all service area ZIP Codes with over 90,000 residents, and ZIP Code 37211, where the Southern Hills is located, is also a highly populated area with over 80,000 residents. Combined, these two ZIP Codes have a population base that is almost the same as the City of Chattanooga and the City of Knoxville. The dense and growing population surrounding Southern Hills and the Century Farms FSED contributes to the high ED demand at both facilities. As previously established, residents who live in ZIP Code 37135 and ZIP Code 37027 must travel outside their communities to access ED services in these densely populated areas. This is particularly problematic for the residents of ZIP Code 37135 – as **Exhibit 4** shows, ZIP Code 37135 has a rapidly growing, though less dense population. Currently, these patients face significant drive times in congested traffic to seek care at other existing EDs, namely Southern Hills and/or Century Farms FSED, which are already serving densely populated communities. Nolensville FSED is strategically positioned on the border of ZIP Code 37135 and ZIP Code 37027 (as well as Nashville/Davidson and Williamson Counties); it will be accessible to residents who currently face travel barriers to ED services, decreasing travel time to access care, which is vital in emergent cases thereby addressing the portions of the proposed service area that are geographically isolated.

Exhibit 3
2023 Population by ZIP Code Service Area Map



Source: Maptitude and Spotlight

Please see additional detailed discussion of ED access for residents of the service are provided in **Attachment 1N**.

Southern Hills' Care Provided to Residents of the Proposed Service Area

The Southern Hills ED treats approximately 40,000 ED patients annually. Approximately 65 percent of these patients reside in the defined ZIP Code service area. In its first full year of operation, Century Farms FSED, a satellite of Southern Hills, served 15,000 ED visits. Over 70 percent of these patients reside in the defined ZIP Code service area. Southern Hills and Century Farms care for over 40 percent of all patients from the service area ZIP Codes who seek emergency care, more than any other provider in the area. Collectively, TriStar Health affiliates serve almost 64 percent of ED patients from the service area ZIP Codes.

The proposed service area is based on the geographic proximity of the ZIP Codes surrounding the proposed FSED location and the patient origin of Southern Hills' existing ED patients. **Figure 1N-4** provides a map that shows the areas from which TriStar affiliates Southern Hills, Century Farms FSED, and TriStar StoneCrest Medical Center ("StoneCrest") patients came during CY 2021 and CY 2022. **Figure 1N-4** also confirms that many service area patients who currently seek care at existing TriStar facilities will be closer to the proposed FSED. These three facilities serve the most residents from the service area ZIP Codes. The Nolensville FSED will likely result in many patients who live closer to the FSED than Southern Hills choosing to go to the FSED instead of Southern Hills, thereby helping to ease the burden of the high utilization of Southern Hills main ED.

Southern Hills has had success in alleviating some of its constraints with the opening of Century Farms FSED in June 2021. During its first year and a half of operation, the Century Farms FSED has been tremendously successful and is already seeing high volumes of patients. This high utilization has come from increasing local demand coupled with the slight decrease in ED volume at Southern Hills. However, Southern Hills is still experiencing ED constraints – the ED's utilization far exceeds ACEP guidelines, and the ED experiences the highest number of ED visits per treatment room in the service area. Within its first full year of operation, the Century Farms FSED is also exceeding ACEP visit per room guidelines.

Patients who use the Southern Hills ED will clearly benefit from freeing up capacity there. Capacity limitations at Southern Hills are exacerbated by a high percentage of behavioral health patients (8.3 percent) and behavioral health hold patients waiting for a bed, which average 4 to 6 patients per day. As a result, Southern Hills has dedicated two former ED rooms for behavioral health hold rooms and is operating just 21 ED treatment rooms. Now, Southern Hills is providing almost 1,900 visits per room in 21 treatment rooms. This results in long wait times particularly for higher acuity patients. Southern Hills staff works hard to ensure lower acuity patients are seen and discharged as quickly as possible resulting in reasonable average wait times; however, higher acuity patients face long delays. For example, for CY 2022 Southern Hills outpatient ED visit with an ESI of 3 (middle acuity) had an average visit duration or discharge LOS of 193.7 minutes or 3.22 hours. ESI 2 patients, higher acuity, experienced an average discharges LOS of 553.1 minutes or 9.21 hours. These represent average wait times. As discussed in **Attachment 1N**, patients arriving in the afternoon and evening at surge times face even long delays. During these peak or surge hours, Century Farms census of ED patients far exceeds its 21 ED treatment rooms.

The addition of capacity that the proposed Nolensville FSED allows Southern Hills to continue providing high-quality ED care to patients. The proposed project will not only continue to offload some of Southern Hills ED volume but also offer a much-needed improvement in access to ED services for service area residents, especially those living in the southern portion of the service area who currently do not have adequate access to ED services in or near their community. This improved access will become even more important as the service area continues to grow rapidly with the planned economic and residential development in the proposed service area.

Service Area Historical and Projected Utilization – Southern Hills Medical Center and Proposed FSED

The tables below provide the historical utilization from the service area ZIP Codes at the existing Southern Hills ED as well as the total projected utilization at the main Southern Hills ED and the proposed FSED. Note that both tables include in-migration from outside of the proposed service area. The historical data in these tables are for the full ZIP Codes in the service area. However, the Applicant did factor into the projections that most patients will come from the geographically isolated portions of the service area based on shifted market share (See **Exhibit 2**).

Complete the following utilization tables for each county in the service area, if applicable.

Unit Type: ☐ Procedures ☐ Cases ☐ Patients ☑ Other (Specify): ED Visits		
Service Area Zip Codes - Zip Code Name	**Historical Utilization Service Area Residents - Southern Hills/Century Farms – Most Recent (Year = CY 2022)**	**% of Total**
37013 - Antioch	19,428	35.9%
37211 - S. Nashville	15,232	28.2%
37027 - Brentwood	916	1.7%
37135 - Nolensville	397	0.7%
Service Area Subtotal	**35,973**	**66.6%**
Other Davidson County	10,461	19.4%
Other Williamson	306	0.6%
All Other TN	5,578	10.3%
All Other Out of State	1,618	3.0%
Unknown	113	0.2%
Total	**54,049**	**100.0%**

Source: Internal Data, CY 2022 (Internal Data ZIP Code does not align with market data due to variance of sources)
Totals may not foot due to rounding.

Unit Type: ☐ Procedures ☐ Cases ☐ Patients ☑ Other (Specify): ED Visits		
Service Area Zip Codes - Zip Code Name	**Projected Utilization Service Area Residents – Nolensville FSED - Year 1 (Year = 4/25 - 4/26)**	**% of Total**
37013 - Antioch	3,788	35.7%
37211 - S. Nashville	3,388	32.0%
37027 - Brentwood	991	9.3%
37135 - Nolensville	845	8.0%
Service Area Subtotal	**9,012**	**85.0%**
All Other	1,590	15.0%
Total	**10,602**	**100.0%**

Totals may not foot due to rounding.

Unit Type: ☐ Procedures ☐ Cases ☐ Patients ☑ Other (Specify): ED Visits		
Service Area Zip Codes - Zip Code Name	**Projected Utilization Service Area Residents – Southern Hills/Century Farms & Nolensville FSED - Year 1 (Year = 4/25 - 4/26)**	**% of Total**
37013 - Antioch	21,113	34.9%
37211 - S. Nashville	16,127	26.7%
37027 - Brentwood	1,626	2.7%
37135 - Nolensville	1,117	1.8%
Service Area Subtotal	**39,983**	**66.1%**
All Other	20,468	33.9%
Total	**60,451**	**100.0%**

Totals may not foot due to rounding.

Please see the projected utilization by ZIP Code assumptions provided in response to **Question 6N** below. The service area contains two high density ZIP Codes, South Nashville and Antioch, and two less dense but rapidly growing ZIP Codes Nolensville and Brentwood/Brentioch. This population density and the resultant demand combine with the anticipated shift of volume from Southern Hills, Century Farms FSED and other existing EDs to result in the projected utilization below. **Exhibit 14**, shown later, provides the projected market share from each ZIP Code expected to be served by the FSED.

3N. A. Describe the demographics of the population to be served by the proposal.

The following section describes in detail the population and demographic characteristics of the proposed ZIP Code service area.

Population

Population estimates for 2023 through 2028 were obtained from Claritas Spotlight. As shown in **Exhibit 4** below, the Nolensville FSED's service area is projected to grow from 264,662 residents in 2023 to 277,280 residents by 2028, representing a 4.6 percent population growth.

Further, the elderly population in the service area is projected to grow significantly; from 2023 to 2028, the 65 and older population is projected to grow by 18.7 percent. The elderly population residing in ZIP Code 37013, the largest ZIP Code in the service area, is projected to grow by 20.6 percent over the next five years. The rapid growth and aging of the service area population will result in increased demand for healthcare services including emergency services. This is particularly true for the elderly population, which has been documented to have a higher incidence of emergency conditions than any other age cohort.[3]

Exhibit 4
2023-2028 Service Area Population by Age Group

Zip Code	Age 0-17	Age 18-44	Age 45-64	Age 65+	Total
2023					
37013 (Antioch, TN)	23,311	43,567	20,462	8,936	96,276
37027 (Brentwood, TN)	14,836	19,256	18,200	11,503	63,795
37135 (Nolensville, TN)	6,505	7,665	6,349	2,608	23,127
37211 (Nashville, TN)	19,957	35,827	16,847	8,833	81,464
Total Service Area	**64,609**	**106,315**	**61,858**	**31,880**	**264,662**
2028					
37013 (Antioch, TN)	25,069	42,004	21,759	11,253	100,085
37027 (Brentwood, TN)	14,439	21,374	17,991	14,022	67,826
37135 (Nolensville, TN)	6,809	8,596	7,269	3,709	26,383
37211 (Nashville, TN)	20,924	33,834	17,996	10,232	82,986
Total Service Area	**67,241**	**105,808**	**65,015**	**39,216**	**277,280**
Percent Growth					
37013 (Antioch, TN)	7.0%	-3.7%	6.0%	20.6%	3.8%
37027 (Brentwood, TN)	-2.7%	9.9%	-1.2%	18.0%	5.9%
37135 (Nolensville, TN)	4.5%	10.8%	12.7%	29.7%	12.3%
37211 (Nashville, TN)	4.6%	-5.9%	6.4%	13.7%	1.8%
Total Service Area	**3.9%**	**-0.5%**	**4.9%**	**18.7%**	**4.6%**

Source: 2023 Claritas Spotlight

[3] Ukkonen, M., Jämsen, E., Zeitlin, R., & Pauniaho, S. L. (2019). Emergency department visits in older patients: a population-based survey. *BMC emergency medicine*, *19*(1), 20. https://doi.org/10.1186/s12873-019-0236-3

Service Area Race and Ethnicity

The service area includes portions of two Metro Nashville ZIP Codes with a high percentage of minority populations, as shown in **Exhibit 5**. In particular, ZIP Codes 37013 and 37211 have a high percentage of minority (non-white) residents. ZIP Code 37013 is comprised of almost 66.8 percent minority populations (non-white), 33.9 percent of which are Black or African American. ZIP Code 37211 is comprised of 51.3 percent minority (non-white) populations, with 28.5 percent of residents identifying as "other race" and 14.1 percent of residents who are Black or African American. In terms of ethnicity, 25.5 percent of ZIP Code 37013 and 28.2 percent of ZIP Code 37211 residents identify as Hispanic. Portions of both ZIP Code 37013 and 37211 are included in the geographically isolated area that is the focus of the proposed FSED. The proposed FSED will improve access to minority populations in two ways: 1) it will bring ED services closer to geographically isolated portions of the service area, and 2) it will create additional capacity at the Southern Hills ED and the Century Farms FSED, which are in the densely populated portions of the service area.

Exhibit 5
2023 Racial and Ethnic Demographics of the Service Area Population

Zip Code	American Indian	Asian	Black or African - American	Native Hawaiian or Pacific Islander	White or Caucasian	Other Race	Total All Races	Hispanic
37013 (Antioch, TN)	823	5,450	32,653	53	31,960	25,337	96,276	24,559
37027 (Brentwood, TN)	92	5,140	2,591	16	50,707	5,249	63,795	2,515
37135 (Nolensville, TN)	34	1,596	1,497	12	17,620	2,368	23,127	1,271
37211 (Nashville, TN)	922	6,022	11,526	53	39,687	23,254	81,464	22,968
Total Service Area	**1,871**	**18,208**	**48,267**	**134**	**139,974**	**56,208**	**264,662**	**51,313**
Zip Code	**American Indian**	**Asian**	**Black or African - American**	**Native Hawaiian or Pacific Islander**	**White or Caucasian**	**Other Race**	**Total All Races**	**Hispanic**
37013 (Antioch, TN)	0.9%	5.7%	33.9%	0.1%	33.2%	26.3%	100.0%	25.5%
37027 (Brentwood, TN)	0.1%	8.1%	4.1%	0.0%	79.5%	8.2%	100.0%	3.9%
37135 (Nolensville, TN)	0.1%	6.9%	6.5%	0.1%	76.2%	10.2%	100.0%	5.5%
37211 (Nashville, TN)	1.1%	7.4%	14.1%	0.1%	48.7%	28.5%	100.0%	28.2%
Total Service Area	**0.7%**	**6.9%**	**18.2%**	**0.1%**	**52.9%**	**21.2%**	**100.0%**	**19.4%**

Source: 2023 Claritas Spotlight. Note: Hispanic is considered an ethnicity not a race.

The race/ethnicity of the communities that Southern Hills and Century Farms serve are reflective of the area demographic shown above. **Exhibit 6** presents the CY 2022 race data for ED visits from the ZIP Code service area residents served by Southern Hills and Century Farms EDs and demonstrates the diversity of resident of the proposed service area served by Southern Hills and Century Farms ED. Southern Hills' staff also represents this diversity at all levels with staff representing 65 countries with 35 languages spoken. The Nolensville FSED will also be accessible to racial and ethnic minorities in the service area consistent with the practices of Southern Hills and Century Farms ED patients.

Exhibit 6
Southern Hills and Century Farms FSED
ED Visit from the Nolensville FSED Service Area ZIP Codes
by Race – CY 2022

Race	Southern Hills	Century Farms
Other*	36.9%	22.3%
White	30.6%	28.1%
Black or African American	26.9%	43.7%
Asian	3.6%	3.7%
American Indian	0.1%	0.1%
Alaskan Native	0.1%	0.2%
Unknown	1.8%	1.8%
Total	**100.0%**	**100.0%**
% Non-White	**69.4%**	**71.9%**

Source: Internal data.
Other includes Hispanic/Latino patients that do not identify as Black and patients with more than one race as well as other races.

Service Area Low Income and Uninsured Residents

An important component of the proposed project is increasing access to care by reducing financial barriers. As shown in **Exhibit 7**, 12.1 percent of service area residents are below the poverty level, according to the U.S. Census Bureau. This is significantly higher than the percentage of residents in Williamson County who are below poverty level, which is 3.9 percent. Notably, service area ZIP Codes 37211 and 37013 – the location of Southern Hills and Century Farms EDs, with 17.1 percent and 15.6 percent, respectively – have a higher percentage of residents below the poverty level than Nashville/Davidson County (14.3 percent) and Tennessee (14.3 percent). Portions of these two ZIP Codes are included in the geographically isolated areas that are the target of the proposed FSED in terms of increased access to care.

While many of the densely populated areas are in the northern portions of ZIP Codes 37211 and 37013, Southern Hills and the Century Farms FSED are located in those areas and are very highly utilized. By locating the proposed FSED to the south in Nolensville, it is expected that some of the ED visits going to Southern Hills and Century Farms will choose to go to the Nolensville FSED and will thus alleviate some of the capacity pressure at Southern Hills and Century Farms. By having the Nolensville FSED, in other words, access to ED care in the more densely populated areas in the northern part of ZIP Codes 37211 and 37013 will be improved to the benefit patients in the in those communities.

Research shows that individuals with lower incomes consistently experience worse health outcomes than individuals with higher incomes and those living in poverty. Individuals who live in low-income or high-poverty neighborhoods are likely to experience poor health due to a combination of these socioeconomic factors, including limited access to proper nutrition and healthy foods, shelter, utilities, and other elements.[4] Further, those living below poverty levels also tend to have limited access to personal transportation.[5] By alleviating capacity constraints a Southern Hills and Century Farms as well as adding a new access point, the proposed project will increase access to patients who are more likely to need emergent care and have limited access to transportation to access existing EDs that are further away from their communities.

[4] https://www.aafp.org/about/policies/all/poverty-health.html
[5] https://nhts.ornl.gov/briefs/PovertyBrief.pdf

Exhibit 7

Service Area Poverty Level

Area	% of Persons Below Poverty Level
ZIP Code 37013	17.1%
ZIP Code 37027	3.6%
ZIP Code 37135	0.8%
ZIP Code 37211	15.6%
Total Service Area	**12.1%**
Davidson County	**14.3%**
Williamson County	**3.9%**
Tennessee	**14.3%**

Source: U.S. Census Bureau, 2021: ACS 5-Year Estimates Subject Tables: Poverty Status In The Past 12 Months

The income levels of the communities that Southern Hills and Century Farms serve are reflected in the payor mix for the Southern Hills and Century Farms EDs. **Exhibit 8** presents the CY 2022 payor mix of ED visits for ZIP Code service area residents. Alleviating capacity constraints at Southern Hills and Century Farms will ensure that these communities will have access to plenty of ED capacity to meet current and growing demand. The Nolensville FSED will be accessible to low income populations (TennCare/Medicaid and Uncompensated Care) patients, who represent 63.2 percent and 59.9 percent of visits at Southern Hills and Century Farms, respectively.

Exhibit 8

Southern Hills and Century Farm FSED

ED Visits from the Nolensville FSED Service Area ZIP Codes

By Payor Mix – CY 2022

Payor	**Southern Hills**	**Century Farms**
TennCare/Medicaid	34.4%	45.7%
Uncompensated Care*	28.8%	14.1%
Commercial/Managed Care	20.4%	31.5%
Medicare	16.3%	8.7%
Total	100.0%	100.0%
Total TennCare/Medicaid & Uncompensated Care	**63.2%**	**59.9%**

Source: Internal data.

**Charity care and uninsured.*

As a hospital emergency room operating under the Southern Hills license, the Nolensville FSED will care for all who need emergency care. As previously established, the proposed Nolensville FSED will be part of the larger TriStar Health network, which requires all facilities within its system to adhere to all financial assistance and charity/indigent care policies. Financial relief is available to those patients who have received non-elective care and do not qualify for state or federal assistance and are unable to establish partial payments or pay their balance. Moreover, all self-pay patients will receive a discount similar to managed care, referred to as an "uninsured discount." The Uninsured Discount is available to patients who have no third-party payer source of payment or do not qualify for Medicaid, Charity, or any other discount program the facility offers. See **Attachment 4N-1** for the Uninsured Discount and Charity Care Write Off Policies. See **Attachment 4N-3** for Discount Policy for Patients.

B. Provide the following data for each county in the service area:

- Using current and projected population data from the Department of Health. (www.tn.gov/health/health-program-areas/statistics/health-data/population.html);
- the most recent enrollee data from the Division of TennCare (https://www.tn.gov/tenncare/information-statistics/enrollment-data.html),
- and US Census Bureau demographic information (https://www.census.gov/quickfacts/fact/table/US/PST045219).

Note that the Department of Health Statistics and TennCare does not provide data on a ZIP Code level. Southern Hills has defined the proposed service area at a ZIP Code level; however, the table below provides the population and demographic data at the county level in which each service area ZIP Code is located for comparative purposes. Notably, the total service area is growing faster than Nashville/Davidson County and Tennessee; however, ZIP Code 37135 is growing significantly faster than the total service area, Nashville/Davidson County, Williamson County, and the state. As previously discussed, the service area also has a significant percentage of residents below the poverty level. See **Attachment 3N** for U.S. Census Bureau Data used in the table below.

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Census Bureau**				TennCare***	
	Total Population-Current Year (2023)	Total Population-Projected Year (2027)	Total Population-% Change	*Target Population-Current Year (2023)	Target Population-Project Year (2027)	Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
37013	96,276	100,085	4.0%	96,276	100,085	4.0%	100.0%	31.5	$ 61,801	17,317	17.1%		
37027	63,795	67,826	6.3%	63,795	67,826	6.3%	100.0%	42.5	$ 135,284	2,156	3.6%		
37135	23,127	26,383	14.1%	23,127	26,383	14.1%	100.0%	36.9	$ 131,594	161	0.8%		
37211	81,464	82,986	1.9%	81,464	82,986	1.9%	100.0%	33.0	$ 61,781	11,329	15.6%		
Service Area Total	**264,662**	**277,280**	**4.8%**	**264,662**	**277,280**	**4.8%**	**100.0%**			**30,963**			
Nashville/Davidson County	**722,445**	**746,905**	**3.4%**	**722,445**	**746,905**	**3.4%**	**100.0%**	**34.6**	**$ 66,047**	**98,412**	**14.3%**	**161,818**	**22.4%**
Williamson County	**264,071**	**295,116**	**11.8%**	**264,071**	**295,116**	**11.8%**	**100.0%**	**39.5**	**$ 116,429**	**9,420**	**3.9%**	**16,841**	**6.4%**
State of TN Total	**7,071,060**	**7,331,859**	**3.7%**	**7,071,060**	**7,331,859**	**3.7%**	**100.0%**	**38.8**	**$ 58,516**	**955,929**	**14.3%**	**1,736,417**	**24.6%**

*Target Population is population that project will primarily serve. For example, nursing home, home health agency, and hospice agency projects typically primarily serve the Age 65+ population. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2023, then default Projected Year is 2027.
Be sure to identify the target population, e.g. Age 65+, the current year and projected year being used.
The target population is the same as total population for this application.

***Most recent 2021 data. Note % of population below poverty is calculated by the US Census Bureau and will not equal the percent of the population from the Department of Health. The Census Bureau does not calculate a weighted average of the medians for the service area counties, nor is the data available to calculate a weighted median.*

****Data from Decemeber 2022*

Note: Used Spotlight Data for ZIP Codes and total service area

4N. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly those who are uninsured or underinsured, the elderly, women, racial and ethnic minorities, TennCare or Medicaid recipients, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

The proposed FSED will address the emergency care needs of the service area population. The service area is rapidly growing and aging. The service area has a high percentage of low income and minority populations, who are already served by Southern Hills' ED and the Century Farms FSED. The proposed Nolensville FSED will service a portion of the existing service area already served by these EDs bringing services closer to home for a geographically isolated area. The proposed FSED is also expected to alleviate capacity constraints at Southern Hills' ED and the Century Farms FSED. This will allow Southern Hills to better serve its existing base of patients, including minority and low-income patients, as the area grows.

In accordance with the Southern Hills' practice, and applicable Federal and State law, all patients presenting at the proposed FSED with emergency care needs will be served without regard to age, gender, race, ethnicity, income, insurance, or ability to pay – just as they are being served at the Southern Hills main hospital ED. As previously discussed, the proposed Nolensville FSED will be part of TriStar Health, which requires all facilities within it to adhere to all financial assistance and charity/indigent care policies. Financial relief is available to those patients who have received non-elective care and do not qualify for state or federal assistance and are unable to establish partial payments or pay their balance. Moreover, all self-pay patients will receive a discount similar to managed care, referred to as an "uninsured discount." The Uninsured Discount is available to patients who have no third-party payer source of payment or do not qualify for Medicaid, Charity, or any other discount program the facility offers.[6] See **Attachment 4N-1** for the Underinsured Discount and Charity Write Off Policies. See **Attachment 4N-3** for Discount Policy for Patients.

The proposed FSED will not discriminate in its service to any patient. The proposed FSED will serve all patients regardless of race and ethnicity consistent with Southern Hills policies and experience. The proposed service area is comprised of 18.2 percent African American and 19.4 percent Hispanic Population. Please see **Attachment 4N-2** for the Non-Discrimination Policy that will apply to the FSED.

As such, Southern Hills has vast experience serving a clinically diverse patient population as presented in **Exhibit 6** above. As the hospital of choice for this community, residents already seek care at the main hospital location. Southern Hills is very active in the Nashville Community and includes having multiple important relationships in the service area. Southern Hills' strong community relationships are demonstrated by the significant support from community leaders as noted throughout this application and in the letters of support in **Attachment 6N.** See **Attachment 1N Question 18** for a list of Southern Hills' community linkages.

These are just some of the ways in which Southern Hills addresses community need beyond just direct care to TennCare and low-income groups. Moreover, Southern Hills has diverse employees, medical staff, and Board composition that mirrors the community it serves. The proposed ED will serve all patients in the service area that present and will enhance access to care for the growing Nolensville area by adding a new access point for ED services, relieving capacity constraints for patients continuing to seek care at Southern Hills.

Note that the applicant has no way to control or predict the type of patients (i.e., behavioral health patients) that will choose to present at the proposed FSED. The largest percentage of patients are expected to be walk-in patients who choose to visit the FSED to treat a variety of diagnoses for a variety of reasons

[6] https://tristarhealth.com/patient-financial/charity-policy

whether it be proximity to home or the expectation of timely travel or timely access to care. It is expected that EMS patients will also utilize the facility, and the EMS provider will determine which patients are appropriate given the patient's condition, location, patient choice, and a variety of other factors.

TriStar Southern Hills expects that the types of patients that seek care at existing TriStar-affiliated FSEDs will also seek care at the proposed FSED. A review of the principal diagnosis of the FSED patient visits seen by TriStar affiliated FSEDs for 2022 includes 4,530 different principal diagnoses. For this reason, it is very difficult to anticipate what types of patients will present to the proposed FSED. For this time period, the top five diagnoses included:

- COVID-19
- Acute upper respiratory infection, unspecified
- Viral infection, unspecified
- Other chest pain
- Urinary tract infection, site not specified

These top 5 diagnoses represent just 14.2 percent of all patients seen, emphasizing the diverse patient base treated at TriStar FSEDs. Thus, it would be almost impossible to fully categorize or predict the range of patients that will present at the proposed FSED. To provide a relevant example, in 2022, Century Farms FSED provided the following visits:

- Cardiac Arrest – 11 patient visits
- Other Cardiac – 872 patient visits
- Neurology – 620 patient visits
- Spine – 302 patient visits
- Traumatic Injuries (not requiring trauma level care -orthopedic fractures, limb injuries, superficial injuries) – 3,336 patient visits

Please see additional discussion care for time sensitive emergencies such as cardiac arrest, stroke, and sepsis in **Attachment 1N**.

5N. Describe the existing and approved but unimplemented services of similar healthcare providers 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. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days. Average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This does not apply to projects that are solely relocating a service.

Service Area County Emergency Care Providers

The proposed FSED location is in Williamson County on the Nashville/Davidson County line. In the proposed service area ZIP Codes, Southern Hills and Century Farms FSED are the only emergency care providers. The ED providers in Nashville/Davidson and Williamson Counties[7] are:

- Metro Nashville General Hospital
- Saint Thomas Midtown Hospital
- Saint Thomas West Hospital
- TriStar Centennial Medical Center
    - TriStar Bellevue FSED a campus of TriStar Centennial *(approved, but not open)*
- TriStar Skyline Medical Center
- TriStar Southern Hills Medical Center
    - TriStar Century Farms FSED a campus of TriStar Southern Hills
- TriStar Summit Medical Center
- Vanderbilt University Medical Center
- Williamson Medical Center

Trends in utilization for these providers, the impact of COVID-19 on ED visit volume, and the subsequent rebound in ED usage are discussed in detail in **Attachment 1N**. Also discussed are the long ED wait times at several Nashville/Davidson County ED providers and the high level of utilization in relation to ACEP guidelines at many area EDs. Finally, ED diversion data is presented to show that most EDs in the area also experience capacity constraints resulting in ED diversion, which limits access to care.

As previously stated, the highly utilized Southern Hills and Century Farms EDs are the only EDs in the service area ZIP Codes. However, patients in Nolensville and Brentwood/Brentioch (ZIP Codes 37135 and 37027) do not have an ED in their local ZIP Code, and the drive times specifically to local EDs from these ZIP Codes can be lengthy and unpredictable due to heavy traffic. **Figure 1N-5** shown in **Attachment 1N** demonstrates the significant impact that traffic can have on travel times to the existing EDs surrounding the proposed service area, including a geographically isolated area (See **Exhibit 2**). Traffic can add anywhere from 5 to 23 minutes to travel times for service area residents (See **Figure 1N-5**).

Because Southern Hills and Century Farms are the most proximal ED providers, service area residents rely most heavily on these two facilities for their ED care. Accordingly, both facilities are highly utilized well beyond ACEP guidelines. Between 2020 and 2022, Southern Hills and Century Farms collectively experienced almost 40 percent growth in ED visit volume. In 2022, its first full year of operation, Century Farms provided over 15,000 visits. With currently high utilization levels and expected population growth, it is quite evident that additional ED capacity is needed in the proposed service area. Please see **Attachment 1N** for further discussion. The development of the proposed Nolensville FSED will both increase local access to care and plan for more capacity to meet growing demand.

[7] Outside of Nashville/Davidson and Williamson Counties, TriStar Summit Medical Center operates a FSED in Mt. Juliet (Wilson County), and TriStar Centennial Medical Central operates an FSED in Spring Hill (Maury County on the border of Williamson County), neither of which are located in the service area nor in Nashville/Davidson and Williamson Counties.

Nashville/Davidson County Hospital ED Diversion Experience

Diversion status indicates that a hospital is in some way unable to accept patients through its emergency department due to capacity constraints. The Metro Nashville/Davidson County Fire Department EMS maintains logs of hospital diversion status and provides monthly summaries to the leadership of area hospitals. These reports are instructive as a way to identify capacity constraints that impact access to emergency services. **Exhibit 9** provides the ED diversion hours for all Nashville/Davidson County EDs from CY 2021 to CY 2022. Note that Williamson County diversion data is not publicly available and could not be obtained.

Exhibit 9 demonstrates that all the major Nashville hospitals, especially both trauma centers – VUMC and Skyline, experienced significant diversion between CY 2021 and CY 2022. On average, VUMC has been on diversion over 75 percent of the time over the past two years, while Skyline has been on diversion approximately 20 percent of the time.

There are a variety of factors that have contributed to the increase in diversion hours across TriStar Hospitals in Nashville/Davidson County. Like many area hospitals, TriStar Hospital EDs are still rebounding from the impact of COVID impacting overall volume. In addition, various surges in COVID have resulted in peaks in diversion status at various times over the last several years. The Delta variant of COVID-19 began to surge in July 2021. The hospitals are also treating more complex patients due to patient delays in seeking routine and low acuity care during the early phases of COVID-19.

See additional discussion related to the impact of ED diversion on capacity in **Attachment 1N**.

The diversion data presented herein demonstrates the need for improved access to ED capacity in the overall community. While Southern Hills does not experience significant diversion, it is highly utilized and capacity constrained, which can be inconvenient for the patient. Century Farms FSED, as previously stated, is also highly utilized and simply does not have the capacity to treat all of the patients in the service area in need of ED services. Thus, if patients decide to seek care at other area EDs, they must travel long distances in congested traffic only to find potentially that many area EDs are not accepting ED patients due to diversion. The proposed FSED will provide a much-needed access point for ED care for service area residents and increased ED capacity in the county overall.

Exhibit 9

2021 - 2022 Monthly ER Diversion Data (in Hours)

Month	Vanderbilt University Medical Center	TriStar Skyline	TriStar Summit	Saint Thomas Midtown	Saint Thomas West	TriStar Southern Hills	TriStar Centennial	Nashville General	Century Farm FSED
Jan-21	507.6	28.2	83.3	307.9	728.6	1.8	0.0	129.4	
Feb-21	340.8	1.5	32.8	9.8	12.9	0.0	0.0	87.8	
Mar-21	617.1	18.5	101.3	24.1	83.8	0.0	51.8	265.6	
Apr-21	517.6	25.4	78.0	45.5	303.3	0.0	48.0	0.0	
May-21	660.1	25.0	136.3	156.4	98.4	0.0	0.0	0.0	
Jun-21	586.8	24.4	124.8	68.5	425.7	3.4	7.3	0.0	0.0
Jul-21	589.9	63.3	156.5	40.3	180.1	127.2	40.9	0.0	116.1
Aug-21	381.1	161.5	355.8	118.0	74.4	303.6	204.1	5.8	0.0
Sep-21	310.3	297.3	375.5	75.9	32.0	317.7	176.4	14.1	1.8
Oct-21	636.9	168.7	249.8	44.6	18.2	84.3	65.4	45.6	0.0
Nov-21	549.2	144.8	158.9	80.9	22.6	17.8	6.7	0.0	22.8
Dec-21	540.7	246.3	328.5	66.7	108.7	33.7	24.2	0.0	0.0
Jan-22	468.3	219.6	241.0	48.6	30.3	59.2	14.0	7.2	1.6
Feb-22	558.5	211.4	46.8	47.0	17.1	0.0	12.0	0.0	0.0
Mar-22	634.8	17.6	110.3	13.1	0.0	0.0	0.0	0.0	0.0
Apr-22	673.6	109.8	0.0	58.3	3.8	3.7	5.7	0.0	0.0
May-22	559.4	160.7	10.8	62.8	7.6	4.1	149.6	0.0	29.4
Jun-22	668.5	167.7	70.3	92.6	43.8	0.0	1.4	0.0	0.0
Jul-22	500.9	275.5	13.4	105.7	7.9	10.5	28.4	0.0	5.4
Aug-22	490.0	319.6	5.2	204.8	66.1	3.7	84.4	0.0	0.0
Sep-22	695.2	277.5	2.8	114.9	34.4	7.5	27.4	0.0	0.0
Oct-22	703.3	148.6	81.8	56.6	52.2	0.0	12.0	0.0	0.0
Nov-22	487.7	96.0	152.0	129.4	73.9	0.0	2.2	19.2	0.0
Dec-22	403.5	131.2	338.4	102.0	**67**	**-**	4.3	**-**	285.7
Total Hours	**13,082**	**3,340**	**3,254**	**2,074**	**2,493**	**978**	**966**	**575**	**463**
Average Monthly Hours	**545**	**139**	**136**	**86**	**104**	**41**	**40**	**24**	**24**
Avg % of Time on Diversion	**74.7%**	**19.1%**	**18.6%**	**11.8%**	**14.2%**	**5.6%**	**5.5%**	**3.3%**	**3.3%**

Source: Nashville/Davidson County EMS

Service Area Urgent Care Providers Are Not an Alternative

Minor, non-emergent conditions are often served in an urgent care center ("UCC") or physician's office. It is important to note that UCCs are not equipped to provide emergency care and therefore are not a substitute for the proposed FSED for multiple reasons. UCCs are not licensed acute care facilities. They are not required to and do not care for all comers. They do not publicly report utilization. For medical emergencies, they are not acceptable alternatives to a hospital-operated emergency room. Moreover, UCCs are not open 24 hours a day. Another important distinction between a hospital affiliated FSED and a UCC relates to the obligation to serve all patients regardless of ability to pay and meet EMTALA requirements. A UCC has no obligation to do so. By contrast, hospital affiliated FSEDs are required to serve all patients regardless of ability to pay. Below is a list of urgent care centers and walk-in clinics in the proposed service area:

- CareNow Urgent Care – Nolensville (37135) - TriStar affiliate
- CareNow Urgent Care – Antioch (37013) – TriStar affiliate
- CareNow Urgent Care – Brentwood (37027) – TriStar affiliate
- Urgent Care Group (37027)
- CareNow Urgent Care – Brentwood Health Park (37027) – TriStar affiliate
- Physicians Urgent Care (37027)
- AFC Urgent Care Nashville South (37211)
- The Little Clinic – Nolensville (37027)
- Vanderbilt Health and Williamson Medical Center Walk-In Clinic – Nolensville (37135)
- Nolensville Clinic (37135)
- Southern Hills Specialty Clinic (37027) – an affiliate of Southern Hills Medical Center
- Minute Clinic at CVS (37027)
- The Little Clinic – Franklin (37027)
- Vanderbilt Health and Williamson Medical Center Walk-In Clinic – Brentwood (37027)
- America's Family Doctor & Walk In Clinics (37027)
- Hills Side Medical Clinic (37027)
- Edmondson Pike Family Practice (37211)
- Cape Sierra Clinic LLC (37211)
- Knolls Place Medical Clinic (37211)

UCCs only offer limited services. The below table compares services that are typically available in emergency rooms compared to those of UCCs. It is evident that UCCs do not provide emergency care and are therefore not effective alternatives to FSEDs. The following chart provides some examples of the types of patients that can appropriately be seen at an FSED that are inappropriate for a UCC. For these reasons, UCCs in the area are not an alternative and cannot address the access issues that service area patients face for emergency care.

Capabilities of the Emergency Department Compared to Typical Urgent Care Center			
Conditions	Urgent Care	Southern Hills Campus ED	Proposed Nolensville FSED
Stroke	X	✓	✓
Severe Chest Pain	X	✓	✓
Traumatic Injuries	X	✓	✓
EMS Offload	X	✓	✓
Advance Life Support	X	✓	✓
Deep Puncture Wounds	X	✓	✓
Complex Radiological Services	X	✓	✓
Patients in Labor	X	✓	✓
Complex Lab Services	X	✓	✓
Complex Imaging Services	X	✓	✓

The following photograph shows an example of TriStar Health FSED treatment room and some of the typical equipment available in an FSED that clearly is not available in an urgent care center. Based on capability, equipment, facility design, and operational licensure requirements, a UCC is not an alternative for an FSED much less a hospital ED. With the same quality of care and accreditation standards as a hospital-based ED, FSEDs are able to see patients faster than traditional emergency rooms. This can mean the difference between life and death for someone experiencing a medical crisis. As presented in **Attachment 1N**, TriStar Health FSEDs serve all patients in all ED acuity levels and are open 24 hours a day, 7 days a week.

> *"With limited road infrastructure and an increasingly high traffic volume, transit times to the three closest ER facilities (Tristar Southern Hills, Tristar StoneCrest, and Williamson Medical Center) are getting longer. An ER facility in the Nolensville, SE Davidson and East Brentwood area would provide just-in-time medical intervention.*
>
> *A dog attacked my 86-year-old mother-in-law in her hand and arms. She was bleeding profusely, with tears to skin and flesh. She required medical intervention that was beyond the scope of an urgent clinic. We had to travel almost a half-hour with no ER nearby to receive initial medical intervention. Eventually, she was transported to Nashville for specialist care. It was a close call. We were lucky. Others facing time and distance delays might not be as lucky."*
>
> *Jeff Glick*
> *Nolensville Resident*

FSED Treatment Room Example

1. **Adult Resuscitation/Intubation Cart**
2. **Pediatric Resuscitation/Intubation Cart**
3. **Cardiac Monitor**
4. **Rapid Blood Infuser**
5. **Critical Equipment / Supplies**
    a) Pediatric / Adult Ventilator
    b) Cricothyrotomy Kit
    c) Chest Tube Kit
    d) Central Lines
    e) Foley Catheters
6. **Pyxis: Critical Medications**

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

Historical Utilization – Southern Hills and Century Farms FSED

Exhibit 10 provides the historical trend in ED visits from 2020 through 2022 for Southern Hills, the host hospital. Southern Hills provided 38,866 visits in 2022 in 23 ED reported treatment rooms or 1,690 visits per room, well over ACEP guidelines for a facility of this size. In reality, Southern Hills is only able to operate 21 ED treatment rooms as two rooms are permanently used for behavioral health holding. With just 21 rooms, Southern Hills is providing 1,851 visits per room annually, which far exceeds ACEP guidelines. Southern Hills is the highest utilized ED (on a visits per room basis) in Nashville/Davidson and Williamson Counties. From 2020 to 2022, Southern Hills experienced a 0.4 percent increase in ED visits; however, during this period Southern Hills opened the Century Farms FSED. Collectively, Southern Hills and Century Farms have experienced almost a 40 percent increase in ED volume and are operated at well above pre-COVID levels.

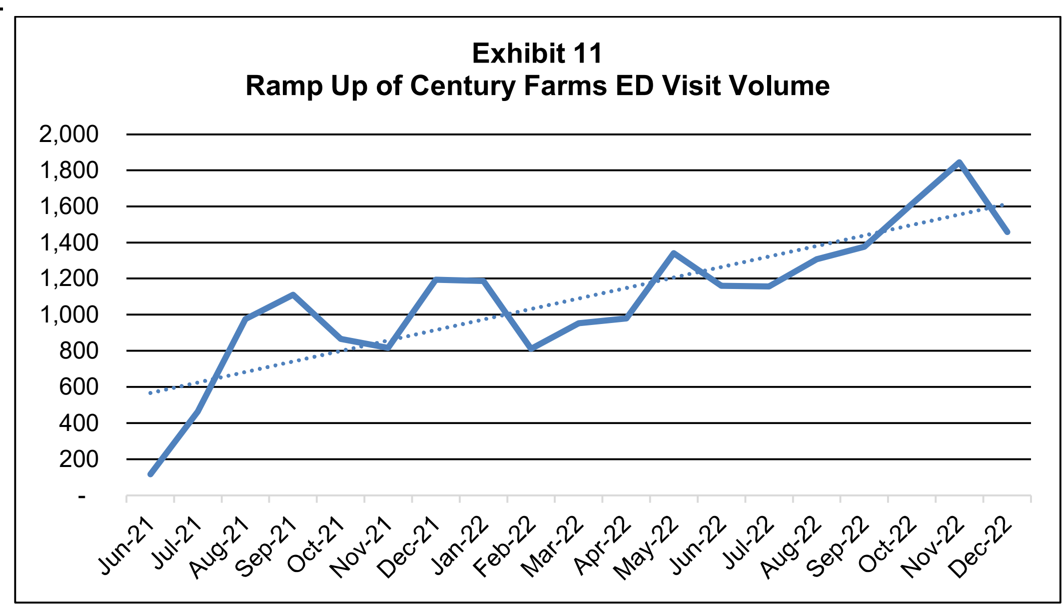
Exhibit 10
TriStar Southern Hills Medical Center Trends in ED Visits CY 2020-2022

Calendar Year	TriStar Southern Hills	Century Farms FSED	Total
2020	38,699		38,699
2021*	40,089	5,541	45,630
2022	38,866	15,183	54,049
% Change 2020-2022	**0.4%**	**N/A**	**39.7%**
CAGR	**0.2%**	**N/A**	**18.2%**

Source: Internal Data

** Century Farms FSED opened June 2021*

Since its opening, Century Farms has seen a steady and significant ramp up in ED volume. See **Exhibit 11** below.



In CY 2022, Century Farms FSED provided 15,183 ED visits in its 11 treatment bays resulting in 1,380 ED visits/treatment bays – well above ACEP capacity guidelines for a facility of this size.

It is evident that the only two EDs in ZIP Codes in the service area – Southern Hills ED and Century Farms FSED – are highly utilized and experiencing increased demand for its ED services. While Southern Hills was able to offload some of its patients to Century Farms, capacity constraints still persist.

Southern Hills also cares for more ED patients from the ZIP Codes in the service area than any other provider. According to TDH HDDS data, in CY 2021, Southern Hills cared for 36.0 percent of the ED patients from the service area. Combined with TriStar Health affiliates, TriStar Health EDs cared for 57.4 percent of service area patients in CY 2021. See **Table 3A1** in **Attachment 1N**.

Southern Hills has considered many alternatives to the proposed project, which are discussed in detail in **Attachment 1N Criterion 2A**. The proposed FSED is the most effective alternative to improve access to emergency services for service area residents and to help alleviate capacity constraints at Southern Hills. See **Attachment 6N** for Letters of Support from physicians and community leaders.

Projected Utilization

In order to project the utilization of the proposed FSED, the historical utilization by service area residents by ZIP Code for 2022 was analyzed using THA data for the first half of 2022 and internal data for the second half.[8] Data for the Southern Hills and affiliate facilities in the area and all other providers were also considered as shown below in **Exhibit 12**. The service area residents had 74,932 ED visits in CY 2022.

Exhibit 12
CY 2022 Service Area ED Visits

		Antioch	**S. Nashville**	**Brentwood**	**Nolensville**	
Hospital	**ZIP Code:**	**37013**	**37211**	**37027**	**37135**	**Total**
TriStar Southern Hills		10,182	14,107	736	250	25,275
TriStar Century Farms FSED		9,246	1,125	180	147	10,698
TriStar StoneCrest		4,096	716	104	770	5,686
TriStar Centennial		2,428	2,244	688	160	5,520
TriStar Summit		1,954	700	50	46	2,750
TriStar Skyline		754	670	92	18	1,534
Total TriStar System		***28,660***	***19,562***	***1,850***	***1,391***	***51,463***
Other Area Providers		6,316	7,122	7,562	2,469	23,469
Total Service Area Visits		**34,976**	**26,684**	**9,412**	**3,860**	**74,932**

Source: THA Data Q1-Q2, 2022 annualized, Internal data through 12/31/2022
Data for all non-TriStar facilities is masked per THA data use guidelines.
Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

These data were used to project the baseline ED visit volume for the service area as shown below based on the following assumptions:

- CY 2022 to Project Year 1 (April 2025 – March 2026) were projected based on the projected CAGR population growth rate by ZIP Code as shown in **Exhibit 13** which results in an average overall growth rate of 0.9 percent**.** These rates are conservative considering that the service area ED visits have historically grown by 1.8 percent from CY 2020 to CY 2021 (see **Table 3A3** in **Attachment 1N**).
- Overall, population growth alone results in 3,363 incremental visits by Project Year 2 (Year 2026), which the proposed FSED will be available to serve, as shown in **Exhibit 13** below. By Project Year 2, the service area demand for ED visits is projected to increase to 78,195.
- It was assumed that all providers would maintain their relative market shares from 2022 throughout the projection time period.

Projected ED Visits by service area ZIP Code are presented in **Exhibit 13**.

[8] Based on THA's data release policy, data for providers that are not affiliated with TriStar are masked/grouped.

Exhibit 13
Total Service Area Projected ED Visits Project Year 2025 and Project Year 2026

Project Year 1 (April 2025) Service Area Visits					
	Antioch	**S. Nashville**	**Brentwood**	**Nolensville**	
Hospital ZIP Code:	**37013**	**37211**	**37027**	**37135**	**Total**
TriStar Southern Hills	10,523	14,331	775	280	25,909
TriStar Century Farms FSED	9,556	1,143	190	164	11,053
TriStar StoneCrest	4,233	727	110	861	5,931
TriStar Centennial	2,509	2,280	725	179	5,693
TriStar Summit	2,020	711	53	51	2,835
TriStar Skyline	779	681	97	20	1,577
Total TriStar System	29,621	19,872	1,949	1,556	52,998
Other Area Providers	6,477	7,208	8,238	2,569	24,493
Total Service Area Visits	**36,098**	**27,080**	**10,187**	**4,125**	**77,491**

Project Year 2 (April 2026) Service Area Visits					
	Antioch	**S. Nashville**	**Brentwood**	**Nolensville**	
Hospital ZIP Code:	**37013**	**37211**	**37027**	**37135**	**Total**
TriStar Southern Hills	10,605	14,384	796	283	26,068
TriStar Century Farms FSED	9,630	1,147	195	166	11,139
TriStar StoneCrest	4,266	730	112	872	5,981
TriStar Centennial	2,529	2,288	744	181	5,742
TriStar Summit	2,035	714	54	52	2,855
TriStar Skyline	785	683	100	20	1,588
Total TriStar System	29,852	19,946	2,001	1,575	53,374
Other Area Providers	6,528	7,235	8,458	2,601	24,822
Total Service Area Visits	**36,380**	**27,181**	**10,459**	**4,176**	**78,195**

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

Next, the base of patients that would shift from existing service area TriStar Health affiliates and unaffiliated providers to the proposed FSED by ZIP Code was calculated based on the assumption that at least some patients closer to the proposed FSED would shift their use to the new facility. These shift percentages consider the following:

- Shift percentages were adjusted by ZIP Code based on the relative proximity of each existing hospital and the FSED to the ZIP Code population.
- Patients of the host hospital and affiliates are projected to experience the largest percentage shift to the new FSED based on patient preference for TriStar Health affiliates.
- Finally, less than 10 percent market share shift by ZIP Code was projected to come from other existing providers based on the increased access to care in the service area that will be created through the proposed FSED as summarized in the table.
- The patient shifts were assumed to increase slightly from Year 1 to Year 2 based on a ramp-up period of for the first year.
- It was assumed that 15 percent of patients at the FSED would come from outside of the service area ZIP Codes.

Based on these assumptions, **Exhibit 14** summarizes the resultant Nolensville FSED projected market share by ZIP Code based on a combination of shifted volume from TriStar Health affiliates and other providers. These market share projections by ZIP Code are reasonable and based on proximity to the proposed FSED.

Exhibit 14
Project Year 2 FSED Market Share by ZIP Code

ZIP Code	FSED Volume	FSED % Market Share
37013 - Antioch	4,242	11.7%
37211 - S. Nashville	3,778	13.9%
37027 - Brentwood	1,130	10.8%
37135 - Nolensville	951	22.8%
Total Service Area	**10,101**	**12.9%**

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

Exhibit 15 presents the total projected Nolensville FSED utilization for the service area with in-migration from outside the area. This volume is also compared to the incremental growth in the demand projected for the service area.

Exhibit 15
Summary of Projected Nolensville ED Visits

	Year 1	Year 2
Visits Shifted from Southern Hills/Century Farms	5,991	6,704
Visits Shifted from Other TriStar Affiliates	1,749	1,960
Total Visits Shifted from TriStar Affiliates	7,739	8,664
Visits Shifted from Market Share Capture	1,272	1,437
Total Service Area Patients	9,012	10,101
Patients from Outside the Service Area	1,590	1,783
Total Projected FSED Visits	10,602	11,883

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

It is important to note that the projected incremental growth in demand projected for the service area is expected to exceed the potential shift of patients from other non-affiliated providers. Thus, growth in demand is expected to offset any potential impact on existing unaffiliated providers as shown in **Exhibit 16**.

Exhibit 16
FSED Projected Utilization and Shift from Existing Providers

CY 2022 Service Area Visits	74,932
Projected Year 2 Service Area Visits	78,195
Incremental Visits from Service Area Population Growth	3,263
Projected Shift from Other Providers	1,437

The total volume for Southern Hills and the proposed FSED was based on the baseline service area projection above, less the shift from Southern Hills and its affiliates to the FSED, plus the incremental growth and shifts to the FSED from other providers. Southern Hills is the primary provider of ED services in the service area, and therefore has the greatest market share in the total service area of all existing providers. It is projected that a majority of the ED visits to the proposed FSED will come from the shift patients choosing to go to the Nolensville FSED because it is closer than Southern Hills. This will help alleviate some of the volume burden on the host hospital ED. The total service area patients and total patients served by Southern Hills and the Nolensville FSED are summarized in **Exhibit 17**.

Exhibit 17
Projected Total ED Volume – TriStar Southern Hills/Century Farms and Nolensville FSED

	2021	2022	2023	2024	Year 1 (April 2025)	Year 2 April 2026)
Southern Hills/Century Farms Baseline Volume from Nolensville FSED Service Area	29,960	35,973	36,210	36,449	36,962	37,207
Shift from Tri-Star Affiliates					1,749	1,960
Incremental FSED Visits (including population growth)					1,272	1,437
Total Southern Hills/Century Farms + Nolensville FSED Service Area Visits	29,960	35,973	36,210	36,449	39,983	40,604
Visits from Outside the Service Area*	15,670	18,076	18,257	18,439	20,468	22,455
Total Southern Hills/Century Farms + Nolensville FSED Visits	**45,630**	**54,049**	**54,467**	**54,889**	**60,451**	**63,059**

Note: totals and shifted figures may not tie out due to rounding and will not foot with hand calculation. The row labeled "Shift to East Nashville, FSED – Other Affiliates" includes TriStar affiliates except TriStar Skyline to avoid double counting the volume from Skyline.
**Includes 15% in-migration for the FSED*

Finally, the acuity of ED patients was also projected for Southern Hills and the Nolensville FSED (See **Exhibit 18**). It was assumed that Southern Hills' acuity levels would remain consistent with historical experience. The acuity levels for the FSED are based on the experience of Century Farms as the most proximate TriStar affiliated FSED. (See **Exhibit 19** for specific CPT Codes represented by each ER Level). These projections are consistent with TriStar Health's actual experience of FSEDs in the greater Nashville area (See **Exhibit 20** for CY 2022 ED Visits by Level of Care of other FSEDs operated by TriStar Hospitals).

Exhibit 18
TriStar Southern Hills/Century Farms FSED and Nolensville FSED ED Visits by Level of Care - Project Year 1

Level of Care	Main ED (Southern Hills)	Existing FSED (Century Farms)	Proposed FSED	Combined	Percent of Total
ER Level 1	1,028	490	355	1,873	**3.1%**
ER Level 2	2,404	1,571	1,140	5,115	**8.5%**
ER Level 3	13,119	7,456	5,412	25,987	**43.0%**
ER Level 4	12,277	4,383	3,181	19,841	**32.8%**
ER Level 5	6,306	705	512	7,523	**12.4%**
Critical Care	108	2	1	111	**0.2%**
Total	**35,242**	**14,607**	**10,602**	**60,451**	**100.0%**

Note: CPT Code ED level. Level 5 and Critical Care are most acute, and Level 1 is least acute.
Note: totals and shifted figures may not tie out due to rounding and will not foot with hand calculation.
Does not include Century Farms ED

Exhibit 19

ER Level	CPT Code
ER Level 1	99281
ER Level 2	99282
ER Level 3	99283
ER Level 4	99284
ER Level 5	99285
Critical Care	99291-99292

Exhibit 20

CY 2022 ED Visits by Level of Care for Other FSEDs operated by TriStar Hospitals

Level of Care	Century Farms FSED	Mt Juliet FSED	Natchez FSED	Portland FSED	Spring Hill FSED
ER Level 1	509	662	574	317	956
ER Level 2	1,633	1,544	1,666	696	5,162
ER Level 3	7,751	8,301	8,808	5,621	7,566
ER Level 4	4,556	6,881	5,554	4,578	1,636
ER Level 5	733	1,615	1,666	1,207	542
Critical Care	2	6	24	14	7
Total	**15,184**	**19,009**	**18,292**	**12,433**	**15,869**

CY 2022 Percent of Total ED Visits by Level of Care for Other FSEDs operated by TriStar Hospitals

Level of Care	Century Farms FSED	Mt Juliet FSED	Natchez FSED	Portland FSED	Spring Hill FSED
ER Level 1	3.4%	3.5%	3.1%	2.5%	6.0%
ER Level 2	10.8%	8.1%	9.1%	5.6%	32.5%
ER Level 3	51.0%	43.7%	48.2%	45.2%	47.7%
ER Level 4	30.0%	36.2%	30.4%	36.8%	10.3%
ER Level 5	4.8%	8.5%	9.1%	9.7%	3.4%
Critical Care	0.0%	0.0%	0.1%	0.1%	0.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Note: CPT Code ED level. Level 5 and Critical Care are most acute and Level 1 is least acute.

Note: totals and shifted figures may not tie out due to rounding and will not foot with hand calculation.

7N.

CON Number	Project Name	Date Approved	Expiration Date
CN1707-023	TriStar StoneCrest Surgery Center	10/25/2017	6/1/2024
CN 2111-031A	Parkridge East Hospital – East Ridge FSED	2/23/2022	4/1/2025
CN 2205-027	TriStar Centennial – Bellevue FSED	8/24/2022	10/1/2025
CN 2208-036	Parkridge Medical Center – Soddy Daisy FSED	10/26/2022	12/1/2025
CN 2302-006	TriStar Skyline East Nashville FSED	N/A	N/A

- **Complete the above chart by entering information for each applicable outstanding CON by applicant or share common ownership; and**
- **Describe the current progress and status of each applicable outstanding CON and how the project relates to them.**

The Applicant does not have any outstanding CON applications. The Applicant's Tri-Star affiliates have several approved CONs as noted above. The status of each is summarized below:

- CN 1707-023 – The StoneCrest Surgery Center project requested and was granted an extension through June 1, 2023, to evaluate the impact of the acquisition of an existing surgery center in Rutherford County and the impact of the pandemic. On March 2, 2023, permission was requested to extend this CON for one more year. On March 31, 2023, the HFC granted the extension request.
- CN 2111-031A – Parkridge East Hospital was approved for a new FSED in East Ridge, Hamilton County, Tennessee. The project was approved on February 23, 2022. Groundwork and construction meetings began in January 2023. As of April 15, 2023, project update, construction is on track and were able to put RTU roof curb in place. The project is expected to be completed by September 2, 2023.
- CN 2205-027 – TriStar Centennial Medical Center was approved for a FSED CON for the Bellevue community. This application was approved at the Commission's August 24, 2022, meeting. Construction plans have been submitted to Metro Nashville Codes Department for review. Construction is expected to begin in first quarter 2024, with an opening in September/October 2024.
- CN 2208-036 – Parkridge Medical Center was approved for a new FSED in Soddy Daisy, Hamilton County, Tennessee. The project was approved on October 26, 2022. Construction is scheduled to begin in July/August.
- CN 2302-006 TriStar Skyline East Nashville FSED was submitted on March 1, 2023. The application was deemed complete on March 15, 2023. The Commission approved the CON application at the April 26, 2023, HFC Meeting.

CONSUMER ADVANTAGE ATTRIBUTED TO COMPETITION

The responses to this section of the application help determine whether the effects attributed to competition or duplication would be positive for consumers within the service area.

1C. List all transfer agreements relevant to the proposed project.

Please see **Attachment 1C-1, 1C-2,** and **1C-3** for copies of Southern Hills transfer agreements, list of Southern Hills' community linkages and Community Benefit Report.

2C. List all commercial private insurance plans contracted or plan to be contracted by the applicant.

See **Exhibit 21** for the list of all major commercial private insurance groups currently contracted by Southern Hills:

Exhibit 21 **List of Major Commercial Insurance Groups and Managed Care Organizations**
Aetna
Amerigroup
Blue Cross Blue Shield
Cigna
Coventry
HCA Employees
HOA/Alliant
Humana
Oscar
PHCS Multiplan
United Healthcare
WellCare
WellPoint

Source: Internal Data

Please see **Attachment 2C** for a detailed list of commercial insurance plans and managed care contracts in which Southern Hills participates. These agreements will extend to the proposed FSED.

The only major plans that Southern Hills is out of network with are Blue Cross Network S and Cigna Local Plus. These plans will also remain out of network for the FSED. Southern Hills provides an appropriate medical screening examination and any necessary stabilizing treatment to any individual who comes to its Emergency Department or FSED and requests such examination, as required by EMTALA.

3C. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact upon consumer charges and consumer choice of services.

Positive Effects

The proposed FSED will have several positive effects including:

- Providing ED access in the proposed service area, which includes a geographically isolated area (See **Exhibit 2**). Currently, the proposed service area has very limited options for emergency services. This rapidly growing area relies on large and crowded hospitals accessible by often congested interstate highways and hospitals over 15 minutes away for their ER services. Nolensville Pike/Road, I-65, I-24, Clovercroft Road, Concord Road, Kidd Road/McFarlin Road, and/or Rocky Springs Road are often congested/crowded making access to emergency care difficult. Several EDs in the Nashville area are often crowded with long wait times and are often on diversion.
- Increasing timely access to life saving services and improving outcomes for patients who reside in an area with limited access to ED services today. Southern Hills proposed project will bring emergency access into this rapidly growing area. A FSED in Nolensville will offer convenient and quick access to residents who currently have to travel to Nashville, Franklin, or Smyrna for life saving emergency care.
- Planning for the growing service area need projected based on population growth and aging as well as residential and commercial development in the service area; Nolensville's population increased by 145 percent from 2010 to 2022, with no signs of slowing down[9]. The growth has forced frequent rezoning of schools and brought retail and businesses to the area as well as a full-time fire station and new housing developments. South Nashville, Brentwood/Brentioch, and Antioch are also rapidly growing.
- Providing increased local access as desired by consumers in the community and enhanced access to emergency services as expressed in letters of support; and
- Helping to alleviate capacity issues at the Southern Hills ED and Century Farms, who's patients are facing long wait times, particularly higher acuity patients. Southern Hills ED routinely faces ED census levels that far exceed its 21 current ED treatment rooms.

Adding a new ED access point for residents of the proposed service area is the most important consumer benefit from this project. As described in detail above, patients from the service area often face heavy traffic congestion traveling to existing hospitals for which they rely upon for ED care. Adding an ED access point at Ava Place near the intersection of Burkitt Place Drive and Nolensville Road will provide ready access to emergency services for local patients in the proposed service area. This location is on the Williamson County/Davidson County border making it highly accessible to residents of South Nashville, Antioch, and eastern Brentwood/Brentioch as well as Nolensville. This will enhance access to a rapidly growing area with significant residential and commercial development and allow patients to be served in a more convenient manner within their existing community. Southern Hills plans to offer the same level of care patients receive at the main campus to residents in a much closer and more convenient manner within their existing community.

The proposed service area is expected to grow in population by 4.6 percent in the next five years. Furthermore, the population age 65 and older is projected to grow by 18.7 percent from 2023 to 2028, a percentage that far outpaces all other age groups in the service area. The chronic overcrowding of EDs by elderly patients has been well documented by research[10], and the elderly population is positively associated with increased usage of health care resources. As such, the significant growth in the 65+ population poses a substantial challenge, and the proposed FSED will make ED services more readily available to this vulnerable group. This is discussed more in **Attachment 1N – FSED Criteria and Standards, Criteria 2.**

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[9] https://tennessee.hometownlocator.com/zip-codes/data,zipcode,37135.cfm and www.zipdatamaps.com/37135.

[10] Ukkonen, M., Jämsen, E., Zeitlin, R., & Pauniaho, S. L. (2019). Emergency department visits in older patients: a population-based survey. *BMC emergency medicine*, *19*(1), 20. https://doi.org/10.1186/s12873-019-0236-3

In CY 2022, the most recent full year of data available, 83,857 emergency room patients from the service area ZIP Codes were seen at local hospitals and throughout the region. These residents traveled by car and by ambulance through congested areas on local roads and highways to often overcrowded existing EDs. The proposed service area needs improved accessibility to emergency care, and its robust and growing population will ensure that most of the FSED's treatment capacity will be used by the service area residents.

As previously established, Southern Hills ED is highly utilized and experiencing capacity constraints. Southern Hills ED's utilization rate of 1,746 (CY 2021) visits per bed per year is 38.0 percent higher than the regional average of 1,081 visits per bed and higher than the ACEP "low range" standard. The proposed FSED will add an access point for emergency care in the service area and the only one in Nolensville, increasing the accessibility of services. Building a FSED in service area ZIP Codes where Southern Hills served over 35 percent of emergency patients in CY 2021 will allow patients to have greater access to care and make Southern Hills' main ED more accessible to patients as well.

Negative Effects

There are no material negative impacts for consumers. ED services will be made more readily available in a community that is separated by physical barriers and often congested highways from existing ED services.

Opponents may point to the projected modest impact on other hospitals' utilization, but the impact on other providers is no longer part of the Tennessee CON statute. By legislation, orderly development is no longer part of the statutory framework. The impact of some patients choosing to go to an ED closer to their homes will be positive for consumers and these other facilities because: (a) patient access is enhanced as has been noted before and (b) the other facilities face long wait times and congested facilities as well, so this new ED will help those facilities to manage their patient flow better. Further, TriStar Health FSEDs have a strong track record of transferring patients who need to be admitted or require more complex services to other providers as shown by the data in **Attachment 1N.**

There is rapid growth and aging of the service area population, which will result in almost 2,559 incremental ED visits or almost 25 percent of the projected volume for the proposed FSED. Much of the FSED's volume will consist of patient visits from within the proposed service area that have been shifted from the applicant's own main campus. Southern Hills does anticipate that with increased access, some service area patients will shift from other non-affiliated ED providers; however, growth in demand is expected to offset this shift. The proposed FSED will not significantly impact other hospital EDs because any shift of volume will be replaced with incremental organic population growth in the proposed service area and other rapidly growing parts of greater Nashville and surrounding areas.

4C. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements, CMS, and/or accrediting agencies requirements, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

As previously discussed, Southern Hills, the applicant, is part of TriStar Health and an affiliate of HCA Healthcare, one of the largest providers of healthcare and hospital services in the U.S. and U.K. With Southern Hills' local, statewide, and national affiliations, Southern Hills expects to be able to recruit highly qualified individuals with the appropriate licensure to staff and support the FSED. Southern Hills staff is highly diverse at all levels representing 65 countries with 35 languages spoken.

Southern Hills also has the benefit of a Nurse Residency Program to garner future nurses to meet the growing need for personnel across its service area. Southern Hills has had strong success integrating nurse residents into its existing ED and will utilize this talent pool for recruitment at the future FSED. There are no differences in the initial staff of a new FSED between the proposed Nolensville FSED and the other approved and new FSEDs operated by Southern Hills' affiliates. However, as the volume of an FSED increases additional staff will be added as needed. Southern Hills has in place the clinical

and administrative leadership needed to develop and operate the proposed FSED.

Southern Hills has an ACGME-accredited Family Medicine Residency Program, which is a structured three-year program focused on giving our residents the experiences needed to provide comprehensive care to patients of any age. Southern Hills also has an agreement with Meharry Medical College to train third and fourth year medical students. Please see **Attachment 4C-1** for a list of Southern Hills' clinical training affiliations. In addition, affiliate TriStar Skyline has an Emergency Medicine Residency Program.

TriStar Health and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals, which has been exacerbated by the COVID-19 pandemic. To this extent HCA Healthcare has opened in Nashville the Galen College of Nursing, which now has campuses and programs in Tennessee, Kentucky, Ohio, Virginia, South Carolina, Florida, and Texas. The Nashville campus offers a 3-year Bachelor of Science in Nursing, an Associate Degree in Nursing ("ADN") and an LPN to ADN Bridge program. This relationship will assist with ongoing recruitment of staff within TriStar Health as well as recruitment for the proposed FSED. TriStar Health is also committed to increasing its nursing residency programs.

The Thomas F. Frist, Jr. College of Medicine at Belmont University in Nashville, is a new medical school founded in alliance with HCA Healthcare to focus on training diverse physician leaders who embrace and value a whole-person approach to healing. The Thomas F. Frist, Jr. College of Medicine at Belmont University will be housed in a new building that is currently under construction on Belmont's campus. The nearly 200,000-square-foot building will be located within a block of Belmont's Gordon E. Inman Center and McWhorter Hall, which house the University's well-known nursing, physical therapy, occupational therapy, social work, and pharmacy programs. The College of Medicine has recruited a leadership team comprised of experts from across the country and is currently recruiting clinical faculty. The College also recently announced that it has achieved accrediting "candidate status" from the LCME accrediting body. TriStar Health and HCA Healthcare look forward to working collaboratively with Belmont to support the supply of healthcare professionals entering and staying in the profession and to ensure that they have access to training in emergency medicine.

HCA Healthcare is also the largest and most experienced operator of FSEDs in the U.S. HCA Healthcare has operated hospital affiliated FSEDs since 1985. Today, HCA Healthcare operates approximately 130 FSEDs in 20 states. HCA Healthcare operates its FSEDs as a department of a hospital and each FSED has all of the essential characteristics of a hospital-based emergency department, including the following:

- Operate 24 hours a day/seven days a week as a licensed department of the hospital and provides the same emergency services and care for any condition as the on-campus emergency department.

- Provide on-site diagnostic imaging and clinical laboratory services also operated as part of the host hospital and meeting all required clinical certifications and accreditations as the host hospital.

- Staffed by board-certified emergency physicians that are on the hospital's medical staff and by experienced ACLS-trained emergency nursing staff.

- Accredited by The Joint Commission as part of the host hospital.

- Licensed by all required state agencies as part of the host hospital.

- Provide the same signage requirements as the main hospital's emergency department.

- Provide access to on-call specialty physician for consultations.

- Operate in compliance with the federal Emergency Medical Treatment and Labor Act (EMTALA) regulations as well as appropriate state regulations (see **Attachment 4C-2** for TriStar Health's EMTALA Policies).

- Accept patients transported by EMS.

- Have established transfer agreements with local general acute care hospitals.

- Provide free and reduced cost care in alignment with the host hospital's financial assistance policies.

- When needed, providing rapid transfer to a hospital chosen by the patient or by the emergency department physician's assessment of the best location for treatment.

Furthermore, the Applicant, Southern Hills, has experience in implementing and operating Century Farms FSED, which differs from other EDs in the market. Century Farms has a highly trained staff; their nurses are trained in advanced respiratory care (i.e., ABGs, set-up ventilators, breathing treatments) as well as PALS, ACLS, BLS, TNCC, and ENCP certification. This is essential because not all ED nurses have this training since hospitals frequently have respiratory therapists. Whereas FSED typically do not. Century Farms doctors are also board certified in emergency medicine and are PALS, ACLS, BLS, TNCC, and ENCP certified.

Century Farms FSED has implemented measures to improve proficiency in its throughput process, such as the nursing team providing team nursing care, which expedites care in the FSED. Century Farms FSED's partnership with Ambulnz has also resulted in very efficient convalescent service when patients need transport to the admitting hospitals. Century Farms FSED throughput expertise has resulted in the following:

- Arrival to Greet (the time it takes a patient to see a provider) is less than 5 minutes.
- The discharge length of stay ("LOS") is less than 90 minutes.
- Low Acuity Discharge LOS is less than 60 minutes.

The highly trained staffed and proficient throughput process has improved patients' experience at an ED, and Century Farms is consistently nationally ranked in the 70+ percentile for patient experience.

The success of Century Farms FSED is demonstrated by its high utilization levels, which reflect the need the community had for the service and the acceptance of this type of facility to meet the need. In its first full year of operation (CY 2022) Century Farms FSED provided more than 15,000 visits including:

- Pediatric Visits 3,299 pediatric patients treated
- Cardiac Arrest patients – 11 patients
- Cardiac patient visits – 872
- Neurology patient visits – 620
- Spine patient visits – 302
- Trauma patient visits (orthopedic fractures, limb injuries, superficial injuries) – 3,336
- Abdominal pain patient visits – 2,196

Southern Hills has documented its unique experience and expertise in operating FSEDs and has all the appropriate resources and is familiar with, and meets, all human resource requirements of the Tennessee Board for Licensing Health Care Facilities and the Joint Commission. The applicant is licensed and accredited by these bodies.

5C. Document the category of license/certification that is applicable to the project and why. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Licensure and Certifications
Southern Hills is licensed by the Tennessee Board for Licensing Health Care Facilities and the license is in good standing. Southern Hills is certified to participate in the Medicaid and Medicare programs and currently meets all requirements of certification. Southern Hills is accredited by The Joint Commission. See **Attachment 5C-1** and **Attachment 2Q** for Southern Hills' Hospital License and The Joint Commission Accreditation.

Clinical Leadership
Medical direction at the proposed Nolensville FSED will be provided by Dr. Brad Hoover, MD. Currently, Dr. Hoover is the Medical Director for the Southern Hills ED. Dr. Tincher is the regional lead for Envision, the physician group that staffs the ED Southern Hills and that will staff the proposed FSED. Dr. Hoover and Dr. Tincher are board certified by the American Board of Emergency Medicine, and they have collectively 50 years of experience in providing emergency care. See **Attachment 5C-2** for Dr. Hoover's and Dr. Tincher's C.V.'s.

Leadership plays a central role in improving organizational performance. Leadership includes the Governing Board, Medical Executive Committee, the Chief Executive Officer and Senior Leadership, Department Directors, and Nursing Officers/Managers/Supervisors. The leaders set expectations, develop plans, and manage processes to measure, analyze, and improve the quality of the hospital's clinical and support activities. The leaders are responsible for adopting an approach to Performance Improvement which is utilized in reporting and in team activities. Leaders are also responsible for setting policy/procedure and priorities, as well as reprioritizing priorities when there are unexpected outcomes.

Leaders set a positive Performance Improvement culture in the organization through planning, providing support/resources and empowering staff as appropriate. Leaders also actively participate in interdisciplinary Performance Improvement, as appropriate. The Performance Improvement Program is the shared responsibility of the Board of Governors, the Medical Staff, and Senior Leadership of the hospital with specific areas of the program delegated to each including education on the approach and method of the Performance Improvement.

Plan for Improvement of Organization Performance and Clinical Excellence
As a department of Southern Hills, Nolensville FSED will be part of Southern Hills' existing methods to ensure and maintain quality of care. At Southern Hills, a collaborative multidisciplinary team approach, which considers the unique knowledge, judgment, and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for quality. Southern Hills is committed to providing a seamless continuum of health care both for individuals and for the community, linking together a full range of health care providers and services. Southern Hills' goal is to provide services which are measurably more accessible, affordable, and which are improving in quality on a continuous basis. The continuum of services may begin prior to admission, such as in an ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

Nolensville FSED will be an extension of the Emergency Department at Southern Hills and a licensed department of Southern Hills and will therefore adhere to TriStar Health's plan for improving organizational performance, including planned performance assessment and improvement activities, initiating activities designed to follow-up on unusual occurrences or specific concerns/issues, which may include following policies and procedures for ensuring staff competency and follow-up as appropriate on patient/family complaints and patient questionnaire results. Input and feedback from patients, staff and physicians guide the improvement process. Southern Hills addresses methods to ensure and maintain patients' quality of care.

Southern Hills is dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. As a satellite ED to Southern Hills, the proposed Nolensville FSED will maintain the highest standards and quality of care, consistent with the high standard that Southern Hills has sustained throughout its history of providing patient care. In this regard, Southern Hills provides a robust Quality Assurance and Performance Improvement ("QAPI") Plan which is framed by the following essential elements:

- Design and Scope that encompasses the full range of services and departments;
- Governance and Leadership that actively engage with system expectations and priorities;
- Feedback, Data Systems, and Monitoring to continuously assess a wide range of care and service;
- Performance Improvement Projects to improve care or services based on the data captured; and
- Systematic Analysis and Systematic Action to create real impact and long-lasting improvement.

Further, Southern Hills provides a robust Utilization Review ("UR") program that provides ongoing concurrent reviews of patient care to determine whether treatments are medically necessary and, if not, to assist in placing patients in more appropriate care settings. Internal case management serves an important advisory purpose in enhancing and maintaining the quality of care provided. To this extent, systems are in place to conduct prospective, concurrent, and retrospective utilization reviews to ensure quality of care and protect revenue integrity. For more details, see **Attachment 5C-3** for TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence and Risk Management Plan.

Clinical Staff Training and Requirements

Nolensville FSED will be operationally integrated with Southern Hills' main ED. As such, it will comply with all of the specific State Health Plan standards for staffing planning and recruitment, training and competencies, supervision, the presence of at least one Board-certified Emergency Physician and RN at all times (24/7/365), staffing with RN's, operation under the same bylaws, hospital medical staff and nursing staff organizations, hospital standards of care, and written policies and procedures. The Medical Director of Southern Hills' emergency department is Dr. Hoover. He will serve as Medical Director of the FSED. Dr. Tincher will also serve in a regional oversight role. Copies of Dr. Hoover's and Dr. Tincher's C.V.'s are attached as **Attachment 5C-2**. Letters of support from Dr. Hoover and Dr. Tincher are also provided in **Attachment 5C-2.**

In its dedication to enhance quality assurance and performance improvement, Southern Hills employees are held to the highest standards and are expected to adhere to policies created by the Administration. These policies are developed in compliance with The Joint Commission guidelines for education, competency, and continuing education. Appropriate clinical licenses and certifications are required and documented. Moreover, during the recruitment process, employees are thoroughly vetted to ensure they meet the requirements identified in the job description. Upon hiring, employees are obligated to attend system-wide and department-specific orientation. New hires complete an initial skills checklist and competency assessment and undergo annual performance evaluation to appraise technical competency thereafter. Furthermore, Southern Hills will continue to require all clinical staff members to attend continuing education programs, and receive annual in-services on HIPAA, Medicare Compliance, and OSHA. Southern Hills offers an array of programs and resources to support employees in learning new skills and advancing their careers. For example, employees may take classes or workshops in the areas of computer technology skills, career and work-specific skills, and leadership and management skills. See **Attachment 5C-4** for Equal Employment Opportunity and Staff Education Policies. See **Attachment 4C-1** for List of Clinical Affiliations.

6C. See INSTRUCTIONS to assist in completing the following tables.

□ Project Only
▪ Total Facility

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency.

		Year 2020	Year 2021	Year 2022
A.	Utilization Data			
	Specify Unit of Measure (ED Visits)	38,719	40,169	38,881
	Admissions	5,230	5,479	5,619
B.	Revenue from Services to Patients			
1	Inpatient Services	387,938,018	424,652,384	428,796,630
2	Outpatient Services	424,330,182	515,551,788	604,899,190
3	Emergency Services*			
4	Other Operating Revenue (Specify)			
	Gross Operating Revenue	812,268,200	940,204,172	1,033,695,820
C.	Deductions from Gross Operating Revenue			
1	Contractual Adjustments	552,311,374	665,748,694	727,096,920
2	Provision for Charity Care	121,602,237	126,402,767	171,218,580
3	Provisions for Bad Debt	10,183,658	19,154,334	6,813,628
	Total Deductions	684,097,269	811,305,795	905,129,128
NET OPERATING REVENUE		128,170,931	128,898,377	128,566,693

**Included in outpatient services.*

NOTE: From a financial reporting perspective, ED patients that are discharged are considered outpatients, and ED patients that are admitted are considered inpatients. Therefore, the gross revenue from these patients is grouped in this way.

■ Project Only
□ Total Facility

PROJECTED DATA CHART

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

		Year 1 (2024)	Year 2 (2025)
A.	Utilization Data		
	ED Visits	10,602	11,883
B.	Revenue from Services to Patients		
	1 Inpatient Services*	$ -	$ -
	2 Outpatient Services	$ -	$ -
	3 Emergency Services	$ 70,068,618	$ 84,817,527
	4 Other Operating Revenue (Specify)	$ -	$ -
	Gross Operating Revenue	$ 70,068,618	$ 84,817,527
C	Deductions from Gross Operating Revenue		
	1 Contractual Adjustments	$ 53,468,537	$ 65,152,825
	2 Provision for Charity Care	$ 9,751,720	$ 11,809,573
	3 Provisions for Bad Debt	$ -	$ -
	Total Deductions	$ 63,220,256	$ 76,962,397
NET OPERATING REVENUE		$ 6,848,362	$ 7,855,129

**No inpatient services offered at the FSED*

7C. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Historical and Projected Data Charts of the proposed project.

Project Only Chart

	Previous Year to Most Recent Year Year ____	Most Recent Year Year____	Year One Year 2024	Year Two Year 2025	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)**	NA	NA	$6,609	$7,138	NA
Deduction from Revenue *(Total Deductions/Utilization Data)*	NA	NA	$5,963	$6,477	NA
Average Net Charge *(Net Operating Revenue/Utilization Data)*	NA	NA	$646	$661	NA

**Includes ED facility fee and all associated ancillary charges.*

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

8C. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

The average ED charges per visit for the Nolensville FSED are projected to be $6,609 and $7,138 in the first and second years of operation, respectively. This is an all-inclusive average charge representing the visit along with any associated imaging, lab services, and pharmacy services required by the patient. The projected charges are based on, and comparable to the ED charges already in place at Southern Hills. The proposed FSED is not expected to have any impact on the charges for ED services at Southern Hills or any affiliate.

9C. Compare the proposed project charges to those of similar facilities/services in the service area/adjoiningservices areas, or to proposed charges of recently approved Certificates of Need.

If applicable, compare the proposed charges of the project to the current Medicare allowable fee scheduleby common procedure terminology (CPT) code(s).

The proposed charges are based on the existing charges of Southern Hills' ED, which are comparable throughout TriStar Health. It is difficult to compare the charges for ED services given the multiple levels of care and associated ancillary charges that varying types of ED patients experience. **Exhibit 22** provides a comparison of gross charges by CPT Code for Codes 99281-99285 for the ED providers in Nashville/Davidson and Williamson Counties.

Exhibit 22
Nashville/Davidson and Williamson Counties ED Gross Charges by CPT Code

CPT Code:	99281	99282	99283	99284	99285
TriStar Skyline Medical Center	$663	$957	$1,483	$2,860	$3,713
Metro Nashville General Hospital	$261	$273	$421	$675	$850
Saint Thomas Midtown Hospital	$703	$1,161	$1,415	$1,845	$2,243
Saint Thomas West Hospital	$641	$1,058	$1,290	$1,682	$2,046
TriStar Centennial Medical Center	$479	$782	$1,714	$2,975	$3,900
Bellevue FSED*	$479	$782	$1,714	$2,975	$3,900
TriStar Southern Hills Medical Center	$976	$1,140	$1,733	$2,967	$3,857
Century Farms FSED	$976	$1,140	$1,733	$2,967	$3,857
TriStar Summit Medical Center	$515	$725	$1,632	$2,822	$3,672
Vanderbilt University Medical Center	$372	$678	$1,323	$2,130	$3,127
Williamson Medical Center	$437	$990	$1,858	$2,495	$4,045

Source: Hospital Chargemaster

**Approved but not yet implemented*

It is important to consider several factors when reviewing these data:

- Comparison of CPT charges for ED services are not meaningful:
    - Gross charges do not reflect what either patients or payors pay for ED services as payors have discounted rates and insured patients are only responsible for co-pays and deductibles. Self-pay patients and even those with insurance may also qualify for a self-pay discount. In addition, low-income individuals may qualify for charity care.
    - Charges for this single visit CPT code do include associated ancillary charges that vary based on patient experience and acuity.
    - It is not possible to fully acuity-adjust ED patient charges for accurate comparison.
- The amount that patients pay is largely determined by their health insurance coverage. If a patient does not have health insurance, their financial liability will be determined by the application of TriStar Southern Hills' uninsured discount to their bill for non-elective services.
- Comparisons of charge rates between hospitals **will not** reflect distinctions in prices due to variations in pricing methodology. For example, if an item or service is priced as a case rate (a set rate for an episode of care) with a particular payor or for a particular hospital, but as a per day rate with a different payer or hospital, then these rates cannot be compared without first determining the patient's length of stay and then applying the applicable contractual enhancements (e.g., stoploss or trauma activation).

More relevant than gross charge comparison is the payment rates or cost of care between facilities. For government payors, payment rates are very likely the same or similar for all providers in the service area.

10C. 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. Report the estimated gross operating revenue dollar amount and percentage of project gross operating revenue anticipated by payor classification for the first and second year of the project by completing the table below.

Applicant's Projected Payor MixProject Only Chart

	Year 1		Year 2	
Payor Source	Gross Operating Revenue	% of Total	Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	$6,306,176	9%	$7,633,577	9%
TennCare/Medicaid	$32,231,564	46%	$39,016,062	46%
Commercial/Other Managed Care	$17,517,155	25%	$21,204,382	25%
Self-Pay	$9,809,607	14%	$11,874,454	14%
Other(Work Comp, TriCare, VA, and Healthcare Exchange plans)	$4,204,117	6%	$5,089,052	6%
Total*	$70,068,618	100%	$84,817,527	100%
Charity Care (included self pay discounts)	$9,751,720		$11,809,573	

**Needs to match Gross Operating Revenue Year One and Year Two on Projected Data Chart*

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

Southern Hills participates in both Medicare and TennCare/Medicaid. As a satellite ED to Southern Hills, the proposed Nolensville FSED will be included in all state and federal revenue programs for the host hospital, Southern Hills, including Medicare and TennCare. Moreover, the proposed Nolensville FSED will be part of the TriStar Health network, which requires all facilities within it to adhere to all financial assistance and charity/indigent care policies. **Exhibit 23** compares the percentage of Medicare, TennCare/Medicaid, and self-pay ED visits for each of the hospitals in Nashville/Davidson and Williamson Counties. TriStar Southern Hills provides the second largest percentage of care to Medicaid/TennCare and self-pay patients. Southern Hills is second only to Nashville General, the public safety net hospital for Nashville. The proposed FSED as part of Southern Hills is also projected to provide a high percentage of services to TennCare/Medicaid and self-pay patients. Most charity care patients are included in the self-pay category.

Exhibit 23

FY 2021 Comparison of Existing EDs
Visits by Payor

	Medicare	Medicaid/ TennCare	Self Pay
TriStar Southern Hills	15.6%	**34.0%**	**26.7%**
Nashville General	10.4%	23.0%	33.4%
St. Thomas Midtown	24.4%	22.4%	21.7%
St. Thomas West	44.7%	7.6%	14.3%
TriStar Skyline	28.6%	10.6%	18.1%
TriStar Centennial	20.0%	42.4%	12.1%
TriStar Summit	28.3%	27.3%	14.4%
WMC	15.1%	11.7%	7.2%

Source: 2021 JARs, Schedule I.

Financial relief is available to those patients who have received non-elective care and do not qualify for state or federal assistance and are unable to establish partial payments or pay their balance. Contractual adjustments, charity care, and bad debt are defined consistently with how the terms are used on the JARs. Patients who do not have insurance (self-pay) receive a discount from charges. Many of these same patients' charges are written off as charity care based on income levels.

Moreover, all self-pay patients will receive a discount similar to managed care, referred to as an "uninsured discount." The Uninsured Discount is available to patients who have no third-party payer source of payment or do not qualify for Medicaid, Charity, or any other discount program the facility offers. In CY 2022, Southern Hills wrote off approximately $171 million in charity care dollars.[11] See **Attachment 4N-1** for the Uninsured Discount and Charity Care Write Off Policies. Southern Hills offers a prompt pay discount of 20 percent for patients paying estimated deductible and co pays at the time of service. When recording this discount, it will be reflected in our contractual adjustments line and not shown as Charity or bad debt. See **Attachment 4N-3** for Discount Policy for Patients, which governs these practices. The below table highlights the projected payor mix for PY 1 and 2.

QUALITY STANDARDS

1Q. Per PC 1043, Acts of 2016, any receiving a CON after July 1, 2016, must report annually using forms prescribed by the Agency concerning appropriate quality measures. Please attest that the applicant will submit an annual Quality Measure report when due.

Upon approval, Nolensville FSED will submit quality measure information as prescribed by the Agency. The applicant attests that these forms will be submitted annually and in a timely manner.

2Q. The proposal shall provide health care that meets appropriate quality standards. Please address each of the following questions.

- **Does the applicant commit to maintaining the staffing comparable to the staffing chart presented inits CON application?**

  Yes. An increasing body of evidence shows that appropriate staffing ratios in the emergency department contribute to improved patient outcomes and greater satisfaction for both patients and staff. The applicant and its ultimate parent, HCA Healthcare (which as previously discussed, owns, manages, and operates 130 FSEDs nationally) understand the staffing requirements for this type of facility and the recruitment processes that will identify superior candidates for these professional positions. In its dedication to ensuring and maintaining the quality of care provided, the Nolensville FSED, as a satellite ED to Southern Hills main ED, commits to maintaining the staffing comparable to the staffing chart presented in this application. See response to **Question 8Q**.

- **Does the applicant commit to obtaining and maintaining all applicable state licenses in good standing?**

  Yes. The applicant commits to obtaining and maintaining all applicable state licenses in good standing. See **Attachment 2Q** for correspondence with The Joint Commission confirming the applicant's continued Medicare participation. As a satellite ED to Southern Hills, the proposed Nolensville FSED will be included in the accreditations and licensure for the host hospital, Southern Hills.

- **Does the applicant commit to obtaining and maintaining TennCare and Medicare certification(s), if participation in such programs are indicated in the application?**

  Yes. The proposed Nolensville FSED will accept all government payors, including Medicare and TennCare, and will treat all patients regardless of their ability to pay.

[11] Charity care and uninsured discounts for Southern Hills.

3Q. Please complete the chart below on accreditation, certification, and licensure plans.
Note: if the applicant does not plan to participate in these types of assessments, explain why since quality healthcare must be demonstrated.

Credential	Agency	Status (Active or Will Apply)	Provider Number or Certification Type
Licensure	○ Health Facilities Commission/Licensure Division ○ Intellectual & Developmental Disabilities ○ Mental Health & Substance Abuse Services	Health Facilities Commission – Active	#19214
Certification	○ Medicare ○ TennCare/Medicaid ○ Other: ____________	Active	# 44-0197
Accreditation(s)	The Joint Commission	Active	#7890

4Q. If checked "TennCare/Medicaid" box, please list all Managed Care Organizations currently or will be contracted.

In its efforts to reduce healthcare costs and increase access to care for its service area, Southern Hills is currently contracted with numerous Managed Care Organizations ("MCOs"). Please see **Attachment 2C** for a list of all managed care contracts in which Southern Hills participates.

5Q. Do you attest that you will submit a Quality Measure Report annually to verify the license, certification, and/or accreditation status of the applicant, if approved?

☑Yes ☐ No

6Q. For an existing healthcare institution applying for a CON:

- **Has it maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action should be discussed to include any of the following: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions and what measures the applicant has or will put into place to avoid similar findings in the future.**

  Southern Hills has maintained compliance with all applicable federal and state regulations for the three years prior to this CON application.

- **Has the entity been decertified within the prior three years? If yes, please explain in detail. (This provisionshall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility.)**

  No. Southern Hills has maintained all its certifications, licensures, and accreditations within the prior three years and has not been decertified.

7Q. Respond to all of the following and for such occurrences, identify, explain, and provide documentation if occurred in last five (5) years.

- **Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);**
- **Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or**

The applicant has made a good faith effort to respond to this question regarding the entities identified in the organizational chart for direct upstream ownership of TriStar Southern Hills, to the best of its knowledge, information, and belief. Due to the breadth of the question and lack of definition of key terms, the applicant cannot represent these responses as totally comprehensive, but no responsive information is intentionally being withheld.

Been subject to any of the following:

- **Final Order or Judgement in a state licensure action;**
  The applicant assumes for the purpose of this question that "state licensure action" refers to facility licensure. TriStar Southern Hills has not been subjected to a Final Order or Judgement in a state licensure action. The other entities in the chain of ownership do not hold a hospital license.

- **Criminal fines in cases involving a Federal or State health care offense;**
  None.

- **Civil monetary penalties in cases involving a Federal or State health care offense;**
  None. The applicant is not aware that any of its entities upstream have been involved in civil litigation whereby a judgement or settlement was entered in payment of Civil Monetary Penalty

- **Administrative monetary penalties in cases involving a Federal or State health care offense;**
  None. The applicant is not aware that any of its entities upstream have been involved whereby a judgment or settlement was entered into resulting in payment of Administrative Monetary Penalty

- **Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services;**
  None. The applicant is not aware that any of its upstream entities have been involved in any agreement requiring payment of an administrative or civil monetary penalty to the federal government or any state government for claims related to the provision of health care items or services.

- **Suspension or termination of participation in Medicare or TennCare/Medicaid programs; and/or**
  None.

- **Is presently subject of/to an investigation, or party in any regulatory or criminal action of which you are aware.**

  In light of the breadth and scope of services provided and the business conducted by the entities upstream from the applicant, it is likely that at any given time one or more are involved, in some capacity, in some type of investigation or regulatory action. However, neither TriStar Southern Hills nor any of its upstream entities are the subject of a criminal action. With regard to an investigation, TriStar Southern Hills is currently responding to an investigation that was commenced by the Department of Justice in June of 2021 related to anatomic pathology services performed by third-party pathology laboratories on behalf of certain HCA patients. TriStar Southern Hills is cooperating with the investigation and has produced documents and other information to the Justice Department government in connection with this matter.

Further, on December 29, 2021, TriStar Centennial, Southern Hills affiliate, entered into a settlement agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services ("OIG"). This settlement was in connection with a 2017 CMS survey that resulted in certain alleged EMTALA claims, which were disputed by TriStar Centennial. The OIG and TriStar Centennial agreed to the settlement pursuant to which TriStar Centennial paid the U.S. Department of Health and Human Services $725,000 without any admission of wrongdoing by TriStar Centennial or any concession as to the lack of merit of the allegations by the OIG.

The Commission Staff have previously asked Southern Hills affiliates to confirm whether the following Corporate Integrity Agreement is still active: Envision Healthcare Corporation Corporate Integrity Agreement (hhs.gov). According to the Office of Inspector General's website, the Envision Healthcare Corporate Integrity Agreement (CIA) was effective December 15, 2017. Section II.A of the CIA set the term of the agreement at 5 years. The term expired at the end of December 14, 2022. Southern Hills does not know if the Office of Inspector General (OIG) has released Envision Healthcare from the CIA yet.

8Q. Provide the project staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positionsfor these positions.

Position Classification	Existing FTEs (enter year)	Projected FTEs Year 1
A. Direct Patient Care Positions		
Nurses(1)	0	11.5
Radiology Tech	0	4.2
Ultrasonographer (2)	0	0.5
Med Tech	0	5.2
Pharmacists (3)	0	0.6
Total Direct Patient Care Positions	**0**	**22.0**

B. Non-Patient Care Positions		
Position 1	0	0
Position 2	0	0
Position "etc."	0	0
Total Non-Patient Care Positions	0	0
Total Employees *(A+B)*	**0**	**22.0**
C. Contractual Staff (4)	0	9.8
Total Staff *(A+B+C)*	**0**	**31.8**

(1) Registered Nurses (10.5 FTEs) and leadership registered nurses (1.0 FTE)
(2) Available on-call as needed.
(3) Onsite staff and also available on call as needed.
(4) Includes physicians (4.2 FTEs), security staff (4.2 FTEs), and environmental services (1.4 FTEs).

TriStar utilizes a centralized shared service model for registration, with each facility, charged a contract service expense for these duties. Thus, Nolensville FSED registration will be completed virtually through a centralized service. With the centralized shared service model, the facility does not record actual FTEs on its individual financial reports. This method of accounting is used regardless of whether the registration staff is physically on site or if these duties are completed virtually. The Century Farms FSED was a pilot site for virtual registration. It has proven to work well and is an efficient cost-reduction model. Other non-patient care positions are shown in the staffing chart. EVS tech is shown on the staffing chart at 1.2 FTEs, and security is in the other category at 4.2 FTEs.

Ultrasonographer is listed as 0.5 FTE because this is the estimated amount of time the sonographer will be needed at the facility. The new location will be added to the Southern Hills ultrasound department call rotation, and call shifts will be covered by the existing ultrasound department and this incremental 0.5 FTE.

Two individual pharmacists are expected to work a combined equivalent of 0.6 FTE. The FSED will not need a 24/7 pharmacist because of computerized provider order entry ("CPOE") and Pyxis system technology. This new location will be added to the Southern Hills pharmacy department.

DEVELOPMENT SCHEDULE

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

- Complete the Project Completion Forecast Chart below. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
- If the CON is granted and the project cannot be completed within the standard completion time period (3 years for hospital and nursing home projects and 2 years for all others), please document why an extended period should be approved and document the "good cause" for such an extension.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HFC action on the date listed in Item 1 below, indicate the number of days from the HFC decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date (Month/Year)
1. Initial HFC Decision Date		6/28/2023
2. Building Construction Commenced	255	3/9/2024
3. Construction 100% Complete (Approval for Occupancy)	300	1/3/2025
4. Issuance of License	90	4/3/2025
5. Issuance of Service	60	6/2/2025
6. Final Project Report Form Submitted (Form HR0055)	120	9/30/2025

Note: If an opponent initiates a contested case hearing as an appeal of the CON, the completion forecast may be adjusted.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF ___Davidson_____

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

[signature] / CEO

Signature/Title

Sworn to and subscribed before me this the 20 day of April, 2023, a Notary Public in and for the County of Davidson, State of Tennessee.

[signature: Beth Marrero]

NOTARY PUBLIC

My Commission expires 07/09/2024.

BETH MARRERO STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY MY COMMISSION EXPIRES 7-9-2024

HF-0056
Revised 7/02 - All forms prior to this date are obsolete

Attachment 3A
Proof of Publication

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Facilities Commission and all interested parties, in accordance with T.C.A. §68-11-1601 et seq., and the Rules of the Health Facilities Commission, that TriStar Southern Hills Medical Center (Hospital), owned by HCA Health Services of Tennessee, Inc., with an ownership type of corporation and to be Self-Managed, intends to file an application for a Certificate of Need for the establishment of a freestanding emergency department ("FSED") in the town of Nolensville, Williamson County, Tennessee. The FSED will consist of approximately 11,900 square feet with 12 exam rooms, including 1 trauma room, a lab, an imaging department, a nurse station, and associated support spaces. The FSED will have two covered entry canopies, one for emergency vehicle access/drop off and one for public drop off. The proposed project will be located on Ava Place near the intersection of Burkitt Place Drive and Nolensville Road with the entrances to the facility expected to come off of Ava Place, in Nolensville, TN 37135 on approximately 2.8 acres more or less as further described as a portion of Lot 3 of the Final Plat of Burkitt Commons II, of record in Plat Book P74, Page 90 in the Register's Office of Williamson County, Tennessee. The estimated project cost is approximately $18,000,000, including the value of the land and building to be constructed.

The anticipated date of filing the application is on or before May 1, 2023.

The contact person for this project is Drew Tyrer, CEO of TriStar Southern Hills Medical Center, who may be reached at TriStar Southern Hills Medical Center – 391 Wallace Road, Nashville, Tennessee 37211 – 615-7814000.

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

Health Facilities Commission
Andrew Jackson Building, 9th Floor
502 Deaderick Street Nashville, TN 37243

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

Public Notices

Classifieds

To advertise, visit:
classifieds.tennessean.com
Classifieds Phone: **800.828.4237**
Classifieds Email: **tnclassifieds@gannett.com**
Public Notices/Legals Email: **publicnotice@tnmedia.com**

All classified ads are subject to the applicable rate card, copies of which are available from our Advertising Dept. All ads are subject to approval before publication. The Tennessean reserves the right to edit, refuse, reject, classify or cancel any ad at any time. Errors must be reported in the first day of publication. The Tennessean shall not be liable for any loss or expense that results from an error in or omission of an advertisement. No refunds for early cancellation of order.

General

Oriental Rug Repairer

Oriental Rug Repairer to reweave damaged areas of Oriental and other expensive rugs, following color pattern and weave of rugs; to establish foundation of rug where damaged area need to be reconstructed, cashmere worn areas; to fill in areas where pile eaten by moths; to reapply and fix fringe and salvage fringe. Two years experience in the job offered.

Send resume to Nashville Fine Rugs, LLC 4105 Hillsboro Pike, Nashville, TN 37215

TN-GCI1041673-01

General

LOOKING FOR A CONTRACTOR CHECK THE BUSINESS SERVICES!

General

We're Hiring!
Join Our Warehouse Team
Industrial Seamstress - Warehouse Associate

PERKS INCLUDE:
- Flexible schedules
- Merchandise discounts
- Opportunities to grow

+MORE!

SCAN AND APPLY NOW!

OLD NAVY | GAP | BANANA REPUBLIC | ATHLETA

TN-GCI1040761-01

Real Estate Rentals
great places to live...

Apt Unf-Madison

Now Leasing 1 Bedrooms for Seniors 62 & Older. Income Based Rent & Paid Utilities. , (615)868-8653 TTY 711 (Equal Housing Opportunity)

Rooms For Rent

KNIGHTS INN - weekly/monthly rates & efficiencys - Free local calls, free HBO & WiFi, $250 & Up. 615-678-6526

Real Estate Homes
starting fresh...

Commercial

Equal Housing Opportunity
All real estate advertising in this newspaper is subject to the Federal Fair Housing Act of 1968 as amended which makes it illegal to advertise "any preferences, limitation, or discrimination based on race, color, religion, sex, handicap, familial status or nation origin, or an intention to make any such preference, limitation or discrimination.
"This newspaper will not knowingly accept any advertisement for real estate which is in violation of the law. Our readers are hereby informed that all dwellings advertised in this newspaper area available on an equal opportunity basis. To complain of discrimination, call HUD Toll-free at 1-800-669-9777. For hearing impaired call 1-800-927-9275.

Automotive Cars
best deal for you...

Autos Wanted

All Autos Wanted!
Cash Paid for Junk Cars, Any cond.
Call: 615-766-6460

Recreational Vehicle

I BUY CAMPERS, TRAILERS, & MOTOR HOMES- ALL TYPES. ready to go or need work. For FAST CASH Call Lawrence at 931-242-3135

Business & Service Directory

to advertise, email: **ServiceDirectory@tennessean.com**
or call: **800.828.4237**

Home Improvement

LOOK
ENGLISH HOME IMPROVEMENTS
- Serving Middle TN & Western KY
- A+ Rating with the BBB
- Named a top 3 Nashville Contractor
- Licensed TN # 00068088 & Insured Complete Contractor

"We do it all from Roofs to Additions"
•Window Special•
Buy 10 - Get 2 FREE
Tell us you saw us in the Tennessean & save $500 off your home improvement.
615-746-0990
EnglishHomeImprovements.com

Hertz Asphalt and Concrete Services
Parking Lots, Driveways, Seal Coating, and Repairs
- 2 Free Estimates for Asphalt or Concrete
- No Job Too Large or Too Small

Mention This Ad and Get $100 Off!
BBB A+ Member
615-941-2941 or 615-498-6008

Your merchandise is as good as gone. Call 242-SALE today.

Home Improvement

Samuel's Home Improvement
615-397-0126
•Decks •Windows •Doors
•Painting •Crown Molding
•Floors •Roofing/Repairs
Any Home Improvement
⋆Free Estimates⋆

Lawn - Garden Care

CALL 615-946-3427
Removal, Topping, Trimming, Stump, Pruning, Lots/Fence Cleaning.
15 Yrs. Exp.

COOK'S LAWNCARE SERVICE & LANDSCAPING
Sod Installation, Hedge Trimming, Beds Mulched, Aerating & Power Seeding, Lawn Maintenance, Retaining Walls, Patios & Decks, Tree Service, Grading, Leaf Removal, Spring Clean Ups
Lic & Ins
TN License #00004796
615-415-5727
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_Tree Removal
• Trimming
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æ✓Licensed æ✓ Insured
Residential & Commercial
615-394-3498

Pets

to advertise, visit: **classifieds.tennessean.com**
or call: **800.828.4237**

Domestic Pets

AKC Siberian Husky, female. 2 yrs old. Grey & white. Great Momma - gentle! $500. Text 931-510-8888

AKC Siberian Husky, male, 2yrs old, red & white, long hair. Great dog! $600. Text 931-510-8888

Bichon Puppies CKC Reg. M/F, UTD shots/deworming, Health Guarantee M $500, F $700. Text/call 270-392-9464

Black adorable Lhasapoo puppies: kid friendly, great pets! UTD on shots, worming. $500. 270-475-2714

Boxer, Males / Females, , 8 weeks, Brindle / Reverse Brindle CKC Registered $600.00 (270)646-7111 Chuckchchn@aol.com

Cavalier King Charles Spaniels, CKC, M/F, 6 wks. Crate trained. Nashville 615-319-6802

Golden Retrievers, M/F, 8 wks 3/20/2023, Light Golden AKC reg. papers in hand $300. (731)648-9308 boomail@charter.net

Domestic Pets

Great Pyrenees AKC , 14 wks, White /badger markings raised and kept with goats. Vet checked & up to date on shots & worming. You will not be disappointed with their temperament $400 (615)801-6065 sheltonssprings@gmail.com

Lab Puppies, Black/Yellow, Shots/Wormed, Good Bloodlines, very sharp pups, $500 (731)592-0169

Shichon Original Teddy Bears, M/F, CKC, Reg., UTD shots/deworming, $600. Text/call 270-392-9937

Shi-Chon Puppies-Males, Beautiful Sweet Babies, Ready for your Home! (270)465-1601

SHIH-POO PUPPIES- Males & Females., 7 wks, 1st shots & wormed, pad trained. $800. 615-578-3809

Pet Services

Free Easter Pet Portraits! All pets welcome! , Friday, April 7th 3pm-6pm LebanonAnimalHospital 1613 W Main St

When you advertise merchandise in **The Tennessean Classifieds**, for as little as $1 per day, you'd better be ready to part with it. Call 242-SALE or place your ad online @ www.tennessean.com

Whats Hot Announce
messages & notices...

Announcements

7 very important scripture cards for donation of any dollar amt. If you would like to receive a set send a check or money order for any dollar mount to Allen or Patricia Underwood, PO BOX 287, Huntsville, AL 35804

Davidson East

Nashville , Vintage Collectibles, 1113 Massman Dr, Fri&Sat, 8:30-3, All vintage- rubber face plush, dolls, McCoy pottery, carnival chalkware, wood boxes & trunks(lots!), Maxfield Parrish prints, soapstone, pyrography, small tables, baskets, decanters, rugs, clothes, African & Native American decor, inversion tbl, DOGWOODESTATESALES.COM,

Davidson South

BRENTWOOD: BANBURY CROSSING, 37027.
April 8th; 8am-? (Rain day 4/15)
(Off Edmondson Pike)
Homeowners Association
HUGE SUBDIVISON SALE!

Assorted Merch
all kinds of things...

General Merchandise

MASTERS WINNERS on the front of a Wheaties box: A. Palmer $40, T. Woods $40, J. Spieth $20. (615)298-4572

NATIONAL PARKS QUARTERS-, complete set of all 56 quarters, in album, $30, singles $.50 each. (615)298-4572

Wanted to Buy

RECORDS & CDs WANTED-LPs/45s/78s Personal & DJ Collections/Promo Items Old Stock etc. CASH PAID. 615-256-6763

WANTED- Silver Eagles, Gold, Silver Platinum Coins, Rare Coins, Pre-1972 All Sports cards, etc. 615-497-9852

Public Notices

0005654554

NOTICE
Horton Highway Utility District will hold their regular monthly Board Meeting on Wednesday, April 12, 2023 at 3PM. The Board Meeting will be held at Horton Highway Utility District, 102 S Horton Pkwy., Chapel Hill, TN 37034.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

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Andrew Jackson Building, 9th Floor
502 Deaderick Street Nashville, TN 37243

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Public Notices

NOTICE TO FURNISHERS OF LABOR AND MATERIALS TO:
Lu, Inc.
PROJECT NO.: 98304-4132-04
CONTRACT NO.: CNV115
COUNTY: Davidson
The Tennessee Department of Transportation is about to make final settlement with the contractor for construction of the above numbered project. All persons wishing to file claims pursuant to Section 54-5-122, T.C.A. must file same with the Director of Construction, Tennessee Department of Transportation, Suite 700 James K. Polk Bldg., Nashville, Tennessee 37243-0326, on or before 5/12/2023.

Public Notices

NOTICE TO FURNISHERS OF LABOR AND MATERIALS TO:
Vulcan Construction Materials, LLC
PROJECT NO.: 19019-3224-94, 19019-8224-14
CONTRACT NO.: CNV147
COUNTY: Davidson
The Tennessee Department of Transportation is about to make final settlement with the contractor for construction of the above numbered project. All persons wishing to file claims pursuant to Section 54-5-122, T.C.A. must file same with the Director of Construction, Tennessee Department of Transportation, Suite 700 James K. Polk Bldg., Nashville, Tennessee 37243-0326, on or before 5/12/2023.

AFFIDAVIT OF PUBLICATION

0005653721
Newspaper The Tennessean

State of Tennessee

Account Number NAS-0000004912
Advertiser TRISTAR SOUTHERN HILLS MEDICAL

TRISTAR SOUTHERN HILLS MEDICAL
391 WALLACE RD
NASHVILLE, TN
37211

TEAR SHEET ATTACHED

Jackie Cooper Sales Assistant for the above mentioned newspaper,

hereby certify that the attached advertisement appeared in said newspaper on the following dates:

04/06/23

Jackie Cooper

Subscribed and sworn to before me this 6 day of April 2023.

Charly Neel
Notary Public

Affidavits Requested:

1

NOTIFICATIONOFINTENTTOAPPLYFORACERTIFICATEC

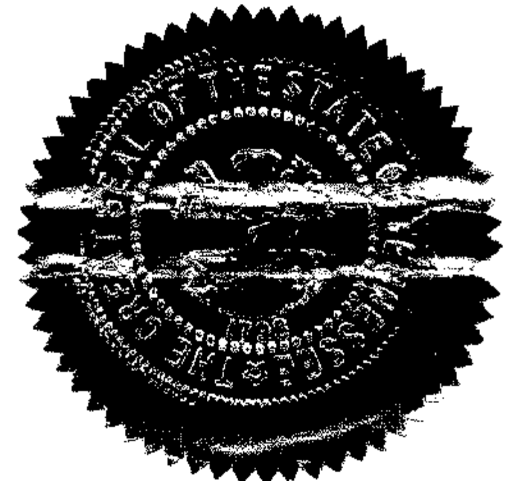
Attachment 7A-1
Articles of Incorporation

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 HCA HEALTH SERVICES OF TENNESSEE, INC.,
(Name of 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 July Twenty-ninth, *19* 81.

Gentry Crowell
Secretary of State



FILED
SECRETARY OF STATE
1981 JUL 29 PM 3:33

00224 00808

CHARTER

OF

HCA HEALTH SERVICES OF TENNESSEE, INC.

The undersigned natural persons, having capacity to 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 HCA HEALTH SERVICES OF TENNESSEE, INC.

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.

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.

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

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.

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

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

00224 00809

(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 to the extent of unreserved and unrestricted capital surplus.

DATED: July 22, 1981.

Charles L. Kown

Bettye D. Daugherty

Ruth B. Foster

Secretary of State
Corporations Section
James K. Polk Building, Suite 1800
Nashville, Tennessee 37243-0306

DATE: 11/02/90
REQUEST NUMBER: 1982-1236
TELEPHONE CONTACT: (615) 741-0537
FILE DATE/TIME: 11/02/90 1559
EFFECTIVE DATE/TIME: 11/02/90 1559
CONTROL NUMBER: 0105942

TO:
HCA HOSPITAL CORPORATION OF AMERICA
P.O. BOX 550

NASHVILLE, TN 37202

BOOK 8237 PAGE 389

RE:
HCA HEALTH SERVICES OF TENNESSEE, INC.
CHARTER AMENDMENT

THIS WILL ACKNOWLEDGE THE FILING OF THE ENCLOSED DOCUMENT ON THE DATE SHOWN ABOVE TO BE EFFECTIVE AS INDICATED.

PLEASE BE ADVISED THAT THIS DOCUMENT MUST ALSO BE FILED IN THE OFFICE OF THE REGISTER OF DEEDS IN THE COUNTY WHEREIN A CORPORATION HAS ITS PRINCIPAL OFFICE IF SUCH PRINCIPAL OFFICE IS IN TENNESSEE.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE CORPORATION CONTROL NUMBER GIVEN ABOVE.

72438
IDENTIF. REFERENCE
Nov 14 3 42 PM '90
FELIX Z. WILSON II REGISTER
DAVIDSON COUNTY TN.

7140 11/14 0101 03CHECK 5.00

FOR: CHARTER AMENDMENT

RECEIVED: $10.00

ON DATE: 11/02/90

FROM:
HCA HOSPITAL CORPORATION OF AMERICA
P.O. BOX 550

NASHVILLE, TN 37202

RECEIPT NUMBER: 00001133333
ACCOUNT NUMBER: 00059042

BRYANT MILLSAPS
SECRETARY OF STATE

SS-4458

FILED
STATE OF TENNESSEE
1990 NOV -2 PM 3:59

ARTICLES OF AMENDMENT TO THE
CHARTER OF
HCA HEALTH SERVICES OF TENNESSEE, INC.

Pursuant to the provisions of the Tennessee Business Corporation Act, the undersigned corporation adopts the following Amendment to its Charter:

1. The name of the corporation is HCA Health Services of Tennessee, Inc.

2. The amendment adopted shall delete the Sixth Article in its entirety and substitute the following therefore:

   "The maximum number of shares which the Corporation shall have the authority to issue is Two Thousand (2,000) shares of Common Stock, par value of $1.00 per share."

3. The amendment was duly adopted by the unanimous vote of the Board of Directors taken by unanimous written consent dated as of October 29, 1990.

4. Shareholder action was not required for the adoption of the amendment.

DATED: October 29, 1990

HCA HEALTH SERVICES OF TENNESSEE, INC.

By: [signature]
John O. Colton
President

ATTESTED TO:

By: [signature]
Bettye D. Daugherty
Secretary

Attachment 7A-2

Corporate Existence

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

WOLTERS KLUWER
E
600 SOUTH
SPRINGFIELD, IL 62704

December 6, 2021

Request Type: Certificate of Existence/Authorization
Request #: 0448803

Issuance Date: 12/06/2021
Copies Requested: 1

Document Receipt

Receipt # : 006758211	Filing Fee:	$20.00
Payment-Credit Card - State Payment Center - CC #: 3819580133		$20.00

Regarding: HCA HEALTH SERVICES OF TENNESSEE, INC.
Filing Type: For-profit Corporation - Domestic
Formation/Qualification Date: 07/29/1981
Status: Active
Duration Term: Perpetual
Business County: DAVIDSON COUNTY

Control # : 105942
Date Formed: 07/29/1981
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

HCA HEALTH SERVICES OF TENNESSEE, INC.

* is a Corporation duly incorporated under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, interest, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 050301918

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Filing Information

Name: HCA HEALTH SERVICES OF TENNESSEE, INC.

General Information

SOS Control #	000105942	Formation Locale:	TENNESSEE
Filing Type:	For-profit Corporation - Domestic	Date Formed:	07/29/1981
	07/29/1981 4:30 PM	Fiscal Year Close	12
Status:	Active		
Duration Term:	Perpetual		

Registered Agent Address
C T CORPORATION SYSTEM
300 MONTVUE RD
KNOXVILLE, TN 37919-5546

Principal Address
1 PARK PLZ
NASHVILLE, TN 37203-6527

The following document(s) was/were filed in this office on the date(s) indicated below:

Date Filed	Filing Description	Image #
04/12/2022	Assumed Name Renewal	B1199-4022

Assumed Name Changed From: TriStar Ashland City Medical Center To: TriStar Ashland City Medical Center
Expiration Date Changed From: 04/19/2022 To: 04/12/2027

04/12/2022	Assumed Name Renewal	B1199-4015

Assumed Name Changed From: TriStar Centennial Medical Center To: TriStar Centennial Medical Center
Expiration Date Changed From: 04/19/2022 To: 04/12/2027

04/12/2022	Assumed Name Renewal	B1199-4006

Assumed Name Changed From: TriStar Centennial Women's & Children's Hospital To: TriStar Centennial Women's & Children's Hospital
Expiration Date Changed From: 04/19/2022 To: 04/12/2027

04/12/2022	Assumed Name Renewal	B1199-3989

Assumed Name Changed From: TriStar Parthenon Pavilion To: TriStar Parthenon Pavilion
Expiration Date Changed From: 04/19/2022 To: 04/12/2027

04/12/2022	Assumed Name Renewal	B1199-3974

Assumed Name Changed From: TriStar Southern Hills Medical Center To: TriStar Southern Hills Medical Center
Expiration Date Changed From: 04/19/2022 To: 04/12/2027

04/12/2022	Assumed Name Renewal	B1199-3964

Assumed Name Changed From: TriStar StoneCrest Medical Center To: TriStar StoneCrest Medical Center

Filing Information

Name: HCA HEALTH SERVICES OF TENNESSEE, INC.

Expiration Date Changed From: 04/19/2022 To: 04/12/2027

04/12/2022 Assumed Name Renewal B1199-3959

Assumed Name Changed From: TriStar Summit Medical Center To: TriStar Summit Medical Center

Expiration Date Changed From: 04/19/2022 To: 04/12/2027

03/24/2022 2021 Annual Report B1186-0215

01/12/2022 Assumed Name Renewal B1145-0438

Assumed Name Changed From: STONECREST MEDICAL CENTER To: STONECREST MEDICAL CENTER

Expiration Date Changed From: 01/13/2022 To: 01/12/2027

03/25/2021 2020 Annual Report B1006-5501

09/16/2020 Assumed Name Renewal B0809-9216

Assumed Name Changed From: WOMEN'S HOSPITAL AT CENTENNIAL MEDICAL CENTER To: WOMEN'S HOSPITAL AT CENTENNIAL MEDICAL CENTER

Expiration Date Changed From: 10/09/2020 To: 09/16/2025

04/02/2020 Assumed Name Renewal B0844-4839

Assumed Name Changed From: CENTENNIAL MEDICAL CENTER AT ASHLAND CITY To: CENTENNIAL MEDICA CENTER AT ASHLAND CITY

Expiration Date Changed From: 05/01/2020 To: 04/02/2025

03/26/2020 2019 Annual Report B0847-0362

03/20/2019 2018 Annual Report B0673-6985

03/07/2018 2017 Annual Report B0511-9002

01/26/2018 Registered Agent Change (by Agent) *B0478-4994

Registered Agent Physical Address 1 Changed From: 800 S GAY ST To: 300 MONTVUE RD

Registered Agent Physical Address 2 Changed From: STE 2021 To: No Value

Registered Agent Physical Postal Code Changed From: 37929-9710 To: 37919-5546

04/19/2017 Assumed Name Renewal B0337-9227

Assumed Name Changed From: TriStar Ashland City Medical Center To: TriStar Ashland City Medical Center

Expiration Date Changed From: 05/18/2017 To: 04/19/2022

04/19/2017 Assumed Name Renewal B0337-9228

Assumed Name Changed From: TriStar Centennial Medical Center To: TriStar Centennial Medical Center

Expiration Date Changed From: 05/18/2017 To: 04/19/2022

04/19/2017 Assumed Name Renewal B0337-9229

Assumed Name Changed From: TriStar Centennial Women's & Children's Hospital To: TriStar Centennial Women's & Children's Hospital

Expiration Date Changed From: 05/18/2017 To: 04/19/2022

04/19/2017 Assumed Name Renewal B0337-9230

Assumed Name Changed From: TriStar Parthenon Pavilion To: TriStar Parthenon Pavilion

Expiration Date Changed From: 05/18/2017 To: 04/19/2022

Filing Information

Name: HCA HEALTH SERVICES OF TENNESSEE, INC.

04/19/2017	Assumed Name Renewal	B0337-9231

Assumed Name Changed From: TriStar Southern Hills Medical Center To: TriStar Southern Hills Medical Center

Expiration Date Changed From: 05/18/2017 To: 04/19/2022

04/19/2017 Assumed Name Renewal B0337-9232

Assumed Name Changed From: TriStar StoneCrest Medical Center To: TriStar StoneCrest Medical Center

Expiration Date Changed From: 05/18/2017 To: 04/19/2022

04/19/2017 Assumed Name Renewal B0337-9233

Assumed Name Changed From: TriStar Summit Medical Center To: TriStar Summit Medical Center

Expiration Date Changed From: 05/18/2017 To: 04/19/2022

02/22/2017 2016 Annual Report B0349-6221

01/13/2017 Assumed Name Renewal B0311-8701

Assumed Name Changed From: STONECREST MEDICAL CENTER To: STONECREST MEDICAL CENTER

Expiration Date Changed From: 02/13/2017 To: 01/13/2022

02/27/2016 2015 Annual Report B0204-8087

10/09/2015 Assumed Name Renewal B0133-8391

Assumed Name Changed From: WOMEN'S HOSPITAL AT CENTENNIAL MEDICAL CENTER To: WOMEN'S HOSPITAL AT CENTENNIAL MEDICAL CENTER

Expiration Date Changed From: 10/21/2015 To: 10/09/2020

05/01/2015 Assumed Name Renewal B0094-4006

Assumed Name Changed From: CENTENNIAL MEDICAL CENTER AT ASHLAND CITY To: CENTENNIAL MEDICA CENTER AT ASHLAND CITY

Expiration Date Changed From: 06/07/2015 To: 05/01/2020

03/17/2015 2014 Annual Report B0062-8313

03/24/2014 2013 Annual Report 7308-1378

12/10/2013 Assumed Name Renewal 7261-2622

Assumed Name Changed From: SOUTHERN HILLS MEDICAL CENTER To: SOUTHERN HILLS MEDICAL CENTER

Expiration Date Changed From: 01/15/2014 To: 12/10/2018

03/28/2013 2012 Annual Report 7178-1045

11/08/2012 Assumed Name Renewal 7113-2088

Assumed Name Changed From: SUMMIT MEDICAL CENTER To: SUMMIT MEDICAL CENTER

Expiration Date Changed From: 12/01/2012 To: 11/08/2017

05/18/2012 Assumed Name 7056-2233

New Assumed Name Changed From: No Value To: TriStar Ashland City Medical Center

05/18/2012 Assumed Name 7056-2234

New Assumed Name Changed From: No Value To: TriStar Parthenon Pavilion

05/18/2012 Assumed Name 7056-2236

Filing Information

Name: HCA HEALTH SERVICES OF TENNESSEE, INC.

New Assumed Name Changed From: No Value To: TriStar Centennial Medical Center

05/18/2012 Assumed Name 7056-2237

New Assumed Name Changed From: No Value To: TriStar Centennial Women's & Children's Hospital

05/18/2012 Assumed Name 7056-2242

New Assumed Name Changed From: No Value To: TriStar Southern Hills Medical Center

05/18/2012 Assumed Name 7056-2243

New Assumed Name Changed From: No Value To: TriStar StoneCrest Medical Center

05/18/2012 Assumed Name 7056-2244

New Assumed Name Changed From: No Value To: TriStar Summit Medical Center

03/26/2012 2011 Annual Report 7020-1603

Principal Address 1 Changed From: ONE PARK PLAZA To: 1 PARK PLZ

Principal Postal Code Changed From: 37203 To: 37203-6527

Principal County Changed From: No value To: DAVIDSON COUNTY

02/13/2012 Assumed Name Renewal 6995-2117

Assumed Name Changed From: STONECREST MEDICAL CENTER To: STONECREST MEDICAL CENTER

Expiration Date Changed From: 02/28/2012 To: 02/13/2017

12/22/2011 Assumed Name Renewal 6972-0458

Assumed Name Changed From: CENTENNIAL MEDICAL CENTER To: CENTENNIAL MEDICAL CENTER

Expiration Date Changed From: 01/06/2012 To: 12/22/2016

03/30/2011 2010 Annual Report 6867-0724

10/21/2010 Assumed Name Renewal 6786-0279

Assumed Name Changed From: WOMEN'S HOSPITAL AT CENTENNIAL MEDICAL CENTER To: WOMEN'S HOSPITAL AT CENTENNIAL MEDICAL CENTER

Expiration Date Changed From: 11/08/2010 To: 10/21/2015

06/07/2010 Assumed Name Renewal 6727-2996

Assumed Name Changed From: CENTENNIAL MEDICAL CENTER AT ASHLAND CITY To: CENTENNIAL MEDICA CENTER AT ASHLAND CITY

Expiration Date Changed From: 07/27/2010 To: 06/07/2015

02/26/2010 2009 Annual Report A0007-3178

09/02/2009 Assumed Name Renewal 6589-3206

09/02/2009 Assumed Name 6590-1522

09/02/2009 Assumed Name 6590-1523

09/02/2009 Assumed Name 6590-1524

04/15/2009 2008 Annual Report 6519-1012

12/15/2008 Assumed Name Renewal 6409-2118

03/11/2008 2007 Annual Report 6240-2334

11/02/2007 Assumed Name Renewal 6154-0550

Filing Information

Name: HCA HEALTH SERVICES OF TENNESSEE, INC.

04/02/2007	2006 Annual Report	6013-0159
01/10/2007	Assumed Name Renewal	5913-0461
12/08/2006	Assumed Name Renewal	5898-2670
03/17/2006	2005 Annual Report	5723-1257
01/06/2006	Assumed Name Cancellation	5640-0132
09/28/2005	Assumed Name Renewal	5567-0690
05/25/2005	Assumed Name Renewal	5464-0925
03/22/2005	2004 Annual Report	5398-2661
09/27/2004	Registered Agent Change (by Agent)	5243-0482
Registered Agent Physical Address Changed		
06/09/2004	Assumed Name	5155-0129
03/12/2004	2003 Annual Report	5062-1520
01/15/2004	Assumed Name	4999-2409
08/15/2003	Assumed Name Renewal	4888-0302
04/07/2003	2002 Annual Report	4786-3300
03/12/2003	Assumed Name	4750-2907
02/11/2003	Assumed Name	4725-0245
11/27/2002	Assumed Name Renewal	4664-0159
03/27/2002	2001 Annual Report	4460-2906
02/28/2002	Assumed Name	4431-0383
12/18/2001	Registered Agent Change (by Entity)	4371-0253
Registered Agent Physical Address Changed		
Registered Agent Changed		
12/12/2001	Assumed Name Renewal	4366-0671
03/20/2001	2000 Annual Report	4152-1116
Mail Address Changed		
02/28/2001	Assumed Name Cancellation	4135-1404
02/14/2001	Assumed Name	4123-0593
11/08/2000	Assumed Name	4046-0945
09/13/2000	Assumed Name	4002-0994
09/08/2000	Assumed Name Change	4000-0327
07/27/2000	Assumed Name	3962-1010
05/08/2000	Registered Agent Change (by Agent)	3904-0007
Registered Agent Physical Address Changed		
03/29/2000	1999 Annual Report	3866-0548

Filing Information

Name: HCA HEALTH SERVICES OF TENNESSEE, INC.

01/11/2000	Assumed Name Change	3795-0816
10/06/1999	Assumed Name Renewal	3752-2435
01/15/1998	Assumed Name Cancellation	3436-0777
01/15/1998	Assumed Name Cancellation	3436-0778
01/15/1998	Assumed Name	3436-0781
01/15/1998	Assumed Name	3436-0782
12/01/1997	Assumed Name Cancellation	3417-1067
12/01/1997	Assumed Name	3417-1069
02/26/1997	CMS Annual Report Update	3296-1232
Mail Address Changed		
01/06/1997	Assumed Name Cancellation	3264-0620
01/06/1997	Assumed Name	3266-0622
12/12/1996	Articles/Statement of Correction	3252-1081
11/18/1996	Assumed Name	3242-2627
11/15/1996	Assumed Name Cancellation	3242-1896
11/15/1996	Assumed Name Cancellation	3242-1899
11/15/1996	Assumed Name	3242-1901
04/09/1996	Assumed Name Cancellation	3158-0013
04/09/1996	Assumed Name	3158-0019
12/09/1994	Assumed Name	2923-0857
12/09/1994	Assumed Name Cancellation	2923-0859
11/22/1994	Registered Agent Change (by Entity)	2916-2454
Registered Agent Physical Address Changed		
Registered Agent Changed		
10/13/1994	Assumed Name	2903-1746
09/29/1994	Assumed Name	2897-1037
09/26/1994	Assumed Name	2895-1176
09/07/1994	Assumed Name	2887-2185
08/01/1994	Assumed Name	2874-1757
04/22/1994	Registered Agent Change (by Entity)	2839-2315
Registered Agent Changed		
11/02/1990	Articles of Amendment	1982-1236
Shares of Stock Changed		
06/16/1990	Administrative Amendment	FYC/REVENUE

Filing Information

Name: HCA HEALTH SERVICES OF TENNESSEE, INC.

Fiscal Year Close Changed

09/25/1989	Assumed Name	1462-0283
09/25/1989	Assumed Name	1462-0284
09/25/1989	Assumed Name	1462-0285
05/09/1984	Merger	473 02887

Merged Control # Changed From: 000050601

Merged Control # Changed From: 000105942

12/12/1983	Merger	452 01596

Merged Control # Changed From: 000009236

Merged Control # Changed From: 000105942

08/16/1983	Merger	433 01929

Merged Control # Changed From: 000032057

Merged Control # Changed From: 000105942

08/26/1981	Merger	232 00806

Merged Control # Changed From: 000096353

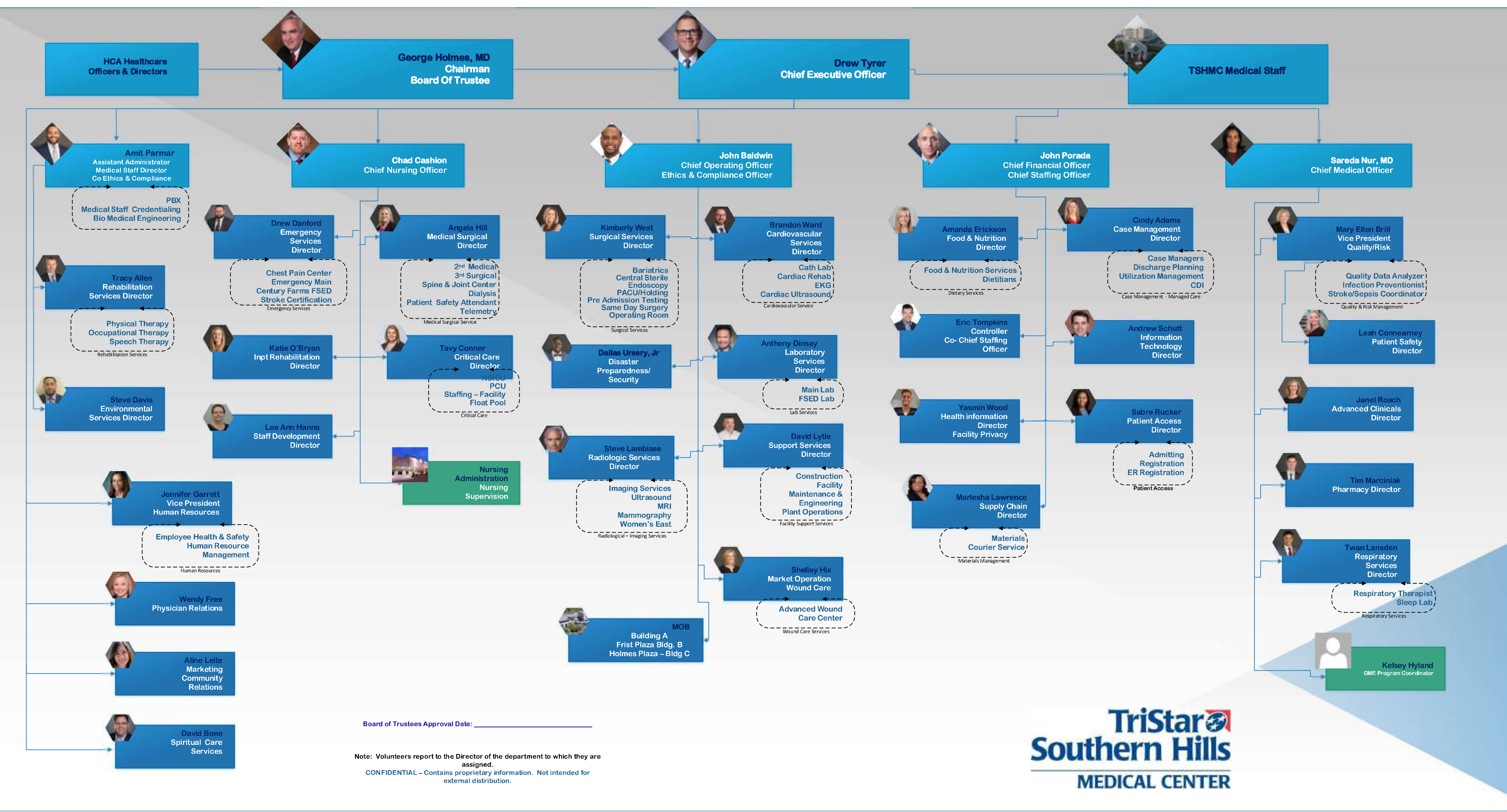
Merged Control # Changed From: 000105942

07/29/1981	Initial Filing	224 00808

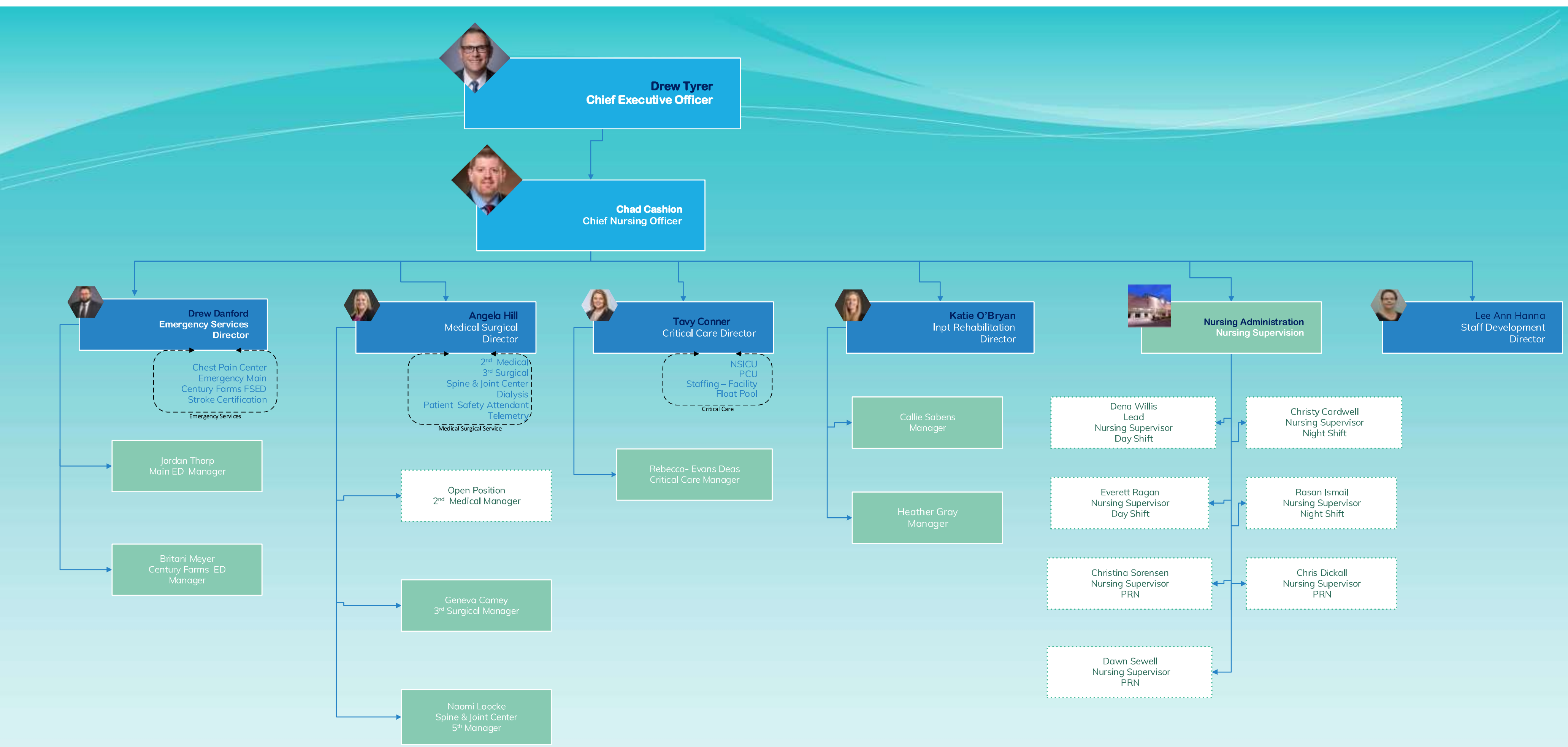
Active Assumed Names (if any)	Date	Expires
TriStar Summit Medical Center	05/18/2012	04/12/2027
TriStar StoneCrest Medical Center	05/18/2012	04/12/2027
TriStar Southern Hills Medical Center	05/18/2012	04/12/2027
TriStar Centennial Women's & Children's Hospital	05/18/2012	04/12/2027
TriStar Centennial Medical Center	05/18/2012	04/12/2027
TriStar Parthenon Pavilion	05/18/2012	04/12/2027
TriStar Ashland City Medical Center	05/18/2012	04/12/2027
WOMEN'S HOSPITAL AT CENTENNIAL MEDICAL CENTER	11/08/2005	09/16/2025
STONECREST MEDICAL CENTER	02/28/2007	01/12/2027
CENTENNIAL MEDICAL CENTER AT ASHLAND CITY	07/27/2005	04/02/2025

Attachment 7A-3

Organizational Chart



HCA Healthcare
Officers & Directors
George Holmes, MD
Chairman
Board Of Trustee
Drew Tyrer
Chief Executive Officer
TSHMC Medical Staff
Amit Parmar
Assistant Administrator
Medical Staff Director
Co Ethics & Compliance
PBX
Medical Staff Credentialing
Bio Medical Engineering
Chad Cashion
Chief Nursing Officer
John Baldwin
Chief Operating Officer
Ethics & Compliance Officer
John Porada
Chief Financial Officer
Chief Staffing Officer
Sareda Nur, MD
Chief Medical Officer
Drew Danford
Emergency
Services
Director
Chest Pain Center
Emergency Main
Century Farms FSED
Stroke Certification
Angela Hill
Medical Surgical
Director
2nd Medical
3rd Surgical
Spine & Joint Center
Dialysis
Patient Safety Attendant
Telemetry
Kimberly West
Surgical Services
Director
Bariatrics
Central Sterile
Endoscopy
PACU/Holding
Pre Admission Testing
Same Day Surgery
Operating Room
Brandon Ward
Cardiovascular
Services
Director
Cath Lab
Cardiac Rehab
EKG
Cardiac Ultrasound
Amanda Erickson
Food & Nutrition
Director
Food & Nutrition Services
Dietitians
Cindy Adams
Case Management
Director
Case Managers
Discharge Planning
Utilization Management
CDI
Mary Ellen Brill
Vice President
Quality/Risk
Quality Data Analyzer
Infection Preventionist
Stroke/Sepsis Coordinator
Tracy Allen
Rehabilitation
Services Director
Physical Therapy
Occupational Therapy
Speech Therapy
Katie O'Bryan
Inpt Rehabilitation
Director
Tavy Conner
Critical Care
Director
NSICU
PCU
Staffing – Facility
Float Pool
Dallas Ursery, Jr
Disaster
Preparedness/
Security
Anthony Dinsay
Laboratory
Services
Director
Main Lab
FSED Lab
Eric Tompkins
Controller
Co- Chief Staffing
Officer
Andrew Schutt
Information
Technology
Director
Leah Connearney
Patient Safety
Director
Steve Davis
Environmental
Services Director
Lee Ann Hanna
Staff Development
Director
Yasmin Wood
Health information
Director
Facility Privacy
Sabre Rucker
Patient Access
Director
Admitting
Registration
ER Registration
Janel Roach
Advanced Clinicals
Director
Nursing
Administration
Nursing
Supervision
Steve Lambiase
Radiologic Services
Director
Imaging Services
Ultrasound
MRI
Mammography
Women's East
David Lytle
Support Services
Director
Construction
Facility
Maintenance &
Engineering
Plant Operations
Marlesha Lawrence
Supply Chain
Director
Materials
Courier Service
Tim Marciniak
Pharmacy Director
Jennifer Garrett
Vice President
Human Resources
Employee Health & Safety
Human Resource
Management
Shelley Hix
Market Operation
Wound Care
Advanced Wound
Care Center
Twan Lansden
Respiratory
Services
Director
Respiratory Therapist
Sleep Lab
Wendy Free
Physician Relations
MOB
Building A
Frist Plaza Bldg. B
Holmes Plaza – Bldg C
Kelsey Hyland
GME Program Coordinator
Aline Leite
Marketing
Community
Relations
David Bone
Spiritual Care
Services
Board of Trustees Approval Date: ___________________
Note: Volunteers report to the Director of the department to which they are assigned.
CONFIDENTIAL – Contains proprietary information. Not intended for external distribution.
TriStar
Southern Hills
MEDICAL CENTER



Board of Trustees Approval Date: ___________________________

Note: Volunteers report to the Director of the department to which they are assigned.

CONFIDENTIAL – Contains proprietary information. Not intended for external distribution.

TriStar Southern Hills
MEDICAL CENTER

Attachment 7A-4

TriStar Southern Hills Medical Center Officers and Directors

January 1, 2023

OFFICERS AND DIRECTORS OF HCA HEALTH SERVICES OF TENNESSEE, INC.

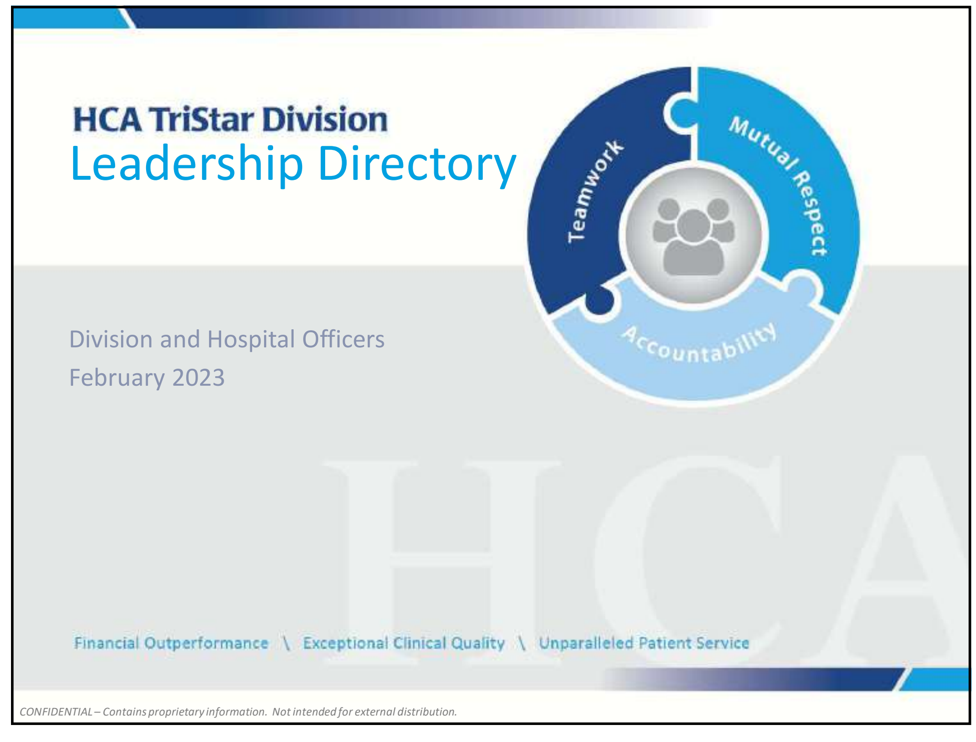
	Name	Title	Address
*	**Samuel N. Hazen**	**President**	**One Park Plaza Nashville, TN 37203**
	Greg Beasley	Senior Vice President	13355 Noel Road, Ste. 1200 Dallas, TX 75240
	Mitch Edgeworth	Senior Vice President	1000 Health Park Drive, Ste 500 Brentwood, TN 37027
	Jon M. Foster	Senior Vice President	One Park Plaza Nashville, TN 37203
	John M. Hackett	Senior Vice President and Treasurer	One Park Plaza Nashville, TN 37203
	Michael R. McAlevey	Senior Vice President	One Park Plaza Nashville, TN 37203
	Tim McManus	Senior Vice President	One Park Plaza Nashville, TN 37203
	Joseph A. Sowell, III	Senior Vice President	One Park Plaza Nashville, TN 37203
*	**Christopher F. Wyatt**	**Senior Vice President**	**One Park Plaza Nashville, TN 37203**
	Kevin A. Ball	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
	Mike T. Bray	Vice President	One Park Plaza Nashville, TN 37203
	Louis Caputo	Vice President	200 StoneCrest Blvd. Smyrna, TN 37167
	Scott Cihak *(through 1/6/2023)*	Vice President	2300 Patterson Street Nashville, TN 37203
	Monica Cintado	Vice President	One Park Plaza Nashville, TN 37203
	Natalie H. Cline	Vice President and Secretary	One Park Plaza Nashville, TN 37203

Daphne David	Vice President	5655 Frist Blvd. Hermitage, TN 37076
Jaime DeRensis	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Melissa J. Egan	Vice President and Assistant Secretary	13355 Noel Road, Ste. 1200 Dallas, TX 75240
Tim D. Evans	Vice President	One Park Plaza Nashville, TN 37203
Wes Fountain	Vice President	1000 Health Park Drive, Ste 500 Brentwood, TN 37027
* **John M. Franck II**	**Vice President and Assistant Secretary**	**One Park Plaza** **Nashville, TN 37203**
Ronald Lee Grubbs, Jr.	Vice President	One Park Plaza Nashville, TN 37203
Seth A. Killingbeck	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Jeff McInturff	Vice President	One Park Plaza Nashville, TN 37203
T. Scott Noonan	Vice President	One Park Plaza Nashville, TN 37203
Tom Ozburn *(effective 2/1/2023)*	Vice President	2300 Patterson Street Nashville, TN 37203
Nicholas L. Paul	Vice President	1100 Dr. Martin L. King, Jr. Blvd Suite 1500 Nashville, TN 37203
Peter Rossell	Vice President	One Park Plaza Nashville, TN 37203
Brittain Sexton	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Brad Spicer	Vice President	One Park Plaza Nashville, TN 37203
Greg Swinney	Vice President	13355 Noel Road, Ste. 1200 Dallas, TX 75240
Drew Tyrer	Vice President	391 Wallace Road Nashville, TN 37211

David Whalen	Vice President	13355 Noel Road, Ste. 1200 Dallas, TX 75240
Daniel Winkler	Vice President	One Park Plaza Nashville, TN 37203
Russ Young	Vice President	One Park Plaza Nashville, TN 37203
Doug L. Downey	Assistant Secretary	One Park Plaza Nashville, TN 37203
Deborah H. Mullin	Assistant Secretary	One Park Plaza Nashville, TN 37203
Shirley Scharf-Cheatham	Assistant Secretary	One Park Plaza Nashville, TN 37203
John I. Starling	Assistant Secretary	One Park Plaza Nashville, TN 37203
Julie Wickwire	Assistant Secretary	One Park Plaza Nashville, TN 37203

***Directors**

Persons employed in the capacity of Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Administrator and Assistant Administrator of facilities owned and/or operated by this Company or by a partnership for which this Company acts as general partner or by a limited liability company for which this Company acts as managing member, are hereby authorized to, subject to the Company's policies and procedures, (a) manage the facilities and all day-to-day operations of, and the employees and agents of the Company at, such facilities, and take such other acts as are necessary or appropriate for the proper functioning of the facilities, and (b) negotiate and enter into contracts and agreements necessary to conduct the day-to-day business of such facilities, including, but not limited to, physician contracts, personal property leases, purchase agreements, cost reports, and similar documents (but specifically excluding any contracts or leases relating to real estate, except for leases to tenants in buildings owned by or leased to the Company entered into pursuant to the Company's policies and procedures) which with the advice of legal counsel shall be deemed appropriate and advisable, and to execute and deliver Certificates of Resolution required in connection with such contracts and agreements.



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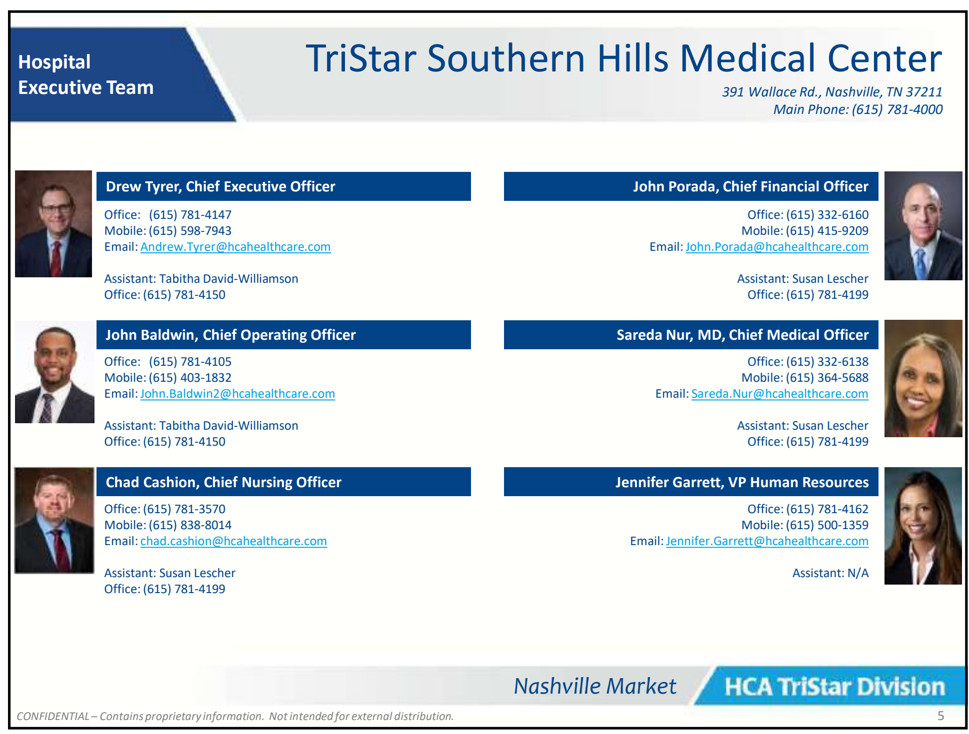

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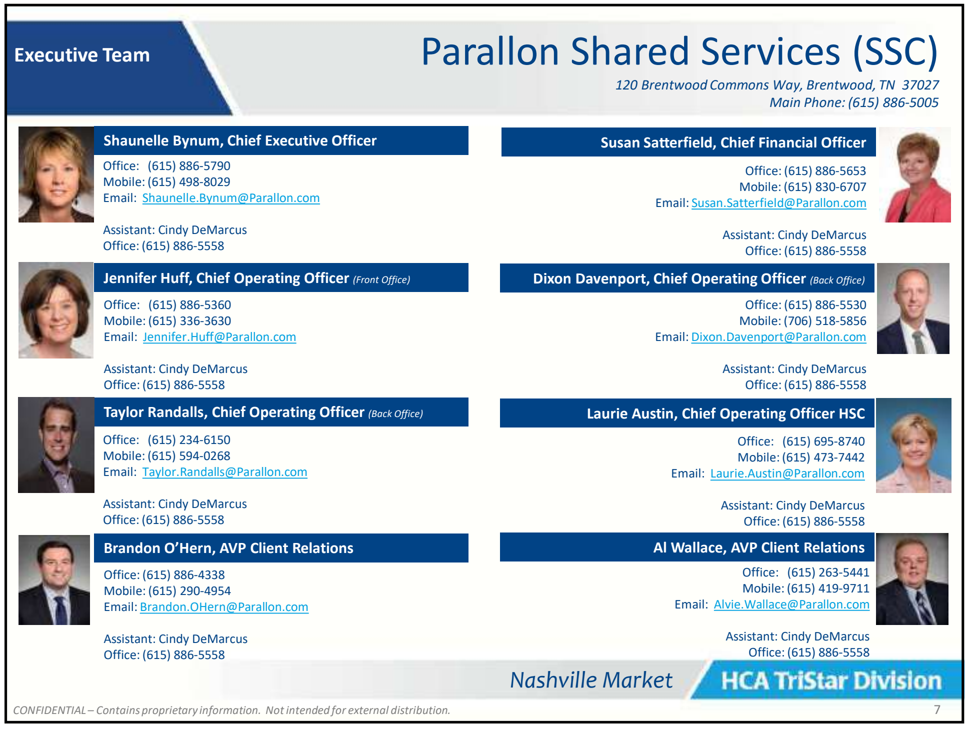

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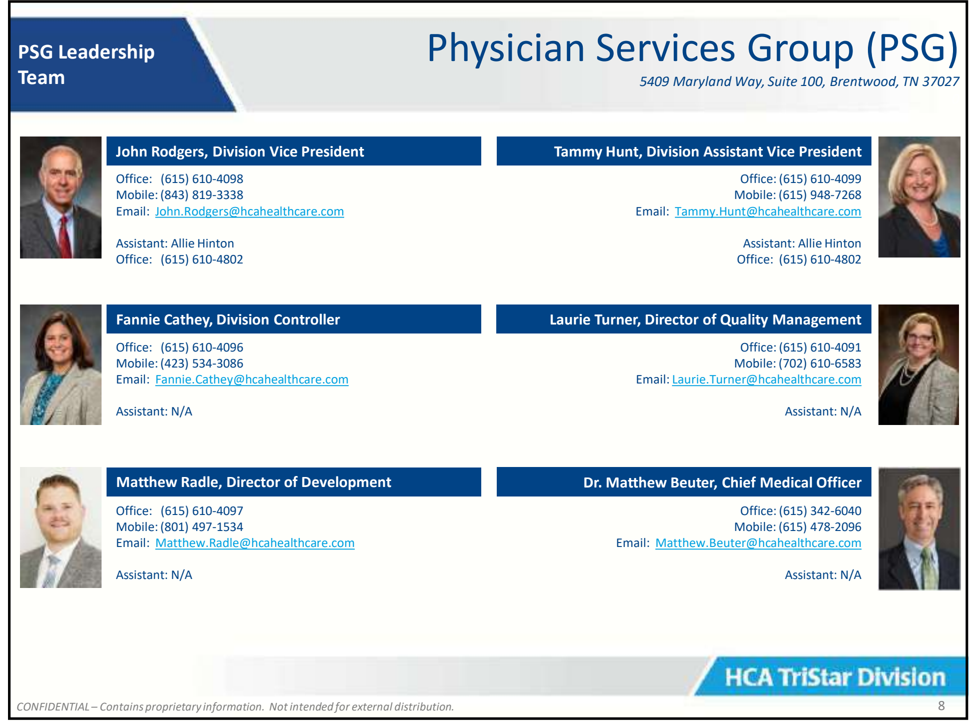

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Attachment 9A

Contract for Site

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REAL ESTATE PURCHASE AND SALE AGREEMENT

THIS REAL ESTATE PURCHASE AND SALE AGREEMENT (*"Agreement"*) is made and entered into effective as of the date the last of the Parties executes this Agreement (*"Effective Date"*), by and between **BURKITT COMMONS II, LLC**, a Tennessee limited liability company (*"Seller"*), and **HCA HEALTH SERVICES OF TENNESSEE, INC.**, a Tennessee corporation, its successors and assigns (*"Purchaser"*). Seller and Purchaser are sometimes referred to in this Agreement individually as a *"Party"* and collectively as the *"Parties."*

A. Seller owns certain real property situated in Davidson and Williamson Counties, Tennessee, located generally at the intersection of Nolensville Rd. and Burkitt Place Dr., Nolensville, Tennessee, and identified as Lot 1 and a portion of Lot 3 of the Final Plat of Burkitt Commons II, of record in Plat Book P74, Page 90 in the Register's Office of Williamson County, Tennessee (the "*Existing Plat*"), and being generally depicted as Lot 1 and Lot 3 Portion on Exhibit A attached to this Agreement (the *"Land"*). The description of the Land as established by the Final Plat (defined below) will govern. The Land, all appurtenances to the Land, and all improvements located on the Land as of the Effective Date, are referred to collectively in this Agreement as the *"Property."* Seller desires to sell, and Purchaser desires to purchase, the Property according to the terms and conditions of this Agreement.

IN CONSIDERATION of $10.00, the premises, the agreements contained in this Agreement and other good and valuable consideration, the receipt and legal sufficiency of which are acknowledged, the Parties agree to the following:

1. SALE OF PROPERTY. Seller and Purchaser agree to sell, purchase and transfer the Property in the Delivery Condition and according to the terms of this Agreement. *"Delivery Condition"* means that the Property is (i) free of all tenancies or other rights of occupancy and physically free of all tenants or other occupants and physically free of all personal property of Seller, tenants and other occupants, (ii) without change from the Contingency Date with respect to the environmental condition of the Property, and (iii) without change from the Contingency Date with respect to the physical condition of Property (other than environmental conditions) other than ordinary wear and tear.

2. PURCHASE PRICE. The purchase price (*"Purchase Price"*) for the Property is $8,956,000.00.

3. EARNEST MONEY. Purchaser shall deliver $200,000.00 (*"Earnest Money"*) to First American Title Insurance Company – National Commercial Services having an address of 2095 Exeter Road, Suite 80-345, Germantown, Tennessee 38138, Attn.: Rita Bost (*"Title Company"* or "*Escrow Agent*") within three (3) business days after the Effective Date. The Earnest Money will be held and disbursed according to this Agreement and applied toward the Purchase Price at Closing.

4. PRORATIONS AND ADJUSTMENTS. The following prorations and adjustments will be made to the Purchase Price at Closing. Other items of proration not enumerated below, will be prorated or allocated consistent with local custom where the Property is located.

(a) Taxes. All taxes imposed on the Property (*"Taxes"*) for the year in which Closing occurs which are not yet due and payable will be prorated to the Closing Date. This proration will be based on the latest information available regarding Taxes and on a 365-day calendar year and will be final on the Closing Date. Taxes allocable to the Closing Date will be charged to Purchaser. If Taxes for the year in which Closing occurs have not been fixed by the Closing Date, then the proration will be based upon the Purchase Price and rate of levy for the previous calendar year. Seller will be responsible to pay for all special assessments by any governmental authority that are due, assessed, approved or contemplated by such authority on or before the Closing Date. All refunds of Taxes received by Seller or Purchaser after the Closing with respect to any property tax appeals (each a *"Tax Refund"*) will be applied as follows. First, such Tax Refund will be applied to reimburse Seller or Purchaser, as the case may be, for third party expenses incurred in protesting and obtaining such Tax

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Refund. Second, such Tax Refunds will be paid (i) to Seller if such Tax Refund is for any period which ends before the Closing Date, (ii) to Purchaser if such Tax Refund is for any period which commences on or after the Closing Date, or (iii) to Seller and Purchaser prorated based on the Closing Date, if such Tax Refund is for a period which includes the Closing Date. If Seller or Purchaser receives any Tax Refund, then each shall retain or promptly pay such amounts (or portions of such amounts) in order that such payments are applied in the manner set forth in this Section 4(a). Purchaser and Seller agree to cooperate with respect to any pending Tax Refund request. The provisions of this Section 4(a) will survive Closing.

(b) Utilities. All pro-ratable public utility costs (including heat, light, power, electricity, and water or fuel remaining for the production of the same, rents, if applicable, and private service contracts, if any), will be prorated and adjusted to the Closing Date based on final readings of such utilities. If such final readings have not been obtained by the Closing Date, then such utility costs will be prorated based on the most recent bills received by Seller. Recurring special charges and special taxes will be prorated based on the last ascertainable bill.

(c) Private Fees and Assessments. If the Property is a part of a subdivision or subject to a declaration, reciprocal easement agreement or other instrument or arrangement (each, a "***Private Restriction***") and is subject to the imposition of fees or assessments in connection with such Private Restriction, then (i) all regular and ordinary fees imposed on the Property pursuant to such Private Restriction ("***Regular Private Assessments***") for the year in which Closing occurs will be prorated and adjusted to the Closing Date, (ii) Seller will be responsible to pay for all special assessments or reimbursements under any Private Restriction that are due, assessed, approved or contemplated on or prior to the Closing Date or allocable to any period prior to the Closing Date, and (iii) Seller will not be credited for any cash reserves from Regular Private Assessments previously paid by Seller.

(d) Expenses. Seller will be responsible to pay for: (i) all expenses in connection with the payment of any Seller Encumbrances and recording costs to release any Seller Encumbrances, (ii) the costs of obtaining the Title Commitment and the premium for Purchaser's owner's policy of title insurance and endorsements to such policy, (iii) Seller's attorneys' fees, (iv) 1/2 of the customary escrow or closing fees charged by the Title Company, and (v) such other expenses provided to be paid by Seller in this Agreement. Purchaser will be responsible to pay for: (i) recording fees not related to the release of Seller Encumbrances, (ii) all real estate transfer taxes, documentary stamp taxes or similar charges or taxes, if any (iii) Purchaser's expenses for tests, inspections and surveys, and the cost of Purchaser's financing, if any, (iv) Purchaser's attorneys' fees, (v) 1/2 of the customary escrow or closing fees charged by the Title Company, and (vi) such other expenses provided to be paid by Purchaser in this Agreement.

5. ITEMS TO BE DELIVERED BY SELLER. Seller shall deliver to Purchaser or otherwise make available to Purchaser and its consultants for review and copying, within five days following the Effective Date, all Property Information (defined below) that is in the possession or control of Seller. If Purchaser does not acquire the Property pursuant to this Agreement, then Purchaser shall return any Property Information received by Purchaser to Seller within ten business days after termination of this Agreement. "***Property Information***" means any of the following with respect to the Property: (i) Seller's most recent title policy and survey, (ii) Seller's most recent environmental study, report or assessment, and (iii) a summary of all pending and threatened litigation or condemnation proceedings, and all claims by third parties against Seller as the same relate to the Property. Except for the summary described in subsection (iii) above, all such Property Information will be provided without any representation or warranty whatsoever as to accuracy and completeness or otherwise, and if Purchaser chooses to rely on any such documentation, Purchaser will be doing so at its own risk.

6. INVESTIGATION OF THE PROPERTY BY PURCHASER. Seller grants to Purchaser and its agents and representatives the reasonable right of access to the Property from and after the Effective Date through

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the Closing or the earlier termination of this Agreement, and Purchaser, its agents and representatives, may conduct a complete physical inspection of the Property including, without limitation, preparation of boundary line, spot and topographical surveys, soil sampling and boring tests, environmental and hazardous waste and substance investigations and such other engineering and mechanical inspections and investigations as Purchaser may reasonably require, provided that Purchaser shall not conduct any invasive testing (including, without limitation, through the taking of samples) in or on the Property other than in connection with a customary "Phase I" environmental site assessment and Purchaser's customary geotechnical investigations without Seller's prior written consent (which consent shall not be unreasonably withheld, conditioned or delayed). Purchaser shall indemnify Seller against any mechanic's liens arising from Purchaser's inspections or other claims, costs, liabilities or expenses (including reasonable attorneys' fees) against the Property or Seller's ownership in the Property resulting from the negligence or willful misconduct of Purchaser or its consultants or agents in the performance of its inspections. Purchaser shall restore any damage to the Property caused by such inspections to substantially the same condition as it existed prior to such investigations. The provisions of this Section 6 will survive the expiration or earlier termination of this Agreement.

7. CONTINGENCIES. Purchaser may terminate this Agreement for any reason or for no reason in Purchaser's sole and absolute discretion, on or before the date that is 90 days from the Effective Date ("***Contingency Date***"). Without limiting the generality of the previous sentence, Purchaser's obligation to proceed to Closing is subject to the fulfillment, by satisfaction or waiver, in Purchaser's sole and absolute discretion, of the following contingencies (a) through (c) of this Section 7, which contingencies shall be deemed satisfied or irrevocably waived by Purchaser unless Purchaser terminates (or is deemed to have terminated) this Agreement on or before the Contingency Date. If Purchaser elects to terminate this Agreement as provided in this Section 7, then Purchaser will provide written notice to Seller of such termination on or before the Contingency Date. If Purchaser does not give written notice to Seller on or before the Contingency Date that Purchaser has elected to either terminate this Agreement or otherwise proceed to Closing, then Purchaser will be deemed to have elected to terminate this Agreement and this Agreement will terminate upon the expiration of the Contingency Date. Upon termination of this Agreement pursuant to this Section 7, the Earnest Money will be returned to Purchaser (less $100.00 to be paid to Seller as independent consideration for the rights granted to Purchaser in this Agreement) and the Parties will have no further obligations under this Agreement except for those which expressly survive the termination of this Agreement. Seller consents to the release of the Earnest Money to Purchaser pursuant to this Section 7 and confirms that Title Company may, and authorizes Title Company to, release the Earnest Money to Seller pursuant to this Section 7 without any further consent or authorization from Seller. Seller agrees to reasonably cooperate with Purchaser, at no cost or expense to Seller, in Purchaser's attempt to satisfy the contingencies set forth in this Agreement (and inspections of documents and materials furnished by Seller or made available for inspection in Seller's offices), and in connection with such cooperation, Seller agrees to negotiate the terms of the Sign Easement Agreement (as defined below), in good faith and to execute such documents reasonably requested by Purchaser to make applications and obtain approvals or otherwise as is reasonably necessary for Purchaser to satisfy such contingencies.

(a) General Investigation. Purchaser's satisfaction (i) with the condition of the Property in every respect for the ownership, use and operation of the Property contemplated by Purchaser, and (ii) with the zoning of the Property and with the terms of all applicable zoning and Private Restrictions, and Purchaser's determination that the Property fully complies with all applicable codes and regulations, and Purchaser's determination that Purchaser's intended use and plans for the Property are not adversely impacted by applicable zoning or Private Restrictions.

(b) Title and Survey Matters. Purchaser's approval of (i) a commitment for an ALTA owner's policy of title insurance ("***Title Commitment***") from Title Company, in a form satisfactory to Purchaser, reflecting good and marketable fee simple title to the Property, to insure the Property and all easements and other rights benefiting the Property in a condition approved by Purchaser with such coverage and including

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such endorsements as Purchaser may require, and (ii) a survey of the Property ("***Survey***") as may be required by Purchaser. If the Title Commitment or Survey discloses any defects which are unsatisfactory to Purchaser ("***Title & Survey Objections***"), then Purchaser will notify Seller of such Title & Survey Objections ("***Objection Notice***") at least thirty (30) days prior to the Contingency Date. Purchaser has no obligation to separately object, and is deemed to have timely objected, to the following items which items are deemed included in Title & Survey Objections: (i) all requirements under the Title Commitment required by the Title Commitment to be performed or provided by Seller, (ii) the so-called "standard exceptions" including any exceptions for mechanics' liens, materialmens' liens, the rights of tenants under leases, or the rights of any parties in possession (except the removal of the "survey exception" shall be the responsibility of Purchaser), and (iii) Seller Encumbrances (defined below). Seller will have 15 days from receipt of the Objection Notice to commit or decline to cure the Title & Survey Objections ("***Seller's Title Notice***"). If Seller does not cure or commit to cure the Title & Survey Objections within said 15 day period or if Seller notifies Purchaser that it will not attempt to cure, Purchaser shall elect to either (i) terminate this Agreement on or before the Contingency Date, or (ii) accept title as it then is without any reduction in the Purchase Price, in which case all such items shall be Permitted Exceptions hereunder. In the event Purchaser fails to notify Seller of it election of either option (i) or (ii) in the preceding sentence before the Contingency Date, then Purchaser shall be deemed to have elected option (ii). If Purchaser does not timely provide on Objection Notice as provided above, Purchaser shall be deemed to have approved the Title Commitment and the Survey. Notwithstanding anything in this Agreement to the contrary, (i) with respect to title matters not disclosed on the initial Title Commitment and which are not caused by Purchaser, the parties shall conduct the objection and response process described above with each party having no more than five (5) business days to object and respond, and (ii) the following shall be considered "***Permitted Exceptions***" hereunder: (i) current real estate taxes not yet due and payable; (ii) all survey matters and title exceptions shown on or disclosed by the Title Commitment and/or the Survey except any such matters and/or exceptions that Seller commits to remove in the Seller's Title Notice; (c) all items otherwise deemed to be Permitted Exceptions hereunder.

(c) Signage Easement. Purchaser's satisfaction with all of the terms, conditions and location of an exclusive signage easement for the benefit of the Property upon a portion of property generally depicted as Lot 4 on Exhibit A ("***Sign Easement***"). The Parties will negotiate in good faith to finalize prior to the expiration of the Contingency Date a recordable easement agreement for the Sign Easement ("***Sign Easement Agreement***") providing for, among other things, the location and the terms of maintenance for Purchaser's signs within the Sign Easement.

8. PRE-CLOSING MATTERS. From and after the Effective Date and until the Closing or earlier termination of this Agreement, Seller shall operate the Property in accordance with the following terms and conditions:

(a) Operation of Property. Seller shall operate, maintain and manage the Property in substantially the same manner as Seller has in the past, including maintenance of property and general liability insurance with respect to the Property. Seller shall make all payments of principal and interest as they come due under any note or other evidence of indebtedness secured by any encumbrance on the Property and otherwise perform the obligations of grantor under such notes and encumbrances. Seller shall not enter into any settlement or other agreement which results in an increase in Taxes. Seller shall not enter into any agreement or lease with or grant any option or right to any person other than Purchaser with respect to the sale, transfer, conveyance, possession, use or occupancy of all or any portion of the Property. Seller shall take such steps as are necessary to terminate all leases and all third party contracts as the same relate to the Property. Seller shall not willingly take any other action which would cause any representation or warranty set out in this Agreement to be untrue as of Closing without Purchaser's prior consent. Seller shall immediately notify Purchaser if any of the representations and warranties in this Agreement become untrue or inaccurate on or before the Closing Date. Seller shall not willingly permit any new title matters not caused by Purchaser to affect the Property after the Effective Date.

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(b) Release of Encumbrances. On or before Closing, Seller shall cause, at Seller's sole cost and expense, any and all assessments, liens (monetary and otherwise), security interests, mortgages or deeds of trust and other monetary liens affecting the Property which were caused by, through or under Seller, its employees, agents or contractors ("***Seller Encumbrances***"), to be satisfied and released. The proceeds due at Closing may be applied by Seller to satisfy and release any Seller Encumbrances.

(c) Filing of Plat. Lot 1, as shown on the Existing Plat, is a separate legal lot. Lot 3 Portion, as shown on Exhibit A to this Agreement, is not a separate legal lot as of the Effective Date. Seller shall use commercially reasonable efforts to cause a plat to be prepared to establish Lot 3 Portion as a separate legal lot ("***Proposed Plat***"), and submit the Proposed Plat to Purchaser for Purchaser's review and approval, which approval shall not be unreasonably withheld, conditioned or delayed, and shall be provided or not no later than ten (10) days after submission to Purchaser. The Proposed Plat shall comply with all applicable laws, rules and regulations and Seller shall hold Purchaser harmless from all claims that the Proposed Plat does not comply with such laws, rules or regulations, notwithstanding Purchaser's approval of the Proposed Plat. If Purchaser approves the Proposed Plat, then Seller will submit the Proposed Plat to the applicable governing authorities for review and approval. Any revisions or conditions to the Proposed Plat made by Seller or required to be made by any of the applicable governmental authorities will be submitted to Purchaser for Purchaser's review and approval, which approval shall not be unreasonably withheld, conditioned or delayed, and shall be provided no later than ten (10) days after submission to Purchaser, and if Purchaser fails to respond within such ten (10) day period, the Proposed Plat shall be deemed approved by Purchaser. The Proposed Plat, as fully and finally approved by Purchaser, Seller and the applicable governmental authorities, is the "***Final Plat***." Seller shall use commercially reasonable efforts to cause the Final Plat to be duly executed by all of the necessary parties and, if required, by all of the applicable governmental authorities, and recorded in the land records so as to establish Lot 3 Portion as a separate legal lot. Seller shall perform the work in this Section 8(c) at Seller's sole cost and expense, in a good and workmanlike manner, and in compliance with all applicable laws, rules and regulations and with all necessary permits. Seller shall use commercially reasonable efforts to complete such work on or before the Closing Date, provided that if despite such commercially reasonable efforts, Seller is unable to complete the filing of the Final Plat by the Closing Date, the Closing Date shall be automatically extended until the date the Final Plat is recorded, which extension shall not exceed ninety (90) days, and if after such ninety (90) day period the Final Plat has still not been recorded, then at any time prior to the recording of the Final Plat either party may terminate this Agreement upon written notice to the other and the Earnest Money shall be returned to Purchaser, and if Seller terminates this Agreement as provided in this Section 8(c), then Seller shall reimburse Purchaser for the actual and reasonable out-of-pocket costs incurred by Purchaser in connection with the transaction contemplated by this Agreement, which reimbursement shall not exceed $50,000.00.

9. CONDITIONS PRECEDENT TO CLOSING. In addition to any other conditions set forth in this Agreement, Purchaser's obligation to Close under this Agreement is subject to each and all of the following conditions precedent (a) through (f) of this Section 9. The full and complete satisfaction of each such condition precedent (as opposed to the substantial or material satisfaction) is material to Purchaser. If any such conditions are not satisfied by the Closing Date, then Purchaser may, upon written notice to Seller, cancel this Agreement in which event the Earnest Money shall be refunded to Purchaser, and if any of such conditions are not satisfied by the Closing Date due to a default by Seller, then Purchaser will be entitled to additional remedies to the extent set forth in this Agreement. The conditions in this Section 9 are solely for the benefit of Purchaser and may be waived by Purchaser in its sole and absolute discretion.

(a) Seller's Representations and Warranties. All of Seller's representations and warranties contained in this Agreement must be true and correct when made and also upon the Closing Date, in each case in all material respects.

(b) Documents and Covenants. All covenants and agreements of Seller in this Agreement

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must have been duly and timely performed and satisfied in all material respects.

(c) Delivery Condition. The Property must be in the Delivery Condition.

(d) Title Company Committed. Title Company must be irrevocably committed to issue, upon payment of the applicable premiums, Purchaser's owner's policy of title insurance, reflecting good and marketable fee simple title to the Property (as established by the recorded Final Plat) vested in Purchaser, insuring the Property and all easements and other rights benefiting the Property in accordance with the results of the objection and resolution process described in Section 7(b) hereof ("***Owner's Polic***y").

(e) Regulatory Compliance. Purchaser must be satisfied, in its sole and absolute discretion, that the transactions contemplated by this Agreement will not result in a violation of any applicable laws and regulations including, without limitation, federal and state health care laws and regulations such as, by way of example and not limitation, Medicare Anti-Kickback and Stark laws and regulations, provided that this condition precedent shall not, in and of itself, be the basis for the return of the Earnest Money to Purchaser.

(f) Filing of Plat. The Final Plat must be recorded.

10. CLOSING.

(a) Place and Closing Date. The closing of the purchase and sale of the Property ("***Closing***") will take place on the date that is 30 days after the Contingency Date ("***Closing Date***"), or such other date as the Parties may mutually agree in writing signed by each of them. Closing will not be conducted "in person" at any specified time or place on the Closing Date. Rather, Closing will be conducted on the Closing Date in escrow via email and delivery of documents, funds and instructions to and through Title Company.

(b) Possession. At Closing, Seller shall deliver possession of the Property to Purchaser in the Delivery Condition.

(c) Seller's Obligations at Closing. At Closing, Seller shall deliver or cause to be delivered to Purchaser, the following items, all of which shall be duly executed and acknowledged in recordable form, where appropriate:

(i) Deed. A special warranty deed, in customary form, conveying to Purchaser or its designee fee simple title to the Property as described in the recorded Final Plat, subject only to the Permitted Exceptions.

(ii) Sign Easement. The Sign Easement Agreement to the extent finalized and approved by the parties prior to the Contingency Date.

(iii) Assignment of Intangibles. An assignment, in customary form, assigning (to the extent assignable) all of Seller's right, title and interest in, to and under all intangible rights and property applicable to the Property, if any, including, without limitation, (i) all development rights, permits, approvals, licenses, plans and drawings, and (ii) all warranties, guarantees and indemnities (including, without limitation, those for workmanship, materials and performance) which may exist from, by or against any contractor, subcontractor, manufacturer, laborer or supplier of labor, materials or other services relating to the Property or any improvements located on the Property ("***Assignment of Intangibles***").

(iv) Releases. Such written release of any Seller Encumbrances then affecting the Property as shown by the Title Commitment updated to Closing.

(v) Seller's Affidavit; FIRPTA Affidavit. A seller's affidavit as required by the Title

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Company in order for the Title Company to issue the Owner's Policy, and an affidavit pursuant to Section 1445 of the Internal Revenue Code of 1986, as amended (the "***Code***"), certifying that Seller is not a foreign corporation, foreign partnership, foreign trust, foreign estate or foreign person (as those terms are defined in the Internal Revenue Code and regulations promulgated under the Code).

(vi) Bring-Down Certificate. A certificate, in customary form, certifying that the representations of Seller in this Agreement are true and correct as of the Closing Date (or otherwise note any representations that are not true and correct as of the Closing Date).

(vii) Private Restriction Transfer Documents. All notices, certifications, approvals, consents and other documentation that may be required under any Private Restrictions to transfer the Property pursuant to this Agreement.

(viii) Miscellaneous. Any other documents reasonably required by this Agreement or the Title Company to be executed or delivered by Seller to cause Title Company to issue the Owner's Policy, including without limitation, a closing statement, consents and approvals, marital waivers, certified copies of death certificates or other vital records, trust documentation, current certificates of good standing and other evidence of authority of Seller to sell the Property pursuant to this Agreement and of Seller's signatory to execute documents in connection with the transaction contemplated by this Agreement, all as is reasonably satisfactory to the Title Company.

(d) Purchaser's Obligations at Closing. At Closing, Purchaser shall deliver or cause to be delivered to Title Company to be held in escrow for Closing, the following items, all of which shall be duly executed and acknowledged in recordable form, where appropriate:

(i) Purchase Price. The Purchase Price, subject to the prorations and adjustments provided in this Agreement, by federal wire transfer of funds to Title Company's escrow account for disbursement in accordance with a closing statement mutually agreeable to Purchaser and Seller.

(ii) Miscellaneous. Deliver any other documents reasonably required by this Agreement or the Title Company to be delivered by Purchaser or necessary to implement and effectuate the Closing.

11. REPRESENTATIONS, WARRANTIES AND COVENANTS. In order to induce Purchaser to enter into this Agreement, and in addition to any other representations, warranties or covenants contained in this Agreement, Seller makes the following representations and warranties, each of which is material to Purchaser and each of which is effective as of the Effective Date and will survive Closing.

(a) Representations and Warranties – Seller. Seller is in good standing under the laws of the state in which it is organized or incorporated. The execution, delivery of and performance under this Agreement is pursuant to authority validly and duly conferred upon Seller and the signatories of Seller to this Agreement. The consummation of the transaction contemplated by this Agreement and the compliance by Seller with the terms of this Agreement do not conflict with or result in breach of any of the terms or provisions of, or constitute default under any agreement, lease, arrangement, understanding, accord, document or instrument by which Seller or the Property is bound, and will not and does not constitute a violation of any applicable law, rule, regulation, judgment, order or decree of any governmental instrumentality or court, domestic or foreign, to which Seller or the Property is subject. Seller acknowledges and agrees that Purchaser will not assume any liabilities, indebtedness, commitments or obligations of any nature whatsoever (whether fixed or contingent) of Seller with respect to the Property or otherwise except as otherwise expressly provided in this Agreement and/or any document signed by Seller at closing or by operation of law.

(b) Representations and Warranties – Property. Seller is the sole owner of the Property

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and has good and marketable fee simple title to the Property. No other person has any basis to assert any interest in any portion of the Property or its proceeds. All bills and invoices for labor and material of any kind and relating to the Property have been paid in full, and there are no mechanic's or materialmen's liens or other claims outstanding or available to any party in connection with the Property. There are no pending or threatened, matters of litigation, administrative action or examination, claim or demand whatsoever relating to the Property. Seller has not received any notice of any pending and, to the knowledge of Seller, there is not contemplated any eminent domain, condemnation or other governmental taking of any part of the Property. Seller has received no notice of any public improvements in the nature of offsite improvements or otherwise which have been ordered to be made or which have not been assessed including, but not limited to, any road impact fee obligation, and there are no special or general assessments (public or private) not of record pending or affecting the Property. The condition of the Property does not and will not prior to Closing violate any zoning, building, health, fire or similar statute, ordinance, regulation or code and Seller has not received any notice, written or otherwise, from any governmental agency alleging any such violations. There are no unperformed obligations relative to the Property outstanding to any governmental or quasi-governmental body or authority. Seller is not in default under any Private Restrictions, and there exist no events or circumstances which, with the passage of time or the giving of notice, constitutes a default by Seller under any Private Restrictions.

(c) Representations and Warranties – Hazardous Waste. During, and, to Seller's knowledge, prior to, Seller's ownership of the Property, subject to the Property Information, (i) no storage tanks or related pipes, vents or other equipment are, or have been, located in, on, under or above the surface of the Property, (ii) the Property is not and has not been listed or threatened to be listed on the National Priorities List by the Environmental Protection Agency or any other applicable governmental or quasi-governmental authority, there have been no discussions between Seller or its agents and state or federal officials concerning the possibility of such listings, (iii) there has been no release, disposal, discharge, deposit, injection, dumping, leaking, spilling, pumping, pouring, emitting, leaching, placing or escape of any Hazardous Substance on, in, under the surface or from the Property, and (iv) there is no, and has been no, facility in or on the Property used for the treatment, storage or disposal of any Hazardous Substance. "***Hazardous Substance***" means any substance which is toxic, ignitable, reactive, corrosive, radioactive, flammable, explosive, or a human health or safety hazard, including but not limited to asbestos, petroleum products, by-products and wastes, polychlorinated biphenyls (PCB's), radon and substances defined as "hazardous substances," "hazardous materials," "toxic substances", or "hazardous wastes" in CERCLA; the Hazardous Materials Transportation Act, 49 U.S.C. Section 1801, et seq.; the Resource Conservation and Recovery Act, 42 U.S.C. Section 6901 et seq.; the Clean Water Act, 33 U.S.C. Section 1251 et seq.; the Toxic Substances Control Act, 15 U.S.C. Section 2601 et seq.; the Clean Air Act, 42 U.S.C. Section 7401 et seq.; and any other applicable statutes, laws, ordinances, rules and regulations of any governmental or quasi-governmental authority or body having jurisdiction over the Property.

(d) Non-Referral Source. Seller represents and warrants to Purchaser that Seller is not a Referral Source (defined below) and no ownership or beneficial interest in Seller is owned, or held by, any Referral Source. For purposes of this Section 11(d), "***Referral Source***" means any of the following:

(i) A physician, an immediate family member or member of a physician's immediate family, an entity owned in whole or in part by a physician or by an immediate family member or member of a physician's immediate family;

(ii) Any other Person (as defined in this Section 11(d)) who (a) makes, who is in a position to make, or who could influence the making of referrals of patients to any health care facility, (b) has a provider number issued by Medicare, Medicaid or any other governmental health care program, or (c) provides services to patients who have conditions that might need to be referred for clinical or medical care, and participates in any way in directing, recommending, arranging for or steering patients to any health care

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provider or facility; or

(iii) Any Person or entity that is an Affiliate (defined below) of any Person or other entity described in clause (i) or (ii) above.

"***Immediate family member or member of a physician's immediate family***" means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

"***Affiliate***" means as to the Person in question, any Person that directly or indirectly controls or is controlled by or is under common control with such Person in question. For purposes of this definition, "control" (including the correlative meanings of the terms "controlled by" and "under common control with"), as used herein, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities, partnership interests or other equity interests.

"***Person***" means any one or more natural persons, corporations, partnerships, limited liability companies, firms, trusts, trustees, governments, governmental authorities or other entities.

(e) Importance of Representations and Warranties. SELLER HAS FULLY REVIEWED THE REPRESENTATIONS AND WARRANTIES SET FORTH IN THIS AGREEMENT WITH SELLER'S COUNSEL (OR IF NOT WITH SELLER'S COUNSEL, THEN SELLER ACKNOWLEDGES THAT SELLER HAS HAD AN OPPORTUNITY TO REVIEW SUCH REPRESENTATIONS AND WARRANTIES WITH SELLER'S COUNSEL BUT HAS DECLINED TO DO SO), AND UNDERSTANDS THE MEANING, SIGNIFICANCE AND EFFECT OF SUCH REPRESENTATIONS AND WARRANTIES. SELLER ACKNOWLEDGES AND AGREES THAT THE REPRESENTATIONS AND WARRANTIES CONTAINED IN THIS AGREEMENT ARE AN INTEGRAL PART OF THIS AGREEMENT, AND THAT PURCHASER WOULD NOT HAVE AGREED TO PURCHASE THE PROPERTY FROM SELLER FOR THE PURCHASE PRICE WITHOUT THE TRUTHFULNESS OF THE REPRESENTATIONS AND WARRANTIES SET FORTH IN THIS AGREEMENT.

(f) AS-IS CONDITION. SUBJECT TO SELLER'S REPRESENTATIONS AND WARRANTIES EXPRESSLY SET FORTH HEREIN AND/OR IN ANY DOCUMENTS DELIVERED PURSUANT TO THE TERMS HEREOF BY SELLER TO PURCHASER AT CLOSING, AND ACKNOWLEDGING THE PRIOR USE OF THE PROPERTY AND PURCHASER'S OPPORTUNITY TO INSPECT THE PROPERTY, PURCHASER AGREES TO PURCHASE THE PROPERTY "AS IS," "WHERE IS," WITH ALL FAULTS AND CONDITIONS THEREON. ANY WRITTEN OR ORAL INFORMATION, REPORTS, STATEMENTS, DOCUMENTS OR RECORDS CONCERNING THE PROPERTY ("DISCLOSURES") PROVIDED OR MADE AVAILABLE TO PURCHASER, ITS AGENTS OR CONSTITUENTS BY SELLER, SELLER'S AGENTS, EMPLOYEES OR THIRD PARTIES REPRESENTING OR PURPORTING TO REPRESENT SELLER, SHALL NOT BE REPRESENTATIONS OR WARRANTIES, UNLESS SPECIFICALLY SET FORTH IN THIS AGREEMENT. IN PURCHASING THE PROPERTY OR TAKING OTHER ACTION HEREUNDER, PURCHASER HAS NOT AND SHALL NOT RELY ON ANY SUCH DISCLOSURES EXCEPT AS SPECIFICALLY SET FORTH IN THIS AGREEMENT, BUT RATHER, PURCHASER SHALL RELY ONLY ON PURCHASER'S OWN INSPECTION OF THE PROPERTY. PURCHASER ACKNOWLEDGES THAT THE PURCHASE PRICE REFLECTS AND TAKES INTO ACCOUNT THAT THE PROPERTY IS BEING SOLD "AS IS. PURCHASER ACKNOWLEDGES AND AGREES THAT EXCEPT AS EXPRESSLY SET FORTH HEREIN AND IN ANY DOCUMENTS DELIVERED PURSUANT TO THE TERMS HEREOF BY SELLER TO PURCHASER AT CLOSING, SELLER HAS NOT MADE, DOES NOT MAKE AND SPECIFICALLY DISCLAIMS ANY REPRESENTATIONS, WARRANTIES, PROMISES, COVENANTS, AGREEMENTS OR GUARANTIES OF ANY KIND OR CHARACTER WHATSOEVER, WHETHER EXPRESS OR IMPLIED, ORAL OR WRITTEN, PAST, PRESENT OR FUTURE, OF, AS TO, CONCERNING OR WITH RESPECT TO THE PROPERTY INCLUDING, WITHOUT LIMITATION, (A) THE NATURE, QUALITY OR PHYSICAL CONDITION OF THE PROPERTY, (B) THE CONSTRUCTION OF THE IMPROVEMENTS AND WHETHER THERE EXISTS ANY CONSTRUCTION DEFECTS THEREIN, (C) THE WATER, SOIL AND GEOLOGY OF THE PROPERTY, (D) THE INCOME

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TO BE DERIVED FROM THE PROPERTY, THE SUITABILITY OF THE PROPERTY FOR ANY AND ALL ACTIVITIES AND USES WHICH PURCHASER MAY CONDUCT THEREON, (E) THE COMPLIANCE OF OR BY THE PROPERTY OR THE OPERATION THEREOF WITH ANY LAWS, RULES, ORDINANCES OR REGULATIONS OF ANY GOVERNMENTAL AUTHORITY OR BODY HAVING JURISDICTION THEREOVER, (F) THE HABITABILITY OR FITNESS OF THE PROPERTY FOR A PARTICULAR PURPOSE, (G) THE MARKETABILITY OF THE PROPERTY OR THE ABILITY TO LEASE OR SELL UNITS THEREIN, (H) THE STATUS OR CONDITION OF ENTITLEMENTS PERTAINING TO THE PROPERTY, AND (I) ANY MATTER REGARDING TERMITES OR WASTES, AS DEFINED BY THE U.S. ENVIRONMENTAL PROTECTION AGENCY REGULATIONS AT 40 C.F.R., OR ANY HAZARDOUS MATERIALS OR HAZARDOUS SUBSTANCES. PURCHASER FURTHER ACKNOWLEDGES AND AGREES THAT EXCEPT AS OTHERWISE SET FORTH HEREIN, SELLER IS UNDER NO DUTY TO MAKE ANY AFFIRMATIVE DISCLOSURES REGARDING ANY MATTER WHICH MAY BE KNOWN TO SELLER.

12. BREACH OF REPRESENTATIONS, WARRANTIES OR COVENANTS. If any of the representations and warranties of Seller in this Agreement become untrue or inaccurate in any material respect on or before the Closing Date, then Purchaser will have the right and option, at any time up to and including the Closing Date, to terminate this Agreement and receive the Earnest Money and Purchaser will not have any further obligations hereunder. For the purposes of this Agreement, "Seller's knowledge," or words of similar import, shall mean the actual knowledge of John F. McReynolds, without inquiry or investigation, and without imposition of personal liability on such individual whatsoever. Notwithstanding any other term or condition hereof, Purchaser shall not be allowed to bring a claim after closing for the breach of any representation or warranty which Purchaser knew was inaccurate before the closing. Seller shall have no liability to Purchaser for any consequential, exemplary, special or punitive damages caused or allegedly caused by, or attributable to, any breach of Seller's representations and warranties. The representations and warranties in Section 11 will survive the Closing for a period of three (3) months.

13. DEFAULTS AND REMEDIES.

(a) Default by Seller. If a default of this Agreement by Seller occurs (including, without limitation, if any representation or warranty set forth in this Agreement by Seller is untrue when made or becomes untrue prior to the Closing Date due to the acts of Seller), and such default is not cured by Seller within five (5) business days following written notice from Purchaser, then Purchaser may elect, as its sole and exclusive remedy, to either (a) terminate this Agreement in which event Escrow Agent shall refund the Deposit to Purchaser and Seller shall reimburse Purchaser for its actual out-of-pocket costs in connection with this Agreement and its pursuit of the Property (such reimbursement not to exceed $50,000 in the aggregate), or (b) seek specific performance of Seller's obligation to convey the Property to Purchaser, or (c) waive such default or breach and close the purchase of the Property pursuant to the terms of this Agreement.

(b) Default by Purchaser. If Purchaser fails to close the purchase of the Property as contemplated in this Agreement due to the default of Purchaser, then Seller, as its sole and exclusive remedy, may terminate this Agreement and retain the Earnest Money as stipulated and liquidated damages (and not as a penalty) in lieu of, and as full compensation for, all other rights or claims of Seller against Purchaser by reason of such default, and upon such termination the Parties will be released from any and all liability under this Agreement except for those liabilities which expressly survive the termination of this Agreement. The Parties acknowledge that the damages to Seller resulting from Purchaser's breach would be difficult, if not impossible, to ascertain with any accuracy, and that the liquidated damage amount provided in this Section 13(b) is a reasonable and proper remedy in light of the circumstances and represents both Parties' best efforts to approximate such potential damages.

(c) Attorneys' Fees. In any action or litigation between Purchaser and Seller as a result of failure to perform or default under this Agreement, the prevailing Party will be entitled to recover its reasonable attorneys' fees and court costs from the non-prevailing Party.

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14. EMINENT DOMAIN. If at any time prior to the Closing, any notice of a proceeding is received or proceeding is commenced or consummated for the taking of all or any part of the Property for public or quasi-public use pursuant to the power of eminent domain or otherwise, Seller shall promptly give written notice thereof to Purchaser. The commencement or completion of any such proceeding will have no effect on this Agreement unless Purchaser, by reason thereof, elects at its option, within 30 days after receipt by it of Seller's notice of such taking, to cancel this Agreement by giving written notice thereof to Seller to such effect, and upon the giving of such notice, the Earnest Money will be released to Purchaser and this Agreement will become null and void and of no further force or effect, with neither Party having any further rights or liabilities hereunder. If Purchaser elects to proceed with the performance of this Agreement, notwithstanding the commencement of any such proceedings, or the completion of any such taking, then Seller shall assign any and all awards and other compensation for any such taking to Purchaser, and Seller shall convey all or such portion of the Property, if any, as is left after such taking in accordance with the terms of this Agreement.

15. RISK OF LOSS OR DAMAGE. Seller assumes the risk of loss or damage to the Property until Closing. If such loss or damage occurs in any material respect, then Purchaser may either: (i) terminate this Agreement and receive the Earnest Money, or (ii) purchase the Property as is. If Purchaser elects to purchase the Property as is, then Seller shall pay or assign to Purchaser all insurance proceeds received by or owed to Seller, as the case may be, and the Purchase Price shall be reduced by the amount of any deductible.

16. ASSIGNMENT. Purchaser may not assign this Agreement or its rights under this Agreement without Seller's prior written consent, which consent shall be in Seller's sole and absolute discretion, provided that Purchaser may assign this Agreement and its rights under this Agreement without the necessity of obtaining the prior consent, written or otherwise, of Seller to any entity controlling, controlled by, or under common control with, Purchaser, upon written notice to Seller.

17. BROKERS' COMMISSIONS. Each Party represents and warrants to the other Party that no third party broker or finder has been engaged or consulted by such Party or through such Party's actions is entitled to compensation as a consequence of this transaction except for Purchaser's Broker and Seller's Broker. "***Purchaser's Broker***" means Cushman & Wakefield Commercial Real Estate, representing Purchaser only. "***Seller's Broker***" means any third party broker or finder that has been engaged or consulted by Seller or through Seller's actions is entitled to compensation as a consequence of this transaction, representing Seller only. Seller shall pay a commission to Purchaser's Broker at Closing in an amount equal to 3% of the Purchase Price and Seller shall pay a commission to Seller's Broker at Closing pursuant to a separate agreement between Seller and Seller's Broker. Each Party shall indemnify, defend and hold the other Party harmless against any and all claims of any other brokers, finders or the like, claiming any right to commission or compensation by or through acts of such Party or such Party's partners, agents or affiliates in connection with this Agreement. These indemnity obligations include all damages, losses, costs, liabilities and expenses, including reasonable attorneys' fees and litigation costs, which may be incurred by the Party being indemnified. The provisions of this Section 17 will survive the expiration or earlier termination of this Agreement.

18. NOTICES. Any notice, request, approval, demand, instruction or other communication to be given to either Party under this Agreement must be in writing, and will be conclusively deemed to be delivered when personally delivered or when (a) hand-delivered; or (b) deposited for prepaid overnight delivery with an overnight courier such as UPS or other national overnight courier service; (c) if the receiving Party's address for notices is a P.O. Box, then when deposited with U.S. Mail; or (d) electronic mail; and such notices are addressed to the addresses provided on the signature page of this Agreement or to such other addresses as either Party may have furnished to the other from time to time, in writing, as a place for the service of notice. All notices will be effective upon being sent in the manner described in this Section 18. However, the time period in which a response to any such notice must be given will commence to run from the date of receipt by the addressee of such notice. Rejection or other refusal to accept or the inability to deliver because of changed address of which no notice was given, will be deemed to be receipt of the notice as of the date of such rejection,

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refusal, or inability to deliver.

19. LIKE-KIND EXCHANGE. Either Party may consummate the purchase or sale of the Property as part of a like kind exchange ("***Exchange***") pursuant to §1031 of the Code, provided that: (i) the Closing cannot be delayed or affected by reason of the Exchange nor can the consummation or accomplishment of the Exchange be a condition precedent or condition subsequent to either Party's obligations under this Agreement; (ii) the exchanging Party shall effect the Exchange through an assignment of this Agreement, or its rights under this Agreement, to a qualified intermediary; and (iii) the non-exchanging Party will not be required to take an assignment of any purchase agreement or be required to acquire or hold title to any real property for purposes of consummating the Exchange. The non-exchanging Party will not by this Agreement or acquiescence to the Exchange (1) have its rights under this Agreement affected or diminished in any manner or (2) be responsible for compliance with or be deemed to have warranted to the exchanging Party that the Exchange in fact complies with the Code.

20. OFAC COMPLIANCE. Each Party represents and warrants to the other Party that: neither such Party, nor any of its affiliates, nor any of its respective partners, members, shareholders or other equity owners, and none of its respective employees, officers, directors, representatives or agents is, nor will they become, a person or entity with whom United States persons or entities are restricted from doing business under regulations of the Office of Foreign Asset Control ("***OFAC***") of the Department of the Treasury (including those named on OFAC's Specially Designated and Blocked Persons List) or under any statute, executive order (including, without limitation, the September 24, 2001, Executive Order Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit, or Support Terrorism), or other governmental action, and is not and will not engage in any dealings or transactions or be otherwise associated with such persons or entities.

21. MISCELLANEOUS. All of the recitals above and all exhibits attached to this Agreement are incorporated into this Agreement by this reference. The section headings of this Agreement are for convenience only and must not be considered in the interpretation of the terms and provisions of this Agreement. This Agreement is binding upon and inures to the benefit of the Parties and their respective successors and assigns. The word "person" as used in this Agreement, includes all individuals, partnerships, corporations, or any other entities whatsoever. If any provision of this Agreement is unenforceable or inapplicable, the other provisions of this Agreement will remain in full force and effect as if the unenforceable or inapplicable provision had never been contained in this Agreement. This Agreement may be executed in counterparts. Electronic signatures (including scanned signatures in .PDF format) sent via e-mail will have the same force and effect as executed originals. This Agreement must be governed by and construed in accordance with the laws of the state in which the Property is situated. This Agreement constitutes the entire agreement between the Parties. No subsequent alteration, amendment, change, deletion or addition to this Agreement will be binding upon the Parties unless in writing and signed by both Parties. Time is of the essence in the performance of the obligations of the Parties under this Agreement. If any date, time period or deadline under this Agreement falls on a weekend, a state or federal holiday, or any other day on which Title Company or the governmental office for the recordation of deeds is not open for business, then such date will be extended to the next occurring business day. As used in this Agreement, "business day" means any day other than a Saturday, Sunday or state or federal holiday. THE PARTIES AND EACH PARTY'S COUNSEL HAVE NEGOTIATED AND REVIEWED THIS AGREEMENT (OR IF ANY PARTY'S COUNSEL HAS NOT NEGOTIATED OR REVIEWED THIS AGREEMENT, THEN SUCH PARTY ACKNOWLEDGES THAT IT HAS HAD AN OPPORTUNITY TO HAVE ITS COUNSEL NEGOTIATE AND REVIEW THIS AGREEMENT BUT HAS DECLINED TO DO SO), AND THIS AGREEMENT CONSTITUTES AN ARM'S LENGTH TRANSACTION BETWEEN A SOPHISTICATED PURCHASER AND SELLER OF REAL PROPERTY. Accordingly, this Agreement (and any amendments to this Agreement) shall be construed as having been prepared by the Parties and not by any one Party. Consequently, any rule of construction to the effect that any ambiguities be resolved against the drafting Party shall not be employed in the interpretation of this Agreement or any amendments to this Agreement.

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22. ESCROW PROVISIONS. In performing any of its duties hereunder Escrow Agent shall not incur any liability to anyone for any damages, losses, or expenses except for gross negligence, willful default or breach of trust, and Escrow Agent shall accordingly not incur any such liability with respect to (i) any action taken or omitted in good faith upon advice of Escrow Agent's counsel given with respect to any questions relating to the duties and responsibilities of Escrow Agent under this Agreement, or (ii) any action taken or omitted in reliance upon any instrument, including any written notice or instruction provided for in the this Agreement, not only as to its due execution and the validity and effectiveness of its provisions, but also as to the truth and accuracy of any information contained therein, which Escrow Agent shall in good faith believe to be genuine, to have been signed or presented by a proper person or persons and to conform with the provisions of this Agreement. Seller and Purchaser hereby agree jointly and severally to indemnify and hold harmless Escrow Agent against any and all losses, claims, and counsel fees and disbursements which may be imposed upon Escrow Agent or incurred by Escrow Agent hereunder, or in the performance of its duties hereunder, including any litigation arising from this Agreement or involving the subject matter hereof. In the event of any dispute between Seller and Purchaser as to a default or breach of the Agreement, Seller and Purchaser agree that Escrow Agent may be released of any further obligation under the Agreement by tendering any funds held by it into a court of competent jurisdiction in an action in the nature of an interpleader for resolution by said court of the ultimate disposition of said funds. Any costs, including attorneys' fees and court costs, incurred by Escrow Agent in such an action shall be paid in accordance with this Agreement

23. NO OFFER. The presentation of this Agreement by Purchaser for review by Seller does not constitute an offer on the part of Purchaser to enter into the transactions contemplated by this Agreement. This Agreement will become effective and legally binding only when it has been duly signed by each Party and delivered to the other Party.

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SELLER SIGNATURE PAGE TO REAL ESTATE PURCHASE AND SALE AGREEMENT

Seller has executed this Agreement effective as of the Effective Date.

SELLER:

BURKITT COMMONS II, LLC,
a Tennessee limited liability company

DocuSigned by:

By: ______________________________
03828A7FBC73460...
Name: John F. McReynolds
Title: Authorized Signatory

Date: 1/10/2023, XXXX

Seller's Notice Address:

407 Church Street, Suite 2
Franklin, Tennessee 37064
Attn: John F. McReynolds
Email: XXXXXXXXXXXXXXX
John@mcrgrpllc.com

With a copy to:

Kaalberg Law, PLLC
123 South 11th Street
Nashville, Tennessee 37206
Attn: Aaron Kaalberg
Email: aaron@kaalberglaw.com

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PURCHASER SIGNATURE PAGE TO REAL ESTATE PURCHASE AND SALE AGREEMENT

Purchaser has executed this Agreement effective as of the Effective Date.

PURCHASER:

HCA HEALTH SERVICES OF TENNESSEE, INC.,
a Tennessee corporation

By: ______________________________
Joseph A. Sowell, III, Senior Vice President

Date: 1-9-2023 ~~, 2022~~

Purchaser's Notice Address:

HCA Health Services of Tennessee, Inc.
One Park Plaza
Nashville, TN 37203
Attn: Vice President, Real Estate

With a copy to:

HCA Health Services of Tennessee, Inc.
1100 Dr. Martin L. King Jr. Blvd., Suite 500
Nashville, TN 37203
Attn: Andrew P. Gulotta, Esq.

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EXHIBIT A TO REAL ESTATE PURCHASE AND SALE AGREEMENT

[*End of Exhibit A*]

FIRST AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT

THIS FIRST AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT ("***Amendment***") is made and entered into effective as of the date the last of the Parties executes this Amendment ("***Effective Date***"), by and between **BURKITT COMMONS II, LLC**, a Tennessee limited liability company ("***Seller***"), and **HCA HEALTH SERVICES OF TENNESSEE, INC.**, a Tennessee corporation ("***Purchaser***"). Seller and Purchaser are sometimes referred to in this Amendment individually as a "***Party***" and collectively as the "***Parties.***"

A. Seller and Purchaser are parties to that certain Real Estate Purchase and Sale Agreement, dated effective January 10, 2023 ("***Purchase Agreement***") for the purchase and sale of certain real property located in Williamson County and Davidson County, Tennessee, and more particularly described in the Purchase Agreement.

B. Seller and Purchaser desire to amend the Purchase Agreement to, among other things, amend the Contingency Date, all as provided in this Amendment.

IN CONSIDERATION of the premises, the agreements contained in this Amendment and other good and valuable consideration, the receipt and legal sufficiency of which are acknowledged, the Parties agree to the following:

1. Contingency Date. The Contingency Date, as defined in Section 7 of the Purchase Agreement, is amended to mean June 9, 2023.

2. Miscellaneous. Except as amended by this Amendment, all of the terms, conditions and agreements of the Purchase Agreement remain in full force and effect. All capitalized terms used but not defined in this Amendment have the meaning given to them in the Purchase Agreement. If there is any conflict between the terms of this Amendment and the terms of the Purchase Agreement, then the terms of this Amendment control. All of the recitals above and all exhibits attached to this Amendment are incorporated into this Amendment by this reference. This Amendment is binding upon and inures to the benefit of the Parties and their respective successors and assigns. If any provision of this Amendment is unenforceable or inapplicable, the other provisions of this Amendment will remain in full force and effect as if the unenforceable or inapplicable provision had never been contained in this Amendment. This Amendment may be executed in counterparts. Electronic signatures (including scanned signatures in .PDF format) sent via e-mail will have the same force and effect as executed originals.

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SIGNATURE PAGE TO
FIRST AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT

The Parties have executed this Amendment effective as of the Effective Date.

SELLER:

BURKITT COMMONS II, LLC,
a Tennessee limited liability company

By: ______________________________
Name: John F. McReynolds
Title: Authorized Signatory

Date: 4/8, 2023

PURCHASER:

HCA HEALTH SERVICES OF TENNESSEE, INC.,
a Tennessee corporation

By: ______________________________
Nicholas L. Paul, Vice President

Date: __________________________, 2023

SIGNATURE PAGE TO
FIRST AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT

The Parties have executed this Amendment effective as of the Effective Date.

SELLER:

BURKITT COMMONS II, LLC,
a Tennessee limited liability company

By: ________________________________
Name: John F. McReynolds
Title: Authorized Signatory

Date: __________________________, 2023

PURCHASER:

HCA HEALTH SERVICES OF TENNESSEE, INC.,
a Tennessee corporation

By: Nicholas L. Paul
Nicholas L. Paul, Vice President

Date: April 6, 2023

SECOND AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT

THIS SECOND AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT ("***Amendment***") is made and entered into effective as of the date the last of the Parties executes this Amendment ("***Effective Date***"), by and between **BURKITT COMMONS II, LLC**, a Tennessee limited liability company ("***Seller***"), and **HCA HEALTH SERVICES OF TENNESSEE, INC.**, a Tennessee corporation ("***Purchaser***"). Seller and Purchaser are sometimes referred to in this Amendment individually as a "***Party***" and collectively as the "***Parties***."

A. Seller and Purchaser are parties to that certain Real Estate Purchase and Sale Agreement, dated effective January 10, 2023, as amended by First Amendment to Real Estate Purchase and Sale Agreement, dated effective April 8, 2023 (collectively, "***Purchase Agreement***") for the purchase and sale of certain real property located in Williamson County and Davidson County, Tennessee, and more particularly described in the Purchase Agreement.

B. Seller and Purchaser desire to amend the Purchase Agreement as provided in this Amendment.

IN CONSIDERATION of the premises, the agreements contained in this Amendment and other good and valuable consideration, the receipt and legal sufficiency of which are acknowledged, the Parties agree to the following:

1. Land. The Land, as defined in Recital A of the Purchase Agreement, is amended to mean Lot 1 and Lot 3, Final Plat, Burkitt Commons II, as shown on plat of record in Plat Book P74, Page 90 in the Register's Office for Williamson County, Tennessee, and being depicted on Exhibit A attached to this Amendment.

2. Purchase Price. The Purchase Price, as defined in Section 2 of the Purchase Agreement, is amended to mean $10,602,976.99.

3. Deleted Provisions. The following sections of the Purchase Agreement are deleted and of no further force or effect: Section 7(c), Section 8(c), Section 9(f), and Section 10(c)(ii). Exhibit A attached to the Purchase Agreement is deleted and of no further force or effect. All references in the Purchase Agreement to the Sign Easement Agreement and Final Plat are deleted and of no further force or effect.

4. Termination of Hardee's Lease. A portion of Lot 3 is subject to that certain Ground Lease dated April 22, 2021, by and between Seller, as landlord, and Hardee's Restaurants, LLC, a Delaware limited liability company ("***Tenant***"), as tenant, evidenced by Memorandum of Lease dated June 16, 2021, and recorded June 18, 2021 as Instrument No.: 20210618-0082789 in the in the Register's Office for Davidson County, Tennessee and by Memorandum of Lease dated June 16, 2021, and recorded June 21, 2021 in Book 8605, Page 685 in the Register's Office for Williamson County, Tennessee (collectively, the "***Hardee's Lease***"). Seller and Tenant have terminated, or intend to terminate, the Hardee's Lease. Prior to or at Closing, Seller shall cause a termination of the Hardee's Lease executed by Seller and Tenant and terminating the Hardee's Lease and terminating all of Tenant's right, title and interest in and to any portion of the Property, to be recorded in the Register's Office for Williamson County, Tennessee and in the Register's Office for Davidson County, Tennessee.

5. Miscellaneous. All of the recitals above and all exhibits attached to this Amendment are incorporated into this Amendment by this reference. Except as amended by this Amendment, all of the terms, conditions and agreements of the Purchase Agreement remain in full force and effect. All capitalized terms used but not defined in this Amendment have the meaning given to them in the Purchase Agreement. If there is any conflict between the terms of this Amendment and the terms of the Purchase Agreement, then the terms of this Amendment control. All of the recitals above and all exhibits attached to this Amendment

are incorporated into this Amendment by this reference. This Amendment is binding upon and inures to the benefit of the Parties and their respective successors and assigns. If any provision of this Amendment is unenforceable or inapplicable, the other provisions of this Amendment will remain in full force and effect as if the unenforceable or inapplicable provision had never been contained in this Amendment. This Amendment may be executed in counterparts. Electronic signatures (including scanned signatures in .PDF format) sent via e-mail will have the same force and effect as executed originals.

[*Remainder of Page Intentionally Left Blank; Signature Page to Follow*]

SIGNATURE PAGE TO
SECOND AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT

The Parties have executed this Amendment effective as of the Effective Date.

SELLER:

BURKITT COMMONS II, LLC,
a Tennessee limited liability company

By: ______________________
Name: John F. McReynolds
Title: Authorized Signatory

Date: 4 - 14, 2023

PURCHASER:

HCA HEALTH SERVICES OF TENNESSEE, INC.,
a Tennessee corporation

By: ______________________
Nicholas L. Paul, Vice President

Date: ______________________, 2023

SIGNATURE PAGE TO
SECOND AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT

The Parties have executed this Amendment effective as of the Effective Date.

SELLER:

BURKITT COMMONS II, LLC,
a Tennessee limited liability company

By: ______________________________
Name: John F. McReynolds
Title: Authorized Signatory

Date: ________________________, 2023

PURCHASER:

HCA HEALTH SERVICES OF TENNESSEE, INC.,
a Tennessee corporation

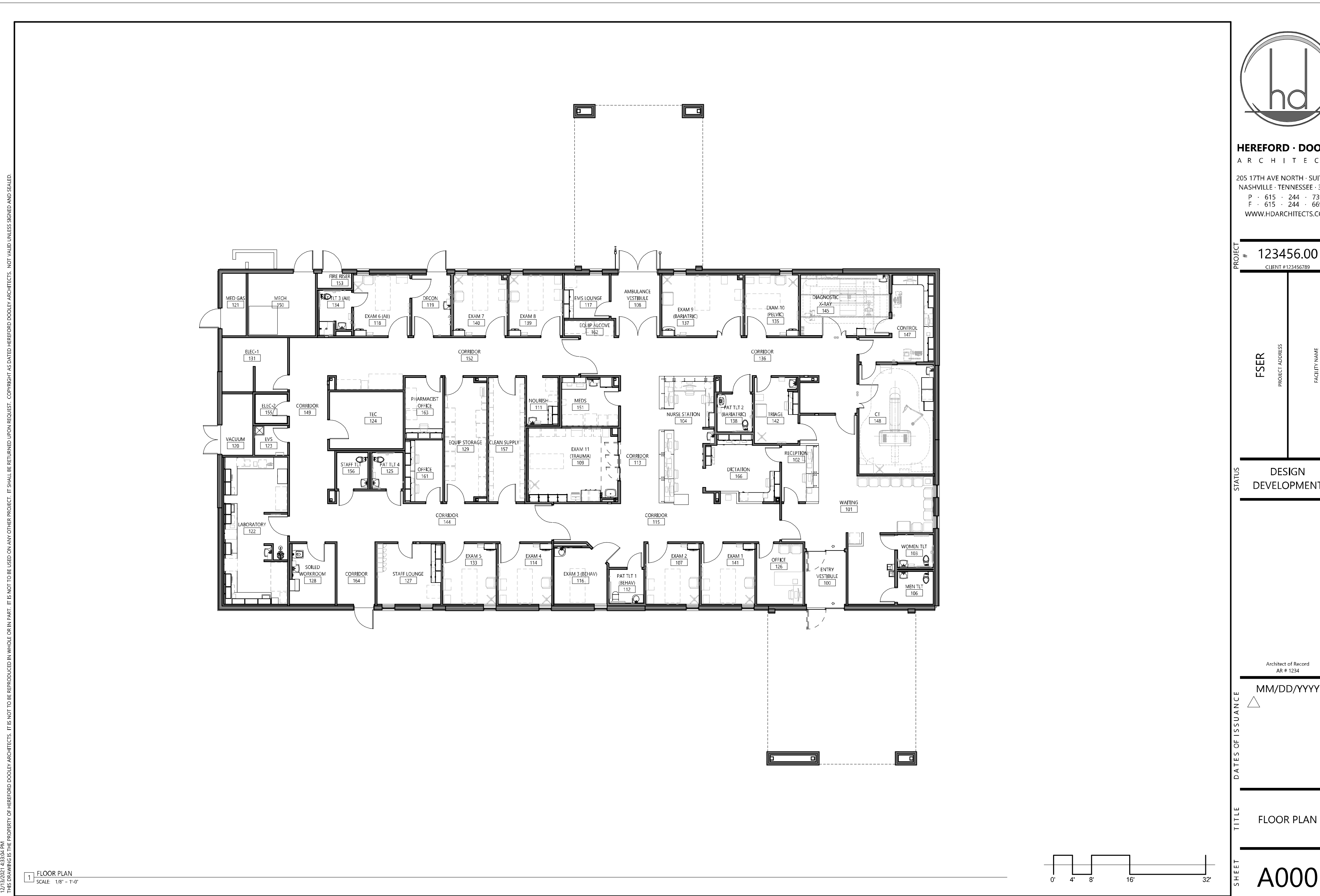
By: ______________________________
Joseph A. Sowell, III, Senior Vice President

Date: April 17, 2023

EXHIBIT A TO SECOND AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT

[*End of Exhibit A*]

Attachment 10A
Proposed Floor Plan



12/13/2021 4:33:04 PM
THIS DRAWING IS THE PROPERTY OF HEREFORD DOOLEY ARCHITECTS. IT IS NOT TO BE REPRODUCED IN WHOLE OR IN PART. IT IS NOT TO BE USED ON ANY OTHER PROJECT. IT SHALL BE RETURNED UPON REQUEST. COPYRIGHT AS DATED HEREFORD DOOLEY ARCHITECTS. NOT VALID UNLESS SIGNED AND SEALED.

1 FLOOR PLAN
SCALE: 1/8" = 1'-0"

0' 4' 8' 16' 32'

HEREFORD · DOOLEY
ARCHITECTS

205 17TH AVE NORTH · SUITE 203
NASHVILLE · TENNESSEE · 37203
P · 615 · 244 · 7399
F · 615 · 244 · 6697
WWW.HDARCHITECTS.COM

PROJECT # 123456.00
CLIENT #123456789

FSER
PROJECT ADDRESS
FACILITY NAME

STATUS: DESIGN DEVELOPMENT

Architect of Record
AR # 1234

DATES OF ISSUANCE: MM/DD/YYYY

TITLE: FLOOR PLAN

SHEET: A000

Attachment 11A

Public Transportation (Bus) Route

Bellevue

BELLEVUE

Routes continue to Joelton, Springfield, Pleasant View, and Clarksville

Routes continue to Gallatin

KEY

- 50 Frequent Service
- 4 Local Service
- 76 Connector Service
- 84 Express Service
- WeGo Star Regional Rail and Station
- 64 Star Shuttle Service
- Buses travel in direction of arrow
- A Park & Ride – see reverse side for route information
- 1 100 Oaks Mall – Point of interest – see separate list for route information
- H Hospital
- 65 Interstate Highway
- 70 U.S. Highway
- 24 State Highway

GOODLETTSVILLE

HENDERSONVILLE

OLD HICKORY LAKE

WHITES CREEK

MADISON

OLD HICKORY

LAKEWOOD

Star: Riverfront, Donelson, Hermitage, Mt. Juliet, Martha, Hamilton Springs, Lebanon

BORDEAUX

CUMBERLAND RIVER

HERMITAGE

DOWNTOWN – See the reverse side for detail

DONELSON

HICKORY BEND

J PERCY PRIEST LAKE

Route 88 continues to Dickson

BELLE MEADE

BERRY HILL

see Bellevue inset above for continuation of route

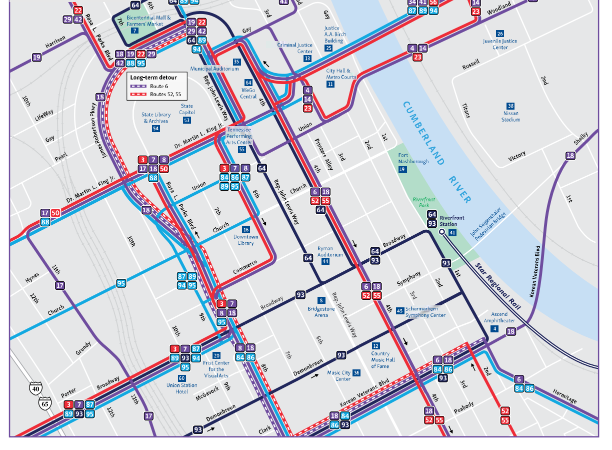
FOREST HILLS

OAK HILL

Route 95 continues to Franklin and Spring Hill

Routes continue to La Vergne, Smyrna, and Murfreesboro

0 1 2 3 4 miles



#	Point of Interest	Grid
1	100 Oaks Mall	E3
2	Adventure Science Center	D3
3	Airport (Nashville International)	D4
4	Ascend Amphitheater	•
5	Belle Meade Plantation	E1
6	Belmont University	D2
7	Bicentennial Mall & Farmers' Market	•
8	Bridgestone Arena	•
9	Centennial Medical Center	D2
10	Centennial Park & Parthenon	D2
11	City Hall & Metro Courts	•
12	Country Music Hall of Fame	•
13	Criminal Justice Center	•
14	Dell Corporation	E4
15	Donelson Station	D4
16	Downtown Library	•
17	Frist Horizon Park	D3
18	Fisk University	D2
19	Fort Nashborough	•
20	Frist Center for the Visual Arts	•
21	Gaylord Opryland Resort & Convention Center	C4
22	Greyhound Bus Station	D3
23	Hermitage Station	C5
24	Hillsboro Transit Center	E2
25	Justice A. A. Birch Building	•
26	Juvenile Justice Center	•
27	Lentz Public Health Center	D2
28	Lipscomb University	E2
29	Looby Center	C2
30	The Mall at Green Hills	E2
31	Meharry Medical College	D2
32	Metro Action Commssion	D3
33	Metro General Hospital at Meharry	D2
34	Metro Water Services	C2
35	Municipal Auditorium	•
36	Music City Center	•
37	Nashville State Community College	D1
38	Nissan Stadium	•
39	Opry Mills	C4
40	Richard H. Fulton Complex	D3
41	Riverfront Station	•
42	RiverGate Mall	A4
43	Rochelle Center	D3
44	Ryman Auditorium	•
45	Schermerhorn Symphony Center	•
46	Shelby Park	D3
47	Skyline Medical Center	B3
48	Social Security Office (MetroCenter Branch)	C2
49	Social Security Office (Rivergate Branch)	A4
50	St. Thomas Midtown Hospital	D2
51	St. Thomas Sports Park	C2
52	St. Thomas West Hospital	D2
53	State Capitol	•
54	State Library & Archives	•
55	Tennessee Performing Arts Center	•
56	Tennessee School for the Blind	D5
57	Tennessee State Fairgrounds	D3
58	Tennessee State University	D2
59	Trevecca Nazarene University	D3
60	Union Station Hotel	•
61	Vanderbilt University	D2
62	Vanderbilt University Medical Center	D2
63	Veterans Administration Hospital	D2
64	WeGo Central	•
65	Zoo (Nashville Zoo at Grassmere)	E3

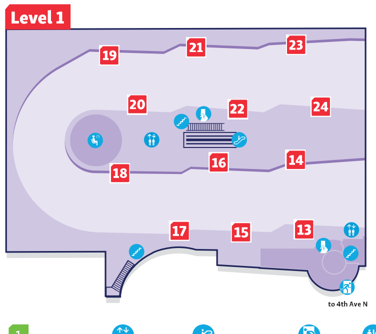
• See Downtown Inset

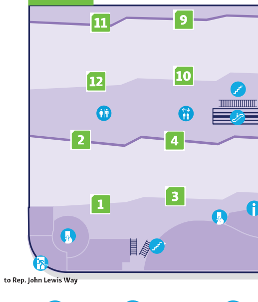
Route Information

Frequent Service	Board at Bay	Monday-Friday AM RUSH (6:15-8:15)	Monday-Friday MIDDAY (8:15-3:15)	Monday-Friday PM RUSH (3:15-6:15)	Monday-Friday EVENING (6:15-12:15)	Saturday DAYTIME	Saturday EVENING (6:15-11:15)	Sunday ALL DAY
3 West End	5	10	15	10	20–30	20	30	20
22 Bordeaux	10	15	15	15	30	25-30	30	30
23 Dickerson Pike	24	12 (24 Parkwood)	12 (24 Parkwood)	12 (24 Parkwood)	20–30 (40–60 Parkwood)	25	30	25–30
50 Charlotte Pike	1	15	15	15	30	20–30	30	20-30
52 Nolensville Pike	19	10	15	10	20-30	20	20-30	20-30
55 Murfreesboro Pike	15	10	10	10	15–30	15	20-30	20–30
56 Gallatin Pike	18	10	10	10	15–30	20	20-30	20–30
Local Service		AM RUSH (6:15-8:15)	MIDDAY (8:15-3:15)	PM RUSH (3:15-6:15)	EVENING (6:15-12:15)	DAYTIME	EVENING (6:15-11:15)	ALL DAY
4 Shelby	14	40 (20 Shelby & 19th)	40 (20 Shelby & 19th)	40 (20 Shelby & 19th)	40–60	40	40–60	40
6 Lebanon Pike	23	20-30	60	20-30	60	60	60	60
7 Hillsboro Pike	9	15	20	15	30	30	30–60	30–60
8 8th Avenue South	7	30	40	30	40-60	40	60	60
9 MetroCenter	7	25	25	25	—	—	—	—
14 Whites Creek	20	30	60	30	60	60	60	60
17 12th Avenue South	11	20	30	20	60	30	60	60
18 Airport	13	45	45	50	60	60	60	60
19 Herman	4	20	30	20	40	40	40	40
28 Meridian	2	30	60	30	60	60	60	60
29 Jefferson	8	20	30	20	30	30	30	30
34 Opry Mills	20	60	60	60	60	60	60	60
41 Golden Valley	12	60	—	60	—	—	—	—
42 St. Cecilia/Cumberland	6	30	60	30	60	60	60	60
Connector Service		AM RUSH (6:15-8:15)	MIDDAY (8:15-3:15)	PM RUSH (3:15-6:15)	EVENING (6:15-12:15)	DAYTIME	EVENING (6:15-11:15)	ALL DAY
75 Midtown	—	45	45 (with midday gap)	45	—	45 (with midday gap)	—	—
76 Madison	—	30	30	30	45	45	45	45
77 Thompson/Wedgewood	—	60	60	60	—	75	—	—
79 Skyline	—	30-40	30	30	40	45	—	—
Express Service		AM RUSH (6:15-8:15)	MIDDAY (8:15-3:15)	PM RUSH (3:15-6:15)	EVENING (6:15-12:15)	DAYTIME	EVENING (6:15-11:15)	ALL DAY
84 Murfreesboro	2	3 Trips	4 Trips	4 Trips	—	—	—	—
86 Smyrna/La Vergne	2	3 Trips	—	4 Trips	—	—	—	—
87 Gallatin/Hendersonville	4	4 Trips	—	4 Trips	—	—	—	—
88 Dickson	6	2 Trips	—	2 Trips	—	—	—	—
89 Springfield/Joelton	17	2 Trips	—	2 Trips	—	—	—	—
94 Clarksville	7	4 Trips	—	4 Trips	—	—	—	—
95 Spring Hill/Franklin	11	4 Trips	—	4 Trips	—	—	—	—
Train Service		AM RUSH (6:15-8:15)	MIDDAY (8:15-3:15)	PM RUSH (3:15-6:15)	EVENING (6:15-12:15)	DAYTIME	EVENING (6:15-11:15)	ALL DAY
WeGo Star	—	3 Trips	—	3 Trips	—	—	—	—
64 Star Downtown Shuttle	—	3 Trips	—	3 Trips	—	—	—	—
93 Star West End Shuttle	—	3 Trips	—	3 Trips	—	—	—	—

These buses serve WeGo Park & Ride locations. (Routes 22, 52, 55, 56, 6, 34, 84, 86, 87, 88, 89, 94, 95)

WeGo Central





- **Bus Bay** *Ubicación de la Bahía de Autobús*
- **Elevator** *Ascensor*
- **Escalator** *Escaleras mecánica*
- **Exit** *Salida*
- **Restrooms** *Baños*
- **Stairs** *Escaleras*
- **Ticketing** *Venta de boletos*
- **Waiting** *Esperando*
- **Meeting Room** *Sala de Reuniones*

Park & Ride Locations

For regional services, additional Park & Ride lots are available. For route specific Park & Ride information, go to **WeGoTransit.com**.

Location	Grid
A Bellevue	A1
B Dollar General	F4
C Donelson Station	D4
D Hermitage Station	C5
E Hickory Hollow	F5
F Kohl's (Hendersonville)	A5
G Madison Square	B4
H RiverGate	A4
I Staples (Bellevue)	A1
J Temple Baptist Church	C2
K Walton Lane	B3

Local Fares & Passes

Reloadable QuickTicket $3.00
2-Hour Pass $2.00
2-Hour Discounted Pass* $1.00
All-Day Pass $4.00
7-Day Pass $20.00
31-Day Pass $65.00

Children age 4 and younger ride free.

* Youth, seniors, persons with disabilities, and Medicare cardholders may be eligible for discounted fares and passes. Apply at WeGo Central.

Regional Fares & Passes

Reloadable QuickTicket $3.00
1-Ride Regional Bus $4.25
1-Ride Regional Bus Discounted* $2.00
20-Ride Regional Bus $73.50
Star Shuttles (Routes 64 & 93) .... Free

Children age 4 and younger ride free.

* Youth, seniors, persons with disabilities, and Medicare cardholders may be eligible for discounted fares and passes. Apply at WeGo Central.

Please Note:
Local fares and passes are not valid on regional routes.

All bus and train fares are sold through QuickTicket, WeGo's seamless fare payment system. Through QuickTicket, you can pay for your fare using a reloadable card, smartphone app, or non-reloadable ticket on all WeGo routes, services, and vehicles.

For more information on QuickTicket, visit QuickTicketTN.com.

Let's get digital.

For real-time bus info, trip planning, and interactive maps, visit the App Store or wherever you get your apps and start getting digital.

General Information

Destination Signs
Every bus is marked with a route number as well as the destination name or area. As you get on a bus, if you have questions about where the bus is going, please ask the driver.

Park & Ride
Several bus routes provide Park & Ride service that allows you to park your car and ride a bus. Passengers are permitted to use Park & Ride lots as complimentary services by owners of the lots. Please refer to the list below or on the route schedules for locations.

Holiday Service
On the following major holidays, WeGo operates service on a Sunday/Holiday schedule:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Christmas

On Martin Luther King Jr. Day, WeGo operates service on a Saturday schedule.

Snow Route Detours
Be prepared for winter weather and pick up your snow route detours brochure today.

Snow route information may be found at displays around town, online at **WeGoTransit.com**, or by calling Customer Care at **615-862-5950**.

Services for Medicare Cardholders, Seniors, or People with Disabilities
Medicare cardholders, seniors ages 65 and older, and people with disabilities qualify for a reduced fare after registering for an account in person at WeGo Central. All discount fares are available when using a reloadable QuickTicket

Passengers whose disabilities prevent them from using large buses may qualify for special door-to-door van service through WeGo Access.

For more information, please call **615-880-3970** or visit **WeGoTransit.com**.

Access

WeGo's paratransit service operates a fleet of special vans for people with disabilities who are unable to ride the large fixed-route buses.

- This door-to-door service is provided within Davidson County.
- To request an eligibility application, call Access at **615-880-3970** or download a copy from **WeGoTransit.com**.

Title VI

Title VI of the Civil Rights Act of 1964 states that "No Person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." For more information on Title VI, visit **WeGoTransit.com**.

ADA

WeGo Public Transit makes reasonable accomodations in order for individuals with disabilities to fully use transit services.
All requests should be made in advance by filling out and submitting a Reasonable Accommodation Request form. For more information on Reasonable Accommodations, visit **WeGoTransit.com**.

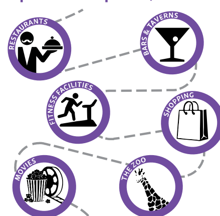
So you want to ride the bus...

but are not quite sure how everything works. WeGo Public Transit offers travel training for individuals or small groups who need assistance.

We'll help you:

- Read a bus schedule
- Identify which route to take
- Pay your fare
- Know how and when to speak with the driver
- Transfer from one bus to another

Explore these places, and more.



Call 615-880-3597 to schedule your session.

For More Information

Customer Care
615-862-5950
6:30 a.m. to 8:00 p.m. – Monday-Friday
8:00 a.m. to 5:00 p.m. – Saturday
10:30 a.m. to 2:30 p.m. – Sunday

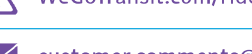
Central
400 Dr. Martin L. King Jr. Blvd.
4:45 a.m. to 12:15 a.m. – Monday-Saturday
5:45 a.m. to 11:15 p.m. – Sundays and holidays

Administrative Offices
615-862-5969
430 Myatt Drive
8:00 a.m. to 4:30 p.m. – Monday-Friday
Closed weekends and holidays

Stay Connected

WeGoTransit

@WeGoTransit

@WeGoTransit

WeGoTransit.com
WeGoTransit.com/ride/alerts
customer.comments@nashville.gov

Hello. Hola. Ciao. Hallo. Ohayo. Bonjour. Namaste.

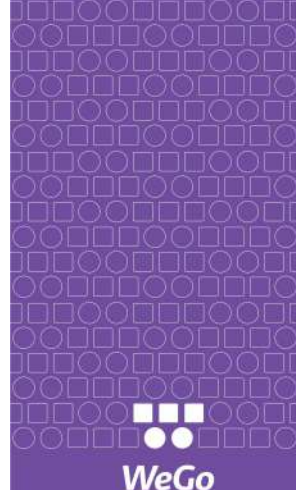
We strive to connect people to their lives and community, one ride at a time. A community belongs to everyone. So do we.

We take service to heart. Whether you're traveling every day or just here and there, we're here to help by creating positive impressions as we get you where you need to go. We even hope to inspire some joy along the way. We aim to offer support and services that make sense and make your life a little easier.

We're always looking for ways to improve our service by making it more reliable, secure, and connected. Because connecting you to life and community isn't just what we do, it's what makes us who we are.

Gail Carr Williams
Board Chair

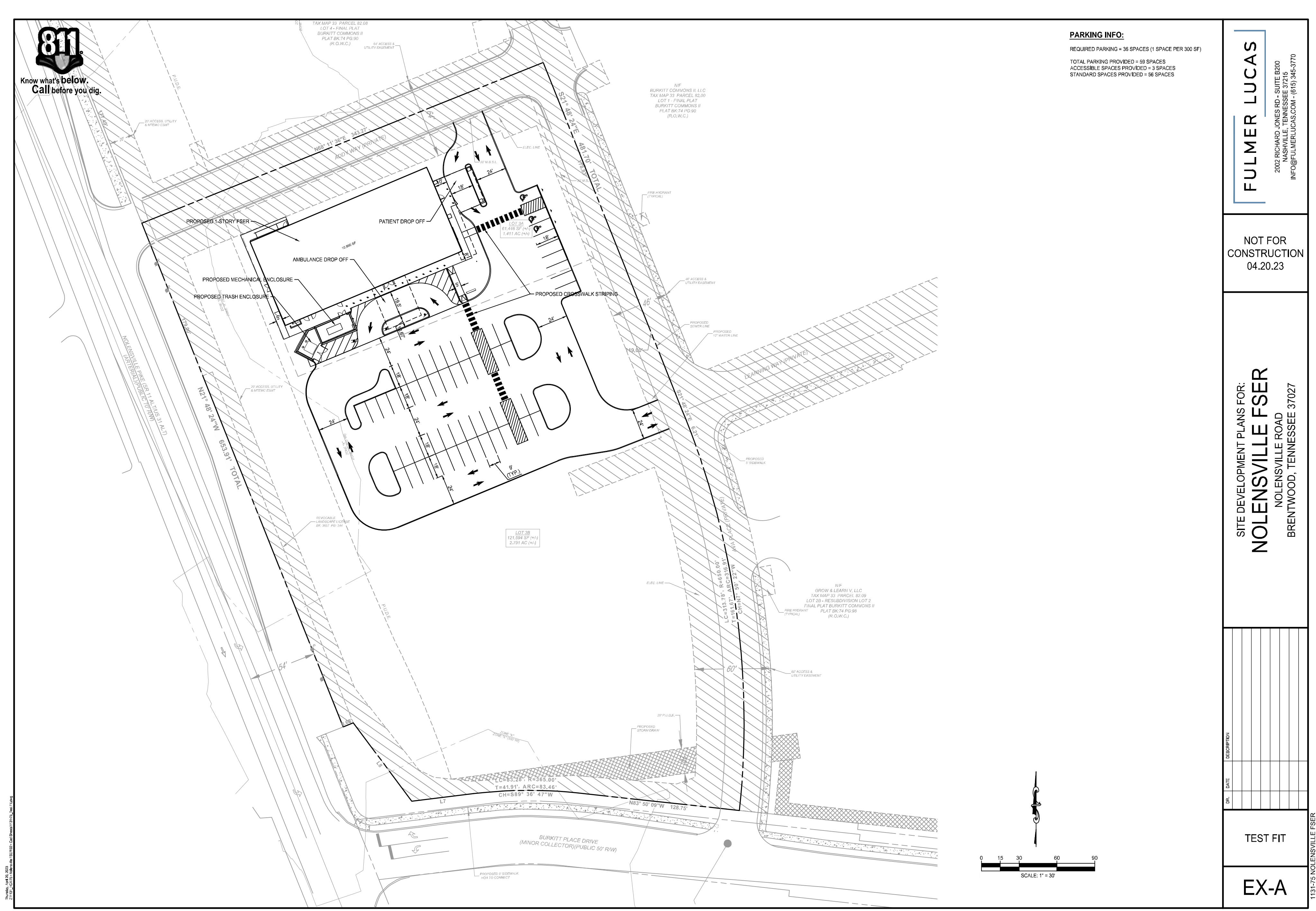
System Map



October 2, 2022

Attachment 12A

Plot Plan



811
Know what's below.
Call before you dig.
PARKING INFO:
REQUIRED PARKING = 36 SPACES (1 SPACE PER 300 SF)
TOTAL PARKING PROVIDED = 59 SPACES
ACCESSIBLE SPACES PROVIDED = 3 SPACES
STANDARD SPACES PROVIDED = 56 SPACES
PROPOSED 1-STORY FSER
PATIENT DROP OFF
AMBULANCE DROP OFF
PROPOSED MECHANICAL ENCLOSURE
PROPOSED TRASH ENCLOSURE
PROPOSED CROSSWALK STRIPING
N21° 48' 24"W 653.91' TOTAL
S21° 48' 24"E 481.70' TOTAL
N68° 11' 36"E 343.27'
LEARNING WAY (PRIVATE)
BURKITT PLACE DRIVE
(MINOR COLLECTOR)(PUBLIC 50' R/W)
N83° 50' 09"W 128.75'
CH=S89° 36' 47"W
LOT 3B
121,594 SF (+/-)
2.791 AC (+/-)
SCALE: 1" = 30'
FULMER LUCAS
2002 RICHARD JONES RD - SUITE B200
NASHVILLE, TENNESSEE 37215
INFO@FULMERLUCAS.COM - (615) 345-3770
NOT FOR
CONSTRUCTION
04.20.23
SITE DEVELOPMENT PLANS FOR:
NOLENSVILLE FSER
NOLENSVILLE ROAD
BRENTWOOD, TENNESSEE 37027
DESCRIPTION
DATE
DR.
TEST FIT
EX-A
1131-75 NOLENSVILLE FSER

Attachment 4E-1

Equipment List > $50,000

42 Working Vendor Item Summary

Report Filters:
Report Time:
11/04/2021 12:50
Ted Bennett
Budget = FSER Template - Updated 9/14/21

Equipment items > $50k

GE Logiq 8 Ultrasound	$60,884
GE Physiologic Monitoring	$98,240
(1 fixed and 4 portable monitors with central station)	
GE XR646 Rad Room	$130,202
GE Optima XR240 Portable X-ray	$63,811
GE Revolution EVO CT System	$376,446

Attachment 4E-2
Funding Letter

TriStar Southern Hills
MEDICAL CENTER

TriStarHealth.com
391 Wallace Road
Nashville, TN 37211
(615) 781-4000

March 15, 2023

Mr. Logan Grant
Executive Director
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

RE: Funding Availability for HCA Health Services of Tennessee, Inc. d/b/a TriStar Southern Hills Medical Center's Proposal Seeking CON Approval to Establish a Freestanding Emergency Department in Williamson County, Tennessee

Dear Mr. Grant,

HCA Health Services of Tennessee, Inc. d/b/a TriStar Southern Hills Medical Center ("TriStar Southern Hills") is filing an application to establish a freestanding emergency department ("FSED") that will function as a satellite emergency department to TriStar Southern Hills in Nolensville, Williamson County. TriStar Southern Hills is part of the TriStar Health System in Eastern Tennessee, and our system's hospitals are owned by HCA Healthcare, Inc. through wholly owned subsidiaries.

As Chief Financial Officer of HCA Health Services of Tennessee, Inc. d/b/a TriStar Southern Hills Medical Center, I am writing to confirm that HCA Healthcare, Inc. is committed to provide through TriStar System up to $18 million to fully fund the proposed project from cash reserves. HCA Healthcare, Inc.'s audited financial statements are provided as an attachment to this application.

Please contact me if you have any questions regarding this information.

Sincerely,

Wes Fountain

Attachment 4E-3
2022 HCA's Annual Report

2022

Annual Report to Shareholders

2022 by the numbers

294K people employed

$27.7B in payroll and benefits

$5.6B federal, state and local taxes incurred

$4.4B in capital investment

2.0M+ admissions

37M+ patient encounters

9.0M emergency room visits

$3.5B estimated cost of uncompensated care provided

$44.2M enterprise giving to community organizations

$17M colleague giving with HCA Healthcare matching

143,878 volunteer hours

6,741 charitable organizations supported through donations and volunteering

$8.8M in student loan assistance

$30.4M tuition reimbursement benefits

$12M in assistance distributed by the HCA Healthcare Hope Fund in 2022 through **4,427** grants for HCA Healthcare colleagues and families

To our valued shareholders,

2022 was another positive year for HCA Healthcare. Our 182 hospitals and approximately 2,300 ambulatory sites of care cared for more than 37 million patients. Our people, nearly 294,000 colleagues and 45,000 physicians on our medical staff, fulfilled our core mission by continuing to show up and deliver high-quality healthcare services to our communities.

The impact of COVID-19 continued to significantly influence the healthcare industry; however, HCA Healthcare performed well by balancing local needs while also developing more enterprise capabilities to support our local networks. As leaders, our actions were informed by lessons learned during the pandemic: the importance of setting clear priorities; the power of teamwork and partnerships; the significance of timely decision-making and execution; and communicating timely and transparently to our stakeholders.

The aftermath of the pandemic created a number of industry-wide challenges. There has been a clear disruption in the labor market; inflationary pressures have driven up costs; and capacity constraints have affected the ability to meet patient demand. To address these matters, our teams continued to incorporate financial resiliency measures while focusing on four key areas: recruitment, retention, new care models, and capacity management. These initiatives will carry us into 2023.

Financially, we ended the year in a solid position. Our revenues for the year totaled $60.2 billion, a 2.5% increase from 2021.

We generated $8.5 billion in cash flows from operations, providing us with the capacity to execute a balanced approach to capital allocation.

- As you see later in this letter, we invested substantial amounts of capital into our facilities.
- We repurchased $7 billion, or over 30 million shares, of common stock.
- We increased our quarterly dividend by 17% over 2021.

Additionally, we generated over $1.2 billion of pre-tax proceeds from divestitures. And, as a taxpaying healthcare provider, we incurred approximately $5.6 billion of federal, state, and local taxes, including $2.3 billion of income, property, and sales and use taxes.

Above all else, we are committed to the care and improvement of human life.

HCA Healthcare's **182 hospitals** are supported by approximately **2,300 ambulatory sites of care** in **20 states** and the U.K., including:

126
surgery centers

130
freestanding emergency rooms

1,616
physician practices

270
urgent care clinics

43
home health and hospice agencies

61
behavioral health sites of care

Learn more about our collective impact at HCAhealthcareImpact.com.

*As of Dec. 31, 2022

Most importantly, we stayed true to our mission and values – caring for our patients, people, and communities.

- We cared for over 2 million inpatient admissions, almost 9 million emergency room visits, over 1.5 million surgical procedures and over 200,000 deliveries.
- 25% of our admissions and 48% of our emergency room visits were for the treatment of patients who were either uninsured or covered under Medicaid.
- We provided uncompensated care at an estimated cost of $3.5 billion.

We believe HCA Healthcare is poised to meet today's challenges and take advantage of the opportunities before us.

On the workforce front, HCA Healthcare made investments in our people this past year. Overall, we believe our workforce initiatives are starting to take hold. This past year, we increased our investment in recruitment to help hire approximately 105,000 colleagues.

To further bolster our nursing development programs, HCA Healthcare opened seven more Galen College of Nursing schools. We expect to open more schools in 2023. HCA Healthcare has more than 93,000 registered nurses holding positions from bedside caregivers to leadership roles in various healthcare settings and at every level throughout the organization. Bringing Galen into the HCA Healthcare family was designed to combine two leading nursing organizations to increase access to nursing education and to provide nursing career development opportunities for HCA Healthcare colleagues.

In 2022, HCA Healthcare invested more than $135 million in our clinical education programs, including centers for clinical advancement. These investments enhance the learning environment for our people so we can advance nursing care for our patients. Workforce development remains a top priority. We anticipate more investments in these areas in the future.

As part of our workforce development initiatives and to help with the country's issue of physician shortages, HCA Healthcare has become a significant provider of medical education. We have 320 Accreditation Council for Graduate Medical Education (ACGME) programs, more than 5,300 residents and fellows, and 66 teaching hospitals across 16 states.

In addition to growing the pipeline of physicians and nurses, it's important that we continue to upgrade our facilities to meet the growing demand for healthcare. In 2022, HCA Healthcare invested $4.4 billion in our existing facilities. That's the most HCA Healthcare has ever invested in our capital spending in a single year. These investments provide us with expanded capacity, advanced clinical technology, and better facilities for our patients.

As part of our capital spending, we continued to expand our outpatient network in key markets. For example, in 2022, HCA Healthcare purchased MD Now Urgent Care, a network of 59 urgent care centers in Florida, which was one of the largest urgent care acquisitions in the healthcare industry.

Adding MD Now Urgent Care in Florida enhances our already strong capabilities in a rapidly growing state by providing convenient outpatient care options for our patients. It also connects MD Now patients to a comprehensive statewide network of care, including acute care and specialty services, should they be needed.

We also announced plans to build new full-service hospitals in Texas and Florida to help meet both states' growing needs for healthcare services.

These facilities and hospitals would provide more resources for the communities we serve and help us deliver the quality care and easier access our patients deserve.

And while we continued to educate our clinicians, update our facilities, and grow our networks, HCA Healthcare continued to remain a leader in operational and clinical excellence.

We are proud to say that in 2022 Ethisphere recognized HCA Healthcare as one of the World's Most Ethical Companies for the 12th time. We were also recognized for the second consecutive year on the 2022 LinkedIn Top Companies ranking, an annual list that helps professionals identify the top workplaces to grow their careers. Additionally, we were named by Military Times as one of the country's best employers based on the company's efforts to recruit, retain, and support current and former service members, military spouses, and military caregivers.

As an organization, we have programs and initiatives that underscore our strong sense of purpose to do what is right for our patients, colleagues, and the communities we serve, and these awards reflect that culture. As a result, and thanks to our clinical staff's hard work and dedication this past year, in the fall 2022, more than 80% of our hospitals rated by The Leapfrog Group received an "A" or "B" Leapfrog Safety Score.

On the innovation front, HCA Healthcare's Care Transformation and Innovation (CT&I) department is working to deliver the healthcare of the future and support our care teams. For example, this past year, we launched a pilot in the Labor and Delivery (L&D) space – "Staff Scheduler." The Staff Scheduler system predicts staffing needs based on a machine-learning algorithm, measures the difficulty of procedures, and improves staffing according to proficiencies and preferences. Since the pilot launched, we have saved time, improved staffing to meet our patients' needs, and increased nurse satisfaction.

CT&I's work to identify, build, and roll out new technology solutions and innovative processes should create better outcomes and experiences for our care teams and patients. We look forward to sharing more of their work.

To further enhance our technology, we decided to update our clinical systems. This updated clinical system is designed to provide HCA Healthcare clinicians with an intuitive, mobile user interface, personalized to our workflows. In addition, we expect it will allow us to standardize our data sets more effectively and utilize cloud-based analytics to support better clinical decisions, improve efficiencies, and create a safer environment for our patients.

And as we continue to innovate and integrate technology into patient care, we are partnering with organizations that share our common goal.

For example, we recently partnered with McKesson Corporation to form an oncology research joint venture combining McKesson's U.S. Oncology Research (USOR) and HCA Healthcare's Sarah Cannon Research Institute (SCRI). Together, USOR and SCRI create a fully integrated oncology research organization with goals to expand clinical research, accelerate drug development, and increase availability and access to clinical trials for community oncology providers and patients. In addition, this joint venture with McKesson, which unifies our oncology research experts, is intended to promote the development of individualized therapies and provide more opportunities for cancer patients to receive new treatments.

HCA Healthcare is collaborating with Johnson & Johnson to address key issues in the healthcare industry, including improving health outcomes through early-stage lung cancer detection for the Black community, providing more resources for our nurses on health equity issues, and collaborating on cardiovascular health initiatives. HCA Healthcare and Johnson & Johnson have had a long and productive relationship, and both companies have worked hard to address many of our country's healthcare challenges. We are excited to collaborate to advance health equity, enhance patient care and provide even greater support to our nurses.

And in conjunction with the HCA Healthcare Foundation and the American Heart Association, we have started a new initiative, Getting to the Heart of Stroke, to help prevent initial and recurrent strokes and improve overall stroke care. This initiative will launch in 15 select HCA Healthcare markets to empower consumers to know and better manage stroke risk, deepen collaboration between healthcare professionals, and improve the overall health of communities. Through this collaboration, we hope to have a significant impact in improving heart and brain health outcomes in order to beat stroke.

Additionally, we continue to show up for our colleagues and the communities we serve in their time of need.

In the aftermath of Hurricane Ian, HCA Healthcare showed up and supported our Florida communities. Our human resources and supply chain teams deployed on-site mini-marts, fuel stations, showers, and laundry services in Florida to assist facilities, colleagues, and nearby health systems in need. In addition, the HCA Healthcare Hope Fund received 776 applications from colleagues, with more than $1.2 million being provided to colleagues impacted by the hurricane. We are incredibly proud of how our Florida colleagues responded before, during, and in the wake of Hurricane Ian.

Furthermore, HCA Healthcare and the HCA Healthcare Foundation showed up and supported several organizations in our communities throughout the year. For example, the Foundation committed approximately $1.38 million over three years to the Girl Scouts of the USA to provide mental wellness workshops to girls in grades 4-12 nationwide, over $350,000 to Kentucky flood relief efforts, $600,000 to Volunteers of America over two years to promote mental wellbeing and resiliency for first responders and front-line caregivers, $250,000 to the American Red Cross to support disaster relief and preparedness nationwide, and more.

Through the HCA Healthcare Foundation's Healthier Tomorrow Fund, we are also aligning with strategic partners who share our goal of creating a more diverse pipeline of healthcare leaders.

The HCA Healthcare Foundation also committed to donating $1.35 million over the next three years to Educate Texas, an initiative of the Communities Foundation of Texas. This grant aims to increase access to student programs that enable healthcare careers, including high schools in Texas that offer Pathways in Technology Early College High School (P-TECH) healthcare career tracks.

We also continued our commitment to support Historically Black Colleges and Universities (HBCUs) and Hispanic-Serving Institutions (HSIs) in communities near our hospitals. As part of this commitment, we are investing $1.5 million to Florida International University's Nicole Wertheim College of Nursing & Health Sciences (NWCNHS) to address the national nursing shortage. Additionally, we announced an investment of $750,000 to The University of Texas at El Paso to advance diversity in healthcare

leadership. HCA Healthcare is also investing $1.55 million to Tennessee State University to fund scholarships for students pursuing healthcare and computer science careers, and $1.5 million to Fisk University to support students pursuing the accelerated dual-degree program with Galen College of Nursing.

HCA Healthcare has announced approximately $6.75 million in gifts since 2021 to multiple colleges and universities as part of our three-year $10 million pledge to HBCUs/HSIs. These partnerships will help support students pursuing a career in healthcare and, in turn, create a more diverse talent pipeline of healthcare leaders.

Our dedication to showing up for the communities we serve also includes understanding how the environment impacts overall health. To help ensure our current and future environmental strategies, like reducing our carbon emissions, are carried out, HCA Healthcare has robust governance in place to prepare and execute our sustainability plans.

We look forward to continuing to show up for our colleagues and communities in 2023 and beyond.

As we push forward on our journey to be the provider system of choice, HCA Healthcare announced organizational changes which, we believe, can be a catalyst for unlocking even more value for our stakeholders. As of January 1, 2023, we have a new operating model that includes a chief operating officer, an additional senior vice president-finance, and three operating groups with five domestic divisions each. The new organizational design reflects a structure that is intended to align better with our strategy, streamline areas that can improve long-term performance, and provide greater focus and better coordination in supporting our business. As mentioned previously, the COVID-19 pandemic taught us that we need to be well-positioned to make timely decisions and act quickly. We believe that's exactly what this structural change will do.

All in all, we are coming out of this pandemic with momentum. We believe HCA Healthcare is well-positioned culturally, competitively, and financially. We are grateful for the hard work and dedication our colleagues showed this past year in carrying out HCA Healthcare's mission, and we want to thank them in advance for what they're going to accomplish in the year ahead.

Thomas F. Frist III
Chairman of the Board

Samuel N. Hazen
Chief Executive Officer

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2022

Or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from ________ to

Commission File Number 1-11239

HCA Healthcare, Inc.
(Exact Name of Registrant as Specified in its Charter)

Delaware **(State or Other Jurisdiction of Incorporation or Organization)**	**27-3865930** **(I.R.S. Employer Identification No.)**
One Park Plaza **Nashville, Tennessee** **(Address of Principal Executive Offices)**	**37203** **(Zip Code)**

Registrant's telephone number, including area code: (615) 344-9551

Securities Registered Pursuant to Section 12(b) of the Act:

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock, $0.01 Par Value	HCA	New York Stock Exchange

Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the Registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒	Accelerated filer ☐
Non-accelerated filer ☐	Smaller reporting company ☐
	Emerging growth company ☐

If an emerging growth company, indicate by check mark if the Registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the Registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes ☐ No ☒

Auditor PCAOB ID Number: 42 Auditor Name: Ernst & Young LLP Auditor Location: Nashville, Tennessee, United States of America

As of January 31, 2023, there were 276,966,400 outstanding shares of the Registrant's common stock. As of June 30, 2022, the aggregate market value of the common stock held by nonaffiliates was approximately $36.171 billion. For purposes of the foregoing calculation only, Hercules Holding II and the Registrant's directors and executive officers have been deemed to be affiliates.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy materials for its 2023 Annual Meeting of Stockholders are incorporated by reference into Part III hereof.

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PART I

Item 1. *Business*

General

HCA Healthcare, Inc. is one of the leading health care services companies in the United States. At December 31, 2022, we operated 182 hospitals, comprised of 175 general, acute care hospitals; five psychiatric hospitals; and two rehabilitation hospitals. In addition, we operated 126 freestanding surgery centers and 21 freestanding endoscopy centers. Our facilities are located in 20 states and England.

The terms "Company," "HCA," "HCA Healthcare," "we," "our" or "us," as used herein and unless otherwise stated or indicated by context, refer to HCA Healthcare, Inc. and its affiliates. The term "affiliates" means direct and indirect subsidiaries of HCA Healthcare, Inc. and partnerships and joint ventures in which such subsidiaries are partners. The terms "facilities" or "hospitals" refer to entities owned and operated by affiliates of HCA, and the term "employees" refers to employees of affiliates of HCA.

Our primary objective is to provide a comprehensive array of quality health care services in the most cost-effective manner possible. Our general, acute care hospitals typically provide a full range of services to accommodate such medical specialties as internal medicine, general surgery, cardiology, oncology, neurosurgery, orthopedics and obstetrics, as well as diagnostic and emergency services. Outpatient and ancillary health care services are provided by our general, acute care hospitals, freestanding surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic centers and rehabilitation facilities. Our psychiatric hospitals provide a full range of mental health care services through inpatient, partial hospitalization and outpatient settings.

Our common stock is traded on the New York Stock Exchange (symbol "HCA"). Through our predecessors, we commenced operations in 1968. HCA Healthcare, Inc. was incorporated in Delaware in October 2010. Our principal executive offices are located at One Park Plaza, Nashville, Tennessee 37203, and our telephone number is (615) 344-9551.

Available Information

We file certain reports with the Securities and Exchange Commission (the "SEC"), including annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. The SEC maintains an Internet site at http://www.sec.gov that contains the reports, proxy and information statements and other information we file. Our website address is www.hcahealthcare.com. Please note that our website address is provided throughout this report as an inactive textual reference only. We make available free of charge, through our website, our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and all amendments to those reports filed or furnished pursuant to Section 13 or 15(d) of the Exchange Act, as soon as reasonably practicable after such material is electronically filed with or furnished to the SEC. The information provided on our website is not part of this report, and is therefore not incorporated by reference unless such information is specifically referenced elsewhere in this report.

Our Code of Conduct is available free of charge upon request to our Investor Relations Department, HCA Healthcare, Inc., One Park Plaza, Nashville, Tennessee 37203, and is also available on the Ethics and Compliance and Corporate Governance portion of our website at www.hcahealthcare.com.

Business Strategy

We are committed to providing the communities we serve with high quality, convenient and cost-effective health care while growing our business and creating long-term value for our stockholders. We strive to be the health care system of choice in the communities we serve by developing comprehensive networks locally and supporting these networks with enterprise expertise and economies of scale. Our strategy is organized around a framework that seeks to drive sustained growth by delivering operational excellence, attracting exceptional physicians and other health care professionals, developing comprehensive services; creating greater access, and coordinating higher quality care for patients.

To achieve these objectives, we align our efforts around the following growth agenda:

- grow our presence in existing markets;
- achieve industry-leading performance in clinical, operational and satisfaction measures;
- recruit and retain physicians and other health care professionals to meet the need for high quality health services;
- continue to utilize economies of scale to grow the Company; and
- pursue a disciplined development strategy.

Our strategy also emphasizes investments that advance our clinical systems and digital capabilities, transform care models with innovative care solutions, expand our workforce development programs and enhance our health care networks and partnerships.

Health Care Facilities

We currently own, manage or operate hospitals, freestanding surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, radiation and oncology therapy centers, comprehensive rehabilitation and physical therapy centers, physician practices, home health, hospice, outpatient physical therapy home and community-based services providers, and various other facilities.

At December 31, 2022, we owned and operated 175 general, acute care hospitals with 48,508 licensed beds. Most of our general, acute care hospitals provide medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic services and emergency services. The general, acute care hospitals also provide outpatient services such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology and physical therapy. Each hospital has an organized medical staff and a local board of trustees or governing board comprised of members of the local community.

At December 31, 2022, we operated five psychiatric hospitals with 593 licensed beds. Our psychiatric hospitals provide therapeutic programs, including child, adolescent and adult psychiatric care and adolescent and adult alcohol and drug abuse treatment and counseling.

We also operate outpatient health care facilities, which include freestanding ambulatory surgery centers (“ASCs”), freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, comprehensive rehabilitation and physical therapy centers, radiation and oncology therapy centers, physician practices and various other facilities. These outpatient services are an integral component of our strategy to develop comprehensive health care networks in select communities. Most of our ASCs are operated through partnerships or limited liability companies, with majority ownership of each partnership or limited liability company typically held by a general partner or member that is an affiliate of HCA.

Certain of our affiliates provide a variety of management services to our health care facilities, including patient safety programs, ethics and compliance programs, national supply contracts, equipment purchasing and leasing contracts, accounting, financial and clinical systems, governmental reimbursement assistance, construction planning and coordination, information technology systems and solutions, legal counsel, human resources services and internal audit services.

COVID-19

We believe the extent of COVID-19’s impact on our operating results and financial condition has been and could continue to be driven by many factors, most of which are beyond our control and ability to forecast. Because of these uncertainties, we cannot estimate how long or to what extent COVID-19 will impact our operations.

Summary Risk Factors

You should carefully read and consider the risk factors set forth under Item 1A, "Risk Factors," as well as all other information contained in this annual report on Form 10-K. Additional risks and uncertainties not presently known to us or that we currently deem immaterial may also affect us. If any of these risks occur, our business, financial position, results of operations, cash flows or prospects could be materially, adversely affected. Our business is subject to the following principal risks and uncertainties:

Risks related to COVID-19 and other potential pandemics:

- COVID-19 has affected, and may continue to affect, our operations. Further, COVID-19 could negatively impact our business, financial condition, and cash flows, particularly if it causes public health conditions and/or economic conditions to deteriorate.
- We are unable to predict the ultimate impact of the CARES Act (as defined below) and other stimulus and relief legislation or the effect that such legislation and other governmental responses intended to assist providers in responding to COVID-19 may have on our business, financial condition, results of operations or cash flows.
- The emergence and effects related to a potential future pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations.

Risks related to our indebtedness:

- Our substantial leverage could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of our variable rate debt and prevent us from meeting our obligations.
- We may not be able to generate sufficient cash to service all of our indebtedness and may not be able to refinance our indebtedness on favorable terms. If we are unable to do so, we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.
- Our debt agreements contain restrictions that limit our flexibility in operating our business.

Risks related to human capital:

- Our results of operations may be adversely affected by competition for staffing, the shortage of experienced nurses and other health care professionals and labor union activity.
- We may be unable to attract, hire and retain a highly qualified and diverse workforce, including key management.
- Our performance depends on our ability to recruit and retain quality physicians.

Risks related to technology, data privacy and cybersecurity:

- A cybersecurity incident or other form of data breach could result in the compromise of our facilities, confidential data or critical data systems. A cybersecurity incident or other form of data breach could also give rise to potential harm to patients; remediation and other expenses; and exposure to liability under HIPAA (as defined below), consumer protection laws, common law theories or other laws. Such incidents could subject us to litigation and foreign, federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.
- Our operations could be impaired by a failure of our information systems.
- Health care technology initiatives, particularly those related to sharing patient data and interoperability, may adversely affect our operations.
- We may not be reimbursed for the cost of expensive, new technology.

Risks related to governmental regulation and other legal matters:

- Our business and results of operations may be adversely affected by health care reform efforts. We are unable to predict whether, what, and when additional health reform measures will be adopted or implemented, and the effects and ultimate impact of any such measures are uncertain and may adversely affect our business and results of operations.

- Changes in government health care programs may adversely affect our revenues.
- If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations.
- State efforts to regulate the construction or expansion of health care facilities could impair our ability to operate and expand our operations.
- We may incur additional tax liabilities.
- We have been and could become the subject of government investigations, claims and litigation.
- We may be subject to liabilities from claims brought against our facilities, which are costly to defend and may require us to pay significant damages if not covered by insurance.

Risks related to operations, strategy, demand and competition:

- Our hospitals and other facilities face competition for patients from other hospitals and health care providers.
- Any increase in the volume of uninsured patients or deterioration in the collectability of uninsured and patient due accounts could adversely affect our results of operations.
- If our volume of patients with private health insurance coverage declines or we are unable to retain and negotiate favorable contracts with private third-party payers, including managed care plans, our revenues may be adversely affected.
- Changes to physician utilization practices and treatment methodologies, third-party payer controls designed to reduce inpatient services or surgical procedures and other factors outside our control that impact demand for medical services may reduce our revenues.
- We may encounter difficulty acquiring hospitals and other health care businesses, encounter challenges integrating the operations of acquired hospitals and other health care businesses and/or become liable for unknown or contingent liabilities as a result of acquisitions.
- Our facilities are heavily concentrated in Florida and Texas, which makes us sensitive to regulatory, economic, public health, environmental and competitive conditions and changes in those states.
- Our business and operations are subject to risks related to climate change.
- We may be adversely affected if we are not able to achieve our environmental, social and governance (“ESG”) goals or otherwise meet the expectations of our stakeholders with respect to ESG matters.
- The industry trend toward value-based purchasing may negatively impact our revenues.

Risks related to macroeconomic conditions:

- Our overall business results may suffer during periods of general economic weakness.
- We are exposed to market risk related to changes in the market values of securities and interest rates.

Risks related to ownership of our common stock:

- There can be no assurance that we will continue to pay dividends.
- Certain of our investors may continue to have influence over us.

Sources of Revenue

Hospital revenues depend upon inpatient occupancy levels, the medical and ancillary services ordered by physicians and provided to patients, the volume of outpatient procedures and the charges or payment rates for such services. Reimbursement rates for inpatient and outpatient services vary significantly depending on the type of third-party payer, the type of service (e.g., medical/surgical, intensive care or psychiatric) and the geographic location of the hospital. Inpatient occupancy levels fluctuate for various reasons, many of which are beyond our control.

We receive payments for patient services from the federal government under the Medicare program, state governments under their respective Medicaid or similar programs, managed care plans (including plans offered through the American Health Benefit Exchanges ("Exchanges")), private insurers and directly from patients. Our revenues by primary third-party payer classification and other (including uninsured patients) for the years ended December 31, 2022, 2021 and 2020 are summarized in the following table (dollars in millions):

	Years Ended December 31,					
	2022	**Ratio**	**2021**	**Ratio**	**2020**	**Ratio**
Medicare	**$ 10,447**	**17.3%**	$ 10,447	17.8%	$ 10,420	20.2%
Managed Medicare	**9,201**	**15.3**	8,424	14.3	6,997	13.6
Medicaid	**2,636**	**4.4**	2,290	3.9	1,965	3.8
Managed Medicaid	**3,998**	**6.6**	3,124	5.3	2,621	5.1
Managed care and other insurers	**29,120**	**48.3**	30,295	51.6	26,535	51.5
International (managed care and other insurers)	**1,317**	**2.2**	1,336	2.3	1,120	2.2
Other	**3,514**	**5.9**	2,836	4.8	1,875	3.6
Revenues	**$ 60,233**	**100.0%**	$ 58,752	100.0%	$ 51,533	100.0%

Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over, some disabled persons, persons with end-stage renal disease and persons with Lou Gehrig's Disease. Medicaid is a federal-state program, administered by the states, that provides hospital and medical benefits to qualifying low-income individuals. All of our general, acute care hospitals located in the United States are eligible to participate in Medicare and Medicaid programs. Amounts received under Medicare and Medicaid programs are generally significantly less than established hospital gross charges for the services provided.

Our hospitals generally offer discounts from established charges to certain group purchasers of health care services, including private health insurers, employers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other managed care plans, including health plans offered through the Exchanges. These discount programs generally limit our ability to increase revenues in response to increasing costs. See Item 1, "Business — Competition." For services under Medicare, Medicaid, HMOs, PPOs and other managed care plans, patients are generally responsible for any exclusions, deductibles or coinsurance features of their coverage. The amounts of such exclusions, deductibles and coinsurance continue to increase. Collection of amounts due from individuals is typically more difficult than from government health care programs or other third-party payers. We provide discounts to uninsured patients who do not qualify for Medicaid or for financial relief under our charity care policy. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance or charity care under our charity care policy. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Medicare

In addition to the reimbursement reductions and adjustments discussed below, the Budget Control Act of 2011 (the "BCA") requires automatic spending reductions to reduce the federal deficit, resulting in a uniform percentage reduction across all Medicare programs of 2% per fiscal year. The Coronavirus Aid, Relief, and Economic Security ("CARES") Act and related legislation temporarily suspended these reductions through March 31, 2022 and reduced the sequestration adjustment from 2% to 1% from April 1 through June 30, 2022. The full 2% reduction resumed on July 1, 2022. The BCA sequestration has been extended through the first six months of 2032. In addition, the American Rescue Plan Act of 2021 ("ARPA") increased the federal budget deficit in a manner that triggers an additional sequestration mandated under the Pay As You Go Act of 2010 ("PAYGO Act"). As a result, a further payment reduction of up to 4% was required to take effect in January 2022. However, Congress has delayed implementation of this payment reduction until 2025. We anticipate that the federal deficit will continue to place pressure on government health care programs, and it is possible that future deficit reduction legislation will impose additional spending reductions.

Inpatient Acute Care

Under the Medicare program, we receive reimbursement under a prospective payment system ("PPS") for general, acute care hospital inpatient services. Under the hospital inpatient PPS, fixed payment amounts per inpatient discharge are established based on the patient's assigned Medicare severity diagnosis-related group ("MS-DRG"). MS-DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis. MS-DRG weights represent the average resources for a given MS-DRG relative to the average

resources for all MS-DRGs. MS-DRG payments are adjusted for area wage differentials. Hospitals, other than those defined as “new,” receive PPS reimbursement for inpatient capital costs based on MS-DRG weights multiplied by a geographically adjusted federal rate. When the cost to treat certain patients falls well outside the normal distribution, providers typically receive additional “outlier” payments. These payments are financed by offsetting reductions in the inpatient PPS rates. A high-cost outlier threshold is set annually at a level that targets estimated outlier payments equaling 5.1% of total inpatient PPS payments for the fiscal year.

MS-DRG rates are updated, and MS-DRG weights are recalibrated, using cost-relative weights each federal fiscal year (which begins October 1). The index used to update the MS-DRG rates (the “market basket”) gives consideration to the inflation experienced by hospitals and entities outside the health care industry in purchasing goods and services. Each federal fiscal year, the annual market basket update is reduced by a productivity adjustment based on the Bureau of Labor Statistics (“BLS”) 10-year moving average of changes in specified economy-wide productivity. A decrease in payment rates or an increase in rates that is below the increase in our costs may adversely affect our results of operations.

For federal fiscal year 2022, the Centers for Medicare & Medicaid Services (“CMS”) increased the MS-DRG rate by approximately 2.5%. This increase reflected a market basket update of 2.7%, reduced by a negative 0.7 percentage point productivity adjustment and increased by 0.5 percentage points in accordance with the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”). For federal fiscal year 2023, CMS increased the MS-DRG rate by approximately 4.3%. This increase reflects a market basket update of 4.1%, reduced by a negative 0.3 percentage point productivity adjustment and increased by 0.5 percentage points as required by MACRA. Additional adjustments may apply, depending on patient-specific or hospital-specific factors. For example, the two-midnight rule limits payments to hospitals when services to Medicare beneficiaries are payable as inpatient services. In addition, under the post-acute care transfer policy, Medicare reimbursement rates may be reduced when an inpatient hospital discharges a patient in a specified MS-DRG to certain post-acute care settings.

CMS has implemented and is implementing a number of programs and requirements intended to transform Medicare from a passive payer to an active purchaser of quality goods and services. For example, hospitals that do not successfully participate in the Hospital Inpatient Quality Reporting Program are subject to a 25% reduction of the market basket update. Hospitals that do not demonstrate meaningful use of electronic health records (“EHRs”) are subject to a 75% reduction of the market basket update.

Further, Medicare does not allow an inpatient hospital discharge to be assigned to a higher paying MS-DRG if certain designated hospital acquired conditions (“HACs”) were not present on admission and the identified HAC is the only condition resulting in the assignment of the higher paying MS-DRG. In this situation, the case is paid as though the secondary diagnosis was not present. There are currently 14 categories of conditions on the list of HACs. In addition, the 25% of hospitals with the worst risk-adjusted HAC scores in the designated performance period receive a 1% reduction in their inpatient PPS Medicare payments. CMS has also established three National Coverage Determinations that prohibit Medicare reimbursement for erroneous surgical procedures performed on an inpatient or outpatient basis.

Under the Hospital Readmission Reduction Program (“HRRP”), payments to hospitals may also be reduced based on readmission rates. Each federal fiscal year, inpatient payments are reduced if a hospital experiences “excess” readmissions within the 30-day time period from the date of discharge for conditions designated by CMS. For federal fiscal year 2017 and subsequent years, CMS has designated six conditions or procedures, including heart attack, pneumonia and total hip arthroplasty. Hospitals with what CMS defines as excess readmissions for these conditions or procedures receive reduced payments for all inpatient discharges, not just discharges relating to the conditions or procedures subject to the excess readmission standard. The amount by which payments are reduced is determined by assessing a hospital’s performance relative to hospitals with similar proportions of dual eligible patients, subject to a cap established by CMS. The reduction in payments to hospitals with excess readmissions can be up to 3% of a hospital’s base payments. Each hospital’s performance is publicly reported by CMS.

In addition, under the Hospital Value-Based Purchasing (“HVBP”) Program, CMS reduces the inpatient PPS payment amount for all discharges by 2.0%. The total amount collected from these reductions is pooled, and the entire amount collected is redistributed as incentive payments to reward hospitals that meet certain quality performance standards established by CMS. CMS scores each hospital based on achievement (relative to other hospitals) and improvement ranges (relative to the hospital’s own past performance) for each applicable performance standard. Hospitals that meet or exceed the quality performance standards receive greater reimbursement under the value-based purchasing program than they would have otherwise. Hospitals that do not achieve the necessary quality performance receive reduced Medicare inpatient hospital payments. Hospitals are scored on a number of individual measures that are categorized into four domains: clinical outcomes; efficiency and cost reduction; safety; and person and community engagement.

As a result of the national public health emergency ("PHE") declared in response to COVID-19, CMS has paused or refined several measures across various hospital quality measurement and value-based purchasing programs. These policies are intended to ensure that the programs neither reward nor penalize hospitals based on circumstances caused by the PHE that the measures were not designed to accommodate. For example, CMS is modifying certain readmissions measures within the HRRP to exclude COVID-19 diagnosed patients. Under the HVBP Program in federal fiscal year 2023, as a result of the measure suppression policy, hospitals will receive a net neutral payment adjustment for each discharge that is equal to the 2% withheld under the program. In addition, facilities that experience extraordinary circumstances beyond their control, that prevent satisfaction of program reporting requirements, may request an exception from CMS.

Outpatient

CMS reimburses hospital outpatient services (and certain Medicare Part B services furnished to hospital inpatients who have no Part A coverage) on a PPS basis. Hospital outpatient services paid under PPS are classified into groups called ambulatory payment classifications ("APCs"). Services for each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit. The APC payment rates are updated for each calendar year. Each calendar year, the annual market basket update is further reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For calendar year 2022, CMS increased APC payment rates by 2.0%. This increase reflected a market basket increase of 2.7% with a negative 0.7 percentage point productivity adjustment. For calendar year 2023, CMS increased payment rates under the outpatient PPS by an estimated 3.8%. This increase reflects a market basket increase of 4.1% with a negative 0.3 percentage point productivity adjustment. CMS requires hospitals to submit quality data relating to outpatient care to avoid receiving a 2.0 percentage point reduction in the annual payment update under the outpatient PPS.

The Medicare reimbursement we receive may also be affected by broad shifts in payment policy. For example, in June 2022, the U.S. Supreme Court invalidated past payment cuts for hospitals participating in the 340B Drug Pricing Program. Although our hospitals do not participate in the 340B program, the decision has implications for all hospitals reimbursed under the outpatient PPS and could affect our Medicare reimbursement for both past and future periods. The 340B program allows participating hospitals to purchase certain outpatient drugs from manufacturers at discounted rates. These hospitals are reimbursed for the discounted drugs under the same Medicare payment methodology and rates that are applied to non-340B hospitals. The past payment cuts, which CMS implemented in 2018, resulted in increased payments for non-340B hospitals, and it has not yet been determined whether the increased payments to non-340B hospitals may be recouped due to budget neutrality principles. Further, depending on future Medicare payment policies, non-340B hospitals may receive decreased reimbursement going forward for outpatient drugs and services. For calendar year 2023, CMS finalized the payment rate for drugs acquired through the 340B program in light of the Supreme Court decision and, as a result of the payment rate change, is implementing a 3.09% reduction to payment rates for non-drug services under the outpatient PPS for calendar year 2023 to achieve budget neutrality. In addition, CMS has, in recent years, phased in an expanded site-neutral payment policy for clinic visit services provided at all off-campus provider-based departments. Under the policy, clinic visit services provided at all off-campus provider-based departments are generally not covered as outpatient department services under the outpatient PPS, but rather are reimbursed at the Medicare Physician Fee Schedule ("Physician Fee Schedule") rate, which is generally lower than the outpatient PPS rate. Before the expanded policy, the Physician Fee Schedule equivalent rate did not apply to "excepted" provider-based departments. The Physician Fee Schedule equivalent rate for calendar year 2023 is substantially less than the outpatient PPS rate.

Rehabilitation

CMS reimburses inpatient rehabilitation facilities ("IRFs") on a PPS basis. Under the IRF PPS, patients are classified into case mix groups that reflect the relative resource intensity typically associated with the patient's clinical condition. The case mix groups are based upon impairment, age, functional motor and cognitive scores, and comorbidities (additional diseases or disorders from which the patient suffers). IRFs are paid a predetermined amount per discharge that reflects the patient's case mix group that is adjusted for facility-specific factors, such as area wage levels, proportion of low-income patients, and location in a rural area. Each federal fiscal year, the IRF rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For federal fiscal year 2022, CMS increased IRF payment rates by an estimated 1.9%, reflecting an IRF market basket update of 2.6% reduced by a negative 0.7 percentage point productivity adjustment. For federal fiscal year 2023, CMS increased IRF payment rates by an estimated 3.9%, reflecting an IRF market basket update of 4.2% with a negative 0.3 percentage point productivity adjustment. In addition, CMS requires IRFs to report quality measures to avoid receiving a reduction of 2.0 percentage points to the market basket update.

In order to qualify for classification as an IRF, at least 60% of a facility's inpatients during the most recent 12-month CMS-defined review period must have required intensive rehabilitation services for one or more of 13 specified conditions. IRFs must also meet additional coverage criteria, including patient selection and care requirements relating to pre-admission screenings, post-admission evaluations, ongoing coordination of care and involvement of rehabilitation physicians. A facility that fails to meet the 60% threshold, or other criteria to be classified as an IRF, will be paid under either the acute care hospital inpatient or outpatient PPS, which generally provide for lower payment amounts. As of December 31, 2022, we had two rehabilitation hospitals and 66 hospital rehabilitation units.

The Improving Medicare Post-Acute Care Transformation Act of 2014 ("IMPACT Act") requires the U.S. Department of Health and Human Services ("HHS"), together with the Medicare Payment Advisory Commission, to work toward a unified payment system for post-acute care services provided by IRFs, home health agencies, skilled nursing facilities, and long-term care hospitals. A unified post-acute care payment system would pay post-acute care providers under a single framework according to a patient's characteristics, rather than based on the post-acute care setting where the patient receives treatment. As required under the statute, CMS issued a report presenting a prototype for a unified post-acute care payment model in July 2022. CMS noted in its report the need for additional analyses and acknowledged that the universal implementation of a unified post-acute care payment system would require congressional action. The Medicare Payment Advisory Commission is required to submit a report to Congress by June 2023.

Psychiatric

Inpatient hospital services furnished in psychiatric hospitals and psychiatric units of general, acute care hospitals and critical access hospitals are reimbursed on a PPS basis. The inpatient psychiatric facility ("IPF") PPS is based upon a per diem payment, with adjustments to account for certain patient and facility characteristics. The IPF PPS contains an "outlier" policy for extraordinarily costly cases and an adjustment to a facility's base payment if it maintains a full-service emergency department. CMS has established the IPF PPS payment rate in a manner intended to be budget neutral. Each federal fiscal year, IPF payment rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For federal fiscal year 2022, CMS increased IPF payment rates by an estimated 2.0%, reflecting a 2.7% IPF market basket update reduced by a negative 0.7 percentage point productivity adjustment. For federal fiscal year 2023, CMS increased IPF payment rates by an estimated 3.8%, which reflects a 4.1% IPF market basket increase with a negative 0.3 percentage point productivity adjustment. Together with other policy changes, total payments to IPFs are anticipated to increase by 2.5% in federal fiscal year 2023. Inpatient psychiatric facilities are required to report quality measures to CMS to avoid receiving a 2.0 percentage point reduction to the market basket update. As of December 31, 2022, we had five psychiatric hospitals and 45 hospital psychiatric units.

Ambulatory Surgery Centers

CMS reimburses ASCs using a predetermined fee schedule. Reimbursements for ASC overhead costs are limited to no more than the overhead costs paid to hospital outpatient departments under the Medicare hospital outpatient PPS for the same procedure. If CMS determines that a procedure is commonly performed in a physician's office, the ASC reimbursement for that procedure is limited to the reimbursement allowable under the Physician Fee Schedule, with limited exceptions. All surgical procedures, other than those that pose a significant safety risk or generally require an overnight stay, are payable as ASC procedures. From time to time, CMS expands the services that may be performed in ASCs, which may result in more Medicare procedures that historically have been performed in hospitals being moved to ASCs, reducing surgical volume in our hospitals. Also, more Medicare procedures that historically have been performed in ASCs may be moved to physicians' offices. Some commercial third-party payers have adopted similar policies.

Historically, CMS updated reimbursement rates for ASCs based on changes to the consumer price index. However, for calendar years through 2023, CMS updates to ASC reimbursement rates will be based on the hospital market basket index, partly to promote site-neutrality between hospitals and ASCs. For each federal fiscal year, the ASC payment system update is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For calendar year 2022, CMS increased ASC payment rates by 2.0%, which reflected a market basket increase of 2.7% and a negative 0.7 percentage point productivity adjustment. For calendar year 2023, CMS increased ASC payment rates by 3.8%, which reflects a market basket increase of 4.1% and a negative 0.3 percentage point productivity adjustment. In addition, CMS has established a quality reporting program for ASCs under which ASCs that fail to report on specified quality measures receive a 2.0 percentage point reduction to the market basket update.

Home Health

CMS reimburses home health agencies under the Home Health PPS. Home health agencies are paid a national, standardized 30-day period payment rate if a period of care meets a certain threshold of home health visits (periods of care that do not meet the visit threshold are paid a per-visit payment rate for the discipline providing care). The daily home health payment rate is adjusted for case-mix and area wage levels. An outlier adjustment may be paid for periods of care where costs exceed a specific threshold amount. Each calendar year, home health payment rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For calendar year 2022, CMS increased home health payment rates by 3.2%, based on a home health payment update percentage of 2.6%, which reflected a 3.1% market basket increase reduced by a 0.5 percentage point productivity adjustment, among other changes. For calendar year 2023, CMS increased home health payment rates by 0.7%, based on a home health payment update percentage of 4.0%, which reflects a 4.1% market basket increase reduced by a 0.1 percentage point productivity adjustment, among other changes. Home health agencies that do not submit required quality data are subject to a 2.0 percentage point reduction to the market basket update. In addition, home health agencies are required to submit a one-time Notice of Admission ("NOA") for each patient that establishes that the beneficiary is under a Medicare home health period of care. Failure to submit the NOA within five calendar days from the start of care results in a reduction to the 30-day period payment amount for each day from the start of care date until the date the NOA is submitted.

CMS began implementing a nationwide expansion of the Home Health Value-Based Purchasing ("HHVBP") Model in January 2022. Under the model, home health agencies will receive increases or reductions to their Medicare fee-for-service payments of up to 5%, based on performance against specific quality measures relative to the performance of other home health providers. Data collected in each performance year will impact Medicare payments two years later. Calendar year 2023 is the first performance year under the expanded HHVBP Model, which will affect payments in calendar year 2025.

Payment of claims for home health services may be impacted by the Review Choice Demonstration, a program intended to identify and prevent home health services fraud, reduce the number of Medicare appeals, and improve provider compliance with Medicare program requirements. The program applies only to home health agencies in certain states, including North Carolina, Florida and Texas. Providers in these states may initially select from the following claims review and approval processes: pre-claim review, post-payment review or a minimal post-payment review with a 25% payment reduction. Home health agencies that maintain high levels of compliance are eligible for additional, less burdensome options.

As noted above, the IMPACT Act requires HHS, in conjunction with the Medicare Payment Advisory Commission, to propose a unified post-acute care payment model by 2023. The unified post-acute care payment system would include home health agencies.

Hospice

Medicare beneficiaries who have a terminal illness and a life expectancy of six months or less may elect to receive hospice benefits (palliative care) instead of standard coverage of treatment for the terminal illness and related conditions. Hospice services are paid under the Hospice PPS, under which CMS sets a daily rate for each day a patient is enrolled in the hospice benefit. The daily rate depends on the level of care provided to a patient (routine home care, continuous home care, inpatient respite care, or general inpatient care). Daily rates are adjusted for factors such as area wage levels. Each federal fiscal year, hospice payment rates are updated using a market basket index, which is reduced by a productivity adjustment based on the BLS 10-year moving average of changes in specified economy-wide productivity. For federal fiscal year 2022, CMS increased hospice payment rates by 2.0%, which reflected a 2.7% market basket update and a negative 0.7 percentage point productivity adjustment. For federal fiscal year 2023, CMS increased hospice payment rates by 3.8%, which reflects a 4.1% market basket update and a negative 0.3 percentage point productivity adjustment. Hospices that fail to satisfy quality reporting requirements receive a 2.0 percentage point reduction to the market basket update. Beginning in 2024, the payment reduction for failure to report quality data will increase to 4.0 percentage points.

Overall payments made by Medicare to each hospice are subject to an inpatient cap and an aggregate cap. The inpatient cap limits the number of days of inpatient care to no more than 20% of total patient care days. The aggregate cap limits the amount of Medicare reimbursement a hospice may receive, based on the number of Medicare patients served. The aggregate cap is updated annually. In federal fiscal year 2023, the aggregate cap is $32,486.92. If a hospice's Medicare payments exceed its inpatient or aggregate caps, it must repay Medicare for the excess amount.

Physician Services

Physician services are reimbursed under the Physician Fee Schedule system, under which CMS has assigned a national relative value unit ("RVU") to most medical procedures and services that reflects the various resources required by a physician to provide the services, relative to all other services. Each RVU is calculated based on a combination of work required in terms of time and intensity of effort for the service, practice expense (overhead) attributable to the service and malpractice insurance expense attributable to the service. These three elements are each modified by a geographic adjustment factor to account for local practice costs and are then aggregated. While RVUs for various services may change in a given year, any alterations are required by statute to be virtually budget neutral, such that total payments made under the Physician Fee Schedule may not differ by more than $20 million from what payments would have been if adjustments were not made. CMS annually reviews resource inputs for select services as part of the potentially misvalued code initiative. To determine the payment rate for a particular service, the sum of the geographically adjusted RVUs is multiplied by a conversion factor. For calendar year 2023, CMS reduced the conversion factor by approximately 4.48%. However, Congress approved a partial offset to this reduction, increasing payment amounts by 2.5%, which will result in a payment reduction of approximately 2% for calendar year 2023.

Medicare payments are adjusted based on participation in the Quality Payment Program ("QPP"), a payment methodology intended to reward high-quality patient care. Physicians and certain other health care clinicians are required to participate in one of two QPP tracks. Under both tracks, performance data collected in each performance year will affect Medicare payments two years later. CMS expects to transition increasing financial risk to providers as the QPP evolves. The Advanced Alternative Payment Model ("Advanced APM") track makes incentive payments available for participation in specific innovative payment models approved by CMS, which are paid two years after the relevant performance period, if a provider has sufficient participation (based on percentage of payments or patients) in an Advanced APM. Providers were able to earn a 5.0% Medicare incentive payment for performance year 2022 (to be paid in 2024), may earn a 3.5% incentive payment for performance year 2023 (to be paid in 2025), and may receive higher Medicare Physician Fee Schedule payment rate updates based on performance in 2025 and beyond. In addition, providers are exempt from the reporting requirements and payment adjustments imposed under the Merit-Based Incentive Payment System ("MIPS"). Alternatively, providers may participate in the MIPS track. Providers electing this option may receive payment incentives or be subject to payment reductions based on their performance with respect to clinical quality, resource use, clinical improvement activities, and meeting Promoting Interoperability standards related to the meaningful use of EHRs. Performance data collected in 2023 will result in payment adjustments of up to 9% in 2025; positive adjustments are subject to a scaling factor to meet budget neutrality requirements. CMS makes available an exception that permits clinicians to request reweighting of any or all performance categories if they encounter an extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of their control.

Other

CMS uses fee schedules to pay for physical, occupational and speech therapies, durable medical equipment, clinical diagnostic laboratory services, nonimplantable orthotics and prosthetics and services provided by independent diagnostic testing facilities.

Under the various PPS structures, the payment rates are adjusted for area differences in wage levels by a factor ("wage index") reflecting the relative wage level in the geographic area compared to the national average wage level and taking into account occupational mix. The redistributive impact of wage index changes is not anticipated to have a material financial impact for 2023. CMS recently finalized a permanent, budget-neutral cap on year-to-year wage index changes to smooth variations and decrease volatility.

Medicare reimburses hospitals for a portion (65%) of deductible and coinsurance amounts that are uncollectable from Medicare beneficiaries.

CMS has implemented contractor reform whereby CMS competitively bids the Medicare fiscal intermediary and Medicare carrier functions to Medicare Administrative Contractors ("MACs"), which are geographically assigned across 12 jurisdictions to service both Part A and Part B providers. Home health and hospice providers are serviced across four MAC jurisdictions. While providers with operations across multiple geographies had the option of having all hospitals use one home office MAC, we chose, in most cases, to use the MACs assigned to the geographic areas in which our hospitals are located. CMS periodically re-solicits bids, and the MAC servicing a geographic area can change as a result of the bid competition. MAC transition periods can impact claims processing functions and the resulting cash flows.

CMS contracts with third parties to promote the integrity of the Medicare program through reviews of quality concerns and detections, and corrections of improper payments. Quality Improvement Organizations ("QIOs"), for example, are groups of physicians and other health care quality experts that work on behalf of CMS to ensure that Medicare pays only for goods and services that are reasonable and necessary, and that are provided in the most appropriate setting. Under the Recovery Audit Contractor ("RAC") program, CMS contracts with RACs on a contingency basis to

conduct post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The compensation for RACs is based on their review of claims submitted to Medicare for billing compliance, including correct coding and medical necessity, and the amount of overpayments and underpayments they identify. CMS limits the number of claims that RACs may audit by limiting the number of records that RACs may request from hospitals based on each provider's claim denial rate for the previous year. CMS has implemented the RAC program on a permanent, nationwide basis and expanded the RAC program to the Managed Medicare program and Medicare Part D. CMS has transitioned some of its other integrity programs to a consolidated model by engaging Unified Program Integrity Contractors ("UPICs") to perform audits, investigations and other integrity activities.

We have established policies and procedures to respond to requests from and payment denials by RACs and other Medicare contractors. Payment recoveries resulting from reviews and denials are appealable through administrative and judicial processes, and we pursue reversal of adverse determinations at appropriate appeal levels. We incur additional costs related to responding to requests and denials, including costs associated with responding to requests for records and pursuing the reversal of payment denials and losses associated with overpayments that are not reversed upon appeal. In recent years, there have been significant delays in the Medicare appeals process. Depending upon changes to and the growth of the RAC program and other Medicare integrity programs and our success in appealing claims in future periods, our cash flows and results of operations could be negatively impacted.

Medicare reimburses teaching hospitals for portions of the direct and indirect costs of graduate medical education ("GME") through statutory formulas that are generally based on the number of medical residents and which take into account patient volume or the number of hospital beds. Accrediting organizations review GME programs for compliance with educational standards. Many of our hospitals operate GME or other residency programs to train physicians and other allied health professionals.

Managed Medicare

Under the Managed Medicare program (also known as Medicare Part C, or Medicare Advantage), the federal government contracts with private health insurers to provide members with Medicare Part A, Part B and Part D benefits. Managed Medicare plans can be structured as HMOs, PPOs or private fee-for-service plans. In addition to covering Part A and Part B benefits, the health insurers may choose to offer supplemental benefits and impose higher premiums and plan costs on beneficiaries. CMS makes fee payment adjustments based on service benchmarks and quality ratings and publishes star ratings to assist beneficiaries with plan selection. According to CMS, nearly half of all Medicare enrollees participate in managed Medicare plans.

Medicaid

Medicaid programs are funded jointly by the federal government and the states and are administered by states under approved plans. Most state Medicaid program payments are made under a PPS or are based on negotiated payment levels with individual hospitals. Medicaid reimbursement is often less than a hospital's cost of services. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act") requires states to expand Medicaid coverage to all individuals under age 65 with incomes effectively at or below 138% of the federal poverty level. However, states may opt out of the expansion without losing existing federal Medicaid funding. A number of states, including Texas and Florida, have opted out of the Medicaid expansion. Among these states, the maximum income level required for individuals and families to qualify for Medicaid varies widely.

Medicaid enrollment has increased as a result of COVID-19. Through COVID-19 relief legislation, Congress authorized a temporary increase in federal funds for certain Medicaid expenditures. The enhanced funding is available to states that maintain continuous Medicaid enrollment and meet certain other conditions. The continuous coverage requirement will expire as of April 1, 2023, and the increase in federal funding will be phased out through calendar year 2023. The resumption of redeterminations for Medicaid enrollees and end of the other conditions of funding may lead to coverage disruptions and dis-enrollments of current Medicaid enrollees.

Because most states must operate with balanced budgets and because the Medicaid program is often a state's largest program, many states have adopted or may consider adopting various strategies to reduce their Medicaid expenditures. Outside of the government response to COVID-19, budgetary pressures have, in recent years, resulted and likely will continue to result in decreased spending, or decreased spending growth, for Medicaid programs in many states. Most states in which we operate have adopted broad-based provider taxes to fund the non-federal share of Medicaid programs or fund indigent care within the state. Many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Some states use, or have applied to use, waivers granted by CMS to implement Medicaid expansion, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary

from federal standards. For example, the Texas Healthcare Transformation and Quality Improvement Program, which is operated under a Medicaid waiver, expands Medicaid managed care programs in the state, provides funding for uncompensated care and supports several delivery system reform initiatives. Although this Texas waiver has been extended through 2030, certain delivery system reform initiatives operate under different approval periods. For example, a directed payment program for hospitals in Texas expires August 31, 2023. If Texas is unable to obtain future extensions of this program or similar programs, our revenues could be negatively impacted. In recent years, aspects of existing or proposed Medicaid waiver programs have been subject to legal challenge, resulting in uncertainty. Additionally, federal policies that shape administration of the Medicaid programs at the state level are subject to change, including as a result of changes in the presidential administration. Where states had previously been permitted to condition Medicaid enrollment on work or other community engagement, the approvals of waivers permitting these conditions have been rescinded, and the federal government is also reexamining block grant funding structures. However, a federal court is permitting Georgia to impose work and community engagement requirements under a Medicaid demonstration program that is expected to launch in mid-2023.

Many state Medicaid programs incorporate value-based purchasing models and related payment and delivery system reform initiatives that incentivize improvements in quality of care and cost-effectiveness. For example, federal funds under the Medicaid program may not be used to reimburse providers for treatment of certain provider-preventable conditions. Each state Medicaid program must deny payments to providers for the treatment of health care-acquired conditions designated by CMS as well as other provider-preventable conditions that may be designated by the state.

Congress has expanded the federal government's involvement in fighting fraud, waste and abuse in the Medicaid program through the Medicaid Integrity Program. CMS employs UPICs to perform post-payment audits of Medicaid claims, identify overpayments and perform other program integrity activities. The UPICs collaborate with states and coordinate provider investigations across the Medicare and Medicaid programs. In addition, state Medicaid agencies are required to establish Medicaid RAC programs. These programs vary by state in design and operation.

Managed Medicaid

Enrollment in managed Medicaid plans has increased in recent years, as state governments seek to control the cost of Medicaid programs. Managed Medicaid programs enable states to contract with one or more entities for patient enrollment, care management and claims adjudication. The states usually do not relinquish program responsibilities for financing, eligibility criteria and core benefit plan design. We generally contract directly with one or more of the designated entities, usually a managed care organization. The provisions of these programs are state-specific. Many states direct managed care plans to pass through supplemental payments to designated providers, independent of services rendered, to ensure consistent funding of providers that serve large numbers of low-income patients. In an effort to more closely tie funds to delivery and outcomes, CMS is limiting these "pass-through payments" that are paid by states under managed Medicaid plan contracts and will generally prohibit such payments by 2027. However, CMS permits new pass-throughs of supplemental provider payments for up to a three-year period when states are transitioning Medicaid populations or services from a fee-for-service system to a managed care system.

Accountable Care Organizations and Bundled Payment Initiatives

An Accountable Care Organization ("ACO") is a network of providers and suppliers that work together to invest in infrastructure and redesign delivery processes to attempt to achieve high quality and efficient delivery of services. Promoting accountability and coordination of care, ACOs are intended to produce savings as a result of improved quality and operational efficiency. ACOs that achieve quality performance standards established by HHS are eligible to share in a portion of the amounts saved by the Medicare program. There are several types of ACO programs, including the Medicare Shared Savings Program.

The CMS Innovation Center is responsible for establishing demonstration projects and other initiatives in order to identify, develop, test and encourage the adoption of new methods of delivering and paying for health care that create savings under the Medicare and Medicaid programs, while improving quality of care. For example, providers participating in bundled payment initiatives agree to receive one payment for services provided to Medicare patients for certain medical conditions or episodes of care, accepting accountability for costs and quality of care. By rewarding providers for increasing quality and reducing costs and penalizing providers if costs exceed a set amount, these models are intended to lead to higher quality, more coordinated care at a lower cost to the Medicare program. Hospitals may receive supplemental Medicare payments or owe repayments to CMS depending on whether overall CMS spending per episode exceeds or falls below a target specified by CMS and whether quality standards are met. The CMS Innovation Center has implemented bundled payment models, including the Bundled Payment Care Improvement Advanced ("BPCI Advanced") program, which is voluntary and expected to run through December 2025. Participation in bundled payment programs is generally

voluntary, but CMS currently requires providers in selected geographic areas to participate in a mandatory bundled program for specified orthopedic procedures and a model for end-stage renal disease treatment. In addition, a mandatory radiation oncology model was expected to begin on January 1, 2023, but CMS has indefinitely delayed its implementation. CMS has indicated that it will provide six months' notice before starting the model.

In a strategic report issued in 2021 and updated in 2022, the CMS Innovation Center highlighted the need to accelerate the movement to value-based care and drive broader system transformation. By 2030, the CMS Innovation Center aims to have all fee-for-service Medicare beneficiaries and most Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care. CMS also indicated it will streamline its payment model portfolio and consider how to ensure broad provider participation, including by implementing more mandatory models. In the 2022 updated report, the CMS Innovation Center indicated that it plans to focus on increased care coordination between primary care physicians and specialists. Moreover, several private third-party payers are increasingly employing alternative payment models, which may increasingly shift financial risk to providers.

Disproportionate Share Hospital and Medicaid Supplemental Payments

In addition to making payments for services provided directly to beneficiaries, Medicare makes additional payments to hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive Supplemental Security Income). Disproportionate Share Hospital ("DSH") payment adjustments are determined annually based on certain statistical information required by HHS and are paid as a percentage addition to MS-DRG payments. Pending litigation challenging the payment formula for prior years and any future policies implemented by CMS may affect how CMS calculates DSH payments and may increase or decrease our payments in the future. CMS has previously proposed making changes to the calculation of Section 1115 Demonstrations in the Medicaid fraction of the DSH formula in a manner that would effectively lower DSH payments for many hospitals, and has indicated that the agency will return to the issue in future rulemaking. These changes could adversely impact our results of operations. CMS also distributes a payment to each DSH hospital that is allocated according to the hospital's proportion of uncompensated care costs relative to the uncompensated care amount of other DSH hospitals.

Some states make additional payments to providers through the Medicaid program that are separate from base payments and not specifically tied to an individual's care. These supplemental payments may be in the form of Medicaid DSH payments, which are intended to offset hospital uncompensated care costs. The federal government distributes federal Medicaid DSH funds to each state based on a statutory formula. The states then distribute the DSH funding among qualifying hospitals. States have broad discretion to define which hospitals qualify for Medicaid DSH payments and the amount of such payments. The Affordable Care Act and subsequent legislation provide for reductions to the Medicaid DSH hospital program, but Congress has delayed the implementation of these reductions until federal fiscal year 2024. Under current law, Medicaid DSH payments will be reduced by $8 billion in each of federal fiscal years 2024 through 2027. Supplemental payments may also be in the form of non-DSH payments, such as upper payment limit payments, which are intended to address the difference between Medicaid fee-for-service payments and Medicare reimbursement rates, or payments under other programs that vary by state under Section 1115 waivers. These supplemental reimbursement programs are designed with input from CMS. The programs are generally authorized for a specified period of time and require CMS's approval to be extended. CMS is considering changes to both DSH and non-DSH types of programs.

TRICARE

TRICARE is the Department of Defense's health care program for members of the armed forces. For inpatient services, TRICARE reimburses hospitals based on a DRG system modeled on the Medicare inpatient PPS. For outpatient services, TRICARE reimburses hospitals based on a PPS that is similar to that utilized for services furnished to Medicare beneficiaries.

Annual Cost Reports

All hospitals, home health agencies, hospice providers and other institutional providers participating in the Medicare, Medicaid and TRICARE programs, whether paid on a reasonable cost basis or under a PPS, are required to meet certain financial reporting requirements. Federal and, where applicable, state regulations require the submission of annual cost reports covering the revenues, costs and expenses associated with the services provided by each provider type to Medicare beneficiaries and Medicaid recipients.

Annual cost reports required under the Medicare and Medicaid programs are subject to routine audits, which may result in adjustments to the amounts ultimately determined to be due to us under these reimbursement programs. These audits often require several years to reach the final determination of amounts due to or from us under these programs. Providers also have rights of appeal, and it is common to contest issues raised in audits of cost reports.

Managed Care and Other Discounted Plans

Most of our hospitals offer discounts from established charges to certain large group purchasers of health care services, including managed care plans and private health insurers. Admissions reimbursed by commercial managed care and other insurers were 30%, 31% and 29% of our total admissions for the years ended December 31, 2022, 2021 and 2020, respectively. Managed care contracts are typically negotiated for terms between one and three years. While we generally have received contracted annual increases to payment rates from managed care payers, there can be no assurance that we will continue to receive increases in the future. Price transparency initiatives may impact our relationships with payers and ability to obtain or maintain favorable contract terms. For example, hospitals are required to publish a list of their standard charges for all items and services, including gross charges, discounted cash prices and payer-specific and de-identified negotiated charges, in a publicly accessible online file. Further, CMS requires health insurers to publish online charges negotiated with providers for health care services. In addition, the No Surprises Act requires providers to send to a patient's health plan a good faith estimate of the expected charges for furnishing scheduled items or services, including billing and diagnostic codes, prior to the scheduled date of the items or services. The estimate must cover any item or service that is reasonably expected to be provided in conjunction with the primary items or services, including those that may be delivered by another provider. However, HHS is deferring enforcement of certain requirements of the No Surprises Act related to the good faith estimates for insured patients until it issues additional regulations. It is not clear what impact, if any, these or future health reform efforts at the federal and state levels, consolidation within the third-party payer industry and vertical integration among third-party payers and health care providers will have on our ability to negotiate reimbursement rates.

Uninsured and Self-Pay Patients

Self-pay revenues are derived from providing health care services to patients without health insurance coverage and from the patient responsibility portion of payments for our health care services that are not covered by an individual's health plan. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government health care programs or private third-party payers. Any increases in uninsured individuals, changes to the payer mix or greater adoption of health plan structures that result in higher patient responsibility amounts could increase amounts due from individuals. The No Surprises Act requires providers to provide uninsured and self-pay patients, in advance of the scheduled date for the item or service or upon request of the individual, a good faith estimate of the expected charges for furnishing scheduled items or services, including billing and diagnostic codes. The estimate must cover any item or service that is reasonably expected to be provided in conjunction with the scheduled item or service or that is reasonably expected to be delivered by another provider. HHS is delaying enforcement with regard to good faith estimates that do not include expected charges for co-providers or co-facilities until the agency issues additional regulations. If the actual charges to the uninsured or self-pay patient are substantially higher than the estimate or the provider furnishes an item or service that was not included in the good faith estimate, the patient can invoke a patient-provider dispute resolution process to challenge the higher amount.

A high percentage of our uninsured patients are initially admitted through our emergency rooms. For the year ended December 31, 2022, approximately 85% of our admissions of uninsured patients occurred through our emergency rooms. The Emergency Medical Treatment and Labor Act ("EMTALA") requires any hospital that participates in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize that condition or make an appropriate transfer of the individual to a facility that can handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. In addition, health insurers are required to reimburse hospitals for emergency services provided to enrollees without prior authorization and without regard to whether a participating provider contract is in place.

Hospital Utilization

We believe the most important factors relating to the overall utilization of a hospital are the quality and market position of the hospital and the number and quality of physicians and other health care professionals providing patient care within the facility. Generally, we believe the ability of a hospital to be a market leader is determined by its breadth of services, level of technology, quality and condition of the facilities, emphasis on quality of care and convenience for patients and physicians. Other factors that impact utilization include the growth in local population, local economic conditions and market penetration of managed care programs.

The following table sets forth certain operating statistics for our health care facilities. Health care facility operations are subject to certain seasonal fluctuations, including decreases in patient utilization during holiday periods and increases in the cold weather months.

	2022	**2021**	**2020**
Number of hospitals at end of period	**182**	182	185
Number of freestanding outpatient surgery centers at end of period(a)	**126**	125	121
Number of licensed beds at end of period(b)	**49,281**	48,803	49,265
Weighted average beds in service(c)	**41,982**	42,148	42,246
Admissions(d)	**2,075,459**	2,089,975	2,009,909
Equivalent admissions(e)	**3,611,299**	3,536,238	3,312,330
Average length of stay (days)(f)	**5.1**	5.2	5.1
Average daily census(g)	**28,778**	29,752	27,734
Occupancy rate(h)	**72%**	74%	69%
Emergency room visits(i)	**8,971,951**	8,475,345	7,450,307
Outpatient surgeries(j)	**1,023,239**	1,008,236	882,483
Inpatient surgeries(k)	**522,151**	522,069	522,385
Days revenues in accounts receivable(l)	**53**	49	45
Outpatient revenues as a % of patient revenues(m)	**38%**	37%	35%

(a) Excludes freestanding endoscopy centers (21 at December 31, 2022, 2021 and 2020).
(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.
(c) Represents the average number of beds in service, weighted based on periods owned.
(d) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.
(e) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.
(f) Represents the average number of days admitted patients stay in our hospitals.
(g) Represents the average number of admitted patients in our hospital beds each day.
(h) Represents the percentage of hospital beds in service that are occupied by patients (admitted and observations). Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.
(i) Represents the number of patients treated in our emergency rooms.
(j) Represents the number of surgeries performed on patients who were not admitted to our hospitals. Pain management and endoscopy procedures are not included in outpatient surgeries.
(k) Represents the number of surgeries performed on patients who have been admitted to our hospitals. Pain management and endoscopy procedures are not included in inpatient surgeries.
(l) Revenues per day is calculated by dividing the revenues for the fourth quarter of each year by the days in the quarter. Days revenues in accounts receivable is then calculated as accounts receivable at the end of the period divided by revenues per day.
(m) Represents the percentage of patient revenues related to patients who are not admitted to our hospitals.

Competition

Generally, other hospitals and facilities in the communities we serve provide services similar to those we offer. Additionally, the number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers, diagnostic and imaging centers and other medical facilities in the geographic areas in which we operate continues to increase. As a result, most of our hospitals and other facilities operate in a highly competitive environment. In some cases,

competing facilities are more established than we are. Some competing facilities are physician-owned or are owned by tax-supported government agencies and many others are owned by not-for-profit entities that may be supported by endowments, charitable contributions and/or tax revenues and are exempt from sales, property and income taxes. Such exemptions and support are not available to our facilities and may provide the tax-supported or not-for-profit entities an advantage in funding capital expenditures. In certain localities there are large teaching hospitals that provide highly specialized facilities, equipment and services that may not be available at most of our hospitals. We also face competition from specialty hospitals and from both our own and unaffiliated freestanding ASCs for market share in certain high margin services. Psychiatric hospitals frequently attract patients from areas outside their immediate locale and, therefore, our psychiatric hospitals and units compete with both local and regional hospitals, including the psychiatric units of general, acute care hospitals.

Trends toward clinical and pricing transparency may impact our competitive position, ability to obtain or maintain favorable contract terms and patient volumes in ways that may be difficult to predict. For example, hospitals are currently required to publish a list of their standard charges for all items and services, including discounted cash prices and payer-specific and de-identified negotiated charges, in a publicly accessible online file. Hospitals are also required to publish a consumer-friendly list of standard charges for certain “shoppable” services (i.e., services that can be scheduled by a patient in advance) and associated ancillary services or, alternatively, maintain an online price estimator tool. CMS may impose civil monetary penalties for noncompliance with these price transparency requirements. Further, CMS requires health insurers to publish online charges negotiated with providers for health care services. Starting January 1, 2023, health insurers must also provide online price comparison tools to help individuals get personalized cost estimates for covered items and services. In addition, the No Surprises Act imposes additional price transparency requirements, including the requirement that providers send uninsured and self-pay patients (in advance of the scheduled date for the item or service or upon request) and health plans of insured patients a good faith estimate of the expected charges and diagnostic codes. Until HHS issues additional regulations, the agency is deferring enforcement of certain requirements regarding providing good faith estimates for insured patients and for good faith estimates sent to uninsured or self-pay patients that do not include expected charges for co-providers or co-facilities.

Our strategies are designed to ensure our hospitals and other facilities are competitive. We believe our hospitals and other facilities compete within local communities on the basis of many factors, including the quality of care, ability to attract and retain quality physicians, skilled clinical personnel and other health care professionals, location, breadth of services, technology offered and quality and condition of the facilities. We focus on operating outpatient services with accessibility and convenient service for patients and predictability and efficiency for physicians.

Two of the most significant factors that impact the competitive position of a hospital are the number and quality of physicians affiliated with or employed by the hospital. Although physicians may at any time terminate their relationship with a hospital we operate, our hospitals seek to retain physicians with varied specialties on the hospitals’ medical staffs and to attract other qualified physicians. We believe physicians refer patients to a hospital on the basis of the quality and scope of services it renders to patients and physicians, the quality of physicians on the medical staff, the location of the hospital and the quality of the hospital’s facilities, technology, equipment and employees. Accordingly, we strive to maintain and provide quality facilities, technology, equipment, employees and services for physicians and patients. Our hospitals face competition from competitors that are implementing physician alignment strategies, such as employing physicians, acquiring physician practice groups and participating in ACOs or other clinical integration models.

Another major factor in the competitive position of our hospitals and other facilities is our ability to negotiate service contracts with group purchasers of health care services. Managed care plans attempt to direct and control the use of health care services and obtain discounts from providers’ established gross charges. Similarly, employers and traditional health insurers continue to attempt to contain costs through negotiations with providers for managed care programs and discounts from established gross charges. Generally, hospitals compete for service contracts with group purchasers of health care services on the basis of price, market reputation, geographic location, quality and range of services, quality of the medical staff and convenience. Our future success will depend, in part, on our ability to retain and renew our contracts with third-party payers and enter into new contracts on favorable terms. Other health care providers may impact our ability to enter into contracts with third-party payers or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care companies to contract with us. Price transparency initiatives and increasing vertical integration efforts involving third-party payers and health care providers, among other factors, may increase these challenges. Moreover, the trend toward consolidation among private third-party payers tends to increase payer bargaining power over fee structures. In addition, health reform efforts may lead to private third-party payers increasingly demanding reduced fees or being unwilling to negotiate reimbursement increases. Health plans increasingly utilize narrow networks that restrict the number of participating providers or tiered networks that impose significantly higher cost sharing obligations on patients that obtain services from providers in a disfavored tier. The importance of obtaining contracts with group purchasers of health care services varies from community to community, depending on the market strength of such organizations.

State certificate of need ("CON") laws, which place limitations on a health care facility's ability to expand services and facilities, make capital expenditures and otherwise make changes in operations, may also have the effect of restricting competition. We currently operate health care facilities in a number of states with CON laws or that require other types of approvals for the establishment or expansion of certain facility types or services. Before issuing a CON or other approval, these states consider the need for additional, changes in, or expanded health care facilities or services. Removal of these requirements could reduce barriers to entry and increase competition in our service areas. In those states that do not require state approval or that set relatively high levels of expenditures before they become reviewable by state authorities, competition in the form of new services, facilities and capital spending is more prevalent. Other federal and state laws and regulations may also adversely impact our ability to expand, such as a regulation commonly known as the "36 Month Rule," which restricts the assumption of Medicare billing privileges for certain home health agencies. In addition, changes in licensure or other laws or regulations and recognition of new provider types or payment models could impact our competitive position. See Item 1, "Business — Regulation and Other Factors."

We and the health care industry as a whole face the challenge of continuing to provide quality patient care while dealing with rising costs and strong competition for patients. Changes in medical technology, existing and future legislation, regulations and interpretations and contracting for provider services by third-party payers remain ongoing challenges.

Admissions, average lengths of stay and reimbursement amounts continue to be negatively affected by third-party payer pre-admission authorization requirements, utilization review and pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Increased competition, admission constraints and third-party payer pressures are expected to continue. To meet these challenges, we intend to expand and update our facilities or acquire or construct new facilities where appropriate, enhance the provision of a comprehensive array of outpatient services, offer market competitive pricing to group purchasers of health care services, upgrade facilities and equipment and offer new or expanded programs and services.

Regulation and Other Factors

Licensure, Certification and Accreditation

Health care facility construction and operation are subject to numerous federal, state and local regulations relating to the adequacy of medical care, equipment, personnel, operating policies and procedures, maintenance of adequate records, fire prevention, rate-setting, building codes and environmental protection. Facilities are subject to periodic inspection by governmental and other authorities to assure continued compliance with the various standards necessary for licensing, certification, and accreditation. We believe our health care facilities are properly licensed under applicable state laws. Each of our acute care hospitals located in the United States is eligible to participate in Medicare and Medicaid programs and is accredited by The Joint Commission. If any facility were to lose its Medicare or Medicaid certification, the facility would be unable to receive reimbursement from federal health care programs. From time to time, we may acquire a facility that is not accredited but for which we will seek accreditation. If any facility were to lose accreditation, the facility would be subject to state surveys, potentially be subject to increased scrutiny by CMS and likely lose payment from private third-party payers.

The Controlled Substances Act and Drug Enforcement Administration ("DEA") regulations require every person who dispenses controlled substances to be registered with the DEA at each principal place of business or professional practice where the person dispenses controlled substances, subject to limited exceptions. Each hospital or clinic must hold a DEA registration at each location and may be subject to similar state registration requirements. In addition, we are subject to a variety of federal and state statutes and regulations that govern operational issues related to pharmaceuticals and controlled substances, such as those related to packaging, storing, and dispensing of pharmaceutical drugs, inventory control and recordkeeping requirements for controlled substances, and other standards intended to prevent diversion of controlled substances. The DEA, the Department of Justice ("DOJ"), HHS, and state boards of pharmacy have broad enforcement powers, may conduct audits and investigations and can impose substantial fines and other penalties, including revocation of registration.

Management believes our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change, and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services. The requirements for licensure, certification and accreditation also include notification or approval in the event of the transfer or change of ownership or certain other changes. Failure to provide required notifications or obtain necessary approvals in these circumstances can result in the inability to complete an acquisition or change of ownership, loss of licensure, lapses in reimbursement or other penalties.

Certificates of Need

In some states where we operate hospitals and other health care providers, the construction or expansion of health care facilities, the acquisition of existing facilities, the transfer or change of ownership, capital expenditures and the addition of new beds or services may be subject to review by and prior approval of, or notifications to, state regulatory agencies under a CON program. Such laws generally require the reviewing state agency to determine the public need for additional or expanded health care facilities and services or other change. Failure to provide required notifications or obtain necessary state approvals can result in the inability to expand facilities, complete an acquisition or expenditure or change ownership or other penalties.

Federal Health Care Program Regulations

Participation in any federal health care program, including the Medicare and Medicaid programs, is heavily regulated by statute and regulation. If a hospital or other provider fails to substantially comply with the numerous conditions of participation in the Medicare and Medicaid programs or performs certain prohibited acts, the provider's participation in the federal health care programs may be terminated, or civil and/or criminal penalties may be imposed. Civil monetary penalties are adjusted annually based on updates to the consumer price index.

Anti-kickback Statute

A section of the Social Security Act known as the "Anti-kickback Statute" prohibits providers and others from directly or indirectly soliciting, receiving, offering or paying any remuneration with the intent of generating referrals or orders for services or items covered by a federal health care program. Courts have interpreted this statute broadly and held that there is a violation of the Anti-kickback Statute if just one purpose of the remuneration is to generate referrals, even if there are other lawful purposes. Furthermore, knowledge of the law or the intent to violate the law is not required. Violations of the Anti-kickback Statute may be punished by criminal fines of up to $100,000 per violation, imprisonment, substantial civil monetary penalties per violation that are subject to annual adjustment based on updates to the consumer price index and damages of up to three times the total amount of the remuneration and/or exclusion from participation in federal health care programs, including Medicare and Medicaid. In addition, submission of a claim for services or items generated in violation of the Anti-kickback Statute may be subject to additional penalties under the federal False Claims Act ("FCA") as a false or fraudulent claim.

The HHS Office of Inspector General (the "OIG"), among other regulatory agencies, is responsible for identifying and eliminating fraud, abuse and waste. The OIG carries out this mission through a nationwide program of audits, investigations and inspections. The OIG provides guidance to the industry through various methods, including advisory opinions and "Special Fraud Alerts." These Special Fraud Alerts do not have the force of law, but identify features of arrangements or transactions that the government believes may cause the arrangements or transactions to violate the Anti-kickback Statute or other federal health care laws. The OIG has identified several incentive arrangements that constitute suspect practices, including: (a) payment of any incentive by a hospital each time a physician refers a patient to the hospital, (b) the use of free or significantly discounted office space or equipment in facilities usually located close to the hospital, (c) provision of free or significantly discounted billing, nursing or other staff services, (d) free training for a physician's office staff in areas such as management techniques and laboratory techniques, (e) guarantees which provide, if the physician's income fails to reach a predetermined level, the hospital will pay any portion of the remainder, (f) low-interest or interest-free loans, or loans which may be forgiven if a physician refers patients to the hospital, (g) payment of the costs of a physician's travel and expenses for conferences or payments to a physician for speaking engagements, (h) coverage on the hospital's group health insurance plans at an inappropriately low cost to the physician, (i) payment for services (which may include consultations at the hospital) which require few, if any, substantive duties by the physician, (j) purchasing goods or services from physicians at prices in excess of their fair market value, (k) rental of space in physician offices, at other than fair market value terms, by persons or entities to which physicians refer, and (l) physician-owned entities (frequently referred to as physician-owned distributorships or PODs) that derive revenue from selling, or arranging for the sale of, implantable medical devices ordered by their physician-owners for use on procedures that physician-owners perform on their own patients at hospitals or ASCs. The OIG has encouraged persons having information about hospitals who offer the above types of incentives to physicians to report such information to the OIG.

The OIG also issues "Special Advisory Bulletins" as a means of providing guidance to health care providers. These bulletins, along with the Special Fraud Alerts, have focused on certain arrangements that could be subject to heightened scrutiny by government enforcement authorities, including: (a) contractual joint venture arrangements and other joint venture arrangements between those in a position to refer business, such as physicians, and those providing items or services for which Medicare or Medicaid pays, and (b) certain "gainsharing" arrangements, i.e., the practice of giving physicians a share of any reduction in a hospital's costs for patient care attributable in part to the physician's efforts.

In addition to issuing Special Fraud Alerts and Special Advisory Bulletins, the OIG issues compliance program guidance for certain types of health care providers. The OIG guidance identifies a number of risk areas under federal fraud and abuse statutes and regulations. These areas of risk include compensation arrangements with physicians, recruitment arrangements with physicians and joint venture relationships with physicians.

As authorized by Congress, the OIG has published safe harbor regulations that outline categories of activities deemed protected from prosecution under the Anti-kickback Statute. Currently, there are statutory exceptions and safe harbors for various activities, including the following: certain investment interests, space rental, equipment rental, practitioner recruitment, personnel services and management contracts, sale of practice, referral services, warranties, discounts, employees, group purchasing organizations, waiver of beneficiary coinsurance and deductible amounts, managed care arrangements, obstetrical malpractice insurance subsidies, investments in group practices, freestanding surgery centers, ambulance replenishing, referral agreements for specialty services, care coordination arrangements, arrangements for patient engagement and support, CMS-sponsored model arrangements, cybersecurity technology and related services, and value-based arrangements.

The fact that conduct or a business arrangement does not fall within a safe harbor or is identified in a Special Fraud Alert, Special Advisory Bulletin or other guidance does not necessarily render the conduct or business arrangement illegal under the Anti-kickback Statute. However, such conduct and business arrangements may lead to increased scrutiny by government enforcement authorities.

We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals, other health care facilities and employed physicians, including employment contracts, leases, medical director agreements and professional service agreements. We also have similar relationships with physicians and facilities to which patients are referred from our facilities and other providers. In addition, we provide financial incentives, including minimum revenue guarantees, to recruit physicians into the communities served by our hospitals. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, including joint ventures and financial relationships with physicians and other referral sources and persons and entities to which we refer patients, do not qualify for safe harbor protection.

Although we believe our arrangements with physicians and other referral sources and referral recipients have been structured to comply with current law and available interpretations, there can be no assurance regulatory authorities enforcing these laws will determine these financial arrangements comply with the Anti-kickback Statute or other applicable laws. An adverse determination could subject us to liabilities under the Social Security Act and other laws, including criminal penalties, civil monetary penalties and exclusion from participation in Medicare, Medicaid or other federal health care programs.

Stark Law

The Social Security Act also includes a provision commonly known as the "Stark Law." The Stark Law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or any of their immediate family members have a financial relationship, if these entities provide certain "designated health services" reimbursable by Medicare or Medicaid unless an exception applies. The Stark Law also prohibits entities that provide designated health services reimbursable by Medicare and Medicaid from billing the Medicare and Medicaid programs for any items or services that result from a prohibited referral and requires the entities to refund amounts received for items or services provided pursuant to the prohibited referral on a timely basis. "Designated health services" include inpatient and outpatient hospital services, clinical laboratory services, radiology and certain other imaging services, radiation therapy services and home health services. Sanctions for violating the Stark Law include denial of payment, substantial civil monetary penalties per claim submitted and exclusion from the federal health care programs. Failure to refund amounts received as a result of a prohibited referral on a timely basis may constitute a false or fraudulent claim and may result in civil penalties and additional penalties under the FCA. The statute also provides for a penalty for a circumvention scheme. These penalties are updated annually based on changes to the consumer price index.

There are exceptions to the self-referral prohibition for many of the customary financial arrangements between physicians and providers, including employment contracts, leases, recruitment agreements and personal service arrangements. Unlike safe harbors under the Anti-kickback Statute with which compliance is voluntary, a financial relationship must comply with every requirement of a Stark Law exception or the arrangement is in violation of the Stark Law. Although there is an exception for a physician's ownership interest in an entire hospital, the Affordable Care Act prohibits physician-owned hospitals established after December 31, 2010 from billing for Medicare or Medicaid patients referred by their physician owners. As a result, the law effectively prevents the formation of new physician-owned hospitals that participate in Medicare or Medicaid. While the Affordable Care Act grandfathers existing physician-owned hospitals, it does not allow these hospitals to increase the percentage of physician ownership and significantly restricts their ability to expand services.

Through a series of rulemakings, CMS has issued final regulations implementing the Stark Law. While these regulations were intended to clarify the requirements of the exceptions to the Stark Law, it is unclear how the government will interpret many of these exceptions for enforcement purposes. Further, we do not always have the benefit of significant regulatory or judicial interpretation of the Stark Law and its implementing regulations. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and are subject to continuing legal and regulatory change. We cannot assure that every relationship complies fully with the Stark Law.

Other Fraud and Abuse Provisions

Certain federal fraud and abuse laws apply to all health benefit programs and provide for criminal penalties. The Social Security Act also imposes criminal and civil penalties for making false claims and statements to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered or for misrepresenting actual services rendered in order to obtain higher reimbursement, billing for unnecessary goods and services and cost report fraud. Federal enforcement officials have the ability to exclude from Medicare and Medicaid any business entities and any investors, officers and managing employees associated with business entities that have committed health care fraud, even if the officer or managing employee had no knowledge of the fraud. Criminal and civil penalties may be imposed for a number of other prohibited activities, including failure to return known overpayments, certain gainsharing arrangements, billing Medicare amounts that are substantially in excess of a provider's usual charges, offering remuneration to influence a Medicare or Medicaid beneficiary's selection of a health care provider, contracting with an individual or entity known to be excluded from a federal health care program, making or accepting a payment to induce a physician to reduce or limit services, and soliciting or receiving any remuneration in return for referring an individual for an item or service payable by a federal health care program. Like the Anti-kickback Statute, these provisions are very broad. Civil penalties may be imposed for the failure to report and return an overpayment within 60 days of identifying the overpayment or by the date a corresponding cost report is due, whichever is later. To avoid liability, providers must, among other things, carefully and accurately code claims for reimbursement, promptly return overpayments and accurately prepare cost reports.

Some of these provisions, including the federal Civil Monetary Penalty Law, require a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute. Substantial civil monetary penalties may be imposed under the federal Civil Monetary Penalty Law. These penalties will be updated annually based on changes to the consumer price index. In some cases, violations of the Civil Monetary Penalty Law may result in penalties of up to three times the remuneration offered, paid, solicited or received. In addition, a violator may be subject to exclusion from federal and state health care programs. Federal and state governments increasingly use the federal Civil Monetary Penalty Law, especially where they believe they cannot meet the higher burden of proof requirements under the Anti-kickback Statute. Further, individuals can receive up to $1,000 for providing information on Medicare fraud and abuse that leads to the recovery of at least $100 of Medicare funds under the Medicare Integrity Program.

In addition, the Eliminating Kickbacks in Recovery Act of 2018 ("EKRA") establishes criminal penalties for paying, receiving, soliciting or offering any remuneration in return for referring a patient to a laboratory, clinical treatment facility or recovery home, or in exchange for an individual using the services of one of these entities. The EKRA prohibitions apply to services covered by government health care programs and by private health plans. There is limited guidance with respect to the application of EKRA.

State Fraud and Abuse Laws

Many states in which we operate also have laws intended to prevent fraud and abuse within the health care industry. Some of these laws are similar to the Anti-kickback Statute, prohibiting payments to physicians for patient referrals, and to the Stark Law, prohibiting certain self-referrals. These state laws often apply regardless of the source of payment for care, and little precedent exists for their interpretation or enforcement. These statutes typically provide for criminal and civil penalties, as well as loss of licensure.

The Federal False Claims Act and Similar State Laws

We are subject to state and federal laws that govern the submission of claims for reimbursement and prohibit the making of false claims or statements. One of the most prominent of these laws is the FCA, which may be enforced by the federal government directly or by a *qui tam* plaintiff, or whistleblower, on the government's behalf. The government may use the FCA to prosecute Medicare and other government program fraud in areas such as coding errors, billing for services not provided and submitting false cost reports. In addition, the FCA covers payments made in connection with the Exchanges created under the Affordable Care Act, if those payments include any federal funds. When a private party brings a *qui tam* action under the FCA, the defendant is not made aware of the lawsuit until the government commences its own investigation or makes a determination whether it will intervene. If a defendant is determined by a court of law to

be liable under the FCA, the defendant may be required to pay three times the actual damages sustained by the government, plus substantial mandatory civil penalties for each separate false claim. These penalties are updated annually based on changes to the consumer price index.

There are many potential bases for liability under the FCA. Liability often arises when an entity knowingly submits a false claim for reimbursement to the federal government. The FCA defines the term "knowingly" broadly. Though simple negligence will not give rise to liability under the FCA, submitting a claim with reckless disregard to its truth or falsity constitutes a "knowing" submission under the FCA and, therefore, may create liability. Submission of claims for services or items generated in violation of the Anti-kickback Statute constitutes a false or fraudulent claim under the FCA. Whistleblowers and the federal government have taken the position, and some courts have held, that providers who allegedly have violated other statutes, such as the Stark Law, have thereby submitted false claims under the FCA. False claims under the FCA also include the knowing and improper failure to report and refund amounts owed to the government in a timely manner following identification of an overpayment. An overpayment is deemed to be identified when a person has, or should have through reasonable diligence, determined that an overpayment was received and quantified the overpayment.

Every entity that receives at least $5 million annually in Medicaid payments must have written policies for all employees, contractors or agents, providing detailed information about false claims, false statements and whistleblower protections under certain federal laws, including the FCA, and similar state laws. In addition, federal law provides an incentive to states to enact false claims laws comparable to the FCA. A number of states in which we operate have adopted their own false claims provisions as well as their own whistleblower provisions under which a private party may file a civil lawsuit in state court. We have adopted and distributed policies pertaining to the FCA and relevant state laws.

HIPAA Administrative Simplification and Privacy, Security and Interoperability Requirements

The Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and implementing regulations require the use of uniform electronic data transmission standards and code sets for certain health care claims and payment transactions submitted or received electronically. In addition, HIPAA requires each provider to use a National Provider Identifier. These provisions are intended to encourage electronic commerce in the health care industry.

The privacy and security regulations promulgated pursuant to HIPAA extensively regulate the use and disclosure of individually identifiable health information, known as "protected health information," and require covered entities, including health plans and most health care providers, to implement administrative, physical and technical safeguards to protect the security of such information. Certain provisions of the security and privacy regulations apply to business associates (entities that handle protected health information on behalf of covered entities), and business associates are subject to direct liability for violation of these provisions. In addition, a covered entity may be subject to penalties as a result of a business associate violating HIPAA, if the business associate is found to be an agent of the covered entity.

Covered entities must report breaches of unsecured protected health information to affected individuals without unreasonable delay but not to exceed 60 days after discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. All non-permitted uses or disclosures of unsecured protected health information are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

Violations of the HIPAA privacy and security regulations may result in criminal penalties and in substantial civil penalties per violation. These civil penalties are updated annually based on updates to the consumer price index. HHS enforces the regulations and performs compliance audits. In addition to enforcement by HHS, state attorneys general are authorized to bring civil actions seeking either injunction or damages in response to violations that threaten the privacy of state residents. HHS may resolve HIPAA violations through informal means, such as allowing a covered entity to implement a corrective action plan, but HHS has the discretion to move directly to impose monetary penalties and is required to impose penalties for violations resulting from willful neglect. We enforce compliance in accordance with HIPAA privacy and security regulations. The Information Protection and Security Department monitors our compliance with the HIPAA privacy and security regulations. The HIPAA privacy regulations and security regulations have and will continue to impose significant costs on our facilities in order to comply with these standards.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. Our facilities remain subject to federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties. For example, the Federal Trade Commission uses its consumer protection authority to initiate enforcement actions in response to data breaches. The California Consumer Privacy Act of 2018 (the "CCPA"), which was significantly amended by the California Privacy Rights Act ("CPRA"), the Colorado Privacy Act, the Utah Privacy Act and the Virginia Consumer Data Protection Act each afford consumers expanded privacy protections. These provide for civil penalties for violations, and the CCPA and CPRA provide for a private right of action for data breaches. Additionally, several privacy bills have been proposed both at the federal and state level that may result in additional legal requirements that impact our business. The potential effects of these laws are far-reaching and may require us to modify our data processing practices and policies and to incur substantial costs and expenses in order to comply. For example, residents in states with comprehensive privacy laws have expanded rights to access and require deletion and portability of their personal information, opt out of certain personal information sharing and receive detailed information about how their personal information is used.

Many foreign data privacy regulations (including the UK Data Protection Legislation) are more stringent than those in the United States. In the case of non-compliance with these regulations, regulators may impose administrative fines which are based on a multi-factored approach.

Health care providers and industry participants are also subject to a growing number of requirements intended to promote the interoperability and exchange of patient health information. For example, health care providers and certain other entities are subject to information blocking restrictions pursuant to the 21st Century Cures Act that prohibit practices that are likely to interfere with the access, exchange or use of electronic health information, except as required by law or specified by HHS as a reasonable and necessary activity. Violations may result in penalties or other disincentives.

EMTALA

All of our hospitals in the United States are subject to EMTALA. This federal law requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every individual who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. There are severe penalties under EMTALA if a hospital fails to screen or appropriately stabilize or transfer an individual or if the hospital delays appropriate treatment in order to first inquire about the individual's ability to pay. Penalties for violations of EMTALA include exclusion from participation in the Medicare program and civil monetary penalties. These civil monetary penalties are adjusted annually based on updates to the consumer price index. In addition, an injured individual, the individual's family or a medical facility that suffers a financial loss as a direct result of a hospital's violation of the law can bring a civil suit against the hospital.

The government broadly interprets EMTALA to cover situations in which individuals do not actually present to a hospital's emergency room, but present for emergency examination or treatment to the hospital's campus, generally, or to a hospital-based clinic that treats emergency medical conditions or are transported in a hospital-owned ambulance, subject to certain exceptions. At least one court has interpreted the law also to apply to a hospital that has been notified of a patient's pending arrival in a non-hospital owned ambulance. In recent years, the government has undertaken enforcement actions in which it has broadly interpreted a hospital's obligations with respect to screening and stabilizing patients who present with a psychiatric emergency. EMTALA does not generally apply to individuals admitted for inpatient services. The government has expressed its intent to investigate and enforce EMTALA violations actively. Hospitals may face conflicting interpretations of EMTALA's requirements with respect to state laws that limit access to abortion or other reproductive health services. For example, HHS has provided guidance regarding EMTALA obligations specific to patients who are pregnant or are experiencing pregnancy loss and the preemption of state law. This guidance is the subject of legal challenges, and a federal district court issued a preliminary injunction prohibiting enforcement of the guidance in Texas and against members of certain professional groups involved in the litigation.

Corporate Practice of Medicine/Fee Splitting

Some of the states in which we operate have laws prohibiting corporations and other entities not owned by physicians or other permitted health professionals from employing physicians or certain other health professionals, practicing medicine for a profit and making certain direct and indirect payments to, or entering into fee-splitting arrangements with, health care providers designed to induce or encourage the referral of patients to, or the recommendation of, particular providers for medical products and services. Possible sanctions for violation of these restrictions include loss of license and civil and criminal penalties. In addition, agreements between the corporation and

the physician or other health professional may be considered void and unenforceable. These statutes vary from state to state, are often vague and have seldom been interpreted by the courts or regulatory agencies.

Health Care Industry Investigations

Significant media and public attention has focused in recent years on the hospital industry. This media and public attention, changes in government personnel and other factors have led to increased scrutiny of the health care industry. Except as may be disclosed in our SEC filings, we are not aware of any material investigations of the Company under federal or state health care laws or regulations. It is possible that governmental entities could initiate investigations or litigation in the future at facilities we operate and that such matters could result in significant penalties, as well as adverse publicity. It is also possible that our executives and managers could be included in governmental investigations or litigation or named as defendants in private litigation.

Our substantial Medicare, Medicaid and other governmental billings result in heightened scrutiny of our operations. We continue to monitor all aspects of our business and have developed a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards.

However, because the law in this area is complex and constantly evolving, governmental investigations or litigation may result in interpretations that are inconsistent with our practices or industry practices.

In public statements surrounding current investigations, governmental authorities have taken positions on a number of issues, including some for which little official interpretation previously has been available, that appear to be inconsistent with practices that have been common within the industry and that previously have not been challenged in this manner. In some instances, government investigations that have in the past been conducted under the civil provisions of federal law may now be conducted as criminal investigations.

Both federal and state government agencies have increased their focus on and coordination of civil and criminal enforcement efforts in the health care area. Through the national Health Care Fraud and Abuse Control Program, the OIG and the DOJ coordinate federal, state and local law enforcement activities with respect to health care fraud against both public and private health plans. The OIG and DOJ have, from time to time, established national enforcement initiatives that target all hospital providers, focusing on specific billing practices or other suspected areas of abuse. In addition, governmental agencies and their agents, such as MACs, fiscal intermediaries and carriers, may conduct audits of our health care operations. Private third-party payers may conduct similar post-payment audits, and we also perform internal audits and monitoring.

In addition to national enforcement initiatives, federal and state investigations have addressed a wide variety of routine health care operations such as: cost reporting and billing practices, including for Medicare outliers; financial arrangements with referral sources; physician recruitment activities; physician joint ventures; and hospital charges and collection practices for self-pay patients. We engage in many of these routine health care operations and other activities that could be the subject of governmental investigations or inquiries. For example, we have significant Medicare and Medicaid billings, numerous financial arrangements with physicians who are referral sources to our hospitals, and joint venture arrangements involving physician investors. Certain of our individual facilities have received, and other facilities may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. Any additional investigations of the Company, our executives or managers could result in significant liabilities or penalties to us, as well as adverse publicity.

Health Care Reform

The health care industry is subject to changing political, regulatory and other influences, along with various scientific and technological initiatives and innovations. In recent years, the U.S. health care industry has undergone significant changes at the federal and state levels, many of which have been aimed at reducing costs and government spending and increasing access to health insurance. The most prominent of these efforts, the Affordable Care Act, affects how health care services are covered, delivered and reimbursed. The Affordable Care Act increased health insurance coverage through a combination of private sector health insurance requirements, public program expansion and other reforms.

There is uncertainty regarding the ongoing net effect of the Affordable Care Act, particularly as it has been, and continues to be, subject to legislative and regulatory changes and court challenges. For example, effective January 1, 2019, the penalty associated with the individual mandate to maintain health insurance was effectively eliminated. However, some states have imposed individual health insurance mandates, and other states have explored or offer public health insurance options. To increase access to health insurance during COVID-19, the ARPA enhanced subsidies for individuals eligible to purchase coverage through Affordable Care Act marketplaces. The Inflation Reduction Act, enacted in August 2022, extends these enhanced subsidies through 2025. In addition, in a final rule published in September 2021,

HHS extended the annual open enrollment period for coverage through federal marketplaces and granted state exchanges flexibility to lengthen their open enrollment periods. These changes and initiatives may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased.

The expansion in public program coverage under the Affordable Care Act has been driven primarily by expanding the categories of individuals eligible for Medicaid coverage and permitting individuals with relatively higher incomes to qualify. However, a number of states, including Texas and Florida, have opted out of the Medicaid expansion provisions. Some states use, or have applied to use, waivers granted by CMS to implement expansion, impose different eligibility or enrollment conditions, or otherwise implement programs that vary from federal standards. The Medicaid landscape is constantly evolving as the federal and state governments consider and test various models of delivery and payment system reform.

In addition, there is uncertainty regarding the potential impact of other reform efforts at the federal and state levels. For example, some members of Congress have proposed measures that would expand government-sponsored coverage, including proposals to expand coverage of federally-funded insurance programs as an alternative to private insurance or establish a single-payer system (such reforms often referred to as “Medicare for All”). Other recent initiatives and proposals include those aimed at price transparency and out-of-network charges, which may impact prices and the relationships between health care providers, insurers and patients. For example, the No Surprises Act imposes various requirements on providers and health plans intended to prevent “surprise” medical bills, and several states have implemented similar laws intended to protect consumers. The No Surprises Act prohibits providers from charging patients an amount beyond the in-network cost sharing amount for items and services rendered by out-of-network providers (i.e., prohibits balance billing), subject to limited exceptions. The No Surprises Act also impacts the payment received by an out-of-network provider from a health plan for items and services to which the prohibitions on balance billing apply. For items and services for which balance billing is prohibited (even when no balance billing occurs), the No Surprises Act establishes an independent dispute resolution (“IDR”) process for providers and payers to handle payment disputes that cannot be resolved through direct negotiations. Regulations implementing the IDR provisions of the No Surprises Act provide that, when making a payment determination, the IDR must consider the qualifying payment amount, or QPA (which is generally the payer’s median contracted rate for the same or similar service in an area), and all additional permissible information submitted by each party. The IDR entity must select the offer that best represents the value of the item or service under dispute. However, the final rule establishing the IDR process is currently the subject of legal challenges. On February 6, 2023, a federal judge vacated parts of the rule, including provisions related to consideration of the QPA. The No Surprises Act also requires providers to send an insured patient’s health plan a good faith estimate of expected charges, including billing and diagnostic codes, prior to when the patient is scheduled to receive the item or service. HHS is deferring enforcement of this requirement until it issues additional regulations. The No Surprises Act also requires providers to provide a good faith estimate of expected charges to uninsured or self-pay individuals in connection with scheduled items or services, in advance of the date of the scheduled item or service or upon request of the individual. HHS is delaying enforcement with regard to good faith estimates that do not include expected charges for co-providers or co-facilities until the agency issues additional regulations. If the actual charges to an uninsured or self-pay patient are substantially higher than the estimate or the provider furnishes an item or service that was not included in the good faith estimate, the patient may invoke a patient-provider dispute resolution process established by regulation to challenge the higher amount.

Other trends toward transparency and value-based purchasing may impact the competitive position and patient volumes of providers. For example, the CMS Care Compare website makes available to the public certain data that hospitals, home health agencies, hospices, and other Medicare-certified providers submit in connection with Medicare reimbursement claims, including performance data on quality measures and patient satisfaction. Medicare reimbursement may be adjusted based on quality and efficiency measures and/or compliance with quality reporting requirements. In addition, hospitals are required by federal regulation to publish online payer-specific negotiated charges and de-identified minimum and maximum charges. Some price transparency obligations apply only to payers. For example, CMS requires health insurers to publish online charges negotiated with providers for health care services. Starting January 1, 2023, health insurers must provide online price comparison tools to help individuals get personalized cost estimates for covered items and services. Other industry participants, such as private payers and large employer groups and their affiliates, may also introduce financial or delivery system reforms. For example, in recent years, there have been trends influenced by private and/or public payers toward enrollment in managed care programs, favoring outpatient care over inpatient care, and provider consolidation. These issues are further discussed in Item 1A, “Risk Factors.”

General Economic and Demographic Factors

The health care industry is impacted by changes in or uncertainty regarding the overall U.S. economy. COVID-19 has adversely impacted, and may in the future adversely impact, economic conditions in the United States. In addition, outside of COVID-19-related stimulus and relief measures, budget deficits at the federal level and within some state and local government entities have had a negative impact on spending for many health and human service programs, including

Medicare, Medicaid and similar programs, which represent significant payer sources for our hospitals and other providers. We anticipate that the federal deficit, the growing magnitude of Medicare and Medicaid expenditures and the aging of the U.S. population will continue to place pressure on government health care programs. Other risks we face during periods of economic weakness and high unemployment include potential declines in the population covered under managed care agreements, increased patient decisions to postpone or cancel elective and nonemergency health care procedures (including delaying surgical procedures), potential increases in the uninsured and underinsured populations, increased adoption of health plan structures that shift financial responsibility to patients and increased difficulties in collecting patient receivables for copayment and deductible amounts.

Compliance Program

We maintain a comprehensive ethics and compliance program that is designed to meet or exceed applicable federal guidelines and industry standards. The program is intended to monitor and raise awareness of various regulatory issues among employees and to emphasize the importance of complying with governmental laws and regulations. As part of the ethics and compliance program, we provide annual ethics and compliance training to our employees and encourage all employees to report any violations to their supervisor, an ethics and compliance officer or to the Company's ethics line available 24 hours a day by phone and internet portal.

Antitrust Laws

The federal government and most states have enacted antitrust laws that prohibit certain types of conduct deemed to be anti-competitive. These laws prohibit price fixing, market allocation, bid-rigging, concerted refusal to deal, market monopolization, price discrimination, tying arrangements, acquisitions of competitors and other practices that have, or may have, an adverse effect on competition. Violations of federal or state antitrust laws can result in various sanctions, including criminal and civil penalties. Antitrust enforcement in the health care industry is currently a priority of the Federal Trade Commission and the DOJ, including with respect to hospital and physician practice acquisitions. We believe we are in compliance with such federal and state laws, but courts or regulatory authorities may reach a determination in the future that could adversely affect our operations and growth strategy.

Environmental Matters

We are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. We do not believe that we will be required to expend any material amounts in order to comply with these laws and regulations as presently in effect. Regulations limiting greenhouse gas emissions and energy inputs may increase in coming years, which may increase our costs associated with compliance, disrupt and adversely affect our operations and could materially, adversely affect our financial performance.

Our environmental strategy is designed to complement our mission of the care and improvement of human life, which extends to the environment. This strategy is centered on incorporating the following four pillars into our operations:

- Managing energy and water responsibly,
- Enhancing our climate resilience,
- Sourcing and consuming efficiently, and
- Managing the environmental impact of our capital programs.

We are pursuing a plan to reduce our scope 1 and scope 2 greenhouse gas emissions by 2030 in line with the Paris Agreement 1.5℃ emissions reduction goal. Our initiatives contemplate operational changes intended to reduce energy consumption, including by accelerating related capital investments, new technology pilots, renewable energy contracting and investments, and medical gas initiatives. We have baselined our scope 1 and scope 2 greenhouse gas emissions for 2021, and we are updating those calculations for 2022 activity to measure trends in our greenhouse gas emissions. We are exploring a process to measure scope 3 greenhouse gas emissions in the future.

In 2022, we released our inaugural Task Force on Climate-related Financial Disclosure ("TCFD") report to provide additional insight into our commitment to improving our environmental impact and strengthening our climate resilience to support the communities we serve. The report follows TCFD guidance and outlines the ways we are integrating climate-related risks and opportunities into our governance structure, our risk management and strategy development processes, and how we establish and track climate-related metrics and targets. We plan to continue following established guidelines to assess and better understand the physical and transition risks from climate change that we believe most significantly impact our operations. We have also integrated climate-related risk assessment into our established enterprise risk management function.

While we currently believe that compliance with existing environmental laws and regulations does not have a material impact on our operations, changes in consumer preferences and additional legislation or regulatory requirements, including those associated with the transition to a low-carbon economy, may increase costs associated with compliance, the operation of our facilities and supplies.

Insurance

As is typical in the health care industry, we are subject to claims and legal actions by patients in the ordinary course of business. Subject, in most cases, to a $15 million per occurrence self-insured retention, our facilities are insured by our insurance subsidiary for losses up to $80 million per occurrence (effective January 1, 2023). The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of either $25 million or $35 million per occurrence, depending on the jurisdiction for the related claim. We also maintain professional liability insurance with unrelated commercial carriers for losses in excess of amounts insured by our insurance subsidiary.

We purchase, from unrelated insurance companies, coverage for cyber security incidents, directors and officers liability and property loss in amounts we believe are reasonable and subject to terms of coverage we believe to be reasonable.

Human Capital Resources

Our workforce is comprised of approximately 294,000 employees (as of December 31, 2022), including approximately 87,000 part-time and PRN employees (references herein to "employees" refer to employees of our affiliates). Our Board of Directors and its committees oversee human capital matters through regular reporting from management and advisors.

Diversity, Equity and Inclusion

We are committed to fostering a culture of inclusion that embraces and supports our patients, colleagues, partners, physicians and communities. Our workforce is comprised of approximately 78% women and 44% people of color. Our policies prohibit discrimination on the basis of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law.

We are dedicated to being an employer of choice. We seek to recruit diverse candidates at all stages of their careers and through a variety of venues and programs. Our Chief Diversity Officer leads a team that is responsible for advancing diversity, equity and inclusion ("DEI") and cultural competence initiatives across the Company. Our Executive Diversity Council, sponsored by our Chief Executive Officer and comprised of executive leaders from the Company, champions DEI across the Company and informs strategic decisions towards DEI goals and objectives. In addition to the Executive Diversity Council, we have implemented DEI Councils comprised of diversity leaders and facility representatives and added division-based DEI leaders to support local deployment of DEI strategies and programs across the enterprise.

In the beginning of 2020, we launched a DEI strategy based on internal and external research to support the advancement of people of color and women into leadership roles. We have since established nine employee resource groups to provide colleagues opportunities to convene around shared experiences, including groups for Black colleagues, women, young professionals, LGBTQ+, Hispanic/Latinx, and Asian colleagues, veterans, colleagues with disabilities, and a group focused on mental health and wellness – each with a senior leader serving as executive sponsor. In addition, the Company launched a sponsorship program in 2022 for a cohort of Black colleagues to support leadership and advancement, which has since expanded to include a broader focus on Black, Asian, and Hispanic leaders.

The Company's Corporate Governance Guidelines reinforce its commitment to diversity by requiring the initial pool of candidates from which the Nominating and Corporate Governance Committee may recommend director nominees to include qualified female and racially/ethnically diverse candidates and the Nominating and Corporate Governance Committee to request that any third-party search firm that it engages to identify such candidates to include qualified female and racially/ethnically diverse candidates in such initial pool.

We encourage you to review the "Diversity, Equity and Inclusion" section of our website, which includes our EEO-1 data, as well as our 2022 Impact Report (available at www.hcahealthcareimpact.com) for more detailed

information regarding our DEI and pay equity programs and initiatives. Nothing on our website, including our 2022 Impact Report or sections thereof, shall be deemed incorporated by reference into this annual report on Form 10-K.

Compensation and Benefits

To recruit and retain a highly qualified and diverse workforce, we design competitive compensation and benefits programs to attract, retain, recognize and reward the performance of our employees. These programs (which vary by location) include an Employee Stock Purchase Plan, a 401(k) Plan, health care and insurance benefits, flexible spending accounts, paid time off, family leave, family care resources, flexible work schedules, employee assistance and wellbeing programs, tuition and student loan payment assistance and on-site services, such as cafeterias and fitness centers, among many others.

Recruitment and Workforce Development

We continue to invest in numerous initiatives to attract and acquire the talent needed to deliver on our mission and business objectives. We are working within our communities to expand access to health care programs and careers, including our expansion of Galen College of Nursing, to specifically address the growing nursing shortage. We are broadening our access to talent through early outreach programs, internships, career paths, and college and diversity recruitment efforts.

Serving the Community

We strive to provide not only the quality health care that our patients deserve, but also to address needs in the communities we serve. We provide opportunities for our colleagues to get involved and be a part of something bigger than our organization. By joining forces with other leading organizations, we believe our collective talents and work has an impact that is only possible when we work together. Through research, partnerships, leadership and investments, we are tackling problems in our communities and throughout the health care industry, from disaster relief to environmental sustainability to new innovations. We also support the HCA Healthcare Foundation, whose mission is to promote health and wellbeing and strive to make a positive impact in all the communities HCA Healthcare serves by providing leadership, service and financial support to effective non-profit organizations.

Culture and Talent Development

HCA Healthcare’s culture is critical to our success. We seek to instill a culture across our system that includes making a positive impact on our patients, communities and each other, and nurture that culture through inclusion, compassion and respect. To assess and improve employee retention and engagement, we connect with our colleagues in several ways to listen to and respond to their concerns, including employee rounding, employee advisory groups and governance councils, and colleague surveys throughout the year. During 2022, we expanded our efforts to improve our colleagues’ engagement by focusing on the vital behavior of personal connection through care, support and growth to better respond to the needs of our colleagues. By providing education, training and opportunities to grow as clinicians and leaders, we seek to support our colleagues throughout their career journey. We also support our colleagues’ development through programs such as tuition assistance, student loan payment assistance, clinical training and certification.

We are highly committed to developing leaders who support our culture, grow our business and lead the industry. We invest in award winning programs offered through the HCA Healthcare Leadership Institute where we develop the capabilities of our current leaders and build our pipeline for the future. These programs are designed to assess, develop and advance leaders at all levels from supervisory to executive. Our commitment to leadership development and succession planning creates the platform for which we continue to deliver on our mission and grow our business.

Health, Safety and Wellness

We focus on supporting employees in ways that have a positive impact on their physical, mental and financial health so they can take care of themselves, their families, their patients and each other. We provide our employees and their families with access to a variety of health and wellness programs that can help with burnout, stress, depression, anxiety, and other health concerns as well as relationship issues, career development, work challenges, retirement planning and financial support. For 2022, this included the following touchpoints:

- Approximately 40,000 visits to the online Wellbeing Hub website;
- More than 17,000 calls to the Nurse Care help line; and
- Approximately 14,000 interactions with Optum Wellbeing Services.

Labor Matters

We are subject to various state and federal laws that regulate wages, hours, benefits and other terms and conditions relating to employment. At December 31, 2022, certain employees at 37 of our domestic hospitals are represented by various labor unions. No union elections occurred at any of our domestic facilities in 2022. While no elections are scheduled in 2023, it is possible that employees at additional hospitals may unionize in the future, or employees currently represented by labor unions may choose to reject that representation. We have not experienced work stoppages that have materially, adversely affected our business or results of operations. However, it is possible that a material work stoppage at one or more of our hospitals may occur in the future.

Physicians are an integral part of the success of our hospitals in delivering quality care to our patients. Our hospitals are staffed by licensed physicians, including both employed physicians and physicians who are not employees of our hospitals. Some physicians provide services in our hospitals under contracts, which generally describe a term of service, provide and establish the duties and obligations of such physicians, require the maintenance of certain performance criteria and set compensation for such services. Any licensed physician may apply to be accepted to the medical staff of any of our hospitals, but the hospital's medical staff and the appropriate governing board of the hospital, in accordance with established credentialing criteria, must approve acceptance to the staff. Members of the medical staffs of our hospitals often also serve on the medical staffs of other hospitals and may terminate their affiliation with one of our hospitals at any time.

Our facilities, like most health care facilities, have experienced rising labor costs and turnover. In some markets, nurse and medical support personnel availability and retention have become significant operating issues for health care providers, including the Company. These challenges have been exacerbated by the effects that COVID-19 has had on health care personnel. Nurse and medical support shortages have resulted in a number of adverse impacts to our business, including capacity and growth constraints, reduced patient satisfaction, reduced physician satisfaction, impact on services offered and increased costs, among others. To address this challenge, we have implemented several initiatives to improve retention, recruiting, compensation programs and productivity.

We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel and to utilize more expensive temporary or contract personnel. As a result, our labor costs could continue to increase at rates in excess of historical levels. We also depend on the available labor pool of employees in each of the markets in which we operate to fill other necessary positions. If there is additional union organizing activity or a significant portion of our employee base unionizes, our costs could increase. In addition, we operate in several states that have adopted mandatory nurse-staffing ratios, mandate staffing committees to develop staffing plans or require public reporting of nurse staffing levels. If these states reduce mandatory nurse to patient ratios or additional states in which we operate adopt mandatory nurse to patient ratios, such changes could significantly affect labor costs and have an adverse impact on revenues if we are required to limit patient admissions in order to meet the required ratios.

The inability to attract, retain and utilize sufficient, quality clinical and non-clinical personnel could impair our capacity, ability to grow and our results of operations.

Information about our Executive Officers

As of February 1, 2023, our executive officers were as follows:

Name	Age	Position(s)
Samuel N. Hazen	62	Chief Executive Officer and Director
Erol R. Akdamar	55	President — American Group
Jennifer L. Berres	52	Senior Vice President and Chief Human Resources Officer
Phillip G. Billington	55	Senior Vice President — Internal Audit Services
Jeff E. Cohen	51	Senior Vice President — Government Relations
Michael S. Cuffe, M.D.	57	Executive Vice President and Chief Clinical Officer
Jon M. Foster	61	Executive Vice President and Chief Operating Officer
Richard A. Hammett	53	President — Atlantic Group
Michael A. Marks	53	Senior Vice President — Finance
Michael R. McAlevey	59	Senior Vice President and Chief Legal Officer
Timothy M. McManus	51	President — National Group
Sammie S. Mosier	48	Senior Vice President and Chief Nurse Executive
P. Martin Paslick	63	Senior Vice President and Chief Information Officer
Deborah M. Reiner	61	Senior Vice President — Marketing and Communications
William B. Rutherford	59	Executive Vice President and Chief Financial Officer
Joseph A. Sowell, III	66	Senior Vice President and Chief Development Officer
Kathryn A. Torres	59	Senior Vice President — Payer Contracting and Alignment
Kathleen M. Whalen	59	Senior Vice President and Chief Ethics and Compliance Officer
Christopher F. Wyatt	45	Senior Vice President and Controller

Samuel N. Hazen has served as Chief Executive Officer since January 2019 and was appointed as a director in September 2018. From November 2016 through December 2018, Mr. Hazen served as the Company's President and Chief Operating Officer. Prior to that, he served as Chief Operating Officer of the Company from January 2015 to November 2016 and as President — Operations of the Company from 2011 to 2015. He also served as President — Western Group from 2001 to 2011 and as Chief Financial Officer — Western Group of the Company from 1995 to 2001. Prior to that time, Mr. Hazen served in various hospital, regional and division Chief Financial Officer positions with the Company, Humana Inc. and Galen Health Care, Inc.

Erol R. Akdamar was appointed President – American Group effective January 1, 2023. Mr. Akdamar previously served as President of the North Texas Division from October 2013 to December 2022. Prior to that, he served as CEO of Medical City Dallas Hospital in Dallas, Texas from 2010 to 2013 and CEO of St. David's South Austin Medical Center in Austin, Texas from 2004 to 2010. Mr. Akdamar began his career with HCA in 1993 with Rapides Regional Medical Center.

Jennifer L. Berres was appointed Senior Vice President and Chief Human Resources Officer effective November 1, 2019. Ms. Berres joined HCA in 1993 and served in various capacities, including as Vice President — Human Resources from April 2013 through October 2019.

Phillip G. Billington was appointed Senior Vice President — Internal Audit Services effective January 1, 2019. Mr. Billington previously served as Vice President — Corporate Internal Audit from June 2005 to December 2018. Prior to joining HCA, Mr. Billington worked as a managing director for FTI Consulting, Inc., a director for KPMG LLP and was a senior manager at Arthur Andersen LLP.

Jeff E. Cohen was appointed Senior Vice President — Government Relations effective October 1, 2019. Prior to joining HCA, Mr. Cohen spent 20 years with the Federation of American Hospitals, most recently as Executive Vice President of Public Affairs, where he managed all advocacy, public affairs and communications for the association.

Michael S. Cuffe, M.D. was appointed Executive Vice President and Chief Clinical Officer effective January 1, 2022. He previously served as President — Physician Services Group from October 2011 through December 2021. From October 2011 to January 2015, Dr. Cuffe also served as a Vice President of the Company. Prior to that time, Dr. Cuffe served Duke University Health System as Vice President for Ambulatory Services and Chief Medical Officer from March 2011 to October 2011 and Vice President Medical Affairs from June 2005 to March 2011. He also served Duke University School of Medicine as Vice Dean for Medical Affairs from June 2008 to March 2011, Deputy Chair of the Department of Medicine from August 2009 to August 2010 and Associate Professor of Medicine from March 2005 to October 2011. Prior that time, Dr. Cuffe served in various leadership roles with the Duke Clinical Research Institute, Duke University Medical Center and Duke University School of Medicine.

Jon M. Foster was appointed Executive Vice President and Chief Operating Officer effective January 1, 2023. Prior to that time, he served as President — American Group from January 2013 to December 2022, President — Southwest Group from February 2011 to January 2013 and Division President for the Central and West Texas Division from January 2006 to February 2011. Mr. Foster joined HCA in March 2001 as President and CEO of St. David's HealthCare in Austin, Texas and served in that position until February 2011. Prior to joining the Company, Mr. Foster served in various executive capacities within the Baptist Health System in Knoxville, Tennessee and The Methodist Hospital System in Houston, Texas.

Richard A. Hammett was appointed President — Atlantic Group effective January 1, 2023. Mr. Hammett previously served as President of the North Florida Division from June 2020 to December 2022. Prior to that, he served as President and CEO of Swedish Medical Center in Englewood, Colorado from 2015 to 2020. Prior to that time, Mr. Hammett held numerous leadership positions within HCA Healthcare, including serving as president and chief executive officer of The Medical Center of Aurora in Aurora, Colorado and chief operating officer and interim CEO of St. David's Medical Center in Austin, Texas.

Michael A. Marks was appointed Senior Vice President — Finance effective January 1, 2023. Mr. Marks previously served as Vice President — Financial Operations Support from March 2021 to December 2022. Prior to that time, he served as CFO of the National Group from December 2008 to February 2021 and CFO of the West Florida Division from January 2006 to November 2008. Mr. Marks joined HCA Healthcare in 1996.

Michael R. McAlevey was appointed Senior Vice President and Chief Legal Officer in January 2022. Prior to joining HCA, Mr. McAlevey served in senior legal and executive roles at General Electric, most recently as Vice President, General Counsel and Business Development Leader for GE Healthcare since 2018. Prior to that, he served as General Counsel and Business Development Leader for GE Aviation from 2011 to 2018 and Chief Corporate, Securities and Finance Counsel for GE from 2003 to 2011. Before joining GE, Mr. McAlevey served as Deputy Director of the United States Securities and Exchange Commission's Division of Corporation Finance from 1998 to 2002.

Timothy M. McManus was appointed President — National Group effective January 1, 2023. Mr. McManus previously served as President of the Capital Division from August 2016 to December 2022. Mr. McManus joined HCA Healthcare in 2007 and served as CEO of Chippenham and Johnston-Willis Medical Center in Richmond, Virginia from June 2012 to July 2016, CEO of Reston Medical Center in Reston, Virginia from June 2010 to June 2012 and CEO of Garden Park Medical Center in Gulfport, Mississippi from September 2007 to May 2010.

Sammie S. Mosier was appointed Senior Vice President and Chief Nurse Executive effective December 1, 2021. Dr. Mosier joined HCA in 1992 as a medical-surgical bedside nurse at Frankfort Regional Medical Center and has held progressive leadership roles, including as Vice President and Assistant Chief Nursing Executive — Clinical Services Group from 2019 to 2021.

P. Martin Paslick was appointed Senior Vice President and Chief Information Officer in June 2012. Prior to that time, he served as Vice President and Chief Operating Officer of Information Technology & Services from March 2010 to May 2012 and Vice President — Information Technology & Services Field Operations from September 2006 to February 2010. From January 1998 to September 2006, he served in various Vice President roles in the Company's Information Technology & Services department. Mr. Paslick joined the Company in 1985.

Deborah M. Reiner was appointed Senior Vice President — Marketing and Communications in October 2017. Prior to that time, she served as Vice President of Marketing and Customer Relationship Management from August 2017 to October 2017 and Vice President of Customer Relationship Management from January 2012 to August 2017. Ms. Reiner joined the Company in 2000 and served in various roles with the Company's Mountain Division from 2000 to 2012.

William B. Rutherford has served as Executive Vice President and Chief Financial Officer since January 2014. Mr. Rutherford previously served as Chief Operating Officer of the Company's Clinical and Physician Services Group from January 2011 to January 2014 and Chief Financial Officer of the Company's Outpatient Services Group from November 2008 to January 2011. Prior to that time, Mr. Rutherford was employed by Summit Consulting Group of Tennessee from July 2007 to November 2008 and was Chief Operating Officer of Psychiatric Solutions, Inc. from March 2006 to June 2007. Mr. Rutherford also previously served in various positions with the Company from 1986 to 2005, including Chief Financial Officer of what was then the Company's Eastern Group, Director of Internal Audit and Director of Operations Support.

Joseph A. Sowell, III was appointed as Senior Vice President and Chief Development Officer in December 2009. From 1987 to 1996 and again from 1999 to 2009, Mr. Sowell was a partner at the law firm of Waller Lansden Dortch & Davis where he specialized in the areas of health care law, mergers and acquisitions, joint ventures, private equity

financing, tax law and general corporate law. He also co-managed the firm's corporate and commercial transactions practice. From 1996 to 1999, Mr. Sowell served as the head of development, and later as the Chief Operating Officer of Arcon Healthcare.

Kathryn A. Torres was appointed Senior Vice President — Payer Contracting and Alignment (formerly Senior Vice President — Employer and Payer Engagement) in July 2016. Ms. Torres joined HCA in 1993 and served in various capacities, including as Vice President of Employer and Payer Engagement and Vice President — Strategy.

Kathleen M. Whalen was appointed Senior Vice President and Chief Ethics and Compliance Officer effective January 1, 2019. Prior to that time, Ms. Whalen served as Vice President — Ethics and Compliance from August 2013 through December 2018 and Assistant Vice President — Ethics and Compliance Program Development from March 2000 through July 2013. Prior to joining HCA in January 1998, Ms. Whalen served as Associate Counsel to President Clinton with responsibility for the White House's ethics program. She began her government service in the ethics division of the General Counsel's Office at the U.S. Commerce Department. Prior to that, she practiced labor and employment law in Dayton, Ohio.

Christopher F. Wyatt was appointed Senior Vice President and Controller in April 2016. Prior to that time, Mr. Wyatt served the Company as Vice President and Chief Financial Officer — IT&S from January 2013 to April 2016 and Chief Financial Officer — Clinical Services Group from October 2010 until January 2013. From 2000 to 2010, Mr. Wyatt served in various capacities with Ernst & Young LLP.

Item 1A. Risk Factors

If any of the events discussed in the following risk factors were to occur, our business, financial position, results of operations, cash flows or prospects could be materially, adversely affected. Additional risks and uncertainties not presently known to us or that we currently deem immaterial may also affect us. COVID-19 amplifies and exacerbates many of the risks we face in our business operations, including those discussed below. Our business is subject to the following material risks and uncertainties.

Risks related to COVID-19 and other potential pandemics:

COVID-19 has affected, and may continue to affect, our operations. Further, COVID-19 could negatively impact our business, financial condition, and cash flows, particularly if it causes public health conditions and/or economic conditions to deteriorate.

As a front-line provider of health care services, we have been and continue to be affected by the health and economic effects of COVID-19. Although vaccines and booster shots for the virus causing COVID-19 are widely available in the United States, COVID-19 has continued to result in a significant number of hospitalizations. COVID-19 continues to evolve, including as a result of mutations of the virus. Due to the concentration of our hospitals in Florida and Texas, we may be particularly sensitive to increases in COVID-19 cases in those states, where COVID-19 could have a disproportionate effect on our business. The extent to which COVID-19 will continue to impact our business, results of operations, financial condition and liquidity will depend on future developments that are uncertain and cannot be accurately predicted. We are unable to predict the severity or duration of impacts related to COVID-19, including direct or indirect impacts on macroeconomic conditions.

We continue to work with federal, state and local health authorities to respond to COVID-19 cases in the markets we serve and continue to take and support measures to try to limit the spread of the virus and to mitigate the burden on the health care system. We expect to continue to incur additional costs, which may be significant, as a result of operational changes in response to COVID-19. Further, our response to COVID-19 has required and may continue to require a substantial investment of management's time and resources across our enterprise, which may affect our ability to properly prioritize and successfully execute on the Company's strategic initiatives.

We have implemented considerable safety measures within our hospitals and other facilities in response to COVID-19. Nonetheless, treatment of COVID-19 patients has associated risks, which may include the manner in which patients and our physicians and clinical staff perceive and respond to such risks. These risks may result in reduced operating capacity, impaired employee morale and increased exposure to workforce disruptions. Furthermore, we have experienced and may continue to experience supply chain disruptions, including delays and price increases in equipment, pharmaceuticals and medical supplies and supply shortages. Continued constraints on staffing and equipment, laboratory resources and pharmaceutical and medical supplies shortages may impact our ability to schedule, admit and treat patients. In addition, we may be subject to claims from patients, employees and others exposed to COVID-19 at our facilities. Such actions may involve large demands, as well as substantial defense costs. Our insurance, a portion of which is provided through our insurance subsidiaries, may not cover all claims against us.

Our operations and financial performance have been, and may continue to be, affected by actions taken by governmental authorities in response to COVID-19. Some of these measures, such as restrictions on elective procedures, reduced, and may in the future reduce, the volume of procedures performed at our facilities, as well as the volume of emergency room and physician office visits unrelated to COVID-19. Moreover, we believe that some individuals have elected to postpone medical care for an undetermined period of time as a result of COVID-19, impacting patient volumes in comparison to pre-pandemic levels. While patient volumes began rebounding in the second quarter of 2021 as the effects of COVID-19 moderated and pandemic-related restrictions and policies were eased, we experienced a resurgence in COVID-19 cases in the latter half of 2021 and early 2022, further impacting the return to pre-pandemic levels. We cannot provide assurances as to the continued recovery and stability of pre-pandemic patient volumes or the ultimate impact on demand. Further, our patient volumes may be adversely impacted by the expanded use of telehealth services from other providers as a result of reduced regulatory barriers on the use and reimbursement of telehealth services and individuals becoming more comfortable with receiving remote care. The Company may not be able to timely innovate its strategies and technologies to meet changing consumer demands as a result of COVID-19. It is possible that COVID-19 could continue to impact patient behavior in future periods.

Beginning in 2020 and continuing through 2022, we experienced increased patient acuity as a result of COVID-19 cases at our hospitals, which led to increased reimbursements. However, the impacts of COVID-19, including patient acuity levels, in future periods may vary, and could exert unpredictable and potentially negative effects on clinical performance metrics that impact reimbursement levels and could adversely affect our results of operations.

Developments related to COVID-19, including broad economic factors related to COVID-19 and public health conditions, may have a material, adverse effect on our business, results of operations, financial position and cash flows. The ongoing impact of COVID-19 on our business will depend on, among other factors, the duration and severity of any severe or widespread outbreaks of COVID-19; the impact of COVID-19 on economic conditions; the volume of canceled or rescheduled procedures at our facilities; the volume of COVID-19 patients cared for across our health systems; the availability, acceptance of, and need for effective vaccines and medical treatments; the spread of potentially more contagious and/or virulent forms of the virus; and the impact of government actions on the health care industry and broader economy. COVID-19 continues to evolve, and we may not be able to predict or effectively respond to future developments.

The foregoing and other continued disruptions to our business as a result of COVID-19 could heighten the risks in certain of the other risk factors described in this annual report on Form 10-K, any of which could have a material, adverse effect on our results of operations and financial position.

We are unable to predict the ultimate impact of the CARES Act and other stimulus and relief legislation or the effect that such legislation and other governmental responses intended to assist providers in responding to COVID-19 may have on our business, financial condition, results of operations or cash flows.

In response to COVID-19, federal and state governments have passed legislation, promulgated regulations and taken other administrative actions intended to assist health care providers in providing care to COVID-19 and other patients and to provide financial relief to health care providers. Together, the CARES Act, the Paycheck Protection Program and Health Care Enhancement ("PPPHCE") Act, the Consolidated Appropriations Act, 2021 ("CAA") and the ARPA authorized over $186 billion in funding to be distributed to hospitals and other health care providers through the Public Health and Social Services Emergency Fund ("PHSSEF"), also known as the Provider Relief Fund, and expanded the Medicare Accelerated and Advance Payment Program. Funds from the Provider Relief Fund are intended to reimburse eligible providers and suppliers for health care-related expenses or lost revenues attributable to COVID-19 and are not required to be repaid, provided that recipients attest to and comply with certain terms and conditions. In addition, a portion of the available funding was distributed to reimburse health care providers that submitted claims requests for COVID-19-related treatment, testing and vaccine administration for uninsured patients at Medicare rates. Recipients of these claims reimbursements must attest to and comply with certain terms and conditions, including confirming that patients are uninsured, limitations on balance billings and not using funds to reimburse expenses or losses that other sources are obligated to reimburse. We received general and targeted distributions from the Provider Relief Fund in 2020, but during the fourth quarter of 2020, we returned or repaid early approximately $6.1 billion of our share of the Provider Relief Fund distributions and all Medicare accelerated payments.

The CARES Act and related legislation have also made other forms of financial assistance available to health care providers. For example, CMS has increased payment under the hospital inpatient PPS by 20% for discharges of individuals diagnosed with COVID-19 and provides an add-on payment for eligible inpatient cases that use certain new products to treat COVID-19.

The CARES Act and related legislation temporarily suspended the Medicare sequestration payment adjustment, which would have otherwise reduced payments to Medicare providers by 2% as required by the BCA. The sequestration

adjustment was phased back in with a 1% reduction beginning April 1, 2022, and returned to 2% on July 1, 2022. The BCA sequestration has been extended through the first six months of 2032. The APRA, in addition to providing funding for health care providers, increased the federal budget deficit in a manner that triggers an additional statutorily mandated sequestration under the PAYGO Act. As a result, an additional Medicare payment reduction of up to 4% was required to take effect in January 2022. However, Congress has delayed implementation of this payment reduction until 2025.

Beyond financial assistance, federal and state governments have enacted legislation, established regulations and issued waivers intended to expand access to and payment for telehealth services, increase access to medical supplies and equipment, prioritize review of drug applications to help with shortages of emergency drugs, and ease various legal and regulatory burdens on health care providers. HHS and CMS have announced other flexibilities for health care providers in response to COVID-19, such as temporary modifications of certain value-based care programs, implementing special scoring and payment policies intended to mitigate negative effects of the PHE on providers participating in some of these programs. It is unclear how these changes will affect our financial condition.

COVID-19 continues to evolve, and there is uncertainty regarding the ultimate impact to our business of governmental efforts to assist health care providers responding to and otherwise affected by COVID-19. As the United States has experienced a moderation of infection and related hospitalization rates in comparison to earlier periods, federal and state governments have shifted to reducing or terminating certain temporary measures that were implemented earlier in the COVID-19 PHE. Many of the measures allowing for flexibility in delivery of care and various financial supports for health care providers are available only until funds expire or for the duration of the PHE. The current PHE declared by HHS expires May 11, 2023. The presidential administration has indicated that the public health emergency will not be extended. Termination of the PHE may impact our operations and financial results. Further, there can be no assurance that the terms and conditions of relief programs will not change or be interpreted in ways that affect our ability to comply with such terms and conditions, including in cases where our partners have retained such assistance. We continue to assess the potential impact of COVID-19 and government responses to COVID-19 on our business, results of operations, financial condition and cash flows.

The emergence and effects related to a potential future pandemic, epidemic or outbreak of an infectious disease could adversely affect our operations.

If a pandemic, epidemic, outbreak of an infectious disease or other public health crisis were to occur in an area in which we operate, our operations could be adversely affected. Such a crisis could diminish the public trust in health care facilities, especially hospitals that fail to accurately or timely diagnose, or are treating (or have treated) patients affected by infectious diseases. If any of our facilities were involved, or perceived as being involved, in treating patients from such an infectious disease, patients might cancel elective procedures or fail to seek needed care at our facilities, and our reputation may be negatively affected. Patient volumes may decline or volumes of uninsured and underinsured patients may increase, depending on the economic circumstances surrounding the pandemic, epidemic or outbreak. Further, a pandemic, epidemic or outbreak might adversely affect our operations by causing a temporary shutdown or diversion of patients, disrupting or delaying production and delivery of materials and products in the supply chain or causing staffing shortages in our facilities. We have disaster plans in place and operate pursuant to infectious disease protocols, but the potential emergence of a pandemic, epidemic or outbreak, as well as the public's and the government's response to the pandemic, epidemic or outbreak, is difficult to predict and could adversely affect our operations.

Risks related to our indebtedness:

Our substantial leverage could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of our variable rate debt and prevent us from meeting our obligations.

We are highly leveraged. As of December 31, 2022, our total indebtedness was $38.084 billion. As of December 31, 2022, we had availability of $1.935 billion under our senior secured cash flow credit facility and $1.600 billion under our senior secured asset-based revolving credit facility, after giving effect to letters of credit and borrowing base limitations. Our high degree of leverage could have important consequences, some of which may be exacerbated by the impact of COVID-19, including:

- increasing our vulnerability to downturns or adverse changes in general economic, industry or competitive conditions and adverse changes in government regulations;
- requiring a substantial portion of cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund our operations, capital expenditures and future business opportunities;

- exposing us to the risk of increased interest rates on our existing borrowings that are at variable rates of interest or refinancing our debt in a rising rate environment;
- limiting our ability to make strategic acquisitions or causing us to make nonstrategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, share repurchases, dividends, product or service line development, debt service requirements, acquisitions and general corporate or other purposes; and
- limiting our ability to adjust to changing market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged.

We and our subsidiaries have the ability to incur additional indebtedness in the future, subject to the restrictions contained in our senior secured credit facilities and the indentures governing our outstanding notes. If new indebtedness is added to our current debt levels, interest rates and the related risks that we now face could intensify.

We may not be able to generate sufficient cash to service all of our indebtedness and may not be able to refinance our indebtedness on favorable terms. If we are unable to do so, we may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which are subject to prevailing economic and competitive conditions, including the impact of COVID-19, and to certain financial, business and other factors beyond our control. We cannot assure you we will maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness.

In addition, we conduct our operations through our subsidiaries. Accordingly, repayment of our indebtedness is dependent on the generation of cash flows by our subsidiaries and their ability to make such cash available to us by dividend, debt repayment or otherwise. Our subsidiaries may not be able to, or may not be permitted to, make distributions to enable us to make payments in respect of our indebtedness. Each subsidiary is a distinct legal entity, and, under certain circumstances, legal and contractual restrictions may limit our ability to obtain cash from our subsidiaries.

We may find it necessary or prudent to refinance our outstanding indebtedness, the terms of which may not be favorable to us. Our ability to refinance our indebtedness on favorable terms, or at all, is directly affected by the then current global economic and financial conditions which affect the availability of debt financing and the rates at which such financing is available. In addition, our ability to incur secured indebtedness depends in part on the value of our assets, which depends, in turn, on the strength of our cash flows and results of operations, and on economic and market conditions and other factors.

If our cash flows and capital resources are insufficient to fund our debt service obligations or we are unable to refinance our indebtedness, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital or restructure our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. If our operating results and available cash are insufficient to meet our debt service obligations, we could face substantial liquidity problems and might be required to dispose of material assets or operations to meet our debt service and other obligations. We may not be able to consummate those dispositions, or the proceeds from the dispositions may not be adequate to meet any debt service obligations then due.

Our debt agreements contain restrictions that limit our flexibility in operating our business.

Our senior secured credit facilities and, to a lesser extent, the indentures governing our outstanding notes contain various covenants that limit our ability to engage in specified types of transactions. These covenants limit our and certain of our subsidiaries' ability to, among other things:

- incur additional indebtedness or issue certain preferred shares;
- pay dividends on, repurchase or make distributions in respect of our capital stock or make other restricted payments;
- make certain investments;
- sell or transfer assets;
- create liens;
- consolidate, merge, sell or otherwise dispose of all or substantially all of our assets; and
- enter into certain transactions with our affiliates.

Under our asset-based revolving credit facility, borrowing availability is subject to a borrowing base of 85% of eligible accounts receivable less customary reserves, with any reduction in the borrowing base commensurately reducing our ability to access this facility as a source of liquidity. In addition, under the asset-based revolving credit facility, when (and for as long as) the combined availability under our asset-based revolving credit facility and the revolving facility under our senior secured cash flow credit facility is less than a specified amount for a certain period of time or, if a payment or bankruptcy event of default has occurred and is continuing, funds deposited into any of our depository accounts will be transferred on a daily basis into a blocked account with the administrative agent and applied to prepay loans under the asset-based revolving credit facility and to collateralize letters of credit issued thereunder.

Under our senior secured credit facilities, we are required to satisfy and maintain specified financial ratios. Our ability to meet those financial ratios may be affected by events beyond our control, and there can be no assurance we will continue to meet those ratios. A breach of any of these covenants could result in a default under both the cash flow credit facility and the asset-based revolving credit facility. Upon the occurrence of an event of default under these senior secured credit facilities, the lenders thereunder could elect to declare all amounts outstanding under the senior secured credit facilities to be immediately due and payable and terminate all commitments to extend further credit, which would also result in an event of default under a significant portion of our other outstanding indebtedness. If we were unable to repay those amounts, the lenders under the senior secured credit facilities could proceed against the collateral granted to them to secure such indebtedness. We have pledged a significant portion of our assets under our senior secured credit facilities. If any of the lenders under the senior secured credit facilities accelerate the repayment of borrowings, there can be no assurance there will be sufficient assets to repay the senior secured credit facilities and our other indebtedness.

Risks related to human capital:

Our results of operations may be adversely affected by competition for staffing, the shortage of experienced nurses and other health care professionals and labor union activity.

Our operations are dependent on the efforts, abilities and experience of our management and medical support personnel, such as nurses, pharmacists and lab technicians, as well as our physicians. We compete with other health care providers in recruiting and retaining qualified management and personnel responsible for the daily operations of each of our hospitals and other facilities, including nurses and other nonphysician health care professionals. In some markets, the availability of nurses and other medical support personnel has been a significant operating issue to health care providers, including at certain of our facilities. The impact of labor shortages across the health care industry may result in other health care facilities, such as nursing homes, limiting admissions, which may constrain our ability to discharge patients to such facilities and further exacerbate the demand on our resources, supplies and staffing.

COVID-19 has exacerbated workforce competition, shortages and capacity restraints, including due to the impact of vaccine mandates on our workforce, and may continue to exacerbate workforce competition, shortages and capacity constraints beyond the duration of COVID-19. We may be required to continue to enhance wages and benefits to recruit and retain nurses and other medical support personnel and to hire more expensive temporary or contract personnel. As a result of shortages, competition and inflationary pressures, our labor costs could continue to increase and/or our capacity could be negatively impacted. We also depend on the available labor pool of employees in each of the markets in which we operate to fill other necessary positions. If there is continued competition for these employees or additional union organizing activity or a significant portion of our employee base unionizes, it is possible our labor costs could increase. When negotiating collective bargaining agreements with unions, whether such agreements are renewals or first contracts, there is the possibility that strikes could occur during the negotiation process, and our continued operation during any strikes could increase our labor costs. The unavailability of staff, or the inability of the Company to control labor costs, could have a material, adverse effect on our capacity, growth prospects and results of operations.

In addition, federal and state laws and regulations may increase our costs of maintaining qualified nurses and other medical support personnel. We operate in several states that have adopted mandatory nurse-staffing ratios, mandate staffing committees to develop staffing plans, or require public reporting of nurse staffing levels. If these states reduce, or if additional states in which we operate adopt, mandatory nurse-staffing ratios or related measures, such changes could significantly affect labor costs and have an adverse impact on revenues if we are required to limit admissions in order to meet the required ratios. If our labor costs continue to increase, we may not be able to offset these increased costs as a significant percentage of our revenues consists of fixed, prospective payments.

We may be unable to attract, hire and retain a highly qualified and diverse workforce, including key management.

The talents and efforts of our employees, particularly our key management, are vital to our success. Our management team has significant industry experience and would be difficult to replace. In addition, institutional knowledge may be lost in any potential managerial transition. We may be unable to retain them or to attract other highly qualified employees, particularly if we do not offer employment terms that are competitive with the rest of the labor market. Our management is focused on mitigating the impact of COVID-19, which has required and will continue to

require a substantial investment of time and resources across our enterprise. Failure to attract, hire, develop, motivate, and retain highly qualified and diverse employee talent, or failure to develop and implement an adequate succession plan for the management team, could disrupt our operations and adversely affect our business and our future success.

Our performance depends on our ability to recruit and retain quality physicians.

The success of our hospitals depends in part on the number and quality of the physicians on the medical staffs of our hospitals, the admitting and utilization practices of those physicians, maintaining good relations with those physicians and controlling costs related to the employment of physicians. Although we employ some physicians, physicians are often not employees of the hospitals at which they practice, and, in many of the markets we serve, physicians may have admitting privileges at other hospitals in addition to our hospitals. We continue to face increasing competition to recruit and retain quality physicians, as well as increasing cost to contract with hospital-based physicians. Such physicians may terminate their affiliation with our hospitals at any time. We anticipate facing increased challenges in this area as the physician population reaches retirement age, especially if there is a shortage of physicians willing and able to provide comparable services. If we are unable to recruit and retain quality physicians to affiliate with our hospitals or adequately contract with hospital-based physicians, our admissions may decrease, our operating performance may decline, and our capacity and growth prospects may be materially adversely affected. If we are unable to provide adequate support personnel or technologically advanced equipment and hospital facilities that meet the needs of those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline.

Risks related to technology, data privacy and cybersecurity:

A cybersecurity incident or other form of data breach could result in the compromise of our facilities, confidential data or critical data systems. A cybersecurity incident or other form of data breach could also give rise to potential harm to patients; remediation and other expenses; and exposure to liability under HIPAA, consumer protection laws, common law theories or other laws. Such incidents could subject us to litigation and foreign, federal and state governmental inquiries, damage our reputation, and otherwise be disruptive to our business.

We, directly and through our vendors and other third parties, collect and store on our networks and devices and third-party technology platforms sensitive information, including intellectual property, proprietary business information and personally identifiable information of our patients and employees. We have made significant investments in technology to adopt and meaningfully use EHR and in the use of medical devices that store sensitive data and are integral to the provision of patient care and to protect our systems, software, equipment, devices and data from cybersecurity risks. In addition, medical devices manufactured by third parties that are used within our facilities are increasingly connected to the internet, hospital networks and other medical devices. The secure maintenance of this information and technology is critical to our business operations. We have implemented multiple layers of security measures to protect the confidentiality, integrity and availability of this data and the systems and devices that store and transmit such data. We embed security measures into software and system development processes and utilize current security technologies, and our defenses are monitored and routinely tested internally and by external parties. We vet the security and integrity of third-party technology platforms hosting infrastructure, applications, and data supporting our operations, and set contractual terms holding them to our security standards.

Despite these efforts, even the most advanced internal control environment is vulnerable to compromise. Threats from malicious persons and groups, new vulnerabilities and advanced new attacks against information systems and devices against us or our vendors and other third parties create risk of cybersecurity incidents, including ransomware, malware and phishing incidents. We have seen, and believe we will continue to see, widely spread vulnerabilities that could affect our or other parties' systems. Mitigation and remediation recommendations continue to evolve, and addressing this and other critical vulnerabilities is a priority for us. The volume and intensity of cyberattacks on hospitals, health systems and other health care entities continue to increase. We are regularly the target of attempted cybersecurity and other threats that could have a security impact, including those by third parties to access, misappropriate or manipulate our information or disrupt our operations, and we expect to continue to experience an increase in cybersecurity threats in the future. While we are periodically exposed to such threats and expect them to continue, we have not experienced any material losses or other material consequences relating to technology failure, cyberattacks or other information or security incidents, whether directed at us or third parties. Internal access management failures could result in the compromise or unauthorized exposure of confidential data. Moreover, hardware, software or applications we use may have inherent vulnerabilities or defects of design, manufacture or operations or could be inadvertently or intentionally implemented or used in a manner that could compromise information security. There can be no assurance that we or our vendors and other third parties will not be subject to cybersecurity threats and incidents that bypass our or their security measures, impact the integrity, availability or privacy of personal health information or other data subject to privacy laws or disrupt our or their information systems, devices or business, including our ability to provide various health care services. In such an

event, we may incur substantial costs, including but not limited to, costs associated with remediating the effects of the cybersecurity incident, costs for security measures to guard against similar future incidents and costs to recover data. Further, consumer confidence in the integrity and security of personal information and critical operations data in the health care industry generally could be shaken to the extent there are successful cyberattacks at other health care services companies, which could have a material, adverse effect on our business, financial position or results of operations.

As a result, cybersecurity, privacy, physical security and the continued development and enhancement of our controls, processes and practices designed to protect our facilities, information systems and data from attack, damage or unauthorized access remain a priority for us. Our Audit and Compliance Committee includes the topic of cybersecurity risk and information security as one of its standing agenda items, and is frequently updated on management's ongoing actions to monitor, identify, assess and mitigate significant cybersecurity matters. Committee meetings regularly include a report from our Chief Security Officer to provide an update on (i) activities within our internal cybersecurity defense center to monitor and respond to both internal and third-party cyber events, (ii) ongoing threats that are being monitored and (iii) the current threat level assessment for the Company. As cyber threats continue to evolve, along with their increased volume and sophistication, we may be required to expend significant additional resources to continue to modify or enhance our protective measures or to investigate and remediate any cybersecurity vulnerabilities or incidents. Although to date no cyberattack or other information or security breach, whether experienced by us or a third party, has resulted in material losses or other material consequences to us, there can be no assurance that our controls and procedures in place to monitor and mitigate the risks of cyber threats, including the remediation of critical information security and software vulnerabilities, will be sufficient and/or timely and that we will not suffer material losses or consequences in the future. Additionally, while we have in place insurance coverage designed to address certain aspects of cyber risks, such insurance coverage may be insufficient to cover all losses or all types of claims that may arise. The occurrence of any of these events could result in (i) harm to patients; (ii) business interruptions and delays; (iii) the loss, misappropriation, corruption or unauthorized access of data; (iv) litigation and potential liability under privacy, security, breach notification and consumer protection laws, common law theories or other applicable laws; (v) reputational damage; and (vi) foreign, federal and state governmental inquiries, any of which could have a material, adverse effect on our financial position and results of operations and harm our business reputation.

Our operations could be impaired by a failure of our information systems.

The performance of our information systems is critical to our business operations. In addition to our shared services initiatives, our information systems are essential to a number of critical areas of our operations, including:

- accounting and financial reporting;
- billing and collecting accounts;
- coding and compliance;
- admissions, provision of care and care coordination;
- clinical systems and medical devices;
- medical records and document storage;
- inventory management;
- negotiating, pricing and administering managed care contracts and supply contracts; and
- monitoring quality of care and collecting data on quality measures necessary for full Medicare payment updates.

Information systems may be vulnerable to damage from a variety of sources, including telecommunications or network failures, human acts such as inadvertent or intentional misuse by employees and cyberattacks, including ransomware and data theft, and natural disasters. Moreover, we rely on various third-party technology platforms, which are increasingly important to our business and continue to grow in complexity and scope. Failure to adequately manage implementations of new technology, updates or enhancements of such platforms or interfaces between platforms could place us at a competitive disadvantage, disrupt our operations, and have a material, adverse impact on our business and results of operations.

We have taken precautionary measures to prevent unanticipated problems that could affect our information systems. Nevertheless, we or our vendors and other third parties that we rely upon may experience system failures and disruptions. The occurrence of any system failure could result in interruptions, delays, the loss or corruption of data and cessations or interruptions in the availability of systems, any of which could have a material, adverse effect on our financial position and results of operations and harm our business reputation.

Health care technology initiatives, particularly those related to sharing patient data and interoperability, may adversely affect our operations.

The federal government is working to promote the adoption of health information technology and the promotion of nationwide health information exchange to improve health care. For example, HHS incentivizes the adoption and meaningful use of certified EHR technology through its Promoting Interoperability Programs. Eligible hospitals and eligible professionals, including our hospitals and employed professionals, are subject to reduced payments from Medicare if they fail to demonstrate meaningful use of certified EHR technology. As these technologies have become widespread, the focus has shifted to increasing patient access to health care data and interoperability. The 21st Century Cures Act and its implementing regulations promote information sharing by prohibiting information blocking by health care providers and certain other entities. Information blocking is defined as engaging in activities likely to interfere with the access, exchange or use of electronic health information, except as required by law or specified by HHS as a reasonable and necessary activity. Current and future initiatives related to health care technology, data sharing and interoperability may require changes to our operations, impose new and complex compliance obligations and require investments in infrastructure. We may be subject to financial penalties or other disincentives or experience reputational damage for failure to comply. It is difficult to predict how these initiatives will affect our relationships with providers and vendors, participation in health care information exchanges or networks, the exchange of patient data and patient engagement.

We may not be reimbursed for the cost of expensive, new technology.

As health care technology continues to advance, the price of purchasing such new technology has significantly increased for providers. Some payers have not adapted their payment systems to adequately cover the cost of these technologies for providers and patients. If payers do not adequately reimburse us for these new technologies, we may be unable to acquire such technologies or we may nevertheless determine to acquire or utilize these technologies in order to treat our patients. In either case, our results of operations and financial position could be adversely affected.

Risks related to governmental regulation and other legal matters:

Our business and results of operations may be adversely affected by health care reform efforts. We are unable to predict whether, what, and when additional health reform measures will be adopted or implemented, and the effects and ultimate impact of any such measures are uncertain and may adversely affect our business and results of operations.

In recent years, the U.S. health care industry has undergone significant changes at the federal and state levels, many of which have been aimed at reducing costs and government spending and increasing access to health insurance. The most prominent of these legislative reform efforts is the Affordable Care Act, which affects how health care services are covered, delivered and reimbursed, and expanded health insurance coverage through a combination of public program expansion and private sector health insurance reforms. The Affordable Care Act has been, and continues to be, subject to legislative and regulatory changes and court challenges. For example, effective January 1, 2019, the penalty associated with the individual mandate to maintain health insurance was effectively eliminated. However, some states have imposed individual health insurance mandates, and other states have explored or offer public health insurance options. To increase access to health insurance during COVID-19, the ARPA enhanced subsidies for individuals eligible to purchase coverage through Affordable Care Act marketplaces as part of the APRA. The Inflation Reduction Act, enacted in August 2022, extends these enhanced subsidies through 2025. These changes and initiatives may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased.

There is uncertainty regarding whether, when and how the Affordable Care Act may be further changed, and how the law will be interpreted and implemented. Changes by Congress or government agencies could eliminate or alter provisions beneficial to us, while leaving in place provisions reducing our reimbursement or otherwise negatively impacting our business.

There is also uncertainty regarding whether, when, and what other health reform initiatives will be adopted and the impact of such efforts on providers and other health care industry participants. Some members of Congress have proposed measures that would expand government-sponsored coverage, including proposals to expand coverage of federally-funded insurance programs as an alternative to private insurance or establish a single-payer system (such reforms often referred to as “Medicare for All”). CMS administrators may grant states additional flexibility in the administration of state Medicaid programs and make changes to Medicaid payment models. Other recent health reform initiatives and proposals at the federal and state levels include those focused on price transparency and out-of-network charges, which may impact prices, our relationships with patients, payers or ancillary providers (such as anesthesiologists, radiologists and pathologists) and our competitive position. For example, among other consumer protections, the No Surprises Act imposes various requirements on providers and health plans intended to prevent “surprise” medical bills. It also establishes an IDR process for providers and payers to handle payment disputes that cannot be resolved through direct negotiations. Trends toward transparency and value-based pricing may impact our competitive position and patient volumes. For example, the

CMS Care Compare website makes publicly available certain data on performance of hospitals and other Medicare-certified providers on quality measures and patient satisfaction, and our patient volumes could decline if any of our facilities achieve poor results. Further, Medicare reimbursement for hospitals is adjusted based on quality and efficiency measures. Other industry participants, such as private payers and large employer groups and their affiliates, may also introduce financial or delivery system reforms. We are unable to predict the nature and success of such initiatives. Health care reform initiatives, including changes to the Affordable Care Act, may have an adverse effect on our business, results of operations, cash flow, capital resources and liquidity.

Changes in government health care programs may adversely affect our revenues.

A significant portion of our patient volume is derived from government health care programs, principally Medicare and Medicaid. Specifically, we derived 43.6% of our revenues from the Medicare and Medicaid programs in 2022. Changes in government health care programs, including as a result of health reform efforts, may reduce the reimbursement we receive and could adversely affect our business and results of operations. In addition, in some cases, private third-party payers rely on all or portions of Medicare payment systems to determine payment rates. Changes to government health care programs that reduce payments under these programs may negatively impact payments from private third-party payers.

In recent years, legislative and regulatory changes have resulted in limitations on and, in some cases, reductions in levels of payments to health care providers for certain services under the Medicare program. For example, Congress established automatic spending reductions under the BCA, resulting in a 2% reduction in Medicare payments beginning in 2013. The CARES Act and related legislation temporarily suspended these reductions through March 31, 2022, and reduced the sequestration adjustment from 2% to 1% from April 1 through June 30, 2022. The full 2% reduction resumed on July 1, 2022. The BCA sequestration has been extended through the first six months of 2032. In addition, as a result of the ARPA, an additional Medicare payment reduction of up to 4% was required to take effect in January 2022; however, Congress has delayed implementation of this reduction until 2025. These reductions are in addition to reductions mandated by the Affordable Care Act and other laws. It is difficult to predict whether, when or what other deficit reduction initiatives may be proposed by Congress, but future legislation may include additional Medicare spending reductions.

From time to time, CMS revises the reimbursement systems used to reimburse health care providers, including changes to the inpatient hospital MS-DRG system and other payment systems, which may result in reduced Medicare payments. For example, under a site neutrality policy, clinic visit services provided by off-campus provider-based departments that were formerly paid under the outpatient PPS are now paid under the Physician Fee Schedule. Further, due to changes to the 340B Drug Pricing Program in prior years and resulting litigation, hospitals that do not participate in the 340B program (including our hospitals) will receive decreased reimbursement going forward for outpatient drugs and services, and may be required to repay previously received payments. As another example, CMS has previously implemented and proposed changes to DSH payment formulas, some of which are the subject of court challenges, and has indicated that the agency will return to DSH payment formulas in future rulemaking. Future changes to these payment policies may adversely impact our results of operations, and any potential legal challenges to changes may take years to resolve. Additionally, as required under the IMPACT Act, HHS and the Medicare Payment Advisory Commission are working toward a unified post-acute care payment model that would include home health agencies and IRFs. A unified post-acute care payment system would pay post-acute care providers under a single framework according to a patient's characteristics, rather than based on the post-acute care setting where the patient receives treatment. In a July 2022 report, CMS acknowledged that universal implementation of such a system would require congressional approval. Under the IMPACT Act, the Medicare Payment Advisory Commission must submit a report to Congress by June 2023. Payment policies for different types of providers and for various items and services continue to evolve. Congress and/or CMS may implement further changes to reimbursement for items or services that result in payment reductions for other items or services or that otherwise affect our business and operations.

Because most states must operate with balanced budgets and the Medicaid program is often a state's largest program, some states have enacted or may consider enacting legislation designed to reduce their Medicaid expenditures. Further, many states have also adopted, or are considering, legislation designed to reduce coverage, enroll Medicaid recipients in managed care programs, and/or impose additional taxes on hospitals to help finance or expand the states' Medicaid systems. Periods of economic weakness may increase the budgetary pressures on many states, and these budgetary pressures may result in decreased spending, or decreased spending growth, for Medicaid programs and the Children's Health Insurance Program in many states. Some states that provide Medicaid supplemental payments are reviewing these programs or have filed waiver requests with CMS to replace these programs, and CMS has performed and continues to perform compliance reviews of some states' programs and is considering changes to the requirements for such programs, which could result in Medicaid supplemental payments being reduced or eliminated. Further, legislation and administrative actions at the federal level may impact the funding for, or structure of, the Medicaid program, and may shape the administration of the Medicaid program at the state level. Federal Medicaid policies are subject to change, including as a result of changes in the presidential administration. For example, where states had

previously been permitted to condition Medicaid enrollment on work or other community engagement, the approvals of waivers permitting these conditions have been rescinded. However, a federal court is permitting Georgia to impose work and community engagement requirements under a Medicaid demonstration program that is expected to launch in mid-2023. The federal government is also reexamining block grant funding structures.

Current or future health care reform and deficit reduction efforts, changes in laws or regulations regarding government health care programs, other changes in the administration of government health care programs and changes by private third-party payers in response to health care reform and other changes to government health care programs could have a material, adverse effect on our financial position and results of operations.

If we fail to comply with extensive laws and government regulations, we could suffer penalties or be required to make significant changes to our operations.

The health care industry is required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things:

- billing and coding for services and properly handling overpayments;
- appropriateness and classification of level and setting of care provided, including proper classification of inpatient admissions, observation services and outpatient care;
- certifications of patient eligibility for home health and hospice services;
- relationships with physicians and other referral sources and referral recipients;
- necessity and adequacy of medical care;
- quality of medical equipment and services;
- qualifications of medical and support personnel;
- the confidentiality, maintenance, interoperability, exchange, data breach, identity theft and security of health-related and personal information and medical records;
- screening, stabilization and transfer of individuals who have emergency medical conditions;
- restrictions on the provision of medical care, including reproductive care;
- licensure, certification and enrollment with government programs;
- the distribution, maintenance and dispensing of pharmaceuticals and controlled substances;
- debt collection, limits or prohibitions on balance billing and billing for out of network services;
- communications with patients and consumers;
- preparing and filing of cost reports;
- operating policies and procedures;
- activities regarding competitors;
- addition of facilities and services; and
- environmental protection.

Among these laws are the federal Anti-kickback Statute, EKRA, the federal Stark Law, the FCA, the No Surprises Act and similar state laws. We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals, other health care facilities, laboratories and employed physicians or who are the recipients of referrals, and these laws govern those relationships. The OIG has enacted safe harbor regulations that outline practices deemed protected from prosecution under the Anti-kickback Statute. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, including joint ventures and financial relationships with physicians and other referral sources and persons and entities to which we refer patients, do not qualify for safe harbor protection. Failure to qualify for a safe harbor does not mean the arrangement necessarily violates the Anti-kickback Statute but may subject the arrangement to greater scrutiny. However, we cannot offer assurance that practices outside of a safe harbor will not be found to violate the Anti-kickback Statute. Allegations of violations of the Anti-kickback Statute

may be brought under the federal Civil Monetary Penalty Law, which requires a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute.

Our financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex and are subject to continuing legal and regulatory change. Thus, we cannot provide assurance that every relationship complies fully with the Stark Law. Unlike the Anti-kickback Statute, failure to meet an exception under the Stark Law results in a violation of the Stark Law, even if such violation is technical in nature.

Additionally, if we violate the Anti-kickback Statute or Stark Law, or if we improperly bill for our services, we may be found to violate the FCA, either under a suit brought by the government or by a private person under a *qui tam*, or "whistleblower," suit. See Item 1, "Business — Regulation and Other Factors."

We develop software programs utilizing machine learning/artificial intelligence for use within our network to improve care. In some cases, software can be considered a medical device under the federal Food, Drug, and Cosmetic Act ("FDCA"). Medical devices are subject to extensive regulation by the Food and Drug Administration ("FDA") under the FDCA. In September 2022, FDA issued non-binding final guidance that describes the types of clinical decision support software that FDA will regulate as a medical device, potentially including software programs that were not previously treated as medical devices. Application of the new guidance may result in our current and/or future software programs providing clinical decision support being subject to FDA regulation. If FDA determines that any of our software programs are medical devices under the FDCA, the distribution and/or use of those software programs may require premarket approval or clearance, and we may be required to cease distribution and/or use of such programs until we obtain any required premarket approval or clearance, which could adversely affect our operations. Failure to seek FDA approval or clearance or noncompliance with other applicable FDA requirements could adversely affect our business, financial condition or results of operations.

We also operate health care facilities in the United Kingdom and have operations and commercial relationships with companies in other foreign jurisdictions and, as a result, are subject to certain U.S. and foreign laws applicable to businesses generally, including anti-corruption and anti-bribery laws. The Foreign Corrupt Practices Act regulates U.S. companies in their dealings with foreign officials, prohibiting bribes and similar practices, and requires that they maintain records that fairly and accurately reflect transactions and appropriate internal accounting controls. In addition, the United Kingdom Bribery Act has wide jurisdiction over certain activities that affect the United Kingdom.

A variety of state, national, foreign and international laws and regulations apply to the collection, use, retention, protection, security, disclosure, transfer and other processing of personal data. For example, the CCPA, which affords consumers expanded privacy protections such as the right to know what personal information is collected and how it is used, went into effect on January 1, 2020, and was recently significantly amended by the CPRA. California residents also have the right to request that a business delete their personal information unless it is necessary for the business to maintain for certain purposes, to direct a business to correct errors in their personal information, and to restrict the use and disclosure of sensitive information. They have the right to know if their personal information is being sold or shared and the right to opt out of the sale or disclosure. Beginning in 2023, under the CPRA's amendments, as well as comprehensive privacy legislation passed in other states, including Colorado, Utah and Virginia, residents of those states will have additional rights with respect to their personal information, such as a right to opt out of certain processing activities for sensitive data and a right to a portable copy of their personal information. The CPRA creates a new regulator responsible for enforcement of the CPRA, and enforcement priorities of the regulatory bodies responsible for enforcing new state privacy laws have yet to be determined or may change in the future. These new state privacy laws provide for civil penalties for violations, and the CCPA and CPRA provide a private right of action for data breaches that may increase data breach litigation. Failure to comply with these and any other comprehensive privacy laws passed at the state or federal level may result in regulatory enforcement action and damage to our reputation. The potential effects of such legislation are far-reaching and may require us to modify our data processing practices and policies and to incur substantial costs and expenses to comply. Moreover, several privacy bills have been proposed both at the federal and state level that may result in additional legal requirements that impact our business. With the United Kingdom's departure from the European Union ("Brexit"), our United Kingdom operations are no longer subject to the European Union's General Data Protection Regulation ("GDPR") but are subject to the UK Data Protection Legislation, which has been amended in connection with Brexit to be functionally similar to the GDPR and which contains stricter privacy restrictions than laws and regulations in the United States and provides for significant fines in the event of violations. These administrative fines are based on a multi-factored approach. Moreover, rules for data transfers outside of the United Kingdom and European Economic Area have changed significantly with Brexit and a recent Court of European Justice decision, and are subject to further revision and updated regulator guidance, making necessary compliance measures challenging to ascertain and implement

with respect to our United Kingdom operations. We expect that there will continue to be new laws, regulations, regulatory guidance, and industry standards concerning privacy, data protection and information security proposed and enacted in various jurisdictions, which could impact our operations and cause us to incur substantial costs.

We send short message service, or SMS, text messages to patients. While we obtain consent from these individuals to send text messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosures we provide, form of consents we obtain or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the "TCPA"), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission, as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and subject us to penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us. Moreover, if wireless carriers or their trade associations, which issue guidelines for texting programs, determine that we have violated their guidelines, our ability to engage in texting programs may be curtailed or revoked, which could impact our operations and cause us to incur costs related to implementing a workaround solution.

We engage in consumer debt collection for HCA-affiliated hospitals and certain non-affiliated hospitals. We also engage in credit reporting for certain non-affiliated hospitals. The federal Fair Debt Collection Practices Act, the Fair Credit Reporting Act and the TCPA restrict the methods that companies may use to contact and seek payment from consumer debtors regarding past due accounts and to report to consumer reporting agencies on the status of those accounts. Many states impose additional requirements on debt collection and credit reporting practices, and some of those requirements may be more stringent than the federal requirements.

Finally, we are subject to various federal, state and local statutes and ordinances regulating the discharge of materials into the environment. For example, our health care operations generate medical waste, such as pharmaceuticals, biological materials and disposable medical instruments, that must be handled, stored, transported, treated and disposed of in compliance with federal, state and local environmental laws and regulations. Environmental regulations also may apply when we build new facilities or renovate existing facilities. If we are found not to be in compliance with such laws and regulations, we may be liable for significant investigation and clean-up costs or be subject to enforcement actions by governmental authorities or lawsuits by private plaintiffs. Moreover, any changes in the environmental regulatory framework (including legislative or regulatory efforts designed to address climate change) could have a material, adverse effect on our business.

If we fail to comply with these or other applicable laws and regulations, which are subject to change, we could be subject to liabilities, including civil penalties, money damages, lapses in reimbursement, the loss of our licenses to operate one or more facilities, exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs, civil lawsuits and criminal penalties. In addition, different interpretations or enforcement of, or amendments to, these and other laws and regulations in the future could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. The costs of compliance with, and the other burdens imposed by, these and other laws or regulatory actions may increase our operational costs, result in interruptions or delays in the availability of systems and/or result in a patient volume decline. We may also face audits or investigations by one or more domestic or foreign government agencies relating to our compliance with these regulations. An adverse outcome under any such investigation or audit, a determination that we have violated these or other laws or a public announcement that we are being investigated for possible violations could result in liability, result in adverse publicity, and adversely affect our business, financial condition, results of operations or prospects.

State efforts to regulate the construction or expansion of health care facilities could impair our ability to operate and expand our operations.

Some states, particularly in the eastern part of the country, require health care providers to obtain prior approval, often known as a CON, for the purchase, construction or expansion of health care facilities, to make certain capital expenditures or to make changes in services or bed capacity. In giving approval, these states consider the need for additional or expanded health care facilities or services. We currently operate health care facilities in a number of states with CON laws or that require other types of approvals for the establishment or expansion of certain facility types or services. The failure to obtain any required CON or other required approval could impair our ability to operate or expand operations. Any such failure could, in turn, adversely affect our ability to attract patients and physicians to our facilities and grow our revenues, which would have an adverse effect on our results of operations.

We may incur additional tax liabilities.

We are subject to tax in the United States as well as those states and foreign jurisdictions in which we do business. Changes in tax laws, including increases in tax rates, or interpretations of tax laws by taxing authorities or other standard setting bodies could increase our tax obligations and have a material, adverse impact on our results of operations.

We are also subject to examination by federal, state and foreign taxing authorities. Management believes HCA Healthcare, Inc., its predecessors, subsidiaries and affiliates properly reported taxable income and paid taxes in accordance with applicable laws and agreements established with the Internal Revenue Service ("IRS"), state and foreign taxing authorities and final resolution of any disputes will not have a material, adverse effect on our results of operations or financial position. However, if payments due upon final resolution of any issues exceed our recorded estimates, such resolutions could have a material, adverse effect on our results of operations or financial position.

We have been and could become the subject of government investigations, claims and litigation.

Health care companies are subject to numerous investigations by various government agencies. Further, under the FCA, private parties have the right to bring *qui tam*, or "whistleblower," suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities and/or affiliates have received, and other facilities and/or affiliates may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material, adverse effect on our financial position, results of operations and liquidity.

Government agencies and their agents, such as the MACs, fiscal intermediaries and carriers, as well as the OIG, CMS and state Medicaid programs, conduct audits of our health care operations. CMS and state Medicaid agencies contract with RACs and other contractors on a contingency fee basis to conduct post-payment reviews to detect and correct improper payments in the Medicare program, including managed Medicare plans, and the Medicaid programs. RAC denials are appealable; however, in recent years, there have been significant delays in the Medicare appeals process. HHS has taken steps to streamline the process and improve efficiency, and has significantly reduced a years-long backlog. Nevertheless, we may experience delays in appealing RAC payment denials. Private third-party payers may conduct similar post-payment audits, and we also perform internal audits and monitoring. Depending on the nature of the conduct found in such audits and whether the underlying conduct could be considered systemic, the resolution of these audits could have a material, adverse effect on our financial position, results of operations and liquidity.

Should we be found out of compliance with applicable laws, regulations or programs, depending on the nature of the findings, our business, our financial position and our results of operations could be negatively impacted.

We may be subject to liabilities from claims brought against our facilities, which are costly to defend and may require us to pay significant damages if not covered by insurance.

We are subject to litigation relating to our business practices, including claims and legal actions by patients and others in the ordinary course of business alleging malpractice, product liability or other legal theories. Many of these actions seek large sums of money as damages and involve significant defense costs. We insure a portion of our professional liability risks through our insurance subsidiary. Management believes our reserves for self-insured retentions and insurance coverage are sufficient to cover insured claims arising out of the operation of our facilities, although some claims may exceed the scope or amount of the coverage limits of our insurance policies. Our insurance subsidiary has entered into certain reinsurance contracts; however, the subsidiary remains liable to the extent that the reinsurers do not meet their obligations under the reinsurance contracts. If payments for claims exceed actuarially determined estimates, are not covered by insurance, or reinsurers, if any, fail to meet their obligations, our results of operations and financial position could be adversely affected.

Risks related to operations, strategy, demand and competition:

Our hospitals and other facilities face competition for patients from other hospitals and health care providers.

The health care business is highly competitive, and competition among hospitals and other health care providers for patients has intensified in recent years. Generally, other hospitals and health care facilities in the communities we serve provide services similar to those we offer. Trends toward transparency and value-based purchasing may have an impact on our competitive position, ability to obtain and maintain favorable contract terms, and patient volumes in ways that are difficult to predict. CMS publicizes on its Care Compare website performance data related to quality measures and data on patient satisfaction surveys that hospitals, home health agencies, hospices and various other types of Medicare-certified facilities submit in connection with their Medicare reimbursement. The Care Compare website provides an overall rating that synthesizes various quality measures into a star rating for each hospital, home health agency and

hospice. If any of our hospitals or other provider types achieve poor results (or results that are lower than our competitors) on quality measures or on patient satisfaction surveys, our competitive position could be negatively affected. Further, hospitals are required to publish online a list of their standard charges for all items and services, including discounted cash prices and payer-specific and de-identified negotiated charges, and must also publish a consumer-friendly list of standard charges for certain "shoppable" services or, alternatively, maintain an online price estimator tool for the shoppable services. HHS also requires health insurers to publish online charges negotiated with providers for health care services, and starting January 1, 2023, health insurers must provide online price comparison tools to help individuals get personalized cost estimates for covered items and services. The No Surprises Act imposes additional price transparency requirements, including requiring providers to send uninsured or self-pay patients (in advance of the date of the scheduled item or service or upon request) and health plans (prior to the scheduled date of the item or service) of insured patients a good faith estimate of the expected charges and diagnostic codes. HHS is deferring enforcement of certain requirements of the No Surprises Act applicable to providing estimates for insured individuals, and is also deferring enforcement with regard to good faith estimates sent to uninsured or self-pay patients that do not include expected charges for co-providers or co-facilities. It is not entirely clear how price transparency requirements will affect consumer behavior, our relationships with payers, or our ability to set and negotiate prices, but our competitive position could be negatively affected if our standard charges are higher or are perceived to be higher than the charges of our competitors.

The number of freestanding specialty hospitals, surgery centers, emergency departments, urgent care centers and diagnostic and imaging centers in the geographic areas in which we operate has increased. Many individuals are seeking a broader range of services at outpatient facilities as a result of the growing availability of stand-alone outpatient health care facilities, the increase in payer reimbursement policies that restrict inpatient coverage and the increase in the services that can be provided on an outpatient basis, including high margin services. Consequently, most of our hospitals operate in a highly competitive environment, which may put pressure on our pricing, ability to contract with third-party payers and strategy for volume growth. Some of the facilities that compete with our hospitals are physician-owned or are owned by governmental agencies or not-for-profit corporations supported by endowments, charitable contributions and/or tax revenues and can finance capital expenditures and operations on a tax-exempt basis. Recent consolidations of not-for-profit hospital entities may intensify this competitive pressure. There is also increasing consolidation in the third-party payer industry, including vertical integration efforts among third-party payers and health care providers, and increasing efforts by payers to influence or direct the patient's choice of provider by the use of narrow networks or other strategies. Health care industry participants are increasingly implementing physician alignment strategies, such as employing physicians, acquiring physician practice groups and participating in ACOs or other clinical integration models. Other industry participants, such as large employer groups and their affiliates and large retail chains, may intensify competitive pressure and affect the industry in ways that are difficult to predict.

Our hospitals compete with specialty hospitals and with both our own and unaffiliated freestanding ASCs and other outpatient providers for market share in certain high margin services and for quality physicians and personnel. If ASCs and other outpatient providers are better able to compete in this environment than our hospitals, our hospitals may experience a decline in patient volume, and we may experience a decrease in margin, even if those patients use our providers. In states that do not require a CON or other type of approval for the purchase, construction or expansion of health care facilities or services, competition in the form of new services, facilities and capital spending is more prevalent. Some states that have historically imposed CON or similar prior approval requirements have removed or are considering removing these requirements, which may reduce barriers to entry and increase competition in our service areas. Changes in licensure or other regulations and recognition of new provider types or payment models could also impact our competitive position. If our competitors are better able to attract patients, make capital expenditures and maintain modern and technologically upgraded facilities and equipment, recruit physicians, expand services or obtain favorable third-party payer contracts at their facilities than our hospitals and other providers, we may experience an overall decline in patient volume. See Item 1, "Business — Competition."

Any increase in the volume of uninsured patients or deterioration in the collectability of uninsured and patient due accounts could adversely affect our results of operations.

The primary collection risks for our accounts receivable relate to the uninsured patient accounts and patient accounts for which the primary third-party payer has paid the amounts covered by the applicable agreement, but patient responsibility amounts (exclusions, deductibles and copayments) remain outstanding. At December 31, 2022, estimated implicit price concessions of $6.780 billion had been recorded to adjust our revenues and accounts receivable to the estimated amounts we expect to collect. The estimated cost of total uncompensated care was $3.491 billion for 2022, $3.350 billion for 2021 and $3.483 billion for 2020.

Any increase in the volume of uninsured patients or deterioration in the collectability of uninsured accounts receivable could adversely affect our cash flows and results of operations. Our facilities may experience growth in total uncompensated care as a result of a number of factors, including conditions impacting the overall economy and

unemployment levels. In addition, legislative and regulatory changes, such as the effective elimination of the financial penalty associated with the Affordable Care Act's individual mandate, may impact the number of individuals that elect to obtain public or private health insurance or the scope of such coverage, if purchased. We are unable to predict what, if any, and when such changes will be made in the future.

We provide uninsured discounts and charity care for individuals, including for those residing in states that choose not to implement the Medicaid expansion or that modify the terms of the program, for undocumented aliens who are not permitted to enroll in an Exchange or government health care programs and for certain others who may not have insurance. Some patients may choose to enroll in lower cost Medicaid plans or other health insurance plans with lower reimbursement levels. We may also be adversely affected by the growth in patient responsibility accounts as a result of increases in the adoption of health plan structures that shift greater payment responsibility for care to individuals through greater exclusions and copayment and deductible amounts. Further, our ability to collect patient responsibility accounts may be limited by statutory, regulatory and investigatory initiatives, including private lawsuits directed at hospital charges and collection practices for uninsured and underinsured patients. For example, the No Surprises Act requires providers to send uninsured and self-pay patients a good faith estimate of expected charges for items and services. The estimate must cover items and services that are reasonably expected to be provided together with the primary item or services, including those that may be provided by other providers. If the uninsured or self-pay patient receives a bill that is substantially greater than the expected charges in the good faith estimate or the provider furnishes an item or service that was not included in the good faith estimate, they may initiate a patient-provider dispute resolution process established by regulation.

If our volume of patients with private health insurance coverage declines or we are unable to retain and negotiate favorable contracts with private third-party payers, including managed care plans, our revenues may be adversely affected.

Broad economic factors, including inflationary pressures, supply chain disruptions, labor shortages, increased unemployment and underemployment rates and reduced consumer spending and confidence, the continued shift of care to an outpatient setting and the aging population may impact our revenue mix. Private third-party payers, including HMOs, PPOs and other managed care plans, typically reimburse health care providers at a higher rate than Medicare, Medicaid or other government health care programs. Reimbursement rates are set forth by contract when our facilities are in-network, and payers utilize plan structures to encourage or require the use of in-network providers. Revenues derived from private third-party payers (domestic only) accounted for 48.3%, 51.6% and 51.5% of our revenues for 2022, 2021 and 2020, respectively. As a result, our ability to maintain or increase patient volumes covered by private third-party payers and to maintain and obtain favorable contracts with private third-party payers significantly affects the revenues and operating results of our facilities.

Private third-party payers, including managed care plans, continue to demand discounted fee structures, and the ongoing trend toward consolidation among payers tends to increase their bargaining power over fee structures. Payers may utilize plan structures such as narrow networks and tiered networks that limit beneficiary provider choices, impose significantly higher cost sharing obligations when care is obtained from providers in a disfavored tier or otherwise shift greater financial responsibility for care to individuals.

Other health care providers may impact our ability to enter into managed care contracts or negotiate increases in our reimbursement and other favorable terms and conditions. For example, some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise restrict the ability of managed care plans to contract with us. In addition to increasing negotiating leverage of private third-party payers, alignment efforts between third-party payers and health care providers may result in other competitive advantages, such as greater access to performance and pricing data. Our future success will depend, in part, on our ability to retain and renew our third-party payer contracts and enter into new contracts on terms favorable to us, which may be impacted by price transparency initiatives. For example, the No Surprises Act requires providers to send health plans of insured patients a good faith estimate of the expected charges and diagnostic codes prior to the scheduled date of the service or item. Further, hospitals are required to publish online payer-specific negotiated charges and de-identified minimum and maximum charges. In addition, starting January 1, 2023, health insurers must provide online price comparison tools to help individuals get personalized cost estimates for covered items and services. Cost-reduction strategies by large employer groups and their affiliates, such as directly contracting with a limited number of providers, may also limit our ability to negotiate favorable terms in our contracts and otherwise intensify competitive pressure. It is not clear what impact, if any, these and future health reform efforts will have on our ability to negotiate reimbursement increases and participate in third-party payer networks on favorable terms. If we are unable to retain and negotiate favorable contracts with third-party payers or experience reductions in payment increases or amounts received from third-party payers, our revenues may be reduced.

Under early COVID-related legislation, states that maintain continuous Medicaid enrollment until the end of the month in which the PHE ends are eligible for a temporary increase in federal funds for state Medicaid expenditures. Under recent legislation, the continuous coverage requirement was decoupled from the PHE timeline and will now expire as of April 1, 2023, and the increase in federal funding will be phased out through calendar year 2023. The resumption of redeterminations for Medicaid enrollees may lead to coverage disruptions and dis-enrollments of current Medicaid enrollees. Furthermore, the number and identity of states that choose to expand or otherwise modify Medicaid programs and the terms of expansion and other program modifications continue to evolve. Some states have imposed individual health insurance mandates with financial penalties for noncompliance. Other states have explored or offer public health insurance options. These variables, among others, make it difficult to predict the number of uninsured individuals.

Changes to physician utilization practices and treatment methodologies, third-party payer controls designed to reduce inpatient services or surgical procedures and other factors outside our control that impact demand for medical services may reduce our revenues.

Controls imposed by Medicare, managed Medicare, Medicaid, managed Medicaid and private third-party payers designed to reduce admissions, intensity of services, surgical volumes and lengths of stay, in some instances referred to as "utilization review," have affected and are expected to increasingly affect our facilities. Utilization review entails the review of the admission and course of treatment of a patient by third-party payers, and may involve prior authorization requirements. The Medicare program also issues national or local coverage determinations that restrict the circumstances under which Medicare pays for certain services. Inpatient utilization, average lengths of stay and occupancy rates continue to be negatively affected by third-party payers' preadmission authorization requirements, coverage restrictions, utilization review and by pressure to maximize outpatient and alternative health care delivery services for less acutely ill patients. Efforts to impose more stringent cost controls are expected to continue. Additionally, trends in physician treatment protocols and health plan design, such as health plans that shift increased costs and accountability for care to patients, could reduce our surgical volumes and admissions in favor of lower intensity and lower cost treatment methodologies or result in patients seeking care from other providers.

Volume, admission and case-mix trends may be impacted by other factors beyond our control, such as changes in volume of certain high acuity services, variations in the prevalence and severity of outbreaks of influenza and other illnesses, such as COVID-19, and medical conditions, seasonal and severe weather conditions, changes in treatment regimens and medical technology and other advances. Further, our operations may be impacted by expansion of in-home acute care models, and our inpatient volumes may decline if various inpatient hospital procedures become eligible for reimbursement by Medicare when performed in outpatient settings. These factors may reduce the demand for services we offer and decrease the reimbursement that we receive. Significant limits on the scope of services reimbursed, cost controls, changes to physician utilization practices, treatment methodologies, reimbursement rates and fees and other factors beyond our control could have a material, adverse effect on our business, financial position and results of operations.

We may encounter difficulty acquiring hospitals and other health care businesses, encounter challenges integrating the operations of acquired hospitals and other health care businesses and/or become liable for unknown or contingent liabilities as a result of acquisitions.

A component of our business strategy is acquiring hospitals and other health care businesses. We may encounter difficulty acquiring new facilities or other businesses as a result of competition from other purchasers that may be willing to pay purchase prices that are higher than we believe are reasonable. Antitrust enforcement in the health care industry is currently a priority of the Federal Trade Commission and the DOJ, including with respect to hospital and physician practice acquisitions. Some states require CONs in order to acquire a hospital or other facility, or to expand facilities or services. In addition, the acquisition of health care facilities often involves licensure approvals or reviews and complex change of ownership processes for Medicare and other payers. Further, many states have laws that restrict the conversion or sale of not-for-profit hospitals to for-profit entities. These laws may require prior approval from the state attorney general, advance notification of the attorney general or other regulators and community involvement. Attorneys general in states without specific requirements may exercise broad discretionary authority over transactions involving the sale of not-for-profits under their general obligations to protect the use of charitable assets. These legislative and administrative efforts often focus on the appropriate valuation of the assets divested and the use of the proceeds of the sale by the non-profit seller and may include consideration of commitments for capital improvements and charity care by the purchaser. Also, the increasingly challenging regulatory and enforcement environment may negatively impact our ability to acquire health care businesses if they are found to have material unresolved compliance issues, such as repayment obligations. Resolving compliance issues as well as completion of oversight, review or approval processes could seriously delay or even prevent our ability to acquire hospitals or other businesses and increase our acquisition costs.

We may be unable to timely and effectively integrate hospitals and other businesses that we acquire with our ongoing operations, or we may experience delays implementing operating procedures and systems. Hospitals and other health care businesses that we acquire may have unknown or contingent liabilities, including liabilities for failure to comply with health care and other laws and regulations, medical and general professional liabilities, workers' compensation liabilities and tax liabilities. Although we typically exclude significant liabilities from our acquisition transactions and seek indemnification from the sellers for these matters, we could experience difficulty enforcing those obligations, experience liability in excess of any indemnification obtained or otherwise incur material liabilities for the pre-acquisition conduct of acquired businesses. Such liabilities and related legal or other costs could harm our business and results of operations.

Our facilities are heavily concentrated in Florida and Texas, which makes us sensitive to regulatory, economic, public health, environmental and competitive conditions and changes in those states.

We operated 182 hospitals at December 31, 2022, and 91 of those hospitals are located in Florida and Texas. Our Florida and Texas facilities' combined revenues represented 50% of our consolidated revenues for the year ended December 31, 2022. This geographic concentration makes us particularly sensitive to regulatory, economic, public health, environmental and competitive conditions in those states. Any material change in the current payment programs or regulatory, economic, public health, environmental or competitive conditions in those states could have a disproportionate effect on our overall business results.

In addition, our hospitals and other facilities in Florida, Texas and other coastal states are located in hurricane-prone areas. In the past, hurricanes have had a disruptive effect on the operations of our hospitals and other facilities in Florida, Texas and other coastal states and the patient populations in those states. Global climate change could also increase the intensity or frequency of hurricanes or other natural disasters. Our business activities could be harmed by a particularly active hurricane season or even a single storm, and the property insurance we obtain may not be adequate to cover losses from future hurricanes or other natural disasters.

Our business and operations are subject to risks related to climate change.

Global climate change presents both immediate and long-term physical risks (such as potential increases in the intensity or frequency of hurricanes, extreme weather conditions or other natural disasters) and risks associated with the transition to a low-carbon economy (such as regulatory or technology changes). These changes could result in, for example, temporary declines in the number of patients seeking our services, closures of our hospitals and related facilities, and supply chain disruptions, as well as increased costs of products, commodities and energy (including utilities), and disruptions in our information systems, which in turn could negatively impact our business and results of operations. In addition, certain of our operations and facilities are located in regions that may be disproportionately impacted by the physical risks of climate change (resulting in potential increases in the intensity or frequency of hurricanes, extreme weather conditions or other natural disasters), and we face the risk of losses incurred as a result of physical damage to our hospitals and related facilities and business interruptions caused by such events. We maintain property insurance coverage to address the impact of physical damage to our facilities and for business interruption losses. However, such insurance coverage may be insufficient to cover all losses and we may experience a material, adverse effect on our results of operations that is not recoverable through our insurance policies. Additionally, if we experience a significant increase in climate-related events that result in material losses we may be unable to obtain similar levels of property insurance coverage in the future. In addition, changes in consumer preferences and additional legislation and regulatory requirements, including those associated with the transition to a low-carbon economy, may increase costs associated with compliance, the operation of our facilities and supplies. Regulations limiting greenhouse gas emissions and energy inputs may also increase in coming years, which may adversely impact us through increased compliance costs for us and our suppliers and vendors. Our response to climate change, our climate change strategies, policies, goals, commitments and disclosure, and/or our ability to achieve our climate-related goals and commitments (which are subject to risks and uncertainties, many of which are outside of our control) could result in reputational harm as a result of negative public sentiment, regulatory scrutiny, litigation and reduced investor and stakeholder confidence.

We may be adversely affected if we are not able to achieve our environmental, social and governance ("ESG") goals or otherwise meet the expectations of our stakeholders with respect to ESG matters.

We strive to deliver shared value through our business, and our diverse stakeholders expect us to make significant progress with respect to certain ESG-related matters. From time to time, we announce certain aspirations and goals relevant to our priority ESG matters. We periodically publish information about our ESG priorities, strategies, goals, targets and progress on our corporate website and update our ESG reporting from time to time. Achievement of these aspirations, targets, plans and goals is subject to risks and uncertainties, many of which are outside of our control, and it is possible that we may not achieve, or be perceived to have not achieved, our ESG goals or certain of our stakeholders

might not be satisfied with our efforts, which could result in reputational harm as a result of negative public sentiment, regulatory scrutiny, litigation and reduced investor and stakeholder confidence. Certain challenges we face in the achievement of our ESG objectives are also captured within our ESG reporting, which is not incorporated by reference into and does not form any part of this Annual Report on Form 10-K or our other filings with the SEC. Standards for tracking and reporting ESG matters continue to evolve. Our selection of voluntary disclosure frameworks and standards, and the interpretation or application of those frameworks and standards, may change from time to time or differ from those of others. This may result in a lack of consistent or meaningful comparative data from period to period or between us and other companies in the same industry. In addition, our processes and controls may not always comply with evolving standards for identifying, measuring and reporting ESG metrics, including ESG-related disclosures that may be required of public companies by the SEC, and such standards may change over time, which could result in significant revisions to our current goals, reported progress in achieving such goals, or ability to achieve such goals in the future. A delay or inability to meet our goals and aspirations, comply with federal, state or international environmental, social and governance laws and regulations, or meet evolving and varied stakeholder expectations and standards could adversely affect public perception of our business, employee morale or patient or shareholder support, expend corporate resources, result in substantial costs and expenses, result in legal or regulatory proceedings against the Company and negatively impact our financial condition and results of operations.

The industry trend toward value-based purchasing may negatively impact our revenues.

There is a trend in the health care industry toward value-based purchasing of health care services. These value-based purchasing programs include both public reporting of quality data and preventable adverse events tied to the quality and efficiency of care provided by facilities. Governmental programs including Medicare currently require hospitals, ASCs, home health agencies, hospices and other providers to report certain quality data to receive full reimbursement updates. In addition, Medicare does not reimburse for care related to certain preventable adverse events (also called "never events"), and federal law prohibits the use of federal funds under the Medicaid program to reimburse providers for medical assistance provided to treat HACs. The 25% of hospitals with the worst risk-adjusted HAC scores in the designated performance period receive a 1% reduction in their inpatient PPS Medicare payments the following year.

Hospitals with excess readmission rates for conditions designated by CMS receive a reduction in their inpatient PPS operating Medicare payments for all Medicare inpatient discharges, not just discharges relating to the conditions subject to the excess readmission standard. The reduction in payments to hospitals with excess readmissions can be up to 3% of a hospital's base payments.

CMS has implemented a value-based purchasing program for inpatient hospital services that reduces inpatient hospital payments for all discharges by 2% in each federal fiscal year. CMS pools the amount collected from these reductions to fund payments to reward hospitals that meet or exceed certain quality performance standards established by CMS. CMS scores each hospital based on achievement (relative to other hospitals) and improvement (relative to the hospital's own past performance). Hospitals that meet or exceed the quality performance standards will receive greater reimbursement under the value-based purchasing program than they would have otherwise. In response to COVID-19, CMS has paused or refined several measures across various hospital quality measurement and value-based purchasing programs. These policies are intended to ensure that these programs neither reward nor penalize hospitals based on circumstances caused by the PHE that the measures were not designed to accommodate.

In January 2022, CMS began implementing a nationwide expansion of the HHVBP Model. Under the model, home health agencies will receive increases or reductions to their Medicare fee-for-service payments of up to 5%, based on performance against specific quality measures relative to the performance of other home health providers. Calendar year 2023 is the first performance year under the expanded HHVBP Model, and data collected in 2023 will impact payments in calendar year 2025.

CMS has developed several alternative payment models that are intended to reduce costs and improve quality of care for Medicare beneficiaries and has signaled its intent to have states apply similar strategies in the Medicaid context. Examples of alternative payment models include bundled payment models in which, depending on whether overall CMS spending per episode exceeds or falls below a target specified by CMS and whether quality standards are met, hospitals may receive supplemental Medicare payments or owe repayments to CMS. Generally, participation in bundled payment programs is voluntary, but CMS currently requires hospitals in selected markets to participate in a bundled payment initiative for specified orthopedic procedures and in a model for end-stage renal disease treatment. In addition, a mandatory radiation oncology model was expected to begin January 1, 2023, but CMS has indefinitely delayed its implementation. CMS has indicated that it is developing more voluntary and mandatory bundled payment models. Participation in mandatory or voluntary demonstration projects, particularly demonstrations with the potential to affect payment, may negatively impact our results of operations.

In a strategic report issued in 2021 and updated in 2022, the CMS Innovation Center highlighted the need to accelerate the movement to value-based care and drive broader system transformation. By 2030, the CMS Innovation Center aims to have all fee-for-service Medicare beneficiaries and the vast majority of Medicaid beneficiaries in an accountable care relationship with providers who are responsible for quality and total medical costs. The CMS Innovation Center signaled its intent to streamline its payment models and to increase provider participation through implementation of more mandatory models.

There are also several state-driven value-based care initiatives. For example, some states have aligned quality metrics across payers through legislation or regulation. Some private third-party payers are also transitioning toward alternative payment models or implementing other value-based care strategies. For example, many large private third-party payers currently require hospitals to report quality data, and several private third-party payers do not reimburse hospitals for certain preventable adverse events. Further, we have implemented a policy pursuant to which we do not bill patients or third-party payers for fees or expenses incurred due to certain preventable adverse events.

We expect value-based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts. It is unclear whether these and other alternative payment models will successfully coordinate care and reduce costs or whether they will decrease aggregate reimbursement. We are unable to predict our future payments or whether we will be subject to payment reductions under these programs or how this trend will affect our results of operations. If we are unable to meet or exceed the quality performance standards under any applicable value-based purchasing program, perform at a level below the outcomes demonstrated by our competitors, or otherwise fail to effectively provide or coordinate the efficient delivery of quality health care services, our reputation in the industry may be negatively impacted, we may receive reduced reimbursement amounts and we may owe repayments to payers, causing our revenues to decline.

Risks related to macroeconomic conditions:

Our overall business results may suffer during periods of general economic weakness.

COVID-19 has adversely impacted, and may in the future adversely impact, economic conditions in the United States. Outside of the governmental response to COVID-19, budget deficits at the federal level and within some state and local government entities have had a negative impact on spending, and may continue to negatively impact spending for health and human service programs, including Medicare, Medicaid and similar programs, which represent significant third-party payer sources for our hospitals. We anticipate that the federal deficit, the growing magnitude of Medicare and Medicaid expenditures and the aging of the U.S. population will continue to place pressure on government health care programs, and it is possible that future deficit reduction legislation will mandate additional Medicare spending reductions. Other risks we face during periods of economic weakness and high unemployment include potential declines in the population covered under managed care agreements, increased patient decisions to postpone or cancel elective and nonemergency health care procedures (including delaying surgical procedures), which may lead to poorer health and higher acuity interventions, potential increases in the uninsured and underinsured populations, increased adoption of health plan structures that shift financial responsibility to patients and further difficulties in collecting patient receivables for copayment and deductible receivables. Further, inflationary pressures may increase operating expenses faster than reflected in updates to the reimbursement systems of governmental and private payers. If general economic conditions, including inflation, deteriorate or remain volatile or uncertain for an extended period of time, our results of operations, liquidity and ability to repay our outstanding debt may be harmed and the trading price of our common stock could decline. These factors may affect the availability, terms or timing on which we may obtain any additional funding and our ability to access our cash. There can be no assurance that we will be able to raise additional funds on terms acceptable to us, if at all.

We are exposed to market risk related to changes in the market values of securities and interest rates.

We are exposed to market risk related to changes in market values of securities. COVID-19 has increased volatility of the capital and credit markets and has adversely impacted economic conditions. The investment securities held by our insurance subsidiaries were $473 million at December 31, 2022. These investments are carried at fair value, with changes in unrealized gains and losses related to factors other than credit loss allowances being recorded as adjustments to other comprehensive income. At December 31, 2022, we had unrealized losses of $38 million on the insurance subsidiaries' investment securities.

We are exposed to market risk related to market illiquidity. Investment securities of our insurance subsidiaries could be impaired by the inability to access the capital markets. Should the insurance subsidiaries require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have

been able to in a normal market environment. We may be required to recognize credit-related impairments on long-term investments in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue specific factors.

We are also exposed to market risk related to changes in interest rates that impact the amount of the interest expense we incur with respect to our floating rate obligations as well as the value of certain investments. We periodically enter into interest rate swap agreements to manage our exposure to these fluctuations. These interest rate swap agreements involve the exchange of fixed and variable rate interest payments between two parties, based on common notional principal amounts and maturity dates.

Risks related to ownership of our common stock:

There can be no assurance that we will continue to pay dividends.

In 2018, the Board of Directors initiated a cash dividend program under which the Company commenced a regular quarterly cash dividend. During 2022, the Board of Directors declared four quarterly dividends of $0.56 per share, or $2.24 per share in the aggregate, on our common stock. On January 26, 2023, our Board of Directors declared a quarterly dividend of $0.60 per share on our common stock payable on March 31, 2023 to stockholders of record at the close of business on March 17, 2023.

The declaration, amount and timing of such dividends are subject to capital availability and determinations by our Board of Directors that cash dividends are in the best interest of our stockholders and are in compliance with all respective laws and our agreements applicable to the declaration and payment of cash dividends. Our ability to pay dividends will depend upon, among other factors, our cash flows from operations, our available capital and potential future capital requirements for strategic transactions, including acquisitions, debt service requirements, share repurchases and investing in our existing markets as well as our results of operations, financial condition and other factors beyond our control that our Board of Directors may deem relevant. A reduction in or suspension or elimination of our dividend payments could have a negative effect on our stock price.

Certain of our investors may continue to have influence over us.

On November 17, 2006, HCA Inc. was acquired by a private investor group, including affiliates of HCA founder, Dr. Thomas F. Frist, Jr. and certain other investors. Through their investment in Hercules Holding II and other holdings, certain of the Frist-affiliated investors continue to hold a significant interest in our outstanding common stock (approximately 25% as of January 31, 2023). In addition, pursuant to a shareholders agreement we entered into with Hercules Holding II and the Frist-affiliated investors, certain representatives of these investors have the continued right to nominate certain of the members of our Board of Directors. As a result, certain of these investors potentially have the ability to influence our decisions to enter into corporate transactions (and the terms thereof) and prevent changes in the composition of our Board of Directors or any transaction that requires stockholder approval.

Item 1B. *Unresolved Staff Comments*

None.

Item 2. *Properties*

The following table lists, by state, the number of hospitals (general, acute care, psychiatric and rehabilitation) directly or indirectly owned and operated by us as of December 31, 2022:

State	Hospitals	Beds
Alaska	1	250
California	5	1,883
Colorado	7	2,471
Florida	46	12,988
Georgia	5	1,487
Idaho	2	442
Indiana	1	278
Kansas	4	1,400
Kentucky	2	384
Louisiana	3	923
Missouri	5	1,072
Nevada	3	1,524
New Hampshire	3	432
North Carolina	7	1,181
South Carolina	3	989
Tennessee	14	2,742
Texas	45	13,609
Utah	8	1,038
Virginia	11	3,300
International		
England	7	888
	182	49,281

In addition to the hospitals listed in the above table, we directly or indirectly operate 126 freestanding surgery centers and 21 freestanding endoscopy centers. We also operate medical office buildings in conjunction with some of our hospitals. These office buildings are primarily occupied by physicians who practice at our hospitals. Twelve of our general, acute care hospitals and five of our other properties have been mortgaged to support our obligations under our senior secured cash flow credit facility.

We maintain our headquarters in approximately 2,031,000 square feet of space in the Nashville, Tennessee area. In addition to the headquarters in Nashville, we maintain regional service centers related to our shared services initiatives. These service centers are located in markets in which we operate hospitals.

We believe our headquarters, hospitals and other facilities are suitable for their respective uses and are, in general, adequate for our present needs. Our properties are subject to various federal, state and local statutes and ordinances regulating their operation. Management does not believe that compliance with such statutes and ordinances will materially affect our financial position or results of operations.

Item 3. *Legal Proceedings*

The information set forth in Note 10 – Contingencies in the notes to the consolidated financial statements is incorporated herein by reference.

Item 4. *Mine Safety Disclosures*

None.

PART II

Item 5. *Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities*

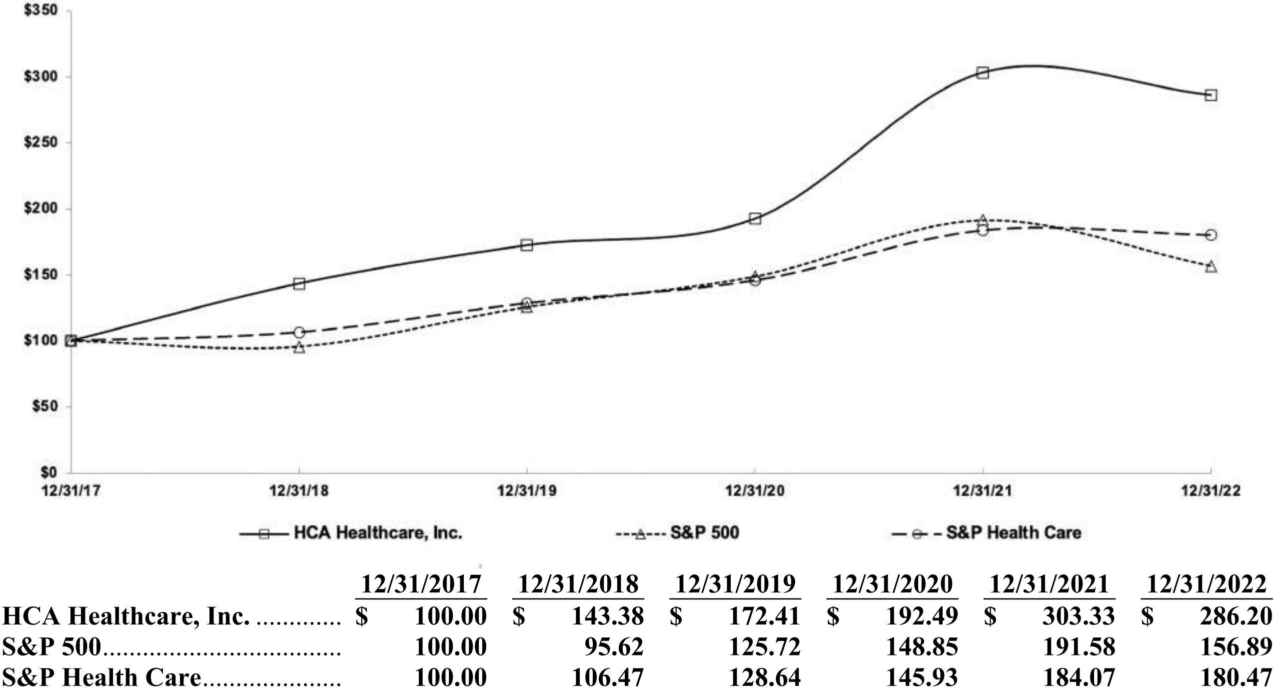
During February 2021, January 2022 and January 2023, our Board of Directors authorized $6 billion, $8 billion and $3 billion, respectively, for share repurchases of the Company's outstanding common stock. The February 2021 authorization was completed during 2022, and at December 31, 2022, there was $1.586 billion of share repurchase authorization that remained available under the January 2022 authorization. All repurchases made during the fourth quarter of 2022, as detailed below, were made pursuant to the January 2022 share repurchase authorization and were made in the open market.

The following table provides certain information with respect to our repurchases of common stock from October 1, 2022 through December 31, 2022 (dollars in billions, except per share amounts).

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares That May Yet Be Purchased Under Publicly Announced Plans or Programs
October 2022	1,753,666	$ 205.58	1,753,666	$ 2.745
November 2022	2,733,018	$ 222.84	2,733,018	$ 2.136
December 2022	2,294,497	$ 239.71	2,294,497	$ 1.586
Total for Fourth Quarter 2022	6,781,181	$ 224.09	6,781,181	$ 1.586

Our common stock is traded on the New York Stock Exchange ("NYSE") (symbol "HCA"). During 2022, our Board of Directors declared four quarterly dividends of $0.56 per share, or $2.24 per share in the aggregate, on our common stock. On January 26, 2023, our Board of Directors declared a quarterly dividend of $0.60 per share on our common stock payable on March 31, 2023 to stockholders of record at the close of business on March 17, 2023. Future declarations of quarterly dividends and the establishment of future record and payment dates are subject to the final determination of our Board of Directors. Our ability to declare future dividends may also from time to time be limited by the terms of our debt agreements. At the close of business on February 1, 2023, there were approximately 400 holders of record of our common stock.

STOCK PERFORMANCE GRAPH
COMPARISON OF 5 YEAR CUMULATIVE TOTAL RETURN
Among HCA Healthcare, Inc., the S&P 500 Index and the S&P Health Care Index



	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022
HCA Healthcare, Inc.	**$ 100.00**	**$ 143.38**	**$ 172.41**	**$ 192.49**	**$ 303.33**	**$ 286.20**
S&P 500....................................	**100.00**	**95.62**	**125.72**	**148.85**	**191.58**	**156.89**
S&P Health Care.....................	**100.00**	**106.47**	**128.64**	**145.93**	**184.07**	**180.47**

The graph shows the cumulative total return to our stockholders for the five-year period ended December 31, 2022, in comparison to the cumulative returns of the S&P 500 Index and the S&P Health Care Index. The graph assumes $100 invested on December 31, 2017 in our common stock and in each index with the subsequent reinvestment of dividends. The stock performance shown on the graph represents historical stock performance and is not necessarily indicative of future stock price performance.

Item 6. [Reserved]

Item 7. *Management's Discussion and Analysis of Financial Condition and Results of Operations*

The accompanying consolidated financial statements present certain information with respect to the financial position, results of operations and cash flows of HCA Healthcare, Inc. which should be read in conjunction with the following discussion and analysis. The terms "HCA," "Company," "we," "our," or "us," as used herein, refer to HCA Healthcare, Inc. and its affiliates. The term "affiliates" means direct and indirect subsidiaries of HCA Healthcare, Inc. and partnerships and joint ventures in which such subsidiaries are partners.

Forward-Looking Statements

This annual report on Form 10-K includes certain disclosures that contain "forward-looking statements," within the meaning of the federal securities laws, which involve risks and uncertainties. Forward-looking statements include statements regarding expected share-based compensation expense, expected capital expenditures, expected dividends, expected share repurchases, expected net claim payments, expected inflationary pressures and all other statements that do not relate solely to historical or current facts, and can be identified by the use of words like "may," "believe," "will," "expect," "project," "estimate," "anticipate," "plan," "initiative" or "continue." These forward-looking statements are based on our current plans and expectations and are subject to a number of known and unknown uncertainties and risks, many of which are beyond our control, which could significantly affect current plans and expectations and our future financial position and results of operations. These factors include, but are not limited to, (1) developments related to COVID-19, including, without limitation, the length and severity of its impact and the spread of virus strains with new epidemiological characteristics; the volume of canceled or rescheduled procedures and the volume and acuity of COVID-19 patients cared for across our health systems; measures we are taking to respond to COVID-19; the impact and terms (including the termination or expiration) of government and administrative regulation and stimulus and relief measures (including the Families First Coronavirus Response Act, the Coronavirus Aid, Relief, and Economic Security ("CARES") Act, the Paycheck Protection Program and Health Care Enhancement Act, the Consolidated Appropriations Act, 2021, the American Rescue Plan Act of 2021 ("ARPA") and other enacted and potential future legislation) and whether various stimulus and relief programs continue or new similar programs are enacted in the future; changes in revenues due to declining patient volumes, changes in payer mix, deteriorating macroeconomic conditions (including increases in uninsured and underinsured patients) and capacity constraints; potential increased expenses related to inflation or labor, supply chain or other expenditures; supply shortages and disruptions; and the timing, availability and adoption of effective medical treatments and vaccines (including boosters), (2) the impact of our substantial indebtedness and the ability to refinance such indebtedness on acceptable terms, (3) the impact of current and future federal and state health reform initiatives and possible changes to other federal, state or local laws and regulations affecting the health care industry, including but not limited to, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Affordable Care Act"), additional changes to the Affordable Care Act, its implementation, or interpretation (including through executive orders and court challenges), and proposals to expand coverage of federally-funded insurance programs as an alternative to private insurance or establish a single-payer system (such reforms often referred to as "Medicare for All"), (4) the effects related to the implementation of sequestration spending reductions required under the Budget Control Act of 2011, related legislation extending these reductions and those required under the Pay-As-You-Go Act of 2010 ("PAYGO Act") as a result of the federal budget deficit impact of the ARPA, and the potential for future deficit reduction legislation that may alter these spending reductions, which include cuts to Medicare payments, or create additional spending reductions, (5) increases in the amount and risk of collectability of uninsured accounts and deductibles and copayment amounts for insured accounts, (6) the ability to achieve operating and financial targets, and attain expected levels of patient volumes and control the costs of providing services, (7) possible changes in Medicare, Medicaid and other state programs, including Medicaid supplemental payment programs or Medicaid waiver programs, that may impact reimbursements to health care providers and insurers and the size of the uninsured or underinsured population, (8) personnel related capacity constraints; increases in wages and the ability to attract, utilize and retain qualified management and other personnel, including affiliated physicians, nurses and medical and technical support personnel; and workforce disruptions, (9) the highly competitive nature of the health care business, (10) changes in service mix, revenue mix and surgical volumes, including potential declines in the population covered under third-party payer agreements, the ability to enter into and renew third-party payer provider agreements on acceptable terms and the impact of consumer-driven health plans and physician utilization trends and practices, (11) the efforts of health insurers, health care providers, large employer groups and others to contain health care costs, (12) the outcome of our continuing efforts to monitor, maintain and comply with appropriate laws, regulations, policies and procedures, (13) the availability and terms of capital to fund the expansion of our business and improvements to our existing facilities, (14) changes in accounting practices, (15) changes in general economic conditions nationally and regionally in our markets, including inflation and economic and business conditions (and the impact thereof on the economy and financial markets), (16) the emergence of and effects related to pandemics, epidemics and infectious diseases, (17) future divestitures which may result in charges and possible impairments of long-lived assets, (18) changes in business strategy or development plans, (19) delays in receiving payments for

Forward-Looking Statements (continued)

services provided, (20) the outcome of pending and any future tax audits, disputes and litigation associated with our tax positions, (21) potential adverse impact of known and unknown government investigations, litigation and other claims that may be made against us, (22) the impact of potential cybersecurity incidents or security breaches, (23) our ongoing ability to demonstrate meaningful use of certified electronic health record ("EHR") technology and the impact of interoperability requirements, (24) the impact of natural disasters, such as hurricanes and floods, physical risks from climate change or similar events beyond our control, (25) changes in U.S. federal, state, or foreign tax laws including interpretive guidance that may be issued by taxing authorities or other standard setting bodies, and (26) other risk factors described in this annual report on Form 10-K. As a consequence, current plans, anticipated actions and future financial position and results of operations may differ from those expressed in any forward-looking statements made by or on behalf of HCA. You are cautioned not to unduly rely on such forward-looking statements when evaluating the information presented in this report, which forward-looking statements reflect management's views only as of the date of this report. We undertake no obligation to revise or update any forward-looking statements, whether as a result of new information, future events or otherwise.

COVID-19

We believe the extent of COVID-19's impact on our operating results and financial condition has been and could continue to be driven by many factors, most of which are beyond our control and ability to forecast. Because of these uncertainties, we cannot estimate how long or to what extent COVID-19 will impact our operations.

2022 Operations Summary

Net income attributable to HCA Healthcare, Inc. totaled $5.643 billion, or $19.15 per diluted share, for 2022, compared to $6.956 billion, or $21.16 per diluted share, for 2021. The 2022 results include gains on sales of facilities of $1.301 billion, or $2.46 per diluted share, and losses on retirement of debt of $78 million, or $0.20 per diluted share. The 2021 results include gains on sales of facilities of $1.620 billion, or $3.69 per diluted share, and losses on retirement of debt of $12 million, or $0.03 per diluted share. Our provisions for income taxes for 2022 and 2021 include tax benefits of $77 million, or $0.26 per diluted share, and $119 million, or $0.36 per diluted share, respectively, related to employee equity award settlements. All "per diluted share" disclosures are based upon amounts net of the applicable income taxes. Shares used for diluted earnings per share were 294.666 million shares and 328.752 million shares for the years ended December 31, 2022 and 2021, respectively. During 2022 and 2021, we repurchased 30.747 million and 37.812 million shares, respectively, of our common stock.

Revenues increased to $60.233 billion for 2022 from $58.752 billion for 2021. Revenues increased 2.5% and 3.2%, respectively, on a consolidated basis and on a same facility basis for 2022, compared to 2021. The consolidated revenues increase can be attributed to the combined impact of a 0.4% increase in revenue per equivalent admission and a 2.1% increase in equivalent admissions. The same facility revenues increase resulted from the net impact of a 3.3% increase in equivalent admissions and a 0.1% decline in revenue per equivalent admission.

During 2022, consolidated admissions declined 0.7% and same facility admissions increased 0.5%, compared to 2021. Inpatient surgical volumes were flat on a consolidated basis and increased 0.9% on a same facility basis during 2022, compared to 2021. Outpatient surgical volumes increased 1.5% on a consolidated basis and increased 1.8% on a same facility basis during 2022, compared to 2021. Emergency room visits increased 5.9% on a consolidated basis and increased 7.6% on a same facility basis during 2022, compared to 2021.

The estimated cost of total uncompensated care increased $141 million for 2022, compared to 2021. Consolidated and same facility uninsured admissions declined 6.0% and 4.6%, respectively, and consolidated and same facility uninsured emergency room visits increased 4.4% and 6.6%, respectively, for 2022, compared to 2021.

Interest expense totaled $1.741 billion for 2022, compared to $1.566 billion for 2021. The $175 million increase in interest expense for 2022 was primarily due to an increase in the average debt balance, which was partially offset by a decline in the average effective interest rate.

Cash flows from operating activities declined $437 million, from $8.959 billion for 2021 to $8.522 billion for 2022. The decline in cash flows from operating activities was related primarily to a negative change in working capital items of $649 million, mainly from a decline in accounts payable and accrued expenses, and a decline in net income of $687 million, excluding gains on sales of facilities and losses on retirement of debt, offset by a decline in cash payments for interest and income taxes of $847 million for 2022 compared to 2021.

Business Strategy

We are committed to providing the communities we serve with high quality, convenient and cost-effective health care while growing our business and creating long-term value for our stockholders. We strive to be the health care system of choice in the communities we serve by developing comprehensive networks locally and supporting these networks with enterprise expertise and economies of scale. Our strategy is organized around a framework that seeks to drive sustained growth by delivering operational excellence, attracting exceptional physicians and other health care professionals, developing comprehensive services, creating greater access, and coordinating higher quality care for patients. To achieve these objectives, we align our efforts around the following growth agenda:

Grow Our Presence in Existing Markets. We believe we are well positioned in a number of large and growing markets that will allow us the opportunity to generate long-term, attractive growth through the expansion of our presence in these markets. We plan to continue recruiting and strategically collaborating with the physician community and developing comprehensive service lines such as cardiology, neurology, oncology, orthopedics and women's services. Additional components of our growth strategy include providing access and convenience through developing various outpatient facilities, including, but not limited to surgery centers, urgent care clinics, freestanding emergency care facilities, imaging centers and home health and hospice services, as well as seeking to improve coordination of care and patient retention across our markets.

Achieve Industry-Leading Performance in Clinical, Operational and Satisfaction Measures. Achieving high levels of patient safety, patient satisfaction and clinical quality are central goals of our business. To achieve these goals, we have implemented a number of initiatives including infection reduction initiatives, hospitalist programs, advanced health information technology and evidence-based medicine programs. We routinely analyze operational practices from our best-performing hospitals to identify ways to implement organization-wide performance improvements and reduce clinical variation. We believe these initiatives will continue to improve patient care, help us achieve cost efficiencies and favorably position us in an environment where our constituents are increasingly focused on quality, efficacy and efficiency.

Recruit and Retain Physicians and Other Health Care Professionals to Meet the Need for High Quality Health Services. We depend on the quality and dedication of the health care providers and other team members who serve at our facilities. We believe a critical component of our growth strategy is our ability to successfully recruit and strategically collaborate with physicians and other health care professionals to provide high quality care. We attract and retain physicians and other health care professionals by providing high quality, convenient facilities with advanced technology, by expanding our specialty services and by building our outpatient operations. We believe our continued investment in the employment, recruitment and retention of physicians and other health care professionals will improve the quality of care at our facilities.

Continue to Utilize Economies of Scale to Grow the Company. We believe there is significant opportunity to continue to grow our company by fully utilizing the scale and scope of our organization. We continue to invest in initiatives such as care navigators, clinical data exchange and centralized patient transfer operations, which will enable us to improve coordination of care and patient retention across our markets. We believe our centrally managed business processes and ability to leverage cost-saving practices across our extensive network will enable us to continue to manage costs effectively. We continue to invest in our Parallon subsidiary group to deploy key components of our support infrastructure, including revenue cycle management, health care group purchasing, supply chain management and staffing functions.

Pursue a Disciplined Development Strategy. We continue to believe there are significant growth opportunities in our markets. We will continue to provide financial and operational resources to analyze and develop our in-market opportunities. To complement our in-market growth agenda and achieve cost savings and other benefits for the patients and communities we serve, we intend to focus on selectively developing and acquiring new hospitals, outpatient facilities and other health care service providers.

Our strategy also emphasizes investments that advance our clinical systems and digital capabilities, transform care models with innovative care solutions, expand our workforce development programs and enhance our health care networks and partnerships.

Critical Accounting Policies and Estimates

The preparation of our consolidated financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent liabilities and the reported amounts of revenues and expenses. Our estimates are based on historical experience and various other assumptions we believe are reasonable under the circumstances. We evaluate our estimates on an ongoing basis and make changes to the estimates and related disclosures as experience develops or new information becomes known. Actual results may differ from these estimates.

We believe the following critical accounting policies affect our more significant judgments and estimates used in the preparation of our consolidated financial statements.

Revenues

Revenues are recorded during the period the health care services are provided, based upon the estimated amounts due from payers. Estimates of contractual allowances under managed care health plans are based upon the payment terms specified in the related contractual agreements. Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The estimated reimbursement amounts are made on a payer-specific basis and are recorded based on the best information available regarding management's interpretation of the applicable laws, regulations and contract terms. Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals. We have invested significant resources to refine and improve our billing systems and the information system data used to make contractual allowance estimates. We have developed standardized calculation processes and related employee training programs to improve the utility of our patient accounting systems.

Patients treated at hospitals for non-elective care, who have income at or below 400% of the federal poverty level, are eligible for charity care, and we limit the patient responsibility amounts for these patients to a percentage of their annual household income, computed on a sliding scale based upon their annual income and the applicable percentage of the federal poverty level. Patients treated at hospitals for non-elective care, who have income above 400% of the federal poverty level, are eligible for certain other discounts which limit the patient responsibility amounts for these patients to a percentage of their annual household income, computed on a sliding scale based upon their annual income and the applicable percentage of the federal poverty level. We apply additional discounts to limit patient responsibility for certain emergency services. The federal poverty level is established by the federal government and is based on income and family size. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance, or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the age of those accounts. Accounts are written off when all reasonable collection efforts have been performed. The estimates for implicit price concessions are based upon management's assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and collections at facilities that represent a majority of our revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. We believe our quarterly updates to the estimated implicit price concession amounts at each of our hospital facilities provide reasonable estimates of our revenues and valuations of our accounts receivable. These routine, quarterly changes in estimates have not resulted in material adjustments to the valuations of our accounts receivable or period-to-period comparisons of our revenues.

Critical Accounting Policies and Estimates (Continued)

Revenues (continued)

To quantify the total impact of and trends related to uninsured patient accounts, we believe it is beneficial to view total uncompensated care, which is comprised of charity care, uninsured discounts and implicit price concessions. A summary of the estimated cost of total uncompensated care for the years ended December 31, follows (dollars in millions):

	2022	2021	2020
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization)	**$ 51,180**	$ 49,074	$ 44,271
Cost-to-charges ratio (patient care costs as percentage of gross patient charges)	**11.0%**	11.3%	12.0%
Total uncompensated care	**$ 31,734**	$ 29,642	$ 29,029
Multiply by the cost-to-charges ratio	**11.0%**	11.3%	12.0%
Estimated cost of total uncompensated care	**$ 3,491**	$ 3,350	$ 3,483

Management expects a continuation of the challenges related to the collection of the patient due accounts. Adverse changes in the percentage of our patients having adequate health care coverage, increases in patient responsibility amounts under certain health care coverages, general economic conditions, patient accounting service center operations, payer mix, or trends in federal, state, and private employer health care coverage could affect the collection of accounts receivable, cash flows and results of operations.

Professional Liability Claims

We, along with virtually all health care providers, operate in an environment with professional liability risks. Our facilities are insured by our insurance subsidiary for losses up to $75 million per occurrence, subject, in most cases, to a $15 million per occurrence self-insured retention. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of either $25 million or $35 million per occurrence, depending on the jurisdiction for the related claim. We purchase excess insurance on an occurrence reported basis for losses in excess of amounts insured by our insurance subsidiary. Provisions for losses related to professional liability risks were $517 million, $453 million and $435 million for the years ended December 31, 2022, 2021 and 2020, respectively. During 2022, 2021 and 2020, we recorded reductions to the provision for professional liability risks of $55 million, $87 million and $112 million, respectively, due to the receipt of updated actuarial information.

Reserves for professional liability risks represent the estimated ultimate cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The estimated ultimate cost includes estimates of direct expenses and fees paid to outside counsel and experts, but does not include the general overhead costs of our insurance subsidiary or corporate office. Individual case reserves are established based upon the particular circumstances of each reported claim and represent our estimates of the future costs that will be paid on reported claims. Case reserves are reduced as claim payments are made and are adjusted upward or downward as our estimates regarding the amounts of future losses are revised. Once the case reserves for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, and geographic location of our hospitals. Several actuarial methods are employed to utilize this data to produce estimates of ultimate losses and reserves for incurred but not reported claims, including: paid and incurred extrapolation methods utilizing paid and incurred loss development to estimate ultimate losses; frequency and severity methods utilizing paid and incurred claims development to estimate ultimate average frequency (number of claims) and ultimate average severity (cost per claim); and Bornhuetter-Ferguson methods which add expected development to actual paid or incurred experience to estimate ultimate losses. These methods use our company-specific historical claims data and other information. Company-specific claim reporting and payment data collected over an approximate 20-year period is used in our reserve estimation process. This company-specific data includes information regarding our business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, professional liability retentions for each policy year, geographic information and other data.

Critical Accounting Policies and Estimates (Continued)

Professional Liability Claims (continued)

Reserves and provisions for professional liability risks are based upon actuarially determined estimates. The estimated reserve ranges, net of amounts receivable under reinsurance contracts, were $1.802 billion to $2.159 billion at December 31, 2022 and $1.752 billion to $2.098 billion at December 31, 2021. Our estimated reserves for professional liability claims may change significantly if future claims differ from expected trends. We perform sensitivity analyses which model the volatility of key actuarial assumptions and monitor our reserves for adequacy relative to all our assumptions in the aggregate. Based on our analysis, we believe the estimated professional liability reserve ranges represent the reasonably likely outcomes for ultimate losses. We consider the number and severity of claims to be the most significant assumptions in estimating reserves for professional liabilities. A 2.5% change in the expected frequency trend could be reasonably likely and would increase the reserve estimate by $29 million or reduce the reserve estimate by $28 million. A 2.5% change in the expected claim severity trend could be reasonably likely and would increase the reserve estimate by $135 million or reduce the reserve estimate by $123 million. We believe adequate reserves have been recorded for our professional liability claims; however, due to the complexity of the claims, the extended period of time to resolve the claims and the wide range of potential outcomes, our ultimate liability for professional liability claims could change by more than the estimated sensitivity amounts and could change materially from our current estimates.

The reserves for professional liability risks cover approximately 2,000 and 2,100 individual claims at December 31, 2022 and 2021, respectively, and estimates for unreported potential claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. The average time period between the occurrence and final resolution for our professional liability claims is approximately five years, although the facts and circumstances of each individual claim can result in an occurrence-to-resolution timeframe that varies from this average. The estimation of the timing of payments beyond a year can vary significantly.

Reserves for professional liability risks were $2.043 billion and $2.022 billion at December 31, 2022 and 2021, respectively. The current portion of these reserves, $515 million and $508 million at December 31, 2022 and 2021, respectively, is included in "other accrued expenses." Obligations covered by reinsurance and excess insurance contracts are included in the reserves for professional liability risks, as we remain liable to the extent reinsurers and excess insurance carriers do not meet their obligations. Reserves for professional liability risks (net of $60 million and $55 million receivable under reinsurance and excess insurance contracts at December 31, 2022 and 2021, respectively) were $1.983 billion and $1.967 billion at December 31, 2022 and 2021, respectively. The estimated total net reserves for professional liability risks at December 31, 2022 and 2021 are comprised of $793 million and $874 million, respectively, of case reserves for known claims and $1.190 billion and $1.093 billion, respectively, of reserves for incurred but not reported claims.

Changes in our professional liability reserves, net of reinsurance recoverable, for the years ended December 31, are summarized in the following table (dollars in millions):

	2022	2021	2020
Net reserves for professional liability claims, January 1	**$ 1,967**	$ 1,924	$ 1,781
Provision for current year claims	**538**	530	519
Favorable development related to prior years' claims	**(21)**	(77)	(84)
Total provision	**517**	453	435
Payments for current year claims	**4**	5	5
Payments for prior years' claims	**493**	379	287
Total claim payments	**497**	384	292
Effect of new retroactive reinsurance contracts	**(4)**	(26)	—
Net reserves for professional liability claims, December 31	**$ 1,983**	$ 1,967	$ 1,924

Critical Accounting Policies and Estimates (Continued)

Income Taxes

We calculate our provision for income taxes using the asset and liability method, under which deferred tax assets and liabilities are recognized by identifying the temporary differences that arise from the recognition of items in different periods for tax and accounting purposes. Deferred tax assets generally represent the tax effects of amounts expensed in our income statement for which tax deductions will be claimed in future periods. Interest and penalties payable to taxing authorities are included as a component of our provision for income taxes. We have elected to treat taxes incurred on global intangible low-taxed income as a period expense.

Although we believe we have properly reported taxable income and paid taxes in accordance with applicable laws, federal, state or foreign taxing authorities may challenge our tax positions upon audit. Significant judgment is required in determining and assessing the impact of uncertain tax positions. We report a liability for unrecognized tax benefits from uncertain tax positions taken or expected to be taken in our income tax returns. During each reporting period, we assess the facts and circumstances related to uncertain tax positions. If the realization of unrecognized tax benefits is deemed probable based upon new facts and circumstances, the estimated liability and the provision for income taxes are reduced in the current period. Final audit results may vary from our estimates.

Results of Operations

Revenue/Volume Trends

Our revenues depend upon inpatient occupancy levels, the ancillary services and therapy programs ordered by physicians and provided to patients, the volume of outpatient procedures and the charge and negotiated payment rates for such services. Patient volumes and the related revenues were negatively impacted by COVID-19 beginning in the first half of 2020, and subsequent periods through the first half of 2022 have experienced fluctuations in COVID-19 volumes and revenues through the various surges, impacting comparisons for most of our patient volume and revenues operating statistics. Gross charges typically do not reflect what our facilities are actually paid. Our facilities have entered into agreements with third-party payers, including government programs and managed care health plans, under which the facilities are paid based upon the cost of providing services, predetermined rates per diagnosis, fixed per diem rates or discounts from gross charges. We do not pursue collection of amounts related to patients who meet our guidelines to qualify for charity care; therefore, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care.

Revenues increased 2.5% to $60.233 billion for 2022 from $58.752 billion for 2021 and increased 14.0% for 2021 from $51.533 billion for 2020. The increase in revenues in 2022 can be attributed to the combined impact of a 0.4% increase in revenue per equivalent admission and a 2.1% increase in equivalent admissions compared to the prior year. The increase in revenues in 2021 can be primarily attributed to the combined impact of a 6.8% increase in revenue per equivalent admission and a 6.8% increase in equivalent admissions compared to the prior year.

Same facility revenues increased 3.2% for the year ended December 31, 2022 compared to the year ended December 31, 2021 and increased 14.4% for the year ended December 31, 2021 compared to the year ended December 31, 2020. The 3.2% increase for 2022 can be attributed to the net impact of a 3.3% increase in equivalent admissions and a 0.1% decline in revenue per equivalent admission. The 14.4% increase for 2021 can be primarily attributed to the combined impact of a 6.3% increase in revenue per equivalent admission and a 7.6% increase in equivalent admissions.

Consolidated admissions declined 0.7% during 2022 compared to 2021 and increased 4.0% during 2021 compared to 2020. Consolidated surgeries increased 1.0% during 2022 compared to 2021 and increased 8.9% during 2021 compared to 2020. Consolidated emergency room visits increased 5.9% during 2022 compared to 2021 and increased 13.8% during 2021 compared to 2020.

Same facility admissions increased 0.5% during 2022 compared to 2021 and increased 4.8% during 2021 compared to 2020. Same facility surgeries increased 1.5% during 2022 compared to 2021 and increased 9.0% during 2021 compared to 2020. Same facility emergency room visits increased 7.6% during 2022 compared to 2021 and increased 15.1% during 2021 compared to 2020.

Results of Operations (continued)

Revenue/Volume Trends (continued)

Same facility uninsured emergency room visits increased 6.6% and same facility uninsured admissions declined 4.6% during 2022 compared to 2021. Same facility uninsured emergency room visits declined 6.3% and same facility uninsured admissions declined 3.5% during 2021 compared to 2020.

The approximate percentages of our admissions related to Medicare, managed Medicare, Medicaid, managed Medicaid, managed care and insurers and the uninsured for the years ended December 31, 2022, 2021 and 2020 are set forth below.

	Years Ended December 31,		
	2022	**2021**	**2020**
Medicare	**22%**	23%	26%
Managed Medicare	**23**	21	20
Medicaid	**4**	5	5
Managed Medicaid	**14**	13	12
Managed care and insurers	**30**	31	29
Uninsured	**7**	7	8
	100%	100%	100%

The approximate percentages of our inpatient revenues related to Medicare, managed Medicare, Medicaid, managed Medicaid, and managed care and insurers for the years ended December 31, 2022, 2021 and 2020 are set forth below.

	Years Ended December 31,		
	2022	**2021**	**2020**
Medicare	**23%**	23%	27%
Managed Medicare	**17**	16	15
Medicaid	**7**	6	5
Managed Medicaid	**8**	6	6
Managed care and insurers	**45**	49	47
	100%	100%	100%

At December 31, 2022, we owned and operated 46 hospitals and 30 surgery centers in the state of Florida. Our Florida facilities' revenues totaled $13.812 billion, $13.670 billion and $11.442 billion for the years ended December 31, 2022, 2021 and 2020, respectively. At December 31, 2022, we owned and operated 45 hospitals and 37 surgery centers in the state of Texas. Our Texas facilities' revenues totaled $16.450 billion, $15.344 billion and $13.528 billion for the years ended December 31, 2022, 2021 and 2020, respectively. During 2022, 2021 and 2020, 58%, 56% and 56%, respectively, of our admissions and 50%, 49% and 49%, respectively, of our revenues were generated by our Florida and Texas facilities. Uninsured admissions in Florida and Texas represented 74%, 72% and 72%, respectively, of our uninsured admissions each year during 2022, 2021 and 2020.

We receive a significant portion of our revenues from government health programs, principally Medicare and Medicaid, which are highly regulated and subject to frequent and substantial changes. Some state Medicaid programs use, or have applied to use, waivers granted by CMS to implement Medicaid expansion, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. We receive supplemental payments in several states. We are aware these supplemental payment programs are currently being reviewed by certain state agencies and some states have made requests to CMS to replace their existing supplemental payment programs. It is possible these reviews and requests will result in the restructuring of such supplemental payment programs and could result in the payment programs being reduced or eliminated. Because deliberations about these programs are ongoing, we are unable to estimate the financial impact the program structure modifications, if any, may have on our results of operations.

Results of Operations (continued)

Key Performance Indicators

We present certain metrics and statistical information that management uses when assessing our results of operations. We believe this information is useful to investors as it provides insight to how management evaluates operational performance and trends between reporting periods. Information on how these metrics and statistical information are defined is provided in the following tables summarizing operating results and operating data.

Operating Results Summary

The following are comparative summaries of operating results and certain operating data for the years ended December 31, 2022, 2021 and 2020 (dollars in millions):

	2022		2021		2020	
	Amount	**Ratio**	**Amount**	**Ratio**	**Amount**	**Ratio**
Revenues	**$ 60,233**	**100.0**	$ 58,752	100.0	$ 51,533	100.0
Salaries and benefits	**27,685**	**46.0**	26,779	45.6	23,874	46.3
Supplies	**9,371**	**15.6**	9,481	16.1	8,369	16.2
Other operating expenses	**11,155**	**18.5**	9,961	17.0	9,307	18.1
Equity in earnings of affiliates	**(45)**	**(0.1)**	(113)	(0.2)	(54)	(0.1)
Depreciation and amortization	**2,969**	**5.0**	2,853	4.9	2,721	5.3
Interest expense	**1,741**	**2.9**	1,566	2.7	1,584	3.1
Losses (gains) on sales of facilities	**(1,301)**	**(2.2)**	(1,620)	(2.8)	7	—
Losses on retirement of debt	**78**	**0.1**	12	—	295	0.6
	51,653	**85.8**	48,919	83.3	46,103	89.5
Income before income taxes	**8,580**	**14.2**	9,833	16.7	5,430	10.5
Provision for income taxes	**1,746**	**2.9**	2,112	3.6	1,043	2.0
Net income	**6,834**	**11.3**	7,721	13.1	4,387	8.5
Net income attributable to noncontrolling interests	**1,191**	**1.9**	765	1.3	633	1.2
Net income attributable to HCA Healthcare, Inc.	**$ 5,643**	**9.4**	$ 6,956	11.8	$ 3,754	7.3
% changes from prior year:						
Revenues	**2.5%**		14.0%		0.4%	
Income before income taxes	**(12.7)**		81.1		3.6	
Net income attributable to HCA Healthcare, Inc.	**(18.9)**		85.3		7.1	
Admissions(a)	**(0.7)**		4.0		(4.7)	
Equivalent admissions(b)	**2.1**		6.8		(9.2)	
Revenue per equivalent admission	**0.4**		6.8		10.5	
Same facility % changes from prior year(c):						
Revenues	**3.2**		14.4		(0.1)	
Admissions(a)	**0.5**		4.8		(4.8)	
Equivalent admissions(b)	**3.3**		7.6		(9.3)	
Revenue per equivalent admission	**(0.1)**		6.3		10.1	

(a) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.

(b) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.

(c) Same facility information excludes the operations of hospitals and their related facilities that were either acquired, divested or removed from service during the current and prior year.

Results of Operations (continued)

Operating Results Summary (continued)

Operating Data:

	2022	2021	2020
Number of hospitals at end of period	**182**	182	185
Number of freestanding outpatient surgical centers at end of period(a)	**126**	125	121
Number of licensed beds at end of period(b)	**49,281**	48,803	49,265
Weighted average beds in service(c)	**41,982**	42,148	42,246
Admissions(d)	**2,075,459**	2,089,975	2,009,909
Equivalent admissions(e)	**3,611,299**	3,536,238	3,312,330
Average length of stay (days)(f)	**5.1**	5.2	5.1
Average daily census(g)	**28,778**	29,752	27,734
Occupancy(h)	**72%**	74%	69%
Emergency room visits(i)	**8,971,951**	8,475,345	7,450,307
Outpatient surgeries(j)	**1,023,239**	1,008,236	882,483
Inpatient surgeries(k)	**522,151**	522,069	522,385
Days revenues in accounts receivable(l)	**53**	49	45
Outpatient revenues as a % of patient revenues(m)	**38%**	37%	35%

(a) Excludes freestanding endoscopy centers (21 at December 31, 2022, 2021 and 2020).

(b) Licensed beds are those beds for which a facility has been granted approval to operate from the applicable state licensing agency.

(c) Represents the average number of beds in service, weighted based on periods owned.

(d) Represents the total number of patients admitted to our hospitals and is used by management and certain investors as a general measure of inpatient volume.

(e) Equivalent admissions are used by management and certain investors as a general measure of combined inpatient and outpatient volume. Equivalent admissions are computed by multiplying admissions (inpatient volume) by the sum of gross inpatient revenue and gross outpatient revenue and then dividing the resulting amount by gross inpatient revenue. The equivalent admissions computation "equates" outpatient revenue to the volume measure (admissions) used to measure inpatient volume, resulting in a general measure of combined inpatient and outpatient volume.

(f) Represents the average number of days admitted patients stay in our hospitals.

(g) Represents the average number of admitted patients in our hospital beds each day.

(h) Represents the percentage of hospital beds in service that are occupied by patients (admitted and observations). Both average daily census and occupancy rate provide measures of the utilization of inpatient rooms.

(i) Represents the number of patients treated in our emergency rooms.

(j) Represents the number of surgeries performed on patients who were not admitted to our hospitals. Pain management and endoscopy procedures are not included in outpatient surgeries.

(k) Represents the number of surgeries performed on patients who have been admitted to our hospitals. Pain management and endoscopy procedures are not included in inpatient surgeries.

(l) Revenues per day is calculated by dividing the revenues for the fourth quarter of each year by the days in the quarter. Days revenues in accounts receivable is then calculated as accounts receivable at the end of the period divided by revenues per day.

(m) Represents the percentage of patient revenues related to patients who are not admitted to our hospitals.

Results of Operations (continued)

Years Ended December 31, 2022 and 2021

Net income attributable to HCA Healthcare, Inc. totaled $5.643 billion, or $19.15 per diluted share, for 2022, compared to $6.956 billion, or $21.16 per diluted share, for 2021. The 2022 results include gains on sales of facilities of $1.301 billion, or $2.46 per diluted share, and losses on retirement of debt of $78 million, or $0.20 per diluted share. The 2022 results include additional expenses and lost revenues estimated at approximately $85 million associated with the impact of Hurricane Ian primarily on our Florida facilities. This amount is prior to any insurance recoveries. Revenues for 2022 include $244 million and other operating expenses include $90 million from provider tax assessments related to the period September through December 2021 for the Texas directed payment program that was approved by CMS in March 2022 for the program year that began September 1, 2021. The 2021 results include gains on sales of facilities of $1.620 billion, or $3.69 per diluted share, and losses on retirement of debt of $12 million, or $0.03 per diluted share. Our provisions for income taxes for 2022 and 2021 include tax benefits of $77 million, or $0.26 per diluted share, and $119 million, or $0.36 per diluted share, respectively, related to employee equity award settlements. All "per diluted share" disclosures are based upon amounts net of the applicable income taxes. Shares used for diluted earnings per share were 294.666 million shares and 328.752 million shares for the years ended December 31, 2022 and 2021, respectively. During 2022 and 2021, we repurchased 30.747 million and 37.812 million shares, respectively, of our common stock.

During 2022, consolidated admissions declined 0.7% and same facility admissions increased 0.5% compared to 2021. Consolidated inpatient surgeries were flat and same facility inpatient surgeries increased 0.9% during 2022 compared to 2021. Emergency room visits increased 5.9% on a consolidated basis and increased 7.6% on a same facility basis during 2022 compared to 2021.

Revenues increased 2.5% to $60.233 billion for 2022 from $58.752 billion for 2021. The increase in revenues was due to the combined impact of a 0.4% increase in revenue per equivalent admission and a 2.1% increase in equivalent admissions compared to 2021. Same facility revenues increased 3.2% due primarily to the net impact of a 3.3% increase in equivalent admissions and a 0.1% decline in revenue per equivalent admission compared to 2021.

Salaries and benefits, as a percentage of revenues, were 46.0% in 2022 and 45.6% in 2021. Salaries and benefits per equivalent admission increased 1.2% in 2022 compared to 2021. Same facility salaries and benefits per full time equivalent increased 3.3% for 2022 compared to 2021 as inflation has impacted our labor costs and as we continue to utilize certain contract, overtime and other premium rate labor costs to support our clinical staff and patients. We expect inflationary pressures will continue to impact our labor costs in the future. We intend to continue reducing our utilization of and rates paid for premium rate labor, but our ability to mitigate labor cost challenges may be affected by labor market conditions and other factors. Share-based compensation expense was $341 million in 2022 and $440 million in 2021.

Supplies, as a percentage of revenues, were 15.6% in 2022 and 16.1% in 2021. Supply costs per equivalent admission declined 3.2% in 2022 compared to 2021. Supply costs per equivalent admission increased 2.4% for medical devices, but declined 18.8% for pharmacy supplies and 1.6% for general medical and surgical items in 2022 compared to 2021. The decline in pharmacy supplies is primarily related to higher utilization of certain COVID-19 therapies during 2021.

Other operating expenses, as a percentage of revenues, were 18.5% in 2022 and 17.0% in 2021. Other operating expenses are primarily comprised of contract services, professional fees, repairs and maintenance, rents and leases, utilities, insurance (including professional liability insurance) and nonincome taxes. The 1.5% increase in other operating expenses, as a percentage of revenues for 2022 compared to 2021, was primarily related to increased costs for supplemental payment programs in certain states, as well as increased professional fees, utilities and insurance premiums. We have seen inflation have a negative impact on certain of these expenses and expect inflationary pressures will continue to impact operating expenses in 2023. Provisions for losses related to professional liability risks were $517 million and $453 million for 2022 and 2021, respectively. During 2022 and 2021, we recorded reductions of $55 million, or $0.14 per diluted share, and $87 million, or $0.20 per diluted share, respectively, to our provision for professional liability risks related to the receipt of updated actuarial information.

Equity in earnings of affiliates was $45 million for 2022 and $113 million for 2021. The decline of $68 million is primarily related to the sale of an equity investment during 2021.

Results of Operations (continued)

Years Ended December 31, 2022 and 2021 (continued)

Depreciation and amortization, as a percentage of revenues, were 5.0% in 2022 and 4.9% in 2021. Depreciation expense was $2.941 billion for 2022 and $2.826 billion for 2021. The increase of $115 million in depreciation expense relates primarily to capital expenditures at our existing facilities (same facility depreciation expense increased $134 million).

Interest expense increased to $1.741 billion for 2022 from $1.566 billion for 2021. The $175 million increase in interest expense was due to an increase in the average debt balance, which was partially offset by a decline in the average effective interest rate. Our average debt balance was $37.363 billion for 2022 compared to $32.109 billion for 2021. The average effective interest rate for our long-term debt was 4.7% for 2022 and 4.9% for 2021.

Gains on sales of facilities were $1.301 billion and $1.620 billion for 2022 and 2021, respectively. The gains on sales of facilities for 2022 are primarily related to the sales of controlling interests in a subsidiary of our group purchasing organization and subsidiaries of our research entities. The gains on sales of facilities for 2021 are primarily related to the sales of five hospitals in Georgia and other health care entity investments.

During 2022, we issued $6.000 billion aggregate principal amount of senior notes. We used a portion of the net proceeds to pay down our revolving credit facilities, and we redeemed all $1.250 billion outstanding aggregate principal amount of our 4.75% senior notes due 2023 and all $1.250 billion outstanding aggregate principal amount of our 5.875% senior notes due 2023. The pretax loss on retirement of debt for these two redemptions was $78 million. During 2021, we issued $2.350 billion aggregate principal amount of senior notes. We also amended and restated our senior secured revolving credit facility and our senior secured asset-based revolving credit facility, including increasing availability under the asset-based revolving credit facility to $4.500 billion, extending the maturity date on both facilities to June 30, 2026 and entering into a new $1.500 billion term loan A facility and a new $500 million term loan B facility (the "Credit Agreement Transactions"). We used the net proceeds from the senior notes issuance and the Credit Agreement Transactions to retire $3.657 billion of term loan facilities. The pretax loss on retirement of debt was $12 million.

The effective income tax rates were 23.6% and 23.3% for 2022 and 2021, respectively. The effective tax rate computations exclude net income attributable to noncontrolling interests as it relates to consolidated partnerships.

Net income attributable to noncontrolling interests increased from $765 million for 2021 to $1.191 billion for 2022. The increase in net income attributable to noncontrolling interests related primarily to the gain on the sale of a controlling interest in a subsidiary of our group purchasing organization and the partnership operations of two of our Texas markets.

For results of operations comparisons relating to years ending December 31, 2021 and 2020, refer to our annual report on Form 10-K, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations for the year ended December 31, 2021, filed with the Securities and Exchange Commission ("SEC") on February 18, 2022.

Liquidity and Capital Resources

Our primary cash requirements are paying our operating expenses, servicing our debt, capital expenditures on our existing properties, acquisitions of hospitals and health care entities, repurchases of our common stock, dividends to stockholders and distributions to noncontrolling interests. Our primary cash sources are cash flows from operating activities, issuances of debt and equity securities and sales of hospitals and health care entities.

Cash provided by operating activities totaled $8.522 billion in 2022 compared to $8.959 billion in 2021 and $9.232 billion in 2020. The $437 million decline in cash provided by operating activities for 2022, compared to 2021, was related primarily to a negative change in working capital items of $649 million, mainly from a decline in accounts payable and accrued expenses, and a decline in net income of $687 million, excluding gains on sales of facilities and losses on retirement of debt, offset by a decline in cash payments for interest and income taxes of $847 million for 2022 compared to 2021. The $273 million decline in cash provided by operating activities for 2021, compared to 2020, was related to a negative change in working capital items of $1.781 billion, primarily from an increase in accounts receivable, offset by the increase in net income, excluding the non-cash impact of losses and gains on sales of facilities, losses on retirement of debt and depreciation and amortization. Cash payments for interest and income taxes increased $1.075 billion for 2021 compared to 2020. During 2020, we deferred $688 million of Social Security taxes as allowed for under the CARES Act. Half of these taxes were paid in January 2022 and the remainder was paid in January 2023. Working capital totaled $3.741 billion at December 31, 2022 and $3.960 billion at December 31, 2021.

Liquidity and Capital Resources (continued)

Cash used in investing activities was $3.389 billion, $2.643 billion and $3.393 billion in 2022, 2021 and 2020, respectively. Excluding acquisitions, capital expenditures were $4.395 billion in 2022, $3.577 billion in 2021 and $2.835 billion in 2020. In response to the risks COVID-19 presented to our business, we reduced certain planned projects and capital expenditures during 2020. Planned capital expenditures are expected to approximate $4.3 billion in 2023. At December 31, 2022, there were projects under construction which had an estimated additional cost to complete and equip over the next five years of approximately $4.707 billion. We expect to finance capital expenditures with internally generated and borrowed funds. We expended $224 million, $1.105 billion and $568 million for acquisitions of hospitals and health care entities during 2022, 2021 and 2020, respectively. Cash flows from sales of hospitals and health care entities declined from $2.160 billion for 2021 (primarily related to the proceeds from our sales of five hospitals in Georgia and other health care entity investments) to $1.237 billion of net proceeds for 2022 (primarily related to proceeds from our sales of other health care entities).

Cash used in financing activities totaled $5.656 billion in 2022, $6.655 billion in 2021 and $4.677 billion in 2020. During 2022, we had a net increase of $3.287 billion in our indebtedness, paid dividends of $653 million and paid $7.000 billion for repurchases of common stock. During 2021, we had a net increase of $3.255 billion in our indebtedness, paid dividends of $624 million and paid $8.215 billion for repurchases of common stock. During 2020, we made net payments of $3.217 billion related to our indebtedness, paid dividends of $153 million and paid $441 million for repurchases of our common stock. During 2022, 2021 and 2020, we made distributions to noncontrolling interests of $1.025 billion, $749 million and $626 million, respectively. The increase in distributions in 2022 is related to the sale of a controlling interest in a subsidiary of our group purchasing organization.

We, or our affiliates, may in the future repurchase portions of our debt or equity securities, subject to certain limitations, from time to time in either the open market or through privately negotiated transactions, in accordance with applicable SEC and other legal requirements. The timing, prices, and sizes of purchases depend upon prevailing trading prices, general economic and market conditions, and other factors, including applicable securities laws.

During February 2021, January 2022 and January 2023, our Board of Directors authorized $6 billion, $8 billion and $3 billion, respectively, for share repurchases of the Company's outstanding common stock. The February 2021 authorization was completed during 2022, and at December 31, 2022, there was $1.586 billion of share repurchase authorization that remained available under the January 2022 authorization. Funds for the repurchase of debt or equity securities have, and are expected to, come primarily from cash generated from operations and borrowed funds.

During 2022, our Board of Directors declared four quarterly dividends of $0.56 per share, or $2.24 per share in the aggregate, on our common stock. On January 26, 2023, our Board of Directors declared a quarterly dividend of $0.60 per share on our common stock payable on March 31, 2023 to stockholders of record at the close of business on March 17, 2023. The timing and amount of future cash dividends will vary based on a number of factors, including future capital requirements for strategic transactions, share repurchases and investing in our existing markets, the availability of financing on acceptable terms, debt service requirements, changes to applicable tax laws or corporate laws, changes to our business model and periodic determinations by our Board of Directors that cash dividends are in the best interest of stockholders and are in compliance with all applicable laws and agreements of the Company.

In addition to cash flows from operations, available sources of capital include amounts available under our senior secured credit facilities ($3.535 billion as of December 31, 2022 and $4.445 billion as of January 31, 2023) and anticipated access to public and private debt and equity markets. Effective in January 2023, availability under our senior secured revolving credit facility was increased by $1.500 billion to total $3.500 billion.

Investments of our insurance subsidiaries, held to maintain statutory equity levels and to provide liquidity to pay claims, totaled $473 million and $541 million at December 31, 2022 and 2021, respectively. The insurance subsidiary maintained net reserves for professional liability risks of $147 million and $154 million at December 31, 2022 and 2021, respectively. Our facilities are insured by our insurance subsidiary for losses up to $75 million per occurrence; however, this coverage is subject, in most cases, to a $15 million per occurrence self-insured retention. Net reserves for the self-insured professional liability risks retained were $1.836 billion and $1.813 billion at December 31, 2022 and 2021, respectively. Claims payments, net of reinsurance recoveries, during the next 12 months are expected to approximate $503 million. We estimate that approximately $459 million of the expected net claim payments during the next 12 months will relate to claims subject to the self-insured retention.

Liquidity and Capital Resources (continued)

Financing Activities

We are a highly leveraged company with significant debt service requirements. Our debt totaled $38.084 billion and $34.579 billion at December 31, 2022 and 2021, respectively. Our interest expense was $1.741 billion for 2022 and $1.566 billion for 2021.

During 2022, we issued $6.000 billion aggregate principal amount of senior notes comprised of (i) $1.000 billion aggregate principal amount of 3 1/8% senior notes due 2027, (ii) $500 million aggregate principal amount of 3 3/8% senior notes due 2029, (iii) $2.000 billion aggregate principal amount of 3 5/8% senior notes due 2032, (iv) $500 million aggregate principal amount of 4 3/8% senior notes due 2042 and (v) $2.000 billion aggregate principal amount of 4 5/8% senior notes due 2052. We used a portion of the net proceeds to pay down our revolving credit facilities, and we redeemed all $1.250 billion outstanding aggregate principal amount of our 4.75% senior notes due 2023 and all $1.250 billion outstanding aggregate principal amount of our 5.875% senior notes due 2023.

Management believes that cash flows from operations, amounts available under our senior secured credit facilities and our anticipated access to public and private debt markets will be sufficient to meet expected liquidity needs for the foreseeable future.

HCA Inc., a direct wholly-owned subsidiary of HCA Healthcare, Inc., is the primary obligor under a substantial portion of our indebtedness, including our senior secured credit facilities and senior notes. The senior secured credit facilities are fully and unconditionally guaranteed on a senior secured basis by substantially all existing and future, direct and indirect, 100% owned material domestic subsidiaries that are "Unrestricted Subsidiaries" under our Indenture dated December 16, 1993 (except for certain special purpose subsidiaries that only guarantee and pledge their assets under our senior secured asset-based revolving credit facility). On May 25, 2022, Standard & Poor's Rating Services ("S&P") announced it had issued an investment grade rating with respect to the issuer credit rating of HCA Healthcare, Inc. and its subsidiaries. S&P's announcement, in conjunction with previously disclosed events, constituted an "Investment Grade Rating Event" or a "Ratings Event," as applicable, under the terms of the indentures governing HCA Inc.'s outstanding senior secured notes and, as a result, the conditions in the senior secured indentures to permit the permanent release of the subsidiary guarantees and all collateral securing the senior secured notes were met. The subsidiary guarantees and collateral securing our senior secured credit facilities are not affected. Following this release of the subsidiary guarantees and collateral securing the senior secured notes, the subsidiary guarantors deregistered with the SEC. As a result, summarized financial information for HCA Healthcare, Inc., HCA Inc. and the subsidiary guarantors, and information about the subsidiary guarantees and affiliates whose securities were pledged as collateral will no longer be presented.

All of the senior notes issued by HCA Inc. in 2014 or later continue to be fully and unconditionally guaranteed on an unsecured basis by HCA Healthcare, Inc. The combined assets, liabilities, and results of operations of HCA Healthcare, Inc. and HCA Inc. are not materially different than the corresponding amounts presented in the consolidated financial statements of HCA Healthcare, Inc. As a result, summarized financial information of HCA Healthcare, Inc. and HCA Inc. is not required to be presented under Rule 13-01 of Regulation S-X.

Market Risk

We are exposed to market risk related to changes in market values of securities. Our insurance subsidiaries held $473 million of investment securities at December 31, 2022. These investments are carried at fair value, with changes in unrealized gains and losses being recorded as adjustments to other comprehensive income. At December 31, 2022, we had unrealized losses of $38 million on the insurance subsidiaries' investment securities.

We are exposed to market risk related to market illiquidity. Investments in debt and equity securities of our insurance subsidiaries could be impaired by the inability to access the capital markets. Should the insurance subsidiaries require significant amounts of cash in excess of normal cash requirements to pay claims and other expenses on short notice, we may have difficulty selling these investments in a timely manner or be forced to sell them at a price less than what we might otherwise have been able to in a normal market environment. We may be required to recognize credit-related impairments on our investment securities in future periods should issuers default on interest payments or should the fair market valuations of the securities deteriorate due to ratings downgrades or other issue-specific factors.

Market Risk (continued)

We are also exposed to market risk related to changes in interest rates. With respect to our interest-bearing liabilities, approximately $4.780 billion of long-term debt at December 31, 2022 was subject to variable rates of interest, while the remaining balance in long-term debt of $33.304 billion at December 31, 2022 was subject to fixed rates of interest. Both the general level of interest rates and, for the senior secured credit facilities, our leverage affect our variable interest rates. Our variable debt is comprised primarily of amounts outstanding under the senior secured credit facilities. The average effective interest rate for our long-term debt was 4.7% for 2022 and 4.9% for 2021.

The estimated fair value of our total long-term debt was $35.555 billion at December 31, 2022. The estimates of fair value are based upon the quoted market prices for the same or similar issues of long-term debt with the same maturities. Based on a hypothetical 1% increase in interest rates, the potential annualized reduction to future pretax earnings would be approximately $48 million. To mitigate the impact of fluctuations in interest rates, we generally target a majority of our debt portfolio to be maintained at fixed rates.

We are exposed to currency translation risk related to our foreign operations. We currently do not consider the market risk related to foreign currency translation to be material to our consolidated financial statements or our liquidity.

Tax Examinations

The Internal Revenue Service ("IRS") was conducting an examination of the Company's 2016, 2017 and 2018 federal income tax returns and the 2019 return for one affiliated partnership at December 31, 2022. We are also subject to examination by state and foreign taxing authorities. Management believes HCA Healthcare, Inc., its predecessors, subsidiaries and affiliates properly reported taxable income and paid taxes in accordance with applicable laws and agreements established with the IRS, state and foreign taxing authorities, and final resolution of any disputes will not have a material, adverse effect on our results of operations or financial position. However, if payments due upon final resolution of any issues exceed our recorded estimates, such resolutions could have a material, adverse effect on our results of operations or financial position.

Item 7A. ***Quantitative and Qualitative Disclosures about Market Risk***

Information with respect to this Item is provided under the caption "Market Risk" under Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Item 8. *Financial Statements and Supplementary Data*

Information with respect to this Item is contained in our consolidated financial statements indicated in the Index to Consolidated Financial Statements on Page F-1 of this annual report on Form 10-K.

Item 9. *Changes in and Disagreements with Accountants on Accounting and Financial Disclosure*

None.

Item 9A. *Controls and Procedures*

1. Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Based on this evaluation, our principal executive officer and our principal financial officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by this annual report.

2. Internal Control Over Financial Reporting

(a) Management's Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining effective internal control over financial reporting, as such term is defined in Exchange Act Rule 13a-15(f). Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Therefore, even those systems determined to be effective, can provide only reasonable assurance with respect to financial statement preparation and presentation.

Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an assessment of the effectiveness of our internal control over financial reporting based on the framework in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Based on our assessment under the framework in Internal Control — Integrated Framework, our management concluded that our internal control over financial reporting was effective as of December 31, 2022.

Ernst & Young LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

(b) Attestation Report of the Independent Registered Public Accounting Firm

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
HCA Healthcare, Inc.

Opinion on Internal Control over Financial Reporting

We have audited HCA Healthcare, Inc.'s internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, HCA Healthcare, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2022, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of HCA Healthcare, Inc. as of December 31, 2022 and 2021, and the related consolidated statements of income, comprehensive income, stockholders' equity (deficit), and cash flows for each of the three years in the period ended December 31, 2022, and the related notes and our report dated February 17, 2023 expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Nashville, Tennessee
February 17, 2023

(c) Changes in Internal Control Over Financial Reporting

During the fourth quarter of 2022, there were no changes in our internal control over financial reporting that materially affected or are reasonably likely to materially affect our internal control over financial reporting.

Item 9B. ***Other Information***

None.

Item 9C. ***Disclosure Regarding Foreign Jurisdictions that Prevent Inspections***

None.

PART III

Item 10. *Directors, Executive Officers and Corporate Governance*

The information required by this Item regarding the identity and business experience of our directors and executive officers is set forth under the heading "Nominees for Election" and "Election of Directors" in the definitive proxy materials of HCA to be filed in connection with our 2023 Annual Meeting of Stockholders with respect to our directors and is set forth in Item 1 of Part I of this annual report on Form 10-K with respect to our executive officers. The information required by this Item contained in such definitive proxy materials is incorporated herein by reference.

Information on the beneficial ownership reporting for our directors and executive officers required by this Item is contained under the caption "Delinquent Section 16(a) Reports" in the definitive proxy materials to be filed in connection with our 2023 Annual Meeting of Stockholders and is incorporated herein by reference.

Information on our Audit and Compliance Committee and Audit Committee Financial Experts required by this Item is contained under the caption "Corporate Governance" in the definitive proxy materials to be filed in connection with our 2023 Annual Meeting of Stockholders and is incorporated herein by reference.

We have a Code of Conduct which is applicable to all our directors, officers and employees (the "Code of Conduct"). The Code of Conduct is available on the Ethics and Compliance and Corporate Governance pages of our website at www.hcahealthcare.com. To the extent required pursuant to applicable SEC regulations, we intend to post amendments to or waivers from our Code of Conduct (to the extent applicable to our chief executive officer, principal financial officer or principal accounting officer) at this location on our website or report the same on a Current Report on Form 8-K. Our Code of Conduct is available free of charge upon request to our Investor Relations Department, HCA Healthcare, Inc., One Park Plaza, Nashville, TN 37203.

Item 11. *Executive Compensation*

The information required by this Item is set forth under the headings "Executive Compensation" and "Compensation Committee Interlocks and Insider Participation" in the definitive proxy materials to be filed in connection with our 2023 Annual Meeting of Stockholders, which information is incorporated herein by reference, except as to information required pursuant to Item 402(v) of SEC Regulation S-K, relating to pay versus performance.

Item 12. *Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters*

Information about security ownership of certain beneficial owners required by this Item is set forth under the heading "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in the definitive proxy materials to be filed in connection with our 2023 Annual Meeting of Stockholders, which information is incorporated herein by reference.

This table provides certain information as of December 31, 2022 with respect to our equity compensation plans:

EQUITY COMPENSATION PLAN INFORMATION
(Share and share unit amounts in millions)

	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))
Equity compensation plans approved by security holders	9.586(1)	$126.38(1)	18.262(2)
Equity compensation plans not approved by security holders	—	—	—
Total	9.586	$126.38	18.262

(1) Includes 1.784 million restricted share units which vest solely based upon continued employment over a specific period of time and 1.715 million performance share units which vest based upon continued employment over a specific period of time and the achievement of predetermined financial targets over time. The performance share units reported reflect the number of performance share units that would vest upon achievement of target performance; the number of performance share units that vest can vary from zero (for actual performance less than 90% of target) to two times the units granted (for actual performance of 110% or more of target). The weighted average exercise price does not take these restricted share units and performance share units into account.

(2) Includes 13.826 million shares available for future grants under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates and 4.436 million shares of common stock reserved for future issuance under the HCA Holdings, Inc. Employee Stock Purchase Plan.

* For additional information concerning our equity compensation plans, see the discussion in Note 2 — Share-Based Compensation in the notes to the consolidated financial statements.

Item 13. *Certain Relationships and Related Transactions, and Director Independence*

The information required by this Item is set forth under the headings "Certain Relationships and Related Party Transactions" and "Corporate Governance" in the definitive proxy materials to be filed in connection with our 2023 Annual Meeting of Stockholders, which information is incorporated herein by reference.

Item 14. *Principal Accountant Fees and Services*

The information required by this Item is set forth under the heading "Ratification of Appointment of Independent Registered Public Accounting Firm" in the definitive proxy materials to be filed in connection with our 2023 Annual Meeting of Stockholders, which information is incorporated herein by reference.

PART IV

Item 15. *Exhibits and Financial Statement Schedules*

(a) Documents filed as part of the report:

1. *Financial Statements.* The accompanying Index to Consolidated Financial Statements on page F-1 of this annual report on Form 10-K is provided in response to this item.

2. *List of Financial Statement Schedules.* All schedules are omitted because the required information is either not present, not present in material amounts or presented within the consolidated financial statements.

3. List of Exhibits

2.1	—	Agreement and Plan of Merger, dated July 24, 2006, by and among HCA Inc., Hercules Holding II, LLC and Hercules Acquisition Corporation (filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed July 25, 2006, and incorporated herein by reference).
2.2	—	Merger Agreement, dated November 22, 2010, by and among HCA Inc., HCA Holdings, Inc., and HCA Merger Sub LLC (filed as Exhibit 2.1 to the Company's Current Report on Form 8-K filed November 24, 2010, and incorporated herein by reference).
3.1	—	Amended and Restated Certificate of Incorporation of the Company (restated for SEC filing purposes only) (filed as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020, and incorporated herein by reference).
3.2	—	Third Amended and Restated Bylaws of the Company (filed as Exhibit 3.1 to the Company's Current Report on Form 8-K filed December 19, 2022, and incorporated herein by reference).
4.1	—	Description of Registered Securities.
4.2	—	Specimen Certificate for shares of Common Stock, par value $0.01 per share, of the Company (filed as Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2017, and incorporated herein by reference).
4.3	—	Security Agreement, dated as of November 17, 2006, by and among HCA Inc., the subsidiary grantors party thereto and The Bank of New York, as collateral agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.4	—	Pledge Agreement, dated as of November 17, 2006, by and among HCA Inc., the subsidiary pledgors party thereto and The Bank of New York, as collateral agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.5(a)	—	$13,550,000,000 — €1,000,000,000 Credit Agreement, dated as of November 17, 2006, by and among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Banc of America Securities LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and joint bookrunners, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A. and Citicorp North America, Inc., as co-syndication agents and Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.8 to the Company's Current Report on Form 8-K filed November 24, 2006, and incorporated herein by reference).
4.5(b)	—	Amendment No. 1 to the Credit Agreement, dated as of February 16, 2007, by and among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.7(b) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).

4.5(c)	—	Amendment No. 2 to the Credit Agreement, dated as of March 2, 2009, by and among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.8(c) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).
4.5(d)	—	Amendment No. 3 to the Credit Agreement, dated as of June 18, 2009, by and among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent, JPMorgan Chase Bank, N.A., and Citicorp North America, Inc., as Co-Syndication Agents, Banc of America Securities, LLC, J.P. Morgan Securities Inc., Citigroup Global Markets Inc. and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as joint lead arrangers and bookrunners, Deutsche Bank Securities and Wachovia Capital Markets LLC, as joint bookrunners and Merrill Lynch Capital Corporation, as documentation agent (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed June 22, 2009, and incorporated herein by reference).
4.5(e)	—	Extension Amendment No. 1 to the Credit Agreement, dated as of April 6, 2010, by and among HCA Inc., HCA UK Capital Limited, the lending institutions from time to time parties thereto, Bank of America, N.A., as administrative agent and collateral agent (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 8, 2010, and incorporated herein by reference).
4.5(f)	—	Amended and Restated Joinder Agreement No. 1, dated as of November 8, 2010, by and among each of the financial institutions listed as a "Replacement-1 Revolving Credit Lender" on Schedule A thereto, HCA Inc., Bank of America, N.A., as Administrative Agent and as Collateral Agent, and the other parties listed on the signature pages thereto (filed as Exhibit 4.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010, and incorporated herein by reference).
4.5(g)	—	Restatement Agreement, dated as of May 4, 2011, by and among HCA Inc., HCA UK Capital Limited, the lenders party thereto and Bank of America, N.A., as administrative agent and collateral agent to the Credit Agreement, dated as of November 17, 2006, as amended on February 16, 2007, March 2, 2009, June 18, 2009, April 6, 2010 and November 8, 2010 (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed May 9, 2011, and incorporated herein by reference).
4.5(h)	—	Extension Amendment No. 1, dated as of April 25, 2012, by and among HCA Inc., HCA UK Capital Limited, each of the U.S. Guarantors, each of the European Guarantors, the lenders party thereto and Bank of America, N.A., as administrative agent, swingline lender and letter of credit issuer (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 26, 2012, and incorporated herein by reference).
4.5(i)	—	Restatement Agreement, dated as of February 26, 2014, to (i) the Credit Agreement, dated as of November 17, 2006 and as amended and restated as of May 4, 2011, by and among the HCA Inc., HCA UK Capital Limited, the lenders party thereto and Bank of America, N.A., as administrative agent and collateral agent and (ii) the U.S. Guarantee, dated as of November 17, 2006, by and among the guarantors party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed February 28, 2014, and incorporated herein by reference).
4.5(j)	—	Supplement No. 14, dated as of November 9, 2015, to the U.S. Guarantee, dated as of November 17, 2006 and amended and restated on February 26, 2014, by and among the guarantors party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.4(j) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
4.5(k)	—	Schedule of Omitted Supplements to the U.S. Guarantee, dated as of November 17, 2006 and amended and restated on February 26, 2014, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
4.5(l)	—	Restatement Agreement, dated as of June 28, 2017, to the Credit Agreement, dated as of November 17, 2006, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as

administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed June 30, 2017, and incorporated herein by reference).

4.5(m)	—	Joinder Agreement No. 8, dated as of July 16, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed July 22, 2019, and incorporated herein by reference).
4.5(n)	—	Joinder Agreement No. 9, dated as of October 8, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed October 10, 2019, and incorporated herein by reference).
4.5(o)	—	Joinder Agreement No. 10, dated as of November 20, 2019, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed November 21, 2019, and incorporated herein by reference).
4.5(p)	—	Restatement Agreement, dated as of June 30, 2021, to the Credit Agreement, dated as of November 17, 2006, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.10 to the Company's Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).
4.5(q)	—	Restatement Agreement dated as of January 4, 2023, by and among HCA Inc., as borrower, the guarantors party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed January 4, 2023, and incorporated herein by reference).
4.6(a)	—	Security Agreement, dated as November 17, 2006, and amended and restated as of March 2, 2009, by and among the Company, the Subsidiary Grantors named therein and Bank of America, N.A., as Collateral Agent (filed as Exhibit 4.10 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).
4.6(b)	—	Supplement No. 2, dated as of October 27, 2011, to the Amended and Restated Security Agreement, dated as of March 2, 2009, as supplemented, by and among the subsidiary grantor named therein and Bank of America, N.A., as collateral agent (filed as Exhibit 4.5(b) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
4.6(c)	—	Schedule of Omitted Supplements to the Security Agreement, dated as of November 17, 2006 and amended and restated as of March 2, 2009, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
4.7(a)	—	Pledge Agreement, dated as of November 17, 2006, and amended and restated as of March 2, 2009, by and among the Company, the Subsidiary Pledgors named therein and Bank of America, N.A., as Collateral Agent (filed as Exhibit 4.11 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2008, and incorporated herein by reference).
4.7(b)	—	Supplement No. 1 dated as of October 27, 2011 to the Amended and Restated Pledge Agreement, dated as of March 2, 2009, by and among the subsidiary pledgors named therein and Bank of America, N.A., as collateral agent (filed as Exhibit 4.6(b) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
4.7(c)	—	Schedule of Omitted Supplements to the Pledge Agreement, dated as of November 6, 2006 and amended and restated as of March 2, 2009, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
4.8(a)	—	$2,500,000,000 Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders from time to time party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed October 3, 2011, and incorporated herein by reference).
4.8(b)	—	Restatement Agreement, dated as of March 7, 2014, to the Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders party thereto and

Bank of America, N.A. as administrative agent and collateral agent (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed March 11, 2014, and incorporated herein by reference).

4.8(c)	—	Joinder Agreement and Amendment No. 1, dated as of October 30, 2014, to the Credit Agreement, dated as of September 30, 2011 and amended and restated as of March 7, 2014, by and among HCA Inc., the subsidiary borrowers party thereto, the lenders party thereto and Bank of America, N.A. as administrative agent and collateral agent (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed October 31, 2014, and incorporated herein by reference).
4.8(d)	—	Restatement Agreement, dated as of June 28, 2017, to the Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., as borrower, the subsidiary borrowers party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed June 30, 2017, and incorporated herein by reference).
4.8(e)	—	Joinder Agreement, dated as of January 3, 2018, to the Credit Agreement, dated as of September 30, 2011 (as amended and restated on March 7, 2014, as further amended on October 30, 2014, and as further amended and restated on June 28, 2017), by and among the subsidiary borrowers party thereto and Bank of America, N.A., as administrative agent (filed as Exhibit 4.7(e) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
4.8(f)	—	Restatement Agreement, dated as of June 30, 2021, to the Credit Agreement, dated as of September 30, 2011, by and among HCA Inc., as parent borrower, the subsidiary borrowers party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.11 to the Company's Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).
4.8(g)	—	Amendment No. 1 to Credit Agreement dated as of January 4, 2023, by and among HCA Inc., as parent borrower, the subsidiary borrowers party thereto, Bank of America, N.A., as administrative agent and collateral agent, and the lenders party thereto (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed January 4, 2023, and incorporated herein by reference).
4.9(a)	—	Security Agreement, dated as of September 30, 2011, by and among HCA Inc., the subsidiary borrowers party thereto and Bank of America, N.A., as collateral agent (filed as Exhibit 4.5 to the Company's Current Report on Form 8-K filed October 3, 2011, and incorporated herein by reference).
4.9(b)	—	Supplement No. 1, dated as of October 27, 2011, to the Security Agreement dated as of September 30, 2011, by and among the subsidiary borrower party thereto and Bank of America, N.A., as collateral agent (filed as Exhibit 4.8(b) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).
4.9(c)	—	Schedule of Omitted Supplements to the Security Agreement dated as of September 30, 2011, filed pursuant to Instruction 2 to Item 601 of Regulation S-K.
4.10(a)	—	General Intercreditor Agreement, dated as of November 17, 2006, by and between Bank of America, N.A., as First Lien Collateral Agent, and The Bank of New York, as Junior Lien Collateral Agent (filed as Exhibit 4.13(a) to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.10(b)	—	Receivables Intercreditor Agreement, dated as of November 17, 2006, by and among Bank of America, N.A., as ABL Collateral Agent, Bank of America, N.A., as CF Collateral Agent and The Bank of New York, as Bonds Collateral Agent (filed as Exhibit 4.13(b) to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.10(c)	—	First Lien Intercreditor Agreement, dated as of April 22, 2009, by and among Bank of America, N.A. as Collateral Agent, Bank of America, N.A. as Authorized Representative under the Credit Agreement and Law Debenture Trust Company of New York as the Initial Additional Authorized Representative (filed as Exhibit 4.5 to the Company's Current Report on Form 8-K filed April 28, 2009, and incorporated herein by reference).
4.10(d)	—	Additional General Intercreditor Agreement, dated as of August 1, 2011, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued

on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 (filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed August 1, 2011, and incorporated herein by reference).

4.10(e) — Additional Receivables Intercreditor Agreement, dated as of August 1, 2011, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent (filed as Exhibit 4.10 to the Company's Current Report on Form 8-K filed August 1, 2011, and incorporated herein by reference).

4.10(f) — Additional General Intercreditor Agreement, dated as of February 16, 2012, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 (filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed February 16, 2012, and incorporated herein by reference).

4.10(g) — Additional Receivables Intercreditor Agreement, dated as of February 16, 2012, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent (filed as Exhibit 4.10 to the Company's Current Report on Form 8-K filed February 16, 2012, and incorporated herein by reference).

4.10(h) — Additional General Intercreditor Agreement, dated as of October 23, 2012, by and among Bank of America, N.A., in its capacity as First Lien Collateral Agent, The Bank of New York Mellon, in its capacity as Junior Lien Collateral Agent and in its capacity as trustee for the Second Lien Notes issued on November 17, 2006, and The Bank of New York Mellon Trust Company, N.A., in its capacity as trustee for the Second Lien Notes issued on February 19, 2009 (filed as Exhibit 4.10 to the Company's Current Report on Form 8-K filed October 23, 2012, and incorporated herein by reference).

4.10(i) — Additional Receivables Intercreditor Agreement, dated as of October 23, 2012, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent (filed as Exhibit 4.11 to the Company's Current Report on Form 8-K filed October 23, 2012, and incorporated herein by reference).

4.11 — Registration Rights Agreement, dated as of November 22, 2010, by and among HCA Holdings, Inc., Hercules Holding II, LLC and certain other parties thereto (filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed November 24, 2010, and incorporated herein by reference).

4.12 — Registration Rights Agreement, dated as of March 16, 1989, by and among HCA-Hospital Corporation of America and the persons listed on the signature pages thereto (filed as Exhibit 4.14 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

4.13 — Assignment and Assumption Agreement, dated as of February 10, 1994, by and between HCA-Hospital Corporation of America and Columbia Healthcare Corporation relating to the Registration Rights Agreement, as amended (filed as Exhibit 4.15 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

4.14(a) — Indenture, dated as of December 16, 1993, by and between the Company and The First National Bank of Chicago, as Trustee (filed as Exhibit 4.16(a) to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

4.14(b) — First Supplemental Indenture, dated as of May 25, 2000, by and between the Company and Bank One Trust Company, N.A., as Trustee (filed as Exhibit 4.16(b) to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

4.14(c) — Second Supplemental Indenture, dated as of July 1, 2001, by and between the Company and Bank One Trust Company, N.A., as Trustee (filed as Exhibit 4.16(c) to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

4.14(d) — Third Supplemental Indenture, dated as of December 5, 2001, by and between the Company and The Bank of New York, as Trustee (filed as Exhibit 4.16(d) to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).

4.14(e)	—	Fourth Supplemental Indenture, dated as of November 14, 2006, by and between the Company and The Bank of New York, as Trustee (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed November 16, 2006, and incorporated herein by reference).
4.15	—	Form of 7.5% Debenture due 2023 (filed as Exhibit 4.17 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.16	—	Form of 8.36% Debenture due 2024 (filed as Exhibit 4.18 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.17	—	Form of Fixed Rate Global Medium-Term Note (filed as Exhibit 4.19 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.18	—	Form of Floating Rate Global Medium-Term Note (filed as Exhibit 4.20 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.19	—	Form of 7.69% Note due 2025 (filed as Exhibit 4.10 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2004, and incorporated herein by reference).
4.20	—	Form of 7.50% Debenture due 2095 (filed as Exhibit 4.23 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.21	—	Form of 7.05% Debenture due 2027 (filed as Exhibit 4.24 to the Company's Registration Statement on Form S-4 (File No. 333-145054), and incorporated herein by reference).
4.22	—	7.50% Note due 2033 in the principal amount of $250,000,000 (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed November 6, 2003, and incorporated herein by reference).
4.23	—	Form of Indenture of HCA Inc. (filed as Exhibit 4.2 to the Registrant's Registration Statement on Form S-3 (File No. 333-175791), and incorporated herein by reference).
4.24	—	Indenture dated as of August 1, 2011, by and among HCA Inc., the guarantors named on Schedule I thereto, Delaware Trust Company (as successor to Law Debenture Trust Company of New York), as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.5 to the Company's Registration Statement on Form S-3 (File No. 333-226709), and incorporated herein by reference).
4.25	—	Indenture, dated as of December 6, 2012, by and among HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as registrar, paying agent and transfer agent (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed December 6, 2012, and incorporated herein by reference).
4.26	—	Supplemental Indenture No. 8, dated as of March 17, 2014, by and among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed March 21, 2014, and incorporated herein by reference).
4.27	—	Form of 5.00% Senior Secured Notes due 2024 (included in Exhibit 4.26).
4.28	—	Additional Receivables Intercreditor Agreement, dated as of March 17, 2014, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral Agent (filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed March 21, 2014, and incorporated herein by reference).
4.29	—	Supplemental Indenture No. 10, dated as of October 17, 2014, by and among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed October 17, 2014, and incorporated herein by reference).
4.30	—	Form of 5.25% Senior Secured Notes due 2025 (included in Exhibit 4.29).
4.31	—	Additional Receivables Intercreditor Agreement, dated as of October 17, 2014, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as New First Lien Collateral

Agent (filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed October 17, 2014, and incorporated herein by reference).

4.32	—	Supplemental Indenture No. 11, dated as of January 16, 2015, by and among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed January 16, 2015, and incorporated herein by reference).
4.33	—	Form of 5.375% Senior Notes due 2025 (included in Exhibit 4.32).
4.34	—	Supplemental Indenture No. 12, dated as of May 20, 2015, by and among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed May 20, 2015, and incorporated herein by reference).
4.35	—	Supplemental Indenture No. 13, dated as of November 13, 2015, by and among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed November 13, 2015, and incorporated herein by reference).
4.36	—	Form of 5.875% Senior Notes due 2026 (included in Exhibit 4.35).
4.37	—	Supplemental Indenture No. 14, dated as of December 8, 2015, by and among HCA Inc., HCA Holdings, Inc., Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed December 8, 2015, and incorporated herein by reference).
4.38	—	Supplemental Indenture No. 15, dated as of March 15, 2016, by and among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed March 15, 2016, and incorporated herein by reference).
4.39	—	Form of 5.250% Senior Secured Notes due 2026 (included in Exhibit 4.38).
4.40	—	Additional Receivables Intercreditor Agreement, dated as of March 15, 2016, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent (filed as Exhibit 4.7 to the Company's Current Report on Form 8-K filed March 15, 2016, and incorporated herein by reference).
4.41	—	Supplemental Indenture No. 16, dated as of August 15, 2016, by and among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Law Debenture Trust Company of New York, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed August 15, 2016, and incorporated herein by reference).
4.42	—	Form of 4.500% Senior Secured Notes due 2027 (included in Exhibit 4.41).
4.43	—	Additional Receivables Intercreditor Agreement, dated as of August 15, 2016, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent (filed as Exhibit 4.8 to the Company's Current Report on Form 8-K filed August 15, 2016, and incorporated herein by reference).
4.44	—	Supplemental Indenture No. 17, dated as of December 9, 2016, by and among HCA Inc., HCA Holdings, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.1 to the Company's Current Report on Form 8-K filed December 9, 2016, and incorporated herein by reference).
4.45	—	Supplemental Indenture No. 18, dated as of June 22, 2017, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed June 22, 2017, and incorporated herein by reference).

4.46 — Form of 5.500% Senior Secured Notes due 2047 (included in Exhibit 4.45).

4.47 — Additional Receivables Intercreditor Agreement, dated as of June 22, 2017, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent (filed as Exhibit 4.7 to the Company's Current Report on Form 8-K filed June 22, 2017, and incorporated herein by reference).

4.48 — Supplemental Indenture No. 19, dated as of August 23, 2018, by and among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed August 23, 2018, and incorporated herein by reference).

4.49 — Form of 5.375% Senior Notes Due 2026 (included in Exhibit 4.48).

4.50 — Supplemental Indenture No. 20, dated as of August 23, 2018, by and among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed August 23, 2018, and incorporated herein by reference).

4.51 — Form of 5.625% Senior Notes Due 2028 (included in Exhibit 4.50).

4.52 — Supplemental Indenture No. 21, dated as of January 22, 2019, by and among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed January 22, 2019, and incorporated herein by reference).

4.53 — Supplemental Indenture No. 22, dated as of January 30, 2019, by and among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed January 30, 2019, and incorporated herein by reference).

4.54 — Form of 5.875% Senior Notes Due 2029 (included in Exhibit 4.53).

4.55 — Supplemental Indenture No. 23, dated as of June 12, 2019, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed June 12, 2019, and incorporated herein by reference).

4.56 — Supplemental Indenture No. 24, dated as of June 12, 2019, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed June 12, 2019, and incorporated herein by reference).

4.57 — Supplemental Indenture No. 25, dated as of June 12, 2019, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed June 12, 2019, and incorporated herein by reference).

4.58 — Form of 4 1/8% Senior Secured Notes due 2029 (included in Exhibit 4.55).

4.59 — Form of 5 1/8% Senior Secured Notes due 2039 (included in Exhibit 4.56).

4.60 — Form of 5 1/4% Senior Secured Notes due 2049 (included in Exhibit 4.57).

4.61 — Additional Receivables Intercreditor Agreement, dated as of June 12, 2019, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent (filed as Exhibit 4.11 to the Company's Current Report on Form 8-K filed June 12, 2019, and incorporated herein by reference).

4.62 — Supplemental Indenture No. 26, dated as of February 26, 2020, by and among HCA Inc., HCA Healthcare, Inc., Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed February 26, 2020, and incorporated herein by reference).

4.63 — Form of 3.500% Senior Notes Due 2030 (included in Exhibit 4.62).

4.64 — Supplemental Indenture No. 27, dated as of June 30, 2021, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).

4.65 — Supplemental Indenture No. 28, dated as of June 30, 2021, by and among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).

4.66 — Form of 2 3/8% Senior Secured Notes Due 2031 (included in Exhibit 4.64).

4.67 — Form of 3 1/2% Senior Secured Notes Due 2051 (included in Exhibit 4.65).

4.68 — Additional Receivables Intercreditor Agreement, dated as of June 30, 2021, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent (filed as Exhibit 4.9 to the Company's Current Report on Form 8-K filed July 1, 2021, and incorporated herein by reference).

4.69 — Supplemental Indenture No. 29, dated as of March 9, 2022, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.2 to the Company's Current Report on Form 8-K filed March 10, 2022, and incorporated herein by reference).

4.70 — Supplemental Indenture No. 30, dated as of March 9, 2022, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.3 to the Company's Current Report on Form 8-K filed March 10, 2022, and incorporated herein by reference).

4.71 — Supplemental Indenture No. 31, dated as of March 9, 2022, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.4 to the Company's Current Report on Form 8-K filed March 10, 2022, and incorporated herein by reference).

4.72 — Supplemental Indenture No. 32, dated as of March 9, 2022, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.5 to the Company's Current Report on Form 8-K filed March 10, 2022, and incorporated herein by reference).

4.73 — Supplemental Indenture No. 33, dated as of March 9, 2022, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein, Delaware Trust Company, as trustee, and Deutsche Bank Trust Company Americas, as paying agent, registrar and transfer agent (filed as Exhibit 4.6 to the Company's Current Report on Form 8-K filed March 10, 2022, and incorporated herein by reference).

4.74 — Form of 3 1/8% Senior Secured Notes due 2027 (included in Exhibit 4.69).

4.75 — Form of 3 3/8% Senior Secured Notes due 2029 (included in Exhibit 4.70).

4.76 — Form of 3 5/8% Senior Secured Notes due 2032 (included in Exhibit 4.71).

4.77 — Form of 4 3/8% Senior Secured Notes due 2042 (included in Exhibit 4.72).

4.78 — Form of 4 5/8% Senior Secured Notes due 2052 (included in Exhibit 4.73).

4.79 — Additional Receivables Intercreditor Agreement, dated as of March 9, 2022, by and between Bank of America, N.A., as ABL Collateral Agent, and Bank of America, N.A., as First Lien Collateral Agent (filed as Exhibit 4.15 to the Company's Current Report on Form 8-K filed March 10, 2022, and incorporated herein by reference).

4.80 — Registration Rights Agreement, dated as of March 9, 2022, among HCA Inc., HCA Healthcare, Inc., the subsidiary guarantors named therein and Citigroup Global Markets Inc., BofA Securities, Inc., J.P. Morgan Securities LLC and Morgan Stanley & Co. LLC as representatives of the other several initial purchasers named therein (filed as Exhibit 4.16 to the Company's Current Report on Form 8-K filed March 10, 2022, and incorporated herein by reference).

10.1 — Form of Indemnity Agreement with certain officers and directors (filed as Exhibit 10.3 to the Company's Registration Statement on Form S-4 (File No. 333-145054) and incorporated herein by reference).

10.2(a)	—	2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates as Amended and Restated (filed as Exhibit 10.11(b) to the Company's Registration Statement on Form S-1 (File No. 333-171369), and incorporated herein by reference).*
10.2(b)	—	First Amendment to 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2011, and incorporated herein by reference).*
10.2(c)	—	Second Amendment to the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.1 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013, and incorporated herein by reference).*
10.3(a)	—	Management Stockholder's Agreement, dated November 17, 2006 (filed as Exhibit 10.12 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).
10.3(b)	—	Form of Omnibus Amendment to HCA Holdings, Inc.'s Management Stockholder's Agreements (filed as Exhibit 10.39 to the Company's Registration Statement on Form S-1 (File No. 333-171369), and incorporated herein by reference).
10.4	—	Form of Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed February 14, 2012, and incorporated herein by reference).*
10.5	—	Form of 2014 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.17(b) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2013, and incorporated herein by reference).*
10.6	—	Retirement Agreement, dated as of January 1, 2002, by and between the Company and Thomas F. Frist, Jr., M.D. (filed as Exhibit 10.30 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2001, and incorporated herein by reference).*
10.7(a)	—	Amended and Restated HCA Supplemental Executive Retirement Plan, effective December 22, 2010, except as provided therein (filed as Exhibit 10.26 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2010, and incorporated herein by reference).*
10.7(b)	—	Amendment, dated December 22, 2020, to Amended and Restated HCA Supplemental Executive Retirement Plan (filed as Exhibit 10.7(b) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020, and incorporated herein by reference).*
10.8(a)	—	Amended and Restated HCA Restoration Plan, effective December 22, 2010 (filed as Exhibit 10.27 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2010, and incorporated herein by reference).*
10.8(b)	—	Amendment to the Amended and Restated HCA Restoration Plan, effective June 5, 2020 (filed as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2020, and incorporated herein by reference).*
10.9(a)	—	Employment Agreement dated November 16, 2006 (Samuel N. Hazen) (filed as Exhibit 10.27(d) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2006, and incorporated herein by reference).*
10.9(b)	—	Employment Agreement dated November 16, 2006 (Charles J. Hall) (filed as Exhibit 10.28(d) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2012, and incorporated herein by reference).*
10.9(c)	—	Amendment to Employment Agreement effective February 9, 2011 (Samuel N. Hazen) (filed as Exhibit 10.29(j) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2010, and incorporated herein by reference).*

10.9(d)	—	Second Amendment to Employment Agreement effective January 29, 2015 (Samuel N. Hazen) (filed as Exhibit 10.23(i) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2014 (File No. 001-11239), and incorporated herein by reference).*
10.9(e)	—	Third Amendment to Employment Agreement effective January 27, 2016 (Samuel N. Hazen) (filed as Exhibit 10.23(j) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2015, and incorporated herein by reference).*
10.9(f)	—	Amendment to Employment Agreement effective January 27, 2016 (Charles J. Hall) (filed as Exhibit 10.23(k) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2015, and incorporated herein by reference).*
10.9(g)	—	Fourth Amendment to Employment Agreement effective November 14, 2016 (Samuel N. Hazen) (filed as Exhibit 10.16(l) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2016, and incorporated herein by reference).*
10.9(h)	—	Fifth Amendment to Employment Agreement effective January 1, 2019 (Samuel N. Hazen) (filed as Exhibit 10.14(i) to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).*
10.9(i)	—	Signing Bonus Agreement, dated as of January 24, 2022, by and between HCA Healthcare, Inc. and Michael R. McAlevey.*
10.10	—	Indemnification Priority and Information Sharing Agreement, dated as of November 1, 2009, by and between HCA Inc. and certain other parties thereto (filed as Exhibit 10.35 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2009, and incorporated herein by reference).
10.11	—	Assignment and Assumption Agreement, dated November 22, 2010, by and among HCA Inc., HCA Holdings, Inc. and HCA Merger Sub LLC (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed November 24, 2010, and incorporated herein by reference).
10.12	—	Omnibus Amendment to Various Stock and Option Plans and the Management Stockholders' Agreement, dated November 22, 2010 (filed as Exhibit 10.2 to the Company's Current Report on Form 8-K filed November 24, 2010, and incorporated herein by reference).*
10.13	—	Omnibus Amendment to Stock Option Agreements Issued Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as amended, effective February 16, 2011 (filed as Exhibit 10.38 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2010, and incorporated herein by reference).*
10.14	—	Stockholders' Agreement, dated as of March 9, 2011, by and among the Company, Hercules Holding II, LLC and the other signatories thereto (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed March 16, 2011, and incorporated herein by reference).
10.15	—	Amendment, dated as of September 21, 2011, to the Stockholders' Agreement, dated as of March 9, 2011 (filed as Exhibit 10.2 to the Company's Current Report on Form 8-K filed September 21, 2011, and incorporated herein by reference).
10.16	—	Form of Director Restricted Share Unit Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.5 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2011, and incorporated herein by reference).*
10.17	—	Executive Severance Policy (filed as Exhibit 10.46 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2013, and incorporated herein by reference).*
10.18	—	HCA Holdings, Inc. Employee Stock Purchase Plan (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 25, 2014 (File No. 001-11239), and incorporated herein by reference).*
10.19	—	Form of 2015 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed February 4, 2015, and incorporated herein by reference).*

10.20	—	Form of 2016 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.50 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2015, and incorporated herein by reference).*
10.21	—	Form of Director Restricted Share Unit Agreement (Annual Award) Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016, and incorporated herein by reference).*
10.22	—	Form of 2017 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.42 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2016, and incorporated herein by reference).*
10.23	—	Form of 2018 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.40 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2017, and incorporated herein by reference).*
10.24	—	Form of 2019 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.41 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).*
10.25	—	Form of 2019 Performance Share Unit Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.42 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2018, and incorporated herein by reference).*
10.26	—	Form of 2020 Stock Appreciation Right Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.32 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2019, and incorporated herein by reference).*
10.27	—	Form of 2020 Performance Share Unit Award Agreement Under the 2006 Stock Incentive Plan for Key Employees of HCA Holdings, Inc. and its Affiliates, as Amended and Restated (filed as Exhibit 10.33 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2019, and incorporated herein by reference).*
10.28	—	2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc., and its Affiliates (filed as Exhibit 4.4 to the Company's Registration Statement on Form S-8, and incorporated herein by reference).*
10.29	—	Form of Stock Appreciation Right Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 4.5 to the Company's Registration Statement on Form S-8 (File No. 333-237967), and incorporated herein by reference).*
10.30	—	Form of Employee Restricted Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 4.6 to the Company's Registration Statement on Form S-8 (File No. 333-237967), and incorporated herein by reference).*
10.31	—	Form of Performance Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 4.7 to the Company's Registration Statement on Form S-8 (File No. 333-237967), and incorporated herein by reference).*
10.32	—	HCA Healthcare, Inc. 2020 Senior Officer Performance Excellence Program (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 2, 2020, and incorporated herein by reference).*
10.33	—	Form of Director Restricted Share Unit Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 10.2 to the Company Quarterly Report on Form 10-Q for the quarter ended March 31, 2020, and incorporated herein by reference).*

10.34	—	Form of 2021 Stock Appreciation Right Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 10.37 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020, and incorporated herein by reference).*
10.35	—	Form of 2021 Performance Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 10.38 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020, and incorporated herein by reference).*
10.36	—	HCA Healthcare, Inc. 2021 Senior Officer Performance Excellence Program (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed April 9, 2021, and incorporated herein by reference).*
10.37	—	Form of 2022 Stock Appreciation Right Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 10.38 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2021, and incorporated herein by reference).*
10.38	—	Form of 2022 Performance Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates (filed as Exhibit 10.39 to the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2021, and incorporated herein by reference).*
10.39	—	HCA Healthcare, Inc. 2022 Senior Officer Performance Excellence Program (filed as Exhibit 10.1 to the Company's Current Report on Form 8-K filed on April 11, 2022, and incorporated herein by reference).*
10.40	—	Form of 2023 Stock Appreciation Right Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates.*
10.41	—	Form of 2023 Performance Share Unit Award Agreement Under the 2020 Stock Incentive Plan for Key Employees of HCA Healthcare, Inc. and its Affiliates.*
21	—	List of Subsidiaries.
22	—	List of Subsidiary Guarantors and Pledged Securities.
23	—	Consent of Ernst & Young LLP.
31.1	—	Certification of Chief Executive Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	—	Certification of Chief Financial Officer Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32	—	Certification Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101	—	The following financial information from our annual report on Form 10-K for the year ended December 31, 2022, filed with the SEC on February 17, 2023, formatted in Extensible Business Reporting Language (XBRL): (i) the consolidated balance sheets at December 31, 2022 and 2021, (ii) the consolidated income statements for the years ended December 31, 2021, 2020 and 2019, (iii) the consolidated comprehensive income statements for the years ended December 31, 2022, 2021 and 2020, (iv) the consolidated statements of stockholders' equity (deficit) for the years ended December 31, 2022, 2021 and 2020, (v) the consolidated statements of cash flows for the years ended December 31, 2022, 2021 and 2020, and (vi) the notes to consolidated financial statements.
104	—	The cover page from the Company's Annual Report on Form 10-K for the year ended December 31, 2022, formatted in Inline XBRL (included in Exhibit 101).

* Management compensatory plan or arrangement.

Item 16. ***Form 10-K Summary***

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

HCA HEALTHCARE, INC.

By: /S/ SAMUEL N. HAZEN
Samuel N. Hazen
Chief Executive Officer

Dated: February 17, 2023

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/S/ SAMUEL N. HAZEN Samuel N. Hazen	Chief Executive Officer and Director (Principal Executive Officer)	February 17, 2023
/S/ WILLIAM B. RUTHERFORD William B. Rutherford	Executive Vice President and Chief Financial Officer (Principal Financial Officer and Principal Accounting Officer)	February 17, 2023
/S/ THOMAS F. FRIST III Thomas F. Frist III	Chairman and Director	February 17, 2023
/S/ MEG G. CROFTON Meg G. Crofton	Director	February 17, 2023
/S/ ROBERT J. DENNIS Robert J. Dennis	Director	February 17, 2023
/S/ NANCY-ANN DEPARLE Nancy-Ann DeParle	Director	February 17, 2023
/S/ WILLIAM R. FRIST William R. Frist	Director	February 17, 2023
/S/ CHARLES O. HOLLIDAY, JR. Charles O. Holliday, Jr.	Director	February 17, 2023
/S/ HUGH F. JOHNSTON Hugh F. Johnston	Director	February 17, 2023
/S/ MICHAEL W. MICHELSON Michael W. Michelson	Director	February 17, 2023
/S/ WAYNE J. RILEY Wayne J. Riley	Director	February 17, 2023
/S/ ANDREA B. SMITH Andrea B. Smith	Director	February 17, 2023

HCA HEALTHCARE, INC.

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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
HCA Healthcare, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of HCA Healthcare, Inc. (the Company) as of December 31, 2022 and 2021, the related consolidated statements of income, comprehensive income, stockholders' equity (deficit) and cash flows for each of the three years in the period ended December 31, 2022, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2022 and 2021, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2022, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 17, 2023 expressed an unqualified opinion thereon.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Revenue Recognition

Description of the Matter

For the year ended December 31, 2022, the Company's revenues were $60.233 billion. As discussed in Note 1 to the consolidated financial statements, revenues are based upon the estimated amounts the Company expects to be entitled to receive from patients and third-party payers. Estimates of contractual allowances under managed care and commercial insurance plans are based upon the payment terms specified in the related contractual agreements. Management continually reviews the contractual allowances estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals. Revenues related to uninsured patients and uninsured copayment and deductible amounts for patients who have health care coverage may have discounts applied (uninsured discounts and contractual discounts). The Company also records estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record these revenues and accounts receivable at the estimated amounts the Company expects to collect. The primary collection risks relate to uninsured patient accounts, including amounts owed from patients after insurance has paid the amounts covered by the applicable agreement. Implicit price concessions relate primarily to amounts due directly from patients and are based upon management's assessment of historical write-offs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators.

Auditing management's estimates of contractual allowances and implicit price concessions was complex and judgmental due to the significant data inputs and subjective assumptions utilized in determining related amounts.

How We Addressed the Matter in Our Audit

We tested internal controls that address the risks of material misstatement related to the measurement and valuation of revenues, including estimation of contractual allowances and implicit price concessions. For example, we tested management's internal controls over the key data inputs to the contractual allowance and implicit price concession models, significant assumptions underlying management's models, and management's internal controls over retrospective reviews of historical reserve accuracy.

To test the estimated contractual allowances and implicit price concessions, we performed audit procedures that included, among others, assessing methodologies and evaluating the significant assumptions discussed above and testing the completeness and accuracy of the underlying data used by the Company in its estimates. We compared the significant assumptions used by management to current industry and economic trends and considered changes, if any, to the Company's business and other relevant factors. We also assessed the historical accuracy of management's estimates as a source of potential corroborative or contrary evidence.

Professional Liability Claims

Description of the Matter

At December 31, 2022, the Company's reserves for professional liability risks were $2.043 billion and the Company's related provision for losses for the year ended December 31, 2022 was $517 million. As discussed in Note 1 to the consolidated financial statements, reserves for professional liability risks represent the estimated ultimate net cost of all reported and unreported losses incurred and unpaid through the consolidated balance sheet date. Management estimates professional liability reserves and provisions for losses using individual case-basis valuations and actuarial analyses. Trends in the average frequency (number of claims) and ultimate average severity (cost per claim) of claims are significant assumptions in estimating the reserves.

Auditing management's professional liability claims reserves was complex and judgmental due to the significant estimations required in determining the reserves, particularly the actuarial methodology and assumptions related to the severity and frequency of claims.

How We Addressed the Matter in Our Audit	We tested management's internal controls that address the risks of material misstatement over the Company's professional liability claims reserves estimation process. For example, we tested internal controls over management's review of the actuarial methodology and significant assumptions, and the completeness and accuracy of claims data supporting the recorded reserves. To test the Company's determination of the estimated professional liability expense and reserves, we performed audit procedures that included, among others, testing the completeness and accuracy of underlying claims data used by the Company and its actuaries in its determination of reserves and reviewing the Company's insurance contracts by policy year to validate self-insured limits, deductibles and coverage limits. Additionally, with the involvement of our actuarial specialists, we performed audit procedures that included, among others, assessing the actuarial valuation methodologies utilized by management and its actuaries, testing the significant assumptions including consideration of Company-specific claim reporting and payment data, assessing the accuracy of management's historical reserve estimates, and developing an independent range of reserves for comparison to the Company's recorded amounts.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 1994.

Nashville, Tennessee
February 17, 2023

HCA HEALTHCARE, INC.
CONSOLIDATED INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2022, 2021 AND 2020
(Dollars in millions, except per share amounts)

	2022	2021	2020
Revenues	**$ 60,233**	$ 58,752	$ 51,533
Salaries and benefits	**27,685**	26,779	23,874
Supplies	**9,371**	9,481	8,369
Other operating expenses	**11,155**	9,961	9,307
Equity in earnings of affiliates	**(45)**	(113)	(54)
Depreciation and amortization	**2,969**	2,853	2,721
Interest expense	**1,741**	1,566	1,584
Losses (gains) on sales of facilities	**(1,301)**	(1,620)	7
Losses on retirement of debt	**78**	12	295
	51,653	48,919	46,103
Income before income taxes	**8,580**	9,833	5,430
Provision for income taxes	**1,746**	2,112	1,043
Net income	**6,834**	7,721	4,387
Net income attributable to noncontrolling interests	**1,191**	765	633
Net income attributable to HCA Healthcare, Inc.	**$ 5,643**	$ 6,956	$ 3,754
Per share data:			
Basic earnings per share	**$ 19.43**	$ 21.52	$ 11.10
Diluted earnings per share	**$ 19.15**	$ 21.16	$ 10.93
Shares used in earnings per share calculations (in millions):			
Basic	**290.348**	323.315	338.274
Diluted	**294.666**	328.752	343.605

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

HCA HEALTHCARE, INC.
CONSOLIDATED COMPREHENSIVE INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2022, 2021 AND 2020
(Dollars in millions)

	2022	2021	2020
Net income	**$ 6,834**	$ 7,721	$ 4,387
Other comprehensive income (loss) before taxes:			
Foreign currency translation	**(111)**	(9)	18
Unrealized gains (losses) on available-for-sale securities	**(55)**	(16)	14
Losses included in other operating expenses	**1**	—	—
	(54)	(16)	14
Defined benefit plans	**49**	87	(71)
Pension costs included in salaries and benefits	**9**	28	28
	58	115	(43)
Change in fair value of derivative financial instruments	**6**	1	(66)
Interest costs included in interest expense	**2**	37	24
	8	38	(42)
Other comprehensive income (loss) before taxes	**(99)**	128	(53)
Income taxes (benefits) related to other comprehensive income items	**(13)**	30	(11)
Other comprehensive income (loss)	**(86)**	98	(42)
Comprehensive income	**6,748**	7,819	4,345
Comprehensive income attributable to noncontrolling interests	**1,191**	765	633
Comprehensive income attributable to HCA Healthcare, Inc.	**$ 5,557**	$ 7,054	$ 3,712

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

HCA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2022 AND 2021
(Dollars in millions)

	2022	2021
ASSETS		
Current assets:		
Cash and cash equivalents	**$ 908**	$ 1,451
Accounts receivable	**8,891**	8,095
Inventories	**2,068**	1,986
Other	**1,776**	2,010
	13,643	13,542
Property and equipment, at cost:		
Land	**2,799**	2,496
Buildings	**20,221**	19,211
Equipment	**29,981**	28,256
Construction in progress	**1,756**	1,387
	54,757	51,350
Accumulated depreciation	**(29,182)**	(27,287)
	25,575	24,063
Investments of insurance subsidiaries	**381**	438
Investments in and advances to affiliates	**823**	448
Goodwill and other intangible assets	**9,653**	9,540
Right-of-use operating lease assets	**2,065**	2,113
Other	**298**	598
	$ 52,438	$ 50,742
LIABILITIES AND STOCKHOLDERS' EQUITY (DEFICIT)		
Current liabilities:		
Accounts payable	**$ 4,239**	$ 4,111
Accrued salaries	**1,712**	1,912
Other accrued expenses	**3,581**	3,322
Long-term debt due within one year	**370**	237
	9,902	9,582
Long-term debt, less debt issuance costs and discounts of $301 and $248	**37,714**	34,342
Professional liability risks	**1,528**	1,514
Right-of-use operating lease obligations	**1,752**	1,755
Income taxes and other liabilities	**1,615**	2,060
Stockholders' equity (deficit):		
Common stock $0.01 par; authorized 1,800,000,000 shares; outstanding 277,378,300 shares — 2022 and 305,476,800 shares — 2021	**3**	3
Accumulated other comprehensive loss	**(490)**	(404)
Retained deficit	**(2,280)**	(532)
Stockholders' deficit attributable to HCA Healthcare, Inc.	**(2,767)**	(933)
Noncontrolling interests	**2,694**	2,422
	(73)	1,489
	$ 52,438	$ 50,742

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

HCA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY (DEFICIT)
FOR THE YEARS ENDED DECEMBER 31, 2022, 2021 AND 2020
(Dollars in millions, except per share amounts)

	Equity (Deficit) Attributable to HCA Healthcare, Inc.						
	Common Stock		Capital in Excess of Par Value	Accumulated Other Comprehensive Loss	Retained Earnings (Deficit)	Equity Attributable to Noncontrolling Interests	Total
	Shares (in millions)	Par Value					
Balances, December 31, 2019 ...	338.446	$ 3	$ —	$ (460)	$ (2,351)	$ 2,243	$ (565)
Comprehensive income (loss)				(42)	3,754	633	4,345
Repurchase of common stock	(3.287)				(441)		(441)
Share-based benefit plans	4.267		300		(35)		265
Cash dividends declared ($0.43 per share)					(150)		(150)
Distributions						(626)	(626)
Other			(6)			70	64
Balances, December 31, 2020 ...	339.426	3	294	(502)	777	2,320	2,892
Comprehensive income				98	6,956	765	7,819
Repurchase of common stock	(37.812)		(578)		(7,637)		(8,215)
Share-based benefit plans	3.863		280				280
Cash dividends declared ($1.92 per share)					(628)		(628)
Distributions						(749)	(749)
Other			4			86	90
Balances, December 31, 2021 ...	305.477	3	-	(404)	(532)	2,422	1,489
Comprehensive income (loss)				**(86)**	**5,643**	**1,191**	**6,748**
Repurchase of common stock	**(30.747)**		**(264)**		**(6,736)**		**(7,000)**
Share-based benefit plans	**2.648**		**282**				**282**
Cash dividends declared ($2.24 per share)					**(655)**		**(655)**
Distributions						**(1,025)**	**(1,025)**
Other			**(18)**			**106**	**88**
Balances, December 31, 2022 ...	**277.378**	**$ 3**	**$ —**	**$ (490)**	**$ (2,280)**	**$ 2,694**	**$ (73)**

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

HCA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED DECEMBER 31, 2022, 2021 AND 2020
(Dollars in millions)

	2022	2021	2020
Cash flows from operating activities:			
Net income	**$ 6,834**	$ 7,721	$ 4,387
Adjustments to reconcile net income to net cash provided by operating activities:			
Increase (decrease) in cash from operating assets and liabilities:			
Accounts receivable	**(797)**	(962)	327
Inventories and other assets	**(59)**	(540)	(304)
Accounts payable and accrued expenses	**(296)**	999	1,255
Depreciation and amortization	**2,969**	2,853	2,721
Income taxes	**571**	(70)	41
Losses (gains) on sales of facilities	**(1,301)**	(1,620)	7
Losses on retirement of debt	**78**	12	295
Amortization of debt issuance costs	**29**	27	30
Share-based compensation	**341**	440	362
Other	**153**	99	111
Net cash provided by operating activities	**8,522**	8,959	9,232
Cash flows from investing activities:			
Purchase of property and equipment	**(4,395)**	(3,577)	(2,835)
Acquisition of hospitals and health care entities	**(224)**	(1,105)	(568)
Sales of hospitals and health care entities	**1,237**	2,160	68
Change in investments	**14**	(117)	(20)
Other	**(21)**	(4)	(38)
Net cash used in investing activities	**(3,389)**	(2,643)	(3,393)
Cash flows from financing activities:			
Issuances of long-term debt	**5,997**	4,344	2,700
Net change in revolving credit facilities	**120**	2,780	(2,480)
Repayment of long-term debt	**(2,830)**	(3,869)	(3,437)
Distributions to noncontrolling interests	**(1,025)**	(749)	(626)
Payment of debt issuance costs	**(53)**	(38)	(35)
Payment of dividends	**(653)**	(624)	(153)
Repurchase of common stock	**(7,000)**	(8,215)	(441)
Other	**(212)**	(284)	(205)
Net cash used in financing activities	**(5,656)**	(6,655)	(4,677)
Effect of exchange rate changes on cash and cash equivalents	**(20)**	(3)	10
Change in cash and cash equivalents	**(543)**	(342)	1,172
Cash and cash equivalents at beginning of period	**1,451**	1,793	621
Cash and cash equivalents at end of period	**$ 908**	$ 1,451	$ 1,793
Interest payments	**$ 1,662**	$ 1,502	$ 1,607
Income tax payments, net	**$ 1,175**	$ 2,182	$ 1,002

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

NOTE 1 — ACCOUNTING POLICIES

Reporting Entity

HCA Healthcare, Inc. is a holding company whose affiliates own and operate hospitals and related health care entities. The term "affiliates" includes direct and indirect subsidiaries of HCA Healthcare, Inc. and partnerships and joint ventures in which such subsidiaries are partners. At December 31, 2022 these affiliates owned and operated 182 hospitals, 126 freestanding surgery centers, 21 freestanding endoscopy centers and provided extensive outpatient and ancillary services. HCA Healthcare, Inc.'s facilities are located in 20 states and England. The terms "Company," "HCA," "we," "our" or "us," as used herein and unless otherwise stated or indicated by context, refer to HCA Healthcare, Inc. and its affiliates. The terms "facilities" or "hospitals" refer to entities owned and operated by affiliates of HCA and the term "employees" refers to employees of affiliates of HCA.

Basis of Presentation

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

The consolidated financial statements include all subsidiaries and entities controlled by HCA. We generally define "control" as ownership of a majority of the voting interest of an entity. The consolidated financial statements include entities in which we absorb a majority of the entity's expected losses, receive a majority of the entity's expected residual returns, or both, as a result of ownership, contractual or other financial interests in the entity. The accounts of acquired entities are included in our consolidated financial statements for periods subsequent to our acquisition of controlling interests. Significant intercompany transactions have been eliminated. Investments in entities we do not control, but in which we have a substantial ownership interest and can exercise significant influence, are accounted for using the equity method.

The majority of our expenses are "cost of revenue" items. Costs that could be classified as general and administrative include our corporate office costs, which were $378 million, $400 million and $416 million for the years ended December 31, 2022, 2021 and 2020, respectively.

COVID-19

We believe the extent of COVID-19's impact on our operating results and financial condition has been and could continue to be driven by many factors, most of which are beyond our control and ability to forecast. Because of these uncertainties, we cannot estimate how long or to what extent COVID-19 will impact our operations.

Revenues

Our revenues generally relate to contracts with patients in which our performance obligations are to provide health care services to the patients. Revenues are recorded during the period our obligations to provide health care services are satisfied. Our performance obligations for inpatient services are generally satisfied over periods that average approximately five days, and revenues are recognized based on charges incurred in relation to total expected charges. Our performance obligations for outpatient services are generally satisfied over a period of less than one day. The contractual relationships with patients, in most cases, also involve a third-party payer (Medicare, Medicaid, managed care health plans and commercial insurance companies, including plans offered through the health insurance exchanges) and the transaction prices for the services provided are dependent upon the terms provided by (Medicare and Medicaid) or negotiated with (managed care health plans and commercial insurance companies) the third-party payers. The payment arrangements with third-party payers for the services we provide to the related patients typically specify payments at amounts less than our standard charges. Medicare generally pays for inpatient and outpatient services at prospectively determined rates based on clinical, diagnostic and other factors. Services provided to patients having Medicaid coverage are generally paid at prospectively determined rates per discharge, per identified service or per covered member. Agreements with commercial insurance carriers, managed care and preferred provider organizations generally provide for payments based upon predetermined rates per diagnosis, per diem rates or discounted fee-for-service rates. Management continually reviews the contractual estimation process to consider and incorporate updates to laws and regulations and the frequent changes in managed care contractual terms resulting from contract renegotiations and renewals.

NOTE 1 — ACCOUNTING POLICIES (continued)

Revenues (continued)

Our revenues are based upon the estimated amounts we expect to be entitled to receive from patients and third-party payers. Estimates of contractual adjustments under managed care and commercial insurance plans are based upon the payment terms specified in the related contractual agreements. Revenues related to uninsured patients and uninsured copayment and deductible amounts for patients who have health care coverage may have discounts applied (uninsured discounts and contractual discounts). We also record estimated implicit price concessions (based primarily on historical collection experience) related to uninsured accounts to record these revenues at the estimated amounts we expect to collect. Our revenues by primary third-party payer classification and other (including uninsured patients) for the years ended December 31, are summarized in the following table (dollars in millions):

	Years Ended December 31,					
	2022	**Ratio**	**2021**	**Ratio**	**2020**	**Ratio**
Medicare	**$ 10,447**	**17.3%**	$ 10,447	17.8%	$ 10,420	20.2%
Managed Medicare	**9,201**	**15.3**	8,424	14.3	6,997	13.6
Medicaid	**2,636**	**4.4**	2,290	3.9	1,965	3.8
Managed Medicaid	**3,998**	**6.6**	3,124	5.3	2,621	5.1
Managed care and other insurers	**29,120**	**48.3**	30,295	51.6	26,535	51.5
International (managed care and other insurers)	**1,317**	**2.2**	1,336	2.3	1,120	2.2
Other	**3,514**	**5.9**	2,836	4.8	1,875	3.6
Revenues	**$ 60,233**	**100.0%**	$ 58,752	100.0%	$ 51,533	100.0%

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined (in relation to certain government programs, primarily Medicare, this is generally referred to as the "cost report" filing and settlement process). The adjustments to estimated Medicare and Medicaid reimbursement and disproportionate-share amounts, related primarily to cost reports filed during the respective year, resulted in net increases to revenues of $56 million, $53 million and $70 million in 2022, 2021 and 2020, respectively. The adjustments to estimated reimbursement amounts related primarily to cost reports filed during previous years resulted in a net increase to revenues of $42 million in 2022, a net increase to revenues of $19 million in 2021 and a net reduction to revenues of $5 million in 2020.

The Emergency Medical Treatment and Labor Act ("EMTALA") requires any hospital participating in the Medicare program to conduct an appropriate medical screening examination of every person who presents to the hospital's emergency room for treatment and, if the individual is suffering from an emergency medical condition, to either stabilize the condition or make an appropriate transfer of the individual to a facility able to handle the condition. The obligation to screen and stabilize emergency medical conditions exists regardless of an individual's ability to pay for treatment. Federal and state laws and regulations require, and our commitment to providing quality patient care encourages, us to provide services to patients who are financially unable to pay for the health care services they receive.

Patients treated at hospitals for non-elective care, who have income at or below 400% of the federal poverty level, are eligible for charity care, and we limit the patient responsibility amounts for these patients to a percentage of their annual household income, computed on a sliding scale based upon their annual income and the applicable percentage of the federal poverty level. Patients treated at hospitals for non-elective care, who have income above 400% of the federal poverty level, are eligible for certain other discounts which limit the patient responsibility amounts for these patients to a percentage of their annual household income, computed on a sliding scale based upon their annual income and the applicable percentage of the federal poverty level. We apply additional discounts to limit patient responsibility for certain emergency services. The federal poverty level is established by the federal government and is based on income and family size. Because we do not pursue collection of amounts determined to qualify as charity care, they are not reported in revenues. We provide discounts to uninsured patients who do not qualify for Medicaid or charity care. We may attempt to provide assistance to uninsured patients to help determine whether they may qualify for Medicaid, other federal or state assistance, or charity care. If an uninsured patient does not qualify for these programs, the uninsured discount is applied.

NOTE 1 — ACCOUNTING POLICIES (continued)

Revenues (continued)

The collection of outstanding receivables from Medicare, Medicaid, managed care payers, other third-party payers and patients is our primary source of cash and is critical to our operating performance. The primary collection risks relate to uninsured patient accounts, including patient accounts for which the primary insurance carrier has paid the amounts covered by the applicable agreement, but patient responsibility amounts (deductibles and copayments) remain outstanding. Implicit price concessions relate primarily to amounts due directly from patients. Estimated implicit price concessions are recorded for all uninsured accounts, regardless of the age of those accounts. Accounts are written off when all reasonable collection efforts have been performed.

The estimates for implicit price concessions are based upon management's assessment of historical writeoffs and expected net collections, business and economic conditions, trends in federal, state and private employer health care coverage and other collection indicators. Management relies on the results of detailed reviews of historical writeoffs and collections at facilities that represent a majority of our revenues and accounts receivable (the "hindsight analysis") as a primary source of information in estimating the collectability of our accounts receivable. We perform the hindsight analysis quarterly, utilizing rolling twelve-months accounts receivable collection and writeoff data. We believe our quarterly updates to the estimated implicit price concession amounts at each of our hospital facilities provide reasonable estimates of our revenues and valuations of our accounts receivable. These routine, quarterly changes in estimates have not resulted in material adjustments to the valuations of our accounts receivable or period-to-period comparisons of our revenues. At December 31, 2022 and 2021, estimated implicit price concessions of $6.780 billion and $6.784 billion, respectively, had been recorded to adjust our revenues and accounts receivable to the estimated amounts we expect to collect.

To quantify the total impact of the trends related to uninsured patient accounts, we believe it is beneficial to view total uncompensated care, which is comprised of charity care, uninsured discounts and implicit price concessions. A summary of the estimated cost of total uncompensated care for the years ended December 31, follows (dollars in millions):

	2022	2021	2020
Patient care costs (salaries and benefits, supplies, other operating expenses and depreciation and amortization)	**$ 51,180**	$ 49,074	$ 44,271
Cost-to-charges ratio (patient care costs as percentage of gross patient charges)	**11.0%**	11.3%	12.0%
Total uncompensated care	**$ 31,734**	$ 29,642	$ 29,029
Multiply by the cost-to-charges ratio	**11.0%**	11.3%	12.0%
Estimated cost of total uncompensated care	**$ 3,491**	$ 3,350	$ 3,483

The total uncompensated care amounts include charity care of $13.615 billion, $13.644 billion and $13.763 billion for the years ended December 31, 2022, 2021 and 2020, respectively. The estimated cost of charity care was $1.498 billion, $1.542 billion and $1.652 billion for the years ended December 31, 2022, 2021 and 2020, respectively.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with a maturity of three months or less when purchased. Our insurance subsidiaries' cash equivalent investments in excess of the amounts required to pay estimated professional liability claims during the next twelve months are not included in cash and cash equivalents as these funds are not available for general corporate purposes. Carrying values of cash and cash equivalents approximate fair value due to the short-term nature of these instruments.

Our cash management system provides for daily investment of available balances and the funding of outstanding checks when presented for payment. Outstanding, but unpresented, checks totaling $656 million and $536 million at December 31, 2022 and 2021, respectively, have been included in "accounts payable" in the consolidated balance sheets. Upon presentation for payment, these checks are funded through available cash balances or our credit facility.

NOTE 1 — ACCOUNTING POLICIES (continued)

Accounts Receivable

We receive payments for services rendered from federal and state agencies (under the Medicare and Medicaid programs), managed care health plans, commercial insurance companies, employers and patients. We recognize that revenues and receivables from government agencies are significant to our operations, but do not believe there are significant credit risks associated with these government agencies. We do not believe there are any other significant concentrations of revenues from any particular payer that would subject us to any significant credit risks in the collection of our accounts receivable. Days revenues in accounts receivable were 53 days, 49 days and 45 days at December 31, 2022, 2021 and 2020, respectively. Changes in general economic conditions, patient accounting service center operations, payer mix, payer claim processing, or federal or state governmental health care coverage could affect our collection of accounts receivable, cash flows and results of operations.

Inventories

Inventories are stated at the lower of cost (first-in, first-out) or market.

Property and Equipment

Depreciation expense, computed using the straight-line method, was $2.941 billion in 2022, $2.826 billion in 2021 and $2.693 billion in 2020. Buildings and improvements are depreciated over estimated useful lives ranging generally from 10 to 40 years. Estimated useful lives of equipment vary generally from four to 10 years.

When events, circumstances or operating results indicate the carrying values of certain property and equipment expected to be held and used might be impaired, we prepare projections of the undiscounted future cash flows expected to result from the use of the assets and their eventual disposition. If the projections indicate the recorded amounts are not expected to be recoverable, such amounts are reduced to estimated fair value. Fair value may be estimated based upon internal evaluations that include quantitative analyses of revenues and cash flows, reviews of recent sales of similar assets and independent appraisals.

Property and equipment to be disposed of are reported at the lower of their carrying amounts or fair value less costs to sell or close. The estimates of fair value are usually based upon recent sales of similar assets and market responses based upon discussions with and offers received from potential buyers.

Investments of Insurance Subsidiaries

At December 31, 2022 and 2021, the investment securities held by our insurance subsidiaries were classified as “available-for-sale” as defined in Accounting Standards Codification (“ASC”) No. 320, *Investments — Debt Securities* and are recorded at fair value. The investment securities are held for the purpose of providing a funding source to pay liability claims covered by the insurance subsidiaries. We perform quarterly assessments of individual investment securities to determine whether declines in fair value are due to credit-related or noncredit-related factors. Our investment securities evaluation process involves subjective judgments, often involves estimating the outcome of future events, and requires a significant level of professional judgment in determining whether a credit-related impairment has occurred. We evaluate, among other things, the financial position and near term prospects of the issuer, conditions in the issuer’s industry, liquidity of the investment, changes in the amount or timing of expected future cash flows from the investment, and recent downgrades of the issuer by a rating agency, to determine if, and when, a decline in the fair value of an investment below amortized cost is considered to be a credit-related impairment. The extent to which the fair value of the investment is less than amortized cost and our ability and intent to retain the investment, to allow for any anticipated recovery of the investment’s fair value, are important components of our investment securities evaluation process.

NOTE 1 — ACCOUNTING POLICIES (continued)

Goodwill and Intangible Assets

Goodwill is not amortized but is subject to annual impairment tests. In addition to the annual impairment review, impairment reviews are performed whenever circumstances indicate a possible impairment may exist. Impairment testing for goodwill is done at the reporting unit level. Reporting units are one level below the business segment level, and our impairment testing is performed at the operating division level. We compare the fair value of the reporting unit assets to the carrying amount, on at least an annual basis, to determine if there is potential impairment. If the fair value of the reporting unit assets is less than their carrying value, an impairment loss is recognized. Fair value is estimated based upon internal evaluations of each reporting unit that include quantitative analyses of market multiples, revenues and cash flows and reviews of recent sales of similar facilities. No goodwill impairments were recognized during 2022, 2021 or 2020.

During 2022, goodwill increased by $262 million related to acquisitions and declined by $105 million related to foreign currency translation and other adjustments. During 2021, goodwill increased by $1.002 billion related to acquisitions and declined by $75 million related to foreign currency translation and other adjustments.

During 2022, identifiable intangible assets declined by $44 million due to amortization and other adjustments. During 2021, identifiable intangible assets increased by $60 million related to acquisitions and declined by $25 million due to amortization and other adjustments. Identifiable intangible assets with finite lives are amortized over estimated lives ranging generally from three to 10 years. The gross carrying amounts of amortizable identifiable intangible assets at both December 31, 2022 and 2021 were $274 million and accumulated amortization was $208 million and $175 million, respectively. The gross carrying amounts of indefinite-lived identifiable intangible assets at December 31, 2022 and 2021 were $293 million and $304 million, respectively. Indefinite-lived identifiable intangible assets are not amortized but are subject to annual impairment tests, and impairment reviews are performed whenever circumstances indicate a possible impairment may exist.

Debt Issuance Costs and Discounts

Debt issuance costs and discounts are amortized based upon the terms of the respective debt obligations. The gross carrying amounts of debt issuance costs and discounts at December 31, 2022 and 2021 were $496 million and $446 million, respectively, and accumulated amortization was $195 million and $198 million, respectively. Amortization of debt issuance costs and discounts is included in interest expense and was $29 million, $27 million and $30 million for 2022, 2021 and 2020, respectively.

Professional Liability Claims

Reserves for professional liability risks were $2.043 billion and $2.022 billion at December 31, 2022 and 2021, respectively. The current portion of the reserves, $515 million and $508 million at December 31, 2022 and 2021, respectively, is included in “other accrued expenses” in the consolidated balance sheets. Provisions for losses related to professional liability risks were $517 million, $453 million and $435 million for 2022, 2021 and 2020, respectively, and are included in “other operating expenses” in our consolidated income statements. Provisions for losses related to professional liability risks are based upon actuarially determined estimates. During 2022, 2021 and 2020, we recorded reductions to the provision for professional liability risks of $55 million, $87 million and $112 million, respectively, due to the receipt of updated actuarial information. Loss and loss expense reserves represent the estimated ultimate net cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves for unpaid losses and loss expenses are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. Adjustments to the estimated reserve amounts are included in current operating results. The reserves for professional liability risks cover approximately 2,000 and 2,100 individual claims at December 31, 2022 and 2021, respectively, and estimates for unreported potential claims. The time period required to resolve these claims can vary depending upon the jurisdiction and whether the claim is settled or litigated. During 2022 and 2021, $497 million and $384 million, respectively, of net payments were made for professional and general liability claims. The estimation of the timing of payments beyond a year can vary significantly. Although considerable variability is inherent in professional liability reserve estimates, we believe the reserves for losses and loss expenses are adequate; however, there can be no assurance the ultimate liability will not exceed our estimates.

NOTE 1 — ACCOUNTING POLICIES (continued)

Professional Liability Claims (continued)

A portion of our professional liability risks is insured through our insurance subsidiary. Subject, in most cases, to a $15 million per occurrence self-insured retention, our facilities are insured by our insurance subsidiary for losses up to $75 million per occurrence. The insurance subsidiary has obtained reinsurance for professional liability risks generally above a retention level of either $25 million or $35 million per occurrence, depending on the jurisdiction for the related claim. We also maintain professional liability insurance with unrelated commercial carriers for losses in excess of amounts insured by our insurance subsidiary.

The obligations covered by reinsurance and excess insurance contracts are included in the reserves for professional liability risks, as we remain liable to the extent the reinsurers and excess insurance carriers do not meet their obligations under the reinsurance and excess insurance contracts. The amounts receivable under the reinsurance contracts were $48 million and $44 million at December 31, 2022 and 2021, respectively, recorded in “other assets,” and $12 million and $11 million at December 31, 2022 and 2021, respectively, recorded in “other current assets.”

Financial Instruments

Derivative financial instruments have been employed to manage risks, including interest rate exposures, and have not been used for trading or speculative purposes. Changes in the fair value of derivatives are recognized periodically either in earnings or in stockholders’ equity, as a component of other comprehensive income, depending on whether the derivative financial instrument qualifies for hedge accounting, and if so, whether it qualifies as a fair value hedge or a cash flow hedge. Gains and losses on derivatives designated as cash flow hedges, to the extent they are effective, are recorded in other comprehensive income, and subsequently reclassified to earnings to offset the impact of the hedged items when they occur. The net interest paid or received on interest rate swaps is recognized as interest expense.

Noncontrolling Interests in Consolidated Entities

The consolidated financial statements include all assets, liabilities, revenues and expenses of less than 100% owned entities that we control. Accordingly, we have recorded noncontrolling interests in the earnings and equity of such entities.

NOTE 2 — SHARE-BASED COMPENSATION

Stock Incentive Plans

Our stock incentive plans are designed to promote the long-term financial interests and growth of the Company by attracting and retaining management and other personnel, motivating them to achieve long range goals and aligning their interests with those of our stockholders. Stock appreciation right (“SARs”) and restricted share unit (“RSUs”) grants vest solely based upon continued employment over a specific period of time, and performance share unit (“PSUs”) grants vest based upon both continued employment over a specific period of time and the achievement of predetermined financial targets over a specific period of time. At December 31, 2022 there were 13.826 million shares available for future grants.

Employee Stock Purchase Plan

Our employee stock purchase plan (“ESPP”) provides our participating employees an opportunity to obtain shares of our common stock at a discount (through payroll deductions over three-month periods). At December 31, 2022, 4.436 million shares of common stock were reserved for ESPP issuances. During 2022, 2021 and 2020, the Company recognized $16 million, $15 million and $13 million, respectively, of compensation expense related to the ESPP.

NOTE 2 — SHARE-BASED COMPENSATION (continued)

SAR, RSU and PSU Activity

The fair value of each SAR award is estimated on the grant date, using valuation models and the weighted average assumptions indicated in the following table. Awards under our stock incentive plans generally vest based on continued employment ("Time SARs" and "RSUs") or based upon continued employment and the achievement of certain financial targets ("Performance SARs" and "PSUs"). PSUs have a three-year cumulative earnings per share target, and the number of PSUs earned can vary from zero (for actual performance of less than 90% of target) to two times the original PSU grant (for actual performance of 110% or more of target). Each grant is valued as a single award with an expected term equal to the average expected term of the component vesting tranches. The expected term of the share-based award is limited by the contractual term. We use historical exercise behavior data and other factors to estimate the expected term of the SARs.

Compensation cost is recognized on the straight-line attribution method. The straight-line attribution method requires that total compensation expense recognized must at least equal the vested portion of the grant-date fair value. The expected volatility is derived using historical stock price information for our common stock and the volatility implied by the trading of options to purchase our stock on open-market exchanges. The risk-free interest rate is the approximate yield on United States Treasury Strips having a life equal to the expected share-based award life on the date of grant. The expected life is an estimate of the number of years a share-based award will be held before it is exercised. The expected dividend yield is estimated based on the assumption that the dividend yield at date of grant will be maintained over the expected life of the grant.

	2022	2021	2020
Risk-free interest rate	**1.64%**	0.68%	1.44%
Expected volatility	**34%**	36%	27%
Expected life, in years	**5.11**	6.17	6.15
Expected dividend yield	**0.95%**	1.10%	1.19%

Information regarding Time SARs and Performance SARs activity during 2022, 2021 and 2020 is summarized below (share amounts in thousands):

	Time SARs	Performance SARs	Total SARs	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term	Aggregate Intrinsic Value (dollars in millions)
SARs outstanding, December 31, 2019	9,050	2,144	11,194	$ 71.79		
Granted	1,120	—	1,120	144.47		
Exercised	(2,159)	(1,325)	(3,484)	44.07		
Cancelled	(175)	—	(175)	111.69		
SARs outstanding, December 31, 2020	7,836	819	8,655	91.53		
Granted	877	—	877	174.98		
Exercised	(2,443)	(533)	(2,976)	67.57		
Cancelled	(108)	—	(108)	138.32		
SARs outstanding, December 31, 2021	6,162	286	6,448	113.15		
Granted	**570**	**—**	**570**	**236.00**		
Exercised	**(660)**	**(159)**	**(819)**	**90.84**		
Cancelled	**(112)**	**—**	**(112)**	**182.87**		
SARs outstanding, December 31, 2022	**5,960**	**127**	**6,087**	**$ 126.38**	**5.7 years**	**$ 691**
SARs exercisable, December 31, 2022	**4,022**	**127**	**4,149**	**$ 102.20**	**4.7 years**	**$ 572**

NOTE 2 — SHARE-BASED COMPENSATION (continued)

The weighted average fair values of SARs granted during 2022, 2021 and 2020 were $69.55, $54.57 and $35.98 per share, respectively. The intrinsic values of SARs exercised during 2022, 2021 and 2020 were $115 million, $404 million and $328 million, respectively. As of December 31, 2022, the unrecognized compensation cost related to nonvested SARs was $40 million.

SAR, RSU and PSU Activity (continued)

Information regarding RSUs and PSUs activity during 2022, 2021 and 2020 is summarized below (share amounts in thousands):

	RSUs	PSUs	Total RSUs and PSUs	Weighted Average Grant Date Fair Value
RSUs and PSUs outstanding, December 31, 2019	2,620	3,035	5,655	$ 105.23
Granted	1,048	808	1,856	144.17
Performance adjustment	—	206	206	81.89
Vested	(1,030)	(1,364)	(2,394)	88.63
Cancelled	(162)	(93)	(255)	124.50
RSUs and PSUs outstanding, December 31, 2020	2,476	2,592	5,068	125.40
Granted	899	689	1,588	174.34
Performance adjustment	—	684	684	102.02
Vested	(992)	(1,772)	(2,764)	106.62
Cancelled	(192)	(110)	(302)	149.07
RSUs and PSUs outstanding, December 31, 2021	2,191	2,083	4,274	150.32
Granted	**611**	**455**	**1,066**	**235.71**
Performance adjustment	**—**	**699**	**699**	**138.45**
Vested	**(878)**	**(1,399)**	**(2,277)**	**138.41**
Cancelled	**(140)**	**(123)**	**(263)**	**183.86**
RSUs and PSUs outstanding, December 31, 2022	**1,784**	**1,715**	**3,499**	**$ 179.18**

The fair values of RSUs and PSUs that vested during 2022, 2021 and 2020 were $550 million, $475 million and $349 million, respectively. As of December 31, 2022, the unrecognized compensation cost related to RSUs and PSUs was $324 million.

NOTE 3 — ACQUISITIONS AND DISPOSITIONS

During 2022, we paid $224 million to acquire nonhospital health care entities (noncontrolling interests of $72 million were recorded). During 2021, we paid $67 million to acquire two hospital facilities, one in southern Georgia and one in Tennessee, $594 million to acquire a network of urgent care centers in Florida and $114 million to acquire other nonhospital health care entities (noncontrolling interests of $117 million were recorded). We also paid $330 million and assumed certain liabilities to acquire an 80% interest (noncontrolling interests of $100 million were recorded) in a venture providing post-acute care services (home health and hospice). During 2020, we paid $568 million to acquire a hospital in New Hampshire and other nonhospital health care entities. Purchase price amounts have been allocated to the related assets acquired and liabilities assumed based upon their respective fair values. The purchase price paid in excess of the fair value of identifiable net assets of these acquired entities aggregated $262 million, $1.002 billion and $279 million in 2022, 2021 and 2020, respectively. The consolidated financial statements include the accounts and operations of the acquired entities subsequent to the respective acquisition dates. The pro forma effects of these acquired entities on our results of operations for periods prior to the respective acquisition dates were not significant.

NOTE 3 — ACQUISITIONS AND DISPOSITIONS (continued)

During 2022, we received proceeds of $326 million and recognized a pretax gain of $274 million ($200 million after tax) related to sales of real estate and other health care entity investments. We also received proceeds of $911 million and recognized a pretax gain of $1.027 billion ($527 million after tax and amounts attributable to noncontrolling interests) related to the sale of a controlling interest in a subsidiary of our group purchasing organization. During 2021, we received proceeds of $1.502 billion and recognized a pretax gain of $1.226 billion ($920 million after tax) related to the sales of five hospital facilities in Georgia, comprised of three facilities from our American Group (northern Georgia market) and two facilities from our National Group (southern Georgia market). We also received proceeds of $658 million and recognized a pretax gain of $394 million ($294 million after tax) related to sales of other health care entity investments and real estate. During 2020, we received proceeds of $68 million and recognized a pretax loss of $7 million ($9 million after tax) related to the sale of a hospital facility from our American Group (Mississippi market) and sales of real estate and other investments.

NOTE 4 — INCOME TAXES

The provision for income taxes consists of the following (dollars in millions):

	2022	2021	2020
Current:			
Federal	**$ 1,222**	$ 1,769	$ 1,021
State	**206**	311	126
Foreign	**18**	15	5
Deferred:			
Federal	**261**	24	(73)
State	**27**	(18)	(39)
Foreign	**12**	11	3
	$ 1,746	$ 2,112	$ 1,043

Our provision for income taxes for the years ended December 31, 2022, 2021 and 2020 included tax benefits of $77 million, $119 million and $92 million, respectively, related to the settlement of employee equity awards. Our foreign pretax income was $66 million, $64 million and $9 million for the years ended December 31, 2022, 2021 and 2020, respectively.

A reconciliation of the federal statutory rate to the effective income tax rate follows:

	2022	2021	2020
Federal statutory rate	**21.0%**	21.0%	21.0%
State income taxes, net of federal tax benefit	**2.3**	2.0	1.9
Change in liability for uncertain tax positions	**0.7**	0.7	(0.2)
Tax benefit from settlements of employee equity awards	**(0.9)**	(1.2)	(1.8)
Other items, net	**0.5**	0.8	0.8
Effective income tax rate on income attributable to HCA Healthcare, Inc.	**23.6**	23.3	21.7
Income attributable to noncontrolling interests from consolidated partnerships	**(3.3)**	(1.8)	(2.5)
Effective income tax rate on income before income taxes	**20.3%**	21.5%	19.2%

NOTE 4 — INCOME TAXES (continued)

A summary of the items comprising our deferred tax assets and liabilities at December 31 follows (dollars in millions):

	2022		2021	
	Assets	**Liabilities**	**Assets**	**Liabilities**
Depreciation and fixed asset basis differences	**$ —**	**$ 938**	$ —	$ 737
Allowances for professional liability and other risks	**430**		426	—
Accounts receivable	**368**		348	—
Compensation	**402**		502	—
Right-of-use lease assets and obligations	**451**	**438**	428	419
Other	**536**	**698**	499	652
	$ 2,187	**$ 2,074**	$ 2,203	$ 1,808

At December 31, 2022, federal and state net operating loss carryforwards (expiring in years 2025 through 2039) available to offset future taxable income approximated $28 million and $193 million, respectively. Utilization of net operating loss carryforwards in any one year may be limited.

The following table summarizes the activity related to our gross unrecognized tax benefits, excluding accrued interest of $129 million and $99 million as of December 31, 2022 and 2021, respectively (dollars in millions):

	2022	2021
Balance at January 1	**$ 576**	$ 469
Additions based on tax positions related to the current year	**25**	57
Additions for tax positions of prior years	**50**	66
Reductions for tax positions of prior years	**(4)**	(6)
Settlements	**(1)**	(3)
Lapse of applicable statutes of limitations	**(7)**	(7)
Balance at December 31	**$ 639**	$ 576

Unrecognized tax benefits of $278 million as of December 31, 2022 ($217 million as of December 31, 2021) would affect the effective rate, if recognized.

The Internal Revenue Service (“IRS”) was conducting an examination of the Company’s 2016, 2017 and 2018 federal income tax returns and the 2019 return for one affiliated partnership at December 31, 2022. We are also subject to examination by state and foreign taxing authorities. Depending on the resolution of any federal, state and foreign tax disputes, the completion of examinations by federal, state or foreign taxing authorities, or the expiration of statutes of limitation for specific taxing jurisdictions, we believe it is reasonably possible that our liability for unrecognized tax benefits may significantly increase or decrease within the next 12 months. However, we are currently unable to estimate the range of any possible change.

NOTE 5 — EARNINGS PER SHARE

We compute basic earnings per share using the weighted average number of common shares outstanding. We compute diluted earnings per share using the weighted average number of common shares outstanding plus the dilutive effect of outstanding SARs, RSUs and PSUs, computed using the treasury stock method. During 2022, 2021 and 2020, we repurchased 30.747 million shares, 37.812 million shares and 3.287 million shares, respectively, of our common stock. The following table sets forth the computations of basic and diluted earnings per share for the years ended December 31, 2022, 2021 and 2020 (dollars and shares in millions, except per share amounts):

	2022	2021	2020
Net income attributable to HCA Healthcare, Inc.	**$ 5,643**	$ 6,956	$ 3,754
Weighted average common shares outstanding	**290.348**	323.315	338.274
Effect of dilutive incremental shares	**4.318**	5.437	5.331
Shares used for diluted earnings per share	**294.666**	328.752	343.605
Earnings per share:			
Basic earnings per share	**$ 19.43**	$ 21.52	$ 11.10
Diluted earnings per share	**$ 19.15**	$ 21.16	$ 10.93

NOTE 6 — INVESTMENTS OF INSURANCE SUBSIDIARIES

A summary of the insurance subsidiaries' investments at December 31 follows (dollars in millions):

	2022			
		Unrealized Amounts		
	Amortized Cost	Gains	Losses	Fair Value
Debt securities	**$ 415**	**$ —**	**$ (38)**	**$ 377**
Money market funds and other	**96**	**—**	**—**	**96**
	$ 511	**$ —**	**$ (38)**	**473**
Amounts classified as current assets				**(92)**
Investment carrying value				**$ 381**

	2021			
		Unrealized Amounts		
	Amortized Cost	Gains	Losses	Fair Value
Debt securities	$ 400	$ 18	$ (2)	$ 416
Money market funds and other	125	—	—	125
	$ 525	$ 18	$ (2)	541
Amounts classified as current assets				(103)
Investment carrying value				$ 438

At December 31, 2022 and 2021, the investments in debt securities of our insurance subsidiaries were classified as "available-for-sale." Changes in unrealized gains and losses are recorded as adjustments to other comprehensive income (loss).

NOTE 6 — INVESTMENTS OF INSURANCE SUBSIDIARIES (continued)

Scheduled maturities of investments in debt securities at December 31, 2022 were as follows (dollars in millions):

	Amortized Cost	Fair Value
Due in one year or less	$ 31	$ 31
Due after one year through five years	121	116
Due after five years through ten years	185	161
Due after ten years	78	69
	$ 415	$ 377

The average expected maturity of the investments in debt securities at December 31, 2022 was 5.3 years, compared to the average scheduled maturity of 8.6 years. Expected and scheduled maturities may differ because the issuers of certain securities have the right to call, prepay or otherwise redeem such obligations prior to their scheduled maturity date.

NOTE 7 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE

Accounting Standards Codification 820, *Fair Value Measurements and Disclosures* ("ASC 820") emphasizes fair value is a market-based measurement, and fair value measurements should be determined based on the assumptions market participants would use in pricing assets or liabilities. ASC 820 utilizes a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumptions about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included in Level 1 that are observable for the asset or liability, either directly or indirectly. Level 2 inputs may include quoted prices for similar assets and liabilities in active markets, as well as inputs observable for the asset or liability (other than quoted prices), such as interest rates, foreign exchange rates, and yield curves observable at commonly quoted intervals. Level 3 inputs are unobservable inputs for the asset or liability, which are typically based on an entity's own assumptions, as there is little, if any, related market activity. In instances where the determination of the fair value measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input significant to the fair value measurement in its entirety. Our assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment.

The investments of our insurance subsidiaries are generally classified within Level 1 or Level 2 of the fair value hierarchy because they are valued using quoted market prices, broker or dealer quotations, or alternative pricing sources with reasonable levels of price transparency.

The following tables summarize our assets and liabilities measured at fair value on a recurring basis as of December 31, 2022 and 2021, aggregated by the level in the fair value hierarchy within which those measurements fall (dollars in millions):

	2022			
		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Investments of insurance subsidiaries:				
Debt securities	**$ 377**	**$ —**	**$ 377**	**$ —**
Money market funds and other	**96**	**96**	**—**	**—**
Investments of insurance subsidiaries	**473**	**96**	**377**	**—**
Less amounts classified as current assets	**(92)**	**(92)**	**—**	**—**
	$ 381	**$ 4**	**$ 377**	**$ —**

NOTE 7 — ASSETS AND LIABILITIES MEASURED AT FAIR VALUE (continued)

	2021			
		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets for Identical Assets and Liabilities (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets:				
Investments of insurance subsidiaries:				
Debt securities	$ 416	$ —	$ 416	$ —
Money market funds and other	125	125	—	—
Investments of insurance subsidiaries	541	125	416	—
Less amounts classified as current assets	(103)	(103)	—	—
	$ 438	$ 22	$ 416	$ —
Liabilities:				
Interest rate swap (Other accrued expenses)	$ 8	$ —	$ 8	$ —

The estimated fair value of our long-term debt was $35.555 billion and $38.541 billion at December 31, 2022 and 2021, respectively, compared to carrying amounts, excluding debt issuance costs and discounts, aggregating $38.385 billion and $34.827 billion, respectively. The estimates of fair value are generally based upon the quoted market prices or quoted market prices for similar issues of long-term debt with the same maturities.

NOTE 8 — LONG-TERM DEBT

A summary of long-term debt at December 31, including related interest rates at December 31, 2022, follows (dollars in millions):

	2022	2021
Senior secured asset-based revolving credit facility (effective interest rate of 5.6%)	**$ 2,900**	$ 2,780
Senior secured revolving credit facility	**—**	—
Senior secured term loan facilities (effective interest rate of 5.9%)	**1,880**	1,960
Senior secured notes	**—**	16,200
Other senior secured debt (effective interest rate of 3.9%)	**953**	935
Senior secured debt	**5,733**	21,875
Senior unsecured notes (effective interest rate of 4.9%)	**32,652**	12,952
Debt issuance costs and discounts	**(301)**	(248)
Total debt (average life of 9.6 years, rates averaging 5.0%)	**38,084**	34,579
Less amounts due within one year	**370**	237
	$ 37,714	$ 34,342

During 2022, we issued $6.000 billion aggregate principal amount of senior notes comprised of (i) $1.000 billion aggregate principal amount of 3 1/8% senior notes due 2027, (ii) $500 million aggregate principal amount of 3 3/8% senior notes due 2029, (iii) $2.000 billion aggregate principal amount of 3 5/8% senior notes due 2032, (iv) $500 million aggregate principal amount of 4 3/8% senior notes due 2042 and (v) $2.000 billion aggregate principal amount of 4 5/8% senior notes due 2052. We used a portion of the net proceeds to pay down our revolving credit facilities, and we redeemed all $1.250 billion outstanding aggregate principal amount of our 4.75% senior notes due 2023 and all $1.250 billion outstanding aggregate principal amount of our 5.875% senior notes due 2023. The pretax loss on retirement of debt for these two redemptions was $78 million.

Also during 2022, Standard & Poor's Rating Services (“S&P”) announced it had issued an investment grade rating with respect to the issuer credit rating of HCA Healthcare, Inc. and its subsidiaries. S&P's announcement, in conjunction with the Moody's Investors Service, Inc. upgrade in 2021, permitted the permanent release of the subsidiary guarantees and all collateral securing our senior secured notes. As a result of these releases, our senior secured notes are now classified as senior unsecured notes. The subsidiary guarantees and collateral securing our senior secured credit facilities are not affected.

NOTE 8 — LONG-TERM DEBT (continued)

Senior Secured Credit Facilities And Other Senior Secured Debt

We have entered into the following senior secured credit facilities: (i) a $4.500 billion asset-based revolving credit facility maturing on June 30, 2026 with a borrowing base of 85% of eligible accounts receivable, subject to customary reserves and eligibility criteria ($2.900 billion outstanding at December 31, 2022) (the "ABL credit facility"); (ii) a $2.000 billion senior secured revolving credit facility maturing on June 30, 2026 (none outstanding at December 31, 2022 without giving effect to certain outstanding letters of credit); (iii) a $1.388 billion senior secured term loan A facility maturing on June 30, 2026; and (iv) a $492 million senior secured term loan B facility maturing on June 30, 2028. We refer to the facilities described under (ii) through (iv) above, collectively, as the "cash flow credit facility" and, together with the ABL credit facility, the "senior secured credit facilities." Finance leases and other secured debt totaled $953 million at December 31, 2022. Effective in January 2023, availability under our senior secured revolving credit facility was increased by $1.500 billion to total $3.500 billion, the senior secured term loan B facility was fully retired and certain administrative updates were made to our credit agreements.

Borrowings under the senior secured credit facilities bear interest at a rate equal to, at our option, either (a) a base rate determined by reference to the higher of (1) the federal funds rate plus 0.50% or (2) the prime rate of Bank of America or (b) a reference rate (LIBOR historically and the Secured Overnight Financing Rate (SOFR) beginning January 4, 2023) for the relevant interest period, plus, in each case, an applicable margin. The applicable margin for borrowings under the senior secured credit facilities may be reduced subject to attaining certain leverage ratios.

The senior secured credit facilities contain a number of covenants that restrict, subject to certain exceptions, our (and some or all of our subsidiaries') ability to incur additional indebtedness, repay subordinated indebtedness, create liens on assets, sell assets, make investments, loans or advances, engage in certain transactions with affiliates, pay dividends and distributions, and enter into sale and leaseback transactions. In addition, we are required to satisfy and maintain a maximum total leverage ratio covenant under the cash flow credit facility and, in certain situations under the ABL credit facility, a minimum interest coverage ratio covenant.

Senior Unsecured Notes

Senior unsecured notes consist of (i) $31.791 billion aggregate principal amount of senior notes with maturities ranging from 2024 to 2052; (ii) an aggregate principal amount of $125 million medium-term notes maturing 2025; and (iii) an aggregate principal amount of $736 million debentures with maturities ranging from 2023 to 2095.

General Debt Information

The senior secured credit facilities are fully and unconditionally guaranteed by substantially all existing and future, direct and indirect, 100% owned material domestic subsidiaries that are "Unrestricted Subsidiaries" under our Indenture (the "1993 Indenture") dated December 16, 1993 (except for certain special purpose subsidiaries that only guarantee and pledge their assets under our ABL credit facility).

All obligations under the ABL credit facility, and the guarantees of those obligations, are secured, subject to permitted liens and other exceptions, by a first-priority lien on substantially all of the receivables of the borrowers and each guarantor under such ABL credit facility (the "Receivables Collateral").

All obligations under the cash flow credit facility and the guarantees of such obligations are secured, subject to permitted liens and other exceptions, by:

- a first-priority lien on the capital stock owned by HCA Inc., or by any guarantor, in each of their respective first-tier subsidiaries;
- a first-priority lien on substantially all present and future assets of HCA Inc. and of each guarantor other than (i) "Principal Properties" (as defined in the 1993 Indenture), (ii) certain other real properties and (iii) deposit accounts, other bank or securities accounts, cash, leaseholds, motor-vehicles and certain other exceptions; and
- a second-priority lien on certain of the Receivables Collateral.

Maturities of long-term debt in years 2024 through 2027 are $2.382 billion, $4.656 billion, $5.316 billion and $2.396 billion, respectively.

NOTE 9 — LEASES

We lease property and equipment under finance and operating leases. For leases with terms greater than 12 months, we record the related assets and obligations at the present value of lease payments over the term. Many of our leases include rental escalation clauses and renewal options that are factored into our determination of lease payments, when appropriate. We do not separate lease and nonlease components of contracts. Generally, we use our estimated incremental borrowing rate to discount the lease payments, as most of our leases do not provide a readily determinable implicit interest rate.

The following table presents our lease-related assets and liabilities at December 31, 2022 and 2021 (dollars in millions):

	Balance Sheet Classification	2022	2021
Assets:			
Operating leases	Right-of-use operating lease assets	**$ 2,065**	$ 2,113
Finance leases	Property and equipment	**587**	637
Total lease assets		**$ 2,652**	$ 2,750
Liabilities:			
Current:			
Operating leases	Other accrued expenses	**$ 364**	$ 392
Finance leases	Long-term debt due within one year	**131**	143
Noncurrent:			
Operating leases	Right-of-use operating lease obligations	**1,752**	1,755
Finance leases	Long-term debt	**579**	577
Total lease liabilities		**$ 2,826**	$ 2,867
Weighted-average remaining term:			
Operating leases		**10.1 years**	10.2 years
Finance leases		**9.5 years**	10.4 years
Weighted-average discount rate:			
Operating leases		**4.4%**	4.4%
Finance leases		**4.5%**	4.4%

The following table presents certain information related to expenses for finance and operating leases for the years ended December 31, 2022, 2021 and 2020 (dollars in millions):

	2022	2021	2020
Finance lease expense:			
Depreciation and amortization	**$ 163**	$ 135	$ 106
Interest	**29**	29	31
Operating leases(1)	**484**	478	447
Short-term lease expense(1)	**329**	354	322
Variable lease expense(1)	**163**	157	154
	$ 1,168	$ 1,153	$ 1,060

(1) Expenses are included in “other operating expenses” in our consolidated income statements.

The following table presents supplemental cash flow information for the years ended December 31, 2022, 2021 and 2020 (dollars in millions):

	2022	2021	2020
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flows for operating leases	**$ 473**	$ 474	$ 445
Operating cash flows for finance leases	**29**	29	31
Financing cash flows for finance leases	**124**	123	86

NOTE 9 — LEASES (continued)

Maturities of Lease Liabilities

The following table reconciles the undiscounted minimum lease payment amounts to the operating and finance lease liabilities recorded on the balance sheet at December 31, 2022 and 2021 (dollars in millions):

	2022		2021	
	Operating Leases	Finance Leases	Operating Leases	Finance Leases
Year 1	**$ 436**	**$ 156**	$ 438	$ 165
Year 2	**380**	**164**	378	126
Year 3	**320**	**125**	320	132
Year 4	**269**	**89**	267	98
Year 5	**222**	**39**	219	70
Thereafter	**1,122**	**359**	1,148	350
Total minimum lease payments	**2,749**	**932**	2,770	941
Less: amount of lease payments representing interest	**(633)**	**(222)**	(623)	(221)
Present value of future minimum lease payments	**2,116**	**710**	2,147	720
Less: current lease obligations	**(364)**	**(131)**	(392)	(143)
Long-term lease obligations	**$ 1,752**	**$ 579**	$ 1,755	$ 577

NOTE 10 — CONTINGENCIES

We operate in a highly regulated and litigious industry. As a result, various lawsuits, claims and legal and regulatory proceedings have been and can be expected to be instituted or asserted against us. We are also subject to claims and suits arising in the ordinary course of business, including claims for personal injuries or wrongful restriction of, or interference with, physicians' staff privileges. In certain of these actions the claimants may seek punitive damages against us, which may not be covered by insurance. We are also subject to claims by various taxing authorities for additional taxes and related interest and penalties. The resolution of any such lawsuits, claims or legal and regulatory proceedings could have a material, adverse effect on our results of operations, financial position or liquidity.

Government Investigations, Claims and Litigation

Health care companies are subject to numerous investigations by various governmental agencies. Under the federal False Claims Act ("FCA"), private parties have the right to bring *qui tam*, or "whistleblower," suits against companies that submit false claims for payments to, or improperly retain overpayments from, the government. Some states have adopted similar state whistleblower and false claims provisions. Certain of our individual facilities have received, and from time to time, other facilities may receive, government inquiries from, and may be subject to investigation by, federal and state agencies. Depending on whether the underlying conduct in these or future inquiries or investigations could be considered systemic, their resolution could have a material, adverse effect on our results of operations, financial position or liquidity.

Texas operates a state Medicaid program pursuant to a waiver from the Centers for Medicare & Medicaid Services under Section 1115 of the Social Security Act ("Program"). The Program includes uncompensated-care pools; payments from these pools are intended to defray the uncompensated costs of services provided by our and other hospitals to Medicaid eligible or uninsured individuals. Separately, we and other hospitals provide charity care services in several communities in the state. In 2018, the Civil Division of the U.S. Department of Justice and the U.S. Attorney's Office for the Southern District of Texas requested information about whether the Program, as operated in Harris County, complied with the laws and regulations applicable to provider related donations, and the Company cooperated with that request. On May 21, 2019, a *qui tam* lawsuit asserting violations of the FCA and the Texas Medicaid Fraud Prevention Act related to the Program, as operated in Harris County, was unsealed by the U.S. District Court for the Southern District of Texas. Both the federal and state governments declined to intervene in the *qui tam* lawsuit. The Company believes that our participation is and has been consistent with the requirements of the Program and is vigorously defending against the lawsuit being pursued by the relator. We cannot predict what effect, if any, the *qui tam* lawsuit could have on the Company.

NOTE 11 — CAPITAL STOCK

The amended and restated certificate of incorporation authorizes the Company to issue up to 1,800,000,000 shares of common stock, and our amended and restated by-laws set the number of directors constituting the board of directors of the Company at not less than three members, the exact number to be determined from time to time by resolution adopted by the affirmative vote of a majority of the total number of directors then in office.

Share Repurchase Transactions

During January 2023, January 2022 and February 2021, our Board of Directors authorized share repurchase programs for up to $3 billion, $8 billion and $6 billion, respectively, of the Company's outstanding common stock. During January 2020 and January 2019, our Board of Directors authorized share repurchase programs for up to $4 billion ($2 billion for each authorization) of our outstanding common stock.

During 2022, we repurchased 30.747 million shares of our common stock at an average price of $227.67 per share through market purchases pursuant to the February 2021 authorization (which was completed during 2022) and the January 2022 authorization. At December 31, 2022, we had $1.586 billion of repurchase authorization available under the January 2022 authorization. During 2021, we repurchased 37.812 million shares of our common stock at an average price of $217.25 per share through market purchases pursuant to each of the $2 billion share repurchase programs authorized during January 2019 and January 2020 (which were completed during 2021) and the $6 billion share repurchase program authorized during February 2021. During 2020, we repurchased 3.287 million shares of our common stock at an average price of $134.18 per share through market purchases pursuant to the $2 billion share repurchase program authorized during January 2019.

NOTE 12 — EMPLOYEE BENEFIT PLANS

We maintain defined contribution benefit plans that are available to employees who meet certain minimum requirements. The plans require that we match specified percentages of participant contributions up to certain maximum levels (generally, 100% of the first 3% to 9%, depending upon years of vesting service, of compensation deferred by participants). Benefits expense under these plans totaled $606 million for 2022, $560 million for 2021 and $552 million for 2020. Our matching contributions are funded during the year following the participant contributions.

We maintain the noncontributory, nonqualified Restoration Plan to provide retirement benefits for eligible employees. Eligibility for the Restoration Plan is based upon earning eligible compensation in excess of a base amount and attaining 1,000 or more hours of service during the plan year. Company credits to participants' hypothetical account balances (the Restoration Plan is not funded) depend upon participants' compensation, years of vesting service, hypothetical investment returns (gains or losses) and certain IRS limitations. Benefits expense under this plan was a $27 million credit for 2022, $38 million expense for 2021 and $35 million expense for 2020. Accrued benefits liabilities under this plan totaled $210 million at December 31, 2022 and $258 million at December 31, 2021.

We maintain a Supplemental Executive Retirement Plan ("SERP") for certain executives (the SERP is not funded). The plan is designed to ensure that upon retirement the participant receives the value of a prescribed life annuity from the combination of the SERP and our other benefit plans. Benefits expense under the plan was $22 million for 2022, $22 million for 2021 and $24 million for 2020. Accrued benefits liabilities under this plan totaled $137 million at December 31, 2022 and $201 million at December 31, 2021.

We maintain defined benefit pension plans which resulted from certain hospital acquisitions in prior years. Benefits expense under these plans was an $11 million credit for 2022, $4 million expense for 2021, and $8 million expense for 2020. Accrued benefits under these plans totaled $9 million of assets at December 31, 2022 and $9 million of liabilities at December 31, 2021.

NOTE 13 — SEGMENT AND GEOGRAPHIC INFORMATION

We operate in one line of business, which is operating hospitals and related health care entities. We operate in two geographically organized groups: the National and American Groups. At December 31, 2022, the National Group included 96 hospitals located in Alaska, California, Florida, Georgia, Idaho, Indiana, northern Kentucky, Nevada, New Hampshire, North Carolina, South Carolina, Utah and Virginia, and the American Group included 79 hospitals located in Colorado, Kansas, southern Kentucky, Louisiana, Missouri, Tennessee and Texas. We also operate seven hospitals in England, and these facilities are included in the Corporate and other group.

Adjusted segment EBITDA is defined as income before depreciation and amortization, interest expense, losses and gains on sales of facilities, losses on retirement of debt, income taxes and net income attributable to noncontrolling interests. We use adjusted segment EBITDA as an analytical indicator for purposes of allocating resources to geographic areas and assessing their performance. Adjusted segment EBITDA is commonly used as an analytical indicator within the health care industry, and also serves as a measure of leverage capacity and debt service ability. Adjusted segment EBITDA should not be considered as a measure of financial performance under generally accepted accounting principles, and the items excluded from adjusted segment EBITDA are significant components in understanding and assessing financial performance. Because adjusted segment EBITDA is not a measurement determined in accordance with generally accepted accounting principles and is thus susceptible to varying calculations, adjusted segment EBITDA, as presented, may not be comparable to other similarly titled measures of other companies. The geographic distributions of our revenues, equity in earnings of affiliates, adjusted segment EBITDA, depreciation and amortization, assets and goodwill and other intangible assets are summarized in the following table (dollars in millions) and represent the operating segments at December 31, 2022:

	For the Year Ended December 31,		
	2022	**2021**	**2020**
Revenues:			
National Group	**$ 30,350**	$ 29,826	$ 25,694
American Group	**26,865**	26,152	23,593
Corporate and other	**3,018**	2,774	2,246
	$ 60,233	$ 58,752	$ 51,533
Equity in earnings of affiliates:			
National Group	**$ (4)**	$ (33)	$ (28)
American Group	**(43)**	(53)	(42)
Corporate and other	**2**	(27)	16
	$ (45)	$ (113)	$ (54)
Adjusted segment EBITDA:			
National Group	**$ 6,379**	$ 7,200	$ 5,532
American Group	**6,055**	6,156	5,333
Corporate and other	**(367)**	(712)	(828)
	$ 12,067	$ 12,644	$ 10,037
Depreciation and amortization:			
National Group	**$ 1,464**	$ 1,359	$ 1,216
American Group	**1,219**	1,183	1,164
Corporate and other	**286**	311	341
	$ 2,969	$ 2,853	$ 2,721

	For the Year Ended December 31,		
	2022	**2021**	**2020**
Adjusted segment EBITDA	**$ 12,067**	$ 12,644	$ 10,037
Depreciation and amortization	**2,969**	2,853	2,721
Interest expense	**1,741**	1,566	1,584
Losses (gains) on sales of facilities	**(1,301)**	(1,620)	7
Losses on retirement of debt	**78**	12	295
Income before income taxes	**$ 8,580**	$ 9,833	$ 5,430

NOTE 13 — SEGMENT AND GEOGRAPHIC INFORMATION (continued)

	December 31,		
	2022	**2021**	**2020**
Assets:			
National Group	**$ 22,863**	$ 21,205	$ 18,913
American Group	**22,216**	21,428	20,760
Corporate and other	**7,359**	8,109	7,817
	$ 52,438	$ 50,742	$ 47,490

	National Group	American Group	Corporate and Other	Total
Goodwill and other intangible assets:				
Balance at December 31, 2019	$ 1,739	$ 5,765	$ 765	$ 8,269
Acquisitions	38	27	279	344
Foreign currency translation, amortization and other	(2)	(17)	(16)	(35)
Balance at December 31, 2020	1,775	5,775	1,028	8,578
Acquisitions	735	67	260	1,062
Foreign currency translation, amortization and other	(18)	(10)	(72)	(100)
Balance at December 31, 2021	2,492	5,832	1,216	9,540
Acquisitions	**165**	**91**	**6**	**262**
Foreign currency translation, amortization and other	**(5)**	**(62)**	**(82)**	**(149)**
Balance at December 31, 2022	**$ 2,652**	**$ 5,861**	**$ 1,140**	**$ 9,653**

Effective January 1, 2023, we reorganized our operations into three geographically organized groups: the National, American and Atlantic Groups. The National Group includes 57 hospitals located in Alaska, California, Idaho, Indiana, Kentucky, Nevada, New Hampshire, North Carolina, Tennessee, Utah and Virginia, the American Group includes 57 hospitals located in Colorado, Central Kansas, Louisiana and Texas, and the Atlantic Group includes 61 hospitals located in Florida, Georgia, Northern Kansas, Missouri and South Carolina. The seven hospitals we operate in England will remain in the Corporate and other group. Operating segment reporting with this reorganized group structure will be provided in periodic filings starting with the first quarter of 2023, with retrospective presentation of all periods presented.

NOTE 14 — OTHER COMPREHENSIVE LOSS

The components of accumulated other comprehensive loss are as follows (dollars in millions):

	Unrealized Gains (Losses) on Available-for-Sale Securities	Foreign Currency Translation Adjustments	Defined Benefit Plans	Change in Fair Value of Derivative Instruments	Total
Balances at December 31, 2019	$ 14	$ (283)	$ (187)	$ (4)	$ (460)
Unrealized gains on available-for-sale securities, net of $3 of income taxes	11				11
Foreign currency translation adjustments, net of $6 of income taxes		12			12
Defined benefit plans, net of $16 income tax benefit			(55)		(55)
Change in fair value of derivative instruments, net of $15 income tax benefit				(51)	(51)
Expense reclassified into operations from other comprehensive income, net of $6 and $5 of income tax benefits, respectively			22	19	41
Balances at December 31, 2020	25	(271)	(220)	(36)	(502)
Unrealized losses on available-for-sale securities, net of $3 income tax benefit	(13)				(13)
Foreign currency translation adjustments, net of $2 income tax benefit		(7)			(7)
Defined benefit plans, net of $20 of income taxes			67		67
Change in fair value of derivative instruments				1	1
Expense reclassified into operations from other comprehensive income, net of $7 and $8 income tax benefits, respectively			21	29	50
Balances at December 31, 2021	12	(278)	(132)	(6)	(404)
Unrealized losses on available-for-sale securities, net of $12 income tax benefit	**(43)**				**(43)**
Foreign currency translation adjustments, net of $16 income tax benefit		**(95)**			**(95)**
Defined benefit plans, net of $11 of income taxes			**38**		**38**
Change in fair value of derivative instruments, net of $1 of income taxes				**5**	**5**
Expense reclassified into operations from other comprehensive income, net of none, $2 and $1 income tax benefits, respectively	**1**		**7**	**1**	**9**
Balances at December 31, 2022	**$ (30)**	**$ (373)**	**$ (87)**	**$ —**	**$ (490)**

NOTE 15 — ACCRUED EXPENSES

A summary of other accrued expenses at December 31 follows (dollars in millions):

	2022	2021
Professional liability risks	**$ 515**	$ 508
Defined contribution benefit plans	**612**	549
Right-of-use operating leases	**364**	392
Taxes other than income	**371**	361
Interest	**402**	353
Government stimulus refund liability	**81**	79
Other	**1,236**	1,080
	$ 3,581	$ 3,322

EXHIBIT 31.1

CERTIFICATIONS

I, Samuel N. Hazen, certify that:

1. I have reviewed this annual report on Form 10-K of HCA Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit and compliance committee of the Registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

By: /S/ SAMUEL N. HAZEN
Samuel N. Hazen
Chief Executive Officer

Date: February 17, 2023

EXHIBIT 31.2

CERTIFICATIONS

I, William B. Rutherford, certify that:

1. I have reviewed this annual report on Form 10-K of HCA Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

(a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

(b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

(c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

(d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit and compliance committee of the Registrant's board of directors (or persons performing the equivalent functions):

(a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

(b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

By: /s/ WILLIAM B. RUTHERFORD

William B. Rutherford

Executive Vice President and Chief Financial Officer

Date: February 17, 2023

EXHIBIT 32

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of HCA Healthcare, Inc. (the "Company") on Form 10-K for the year ended December 31, 2022, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), each of the undersigned certifies, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

By: /s/ SAMUEL N. HAZEN
Samuel N. Hazen
Chief Executive Officer

February 17, 2023

By: /s/ WILLIAM B. RUTHERFORD
William B. Rutherford
Executive Vice President and Chief Financial Officer

February 17, 2023

This document contains forward-looking statements within the meaning of the federal securities laws. These forward-looking statements are based on our current plans and expectations and are subject to a number of known and unknown uncertainties and risks, including those set forth in our earnings releases and reports filed with the Securities and Exchange Commission.

All references to “Company,” “HCA,” “HCA Healthcare,” “we,” and “us” as used herein refer to HCA Healthcare, Inc. and its affiliates.

Directors

Thomas F. Frist III
Chairman
HCA Healthcare

Founder and
Managing Principal
Frist Capital

Samuel N. Hazen
Chief Executive Officer
HCA Healthcare

Meg G. Crofton
Retired President
Parks and Resorts Operations
The Walt Disney Company

Robert J. Dennis
Retired Chairman and
Chief Executive Officer
Genesco Inc.

Nancy-Ann DeParle
Co-founder and
Managing Partner
Consonance Capital
Partners

William R. Frist
Principal
Frist Capital

Charles O. Holliday, Jr
(Not standing for re-election)
Retired Chairman and
Chief Executive Officer
DuPont

Hugh F. Johnston
Vice Chairman and
Chief Financial Officer
PepsiCo, Inc.

Michael W. Michelson
Retired Member
KKR Management LLC

Wayne J. Riley, M.D., M.B.A.
President of SUNY
Downstate Health
Sciences University

Andrea B. Smith
Retired Chief
Administrative Officer
Bank of America Corporation

Executive Officers

Samuel N. Hazen
Chief Executive Officer
and Director

Erol R. Akdamar
President - American Group

Jennifer L. Berres
Senior Vice President and
Chief Human Resources Officer

Phillip G. Billington
Senior Vice President –
Internal Audit Services

Jeff E. Cohen
Senior Vice President –
Government Relations

Michael S. Cuffe, M.D.
Executive Vice President and
Chief Clinical Officer

Jon M. Foster
Executive Vice President and
Chief Operating Officer

Richard A. Hammett
President – Atlantic Group

Michael A. Marks
Senior Vice President - Finance

Michael R. McAlevey
Senior Vice President and
Chief Legal Officer

Timothy M. McManus
President – National Group

Sammie S. Mosier
Senior Vice President and
Chief Nurse Executive

P. Martin Paslick
Senior Vice President and
Chief Information Officer

Deborah M. Reiner
Senior Vice President –
Marketing and
Communications

William B. Rutherford
Executive Vice President
and Chief Financial Officer

Joseph A. Sowell, III
Senior Vice President and
Chief Development Officer

Kathryn A. Torres
Senior Vice President –
Payer Contracting
and Alignment

Kathleen M. Whalen
Senior Vice President and
Chief Ethics and
Compliance Officer

Christopher F. Wyatt
Senior Vice President
and Controller

Corporate Information

Transfer Agent and Registrar
EQ Shareowner Services
P.O. Box 64874
St. Paul, Minnesota 55164-0874
Toll free: 800-468-9716

Certified/Overnight Mail
EQ Shareowner Services
1110 Centre Pointe Curve, Suite 101
Mendota Heights, Minnesota 55120

Independent Registered Public Accounting Firm
Ernst & Young LLP
Nashville, Tennessee

Corporate Headquarters
One Park Plaza
Nashville, Tennessee 37203
615-344-9551

Form 10-K
The Company has filed an annual report on Form 10-K for the year ended December 31, 2022 with the United States Securities and Exchange Commission (SEC). Shareholders may obtain a copy of this report, without charge, by writing:

> Investor Relations, HCA Healthcare, Inc., One Park Plaza, Nashville, TN 37203
> or by visiting the Company's website at www.HCAhealthcare.com.

Common Stock and Dividend Information
The Common Stock of HCA Healthcare, Inc. is listed on the New York Stock Exchange (NYSE) under the symbol "HCA". On February 24, 2023, the Company had approximately 400 shareholders of record. On January 26, 2023, the Company's Board of Directors declared a quarterly dividend of $0.60 per share on our common stock payable on March 31, 2023 to shareholders of record on March 17, 2023. Future declarations of quarterly dividends and the establishment of future record and payment dates are subject to the final determination of the Company's Board of Directors.

Annual Meeting of Shareholders
The annual meeting of shareholders will be held on April 19, 2023, at 2:00 pm local time in a virtual meeting format only, via live webcast at www.virtualshareholdermeeting.com/HCA2023. Shareholders of record as of February 24, 2023 are invited to attend the virtual meeting.

HCA Healthcare
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Nashville, Tennessee 37203
www.HCAhealthcare.com

Freestanding Emergency Department (FSED) Standards and Criteria – Application Guide

As required, TriStar Skyline is using this document as a portion of the application process to address the Certificate of Need (CON) Criteria and Standards for Freestanding Emergency Departments (FSED).

1. Determination of Need in the Proposed Service Area

The applicant must demonstrate need for an emergency department in **at least one** of the following ways: *geographic isolation, capacity challenges, and/or low quality of care at existing emergency department (ED) facilities in the proposed service are* Applicants are not required to address and provide data for all three categories. However, the applicant's ability to demonstrate need in multiple categories may strengthen the application.

A. Geographic Isolation

Check the Box that Applies:

☒ The applicant is demonstrating geographic isolation for the proposed service area. If this boxis checked the applicant must provide the information below.

☐ The applicant is not demonstrating geographic isolation for the proposed service area.

Data:

Utilizing the following table, provide the number of existing ED facilities in the proposed service area, as well as the distance of the proposed FSED from these facilities. This distance should be measured from the center of the county or zip code. If the proposed service area is comprised of contiguous Zip Codes, the applicant shall provide this information on all ED facilities located in thecounty or counties in which the service area Zip Codes are located. Add as many rows and/or columns to the table as necessary to adequately address this portion of the Determination of NeedStandard.

The proposed Nolensville FSED is located on the county line between Nashville/Davidson and Williamson Counties and will serve the geographically isolated Nolensville area, including Nolensville, east Brentwood ("Brentioch"), west Antioch, and a portion of South Nashville including Cane Ridge, Lenox Village and other neighborhoods along Nolensville Road south of Southern Hills. This geographically isolated area is encompassed within four ZIP Codes. The only EDs located within the ZIP Code service area are the Applicant, TriStar Southern Hills Medical Center ("TriStar Southern Hills" or "Southern Hills"), which is 7.3 miles away from the proposed FSED, and its satellite ED – the Century Farms FSED, which is located 5.8 miles away. The proposed FSED will enhance accessibility to emergency care for residents of the proposed service area by being located in Nolensville for folks who live there and by being more easily accessible for residents of portions of southeast Nashville and east Brentwood than other existing EDs due to geographic proximity as well as easier roadway access.

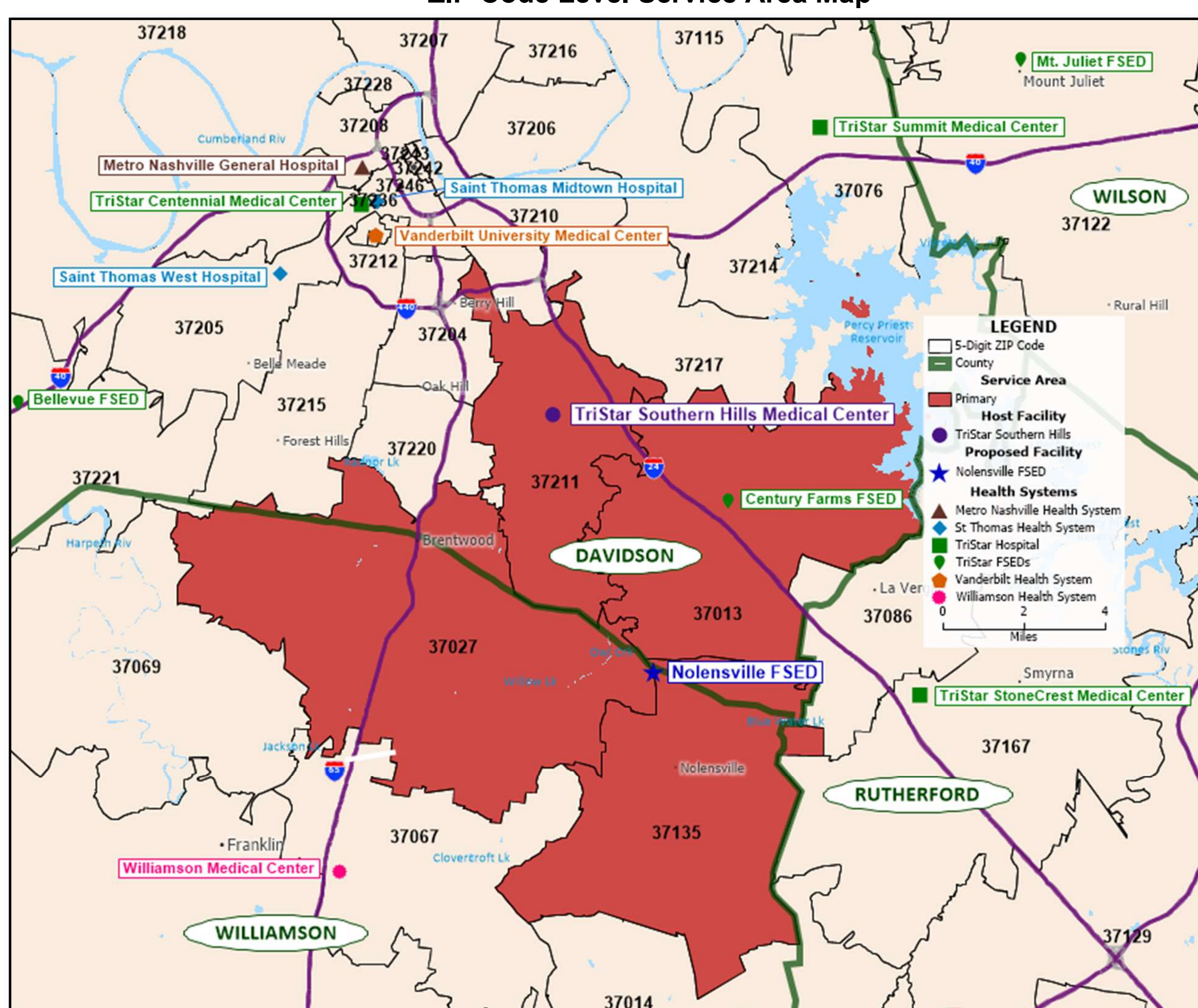
Overview of the Service Area

The proposed service area includes portions of southeast Nashville and northeast Williamson County between Interstates I-65 south and I-24 south. For this Application, the proposed service

area is made up of four (4) ZIP Codes in southeast Nashville, 37013 (Antioch) and 37211 (South Nashville), and in northeast Williamson County, 37135 (Nolensville) and 37027 (Brentwood/Brentioch).

Figure 1N-1 provides the service area map and the existing hospital and FSEDs in the broader region surrounding the service area. Southern Hills and its satellite freestanding emergency department Century Farms are the only EDs in the service area ZIP Codes. Southern Hills is located in the northern portion of ZIP Code 37211. As will be shown, Southern Hills' ED is highly utilized and experiencing capacity constraints. The Century Farms FSED is also highly utilized. Patients in ZIP Codes 37027 and 37135 do not have an ED in their community and must leave their community for emergency care. The driving times are often lengthy and unpredictable due to heavy traffic congestion.

Figure 1N-1
ZIP Code Level Service Area Map



Source: Maptitude
Note: TriStar StoneCrest is included because it is a nearby hospital to the proposed service area. Rutherford County is NOT a part of the proposed service area.

The term "geographic isolation" is not defined in the State Health Plan or the HFC's Standards and Criteria. Southern Hills submits that portions of the ZIP Code service area residents are isolated from emergency services by virtue of being unnecessarily remote from existing

resources, when considering the large base of patients in the area and high utilization of the only EDs in the service area. The applicant's objective in this project is to shorten service area residents' travel time to emergency care, thereby reducing the isolation experienced by patients during a critical time when every minute is important for an emergency intervention. Improving access to emergency care will save lives where time is of the essence and will particularly improve health outcomes for patients experiencing life threatening emergencies such as heart attack, stroke, or serious injuries.

> *"Our entire neighborhood has been affected by the current lack of emergency services. My neighbor needed emergency services and […], the services were all too far away. This is unacceptable. What [if] someone is having a stroke or heart attack? Every minute is crucial for brain and heart tissue to survive. Please open this facility!*
>
> *Countless new communities in Nolensville, Burkitt Ridge, Brentioch, and Cane Ridge will all benefit greatly from this emergency service. This should be a no brainer for approval and for the leaders in the surrounding cities."*
>
> *Kemry Dariphone*
> *Antioch Resident*

> *"Our area sits between locations that are not easy to get to in an emergency setting. The community has grown so much that having an ER facility will bring a better well-being to our area.*
>
> *In a life-or-death situation, there may not be much time to get someone to an ER, so having one in town would help save lives and keep families safe. Right now, we have to take back roads to get to existing facilities and the roads are dark and windy. We need easily accessible emergency care to support our town."*
>
> *Victor Torres*
> *Nolensville Resident*

> *"Currently, Nolensville does not have emergency services close-by, and it is always safe to have an emergency room closer than driving 30 minutes away. In an emergency, you don't always have that much time to get care. I think this emergency room will be a great addition to the community and save lives."*
>
> *Kyle Sparkman*
> *Nolensville Resident*

> *"The south Brentwood/Nolensville area is in need of emergency services. I commute daily from that area to downtown. When sitting in the growing traffic areas, I often think, 'what if myself or family needed emergency services?' The commute wait time could be life or death. As this area and others outside grow, emergency care access is crucial to our community, and this proposed ER won't take away from the small-town feel."*
>
> *Daniel Christian*
> *Brentwood Resident*

> *"Nolensville is home to over 15,000 residents and currently has no dedicated emergency room. The nearest emergency rooms can be upwards of 20 minutes away depending on traffic and EMS availability. That is also assuming that only one emergency arises at a time, which is unrealistic for a growing community like Nolensville."*
>
> *Caleb Hemmer*

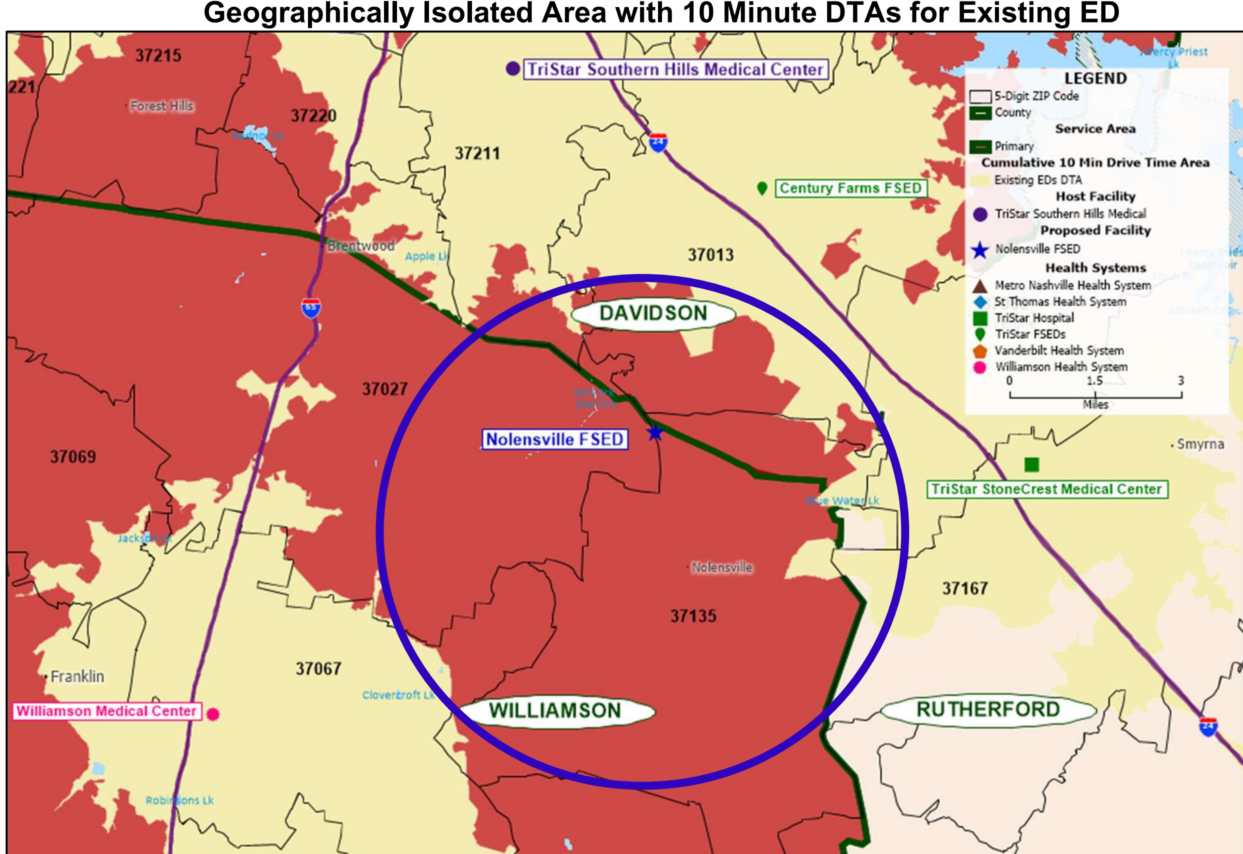
Geographically Isolated Portions of the Service Area

The primary purpose of the proposed project is to address the geographic isolation within the proposed service area. Southern Hills is proposing a FSED on the Davidson County/Williamson County line at Ava Place near the intersection of Burkitt Place and Nolensville Road, in Williamson County, Tennessee, 37135. Southern Hills has identified an area of geographic isolation within four ZIP Code service area proposed for this project. Geographic isolation was determined based on a detailed drive time assessment – shown in **Figure 1N-3** -- and significant input from community members who face travel access barriers to reach the nearest EDs. The proposed FSED is located in an isolated area between Southern Hills, its Century Farms FSED, affiliate TriStar StoneCrest Medical Center (“TriStar StoneCrest” or “StoneCrest”) and Williamson Medical Center (“WMC”), to maximize access to this geographically isolated area.

Figure 1N-2 provides map with a composite 10-minute drive time area (“DTA”) around all existing EDs and FSED including TriStar Southern Hills, Century Farms FSED, TriStar StoneCrest, and WMC, the four most proximate EDs to the service area. The yellow areas represent the geographic area within 10 minute drive time of an existing ED or FSED. The red areas represent portions of Williamson and Davidson Counties that are not within a 10 minute-drive time of existing EDs and FSEDs. This analysis shows the geographically isolated area that is the focus of this project. The geographically isolated area is highlighted by a blue circle.

A 10-minute DTA was chosen because this mapping capability does not consider the impact of traffic on travel times. When traffic is considered, a 10-minute drive can easily exceed 15, 20 or more minutes to reach life-saving care. The 10 min DTAs for existing EDs show that residents in the southern part of ZIP Code 37211 (South Nashville), southwest portion of ZIP Code 37013 (Antioch), the eastern portion of ZIP Code 37027 (Brentwood/Brentioch) and virtually all of ZIP Code 37135 (Nolensville) do not have reasonable access to ED services. The routes from Nolensville to any of the most proximate EDs are via 2 lane roads, through neighborhoods, commercial areas, and school zones, which particularly are impacted during peak traffic times.

Figure 1N-2
Geographically Isolated Area with 10 Minute DTAs for Existing ED



Source: Maptitude

Figure 1N-3 provides a 10 min drive time area around the site for the Nolensville FSED, which shows the area will be within 10 minutes of the proposed FSED without traffic and likely 15 minutes or more with traffic. This drive time area covers the geographic isolated area shown in **Figure 1N-2** and demonstrates that the proposed FSED location will address the geographically isolated area. This map also shows the drive time area/geographically isolated area within the context of the broader Nashville/Davidson County and Williamson County area.

Figure 1N-3
10 Minute DTR for Proposed ED within the County Area

Source: Maptitude

Despite the use of 10 minutes as the travel time estimate, the impact of traffic will make the actual travel times much longer. The geographically isolated area does not include any interstates and travel to the closest EDs is by two lane roads through communities and commercial development, which can be significantly impacted by traffic and adverse weather situations.

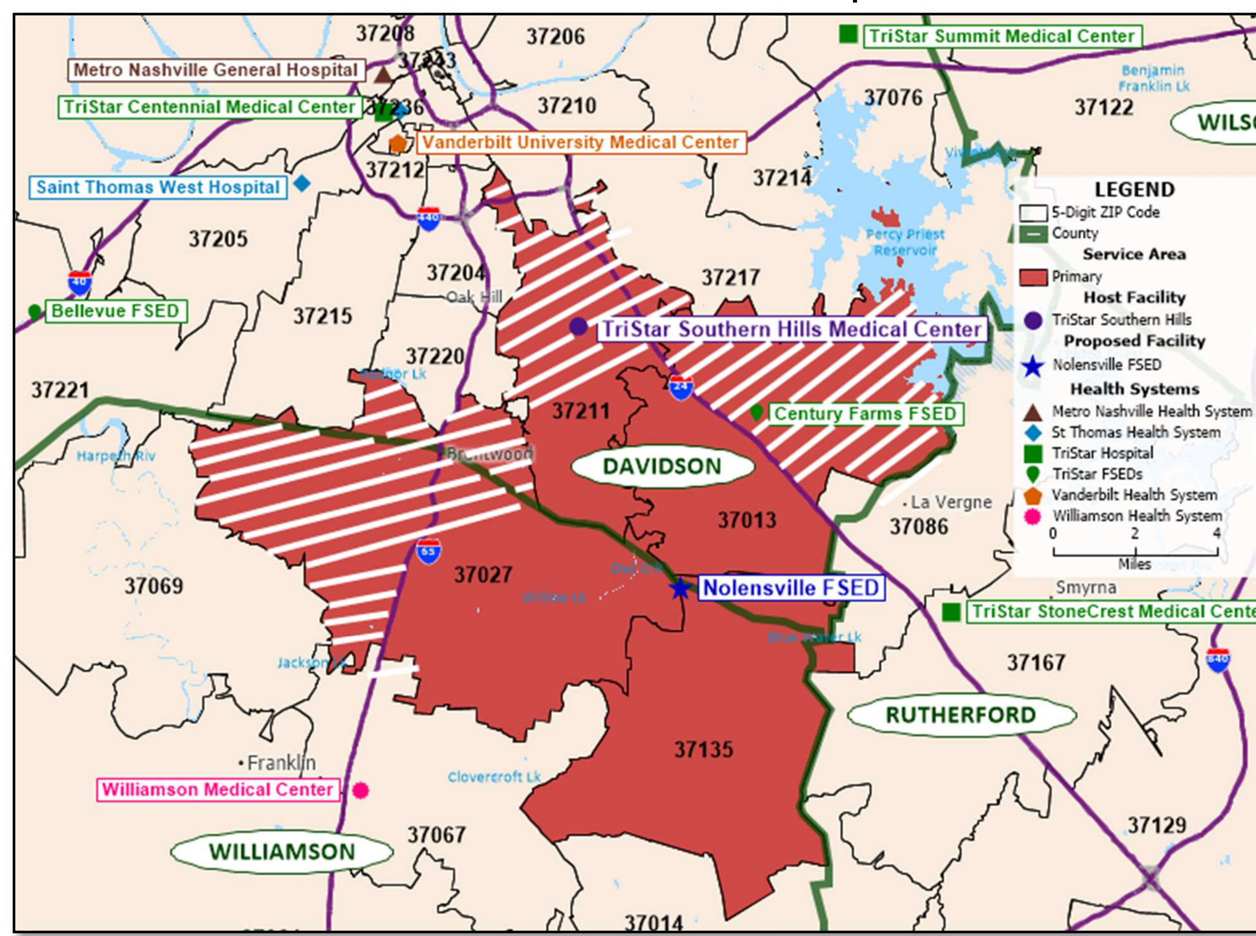
> *"As a Nolensville resident, I support building an ER in the area and think it would be a great asset to the community. While there are many hospitals and TriStar hospitals around, none are very close. With additional traffic and the smaller country roads, it takes longer to get to these services and even dangerous in some cases depending on time of day or weather conditions. Recently my husband had to visit the ER via an ambulance during the icy conditions over the holiday and it took over 30 mins to go straight up Nolensville Rd. late at night with no traffic. For emergency situations that may be life or death this is an extremely long time and having something closer would be a huge benefit to our community.*

This would be a great location that could serve multiple areas, but especially help in long commute times for those that live in southern Nolensville. Again, the country roads to access services in Smyrna and other areas are often dangerous during various weather situations and this would be a great service that would be closer during those times. I think that a new ER would allow people to get care quickly and potentially save lives."

Nicole Campbell
Resident of Nolensville

While the overall service area is defined by four ZIP Codes, to align with the various analyses required of the FSED Criteria, the area of geographic isolation identified by Southern Hills is depicted on **Figure 1N-4** as the ZIP Code area not crosshatched. This is the focus of the area for which it is expected the Nolensville FSED will result in the most significant improvement in geographic access to ED services.

Figure 1N-4
Crosshatch Service Area Map



Source: Maptitude

<u>*Description of the Service Area and its Demographic Trends*</u>

Much of the service area is a highly congested residential area with significant projected population growth. As shown in **Exhibit 4** of the main application, the population of this densely populated service area is expected to grow by 4.6 percent from 2023 to 2028 (from 264,662

residents in 2023 to 277,280 residents in 2028). The Nolensville ZIP Code (37135), which is entirely within the geographically isolated area, is projected to grow by 12.3 percent between 2023 and 2028. Importantly, the service area population is projected to age even more rapidly than it is growing overall. The 65 and up population is expected to grow by 18.7 percent from 2023 to 2028. More specifically, ZIP Code 37013 is comprised of 20.6 percent residents age 65 and older. ZIP Code 37135 is expected to experience 29.7 percent growth of residents age 65 and older between 2023 and 2028. Overall, the service area is expected to age faster than other parts of Nashville/Davidson and Williamson Counties. This is important because older adults use emergency healthcare services at a much higher rate than any other group with patients age 75 and older experiencing ED use rates 57.5 percent higher than younger age groups.[1] People in their 80s and 90s use ED services at even greater rates.[2] The Nolensville FSED will provide expanded access to residents of the geographically isolated area within the proposed service area, particularly elderly residents, as well as reduce the need for travel in significant congested traffic conditions to other existing EDs in Nashville outside of their communities, reducing the travel burden faced by patients and their families.

The service area ZIP Codes also include a high percentage of patients living in poverty. 17.1 percent and 15.6 percent of residents of ZIP Codes 37013 and 37211, respectively, are living in poverty compared to 14.3 percent for both Nashville/Davidson County residents and Tennessee residents. Please see **Exhibit 7** in the main CON application. Importantly, ZIP Code 37013 (Antioch) has a significantly high minority population in comparison to the rest of Nashville at almost 67 percent. The proposed FSED will bring emergency care closer to these communities thereby improving access to low income and minority populations while also alleviating capacity constraints at Southern Hills, which is the largest provider of ED services to these ZIP Codes.

While much of the densely populated areas are in the northern portions of ZIP Codes 37211 and 37013, Southern Hills and the Century Farms FSED are located in those areas and are very highly utilized. By having the proposed Nolensville FSED to the south, some of the ED patients going to Southern Hills and Century Farms are expected to choose to go to the Nolensville FSED and will thus alleviate some of the capacity pressure at Southern Hills and Century Farms. By having the Nolensville FSED, in other words, access to ED care in the more densely populated areas in the northern part of ZIP Codes 37211 and 37013 will also be improved to the benefit patients in the in those communities

Travel Access to ED Care for Service Area Residents

As shown in **Table 1A**, the proposed FSED will be the most proximal provider to the geographic center of service area ZIP Codes 37135 (Nolensville) and 37027 (Brentwood/Brentioch) based on mileage and drive time. Drive times from the center of ZIP Codes 37013 (Nolensville) and 37211 (South Nashville) to Southern Hills and Century Farms FSED (the applicant and host hospital and its existing FSED) are less than travel times to the proposed FSED; however, as previously mentioned, Southern Hills is experiencing capacity constraints and Century Farms' volume has rapidly increased since its opening in June 2021. Accordingly, the proposed FSED will offer an alternative access point to emergency care services for these residents.

Note that, for **Table 1A**, both the driving distance and driving time analyses are calculated based on the ZIP Code center, which does not consider the geographic distribution of individuals residing in the ZIP Code and how this distribution impacts driving patterns and travel conditions. The geographic center of a ZIP Code may not be the population center of the ZIP Code. These analyses show the most proximate (or quickest to get to) ED highlighted in green and the second closest ED highlighted in yellow. However, for most of the ZIP Codes, the proposed FSED or its

[1] NCHS, National Hospital Ambulatory Medical Care Survey 2020. NCHS Data Brief, No. 452, November 2022.

[2] Ukkonen, M., Jämsen, E., Zeitlin, R., & Pauniaho, S. L. (2019). Emergency department visits in older patients: a population-based survey. *BMC emergency medicine*, *19*(1), 20. https://doi.org/10.1186/s12873-019-0236-3

affiliate EDs will be the closest or second closest ED location based on the center of each ZIP Code. For ZIP Codes 37027 and 37135, the proposed FSED will be the closest ED, and for ZIP Code 37013 will be the second closest ED. Century Farms FSED is the nearest ED for ZIP Code 37013 and the second closest for ZIP Code 37211, while Southern Hills is the most proximate ED for ZIP Code 37211 and TriStar StoneCrest is the second closest for ZIP Code 37135. For ZIP Code 37027, WMC is the second most proximate ED.

> *"I recognize the importance of expanding emergency care services in this area to ensure that all residents have access to quality care when they need it most. Currently, many constituents in my district have limited resources for life-saving care and must travel long distances or endure growing wait times. The proposed facility would enhance the overall capacity to provide emergency care and reduce the strain on nearby hospitals and healthcare centers. Most importantly, this additional resource will save lives.*
>
> *This project will have a transformative impact on our community."*
>
> *Heidi Campbell*
> *Tennessee State Senator, District 20*

Existing ED Facilities and Distance (miles) from the Proposed FSED: Table 1A

Emergency Department	37013 (Antioch, TN)	37027 (Brentwood, TN)	37135 (Nolensville, TN)	37211 (Nashville, TN)	Distance in minutes to the Proposed FSED Site
TriStar Southern Hills Medical Center	7.8 miles	8.7 miles	11.4 miles	1.0 miles	7.3 miles
Century Farms FSED	1.4 miles	10.1 miles	9.8 miles	5.8 miles	5.8 miles
TriStar StoneCrest Medical Center*	9.0 miles	15.6 miles	8.6 miles	12.5 miles	8.8 miles
Metro Nashville General Hospital	18.5 miles	16.6 miles	26.8 miles	13.7 miles	22.0 miles
Saint Thomas Midtown Hospital	15.9 miles	15.9 miles	26.1 miles	11.1 miles	21.6 miles
Saint Thomas West Hospital	17.3 miles	17.0 miles	27.2 miles	12.5 miles	22.8 miles
TriStar Centennial Medical Center	17.1 miles	16.5 miles	26.7 miles	11.8 miles	21.9 miles
Bellevue FSED**	26.6 miles	26.3 miles	36.5 miles	21.8 miles	32.7 miles
TriStar Skyline Medical Center	19.9 miles	23.2 miles	33.4 miles	17.3 miles	25.6 miles
TriStar Summit Medical Center	18.3 miles	23.3 miles	33.5 miles	10.6 miles	24.2 miles
Vanderbilt University Medical Center	15.6 miles	15.4 miles	25.6 miles	10.9 miles	21.6 miles
Williamson Medical Center	16.9 miles	7.1 miles	9.8 miles	16.3 miles	13.8 miles
Proposed FSED	**5.3 miles**	**5.9 miles**	**4.1 miles**	**7.5 miles**	

Existing ED Facilities and Time (minutes) from the Proposed FSED: Table 1A

Emergency Department	37013 (Antioch, TN)	37027 (Brentwood, TN)	37135 (Nolensville, TN)	37211 (Nashville, TN)	Distance in minutes to the Proposed FSED Site
TriStar Southern Hills Medical Center	14-28	16-26	22-45	4	14-28
Century Farms FSED	4	16-22	18-28	10-14	12-18
TriStar StoneCrest Medical Center*	12-20	22-35	16-22	16-22	18-24
Metro Nashville General Hospital	26-40	24-45	35-55	20-30	26-45
Saint Thomas Midtown Hospital	24-45	22-40	35-55	18-35	26-45
Saint Thomas West Hospital	24-40	24-40	35-55	18-30	28-40
TriStar Centennial Medical Center	24-45	24-45	35-60	20-35	26-45
Bellevue FSED**	30-45	28-45	40-60	24-35	35-50
TriStar Skyline Medical Center	28-50	30-40	40-60	22-35	35-55
TriStar Summit Medical Center	24-40	28-45	40-60	16-30	30-55
Vanderbilt University Medical Center	24-45	22-40	35-55	18-35	26-40
Williamson Medical Center	30-45	14-24	18-22	22-40	20-35
Proposed FSED	**10-14**	**10-14**	**7-12**	**14-28**	

Source: Google Maps, 2023

Note: Depart time at 8:00am

**TriStar StoneCrest is included because it is a nearby hospital to the proposed service area.*

***Approved but not yet implemented.*

All Measurements from the geographic center of the ZIP Code. Some portions of each ZIP Code may be closer or other providers.

The impact of traffic on travel times can be seen in **Figure 1N- 5** using Google Maps and assuming a patient is traveling to an ED during morning rush hour. For Nolensville (37135) residents, the impact of morning traffic cause residents' travel time to range from 18 minutes to 45 minutes to the closest existing EDs without the addition of the proposed FSED. The Nolensville FSED will significantly reduce travel time for Nolensville 37135) residents to anywhere between 7 to 12 minutes. The Nolensville FSED will also help improve Brentwood/Brentioch (37027) residents' travel time to ED services, especially impacting the high-end travel times. This analysis supports the use of a 10 minutes DTR as mapped above as traffic can add anywhere from 4 to more than 15 minutes to travel time during high traffic periods.

Figure 1N-5
Impact of Traffic on Drive Time to ED Services

	Low End Time	High End Time	Variance
From Nolensville (37135):			
To: Nolensville FSED	7	12	5
To: TriStar Southern Hills	22	45	23
To: Century Farms FSED	18	28	10
To: Williamson Medical Center	18	22	4
From Brentwood (37027):			
To: Nolensville FSED	10	14	4
To: TriStar Southern Hills	16	26	10
To: Century Farms FSED	16	22	6
To: Williamson Medical Center	14	24	10
From Nashville (37211):			
To: Nolensville FSED	14	28	14
To: TriStar Southern Hills	4	4	0
To: Century Farms FSED	10	14	4
To: Williamson Medical Center	22	40	18
From Antioch (37013):			
To: Nolensville FSED	10	14	4
To: TriStar Southern Hills	14	28	14
To: Century Farms FSED	4	4	0
To: Williamson Medical Center	30	45	15

Source: Google Maps, 2023

"Right now, access to emergency services in Nolensville is currently 20-40 minutes away depending on the traffic. My daughter had a bad cut on an artery in her hand and we had to take her all the way to Stonecrest in Smyrna. If we had an option in Nolensville, she would have received treatment much faster."

Erich Chadwick
Nolensville Resident

"With traffic being a consistent issue in Nolensville, this adds an additional barrier when getting to emergency care. Not only should the distance/mil[e]age be taken into account, but the additional external factors that increase the duration and delays the time it takes to travel from place to place, due to traffic congestion, construction, other road hazards, etc."

Kyla Edsell
Brentwood Resident

"It takes us 25-30 minutes to get to the closest ER now. In an emergency, that is way too long. Having an ER close by could make people safer and potentially save lives in a situation where someone needs care quickly."

Kelena Beller
Nolensville Resident

"The traffic congestion on Nolensville Road is significant, especially around the rush hours (AM and PM). Minutes (and seconds) count when a life/limb threat emergency presents, and a FSED can provide 24/7 emergency-physician-trained care to these patients just like an emergency department attached to a hospital. At the Mt Juliet FSED, where I am the medical director, we admit/transfer up to 12% of our patient on a monthly basis. We also are on a pace to see over 20,000 patients in 2023. I am certain a FSED in Nolensville can and will serve a similar purpose to the residents (and visitors) in the region."

Brad Hoover, MD
Regional Medical Director

"Right now, there is nothing open past 7-8 pm and we have to drive to Franklin for the nearest ER. That is a 20-minute drive. A standalone ER, in my opinion, is way more efficient and desperately needed here.

One time, I was experiencing panic attacks that felt like a heart attack. I had to take a 20 min drive to an ER in Franklin, wait at check in. By the time I was seen, I had waited for an hour. Then, after hours of monitoring, I could barely find an uber home at 3am. No one should have to go through that, and an ER in town would help us get care more quickly."

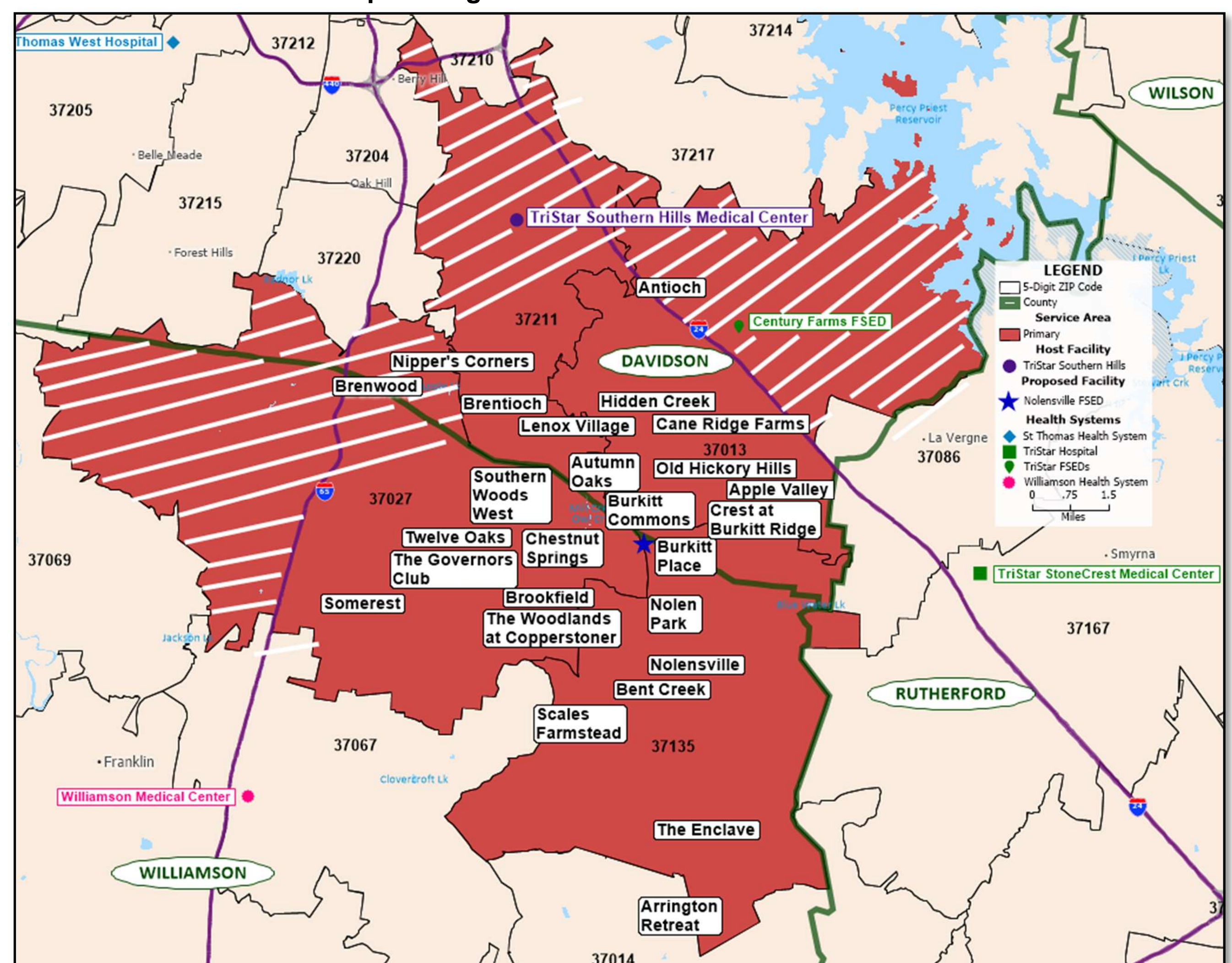
Melissa Cortenbach
Nolensville Resident

"When my son cut his finger very badly, the closest location was over 30 minutes away, and luckily this was after rush hour. Had traffic been bad or the bleeding much worse, we very well might have had to call an ambulance for a simple laceration."

Cary Pierce
Nolensville Resident

Table 1A of the FSED guidelines only considers drive times from the geographic center of each ZIP Codes. As ZIP Codes can be large areas, this is not reflective of the experience of all residents throughout a ZIP Code. The four large ZIP Codes encompass a number of distinct geographic areas, which can vary in access to ED services. As will be shown, traffic congestion and development will continue to exacerbate travel times to access emergency services for residents of these communities. **Figure 1N-6** provides a map of many of the larger subdivisions/ communities in the service area, focusing on the geographically isolated area between I-65 south and I-24 south, and the location of the proposed FSED. **Figure 1N-7** provides the drive times from the actual communities within the service area and their relative access to ED services with and without the proposed FSED. This analysis shows that the proposed FSED will be the closest ED for almost all communities (highlighted in green) with Southern Hills or the Century Farms ED as the second closest ED location (highlighted in yellow). This analysis also shows the reduction in travel time for numerous communities within the geographically isolated area that will be experienced with the development of the proposed Nolensville FSED.

Figure 1N-6
Map of Neighborhoods/Subdivisions in Service Area



Source: Google Map 2023 and Maptitude

Figure 1N-7
Drive-Time Analysis (Distance and Time) of Existing ED Facilities from Communities in the Service Area

Driving Time (miles)								
Residential Area within the Service Area:	**High Wait Times**	**Burkitt Place**	**Burkitt Commons**	**Crest at Burkitt Ridge**	**Nolen Park**	**Autumn Oaks**	**Chestnut Springs**	**Nolensville**
Emergency Department								
Proposed FSED		**0.2**	**0.3**	**1.4**	**1.7**	**1.8**	**2.1**	**2.5**
TriStar Southern Hills Medical Center		7.5	7.3	9.5	9.1	6.4	7.1	9.8
Century Farms FSED		4.1	6.2	2.9	8.0	5.1	6.1	8.0
TriStar StoneCrest Medical Center*		10.5	10.2	9.0	8.5	11.4	11.8	7.3
Metro Nashville General Hospital	High Wait Times	24.1	22.4	22.9	23.3	19.2	20.6	23.9
Saint Thomas Midtown Hospital	High Wait Times	18.2	20.2	19.9	21.2	17.1	18.4	21.8
Saint Thomas West Hospital	High Wait Times	23.1	21.4	22.0	22.4	18.2	19.6	22.9
TriStar Skyline Medical Center		25.6	28.0	24.5	27.6	22.7	25.7	29.1
TriStar Centennial Medical Center		18.9	20.9	21.7	21.9	17.8	19.1	22.5
Bellevue FSED**		19.4	32.4	31.2	34.3	27.5	28.8	32.2
TriStar Summit Medical Center		24.3	24.3	23.2	26.2	21.3	22.3	26.9
Vanderbilt University Medical Center	High Wait Times	21.4	19.7	20.3	20.7	16.5	17.9	21.2
Williamson Medical Center		12.1	13.4	13.5	11.8	12.4	10.6	10.6
Driving Time (minutes)								
Residential Area within the Service Area:	**High Wait Times**	**Burkitt Place**	**Burkitt Commons**	**Crest at Burkitt Ridge**	**Nolen Park**	**Autumn Oaks**	**Chestnut Springs**	**Nolensville**
Emergency Department								
Proposed FSED		**3**	**3**	**3-6**	**4**	**4-7**	**4-6**	**4-7**
TriStar Southern Hills Medical Center		18-40	16-35	18-35	18-40	14-30	14-30	18-40
Century Farms FSED		8-10	14	5-7	14-20	12	10-14	14-22
TriStar StoneCrest Medical Center*		16-22	16-22	12-18	16-24	18-26	16-26	14-18
Metro Nashville General Hospital	High Wait Times	35-60	30-50	30-55	30-50	28-45	26-45	30-50
Saint Thomas Midtown Hospital	High Wait Times	30-65	30-55	30-70	30-55	28-50	26-50	30-55
Saint Thomas West Hospital	High Wait Times	35-60	30-55	30-60	30-50	28-50	26-45	30-55
TriStar Skyline Medical Center		35-70	35-55	35-65	40-65	35-55	35-55	35-60
TriStar Centennial Medical Center		35-70	35-60	30-60	35-60	28-55	28-50	30-60
Bellevue FSED**		35-70	40-60	35-60	40-65	35-55	30-50	35-60
TriStar Summit Medical Center		35-60	30-50	30-55	35-55	30-45	30-50	35-55
Vanderbilt University Medical Center	High Wait Times	35-65	30-55	30-60	30-55	28-50	26-50	30-55
Williamson Medical Center		24-35	26-35	26-40	22-28	24-35	20-30	20-24

Source: Google Maps, 2023

Note: Depart time at 8:00am

**TriStar StoneCrest is included because it is a nearby hospital to the proposed service area.*

***Approved but not yet implemented.*

Figure 1N-7 Continued
Drive-Time Analysis (Distance and Time) of Existing ED Facilities from Communities in the Service Area

Driving Time (miles)								
Residential Area within the Service Area:	**High Wait Times**	**Brookfield**	**Southern Woods West**	**Bent Creek**	**Lenox Village**	**The Woodlands at Copperstone**	**The Governors Club**	**Old Hickory Hills**
Emergency Department								
Proposed FSED		**2.9**	**3.1**	**3.2**	**3.2**	**3.6**	**3.7**	**3.7**
TriStar Southern Hills Medical Center		8.4	7.2	10.6	4.8	9.4	7.7	8.5
Century Farms FSED		7.0	7.0	8.7	9.0	8.1	7.6	1.9
TriStar StoneCrest Medical Center*		10.5	12.7	8.1	12.8	10.5	13.3	8.5
Metro Nashville General Hospital	High Wait Times	20.6	18.1	24.6	18.1	21.1	18.7	20.2
Saint Thomas Midtown Hospital	High Wait Times	18.5	15.9	22.5	16.0	18.9	16.6	17.8
Saint Thomas West Hospital	High Wait Times	19.7	17.1	23.7	17.1	20.1	17.7	19.2
TriStar Skyline Medical Center		25.8	23.3	29.8	22.2	26.2	23.9	21.7
TriStar Centennial Medical Center		19.2	16.6	23.2	16.7	19.6	17.3	17.9
Bellevue FSED**		28.9	26.4	32.9	26.4	29.3	27.0	28.5
TriStar Summit Medical Center		23.3	23.5	27.7	20.8	26.5	24.2	20.4
Vanderbilt University Medical Center	High Wait Times	18.0	15.4	22.0	15.5	18.4	16.0	17.5
Williamson Medical Center		10.3	11.0	10.3	13.3	9.6	9.0	14.7

Driving Time (minutes)								
Residential Area within the Service Area:	**High Wait Times**	**Brookfield**	**Southern Woods West**	**Bent Creek**	**Lenox Village**	**The Woodlands at Copperstone**	**The Governors Club**	**Old Hickory Hills**
Emergency Department								
Proposed FSED		**6-8**	**7-9**	**6-10**	**6-12**	**7-9**	**6-9**	**8-12**
TriStar Southern Hills Medical Center		18-35	16-26	20-40	10-24	18-35	14-26	18-35
Century Farms FSED		14-18	14-18	16-24	14	14-18	12-18	5
TriStar StoneCrest Medical Center*		20-26	20-28	16-22	18-28	20-26	18-28	14-20
Metro Nashville General Hospital	High Wait Times	28-45	26-45	30-50	26-45	28-45	22-40	28-45
Saint Thomas Midtown Hospital	High Wait Times	28-50	26-50	30-55	26-50	28-50	24-45	30-50
Saint Thomas West Hospital	High Wait Times	28-45	26-45	35-55	26-50	28-50	24-40	30-50
TriStar Skyline Medical Center		35-55	35-55	40-60	30-50	35-55	30-50	35-55
TriStar Centennial Medical Center		28-55	28-55	35-60	26-55	28-55	24-45	30-60
Bellevue FSED**		35-50	30-50	40-60	30-55	35-55	30-45	35-55
TriStar Summit Medical Center		35-50	30-50	35-60	28-45	35-55	28-45	30-50
Vanderbilt University Medical Center	High Wait Times	26-50	26-50	30-55	24-50	26-50	22-45	28-50
Williamson Medical Center		20-28	22-30	20-24	24-40	18-26	16-24	28-40

Source: Google Maps, 2023

Note: Depart time at 8:00am

**TriStar StoneCrest is included because it is a nearby hospital to the proposed service area.*

***Approved but not yet implemented.*

Figure 1N-7 Continued
Drive-Time Analysis (Distance and Time) of Existing ED Facilities from Communities in the Service Area

Driving Time (miles)								
Residential Area within the Service Area:	**High Wait Times**	**Brentioch**	**Hidden Creek**	**Apple Valley**	**Twelve Oaks**	**Scales Farmstead**	**Cane Ridge Farms**	**The Enclave**
Emergency Department								
Proposed FSED		**3.9**	**4.1**	**4.3**	**4.6**	**5.2**	**5.9**	**6.1**
TriStar Southern Hills Medical Center		4.6	6.1	9.6	2.8	12.6	8.0	13.4
Century Farms FSED		6.4	1.0	3.1	6.0	10.7	2.9	11.6
TriStar StoneCrest Medical Center*		13.3	10.7	6.4	14.3	9.7	9.2	10.5
Metro Nashville General Hospital	High Wait Times	17.2	19.3	20.3	12.7	26.4	18.4	27.5
Saint Thomas Midtown Hospital	High Wait Times	15.1	16.3	17.9	10.6	24.3	16.0	29.3
Saint Thomas West Hospital	High Wait Times	16.2	18.3	19.3	11.8	25.5	17.4	30.5
TriStar Skyline Medical Center		22.4	23.1	21.8	17.9	31.6	20.0	32.7
TriStar Centennial Medical Center		15.8	17.0	19.0	11.3	25.0	16.7	30.0
Bellevue FSED**		25.5	27.6	28.6	27.4	34.7	26.7	35.8
TriStar Summit Medical Center		19.2	19.5	20.5	24.6	31.9	18.6	30.6
Vanderbilt University Medical Center	High Wait Times	14.5	16.6	17.6	16.5	23.8	15.7	28.8
Williamson Medical Center		13.4	14.4	15.9	8.5	8.1	19.4	13.1

Driving Time (minutes)								
Residential Area within the Service Area:	**High Wait Times**	**Brentioch**	**Hidden Creek**	**Apple Valley**	**Twelve Oaks**	**Scales Farmstead**	**Cane Ridge Farms**	**The Enclave**
Emergency Department								
Proposed FSED		**7-14**	**8-12**	**7-12**	**8-12**	**9-14**	**10-16**	**10-16**
TriStar Southern Hills Medical Center		10-22	12-26	18-35	7-14	24-45	16-30	16-50
Century Farms FSED		12-22	3	5-7	10-20	20-28	6-10	20-35
TriStar StoneCrest Medical Center*		18-35	16-22	10-16	20-35	18-22	12-20	20-24
Metro Nashville General Hospital	High Wait Times	24-40	28-45	28-50	18-35	30-45	24-40	40-60
Saint Thomas Midtown Hospital	High Wait Times	24-45	28-55	28-55	18-40	35-50	26-45	40-60
Saint Thomas West Hospital	High Wait Times	24-45	28-50	30-55	18-35	35-50	26-45	40-60
TriStar Skyline Medical Center		30-50	30-50	30-60	24-45	40-60	28-50	45-70
TriStar Centennial Medical Center		24-45	30-60	30-60	20-40	35-55	26-50	40-65
Bellevue FSED**		30-45	35-50	35-60	30-45	40-55	30-50	45-65
TriStar Summit Medical Center		26-45	28-45	30-55	30-45	40-55	26-45	40-65
Vanderbilt University Medical Center	High Wait Times	22-45	26-50	28-55	24-45	30-50	24-45	40-60
Williamson Medical Center		22-40	26-40	28-45	16-24	16-20	30-60	22-26

Source: Google Maps, 2023

Note: Depart time at 8:00am

**TriStar StoneCrest is included because it is a nearby hospital to the proposed service area.*

***Approved but not yet implemented.*

Figure 1N-3 Continued
Drive-Time Analysis (Distance and Time) of Existing ED Facilities from Communities in the Service Area

Driving Time (miles)						
Residential Area within the Service Area:	**High Wait Times**	**Somerset**	**Nipper's Corner**	**Brentwood**	**Antioch**	**Arrington Retreat**
Emergency Department						
Proposed FSED		**6.1**	**6.0**	**7.9**	**7.1**	**8.1**
TriStar Southern Hills Medical Center		9.2	3.4	6.5	4.2	15.5
Century Farms FSED		10.1	6.6	9.5	3.0	13.6
TriStar StoneCrest Medical Center*		15.8	13.5	16.3	9.9	12.6
Metro Nashville General Hospital	High Wait Times	17.6	14.2	12.7	14.8	33.5
Saint Thomas Midtown Hospital	High Wait Times	15.4	12.1	10.6	12.4	31.3
Saint Thomas West Hospital	High Wait Times	16.6	13.3	11.7	13.8	32.5
TriStar Skyline Medical Center		22.8	19.4	17.9	16.4	38.7
TriStar Centennial Medical Center		16.1	12.8	11.3	13.5	32.3
Bellevue FSED**		25.9	22.5	11.5	23.1	41.8
TriStar Summit Medical Center		23.0	19.7	18.2	11.6	32.6
Vanderbilt University Medical Center	High Wait Times	14.9	11.6	10.0	12.1	30.8
Williamson Medical Center		6.4	12.1	9.9	17.2	12.5
Driving Time (minutes)						
Residential Area within the Service Area:	**High Wait Times**	**Somerset**	**Nipper's Corner**	**Brentwood**	**Antioch**	**Arrington Retreat**
Emergency Department						
Proposed FSED		**10-16**	**10-16**	**14-22**	**14-22**	**12-18**
TriStar Southern Hills Medical Center		18-28	8-14	10-20	9-16	26-50
Century Farms FSED		18-24	10-20	16-28	7-12	22-35
TriStar StoneCrest Medical Center*		24-35	18-35	22-45	14-22	22-26
Metro Nashville General Hospital	High Wait Times	22-35	18-30	16-24	18-30	40-55
Saint Thomas Midtown Hospital	High Wait Times	22-40	18-35	16-28	20-35	40-60
Saint Thomas West Hospital	High Wait Times	22-35	18-35	16-28	20-35	40-60
TriStar Skyline Medical Center		28-45	24-40	22-35	22-40	45-65
TriStar Centennial Medical Center		22-40	18-40	16-35	20-35	40-65
Bellevue FSED**		28-40	24-40	18-35	24-40	45-65
TriStar Summit Medical Center		26-40	24-40	20-35	18-35	45-65
Vanderbilt University Medical Center	High Wait Times	20-40	18-35	14-30	18-35	40-60
Williamson Medical Center		14-24	18-35	12-20	24-50	18-26

Source: Google Maps, 2023

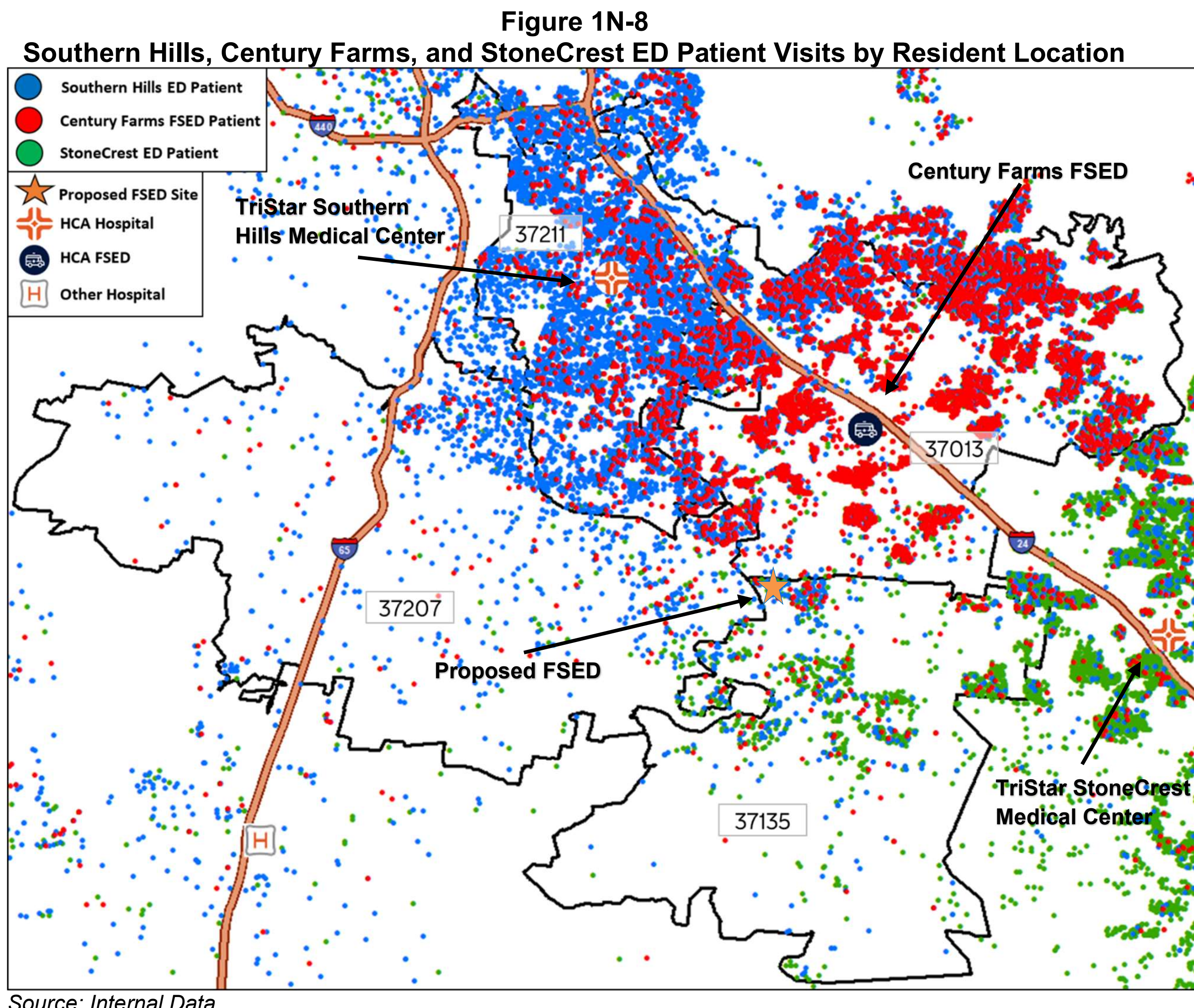
Note: Depart time at 8:00am

**TriStar StoneCrest is included because it is a nearby hospital to the proposed service area.*

***Approved but not yet implemented.*

Figure 1N-8 provides a map that shows the areas from which TriStar affiliates Southern Hills, Century Farms FSED, and TriStar StoneCrest patients came during CY 2021 and CY 2022. **Figure 1N-8** confirms that many service area patients who currently seek care at existing TriStar facilities will be closer to the proposed FSED. This is particularly true for ZIP Code 37135 (Nolensville) residents who currently do not have access ED services in their community and must leave the county and travel north to Southern Hills or the Century Farms ED, or east to StoneCrest in Rutherford County for emergent care. Similarly, residents in the eastern part of ZIP Code 37207 (Brentwood/Bentioch) will also have better access to local services with the proposed FSED. For the patients residing in closer proximity to the proposed FSED, access to emergency care will be greatly enhanced.

Figure 1N-8
Southern Hills, Century Farms, and StoneCrest ED Patient Visits by Resident Location



Source: Internal Data

Economic and Residential Development and the Impact on Access to Care

Nolensville is a growing community within the rapidly developing Middle Tennessee region. Nolensville's growth is compounded by the challenges of high demand for suburban and exurban growth, which depends heavily on the two major interstates and local throughways to move people throughout the community and into other areas in the region. The geographically isolated area sits between the two interstates and relies on congested east-west traffic to reach these highways. Nolensville Road/Nolensville Pike is the major north-south route through the area and there is rapid development and dense commercial/retail along this route.

Williamson County, where Nolensville is located, has experienced significant growth over the last decade. The town is closely situated near both Rutherford and Nashville/Davidson Counties, which are also experiencing unprecedented residential and economic growth and new job creation. This has resulted in population increases decade-over-decade, since the early 90s.

The Town of Nolensville population more than quintupled since 1990 and is expected to continue at an even more rapid rate over the next several years. Nolensville's population increased by 145 percent from 2010 to 2022, from 9,681 in 2010 to 23,673 in 2022.[3] Additional housing opportunities, needed community services and shopping opportunities, job creation, fiscal revenues, and the necessary infrastructure is necessary to support Nolensville's rapid growth. Some of the residential and mixed-use developments that are coming in Nolensville include:

- A development by Southern Land Company on hundreds of acres between I-24 has been approved. The development is planned to have 735 homes, several restaurants, and an elementary school.
- Southwalk, a 27-acre mixed-use development at 7150 Nolensville Road north of Sunset Road, broke ground in 2021. Southwalk will be Nolensville's biggest commercial development yet. It will feature a rooftop bar, a public plaza, a marketplace and restaurant, among other things.
- Nolensville's Village Green at Rocky Fork Road and Nolensville Road will be the first true mixed-use development in the town, offering a walkable, mixed-use area with shops, office space and community amenities next to a park. The development also brings a Publix grocery store which will be the first major grocery store in the rapidly growing Nolensville community.
- Developer Goodall Homes, which has multiple residential communities in Williamson County including Bent Creek in Nolensville, was approved to develop a nearly 300-acre site on Kidd Road in northeast Nolensville to include 444 residential lots as well as a 10-acre site for a future park.

Nolensville is primarily a bedroom community, with a majority of its working population commuting elsewhere for work. Key employment destinations for commuters include Nashville, Franklin, Smyrna, and Murfreesboro. That said, general employment and wage data from the U.S. Census Bureau shows a 73.5 percent average employment rate in comparison to a 61 percent average employment rate for the State of Tennessee, highlighting the relatively strong economic conditions in the town.[4]

Brentwood/Brentioch is a rapidly growing community, only second to Nolensville. According to the Brentwood 2030 Plan, growth and development are mainly directed inward due to the combination of population growth and limitation on the opportunity for annexation. Thus, focusing on filling up the 7,860 acres of remaining development land, primarily zoned for residential use, can potentially add 7,000 more homes to the Brentwood/Brentioch area and increase the population by about 25,000 residents.

[3] https://tennessee.hometownlocator.com/zip-codes/data,zipcode,37135.cfm and www.zipdatamaps.com/37135.
[4] https://cms8.revize.com/revize/nolensvilletn/Town%20of%20Nolensville%20MTP.pdf

Some additional development occurring throughout the service area, including Antioch and South Nashville, are listed below:

- Tanger Outlets is an open-air shopping center along I-24 at Hickory Hollow Parkway in Antioch and is being built by Tanger Factory Outlets Center. The shopping center is underway and expected to open in Fall 2023. Tanger partners will employ about 700 jobs during the construction and once completed, will create approximately 1,100 retail and management positions (full-time and part-time).
- Chick-fil-A Supply has expanded its operations to Antioch, TN, and opened in late 2022. This $16.3 million project will create 45 new jobs over the next five years.
- Mill Ridge Park is a 600-acre property in Southeast Davidson County near Cane Ridge High School, off Old Hickory Boulevard. Nashville's largest destination playground will anchor the new park. The park will include a large event lawn for community performances and festivals. Additionally, it will consist of features like fitness equipment, trail loops, and picnic shelters. The first phase of the Mill Ridge Park Plan is completed, and future phases will occur as funding is available.
- In South Nashville, a two-floor retail and office building off Nolensville Pike called The Shoppes at Harding is nearing completion. The facility currently has one tenant, Eggholic Restaurant, which is already in operation.

These new developments will add jobs, residents, and traffic congestion to the area, further exacerbating limited access to ED services. To reach the nearest EDs, patients must travel through the growing south Nashville and Antioch areas. Thus, the development activity in south Nashville and Antioch reinforces the area's position in the current and foreseeable commercial real estate market. With this comes an influx of residents, visitors, and tourists in and around the proposed service area. The overall growth of the proposed service area impact access to emergency services for residents, especially in the isolated geographic area within the service area identified in **Figure 1N-4**.

> *"Nolensville needs additional emergency services because of increased development of subdivisions and town homes on Nolensville Road from Lenox Village to Nolensville. The increased population growth in that area also drives the need for emergency services. Going to Smyrna or Centennial Medical Center is too far to have to go for urgent emergency care from that area."*
>
> *Tiffany Copeland*
> *Antioch Resident*

> *"Nolensville is growing quickly, and we need emergency services for all of the new people moving here. Many of these new residents are families with children, and we need to keep them safe. It would give everyone some peace of mind to know that care was nearby.*
>
> *The sheer amount of new residents is enough to support this ER, that's why I am happy to offer my full support and hope to see this project passed."*
>
> *Chrissie Hinton*
> *Brentwood Resident*

> *"Did you know that projections show Nolensville doubling from 16,000 people to 32,000 people in the next 10 years? The vast majority of residents in Nolensville are families. The residents like me chose a small town that was safe to raise their*

children in. As parents we have all been in that panic moment rushing to get our children treatment. Or when we ourselves / loved ones experience other emergency health concerns that have us in fear for our well-being. Adding an Emergency Room to Nolensville makes sense! Why should a resident be forced to drive to another town for life saving treatment? Will driving additional distance cause a loss of life?"

John Strack
Nolensville Resident

The significant level of growth in Nolensville puts additional strains on the town's existing transportation network and presents many traffic challenges as the town continues to experience growth pressures. This is particularly true as residents travel in and out of town for work. In 2022, the Town of Nolensville released a Major Thoroughfare Plan (MTP) which included a traffic study. **Figure 1N-9** below shows the existing and projected average daily traffic (ADT) volumes along the major throughways in Nolensville as well as the location of the approximate proposed FSED location from the study. The heaviest volumes along Nolensville Road occur during the morning peak period, as this is the major road that most residents must travel into and out of Nolensville. **Figure 1N-9** shows that future traffic volumes are expected to nearly double or more than double on many of Nolensville's major streets over the next 20 years according to the Nolensville Plan. Moreover, traffic north of Nolensville along Nolensville Pike into Nashville is also highly congested. For example, data from TDOT shows that traffic on Nolensville Pike south of Highway 254 (Old Hickory Boulevard and Bell Rd) has increased from an average daily traffic county of 22,885 in 2020 to 26,377 in 2022.[5] Just north of this intersection, the traffic county on Nolensville Pike increases to 34,549. Thus, traffic increases as one travels north from Nolensville into Nashville. This is the same direction patients must travel for ED services at Southern Hills.

[5] https://tdot.public.ms2soft.com/tcds/tsearch.asp?loc=Tdot&mod=TCDS

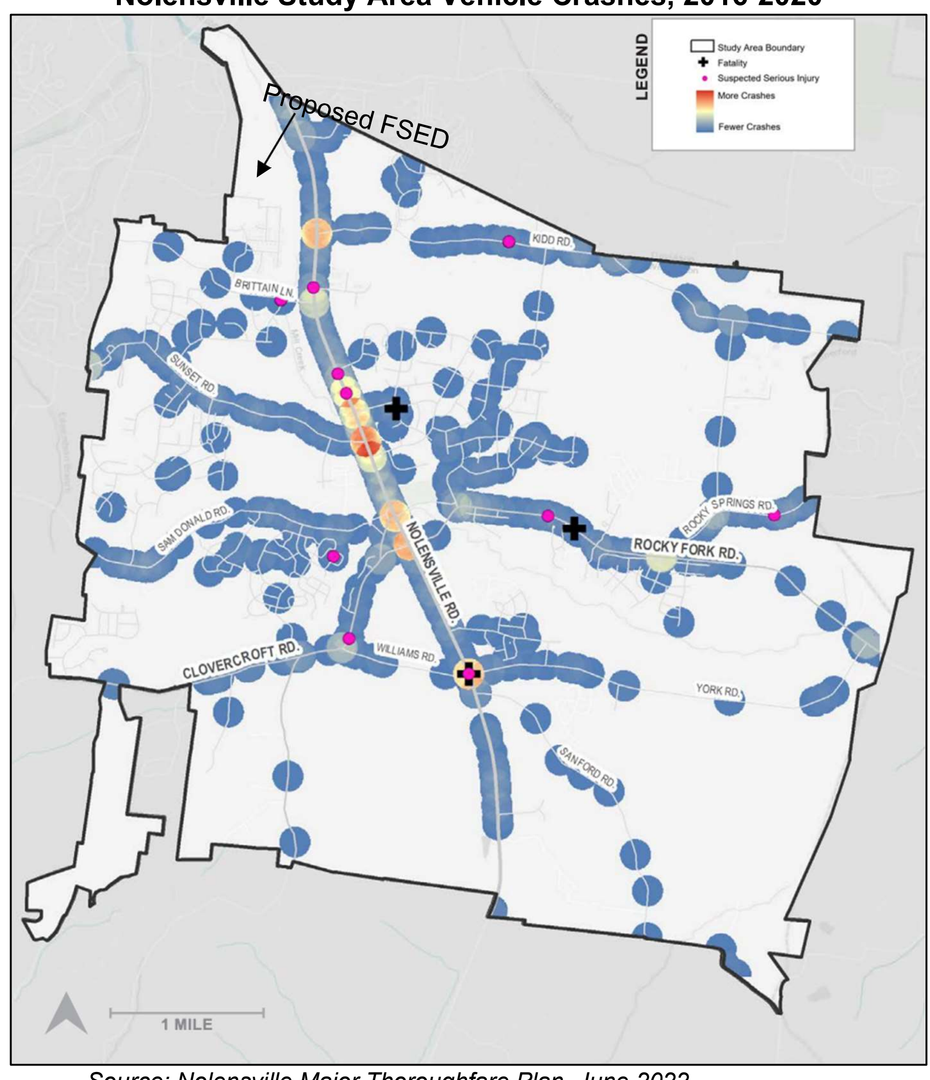
Figure 1N-9
Nolensville Study Area Existing and Projected Traffic Volumes, 2017-2045 (Nashville Area MPO)

Source: Nolensville Major Thoroughfare Plan, June 2022

Along with the heavy traffic congestion comes a significant rate of car crashes. Between 2016 and 2020, 809 vehicle crashes occurred in the Nolensville's study area. **Figure 1N-10** maps the location and severity of these crashes. Notably, crashes are concentrated on Nolensville Road at the Kidd Road intersection, just 1 mile south of the proposed FSED location. With the number of crashes that occur along the major throughways in Nolensville, it is even more important that the community and local EMS services have enhanced access to ED service, as there are no existing EDs in the Nolensville community. This does not even reflect the additional accidents occurring in South Nashville, south Antioch and east Brentwood. The Century Farms ED served 91 patients in car accidents for CY 2022 including 32 transported by EMS and 59 walk-in patients. The proposed FSED will address immediate needs for local car accidents.

While the town is planning to extend throughways, it can only do so much to alleviate existing and impending increases in traffic congestion. Without expanded access to emergency services, residents and visitors of the Nolensville area will undoubtedly experience increasing traffic delays as they travel north to access existing hospital EDs. When it comes to life threatening conditions such as heart attacks or strokes, time is of the essence, and every minute counts.

Figure 1N-10
Nolensville Study Area Vehicle Crashes, 2016-2020



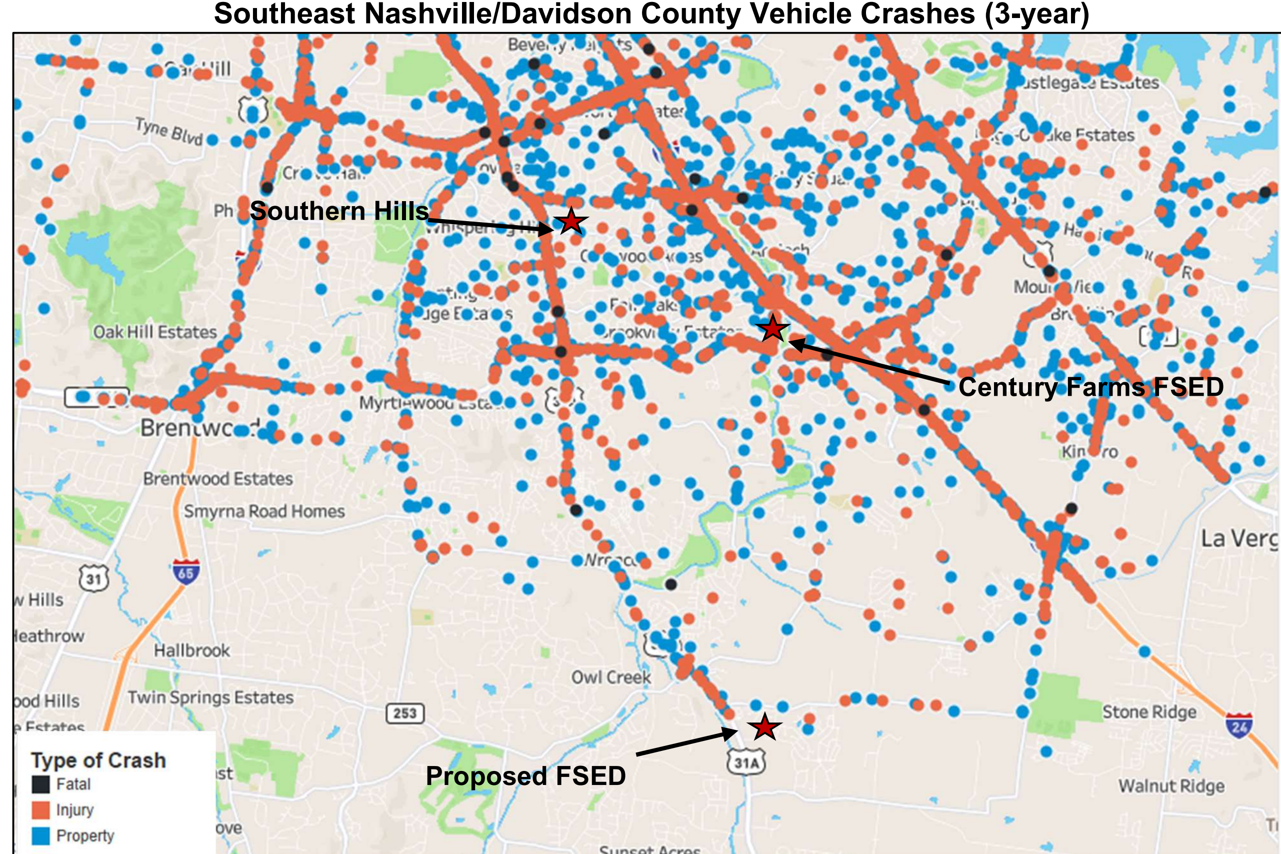
Source: Nolensville Major Thoroughfare Plan, June 2022

"One of our sons had a head injury when sledding down a long, steep icy hill. We made a rushed trip to the Williamson Medical Center ER. Due to the poor road conditions, we traveled Nolensville Road south to Triune and then Highway 96 to Williamson Medical. These roads are maintained during periods of ice and snow. Nolensville Road north at least to Concord Road is also maintained during periods of ice and snow and if the proposed ER had been there, it would have considerably reduced travel time."

Robert Binford
Nolensville Resident

Similarly, the vehicular crashes in South Nashville, Antioch, Brentwood/Brentioch are also numerous as shown in **Figure 1N-11**. The Metro Nashville Police Department maps vehicle crashes for the past three years by type of crash. The proposed FSED will become the closest ED location for patients with car crash related injuries.

Figure 1N-11
Southeast Nashville/Davidson County Vehicle Crashes (3-year)



Source: https://www.nashville.gov/departments/police/data-dashboard/vehicle-crashes-map

"There is no emergency room in Nolensville. As a result, families in Nolensville, east Brentwood and south Nashville have very limited options for emergency services. This rapidly growing area relies on large and crowded hospitals over 15 minutes away for their ER services. This requires patients and first responders to travel 15-20 or more minutes through the traffic headaches of I-65, Clovercroft Road, Concord Road, Nolensville Pike, Kidd Road/McFarlin Road, and/or Rocky Springs Road to access emergency services.

With the rapid growth of Nolensville and the traffic that is accompanying it, my constituents have an increasing need for access to emergency services. The existing emergency care options are much too far away for residents experiencing time-sensitive medical emergencies."

John Rutherford
Metro Nashville District 31 Councilman
District adjacent to proposed Nolensville FSED site

Timely Access to ED Services is Critical for Lifesaving Care
As traffic congestion continues to increase in the area, patients, even when transported by EMS, can miss the "golden hour" when lifesaving and disability preventing treatment, such as thrombolytics as well as other medications that can limit the damage done by a stroke or heart attack. It is important because:

- In the United States, someone has a heart attack **every 40 seconds**.
- Every year, about 805,000 people in the United States have a heart attack.
- 1 in 6 people will have a stroke in their lifetime.
- There is **1 stroke every 40 seconds** in the United States.
- 1 in 10 people will have a seizure in their lifetime.

Reduced travel and transport times to ED services are directly linked to improved outcomes including lives saved. For example:

Condition	Clinical Outcomes[6]	# of Patients in TriStar FSEDs 2022
Cardiac Arrest	Survival Rates: 22% at 0 minutes 8% at 10 minutes 3% at 20 minutes	102
Stroke	1.9 million neurons die every minute a stroke goes untreated	87
Sepsis	1-year mortality risk increases 10% for every hour delay in antibiotic administration	655

The sooner a patient gets medical attention, the better their chances of surviving, recovery, and regaining their quality of life. This proposed FSED will offer a vital access point to emergency care for residents and visitors of service area in a prime, easily accessible location.

"I am a fire captain/ paramedic for the town of Nolensville. A free standing ED would greatly cut down transport times for critical patients in the Nolensville area. It would also help alleviate ED congestion at surrounding hospitals. The exponential growth in Nolensville makes it the perfect place to put a new ED. It will help the community and I hope to see it built."

Sam Killingsworth
Fire Captain/Paramedic
for the Town of Nolensville

[6] **Cardiac:** Yoshikazu, Goto. Relationship Between the Duration of Cardiopulmonary Resuscitation and Favorable Neurological Outcomes After Out-of-Hospital Cardiac Arrest: A Prospective, Nationwide, Population-Based Cohort Study. Journal of the American Heart Association, 2006 March; 115.002819
Stroke: Saver JL. Time is brain--quantified. Stroke. 2006 Jan;37(1):263-6
Sepsis: Peltan et al. ED Door-to-Antibiotic Time and Long-term Mortality in Sepsis. Chest. 2019 May;155(5):938-946

"I had a friend that experienced cardiac arrest and he had to be transported up to Nashville for care. In some emergencies, that long drive can cost someone their life. Time is important and Nolensville needs an ER so that people can get care quickly and efficiently."

Eric Clapp
Brentwood Resident

"I was born with bicuspid aortic valve, that has been replaced 3 times. […] Between the first and second heart valve replacement surgery I tore a leaflet in the aortic valve. With the symptom, my wife took me to the Vanderbilt ER. A transesophageal echocardiogram later determined a leaflet tore, and it was 'flapping in the breeze'. […] After my second heart surgery, medication dropped my blood pressure to the point that blood pressure would not register on the EMT's blood pressure cuff. I was transported to the Vanderbilt ER in an ambulance with lights and sirens. It is a long way from Nolensville when you are in bad shape."

Robert Binford
Nolensville Resident

"With Nolensville being such a family community, it would be helpful to have an ER where easy fixes like broken bones can be taken care of. It might also help save lives in cases of heart attacks, high blood pressure or strokes. I've had to visit an ER several times and it seemed like the drive took forever. Even car accident victims could at least start out there. I think it would be a great asset to Nolensville."

Neischa Alexander
Nolensville Resident

"There was a medical emergency involving my niece and when my brother called 911, they took her all the way to Nashville VUMC children's hospital. There is no ED location in Nolensville, so all of the options are far away which can cost someone their life if the problem is very serious."

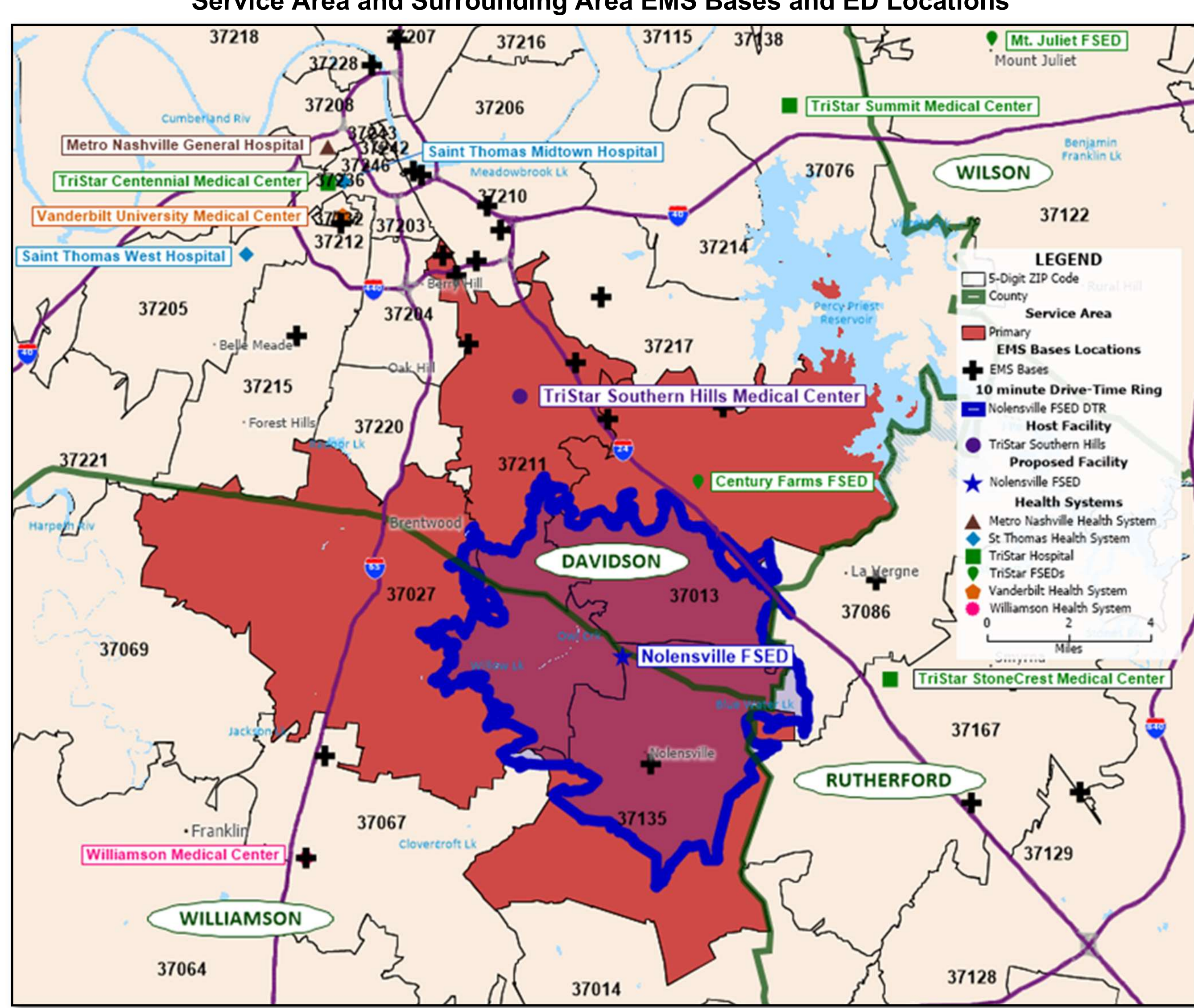
Hala Alaw
Nolensville Resident

<u>*EMS Access in the Service Area*</u>

Traffic congestion and EMS locations also impact access to care for service area residents. Currently, there is a lack of adequate EMS stations in the service area. **Figure 1N-12** provides a map of the service area, the existing hospitals and FSEDs in the counties that include the service area ZIP Codes and the geographically isolated area, and the location of EMS bases with advanced life support ("ALS") and basic life support ("BLS") transport capability. Many of these base locations in Nashville/Davidson County are clustered closer to core Nashville with seven bases in the service area ZIP Codes. Three EMS bases are in the northern portion of the service area in ZIP Code 37211, the home ZIP Code of Southern Hills. There is one EMS base located on the border between ZIP Codes 37211 and 37013, the home ZIP Code of Century Farms FSED. One EMS base located in the service area is in the northern portion of ZIP Code 37013. The last EMS base is located in ZIP Code 37135 (Nolensville), which was recently opened in late February of 2023. Notably, most of the EMS bases are located in the far northern part of the ZIP Codes, where the most proximal EDs are located – TriStar Southern Hills and Century Farms FSED. The pattern of EMS bases in surrounding counties seems also to follow the pattern of hospital EDs and FSEDs.

For service area residents located in ZIP Code 37027 in need of emergency transport services, EMS providers must travel through traffic congestion, pick up the patient, and then travel back through heavy traffic congestion to reach an existing ED, which can significantly delay access to care and increase the time EMS is occupied on medical transports. Service area residents of ZIP Code 37135 will also face similar barriers as only one EMS base is in the ZIP Code. Even with this new EMS base in Nolensville, patients will still need to be transported to distance EDs. When the unit(s) at that EMS base are occupied, the residents will have to rely on outside EMS, which will have the same access barriers as 37027 residents. The Nolensville FSED will offer an alternative access point for EMS services and will significantly decrease EMS travel time for a majority of the service area. This is particularly important considering the vehicle crash analysis within the service area presented in **Figures 1N-10** and **1N-11**.

Figure 1N-12
Service Area and Surrounding Area EMS Bases and ED Locations



Source: Maptitude

The proposed project has the support of local Fire Chief who recognizes the importance of timely access to care for EMS teams and their patients.

> *"Prior to my role in Nolensville, I served Brentwood Fire and Rescue for 24 years. Given my experience in Williamson County, I know the difficulties we face in getting patients to the emergency room in a timely manner. Increase emergency services in Nolensville will improve patient outcomes and allow EMS Team to work more efficiently."*
>
> *David E Windrow*
> *Fire Chief for the Town of Nolensville*

> *"The Nolensville community has seen a tremendous amount of growth over the last three (3) years and their need for urgent medical care has significantly increased. Without access to an FSER, this creates further delays to definitive care and potentially damages patient outcomes. The addition of an FSER in Nolensville would greatly reduce our travel times while allowing our EMS and first responders to have a more efficient return time to our respective zones and be available for community members who need emergency services."*
>
> *Nina Mothershed, AEMT*
> *General Manager of TN Division*
> *Ambulance Company - Ambulnz TN, LLC.*

TriStar conducted a survey of 350 residents of the proposed four ZIP Code service area between February 20th and February 25th, 2023. The results of the survey confirm that residents of the service area are very concerned about timely access to ED. Experts in the survey include:

- **74 percent** of service area residents polled are either very concerned or concerned about the lack of availability of an emergency room in Nolensville.
- **74 percent** of service area residents polled believe it would take them longer than 15 minutes to get to the nearest emergency room during high traffic periods.
- The service area residents polled believe ambulance availability is impacted by the following:
    - **70 percent** slow traffic impeding ambulance
    - **41 percent** the number of emergency rooms near our community
    - **57 percent** the rapid growth of our community
- **89 percent** of service area residents polled feel that an additional emergency room in Nolensville community will greatly enhance or enhance family safety and peace of mind.
- **62 percent** of service area residents polled feel that the proposed service area does not have the proper emergency care facilities to handle workplace disasters or school-related incidents.
- **56 percent** of service area residents polled feel that the proposed service area is not equipped to handle someone experiencing a mental health crisis or overdose.
- **71 percent of service area residents polled feel that it would enhance public safety to have an emergency room closer to them.**

These data confirm that service area residents are concerned about access to the emergency service based on the current location of EDs in relation to their community, the impact of traffic and congestion on travel and transport to the existing EDs and that the proposed service area

does not have sufficient access to emergency services particularly in the event of workplace disasters, school related incidents, and mental health crisis or drug overdose.

Southern Hills serves the highest volume of ED patients from the service area, by far, and is the most proximal provider of ED services to the service area. Along with its Century Farms FSED, it is one of just two EDs in the service area. The proposed FSED will better serve Southern Hills' existing patient base by enhancing access to emergency care within the identified geographic area. Traffic congestion significantly impacts access to care for residents of this area. Additionally, as new developments come to the area, the addition of emergency services will lessen the burden on existing EDs and improve ED services availability in a currently underserved community.

B. Capacity Challenges: Wait Times and Visits per Treatment Room

Check the Box that Applies:

☒ The applicant is demonstrating capacity challenges in the proposed service area. If this box is checked the applicant must provide the information below.

☐ The applicant is not demonstrating capacity challenges in the proposed service area.

Data:

1. Wait Times

To demonstrate wait times in the proposed service area and demonstrate need, complete the below tables for each existing ED facilities in the proposed service area. For this analysis, service area is defined as including all of any county included in a ZIP Code area.

The counties containing the service area ZIP Codes for this project include Nashville/Davidson and Williamson Counties, as the proposed FSED is located on the border of these two counties. The geographically isolated area within the ZIP Codes that make up the service area is on or near the Davidson/Williamson County line and includes the Nolensville area and portions of South Nashville, southwest Antioch, and east Brentwood. Residents of this area rely heavily on Southern Hills and the Century Farm FSED, which are the only two EDs in the ZIP Code area. There is no ED in the geographically isolated area within the proposed service area. In addition, some service area patients travel to other EDs in central Nashville/Davidson County and Williamson County. As will be shown, there are certain EDs within this area and serving residents of the service area that have long ED wait times impacting access to care.

Table 1B1 OP-18 demonstrates that several hospitals in the county service area are experiencing exceedingly high wait times for ED services based on CMS measures.[7]

[7] Although the Applicant has defined the service area for this project, the FSED Criteria require that the service area include the entire county. Applicant submits that including the entire county is not appropriate in this circumstance where the area to be served is very limited, only 4 of 49 ZIP Codes in the county. *See* Davidson County, TN - Tennessee ZIP Codes (zip-codes.com) ("DAVIDSON County, TN Covers 49 ZIP Codes").

Wait Times at Existing ED Facilities in the Proposed Service Area: Tables 1B1 (1-5)

Measure: ED-1 Median Time from ED Arrival to ED Departure for ED Admitted Patients				
Emergency Department	**Timeframe**	**ED Time/Score**	**Tennessee Average**	**National Average**
ED 1	CMS has discontinued mandatory data collection for ED-1 after CY 2018. Therefore, this measure was removed from CMS programs and is no longer publicly reported on Care Compare.[8]			
ED 2				
ED 3				

ED-2: Median Time from Admit Decision to Departure for ED Admitted Patients				
Emergency Department	**Timeframe**	**ED Time/Score**	**Tennessee Average**	**National Average**
ED 1	CMS has discontinued mandatory data collection for ED-2 after CY 2019. Therefore, this measure was removed from CMS programs and is no longer publicly reported on Care Compare.[9]			
ED 2				
ED 3				

Measure: OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients				
Emergency Department	**Timeframe**	**ED Time/Score**	**Tennessee Average**	**National Average**
TriStar Southern Hills Medical Center	4/1/2021 - 3/31/2022	**140 Minutes**	187 Minutes	202 Minutes
TriStar Skyline Medical Center	4/1/2021 - 3/31/2022	174 Minutes	187 Minutes	202 Minutes
TriStar Centennial Medical Center	4/1/2021 - 3/31/2022	156 Minutes	193 Minutes	188 Minutes
TriStar Summit Medical Center	4/1/2021 - 3/31/2022	164 Minutes	187 Minutes	202 Minutes
Williamson Medical Center	4/1/2021 - 3/31/2022	167 Minutes	187 Minutes	202 Minutes
Metro Nashville General Hospital**	4/1/2021 - 3/31/2022	**187 Minutes**	173 Minutes	170 Minutes
Saint Thomas West Hospital^**	4/1/2021 - 3/31/2022	**201 Minutes**	193 Minutes	188 Minutes
Vanderbilt University Medical Center**	4/1/2021 - 3/31/2022	**251 Minutes**	193 Minutes	188 Minutes

Source: Centers for Medicare and Medicaid Services (CMS) Hospital Compare

^ Saint Thomas Midtown Hospital and Saint Thomas West operate on the same license and data is reported collectively on the CMS Hospital Compare Website under Saint Thomas West Hospital.

** Experiencing High Wait Times

Measure: OP-20 Door to Diagnostic Evaluation by Qualified Medical Professional				
Emergency Department	**Timeframe**	**ED Time/Score**	**Tennessee Average**	**National Average**
ED 1	This measure was removed from the Hospital OQR Program beginning with the 2020 Payment Determination Year. As such, the last time data for this measure was reported was for Q1 2018 encounters.[10]			
ED 2				
ED 3				

Measure: OP-22 ED Patient Left without Being Seen				
Emergency Department	**Timeframe**	**ED Time/Score**	**Tennessee Average**	**National Average**
TriStar Southern Hills Medical Center	1/1/2021-12/31/2021	2%	3%	3%
TriStar Skyline Medical Center	1/1/2021-12/31/2021	2%	3%	3%
TriStar Centennial Medical Center	1/1/2021-12/31/2021	1%	3%	3%
Tristar Summit Medical Center	1/1/2021-12/31/2021	1%	3%	3%
Williamson Medical Center	1/1/2021-12/31/2021	2%	3%	3%
Metro Nashville General Hospital	1/1/2021-12/31/2021	4%	3%	3%
Saint Thomas West Hospital*	1/1/2021-12/31/2021	3%	3%	3%
Vanderbilt University Medical Center	1/1/2021-12/31/2021	4%	3%	3%

Source: Centers for Medicare and Medicaid Services (CMS) Hospital Compare

** Saint Thomas Midtown Hospital and Saint Thomas West operate on the same license and data is reported collectively on the CMS Hospital Compare Website under Saint Thomas West Hospital.*

[8] https://hscrc.maryland.gov/SiteAssets/Pages/init_qi_qbr/2.%20RY2022%20QBR%20Final%20Recommendation%202019-12-4.pdf
[9] https://hscrc.maryland.gov/SiteAssets/Pages/init_qi_qbr/2.%20RY2022%20QBR%20Final%20Recommendation%202019-12-4.pdf
[10] https://www.qualityreportingcenter.com/globalassets/migrated-pdf/oqr-february-2019-webinar-qa-10am-508.pdf

Specifically, Metro Nashville General Hospital ("Nashville General"), St. Thomas West and St. Thomas Midtown (combined), and VUMC report significantly long wait times to CMS that exceed the TN average and national average. These data indicate that there are capacity constraints across multiple hospitals in the county service area.

Notably, all TriStar facilities including Southern Hills are below Tennessee and National average wait times regardless of their visits per treatment space. This is due to the operating expectations of all TriStar facilities and HCA's focus nationally on improving the timeliness of care offered by its EDs. Likewise, for measure OP-22, all TriStar facilities in the area are equal to or below the measure of Left Without Treatment ("LWOT") percentages. This is also due to the emphasis in TriStar ED operations on ensuring patients are seen by a provider quickly, so they do not get discouraged by the wait time and leave.

Please note that several of the data tables under **Table 1B1** are no longer recorded by CMS.

Data:

2. ***Visits per Treatment Room***

Complete the following table to provide data on the number of visits per treatment room per year for each of the existing ED facilities in the service area. For this analysis, service area is defined as including all of any county included in the ZIP Code area.

TriStar Southern Hills, the only hospital in the ZIP Code service area and the host hospital for this project, has the highest number of visits per room of all area providers in the counties in which the service area ZIP Codes are located. Southern Hills far exceeds the ACEP benchmark ED capacity for high range EDs, providing 40,169 ED visits in 23 rooms in 2021 or an average of 1,746 visits per room. Based on this definition, Southern Hills has capacity constraints. The proposed service area is defined on a ZIP Code level. All the service area ZIP Codes are in Nashville/Davidson and Williamson Counties as reflected in **Table 1B2**.

Southern Hills and many other hospitals in the county are facing significant capacity constraints, which limit access to care. Southern Hills far exceeds the ACEP benchmark levels by treating 1,746 patients per bed in its 23 ED beds in 2021, the highest utilization rate of any of the twelve area EDs. The Southern Hills ED utilization rate is roughly 45 percent higher than the recommended ACEP average level of 1,212 visits per bed for high-range EDs. It is important to note Southern Hills currently operates 21 of its approved 23 ED beds – two of its approved beds are dedicated for psychiatric holding[11]. Therefore, Southern Hills is even more constrained than shown in **Table 1B2**. When one considers only the beds the Southern Hills uses for ED visits, Southern Hills experienced approximately 1,913 ED visits/ED bed. It is important to note that only a partial year of data was included for the Century Farms FSED for 2021. In 2022, its first full year of operation, Century Farms FSED exceeded ACEP guidelines for visits per room.

Five of the other EDs in the county area are very close to or exceed the high range of ACEP standards as highlighted in green. Of the nine (9) hospitals, all exceed or almost meet the high range of the ACEP guidelines except for VUMC, which is a Level I Trauma Center, and

[11] Southern Hills is in the process of amending its 2021 JARs to show 21 ED treatment rooms not 23.

Nashville General, a busy urban hospital with long wait times, which is discussed further below. While below the ACEP Guidelines for visits/bay, VUMC, St. Thomas West, and Nashville General all experience significantly long wait times.

Visits per Treatment Room in Existing ED Facilities in the Proposed Service Area: Table 1B2 - 2021

Emergency Department	Year(s)	Total Visits	# of Rooms	# of Visits/Room	ACEP	
					Low Range	High Range
Tristar Southern Hills Medical Center	1/1/2021 – 12/31/2021	40,169	23	1,746	1,600	1,212
Century Farms FSED*	1/1/2021 – 12/31/2021	5,525	11	502	1,250	909
TriStar Centennial Medical Center	1/1/2021 – 12/31/2021	62,513	41	1,525	1,622	1,277
Saint Thomas Midtown Hospital	7/1/2020 – 6/30/2021	46,843	32	1,464	1,607	1,216
Tristar Skyline Medical Center	1/1/2021 – 12/31/2021	53,356	43	1,241	1,667	1,250
Tristar Summit Medical Center	1/1/2021 – 12/31/2021	44,664	37	1,207	1,607	1,216
Williamson Medical Center	7/1/2020 – 6/30/2021	43,457	36	1,207	1,607	1,216
Saint Thomas West Hospital	7/1/2020 – 6/30/2021	30,119	27	1,116	1,429	1,200
Metro Nashville General Hospital	7/1/2020 – 6/30/2021	23,059	32	721	1,389	1,250
Vanderbilt University Medical Center	7/1/2020 – 6/30/2021	101,099	135	749	1,613	1,235
Total / Area Average		**450,804**	**417**	**1,081**	**1,568**	**1,233**

Source: 2021 Hospital JARs.

**Century Farms FSED opened June 2021.*

TriStar Centennial Medical Center has an FSED in Spring Hill but it is not in Davidson County or in the service area.

TriStar Summit Medical Center has an FSED in Mt. Juliet but it is not in Davidson County or in the service area.

Note: EDs highlighted in green approximately meet or exceed High Range ACEP guidelines.

The ACEP Guidelines were published in 2016 prior to COVID and prior to the 2018 Facility Guidelines Institute's major revisions to hospital construction standards. Much has changed about the operation of EDs since 2016 particularly the need for greater isolation and airborne infection control. The ACEP Guidelines were also developed as a prospective tool to plan for the design of a renovated or new hospital ED and were not intended as an evaluation tool for retrospective evaluation of the operations of an existing ED. With these limitations, the ACEP guidelines should be considered and a framework to consider the wide variety of factors that impact operations and capacity of an ED and not a definitive benchmark. Such limitations in the applicability of ACEP are considered in the discussion below.

Diversion Status is Indicative of Capacity Constraints

Another measure of capacity at hospital EDs is diversion status. Hospital EDs go on diversion when they have reached saturation levels that create a situation in which additional patients cannot be treated. When a hospital alerts EMS of ED Diversion, it is communicating a capacity message that resources are very limited. The facility will still accept high acuity patients like strokes, STEMIs, traumas and burns, that the hospital has the unique capability to provide. ED Diversion is only communicated to EMS personnel. There are no restrictions for walk-in patients into the ED but wait times do increase during these times. Hospitals may also be on diversion for specific service such as STEMI, Stroke, Trauma, OB if resources are saturated for a specific service. Finally, a hospital may be on total diversion with the intent to stop all patient transports in the event of a circumstance specific to that facility.

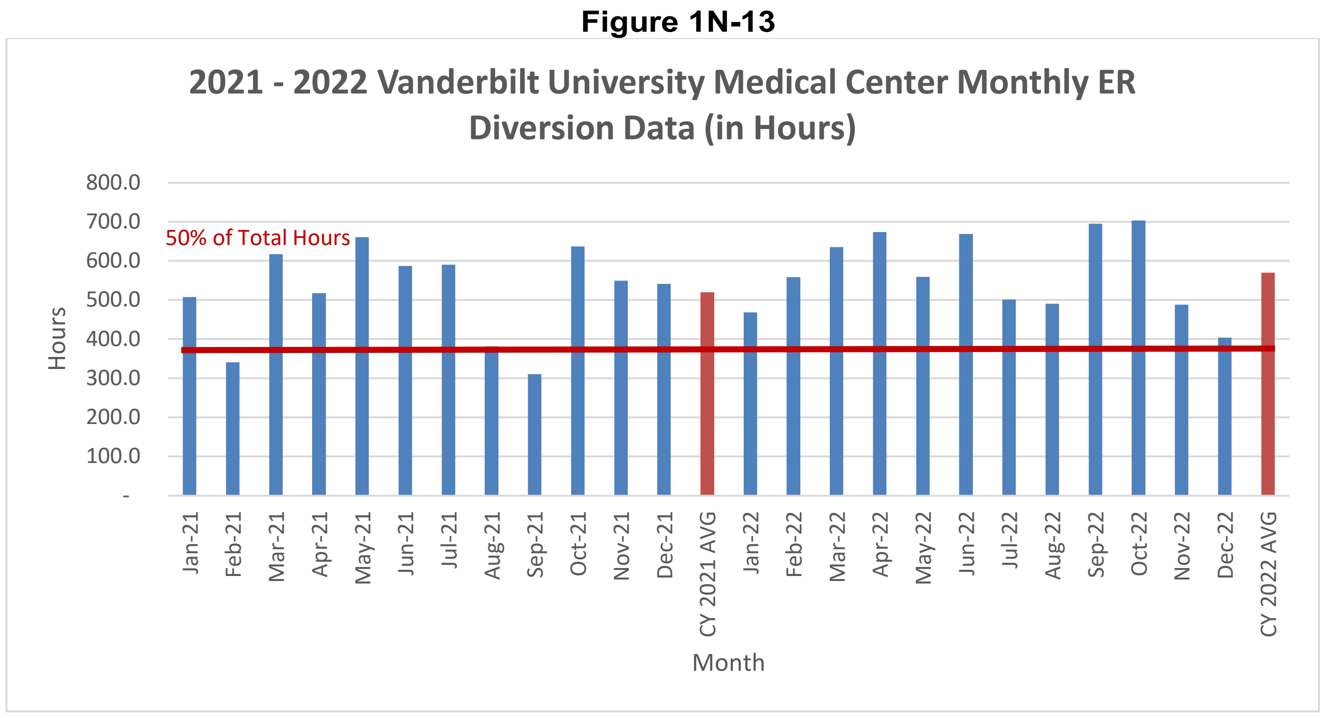
Nashville/Davidson County EMS retains daily records of hospital ED diversion status including full diversion in which EMS providers must "bypass" an ED entirely due to reasons such as capacity constraints, equipment out of order, helipad out of services, or facility lock-down. **Exhibit 9** of the main CON application provides the ED diversion data for all Nashville/Davidson

County hospitals. When contacted, a Williamson County representative said no data is available on diversion for WMC.

VUMC Experiences Significant Capacity Constraints
As previously established, ED data, such as wait times and diversion data, show that several hospitals in Nashville/Davidson County are experiencing capacity constraints that might not be reflected by the ACEP visits person room standards, including VUMC. VUMC is a Level I Trauma Center, teaching hospital, Burn Center, Stroke Center, Comprehensive Regional Pediatric Center, and offers emergency behavioral healthcare, all of which place significant additional operating constraints on ED capacity. These constraints are not reflected in the number of visits per room analysis above in **Table 1B2**. While VUMC is below the ACEP visits per room standard for CY 2019 and 2020, this measure is not a full reflection of the various constraints that VUMC experiences as the regional tertiary and quaternary medical center and as an academic medical center. Such constraints can be seen in the exceedingly high patient visit times presented above based on data from the CMS compare website.

VUMC experienced diversion time in every month of 2021 and 2022 (See **Figure 1N-13**). VUMC's diversion time is conspicuously high exceeding 50 percent of total hours for many months in 2021 and 2022. Regardless of any ACEP visits per room target, VUMC is clearly operating in excess of capacity and more capacity is needed in Metro Nashville to offset VUMC's congested ED, especially considering the high acuity trauma patients treated by VUMC. TriStar Skyline is the other logical location for high acuity trauma and burn care; however, Skyline is also operating at high levels of capacity.

Figure 1N-13



Source: Nashville Fire Department Emergency Medical Services, 2021- April 2022.

Nashville General is a local safety net, community hospital that is operated by the Hospital Authority of the Metropolitan Government of Nashville and Davidson County (the "Hospital Authority"). Nashville General primarily serves the most medically underserved patient populations in Metro Nashville. It serves very few patients from the defined ZIP Code area.

Projected Growth in ED Demand and Impact on Capacity

The Nolensville FSED service area is projected to grow significantly over the next five years, as discussed in more detail in response to **Question 3N** of the CON application. This growth will drive increasing demand for ED services. The significant population growth in the service area is expected to result in increased demand for ED services with almost 80,000 service area visits projected by 2026. This demand will place greater capacity constraints on the area EDs, which are already facing capacity challenges, long wait times at some EDs, and diversion status at all EDs.

> *"Our community is growing at a rapid rate. The addition of an ER in Nolensville will reduce travel times for patients and provide relief for our existing emergency rooms, which are often operating at or near capacity. I think it will be an excellent quality of life addition to our community And I hope you approved this ER."*
>
> *David E Windrow*
> *Fire Chief for the Town of Nolensville*

The proposed FSED will help to improve equitable access to emergency services by adding an ED access point closer to residents' homes and alleviating capacity constraints at Southern Hills, which is the largest provider of care to service area residents. As noted previously, the service area includes communities with high percentages of persons living in poverty and two ZIP Codes with a high percentage of minority populations (ZIP Codes 37013 and 37211). See **Exhibit 5** of the main CON application. Socioeconomic status impacts patients' ability to access healthcare services including emergency services. It is critical that ED services are strategically located where communities in need can access care promptly and that patients have adequate access to emergency services.

As ED services demand continues to recover from COVID and the population of the service area continues to grow and age, the demand for ED services will also grow. With the service area poised for continued economic and residential growth, the area must be ready to provide ED services to all communities and in all events. Additional access to high quality ED services will benefit the community. The additional capacity to handle emergency services provided by this project will make emergency services more readily available to service area residents.

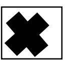
> *"Nolensville has seen tremendous growth which makes the need for additional emergency services twofold. […] The population can support it. […] The growth has led to increased traffic which makes the current emergency service options even further away in terms of travel time.*
>
> *That's why I'm happy to offer my support for the Nolensville ER and hope to see it approved."*
>
> *Erich Chadwick*
> *Nolensville Resident*

C. Low Quality of Care at Existing Emergency Departments in the Service Area

Note: The host hospital ED should NOT be demonstrating low quality of care. This applies to other operators in the proposed service area.

Check the Box that Applies:

☐ The applicant is demonstrating low quality of emergency care in the proposed service area. If this box is checked the applicant must provide the information below.



The applicant is *not* demonstrating low quality of emergency care in the proposed service area.

Data:

If the applicant is demonstrating low quality of care, complete the tables below for each existing ED facility in the proposed service area. The Joint Commission's "Hospital Outpatient Core Measure Set" is utilized to demonstrate the quality of care provided by EDs. Existing emergency facilities should bein the bottom quartile of the state in the measures listed below to demonstrate low-qualityof care. It is the responsibility of the applicant to provide data on the existing facilities in the proposed service area what quartile is applicable for each measure. For this analysis, service area isdefined as including all of any county included in a ZIP Code area.

Not applicable. The applicant is not applying under a Low Quality of Care at Existing Emergency Department in the Service Area criteria.

Quality of Care Provided at Existing ED Facilities in the Proposed Service Area: Tables 1C (1-8)

Measure: OP-1 Median Time to Fibrinolysis

Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
ED 1						
ED 2						
ED 3						

Measure: OP-2 Fibrinolytic Therapy Received Within 30 Minutes

Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
ED 1						
ED 2						
ED 3						

Measure: OP-4 Aspirin at Arrival

Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
ED 1						
ED 2						
ED 3						

Measure: OP-5 Median Time to ECG

Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
ED 1						
ED 2						
ED 3						

Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients

Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
ED 1						
ED 2						
ED 3						

Measure: OP-20: Door to Diagnostic Evaluation by a Qualified Medical Personnel

Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
ED 1						
ED 2						
ED 3						

Measure: OP-21 ED-Median Time to Pain Management for Long Bone Fracture

Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
ED 1						
ED 2						
ED 3						

Measure: OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or HemorrhagicStroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival

Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
ED 1						
ED 2						
ED 3						

D. Other Applicable Data Related to Need and Capacity

Check the Box that Applies:

☐ The applicant is providing additional data related to need and capacity. If this box is checked the applicant must provide the information below.

☒ The applicant is not providing additional data related to need and capacity.

Data:

The applicant may provide data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules at existing EDs in the proposed service area to demonstrate capacity challenges. If the applicant is providing additional data, at a minimum, complete the following table for all ED facilities in the proposed service area. Other relevant categories may be added to the table by the applicant.

Additional Data to Demonstrate Need in the Proposed Service Area: Table 2B

Emergency Department	% of Behavioral Health Patients	Statewide Average	% of Patients Level I or II	Statewide Average	% of Patients Ages 65+	Statewide Average

Not applicable. Please see information under #2 for specific information related to capacity constraints at Southern Hills ED.

2. Expansion of Existing Emergency Department Facility

Applicants seeking expansion of the existing host hospital ED through the establishment of a FSED to decompress patient volumes should demonstrate the existing ED of the host hospital is operating at or above capacity.

Check the Box that Applies:

☒ The applicant is demonstrating the need to decompress volumes at the host hospital ED. If this box is checked the applicant must provide the information below.

☐ The applicant is not demonstrating the need to decompress volumes at the host hospital ED.

A. Visits per Treatment Room

Data:

The applicant should provide data on the number of visits per treatment room per year at the relevant existing ED facility. This number should be compared to the ACEP guidelines found in Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, Figure 5.1, pages 116-117.Complete the following two tables to demonstrate host hospital ED capacity. In order to determine if the host hospital is a low, medium, or high range hospital, utilize Table 5.2, pages 109- 112 in the ACEP Guidelines. The results for the majority of the factors in the first table determine the range selected for the second table. See Table 2A1 below.

The ACEP Guidelines set out 16 factors by which one may categorize an ED as low, mid, or high range in terms of the number of rooms needed for a given range of annual visits. **Table 2A1** summarizes the measures and how the applicant fits into the ACEP scheme. While Southern Hills results vary from low to high range, the hospital ED falls into high range for many of the measures (i.e., 6 low-range results, 4 mid-range results, and 6 high-range results). Given the diversity of these factors for Southern Hills, it has been categorized as Mid-Range. **It is important to note that both Southern Hills' ED and the Century Farms FSED exceed ACEP visit per treatment guidelines at any level.** For this reason, the need for this project is two-fold:

1) to serve the growing community of the proposed service area, which currently does not have access to ED services and is geographically isolated within the proposed service area; and
2) to help Southern Hills continue to meet the need of patients coming to its main hospital ED by adding much-needed ED capacity.

In 2021, Southern Hills, the host hospital, operated well above capacity for a high-range ED according to ACEP guidelines, seeing an average of 1,726 ED visits per bed per year. In fact, Southern Hills has the highest number of ED visits per bed among all Nashville/Davidson and Williamson County ED as shown previously in **Table 1B2**.[12] Furthermore, Southern Hills can only operate 21 ED treatment rooms as two rooms are permanently used for behavioral health holding. Thus, in CY 2022 operated at 1,851 ED visits per bed. There is no question that Southern Hills is highly utilized.

[12] Based on 2021 ED volume as reported on hospitals JARs.

Table 2A1

Table 2A1 Factor	Result/Range	Notes
% Emergency Department Patients Admitted as Inpatients	Mid-Range	Low is < 8%; Applicant is 11.6%
Length of Stay (Hours) in ED	Mid-Range	Mid is between 2.5 hrs and 3.75 hrs; Applicant is 3.5 hrs
% of ED Patients seen in Private Rooms	High-Range	All patients are see in private rooms.
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	Low-Range	Patients who are waiting for test results or discharge will be moved to results waiting rooms, thus, freeing up space.
% of observation and extended stay patient remaining in ED	Low-Range	Observation space will be located outside the emergency department.
# Average Minutes an ED patient admitted as an inpatient remains in ED	High-Range	High is > 150 minutes; applicant is 362 minutes average stay.
Average turnaround time (minutes) for results for lab and imaging studies	High-Range	High is > 90 minutes; applicants average is approximately 122.25 minutes.
% of behavioral health ED patients	High-Range	High is 7%; applicant is 8.5%.
% of ED patients either ESI 4 or 5	High-Range	High is < 25%; applicant is 20.9%
% of ED patients Age 65+	Mid-Range	Mid is 10%-20% elderly, applicant is 13.0%
% of imaging studies performed in ED	High-Range	Multiple imaging rooms, CT(s), mammography room(s), and a potential MRI might be a part of you emergency
Provisions in ED for family consult/grieving rooms	Low-Range	No designated dedicated family amenities
Availability of geriatric specialty area	Low-Range	No designated geriatric area.
Availability of pediatric specialty area	Low-Range	No designated pediatric area.
Availability of prisoner/detention patient specialty area	Mid-Range	The applicant has designated area for detention
Availability of administrative/teaching specialty area	Low-Range	No designated administrative/teaching specialty area.
***The Range Where Majority of Above Factors Fall, i.e. Low, Mid or High range**	**Mid-Range**	

See ACEP Space Standards in Data and Analysis. Number and range – low, mid, high

**While not on the FSED Criteria Guidelines table, the ACEP standards discuss and consider dedicated space for behavioral health and trauma patients, which impacts the availability of treatment spaces for general ED visits.*

Source: 2022 Internal Data

As shown in Table 2A2, the ACEP standards also identify that a mid-range ED with approximately 40,000 visits should have 24,438 departmental gross square footage (“DGSF”) or 838 square feet per bed. Southern Hills only has 11,752 DGSF which equates to 511 square footage per bed, significantly below the ACEP standards. Thus, not only is Southern Hills highly utilized at almost 1,900 visits per treatment room, but also its ED is undersized for the volume of patients it sees. These factors further demonstrate that Southern Hills has limited capacity to meet the needs of service area patients given the growth in population and with the aging of the population.

Host Hospital ED Visits per Treatment Room: Table 2A2

Emergency Department Design: A Practical Guide to Planning, American College of Emergency Physicians – Estimates for Emergency Department Areas and Beds					
Facility/Standard	**CY 2022 Annual Visits***	**Dept. Gross Area**	**Bed Quantities**		
		Square Footage	**Bed Quantity**	**Visits/Beds**	**Area/Bed**
Host Hospital	38,866 ED Visits	11,752 DSGF	23 Spaces	1,690 Visits/Bed	511 SF/Bed
ACEP Standard (Mid-Range)**	40,000 ED Visits	24,438 DGSF	29 Spaces	1,440 Visits/Bed	838 SF/Bed

Use most recent year for host hospital based on internal data (CY 2022**).*

*** Average between Low- Rand and High-Range*

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculations

Southern Hills opened the Century Farms FSED in June 2021 to expand local access to care and alleviate capacity constraints at Southern Hills. However, Century Farms FSED is already highly utilized, seeing 15,183 ED visits in its 11 ED bays in CY 2022, which equates to 1,380 per ED bay, significantly more than the recommended ACEP guidelines. ACEP guidelines show 1,364 visit/room in the low range and 909 visits per room in the high range for an ED with 11 treatment spaces. Century Farms FSED has helped accommodate some of the demand for ED services at Southern Hills, hence the decrease in Southern Hills' ED volume from CY 2021 to CY 2022, which also shows the success of adding an FSED. However, Southern Hills ED continues to be highly utilized and is still experiencing capacity constraints. Additional capacity is clearly a necessity for the hospital to continue to meet the growing demands of its service area.

As shown in **Figure 1N-14** below, with the addition of Century Farms FSED, the total ED visits grew significantly from CY 2020 to CY 2022 at a CAGR of 18.2 percent (or total growth of 39.7 percent). Century Farms resulted in the shift of some patients from the Southern Hills ED and improved access to a portion of Southern Hills growing service area population. This increase in demand for ED services is expected to continue with the ongoing recovery from COVID and the growth and aging of the Metro Nashville/Davidson and Williamson Counties area as well as the service area.

Figure 1N-14
Trends in ED Visits CY 2020-2022

Calendar Year	TriStar Southern Hills	Century Farms FSED	Total
2020	38,699		38,699
2021*	40,089	5,541	45,630
2022	38,864	15,183	54,047
% Change 2020-2022	**0.4%**	**N/A**	**39.7%**
CAGR	**0.2%**	**N/A**	**18.2%**

Source: Internal Data

** Century Farms FSED opened June 2021*

As shown in **Figure 1N-15,** the Southern Hills has exceeded 1,600 visits per room for the past three years even with the opening of the Century Farms FSED.

Figure 1N-15
TriStar Southern Hills Medical Center CY 2020-2022

Calendar Year	ED Visits per Room
2020	1,683
2021*	1,743
2022	1,690
% Change 2020-2022	**0.4%**
CAGR	**0.2%**

Source: Internal Data

**Century Farms FSED opened in mid-2021.*

As will be shown, Southern Hills' high volume results in long wait times for certain patients and many hours in which the ED census far exceed patient volume. Another ongoing impact on the ED capacity is patient holds – patients for whom orders for admission have been written but are waiting for an available bed. ED treatment spaces are also utilized for patient holding in the ED, further limiting access for new patients arriving at the ED. Capacity limitations are further exacerbated by a high percentage of behavioral health patients (8.3 percent) and behavioral health hold patients waiting for a bed, which average 4 to 6 patients per day. As a result, Southern Hills has dedicated two former ED rooms for behavioral health hold rooms and is operating just 21 ED treatment rooms. In CY 2022, Southern Hills is providing almost 1,900 visits per room in 21 treatment rooms. This results in long wait times, particularly for higher acuity patients. For its first full year of operation, the Century Farms FSED operated at 1,380 visits per room, which is well over ACEP guidelines for a facility of this size.

These capacity constraints impact patient wait times and total time from arrival to discharge for outpatients or "discharge LOS". Southern Hill staff works hard to ensure lower acuity patients are seen and discharged as quickly as possible resulting in reasonable average wait times; however, higher acuity patients face long delays. For example, for CY 2022 Southern Hills outpatient ED visit with an ESI of 3 (middle acuity) had an average visit duration or discharge LOS of 193.7 minutes or 3.22 hours. ESI 2 patients, higher acuity, experienced an average discharges LOS of 553.1 minutes or 9.21 hours. These represent average wait times, patients arriving in the evening at surge times face even longer delays.

During these peak or surge hours, Southern Hills' census of ED patients far exceeds its 21 ED treatment rooms as shown in **Figure 1N-16**. Southern Hills ED dashboard tracks the census of ED patients by hour every day of the year. The data allows for a summary of the average census of patients by day of the week and hour of the day (0-23 hours) for all of CY 2022. This census level can then be compared to the number of available treatment spaces. Assuming that 21 treatment rooms are available, the census of patients in the ED exceeds the number of treatment rooms most afternoon and evening time periods, seven days per week as highlighted in RED. There are days/times when the average census exceeds capacity by 6 to 8 patients.

When treatment rooms are used to hold admitted patients, which happens routinely, this further limits capacity and creates a deficit of treatment rooms. **Figure 1N-16** also shows an example of when just two rooms are used for "holding", which is less than typical. On average, there is a much higher census than treatment spaces (deficit) any time from 11 am to midnight. As highlighted in red the deficit can be as high as 8 to 10+ patients. Again, these are averages across all of CY 2022 - to reach average deficits this high, there are peaks census levels and peak deficit that are even greater than these averages. Clearly, there are capacity constraints in the Southern Hills' ED, and additional capacity at the proposed Nolensville FSED is needed to help alleviate these constraints.[13] As shown in **Exhibit 15** in the CON Form, capacity is expected to be assisted by nearly 6,000 patients who would have chosen Southern Hills/Century Farms and will now choose to go to the Nolensville FSED due to the closer proximity.

[13] WMC's ED expansion will not alleviate Southern Hills and Century Farms capacity constraints. Moreover, WMC is too far away to address the needs of South Nashville and Antioch and increase access to the proposed service area. WMC's expansion clearly acknowledges the growth in ED demand throughout Williamson County.

Figure 1N-15
Capacity Dashboard for Southern Hills ED – CY 2022

Analysis with 21 Treatment Rooms Available

Surplus/Deficit Treatment Space — Max Treatment Space Capacity: 21

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	
Sunday	0.17	0.9	2.6	5.5	6.7	7.8	8.6	9.3	7.2	6.0	4.5	1.2	-0.1	1.4	-0.9	-0.8	-2.0	-2.2	1.5	-1.8	-1.1	-3.1	-3.1	-3.2	
Monday	0.3	2.4	4.8	6.9	7.7	7.3	6.6	4.2	1.0	2.5	-2.8	-4.6	-5.3	-5.8	-5.9	-5.3	-6.2	-6.7	-7.6	-8.8	-6.0	-5.5	-5.4	-0.1	
Tuesday	-2.0	1.1	5.1	7.0	9.3	9.6	9.0	8.9	5.0	3.9	0.8	0.5	-3.9	-3.8	-3.5	-0.9	-2.5	-2.6	-5.2	-6.9	-7.8	-3.0	-5.1	-3.1	
Wednesday	0.9	2.5	4.9	6.1	8.6	9.8	10.4	11.4	7.4	4.3	2.5	-1.3	-3.7	-2.8	-3.4	-4.2	-0.8	-1.9	-6.3	-7.0	-5.4	-7.9	-0.1	-0.5	
Thursday	1.9	4.1	7.3	9.6	8.6	9.0	10.2	8.7	7.4	4.6	2.4	-1.8	-3.0	1.0	-2.4	-2.5	-3.2	-1.1	-4.2	-1.2	-6.1	-5.8	-4.7	-0.9	
Friday	0.5	3.7	7.3	8.6	8.7	9.9	10.1	9.5	7.7	6.1	3.9	1.8	-2.4	-3.2	-4.0	-4.5	-1.5	-5.6	-5.9	-4.5	-5.6	-4.1	-3.4	-2.7	
Saturday	-0.6	2.3	5.2	7.7	9.6	9.3	10.1	9.8	8.1	7.3	5.7	3.7	-1.3	1.1	1.4	1.2	1.0	-1.8	1.7	-1.3	-2.7	-2.8	1.2	-2.6	Min
Min	-2.0	0.9	2.6	5.5	6.7	7.3	6.6	4.2	1.0	2.5	-2.8	-4.6	-5.3	-5.8	-5.9	-5.3	-6.2	-6.7	-7.6	-8.8	-7.8	-7.9	-5.4	-3.2	-8.8

Analysis with 19 Treatment Rooms Available

Surplus/Deficit Treatment Space — Max Treatment Space Capacity: 19

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	
Sunday	-1.83	-1.1	0.6	3.5	4.7	5.8	6.6	7.3	5.2	4.0	2.5	-0.8	-2.1	-0.6	-2.9	-2.8	-4.0	-4.2	-0.5	-3.8	-3.1	-5.1	-5.1	-5.2	
Monday	-1.7	0.4	2.8	4.9	5.7	5.3	4.6	2.2	-1.0	0.5	-4.8	-6.6	-7.3	-7.8	-7.9	-7.3	-8.2	-8.7	-9.6	-10.8	-8.0	-7.5	-7.4	-2.1	
Tuesday	-4.0	-0.9	3.1	5.0	7.3	7.6	7.0	6.9	3.0	1.9	-1.2	-1.5	-5.9	-5.8	-5.5	-2.9	-4.5	-4.6	-7.2	-8.9	-9.8	-5.0	-7.1	-5.1	
Wednesday	-1.1	0.5	2.9	4.1	6.6	7.8	8.4	9.4	5.4	2.3	0.5	-3.3	-5.7	-4.8	-5.4	-6.2	-2.8	-3.9	-8.3	-9.0	-7.4	-9.9	-2.1	-2.5	
Thursday	-0.1	2.1	5.3	7.6	6.6	7.0	8.2	6.7	5.4	2.6	0.4	-3.8	-5.0	-1.0	-4.4	-4.5	-5.2	-3.1	-6.2	-3.2	-8.1	-7.8	-6.7	-2.9	
Friday	-1.5	1.7	5.3	6.6	6.7	7.9	8.1	7.5	5.7	4.1	1.9	-0.2	-4.4	-5.2	-6.0	-6.5	-3.5	-7.6	-7.9	-6.5	-7.6	-6.1	-5.4	-4.7	
Saturday	-2.6	0.3	3.2	5.7	7.6	7.3	8.1	7.8	6.1	5.3	3.7	1.7	-3.3	-0.9	-0.6	-0.8	-1.0	-3.8	-0.3	-3.3	-4.7	-4.8	-0.8	-4.6	Min
Min	-4.0	-1.1	0.6	3.5	4.7	5.3	4.6	2.2	-1.0	0.5	-4.8	-6.6	-7.3	-7.8	-7.9	-7.3	-8.2	-8.7	-9.6	-10.8	-9.8	-9.9	-7.4	-5.2	-10.8

The Nolensville FSED will provide additional capacity to accommodate the existing and projected increase in ED visits for the service area. It should also be noted that the proposed FSED facility of 11,900 SF of space will be in the mid-range of 8,250-12,031 GSF that ACEP recommends for its smallest category of annual visits (10,000 annual visits). The combined ED at Southern Hills and the Nolensville FSED should be able to accommodate both Southern Hills' current capacity constraints and the expected growth in the service area. With the proposed satellite freestanding ED project, Southern Hills will have a total of 46 treatment rooms in Nashville/Davidson and Williamson Counties with 23 treatment rooms total at the main campus, 11 treatment rooms at Century Farms FSED, and 12 at the proposed FSED. At a projected utilization of 60,451 visits in year 1 at all locations, Southern Hills and both FSEDs will still be operating at 1,314 visits per room.

Most importantly, the service area, particularly the southern portion of the service area between I-65 south and I-24 south, currently has limited access to ED services; thus, residents must travel through congested traffic to reach the existing hospitals for care. Once they arrive at many of the area EDs, patients face overcrowded conditions, long wait times, and/or diversion depending on the area ED hospital utilized. The success of Century Farms FSED emphasizes the need for the proposed FSED. Because many of the service area residents have historically chosen Southern Hills as their main emergency department, the proposed project will address the vital need to address capacity constraints at the main campus Southern Hills ED, which will be alleviated through the expected shift of volume to the FSED (See **Exhibit 15**).

Based on the geographic isolation of the Nolensville area, Southern Hills has determined that developing an FSED in this area will increase access to care while simultaneously helping to address capacity constraints at the main hospital ED so that it can continue to meet the growing needs of the area. It is expected that based on proximity, some service area patients will choose to use the proposed Nolensville FSED instead of traveling to the Southern Hills main ED and the Century Farms FSED.

B. Additional Data

Check the Box that Applies:

☐ The applicant is providing additional data related to capacity, efficiencies, and demographics.If this box is checked the applicant must provide the information below.

☒ The applicant is not providing additional data related to capacity, efficiencies, and demographics.

Data:

The applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing host hospital ED facility in order to better demonstrate the need for expansion. The applicant may provide data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules.If the applicant is providing additional data, at a minimum, complete the following table for the host hospital ED. Other relevant categories may be added to the table by the applicant.

NOT APPLICABLE

Additional Data to Demonstrate Need in the Proposed Service Area: Table 2B

Emergency Department	% of Behavioral Health Patients	Statewide Average	% of Patients Level I or II	Statewide Average	% of Patients Ages 65+	Statewide Average

3. **<u>Relationship to Existing Similar Services in the Area</u>**

A. All Applicants

Data:

The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed FSED on existing EDs in the service area and shall include how the applicant's services may differ from existing services. Utilize the below tables to address this portion of the standards.

<u>Historical Utilization of Existing Providers Serving the Service Area</u>

Historical Utilization of Existing Providers Serving the Service Area is presented below. **Table 3A1** and **Table 3A2** provide relative percent of emergency care services provided in the service area in CY 2021.[14] It should be noted that Southern Hills and its FSED Century Farms are the only ED providers located inside the proposed service area. Southern Hills and Century Farms FSED are located in the northern portion of ZIP Codes 37211 and 37013, respectively. In total, ZIP Code service area ED visits are understated due to the suppression of data points within the HDDS data, which may impact each provider's respective market share overall and in each ZIP Code.[15]

Southern Hills, by far, cares for the most emergency patients in the service area overall at 36.0 percent, and the most in ZIP Codes 37013 and 37211. Southern Hills serves the most ED patients in the top 3 of all service area ZIP Codes individually. Southern Hills' market share is likely even higher for the more limited area for which geographic isolation has been identified.

Hospital ED Utilization in the Proposed Service Area: Table 3A1 (2021)

Hospital ED	County	PSA Resident ED Visits at Hospital ED (A)	Total Service Area Resident ED Visits (B)	Market Share in Service Area ((A)/(B)) X 100 = Market Share %
TriStar Southern Hills Medical Center	Davidson	30,195	83,857	36.0%
Vanderbilt University Medical Center	Davidson	15,103	83,857	18.0%
Williamson Medical Center	Williamson	7,610	83,857	9.1%
TriStar StoneCrest Medical Center	Davidson	7,093	83,857	8.5%
TriStar Centennial Medical Center	Davidson	6,192	83,857	7.4%
Saint Thomas Midtown Hospital	Davidson	5,823	83,857	6.9%
TriStar Summit Medical Center	Davidson	3,305	83,857	3.9%
Saint Thomas West Hospital	Davidson	2,831	83,857	3.4%
Metropolitan Nashville General Hospital	Davidson	2,641	83,857	3.1%
TriStar Skyline Medical Center	Davidson	1,374	83,857	1.6%
Other TN Hospitals	**All Other TN Counties**	1,690		
Total		83,857		
Satellite ED Visits YR 1		10,602		

Source: TDH 2021 HDDS Data, note the total is higher due to HDDS data suppression.

[14] This represents the most current year of publicly available data.
[15] According to data from THA and HCA internal data, there were a total of 49,209 ED visits for patients residing in the ZIP Code service area, which is 1,139 more than reported in the HDDS data.

Market Shares of ED Facilities in the Proposed Service Area: Table 3A2 (2021)

ZIP Code - County	% Highest Market Share TriStar Southern Hills Medical Center	% 2nd Highest Market Share Vanderbilt University Medical Center	% 3rd Highest Market Share Williamson Medical Center	% Applicant Host ED (if not top 3)
37013 - Davidson County	36.6%	18.3%	1.3%	*Southern Hills is in the top 3.
37027 - Williamson County	8.4%	18.0%	48.9%	*Southern Hills is in the top 3.
37135 - Williamson County	8.0%	15.9%	43.1%	*Southern Hills is in the top 3.
37211 - Davidson County	47.0%	17.9%	2.8%	*Southern Hills is in the top 3.
Total	36.0%	18.0%	9.1%	*Southern Hills is in the top 3.

Source: TDH 2021 HDDS Data, note the total is higher due to HDDS data suppression.

Note that HDDS data suppression results in fewer patients.

Utilization trends of the EDs used by the proposed service area patients are provided in the section of the application that requests historic utilization data (see **Table 3A3** which includes all proposed service area ED visits). Note that from FY 2019 to FY 2020, the total ED visits for all area hospital EDs declined significantly (10.7 percent). However, as previously noted, FY 2020 ED visits were significantly impacted by the COVID-19 pandemic. One study found that in 2020 ED utilization for acute injuries ranging from injury-related visits to medication/drug overdose experienced a significant decline (10 to 19.5 percent).[16] In FY 2021, many Nashville/Davidson and Williamson Counties hospitals were still being impacted by the COVID-19 pandemic, although volumes have rebounded somewhat from the initial impact. In fact, hospitals nationwide are continuing to experience an impact on ED volume to this day, although most have rebounded somewhat from 2020 levels. From FY 2020-2021, total ED visits among Nashville/Davidson and Williamson Counties ED providers increased by 1.8 percent. FY 2022 data is not yet publicly available.

A recent survey has shown hospitals experienced a 14 percent decrease in ED visits in 2020 and expected those numbers to remain below pre-pandemic volumes through 2021. Those same hospitals expected ED visit volume to return to baseline (2019 volumes) by 2022 and to increase approximately 5 percent over baseline levels in 2023.[17] In another survey, it was found that, overall, hospital volumes across all regions have returned to near 2019 levels. This includes ED volumes and procedural volumes.[18]

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[16] Harmon, K. J., Fliss, M. D., Marshall, S. W., Peticolas, K., Proescholdbell, S. K., & Waller, A. E. (2021). The impact of the COVID-19 pandemic on the utilization of emergency department services for the treatment of injuries. *The American journal of emergency medicine*, *47*, 187–191. Advance online publication. https://doi.org/10.1016/j.ajem.2021.04.019

[17] https://www.healthleadersmedia.com/clinical-care/hospital-service-volumes-expected-rebound-survey-finds

[18] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/survey-us-hospital-patient-volumes-move-back-towards-2019-levels

Historical Utilization of EDs in the Proposed Service Area latest 3 years: Table 3A3

County	Facility	FY 2019 ED Visits	FY 2020 ED Visits	FY 2021 ED Visits	% Change FY 2019-2020	% Change FY 2020-2021	% Change FY 2019-2021
Davidson	Metro Nashville General Hospital	16,049	26,435	23,059	64.7%	-12.8%	43.7%
Davidson	Saint Thomas Midtown Hospital	48,296	44,616	46,843	-7.6%	5.0%	-3.0%
Davidson	Saint Thomas West Hospital	35,370	32,516	30,119	-8.1%	-7.4%	-14.8%
Davidson	TriStar Centennial Medical Center	69,906	53,575	62,513	-23.4%	16.7%	-10.6%
Davidson	Tristar Skyline Medical Center	60,595	50,678	53,356	-16.4%	5.3%	-11.9%
Davidson	Tristar Southern Hills Medical Center	46,344	38,719	40,169	-16.5%	3.7%	-13.3%
Davidson	Century Farms FSED*	-	-	5,525	N/A	N/A	N/A
Davidson	Tristar Summit Medical Center	57,173	46,818	44,664	-18.1%	-4.6%	-21.9%
Davidson	Vanderbilt University Medical Center	114,662	104,808	101,099	-8.6%	-3.5%	-11.8%
Williamson	Williamson Medical Center	47,473	44,726	43,457	-5.8%	-2.8%	-8.5%
TOTAL		**495,868**	**442,891**	**450,804**	**-10.7%**	**1.8%**	**-9.1%**

Source: Hospital Joint Annual Reports

NOTE: Fiscal Year varies by facility

**Century Farms FSED opened June 2021.*

TriStar Centennial Medical Center has an FSED in Spring Hill but it is not in Davidson County or in the service area.

TriStar Summit Medical Center has an FSED in Mt. Juliet but it is not in Davidson County or in the service area.

Southern Hills reviewed overall market data for the hospitals in Nashville/Davidson and Williamson Counties to evaluate ED utilization and the impact of COVID-19. Based on Market Share data for CY 2019 through 3 quarters of 2022 annualized, it appears that CY2022 volumes have virtually rebounded to 2019 pre-COVID levels in the metro area as shown in **Figure 1N-17**. Annualized CY 2022 visit volumes are 98.2 percent of CY 2019 visits volumes. It is expected that visit volumes will continue to grow from there forward with population growth and aging. The growing demand for ED services will also continue to increase placing further demands on existing ED capacity.

Figure 1N-17
CY 2019- Annualized 2022 ED Visits – Facilities in Service Area County

CY 2019 ED Visits	CY 2020 ED Visits	CY 2021 ED Visits	CY 2022 ED Visits	% of 2019
536,423	441,310	506,502	526,924	98.2%

Source: THA Market Share Data. Note: all providers masked.

While COVID-19 initially impacted ED visit volumes, the long-lasting implications of COVID are still playing out in the way in which hospital EDs operate. A greater number of patients require isolation and airborne infection protocols, more patients are requiring extended observation, and the overall acuity of patients has been increasing. COVID-19 continues to burden all EDs. In 2022, Southern Hills treated 1,184 COVID patients in its ED, which is down from a high of 1,488 in 2021 but slightly more than the 1,085 COVID patients seen in 2020. ED boarding issues, as will be discussed below, impact Southern Hills and many area hospitals. As patients delayed routine care during COVID, patients are presenting to the hospital at more acute levels which impacts ED operations and hospital inpatient operations, increasing length of stay and inpatient bed availability. All these factors result in long wait times at many area EDs, diversion status, and other factors that document capacity constraints in the area.

Impact on Existing Providers

Orderly development is no longer a statutory consideration; however, it is not anticipated that the project will have any meaningful impact on existing providers. The projected utilization for the proposed FSED is heavily based on the anticipation of shifted volume of patients who would otherwise have gone to either Southern Hills or Century Farms FSED (See **Exhibit 15**). The basis for the projection is discussed in detail in **Question 6N.** Growth anticipated in the service area is expected to generate almost 3,263 incremental visits by the second year of operation of the proposed FSED (Quarter 2 of 2026). This represents over 30 percent of the projected service area visit volume of the proposed FSED in Project Year 2. Collectively, approximately 1,437 visits would be shifted from other unaffiliated providers as described in detail in application form **Question 6N** and shown in **Figure 1N-18** below. The projected growth in demand due to service area population growth alone (incremental volume) more than offsets any shift of visit volume from other unaffiliated providers. It is clear that the proposed project will have very little impact on other existing providers serving the service area.

Figure 1N-18

FSED Projected Utilization and Impact on Existing Providers

CY 2022 Service Area Visits	74,932
Projected Year 2 Service Area Visits	78,195
Incremental Visits from Service Area Population Growth	3,263
Projected Shift from Other Providers	1,437

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

Consistent with the Consumer Advantage criteria, the proposed project will not negatively impact existing providers; rather the FSED will better serve the growing and aging service area population by providing an emergency access point closer to the homes of most in the service area.

Differentiation of the Proposed Service from Existing Services

As previously established, Southern Hills is the primary provider of emergency services for the service area and is highly utilized and capacity constrained. As shown in **Exhibit 18** of the main CON form, FSED's serve patients at all acuity levels. The Nolensville FSED will allow service area residents who need emergency care for high-risk conditions and require prompt and often specialized medical intervention improved access to such services.

Urgent and primary care providers in and around the service area are **not** an alternative in the event of a need for emergency care. Importantly, urgent, and primary care service models:

- Are not 24/7 resources, generally operate with reduced hours on weekends, and are generally closed on major holidays (i.e. – Easter, Thanksgiving, Christmas, etc.),
- Are not able to or required to provide any level of uncompensated care,
- Are not staffed with the types of professionals who often must work as a team to save life and functionality while mobilizing additional inpatient resources for care after stabilization, and
- Are not equipped with complex imaging equipment as well as the same lab and pharmacy.

Furthermore, travel time will be shortened by the presence of the proposed Nolensville FSED in the community closer to where service area patients live and sparing them from having to travel north to Southern Hills, northwest often through congested interstates to the core Nashville hospitals, or southwest on secondary two-lane roads to WMC.

Southern Hills is the primary provider of ED services for service area residents, and it is facing capacity constraints. The other existing Nashville hospitals that serve the service area are highly utilized based on their long ED wait times and they are often on diversion. As service area demand resumes pre-COVID levels and continues to increase based on population growth and aging, the constraints at existing area hospital EDs will only be exacerbated. The service area needs more accessible emergency care, and the Nolensville FSED will provide it closer to the patients' homes.

Southern Hills has long provided high quality care to the proposed service area and is keenly connected to the community's emergency care needs. Southern Hills is an accredited hospital by the Joint Commission, and the Southern Hills 24/7 ED is accredited as a Chest Pain Center and Primary Stroke Center. The proposed satellite FSED location is an extension of the high-quality ED services provided by Southern Hills and TriStar Health as a whole.

B. Rural Service Area Applicants

☐ The proposed service area is rural If this box is checked the applicant must provide the information below.

☒ The proposed service area is not rural.

Data:

Complete the following table to provide patient origin data by ZIP Code for each existing facility as well as the proposed FSED in order to verify the proposed facility will not negatively impact the patient base of the existing rural providers. Applicants may add or remove as many columns and/or rows, as necessary. In an area designated as rural, the proposed facility should not be located within 10 miles of an existing facility. In rural proposed service areas, the location of the proposed FSED should not be closer to an existing ED facility than to the host hospital.

Not applicable. The proposed service area is in Nashville/Davidson and Williamson Counties, which is not rural. The same information requested below is provided in **Table 3A1** above.

Patient Destination and Patient Origin in the Proposed Service Area – Rural: Table 3B1

Hospital ED	**Patient Volumes**					
	ZIP Code 1	**ZIP Code 2**	**ZIP Code 3**	**ZIP Code 4**	**ZIP Code 5**	**ZIP Code 6**
Hospital ED 1						
Hospital ED 2						
Hospital ED 3						
Hospital ED 4						
Hospital ED 5						
Hospital ED 6						
Other Hospitals						
Total						
Proposed FSED YR 1						

C. Critical Access Hospitals

☐ The proposed service area contains a critical access hospital(s). If this box is checked the applicant must provide the information below.

☒ The proposed service area does not contain a critical access hospital(s).

Data:

The location of the proposed FSED should not be closer to an existing CAH than to the host hospital.Provide the distance of the proposed FSED from any existing CAH in the proposed service area and the distance of the proposed FSED from the host hospital ED.

Not Applicable.

4. Host Hospital Emergency Department Quality of Care

The quality of the host hospital should be in the top quartile of the state in order to be approved for the establishment of a FSED. It is the responsibility of the applicant to provide data on the host hospital ED and what quartile is applicable for each measure.

Data:

The Joint Commission's "Hospital Outpatient Core Measure Set" is utilized to demonstrate the quality of care provided by EDs.

Please note that most of the measures in the Hospital Outpatient Core Measure Set are no longer collected or insufficient provider report to create a meaningful comparison. Of the 8 CMS Quality of Care measures in the tables above, only 2 are still used by CMS' outpatient quality reporting (OQR) program:

- OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients and Measure
- OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival.[19]

Percentile is a statistical calculation that shows relative standing for comparison within a set of data. If insufficient data is available within the dataset (e.g., a low response rate), a statistically significant percentile rank cannot be determined.

[19] For OP-23, only 36 out of 98 Tennessee hospitals reported data (36.7 percent), and therefore a statistically significant comparison of percentile rank cannot be determined.

Quality of Care Provided at the Host Hospital ED: Tables 4 (1-8)

Measure: OP-1 Median Time to Fibrinolysis						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
In the CY 2018 OPPS/ASC final rule, CMS removed the OP-1 measure from the hospital OQR program.[20]						

Measure: OP-2 Fibrinolytic Therapy Received Within 30 Minutes						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
This measure was removed from CMS Star Rating calculation due to too few hospitals reporting.[21]						

Measure: OP-4 Aspirin at Arrival						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
In the CY 2018 OPPS/ASC final rule, CMS removed the OP-4 measure from the hospital OQR program.[22]						

Measure: OP-5 Median Time to ECG						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
In the CY 2019 OPPS/ASC final rule, CMS removed the OP-5 measure from the hospital OQR program.[23]						

Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
TriStar Southern Hills Medical Center	4/1/2021-3/31/2021	140 minutes			*X*	

Source: Centers for Medicare and Medicaid Services (CMS) Hospital Compare

Measure: OP-20: Door to Diagnostic Evaluation by a Qualified Medical Personnel						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
In the CY 2018 OPPS/ASC final rule, CMS removed the OP-20 measure from the hospital OQR program.[24]						

Measure: OP-21 ED-Median Time to Pain Management for Long Bone Fracture						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
In the CY 2018 OPPS/ASC final rule, CMS removed the OP-21 measure from the hospital OQR program.[25]						

[20] https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment

[21] https://www.qualityreportingcenter.com/globalassets/2019/11/oqr/pr_jan_2020-op-hc-preview-help-guide-508.pdf

[22] https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment

[23] https://www.qualityreportingcenter.com/globalassets/migrated-pdf/oqr-december-2018-final-rule-qa-pm-508.pdf

[24] https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment

[25] https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment

Measure: OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival						
Emergency Department	**Timeframe**	**ED Time/ Score**	**Check (X) Applicable Quartile**			
			≤25th Percentile	**25th-50th Percentile**	**50th-75th Percentile**	**≥75th Percentile**
N/A	N/A	N/A	Not applicable. Only 36 out of 98 Tennessee hospitals reported data for this measure (i.e., a 36.7 percent response rate). A statistically significant comparison for percentile cannot be determined.			

Source: Centers for Medicare and Medicaid Services (CMS) Hospital Compare

Of the two measures reported by CMS, OP-18 is the only one with enough data available to calculate the percentile for hospitals in the state of Tennessee. For OP-18, Southern Hills scored within the 50th to 75h quartile for all hospitals.[26] It is important to note that CMS Measure OP-18 is not meant to be compared across all hospitals.

Southern Hills is in the "High" category of emergency departments as assigned by CMS based on total visit volume. Among the High emergency departments in the state, Southern Hills is the 2nd lowest for wait times. As noted above, Southern Hills is also lower than the national and Tennessee average for its peer group hospitals. Importantly, Southern Hills' ED times are well below several of the other Nashville providers that serve the service area including VUMC, St. Thomas West/Midtown, and Nashville General. Furthermore, Southern Hills has the shortest wait times of the other providers that serve the service area, despite experiencing capacity constraints as shown in **Figure 1N-19**.

This score, however, represents an average and does not consider the long wait time for high acuity patients and is reflective of Southern Hills' efforts to treat and discharge low acuity patients quickly. As discussed previously, Southern Hills' rapid triage efforts ensure low wait times for lower acuity patients. Capacity constraints, however, result in longer wait times for higher acuity patients. Despite capacity constraints, Southern Hills maintains high quality standards and strives to improve throughput of ED services.

[26] The OP-18 response rate for Tennessee hospitals in 2021 is 91.8 percent (90 out of 98 hospitals). The 75th percentile for OP-18 among Tennessee Hospitals that responded is 134 minutes.

Figure 1N-19

Comparative OP-18 Scores (Minutes) for High Volume Hospitals
MEASURE AGAINST PEER HOSPITALS

Facility Name	City	Score
TRISTAR HORIZON MEDICAL CENTER	DICKSON	122
TRISTAR SOUTHERN HILLS MEDICAL CENTER	NASHVILLE	140
TRISTAR STONECREST MEDICAL CENTER	SMYRNA	144
TRISTAR HENDERSONVILLE MEDICAL CENTER	HENDERSONVILLE	147
ST FRANCIS HOSPITAL	MEMPHIS	162
TRISTAR SUMMIT MEDICAL CENTER	HERMITAGE	164
WILLIAMSON MEDICAL CENTER	FRANKLIN	167
TRISTAR SKYLINE MEDICAL CENTER (Level II Trauma Center)	NASHVILLE	174
COOKEVILLE REGIONAL MEDICAL CENTER	COOKEVILLE	185
JOHNSON CITY MEDICAL CENTER (Level I Trauma Center)	JOHNSON CITY	190
MAURY REGIONAL HOSPITAL	COLUMBIA	195
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	BRISTOL	208
LECONTE MEDICAL CENTER	SEVIERVILLE	211
WELLMONT HOLSTON VALLEY MEDICAL CENTER	KINGSPORT	215
FORT SANDERS REGIONAL MEDICAL CENTER	KNOXVILLE	253
PARKWEST MEDICAL CENTER	KNOXVILLE	260
REGIONAL ONE HEALTH (Level I Trauma Center)	MEMPHIS	269

Source: CMS Hospital Compare, 1/1/2021-12/31/2021

Nashville/Davidson County and the surrounding suburban areas such as Nolensville are more densely populated than most of the rest of Tennessee. Accordingly, the EDs in the Nashville area are likely to be more congested than EDs in smaller, less densely populated rural areas of the state, thereby impacting the amount of time a patient might spend in the ED. It is also important to note that based on CMS data, Southern Hills' median time from ED arrival to ED departure for discharged ED patients is below the state and national average. See **Table 1B1**. If it were true that quality of care could be determined solely based on patients' time spent in the ED, it would also be true that every provider in Nashville/Davidson County offers subpar quality care based on CMS Measure OP-18, which is simply not the case.

5. Appropriate Model for Delivery of Care

The applicant should discuss why a FSED is the appropriate model for the delivery of care in the proposed service area.

The patients who will benefit most, although not exclusively, from the proposed FSED are those who have an emergency medical condition requiring prompt and often specialized medical intervention. Urgent and primary care service models are not 24/7 resources, are not able to provide significant uncompensated care, and are not staffed with the types of professionals who often must work as a team to save life and functionality while mobilizing additional inpatient resources for care after stabilization.

Southern Hills is the largest provider of ED services in the service area. Due to the significant growth in its service area, the Southern Hills ED is very highly utilized and wants to make its ED services more readily available to the patients closer to where they live. The proposed FSED is an extension of emergency care provided by the TriStar Health system and will offer a much-needed alternative access point to emergency care for service area residents. The FSED will not only enhance access to patients with unforeseen, and sometimes critical, needs for medical intervention, but also will result in some patients choosing the FSED because it is closer, which in turn will alleviate some of the emergency service volume present at Southern Hills today.

FSEDs are very appropriate models for improving emergency care in highly populated growth areas that are not large enough to support an additional hospital and have less than optimal accessibility to emergent care. Over the past decades, the healthcare industry has seen the decentralization and dissemination of healthcare access points in order to provide high quality care in a sustainable manner. The appropriateness of FSEDs is evident in the success of the FSED operated by Southern Hills and its TriStar affiliates. TriStar Health System operates 5 existing and 1 approved FSEDs in greater Nashville and the surrounding Middle Tennessee area. TriStar has recently been approved for a FSED in the Bellevue area. EMS providers have recognized the value and appropriate model of FSEDs bringing patients in need of emergency care. The success of the Century Farms FSED confirms the demand for this type of facility and consumers determination through choice that this is an appropriate model of care. FSEDs are being developed nationally by numerous hospitals systems and academic medical centers such as Cleveland Clinic and NTU.

In addition, for the most acute patients, FSEDs can serve a critical role in stabilizing emergent patients before transfer/transport to a higher level of care. **Figure 1N-20** summarizes the transfer pattern of TriStar Spring Hill FSED visits from 2020 through 2022. The Spring Hill FSED was chosen because it is located in Maury County near the border of Williamson County, the same home county as the proposed FSED. TriStar Centennial, in Nashville/Davidson County, is the host hospital for the Spring Hill FSED just as Southern Hills, in Nashville/Davidson County, will be the host hospital for the Nolensville FSED.

First, it should be noted that only a small percentage of patients are transferred to another hospital or provider. In 2022, Spring Hill provided 15,870 ED visits of which 415 or 2.6 percent were transferred to another type of facility. While it varies in CY 2021, between 11.1 percent and 16.7 percent of transfers were to a behavioral health hospital. Including both behavioral health care and general acute care patients, 33.7 percent of its transferred patients went to TriStar affiliate facilities. Over the past three years, on average, 41.3 percent of Spring Hill transfer patients went to TriStar affiliate facilities. However, Spring Hills FSED also transfers many patients to unaffiliated facilities, averaging 58.7 percent over the past three years, including Maury Regional and WMC.

The proposed Nolensville FSED will play an important role in providing increased access to patients who need emergency access and stabilization and transfer to a higher level of care or admitted to a hospital setting. Patients will be transferred based on choice and clinical needs.

Figure 1N-20
Analysis of Transfer Pattern for TriStar FSED in Spring Hill

Transfer Location/Type	2020	2021	2022	Total
TriStar Affiliate				
Shortstay General Hospital	67	143	131	341
Affiliated Trauma Center	39	23	25	87
Behavioral Health Facility	51	60	26	137
Total Affiliate Facility	***157***	***226***	***182***	***565***
Percent Affiliate Facility	***33.7%***	***46.5%***	***43.9%***	***41.3%***
Non Affiliated Hospital or System				
Shortstay General Hospital				
Ascension	27	25	20	72
Maury Regional	91	75	87	253
Vanderbilt Health	75	57	53	185
VA Health System	7	0	2	9
Williamson Medical Center	82	78	50	210
Other Unaffiliated Hospital	0	0	1	1
Behavioral Health Facility	27	25	20	72
Total Unaffiliate Facility	***309***	***260***	***233***	***802***
Percent Affiliate Facility	***66.3%***	***53.5%***	***56.1%***	***58.7%***
Total all Transfers	**466**	**486**	**415**	**1,367**
Percent Behavioral Health	**16.7%**	**17.5%**	**11.1%**	**15.3%**

Source: Internal and market data for Spring Hill FSED.

The availability of emergency care in Nolensville will help save lives and improve health outcomes for people experiencing debilitating or life-threatening illness or injury. Thus, the presence of a state-of-the-art FSED in the middle of this vibrant, growing community will improve access for people in need of emergency services.

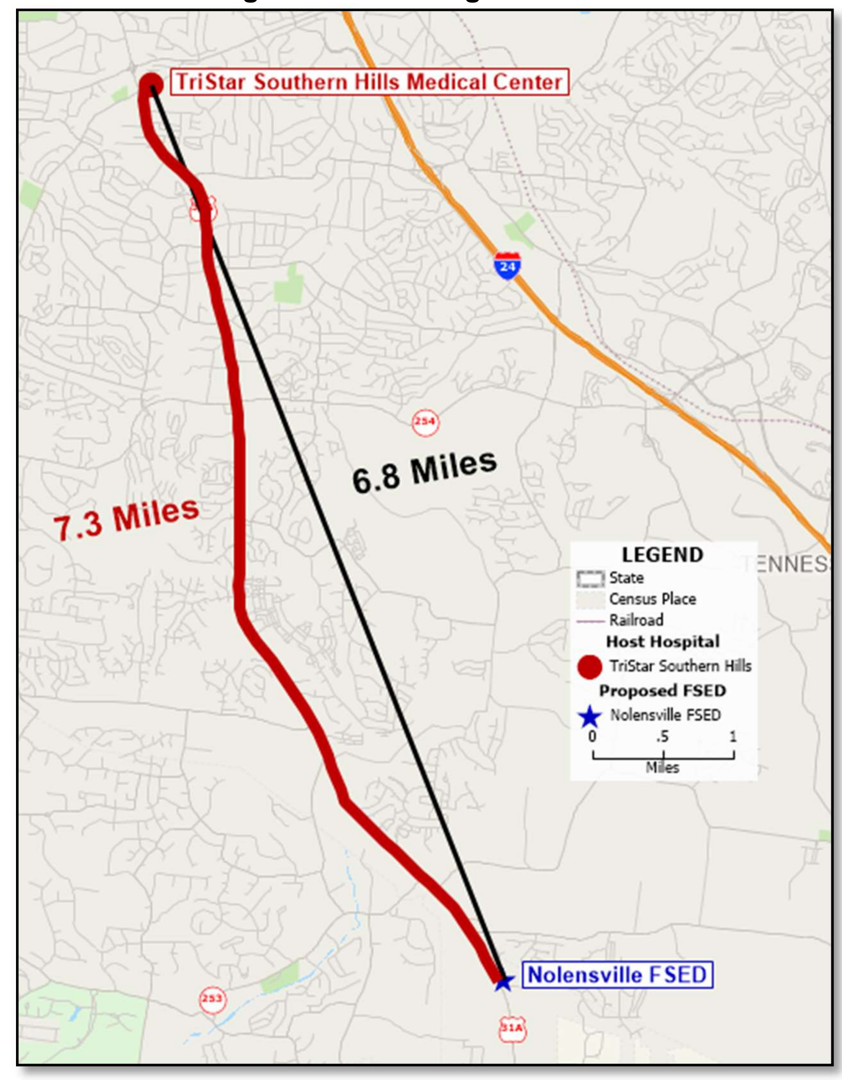
6. Geographic Location

Data:

The FSED should be located within a 35-mile radius of the hospital that is the main provider. A map should also be provided as evidence.

The proposed FSED is located approximately 7.3 driving miles (or approximately 6.8 miles as the crow flies) south/southeast from the host hospital, Southern Hills. The map in **Table 6** demonstrates that the proposed FSED is located within a 35-mile radius of the hospital that is the main provider – TriStar Southern Hills.

Distance from Host Hospital: Table 6
Distance from TriStar Southern Hills Medical Center to Proposed FSED
Driving Miles and Straight-Line Miles



Source: Maptitude

7. <u>Access</u>

The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification.

By definition, an emergency department, including a FSED as proposed here, must serve all who seek care as shown in its policies and procedures and based on EMTALA. The host hospital, Southern Hills, currently serves more emergency patients in the proposed service area than any other provider. Southern Hills provides state-of-the art care to all patients regardless of their ability to pay as evidenced by the significant percentage of TennCare/Medicaid and self-pay patients from the service area who receive emergency care at Southern Hills (see the Applicant's response to **Criterion 8** below). Further, in

CY 2022, Southern Hills wrote off approximately $171 million in charity care dollars[27].

As demonstrated by Southern Hills' historical provision of emergency services for all patients, including medically indigent patients, and Southern Hills' historical provision of charity care overall, the FSED will serve equitably all residents in the proposed service area.

8. Services to High Need Populations

Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are uninsured, low income,or patients with limited access to emergency care.

Data:

Use the following table to compare the payor mix of the host hospital to payor mix of the total service area. Applicants may also present evidence demonstrating limited access to emergency care in the proposed service area when applicable.

The Southern Hills ED serves – and will continue to serve at both its existing and proposed locations – a significant number of uninsured and low-income patients presenting with emergency care needs. In CY 2022, 26.4 percent of Southern Hills ED and Century Farms FSED combined patients were uninsured and/or low-income patients.[28] Southern Hills provides emergency care for more patients in the service area than any other provider and thus ensures access to the medically underserved populations in the area. The proposed FSED will provide enhanced access to emergency care services for all patients, especially those who are uninsured, low income, or patients with limited access to emergency care.

Table 8 total column reflects the total of Southern Hills' 2021 patient visits by payor from HDDS data. This will not reflect the total actual volume for Southern Hills ED due to HDDS data suppression.

[27] Charity care and uninsured discounts for Southern Hills.

[28] Including TennCare/Medicaid, self-pay, and medically indigent/charity care patients.

Southern Hill's ED Services to High Need Populations by Payor: Table 8 (2021)

Payor	ZIP Code	37013	ZIP Code	37027	ZIP Code	37135	ZIP Code	37211	TriStar Southern Hills Medical Center Total	% of Total
	Total ED Patients	% of Total	Total ED Patients	% of Total	Total ED Patients	% of Total	Total ED Patients	% of Total		
Medicare/Medicare Advantage	5,059	12.7%	3,105	32.7%	794	21.8%	4,540	14.7%	6,375	15.0%
TennCare/Medicaid	14,967	37.7%	507	5.3%	372	10.2%	9,994	32.3%	13,831	32.5%
Commercial/ Commercial Other	10,242	25.8%	5,291	55.6%	2,277	62.5%	6,757	21.8%	8,852	20.8%
Self-Pay	5,753	14.5%	394	4.1%	78	2.1%	6,314	20.4%	8,704	20.5%
Medically Indigent/Free	1,433	3.6%	20	0.2%	0	0.0%	1,224	4.0%	1,966	4.6%
Other	2,271	5.7%	192	2.0%	123	3.4%	2,150	6.9%	2,773	6.5%
Total	**39,725**	**100.0%**	**9,509**	**100.0%**	**3,644**	**100.0%**	**30,979**	**100.0%**	**42,501**	**100.0%**

Source: TDH 2021 HDDS Data, note the total is higher due to HDDS data suppression. This may or may not have a significant impact on the payor mix for each ZIP Code.

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculations.

9. **Establishment of Service Area**

A. Establishment of Non-Rural Service Area

☒ The proposed service area is non-rural. If this box is checked the applicant must provide the information below.

☐ The proposed service area is rural.

The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant.

Data:

Socio-demographics of the service area

Projected populations to receive services

Complete the following tables to demonstrate:

a. Patient origin by ZIP Code for the hospital's existing ED in relation to the proposed service area for the FSED.
b. Patient Origin by ZIP Code of the service area residents (i.e., market share).

The applicant may add or remove as many ZIP Code and Hospital ED lines as is necessary.

The proposed service area is not a rural area, with over 264,000 residents in 2023 and an expected growth to almost 277,500 residents by 2028. According to the U.S. Census Bureau, the service area has a high percentage of residents below the poverty line, comprising 17.1 percent and 15.6 percent of the ZIP Codes 37013 and 37211, respectively. This compares to just 14.3 percent of the Tennessee population below the poverty line in Nashville/Davidson and Williamson Counties, 14.3 percent and 3.9 percent, respectively. Poverty and low income are associated with poor health due to greater barriers to accessing medical care, such as lack of health insurance and less ready access to primary care and health specialists. Thus, improving access to care for these individuals is a priority.

As shown in **Table 9A1**, Southern Hills already serves patients from the service area. ZIP Code 37211 is its home ZIP Code and contributes 34.2 percent of its total ED visits in 2021. Collectively with ZIP Codes 37013, 37027, and 37135, this area comprises 71.0 percent of Southern Hills' ED volume.

As shown in **Table 9A2**, the service area ZIP Codes generated approximately 83,857 emergency room visits in CY 2021 based on data from HDDS, which is limited by suppression. Southern Hills serves the most ED patients from the service area (36.0 percent) based on the most recent HDDS data. There are numerous other hospitals included in the other for **Table 9A2**. Service area residents seek ED care from hospitals all over Tennessee. For example, service area residents may seek ED care at another hospital outside of the service area when traveling or visiting family. The number of hospitals in "Other Hospital ED Patients" column are also suppressed based on HDDS data requirements and thus a comprehensive list cannot be provided.

Patient Origin, Ranked Highest to Lowest, Host Hospital: Table 9A1 (2021)

(ZIP Codes in the proposed service area are highlighted below.)

ZIP Code/County	Host Hospital ED Visits	% of Total	Cumulative % Total
37211	14,554	34.2%	68.5%
37013	14,554	34.2%	34.2%
37217	3,498	8.2%	76.7%
37210	1,015	2.4%	79.1%
37086	799	1.9%	81.0%
37027	797	1.9%	82.9%
37207	702	1.7%	84.5%
37167	610	1.4%	85.9%
37214	511	1.2%	87.2%
37076	388	0.9%	88.1%
37115	352	0.8%	88.9%
37203	304	0.7%	89.6%
37135	290	0.7%	90.3%
37209	248	0.6%	90.9%
37206	246	0.6%	91.5%
37208	230	0.5%	92.0%
37129	200	0.5%	92.5%
37130	178	0.4%	92.9%
37218	144	0.3%	93.2%
37128	142	0.3%	93.6%
37122	131	0.3%	93.9%
37204	110	0.3%	94.1%
37221	109	0.3%	94.4%
37138	102	0.2%	94.6%
Sub-Total	***40,214***	60.4%	
Other Areas	2,287	5.4%	100%
Total	**42,501**	65.8%	

Source: TDH 2021 HDDS Data, note the total is higher due to HDDS data suppression.

ED Patient Destination by Hospital ED: Table 9A2 (2021)

(Include all EDs with 620 or More Patients from a ZIP Code)

ZIP Code - County	TriStar Southern Hills Medical Center	Vanderbilt University Medical Center	Williamson Medical Center	TriStar StoneCrest Medical Center	TriStar Centennial Medical Center	Saint Thomas Midtown Hospital	TriStar Summit Medical Center	Saint Thomas West Hospital	Metropolitan Nashville General Hospital	TriStar Skyline Medical Center	*Other Hospital ED Patients	Total
37013 - Davidson County	14,554	7,263	515	5,484	2,835	2,626	2,489	930	1,447	629	953	39,725
37027 - Williamson County	797	1,708	4,650	83	698	528	70	692	30	58	195	9,509
37135 - Williamson County	290	578	1,570	740	134	152	14	90	-	12	64	3,644
37211 - Davidson County	14,554	5,554	875	786	2,525	2,517	732	1,119	1,164	675	478	30,979
Total	**30,195**	**15,103**	**7,610**	**7,093**	**6,192**	**5,823**	**3,305**	**2,831**	**2,641**	**1,374**	**1,690**	**83,857**

Source: TDH 2021 HDDS Data, note the total is higher due to HDDS data suppression.

Note: The top 5 other hospitals in the "Other Hospital ED Patients" column are Saint Thomas Rutherford Hospital, TriStar Hendersonville Medical Center, Vanderbilt Wilson County Hospital, Tennova Healthcare-Clarksville, and TriStar Horizon Medical Center. There are numerous other hospitals beyond these five.

B. Establishment of Rural Service Area

☐ The proposed service area is rural. If this box is checked the applicant must provide the information below.

☒ The proposed service area is non-rural.

Applicants seeking to establish a FSED in a rural service area with limited access to emergency medical care shall establish a service area based upon need.

Data:
Applicants should provide the number of existing ED facilities in the proposed service area.

NOT APPLICABLE.

10. Relationship to Existing Applicable Plans; Underserved Area and Population

Data:
The proposal's relationship to underserved geographic areas and underserved population groupsshall be a significant consideration. Complete the following table of federally designated areas in the proposed service area to address this portion of the standards.

Based on the number of ED visits per room in 2021, Southern Hills was the most highly utilized ED serving the service area. Southern Hills also serves more patients from the service area than any other ED. It is important that service area residents have continued access to care as the entire service area has Federal designations for Health Professional Shortage Areas and Shortage Areas for Mental Health Services. Two of the four services area ZIP Codes have Federal designations for Medically Underserved Areas and Populations. (Please see **Table 10**). Through Southern Hills' existing EDs and the proposed FSED, Southern Hills has and will continue to serve the underserved geographic areas and underserved population groups in the service area.

Underserved Geographic Areas and Underserved Population Groups: Table 10

Proposed Service Area ZIP Code and/or County	Medically Underserved Area Check (X) if Applicable	Medically Underserved Populations Check (X) if Applicable	Health Professional Shortage Area Check (X) if Applicable	Shortage Area for Mental Health Services Check (X) if Applicable
37013 - Davidson County	x	x	x	x
37027 - Williamson County			x	x
37135 - Williamson County			x	x
37211 - Davidson County	x	x	x	x

Source: Health Resources & Services Administration

Note: The above counties containing the service area ZIP codes have Federal designations for all the above categories on the Data Warehouse Site.

11. Composition of Services

Laboratory and radiology services, including but not limited to XRAY and CT scanners, shall be available on-site during all hours of operation. The FSED should also have ready access to pharmacy services and repository services during all hours of operation. Complete the following table to demonstrate the intent to provide the required services.

The proposed Nolensville FSED will have all required services in-house. See **Table 11** below.

Composition of Services: Table 11

Service	Hours Available	On-Site	Contracted or In-House
Laboratory	24/7/365	Yes	In-House
X Ray	24/7/365	Yes	In-House
CT Scanners	24/7/365	Yes	In-House
Ultrasound	24/7/365	Yes	In-House
Pharmacy	24/7/365	Yes*	In-House
Respiratory*	24/7/365	Yes	In-House
Other	NA	NA	NA

**Airway management by nursing and physicians' staff*
Note: A 0.5 FTE will staff the facility. 24/7/365 coverage will be accessible through the main ED.

12. Pediatric Care

The applicant should demonstrate a commitment to maintaining at least a Primary Level of pediatric care at the FSED as defined by CHAPTER 1200-08-30 Standards for Pediatric Emergency Care Facilities including staffing levels, pediatric equipment, staff training, and pediatric services. Applicants should include information detailing the expertise, capabilities, and/or training of staff to stabilize or serve pediatric patients. Additionally, applicants shall demonstrate a referral relationship, including a plan for the rapid transport, to at least a general level pediatric emergencycare facility to allow for a specialized higher level of care for pediatric patients when required.

The host hospital and applicant's ED is classified as a Primary Pediatric Emergency Facility. Its medical staff and department staff are therefore trained and qualified to serve pediatric patients and do so daily. Approximately 14.0 percent of the ED patients in CY 2022 served by TriStar Southern Hills were children and adolescents. The proposed satellite FSED will share that classification and those competencies. It will be staffed by the same Emergency Physician group that covers the main campus ED. All physicians are required to have PALS (Pediatric Advanced Life Support) certification. When needed, transfer to higher levels of pediatric care at The Children's Hospital at TriStar Centennial and the Monroe Carrell Children's Hospital at VUMC will be provided. The proposed FSED will be equipped with a pediatric code cart, medical supplies, an infant warmer and other necessary equipment for pediatric patients.

TriStar Southern Hills has a transfer agreement in place with TriStar Centennial and VUMC. See **Attachment 1C-1**. The Children's Hospital at TriStar Centennial also has an ED, serving emergent pediatric patients 24/7, that is fully staffed with pediatric emergency fellowship trained

physicians. The facility operates with a pediatric unit and ICU, offering a wide variety of sub-specialties.

13. Assurance of Resources

The applicant shall document that it will provide the resources necessary to properly support the applicable level of emergency services. Such documentation should include, but not limited to, a letter of support from applicant's governing board of directors or chief financial officer.

Southern Hills fully commits to develop and maintain the facility resources, equipment, and staffing to provide the appropriate emergency services. Please also see **Attachment-4E-2** for documentation of the applicant's commitment, which is incorporated into the funding assurance letter from Southern Hills' Chief Financial Officer. The financial costs of maintaining and sustaining the resources necessary for this are set forth in the Projected Data Charts for the project; see response to **Question 6C**, **Consumer Advantage Attributed to Competition** in the main application form.

14. Adequate Staffing

A. All Applicants

The applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. If the applicant plans to contract with an emergency physician group, the applicant should provide information on the physician group's ability to meet the staffing requirements. Utilize the following table to demonstrate planned staffing.

The proposed staffing for the Nolensville FSED is summarized in **Table 14** below.

Staffing Patterns: Table 14

Position Type	FTEs Needed for Proposed FSED	FTEs Currently Employed	FTEs that will be Recruited
Physicians	4.2	0.0	4.2
Registered Nurses	11.5	0.0	11.5
ER Tech	0.0	0.0	0.0
EVS Tech	1.4	0.0	1.4
Radiology Tech	4.2	0.0	4.2
CT Tech (1)	0.0	0.0	0.0
Ultrasonographer (2)	0.5	0.0	0.5
Medical Tech	5.2	0.0	5.2
Other (3)	4.8	0.0	4.8
Total	31.8	0.0	31.8

(1) Included in Radiology Tech
(2) Also available on calls
(3) Included pharmacy and security staff

B. Non-Rural Staffing Requirements

☒ The proposed service area is non-rural. If this box is checked the applicant must provide the information below.

☐ The proposed service area is rural.

The applicant shall outline planned staffing patterns including the number and type of physiciansand nurses. Each FSED is required to be staffed by at least one physician and at least one registerednurse at all times (24/7/365). Physicians staffing the FSED should be board certified or board eligibleemergency physicians. If significant barriers exist that limit the applicant's ability to recruit a board certified or board eligible emergency physician, the applicant shall document these barriers for the HSDA to take into consideration. Applicants are encouraged to staff the FSED with registered nursescertified in emergency nursing care and/or advanced cardiac life support. The medical staff of the FSED shall be part of the hospital's single organized medical staff, governed by the same bylaws. The nursing staff of the FSED shall be part of the hospital's single organized nursing staff. The nursing services provided shall comply with the hospital's standards of care and written policies and procedures.

The proposed FSED will be operationally integrated with the main campus ED. As such, it will comply with all the specific State Health Plan standards identified above for staffing planning and recruitment; training and competencies; supervision; the presence of at least one Board-certified Emergency Physician and RN at all times, 24/7/365; staffing with RN's; operation under the same bylaws, hospital medical staff and nursing staff organizations, and hospital standards of care and written policies and procedures.

The Medical Director of the TriStar Southern Hills Emergency Department is Dr. Brad Hoover, MD. Additionally, the FSED will be staffed by the Envision Health physician group. Envision Physician Services is a business unit of Envision Healthcare. Through this service line, Envision provides a variety of physician services via subsidiaries and/or joint ventures to more than 900 healthcare facilities nationwide. TriStar Southern Hills contracts with an Envision subsidiary for Emergency Medicine physician services. Dr. Matthew Tincher serves as the Regional Lead for Envision. Please see **Attachment 5C-2** for letters of support from Dr. Hoover and Dr. Tincher as well as their CVs.

C. Rural Staffing Requirements

☐ The proposed service area is rural. If this box is checked the applicant must provide the information below.

☒ The proposed service area is non-rural.

The applicant shall outline planned staffing patterns including the number and type of physicians.FSEDs proposed to be located in rural areas are required to be staffed in accordance with the Code of Federal Regulations Title 42, Chapter IV, Subchapter G, Part 485, Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs). This standard requires a physician, nurse practitioner,clinical nurse specialist, or physician assistant be available at all times the CAH operates. The standard additionally requires a registered nurse, clinical nurse specialist, or licensed practical nurse to be on duty whenever the CAH has one or more inpatients. However, because FSEDs shall be in operation 24/7/365 and because they will not have inpatients, a registered nurse, clinical nurse specialist, or licensed practical nurse shall be on duty at all times (24/7/365). Additionally, due to thenature of the emergency services provided at an FSED and the hours of operation, a physician, nurse practitioner, clinical nurse specialist, or physician assistant shall be on site at all times.

Not Applicable. The proposed service area is non-rural.

15. <u>Medical Records</u>

The medical records of the FSED shall be integrated into a unified retrieval system with the host hospital.

There is a retrieval system in place at the existing ED which will also be in place at the proposed FSED. An electronic health record is maintained to improve quality and availability of information. This same mechanism is used at all EDs operated within the TriStar Division.

16. <u>Stabilization and Transfer Availability for Emergent Cases</u>

The applicant shall demonstrate the ability of the proposed FSED to perform stabilizing treatmentwithin the FSED and demonstrate a plan for the rapid transport of patients from the FSED to themost appropriate facility with a higher level of emergency care for further treatment. The applicantis encouraged to include air ambulance transport and an on-site helipad in its plan for rapid transport. The stabilization and transfer of emergent cases must be in accordance with the Emergency Medical Treatment and Labor Act.

The applicant is not a new provider of emergency care. It is an existing provider that routinely arranges appropriate stabilization and transport to the most appropriate facility if higher levels of care are needed. The FSED, like the host hospital, does not have a formal helicopter planned given their distance from TriStar Centennial or VUMC and the good availability of ambulance transport when needed. However, building a helicopter pad will be reconsidered if patient care dictates this once the FSED is opened.

The Nolensville FSED will serve as an extension of TriStar Southern Hills and will use the experience of the host hospital's ED to provide emergency services to the proposed service area. The FSED will stabilize and transfer patients as appropriate in accordance with the Emergency Medical Treatment and Labor Act.

17. Education and Signage

The applicant shall demonstrate how the organization will educate communities and emergency medical services (EMS) on the capabilities of the proposed FSED and the ability for the rapid transport of patients from the FSED to the most appropriate hospital for further treatment. It shouldalso inform the community that inpatient services are not provided at the facility and patients requiring inpatient care will be transported by EMS to a full-service hospital. The name, signage, andother forms of communication of the FSED shall clearly indicate that it provides care for emergency and/or urgent medical conditions without the requirement of a scheduled appointment. The applicant is encouraged to demonstrate a plan for educating the community on appropriate use ofemergency services contrasted with appropriate use of urgent or primary care.

The hospital will educate the community regarding the availability of emergency care at the Nolensville FSED. The community will be educated through the development of written brochures available at the FSED, social media messages, website information, and mailings. The community will be educated about services provided at the FSED and the facilitation of transfers for inpatient care. TriStar Southern Hills will provide avenues for further education of proposed service area residents through its involvement in community activities and community boards. The proposed FSED has the support of the Nashville Fire Department and the Nolensville Fire Department demonstrating their understanding of the project and the proposed facilities capabilities.

Patient registration is completed virtually through the Patient Access Virtual Registration service through Parallon. An iPad used for registration is mounted to a stand and is rolled into the patient's room allowing direct interaction with the virtual registrar. The virtual registrar and the patient can see and speak to each other using this platform. This is the process that has been used at Century Farms since its opening in 2021. A patient or their family member can perform the registration. This interaction allows the virtual registrar to provide cost of the service, covered benefits and out of pocket information to help patients make informed decisions about their health care. This service is available 24/7/365. In addition, all out-of-network patients are notified and given the attached form at the time of registration. Their benefits are run, and the estimated liability is calculated. Please see **Attachment 4N-3** for the patient notice provided regarding an out-of-network facility.

18. Community Linkage Plan

The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health and outpatient behavioral health care system, including mental health and substance use, providers/services, providers of psychiatric inpatient services, and working agreements with other related community services assuring continuity of care. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of ED usage.

TriStar Southern Hills works with area organizations to support the communities it serves, to communicate its available resources and services, as well as provide community access points to ensure that all patients have adequate access to care. Organizations with which Southern Hills is affiliated include but are not limited to:

- Nolensville Farmers Market
- Nolensville Buttercup Festival
- Nolensville Art Helps Cancer
- Williamson, Inc.
- United Way of Greater Nashville
- American College of Healthcare Executives of Middle Tennessee
- Nashville Area Chamber of Commerce
- American Heart Association – Greater Nashville
- American Cancer Society
- Friends of Mill Ridge Park
- HCA Hope Fund
- Leukemia and Lymphoma Society
- Crossings Nashville Action Partnership (CNAP)
- American Red Cross
- Project Cure
- Nashville Rescue Mission
- Salvation Army
- Mt. Zion Baptist Church Health Fair
- Meharry Medical College
- Habitat for Humanity
- Catholic Charities of Tennessee
- Tennessee Hospital Association – Agenda 21 Program
- Belmont University Nursing
- Belmont University OT Program
- Belmont University Pharmacy
- Belmont University PT Program
- Chattanooga State MRI
- Columbia State – EMS
- Columbia State - Medical Lab
- Cumberland University Nursing
- ETSU-Nursing Nashville

- ETSU-Nursing Shelbyville
- Fortis Institute Nashville-CV Tech
- Fortis Institute Nashville-Medical Lab
- Fortis Institute Nashville-Nursing
- Fortis Institute Nashville-Radiology
- Fortis Institute Nashville-Surgical-Tech
- Galen College of Nursing – Nursing
- John Overton High School - Health Science Academy
- Lipscomb School of Pharmacy
- Lipscomb University-Dietetics
- Lipscomb University-Nursing
- Meridian Institute of Surgical Assisting
- Middle Tennessee School of Anesthesia
- Middle Tennessee State University Nursing
- Motlow Community College EMS
- Motlow Community College Nursing
- Nashville General Health Sciences- Radiology
- Nashville State Community College Central Sterile
- Nashville State Community College Nursing
- Nashville State Community College PCT Program
- Nashville State Community College Surg Tech
- Nashville State Occupational Therapy Assistant
- South College - Nashville DMS/Sonography
- South College - Nashville Nursing BSN
- South College - Nashville Nursing PN
- South College - Nashville OTA
- TCAT-Murfreesboro Surg Tech
- TN State – HIM
- TN State - Physical Therapy
- TN State - Respiratory Therapy
- TN State – Speech
- Union University- Hendersonville APRN
- UTHSC Pharmacy
- UTHSC Speech Therapy
- UTHSC-Nursing-DNP
- Volunteer State Community College Medical Lab
- Walden University - Nursing APRN/DNP
- Western Governors University – Nursing
- Park Center Nashville SOAR Program

The hospital also works with a network of physician practices to ensure continuity of care for patients. TriStar Southern Hills is open to establishing new relationships as appropriate to better serve patients in the proposed service area.

Southern Hills also has linkages with behavioral health services when FSED patients need such care. TriStar Health Network facilities in metro Nashville/Davidson County include the Skyline Madison campus with a total of 121 inpatient psychiatric beds. Behavioral health services provided at this facility include Adult, Senior, and Adolescent care and the TriStar Centennial also operates Parthenon Pavilion with 134 inpatient psychiatric beds and Adult and Senior care. If an ER patient requires a psychiatric consultation, the patient is first medically cleared by the Emergency Room physician. Once cleared, the Tristar Behavioral Health Transfer Center is notified that a consult is needed. Consults are managed using a tele-psychiatry platform. Based on recommendations from the tele-psychiatrist and in consultation with the Emergency Room physician, the patient is discharged to the appropriate setting based on admission criteria. If the patient requires placement in a behavioral health facility, placement is managed by the Tristar Behavioral Health Transfer Center. The TriStar Behavioral Transfer Center offers a single point of contact to facilitate the transfer of patients quickly and effectively to any behavioral health facility in the area with bed availability whether a TriStar Health affiliate or other facility. Southern Hills has relationships with other behavioral health providers in the area, including VUMC and Middle Tennessee Mental Health Institute ("MTMHI"). Southern Hills works with these facilities in both a referral capacity and as an accepting provider for behavioral health patient admissions.

19. Data Requirements

The applicant shall agree to provide the Department of Health and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services and toreport that data in the time and format requested. As a standard practice, existing data reportingstreams will be relied upon and adapted over time to collect all needed information.

The Applicant agrees to provide the Department of Health/HSDA with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested.

20. Quality Control and Monitoring

The applicant shall identify and document its existing or proposed plan for data reporting, qualityimprovement, and outcome and process monitoring system. The FSED shall be integrated into thehost hospital's quality assessment and process improvement processes.

The Nolensville FSED will be included in Southern Hills' Quality Assessment and Process Improvement programs. Please see additional discussion in response to the quality-related questions in the main application.

21. Provider-Based Status

The applicant shall comply with regulations set forth by 42 CFR 413.65, *Requirements for a determination that a facility or an organization has provider-based status,* in order to obtain provider- based status. The applicant shall demonstrate eligibility to receive Medicare and

Medicaid reimbursement, willingness to serve emergency uninsured patients, and plans to contract with commercial health insurers.

Southern Hills is an existing provider with current eligibility for Medicare and Medicaid reimbursement and will operate the proposed FSED in compliance with these guidelines, just as it operates its main campus ED.

22. Licensure and Quality Considerations

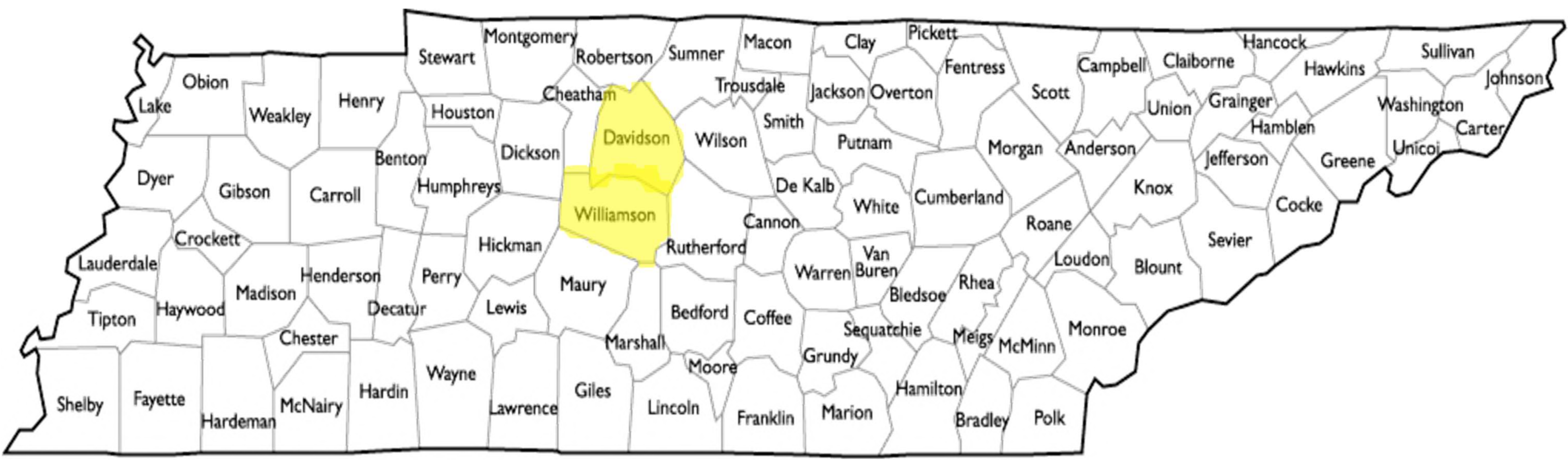
Any applicant for this CON service category shall be in compliance with the appropriate rules of the TDH, the EMTALA, along with any other existing applicable federal guidance and regulation. The applicant shall also demonstrate its accreditation status with the Joint Commission or other applicable accrediting agency. The FSED shall be subject to the same accrediting standards as the licensed hospital with which it is associated. Applicants should address the applicable quality measures found in the HSDA Agency Rules.

Southern Hills is in full compliance with the above standard. Evidence of accreditation and licensure is provided in **Attachment 2Q and Attachment 5C-1**.

Attachment 2N

County Level Service Area Map

County Level Map



Attachment 3N

U.S. Census Bureau Data

https://data.census.gov/table?q=median+age&g=0400000US47_0500000US47037,47187_860XX00US37013,37027,37135,37211&tid=ACSST5Y2021.S0101											
	Tennessee										
	Total		**Percent**		**Male**		**Percent Male**		**Female**		**Percent Female**
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**
Total population	6,859,497	*****	(X)	(X)	3,362,099	±1,514	(X)	(X)	3,497,398	±1,514	(X)
AGE											
Under 5 years	405,867	±873	5.9%	±0.1	207,621	±905	6.2%	±0.1	198,246	±721	5.7%
5 to 9 years	415,626	±3,724	6.1%	±0.1	213,730	±2,708	6.4%	±0.1	201,896	±2,933	5.8%
10 to 14 years	447,531	±3,689	6.5%	±0.1	227,633	±2,800	6.8%	±0.1	219,898	±2,779	6.3%
15 to 19 years	438,290	±1,343	6.4%	±0.1	224,627	±1,210	6.7%	±0.1	213,663	±946	6.1%
20 to 24 years	443,703	±1,532	6.5%	±0.1	222,980	±932	6.6%	±0.1	220,723	±1,124	6.3%
25 to 29 years	482,422	±1,206	7.0%	±0.1	239,746	±808	7.1%	±0.1	242,676	±928	6.9%
30 to 34 years	454,732	±1,307	6.6%	±0.1	224,696	±902	6.7%	±0.1	230,036	±806	6.6%
35 to 39 years	444,180	±5,427	6.5%	±0.1	218,918	±3,284	6.5%	±0.1	225,262	±3,238	6.4%
40 to 44 years	418,807	±5,175	6.1%	±0.1	208,809	±3,215	6.2%	±0.1	209,998	±3,077	6.0%
45 to 49 years	439,227	±1,271	6.4%	±0.1	217,933	±848	6.5%	±0.1	221,294	±722	6.3%
50 to 54 years	446,394	±1,042	6.5%	±0.1	220,308	±660	6.6%	±0.1	226,086	±755	6.5%
55 to 59 years	458,189	±4,372	6.7%	±0.1	220,396	±2,657	6.6%	±0.1	237,793	±3,528	6.8%
60 to 64 years	446,339	±4,671	6.5%	±0.1	215,101	±2,744	6.4%	±0.1	231,238	±3,565	6.6%
65 to 69 years	378,049	±3,670	5.5%	±0.1	179,315	±2,283	5.3%	±0.1	198,734	±2,476	5.7%
70 to 74 years	305,157	±3,549	4.4%	±0.1	140,998	±2,170	4.2%	±0.1	164,159	±2,422	4.7%
75 to 79 years	198,315	±2,924	2.9%	±0.1	89,215	±1,734	2.7%	±0.1	109,100	±2,106	3.1%
80 to 84 years	126,011	±2,436	1.8%	±0.1	52,069	±1,534	1.5%	±0.1	73,942	±1,774	2.1%
85 years and over	110,658	±2,508	1.6%	±0.1	38,004	±1,285	1.1%	±0.1	72,654	±1,870	2.1%
SELECTED AGE CATEGORIES											
5 to 14 years	863,157	±1,004	12.6%	±0.1	441,363	±716	13.1%	±0.1	421,794	±940	12.1%
15 to 17 years	265,219	±668	3.9%	±0.1	135,614	±722	4.0%	±0.1	129,605	±659	3.7%
Under 18 years	1,534,243	±698	22.4%	±0.1	784,598	±1,176	23.3%	±0.1	749,645	±1,233	21.4%
18 to 24 years	616,774	±1,350	9.0%	±0.1	311,993	±927	9.3%	±0.1	304,781	±1,075	8.7%
15 to 44 years	2,682,134	±1,712	39.1%	±0.1	1,339,776	±1,476	39.8%	±0.1	1,342,358	±1,438	38.4%
16 years and over	5,504,783	±2,072	80.3%	±0.1	2,670,093	±1,904	79.4%	±0.1	2,834,690	±1,935	81.1%
18 years and over	5,325,254	±694	77.6%	±0.1	2,577,501	±1,043	76.7%	±0.1	2,747,753	±1,034	78.6%
21 years and over	5,058,420	±3,016	73.7%	±0.1	2,440,765	±2,317	72.6%	±0.1	2,617,655	±2,300	74.8%
60 years and over	1,564,529	±4,597	22.8%	±0.1	714,702	±2,703	21.3%	±0.1	849,827	±3,664	24.3%
62 years and over	1,380,140	±3,789	20.1%	±0.1	625,768	±2,580	18.6%	±0.1	754,372	±2,806	21.6%
65 years and over	1,118,190	±912	16.3%	±0.1	499,601	±631	14.9%	±0.1	618,589	±628	17.7%
75 years and over	434,984	±857	6.3%	±0.1	179,288	±513	5.3%	±0.1	255,696	±660	7.3%
SUMMARY INDICATORS											
Median age (years)	38.8	±0.1	(X)	(X)	37.7	±0.2	(X)	(X)	39.9	±0.1	(X)
Sex ratio (males per 100 females)	96.1	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Age dependency ratio	63.0	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Old-age dependency ratio	26.6	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Child dependency ratio	36.5	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
PERCENT ALLOCATED											
Sex	(X)	(X)	0.1%	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Age	(X)	(X)	1.4%	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)

https://data.census.gov/table?q=mec											
		Davidson County, Tennessee									
		Total		Percent		Male		Percent Male		Female	
Label	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total population	(X)	708,490	*****	(X)	(X)	342,506	±119	(X)	(X)	365,984	±119
AGE											
Under 5 years	±0.1	46,175	±17	6.5%	±0.1	23,406	±29	6.8%	±0.1	22,769	±23
5 to 9 years	±0.1	39,962	±1,399	5.6%	±0.2	19,698	±949	5.8%	±0.3	20,264	±962
10 to 14 years	±0.1	39,227	±1,359	5.5%	±0.2	20,355	±953	5.9%	±0.3	18,872	±950
15 to 19 years	±0.1	40,482	±146	5.7%	±0.1	20,378	±131	5.9%	±0.1	20,104	±70
20 to 24 years	±0.1	50,165	±96	7.1%	±0.1	23,667	±74	6.9%	±0.1	26,498	±70
25 to 29 years	±0.1	73,628	±105	10.4%	±0.1	34,746	±74	10.1%	±0.1	38,882	±87
30 to 34 years	±0.1	68,794	±111	9.7%	±0.1	33,867	±40	9.9%	±0.1	34,927	±100
35 to 39 years	±0.1	54,780	±1,301	7.7%	±0.2	26,609	±1,136	7.8%	±0.3	28,171	±878
40 to 44 years	±0.1	44,567	±1,282	6.3%	±0.2	23,189	±1,136	6.8%	±0.3	21,378	±845
45 to 49 years	±0.1	41,524	±42	5.9%	±0.1	20,751	±42	6.1%	±0.1	20,773	±19
50 to 54 years	±0.1	40,362	±74	5.7%	±0.1	20,063	±46	5.9%	±0.1	20,299	±57
55 to 59 years	±0.1	43,700	±1,236	6.2%	±0.2	20,175	±902	5.9%	±0.3	23,525	±834
60 to 64 years	±0.1	37,564	±1,231	5.3%	±0.2	18,149	±895	5.3%	±0.3	19,415	±831
65 to 69 years	±0.1	32,142	±979	4.5%	±0.1	14,691	±560	4.3%	±0.2	17,451	±725
70 to 74 years	±0.1	22,793	±979	3.2%	±0.1	10,265	±563	3.0%	±0.2	12,528	±718
75 to 79 years	±0.1	13,904	±715	2.0%	±0.1	5,846	±472	1.7%	±0.1	8,058	±537
80 to 84 years	±0.1	9,683	±630	1.4%	±0.1	3,730	±444	1.1%	±0.1	5,953	±533
85 years and over	±0.1	9,038	±722	1.3%	±0.1	2,921	±345	0.9%	±0.1	6,117	±592
SELECTED AGE CATEGORIES											
5 to 14 years	±0.1	79,189	±121	11.2%	±0.1	40,053	±75	11.7%	±0.1	39,136	±111
15 to 17 years	±0.1	21,737	±120	3.1%	±0.1	11,069	±118	3.2%	±0.1	10,668	±42
Under 18 years	±0.1	147,101	*****	20.8%	*****	74,528	±119	21.8%	±0.1	72,573	±120
18 to 24 years	±0.1	68,910	±100	9.7%	±0.1	32,976	±76	9.6%	±0.1	35,934	±80
15 to 44 years	±0.1	332,416	±137	46.9%	±0.1	162,456	±122	47.4%	±0.1	169,960	±76
16 years and over	±0.1	576,595	±576	81.4%	±0.1	275,928	±429	80.6%	±0.1	300,667	±415
18 years and over	±0.1	561,389	*****	79.2%	*****	267,978	±30	78.2%	±0.1	293,411	±30
21 years and over	±0.1	534,204	±761	75.4%	±0.1	254,945	±511	74.4%	±0.2	279,259	±587
60 years and over	±0.1	125,124	±1,231	17.7%	±0.2	55,602	±895	16.2%	±0.3	69,522	±831
62 years and over	±0.1	109,260	±1,139	15.4%	±0.2	48,355	±804	14.1%	±0.2	60,905	±794
65 years and over	±0.1	87,560	±23	12.4%	±0.1	37,453	±4	10.9%	±0.1	50,107	±23
75 years and over	±0.1	32,625	±72	4.6%	±0.1	12,497	±38	3.6%	±0.1	20,128	±50
SUMMARY INDICATORS											
Median age (years)	(X)	34.6	±0.1	(X)	(X)	34.2	±0.1	(X)	(X)	35.1	±0.1
Sex ratio (males per 100 females)	(X)	93.6	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Age dependency ratio	(X)	49.5	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Old-age dependency ratio	(X)	18.5	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Child dependency ratio	(X)	31.0	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
PERCENT ALLOCATED											
Sex	(X)	(X)	(X)	0.1%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Age	(X)	(X)	(X)	2.0%	(X)	(X)	(X)	(X)	(X)	(X)	(X)

https://data.census.gov/table?q=mec											
			Williamson County, Tennessee								
	Percent Female		**Total**		**Percent**		**Male**		**Percent Male**		**Female**
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**
Total population	(X)	(X)	242,386	*****	(X)	(X)	119,474	±153	(X)	(X)	122,912
AGE											
Under 5 years	6.2%	±0.1	13,877	*****	5.7%	*****	7,154	±150	6.0%	±0.1	6,723
5 to 9 years	5.5%	±0.3	18,970	±971	7.8%	±0.4	9,689	±647	8.1%	±0.5	9,281
10 to 14 years	5.2%	±0.3	19,778	±971	8.2%	±0.4	10,146	±643	8.5%	±0.5	9,632
15 to 19 years	5.5%	±0.1	18,845	±170	7.8%	±0.1	9,681	±145	8.1%	±0.1	9,164
20 to 24 years	7.2%	±0.1	12,554	±325	5.2%	±0.1	6,546	±251	5.5%	±0.2	6,008
25 to 29 years	10.6%	±0.1	10,224	±314	4.2%	±0.1	4,788	±233	4.0%	±0.2	5,436
30 to 34 years	9.5%	±0.1	11,935	±77	4.9%	±0.1	5,514	±76	4.6%	±0.1	6,421
35 to 39 years	7.7%	±0.2	16,451	±1,144	6.8%	±0.5	8,132	±687	6.8%	±0.6	8,319
40 to 44 years	5.8%	±0.2	19,151	±1,130	7.9%	±0.5	9,201	±682	7.7%	±0.6	9,950
45 to 49 years	5.7%	±0.1	19,331	±218	8.0%	±0.1	9,622	±146	8.1%	±0.1	9,709
50 to 54 years	5.5%	±0.1	17,802	±217	7.3%	±0.1	8,877	±137	7.4%	±0.1	8,925
55 to 59 years	6.4%	±0.2	16,526	±702	6.8%	±0.3	7,688	±507	6.4%	±0.4	8,838
60 to 64 years	5.3%	±0.2	14,713	±715	6.1%	±0.3	7,524	±502	6.3%	±0.4	7,189
65 to 69 years	4.8%	±0.2	11,050	±703	4.6%	±0.3	5,392	±493	4.5%	±0.4	5,658
70 to 74 years	3.4%	±0.2	9,328	±681	3.8%	±0.3	4,439	±457	3.7%	±0.4	4,889
75 to 79 years	2.2%	±0.1	5,510	±366	2.3%	±0.2	2,378	±274	2.0%	±0.2	3,132
80 to 84 years	1.6%	±0.1	3,678	±347	1.5%	±0.1	1,714	±237	1.4%	±0.2	1,964
85 years and over	1.7%	±0.2	2,663	±445	1.1%	±0.2	989	±283	0.8%	±0.2	1,674
SELECTED AGE CATEGORIES											
5 to 14 years	10.7%	±0.1	38,748	*****	16.0%	*****	19,835	±32	16.6%	±0.1	18,913
15 to 17 years	2.9%	±0.1	12,841	*****	5.3%	*****	6,439	±13	5.4%	±0.1	6,402
Under 18 years	19.8%	±0.1	65,466	*****	27.0%	*****	33,428	±143	28.0%	±0.1	32,038
18 to 24 years	9.8%	±0.1	18,558	±334	7.7%	±0.1	9,788	±244	8.2%	±0.2	8,770
15 to 44 years	46.4%	±0.1	89,160	±64	36.8%	±0.1	43,862	±67	36.7%	±0.1	45,298
16 years and over	82.2%	±0.1	185,970	±484	76.7%	±0.2	90,643	±392	75.9%	±0.3	95,327
18 years and over	80.2%	±0.1	176,920	*****	73.0%	*****	86,046	±48	72.0%	±0.1	90,874
21 years and over	76.3%	±0.2	167,938	±624	69.3%	±0.3	81,109	±478	67.9%	±0.4	86,829
60 years and over	19.0%	±0.2	46,942	±702	19.4%	±0.3	22,436	±501	18.8%	±0.4	24,506
62 years and over	16.6%	±0.2	40,323	±752	16.6%	±0.3	18,988	±483	15.9%	±0.4	21,335
65 years and over	13.7%	±0.1	32,229	±61	13.3%	±0.1	14,912	±39	12.5%	±0.1	17,317
75 years and over	5.5%	±0.1	11,851	±163	4.9%	±0.1	5,081	±90	4.3%	±0.1	6,770
SUMMARY INDICATORS											
Median age (years)	(X)	(X)	39.5	±0.4	(X)	(X)	38.6	±0.5	(X)	(X)	40.3
Sex ratio (males per 100 females)	(X)	(X)	97.2	±0.2	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Age dependency ratio	(X)	(X)	67.5	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Old-age dependency ratio	(X)	(X)	22.3	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Child dependency ratio	(X)	(X)	45.2	±0.1	(X)	(X)	(X)	(X)	(X)	(X)	(X)
PERCENT ALLOCATED											
Sex	(X)	(X)	(X)	(X)	0.0%	(X)	(X)	(X)	(X)	(X)	(X)
Age	(X)	(X)	(X)	(X)	1.1%	(X)	(X)	(X)	(X)	(X)	(X)

https://data.census.gov/table?q=mec											
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		Percent Female		Total		Percent		Male		Percent Male	
Label	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total population	±153	(X)	(X)	102,184	±4,796	(X)	(X)	50,254	±3,091	(X)	(X)
AGE											
Under 5 years	±150	5.5%	±0.1	8,935	±1,047	8.7%	±0.9	4,585	±679	9.1%	±1.2
5 to 9 years	±726	7.6%	±0.6	8,584	±1,083	8.4%	±0.9	3,891	±621	7.7%	±1.2
10 to 14 years	±732	7.8%	±0.6	7,770	±905	7.6%	±0.8	4,017	±721	8.0%	±1.3
15 to 19 years	±112	7.5%	±0.1	6,750	±834	6.6%	±0.7	3,318	±542	6.6%	±0.9
20 to 24 years	±196	4.9%	±0.2	6,713	±813	6.6%	±0.7	3,878	±616	7.7%	±1.1
25 to 29 years	±212	4.4%	±0.2	9,205	±1,046	9.0%	±0.9	4,475	±918	8.9%	±1.6
30 to 34 years	±14	5.2%	±0.1	9,565	±949	9.4%	±0.9	4,542	±628	9.0%	±1.2
35 to 39 years	±725	6.8%	±0.6	8,092	±898	7.9%	±0.8	3,770	±607	7.5%	±1.1
40 to 44 years	±721	8.1%	±0.6	8,257	±1,127	8.1%	±1.0	4,490	±756	8.9%	±1.4
45 to 49 years	±145	7.9%	±0.1	6,736	±813	6.6%	±0.8	3,662	±528	7.3%	±1.0
50 to 54 years	±146	7.3%	±0.1	4,969	±573	4.9%	±0.6	2,340	±392	4.7%	±0.8
55 to 59 years	±493	7.2%	±0.4	5,235	±665	5.1%	±0.6	2,606	±448	5.2%	±0.8
60 to 64 years	±490	5.8%	±0.4	4,581	±679	4.5%	±0.7	1,805	±305	3.6%	±0.6
65 to 69 years	±426	4.6%	±0.3	3,038	±375	3.0%	±0.4	1,337	±268	2.7%	±0.5
70 to 74 years	±441	4.0%	±0.4	1,914	±340	1.9%	±0.3	759	±212	1.5%	±0.4
75 to 79 years	±326	2.5%	±0.3	816	±207	0.8%	±0.2	352	±98	0.7%	±0.2
80 to 84 years	±247	1.6%	±0.2	707	±259	0.7%	±0.3	284	±145	0.6%	±0.3
85 years and over	±319	1.4%	±0.3	317	±133	0.3%	±0.1	143	±98	0.3%	±0.2
SELECTED AGE CATEGORIES											
5 to 14 years	±33	15.4%	±0.1	16,354	±1,468	16.0%	±1.1	7,908	±928	15.7%	±1.5
15 to 17 years	±13	5.2%	±0.1	4,160	±559	4.1%	±0.5	1,891	±366	3.8%	±0.7
Under 18 years	±143	26.1%	±0.1	29,449	±2,235	28.8%	±1.3	14,384	±1,288	28.6%	±1.8
18 to 24 years	±217	7.1%	±0.2	9,303	±979	9.1%	±0.8	5,305	±761	10.6%	±1.2
15 to 44 years	±15	36.9%	±0.1	48,582	±2,831	47.5%	±1.4	24,473	±2,072	48.7%	±2.1
16 years and over	±338	77.6%	±0.3	75,711	±3,460	74.1%	±1.4	37,314	±2,419	74.3%	±1.8
18 years and over	±47	73.9%	±0.1	72,735	±3,178	71.2%	±1.3	35,870	±2,320	71.4%	±1.8
21 years and over	±447	70.6%	±0.4	69,477	±3,024	68.0%	±1.3	34,158	±2,192	68.0%	±1.8
60 years and over	±494	19.9%	±0.4	11,373	±890	11.1%	±0.9	4,680	±434	9.3%	±0.9
62 years and over	±461	17.4%	±0.4	9,505	±851	9.3%	±0.9	3,973	±416	7.9%	±0.9
65 years and over	±58	14.1%	±0.1	6,792	±618	6.6%	±0.6	2,875	±367	5.7%	±0.7
75 years and over	±118	5.5%	±0.1	1,840	±369	1.8%	±0.4	779	±162	1.6%	±0.3
SUMMARY INDICATORS											
Median age (years)	±0.4	(X)	(X)	31.5	±0.7	(X)	(X)	31.1	±1.4	(X)	(X)
Sex ratio (males per 100 females)	(X)	(X)	(X)	96.8	±5.5	(X)	(X)	(X)	(X)	(X)	(X)
Age dependency ratio	(X)	(X)	(X)	55.0	±2.9	(X)	(X)	(X)	(X)	(X)	(X)
Old-age dependency ratio	(X)	(X)	(X)	10.3	±1.0	(X)	(X)	(X)	(X)	(X)	(X)
Child dependency ratio	(X)	(X)	(X)	44.7	±2.8	(X)	(X)	(X)	(X)	(X)	(X)
PERCENT ALLOCATED											
Sex	(X)	(X)	(X)	(X)	(X)	0.1%	(X)	(X)	(X)	(X)	(X)
Age	(X)	(X)	(X)	(X)	(X)	1.9%	(X)	(X)	(X)	(X)	(X)

https://data.census.gov/table?q=mec											
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	Female		Percent Female		Total		Percent		Male		Percent Male
Label	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Total population	51,930	±2,480	(X)	(X)	60,610	±1,536	(X)	(X)	30,207	±971	(X)
AGE											
Under 5 years	4,350	±608	8.4%	±1.0	2,539	±454	4.2%	±0.7	1,353	±245	4.5%
5 to 9 years	4,693	±774	9.0%	±1.3	3,710	±419	6.1%	±0.7	1,879	±295	6.2%
10 to 14 years	3,753	±542	7.2%	±1.0	4,670	±507	7.7%	±0.9	2,757	±390	9.1%
15 to 19 years	3,432	±549	6.6%	±1.0	5,784	±548	9.5%	±0.9	3,286	±472	10.9%
20 to 24 years	2,835	±485	5.5%	±0.9	3,181	±571	5.2%	±0.9	1,883	±513	6.2%
25 to 29 years	4,730	±566	9.1%	±1.1	2,249	±364	3.7%	±0.6	1,142	±255	3.8%
30 to 34 years	5,023	±641	9.7%	±1.2	3,012	±564	5.0%	±0.9	1,282	±279	4.2%
35 to 39 years	4,322	±528	8.3%	±0.9	3,180	±548	5.2%	±0.9	1,343	±289	4.4%
40 to 44 years	3,767	±692	7.3%	±1.2	4,081	±447	6.7%	±0.8	1,969	±237	6.5%
45 to 49 years	3,074	±477	5.9%	±0.9	5,122	±442	8.5%	±0.7	2,464	±297	8.2%
50 to 54 years	2,629	±350	5.1%	±0.7	4,707	±566	7.8%	±0.9	2,140	±299	7.1%
55 to 59 years	2,629	±474	5.1%	±0.8	4,844	±542	8.0%	±0.8	2,347	±311	7.8%
60 to 64 years	2,776	±601	5.3%	±1.1	4,229	±638	7.0%	±1.1	2,103	±352	7.0%
65 to 69 years	1,701	±253	3.3%	±0.5	3,298	±555	5.4%	±0.9	1,670	±449	5.5%
70 to 74 years	1,155	±223	2.2%	±0.4	2,698	±412	4.5%	±0.7	1,159	±207	3.8%
75 to 79 years	464	±183	0.9%	±0.4	1,614	±239	2.7%	±0.4	711	±165	2.4%
80 to 84 years	423	±175	0.8%	±0.3	1,097	±307	1.8%	±0.5	455	±218	1.5%
85 years and over	174	±81	0.3%	±0.2	595	±142	1.0%	±0.2	264	±87	0.9%
SELECTED AGE CATEGORIES											
5 to 14 years	8,446	±916	16.3%	±1.4	8,380	±671	13.8%	±1.2	4,636	±499	15.3%
15 to 17 years	2,269	±442	4.4%	±0.8	4,255	±502	7.0%	±0.9	2,427	±393	8.0%
Under 18 years	15,065	±1,304	29.0%	±1.6	15,174	±864	25.0%	±1.5	8,416	±698	27.9%
18 to 24 years	3,998	±559	7.7%	±1.0	4,710	±648	7.8%	±1.0	2,742	±565	9.1%
15 to 44 years	24,109	±1,407	46.4%	±1.6	21,487	±1,031	35.5%	±1.3	10,905	±832	36.1%
16 years and over	38,397	±1,754	73.9%	±1.6	48,660	±1,620	80.3%	±1.3	23,752	±1,000	78.6%
18 years and over	36,865	±1,635	71.0%	±1.6	45,436	±1,666	75.0%	±1.5	21,791	±953	72.1%
21 years and over	35,319	±1,606	68.0%	±1.5	43,526	±1,646	71.8%	±1.6	20,717	±922	68.6%
60 years and over	6,693	±697	12.9%	±1.3	13,531	±997	22.3%	±1.6	6,362	±608	21.1%
62 years and over	5,532	±686	10.7%	±1.3	11,563	±890	19.1%	±1.4	5,389	±533	17.8%
65 years and over	3,917	±423	7.5%	±0.9	9,302	±757	15.3%	±1.2	4,259	±495	14.1%
75 years and over	1,061	±273	2.0%	±0.5	3,306	±403	5.5%	±0.7	1,430	±251	4.7%
SUMMARY INDICATORS											
Median age (years)	31.8	±0.9	(X)	(X)	42.5	±1.2	(X)	(X)	40.4	±1.8	(X)
Sex ratio (males per 100 females)	(X)	(X)	(X)	(X)	99.4	±5.3	(X)	(X)	(X)	(X)	(X)
Age dependency ratio	(X)	(X)	(X)	(X)	67.7	±4.1	(X)	(X)	(X)	(X)	(X)
Old-age dependency ratio	(X)	(X)	(X)	(X)	25.7	±2.3	(X)	(X)	(X)	(X)	(X)
Child dependency ratio	(X)	(X)	(X)	(X)	42.0	±3.3	(X)	(X)	(X)	(X)	(X)
PERCENT ALLOCATED											
Sex	(X)	(X)	(X)	(X)	(X)	(X)	0.1%	(X)	(X)	(X)	(X)
Age	(X)	(X)	(X)	(X)	(X)	(X)	1.6%	(X)	(X)	(X)	(X)

https://data.census.gov/table?q=mec											
						ZCTA5 37135					
		Female		Percent Female		Total		Percent		Male	
Label	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total population	(X)	30,403	±1,245	(X)	(X)	21,171	±1,619	(X)	(X)	10,439	±838
AGE											
Under 5 years	±0.8	1,186	±351	3.9%	±1.1	1,506	±370	7.1%	±1.7	944	±322
5 to 9 years	±1.0	1,831	±288	6.0%	±0.9	1,893	±455	8.9%	±2.3	951	±266
10 to 14 years	±1.3	1,913	±288	6.3%	±1.0	1,681	±339	7.9%	±1.6	862	±238
15 to 19 years	±1.5	2,498	±342	8.2%	±1.2	1,749	±532	8.3%	±2.2	735	±255
20 to 24 years	±1.6	1,298	±310	4.3%	±1.0	1,328	±620	6.3%	±2.8	684	±332
25 to 29 years	±0.8	1,107	±249	3.6%	±0.8	413	±245	2.0%	±1.2	172	±166
30 to 34 years	±0.9	1,730	±476	5.7%	±1.5	1,350	±360	6.4%	±1.7	570	±221
35 to 39 years	±1.0	1,837	±371	6.0%	±1.2	1,840	±350	8.7%	±1.8	915	±215
40 to 44 years	±0.8	2,112	±340	6.9%	±1.2	1,474	±566	7.0%	±2.4	697	±226
45 to 49 years	±1.0	2,658	±331	8.7%	±1.1	2,007	±391	9.5%	±1.6	920	±265
50 to 54 years	±1.0	2,567	±427	8.4%	±1.3	2,122	±596	10.0%	±2.8	1,245	±337
55 to 59 years	±1.0	2,497	±356	8.2%	±1.1	1,253	±429	5.9%	±1.9	693	±336
60 to 64 years	±1.2	2,126	±347	7.0%	±1.2	841	±219	4.0%	±1.0	388	±147
65 to 69 years	±1.5	1,628	±265	5.4%	±0.9	909	±388	4.3%	±1.8	286	±125
70 to 74 years	±0.7	1,539	±306	5.1%	±1.0	487	±210	2.3%	±1.0	271	±135
75 to 79 years	±0.6	903	±173	3.0%	±0.6	135	±88	0.6%	±0.4	47	±43
80 to 84 years	±0.7	642	±163	2.1%	±0.5	85	±79	0.4%	±0.4	43	±45
85 years and over	±0.3	331	±107	1.1%	±0.3	98	±79	0.5%	±0.4	16	±21
SELECTED AGE CATEGORIES											
5 to 14 years	±1.6	3,744	±385	12.3%	±1.3	3,574	±533	16.9%	±2.7	1,813	±307
15 to 17 years	±1.3	1,828	±314	6.0%	±1.1	1,212	±433	5.7%	±1.9	674	±244
Under 18 years	±2.1	6,758	±536	22.2%	±1.7	6,292	±739	29.7%	±3.0	3,431	±419
18 to 24 years	±1.8	1,968	±345	6.5%	±1.1	1,865	±681	8.8%	±2.9	745	±332
15 to 44 years	±2.2	10,582	±780	34.8%	±1.8	8,154	±1,063	38.5%	±2.9	3,773	±474
16 years and over	±1.9	24,908	±1,151	81.9%	±1.6	15,626	±1,450	73.8%	±3.0	7,525	±798
18 years and over	±2.1	23,645	±1,185	77.8%	±1.7	14,879	±1,399	70.3%	±3.0	7,008	±755
21 years and over	±2.2	22,809	±1,162	75.0%	±1.8	13,984	±1,183	66.1%	±2.8	6,841	±752
60 years and over	±2.0	7,169	±531	23.6%	±1.8	2,555	±527	12.1%	±2.4	1,051	±235
62 years and over	±1.7	6,174	±519	20.3%	±1.7	2,293	±503	10.8%	±2.3	913	±208
65 years and over	±1.6	5,043	±438	16.6%	±1.4	1,714	±436	8.1%	±2.0	663	±184
75 years and over	±0.8	1,876	±262	6.2%	±0.9	318	±137	1.5%	±0.7	106	±68
SUMMARY INDICATORS											
Median age (years)	(X)	44.3	±1.4	(X)	(X)	36.9	±1.4	(X)	(X)	36.9	±1.7
Sex ratio (males per 100 females)	(X)	(X)	(X)	(X)	(X)	97.3	±8.5	(X)	(X)	(X)	(X)
Age dependency ratio	(X)	(X)	(X)	(X)	(X)	60.8	±8.7	(X)	(X)	(X)	(X)
Old-age dependency ratio	(X)	(X)	(X)	(X)	(X)	13.0	±3.6	(X)	(X)	(X)	(X)
Child dependency ratio	(X)	(X)	(X)	(X)	(X)	47.8	±7.2	(X)	(X)	(X)	(X)
PERCENT ALLOCATED											
Sex	(X)	(X)	(X)	(X)	(X)	(X)	(X)	0.0%	(X)	(X)	(X)
Age	(X)	(X)	(X)	(X)	(X)	(X)	(X)	0.2%	(X)	(X)	(X)

https://data.census.gov/table?q=mec											
							ZCTA5 37211				
	Percent Male		Female		Percent Female		Total		Percent		Male
Label	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Total population	(X)	(X)	10,732	±1,020	(X)	(X)	75,073	±2,967	(X)	(X)	38,170
AGE											
Under 5 years	9.0%	±2.9	562	±159	5.2%	±1.4	5,994	±885	8.0%	±1.1	2,687
5 to 9 years	9.1%	±2.7	942	±315	8.8%	±3.1	3,978	±579	5.3%	±0.7	1,999
10 to 14 years	8.3%	±2.4	819	±248	7.6%	±2.1	4,362	±607	5.8%	±0.8	2,193
15 to 19 years	7.0%	±2.4	1,014	±404	9.4%	±3.2	3,491	±607	4.7%	±0.8	1,876
20 to 24 years	6.6%	±3.0	644	±361	6.0%	±3.2	5,568	±745	7.4%	±0.9	2,935
25 to 29 years	1.6%	±1.6	241	±153	2.2%	±1.5	8,477	±981	11.3%	±1.2	4,300
30 to 34 years	5.5%	±2.1	780	±231	7.3%	±2.2	9,014	±1,174	12.0%	±1.3	4,935
35 to 39 years	8.8%	±2.0	925	±248	8.6%	±2.5	5,988	±881	8.0%	±1.1	3,543
40 to 44 years	6.7%	±2.1	777	±408	7.2%	±3.5	4,259	±540	5.7%	±0.7	2,288
45 to 49 years	8.8%	±2.4	1,087	±307	10.1%	±2.8	4,422	±583	5.9%	±0.7	2,101
50 to 54 years	11.9%	±3.3	877	±324	8.2%	±3.0	3,712	±650	4.9%	±0.9	2,167
55 to 59 years	6.6%	±3.0	560	±241	5.2%	±2.3	4,176	±576	5.6%	±0.8	1,769
60 to 64 years	3.7%	±1.4	453	±151	4.2%	±1.5	3,662	±495	4.9%	±0.7	2,023
65 to 69 years	2.7%	±1.1	623	±345	5.8%	±3.1	3,140	±430	4.2%	±0.6	1,526
70 to 74 years	2.6%	±1.3	216	±102	2.0%	±1.0	2,148	±418	2.9%	±0.6	909
75 to 79 years	0.5%	±0.4	88	±73	0.8%	±0.7	1,047	±303	1.4%	±0.4	467
80 to 84 years	0.4%	±0.4	42	±45	0.4%	±0.4	925	±252	1.2%	±0.3	292
85 years and over	0.2%	±0.2	82	±71	0.8%	±0.7	710	±167	0.9%	±0.2	160
SELECTED AGE CATEGORIES											
5 to 14 years	17.4%	±3.3	1,761	±400	16.4%	±3.6	8,340	±876	11.1%	±1.0	4,192
15 to 17 years	6.5%	±2.3	538	±283	5.0%	±2.4	2,110	±416	2.8%	±0.5	1,212
Under 18 years	32.9%	±3.7	2,861	±553	26.7%	±4.2	16,444	±1,314	21.9%	±1.3	8,091
18 to 24 years	7.1%	±3.0	1,120	±470	10.4%	±4.0	6,949	±851	9.3%	±1.0	3,599
15 to 44 years	36.1%	±3.2	4,381	±767	40.8%	±4.6	36,797	±2,201	49.0%	±1.7	19,877
16 years and over	72.1%	±3.5	8,101	±833	75.5%	±4.2	60,190	±2,341	80.2%	±1.3	30,949
18 years and over	67.1%	±3.7	7,871	±832	73.3%	±4.2	58,629	±2,256	78.1%	±1.3	30,079
21 years and over	65.5%	±3.8	7,143	±625	66.6%	±4.2	56,513	±2,139	75.3%	±1.4	29,020
60 years and over	10.1%	±2.1	1,504	±395	14.0%	±3.7	11,632	±821	15.5%	±1.3	5,377
62 years and over	8.7%	±1.8	1,380	±383	12.9%	±3.5	10,076	±726	13.4%	±1.1	4,519
65 years and over	6.4%	±1.6	1,051	±348	9.8%	±3.2	7,970	±640	10.6%	±0.9	3,354
75 years and over	1.0%	±0.6	212	±98	2.0%	±1.0	2,682	±445	3.6%	±0.6	919
SUMMARY INDICATORS											
Median age (years)	(X)	(X)	37.0	±2.3	(X)	(X)	33.0	±0.8	(X)	(X)	33.2
Sex ratio (males per 100 females)	(X)	(X)	(X)	(X)	(X)	(X)	103.4	±5.9	(X)	(X)	(X)
Age dependency ratio	(X)	(X)	(X)	(X)	(X)	(X)	48.2	±2.8	(X)	(X)	(X)
Old-age dependency ratio	(X)	(X)	(X)	(X)	(X)	(X)	15.7	±1.5	(X)	(X)	(X)
Child dependency ratio	(X)	(X)	(X)	(X)	(X)	(X)	32.5	±2.4	(X)	(X)	(X)
PERCENT ALLOCATED											
Sex	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	0.0%	(X)	(X)
Age	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	1.9%	(X)	(X)

https://data.census.gov/table?q=mec							
		Percent Male		Female		Percent Female	
Label	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Total population	±1,796	(X)	(X)	36,903	±1,856	(X)	(X)
AGE							
Under 5 years	±455	7.0%	±1.1	3,307	±624	9.0%	±1.5
5 to 9 years	±407	5.2%	±1.0	1,979	±414	5.4%	±1.1
10 to 14 years	±377	5.7%	±0.9	2,169	±484	5.9%	±1.3
15 to 19 years	±420	4.9%	±1.1	1,615	±345	4.4%	±0.9
20 to 24 years	±463	7.7%	±1.2	2,633	±547	7.1%	±1.4
25 to 29 years	±688	11.3%	±1.6	4,177	±589	11.3%	±1.5
30 to 34 years	±814	12.9%	±1.9	4,079	±605	11.1%	±1.5
35 to 39 years	±572	9.3%	±1.4	2,445	±434	6.6%	±1.2
40 to 44 years	±354	6.0%	±1.0	1,971	±328	5.3%	±0.8
45 to 49 years	±365	5.5%	±0.9	2,321	±397	6.3%	±1.1
50 to 54 years	±421	5.7%	±1.1	1,545	±404	4.2%	±1.1
55 to 59 years	±276	4.6%	±0.8	2,407	±482	6.5%	±1.2
60 to 64 years	±324	5.3%	±0.9	1,639	±311	4.4%	±0.8
65 to 69 years	±262	4.0%	±0.7	1,614	±338	4.4%	±0.9
70 to 74 years	±247	2.4%	±0.6	1,239	±347	3.4%	±0.9
75 to 79 years	±222	1.2%	±0.6	580	±195	1.6%	±0.5
80 to 84 years	±120	0.8%	±0.3	633	±202	1.7%	±0.6
85 years and over	±67	0.4%	±0.2	550	±153	1.5%	±0.4
SELECTED AGE CATEGORIES							
5 to 14 years	±603	11.0%	±1.4	4,148	±598	11.2%	±1.5
15 to 17 years	±366	3.2%	±1.0	898	±227	2.4%	±0.6
Under 18 years	±827	21.2%	±1.7	8,353	±801	22.6%	±1.7
18 to 24 years	±529	9.4%	±1.3	3,350	±602	9.1%	±1.5
15 to 44 years	±1,277	52.1%	±2.0	16,920	±1,253	45.8%	±2.1
16 years and over	±1,393	81.1%	±1.7	29,241	±1,556	79.2%	±1.8
18 years and over	±1,427	78.8%	±1.7	28,550	±1,478	77.4%	±1.7
21 years and over	±1,365	76.0%	±1.7	27,493	±1,410	74.5%	±1.8
60 years and over	±506	14.1%	±1.3	6,255	±578	16.9%	±1.6
62 years and over	±515	11.8%	±1.3	5,557	±509	15.1%	±1.4
65 years and over	±435	8.8%	±1.1	4,616	±466	12.5%	±1.3
75 years and over	±266	2.4%	±0.7	1,763	±308	4.8%	±0.9
SUMMARY INDICATORS							
Median age (years)	±1.0	(X)	(X)	32.9	±1.0	(X)	(X)
Sex ratio (males per 100 females)	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Age dependency ratio	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Old-age dependency ratio	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Child dependency ratio	(X)	(X)	(X)	(X)	(X)	(X)	(X)
PERCENT ALLOCATED							
Sex	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Age	(X)	(X)	(X)	(X)	(X)	(X)	(X)

https://data.census.gov/table?q=median+household+income&g=0400000US47_0500000US47037,47187_860XX00US37013,37027,37135,37211&tid=ACSST5Y2021.S1901								
	Tennessee							
	Households		**Families**		**Married-couple families**		**Nonfamily households**	
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**
Total	2,664,791	±6,361	1,736,369	±8,220	1,273,881	±8,522	928,422	±7,000
Less than $10,000	6.2%	±0.1	3.8%	±0.1	1.3%	±0.1	11.7%	±0.3
$10,000 to $14,999	4.7%	±0.1	2.4%	±0.1	1.1%	±0.1	9.4%	±0.2
$15,000 to $24,999	9.2%	±0.2	6.3%	±0.2	3.6%	±0.1	15.4%	±0.3
$25,000 to $34,999	9.5%	±0.2	7.7%	±0.2	5.7%	±0.2	13.6%	±0.4
$35,000 to $49,999	13.4%	±0.1	12.3%	±0.2	10.4%	±0.2	15.7%	±0.3
$50,000 to $74,999	18.2%	±0.2	18.7%	±0.2	18.8%	±0.3	16.7%	±0.3
$75,000 to $99,999	12.8%	±0.1	15.0%	±0.2	17.0%	±0.3	7.9%	±0.2
$100,000 to $149,999	14.3%	±0.2	18.2%	±0.3	22.1%	±0.3	6.0%	±0.2
$150,000 to $199,999	5.7%	±0.1	7.5%	±0.2	9.5%	±0.2	1.9%	±0.1
$200,000 or more	6.0%	±0.1	8.0%	±0.2	10.4%	±0.2	1.8%	±0.1
Median income (dollars)	58,516	±363	73,248	±461	87,627	±509	34,956	±354
Mean income (dollars)	82,012	±514	97,441	±656	113,609	±788	49,928	±718
PERCENT ALLOCATED								
Household income in the past 12 months	36.3%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	37.0%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	33.4%	(X)

https://data.census.gov/table?q=med								
	Davidson County, Tennessee							
	Households		**Families**		**Married-couple families**		**Nonfamily households**	
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**
Total	293,859	±1,684	157,896	±2,654	108,747	±2,275	135,963	±2,604
Less than $10,000	5.9%	±0.4	4.2%	±0.5	1.3%	±0.3	8.4%	±0.8
$10,000 to $14,999	3.2%	±0.3	1.7%	±0.3	0.7%	±0.2	5.1%	±0.5
$15,000 to $24,999	7.1%	±0.5	5.7%	±0.6	3.0%	±0.5	9.2%	±0.7
$25,000 to $34,999	8.1%	±0.5	6.5%	±0.6	4.2%	±0.5	10.6%	±0.9
$35,000 to $49,999	12.7%	±0.6	10.9%	±0.8	7.8%	±0.8	15.3%	±1.0
$50,000 to $74,999	19.0%	±0.6	16.9%	±0.8	15.9%	±0.9	21.3%	±1.1
$75,000 to $99,999	13.1%	±0.6	14.0%	±0.9	15.1%	±1.0	11.7%	±0.8
$100,000 to $149,999	15.5%	±0.6	18.9%	±0.7	23.5%	±1.0	10.7%	±0.8
$150,000 to $199,999	6.8%	±0.3	9.1%	±0.6	12.1%	±0.8	3.6%	±0.4
$200,000 or more	8.6%	±0.4	12.2%	±0.7	16.5%	±0.9	4.1%	±0.5
Median income (dollars)	66,047	±1,118	82,751	±1,432	102,886	±1,681	51,467	±1,286
Mean income (dollars)	96,207	±1,516	116,303	±2,236	141,440	±2,919	69,998	±2,180
PERCENT ALLOCATED								
Household income in the past 12 months	37.7%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	40.3%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	33.5%	(X)

https://data.census.gov/table?q=med								
	Williamson County, Tennessee							
	Households		**Families**		**Married-couple families**		**Nonfamily households**	
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**
Total	85,311	±576	66,539	±1,170	57,918	±1,187	18,772	±1,211
Less than $10,000	2.0%	±0.5	0.7%	±0.2	0.5%	±0.2	6.7%	±1.9
$10,000 to $14,999	1.3%	±0.3	0.9%	±0.4	0.3%	±0.1	3.2%	±1.0
$15,000 to $24,999	3.3%	±0.6	1.9%	±0.6	1.0%	±0.3	8.6%	±1.7
$25,000 to $34,999	3.3%	±0.5	2.2%	±0.5	1.5%	±0.5	8.1%	±1.7
$35,000 to $49,999	7.6%	±0.9	5.1%	±0.9	3.9%	±0.8	16.6%	±2.9
$50,000 to $74,999	12.9%	±1.0	10.5%	±1.1	9.0%	±1.0	21.4%	±3.0
$75,000 to $99,999	12.1%	±1.2	12.4%	±1.3	11.9%	±1.4	11.6%	±2.0
$100,000 to $149,999	20.0%	±1.3	21.8%	±1.6	22.5%	±1.6	14.0%	±2.9
$150,000 to $199,999	13.9%	±0.9	16.2%	±1.1	17.7%	±1.3	3.9%	±1.3
$200,000 or more	23.6%	±1.0	28.5%	±1.3	31.8%	±1.4	5.9%	±1.2
Median income (dollars)	116,492	±4,166	134,793	±2,490	147,406	±5,571	58,803	±5,855
Mean income (dollars)	156,064	±3,630	176,320	±4,323	N	N	80,178	±4,792
PERCENT ALLOCATED								
Household income in the past 12 months	32.7%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	32.4%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	33.2%	(X)

https://data.census.gov/table?q=med								
	ZCTA5 37013							
	Households		**Families**		**Married-couple families**		**Nonfamily households**	
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**
Total	35,483	±994	23,121	±1,208	15,208	±1,124	12,362	±887
Less than $10,000	4.5%	±1.1	3.7%	±1.1	1.7%	±1.0	6.9%	±2.5
$10,000 to $14,999	2.3%	±0.8	2.1%	±1.1	1.5%	±1.3	3.2%	±1.3
$15,000 to $24,999	7.6%	±1.2	7.6%	±2.0	6.3%	±2.4	8.4%	±2.4
$25,000 to $34,999	8.7%	±1.4	8.2%	±1.7	7.2%	±2.1	10.8%	±2.6
$35,000 to $49,999	14.9%	±2.0	14.7%	±2.9	12.0%	±3.5	20.0%	±3.4
$50,000 to $74,999	22.9%	±2.2	19.4%	±2.3	21.4%	±2.9	26.5%	±4.3
$75,000 to $99,999	15.3%	±1.8	17.3%	±2.5	17.4%	±3.1	11.0%	±2.2
$100,000 to $149,999	15.2%	±1.8	16.7%	±2.4	20.3%	±2.8	8.9%	±2.5
$150,000 to $199,999	5.5%	±1.2	6.1%	±1.2	8.1%	±1.8	3.6%	±2.3
$200,000 or more	3.1%	±0.9	4.1%	±1.4	4.2%	±1.3	0.7%	±0.6
Median income (dollars)	61,801	±2,738	66,994	±4,252	75,053	±7,010	50,364	±2,893
Mean income (dollars)	74,899	±2,989	79,985	±4,103	N	N	58,649	±3,748
PERCENT ALLOCATED								
Household income in the past 12 months	43.9%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	45.8%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	37.0%	(X)

https://data.census.gov/table?q=med								
	ZCTA5 37027							
	Households		**Families**		**Married-couple families**		**Nonfamily households**	
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**
Total	21,914	±864	16,553	±598	14,941	±662	5,361	±650
Less than $10,000	2.1%	±0.9	0.6%	±0.4	0.6%	±0.4	6.9%	±3.2
$10,000 to $14,999	1.0%	±0.3	0.8%	±0.5	0.5%	±0.4	2.0%	±1.0
$15,000 to $24,999	2.0%	±0.5	0.9%	±0.4	0.7%	±0.4	5.6%	±2.1
$25,000 to $34,999	2.7%	±0.9	1.1%	±0.6	1.1%	±0.7	7.4%	±2.8
$35,000 to $49,999	4.9%	±1.0	3.5%	±0.9	3.0%	±0.8	8.9%	±2.9
$50,000 to $74,999	10.4%	±1.8	6.6%	±1.1	5.6%	±1.3	22.4%	±6.1
$75,000 to $99,999	11.6%	±1.9	10.8%	±2.5	9.8%	±2.6	14.4%	±4.1
$100,000 to $149,999	20.1%	±2.4	20.9%	±2.5	20.5%	±2.4	19.4%	±6.8
$150,000 to $199,999	12.3%	±2.0	14.5%	±2.3	15.0%	±2.4	3.7%	±2.1
$200,000 or more	33.0%	±2.0	40.3%	±2.3	43.1%	±2.6	9.2%	±2.9
Median income (dollars)	135,284	±4,369	165,703	±5,149	176,771	±9,557	67,008	±8,985
Mean income (dollars)	198,212	±8,992	228,770	±11,131	N	N	100,641	±12,107
PERCENT ALLOCATED								
Household income in the past 12 months	32.7%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	33.0%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	29.1%	(X)

https://data.census.gov/table?q=med								
	ZCTA5 37135							
	Households		**Families**		**Married-couple families**		**Nonfamily households**	
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**
Total	6,566	±605	5,697	±503	5,113	±530	869	±392
Less than $10,000	0.7%	±0.9	0.3%	±0.5	0.4%	±0.6	3.3%	±5.9
$10,000 to $14,999	0.0%	±0.6	0.0%	±0.7	0.0%	±0.8	0.0%	±4.5
$15,000 to $24,999	0.8%	±0.7	0.4%	±0.5	0.5%	±0.6	3.5%	±4.9
$25,000 to $34,999	0.8%	±0.6	1.1%	±0.8	1.0%	±0.8	0.0%	±4.5
$35,000 to $49,999	4.7%	±2.7	3.5%	±2.8	3.1%	±3.0	10.6%	±8.4
$50,000 to $74,999	13.3%	±4.7	7.0%	±2.7	5.9%	±2.5	54.3%	±22.3
$75,000 to $99,999	14.1%	±4.0	16.3%	±4.8	14.7%	±4.9	9.1%	±7.6
$100,000 to $149,999	20.8%	±5.4	22.2%	±6.2	22.0%	±6.5	16.3%	±12.4
$150,000 to $199,999	23.8%	±5.9	24.9%	±6.4	26.1%	±7.0	2.9%	±3.6
$200,000 or more	21.0%	±5.2	24.2%	±5.9	26.5%	±6.5	0.0%	±4.5
Median income (dollars)	131,594	±17,189	146,496	±19,184	153,403	±9,924	70,654	±9,202
Mean income (dollars)	145,151	±10,099	154,779	±10,717	N	N	73,177	±8,739
PERCENT ALLOCATED								
Household income in the past 12 months	32.2%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	31.6%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	36.4%	(X)

https://data.census.gov/table?q=med								
	ZCTA5 37211							
	Households		**Families**		**Married-couple families**		**Nonfamily households**	
Label	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**	**Estimate**	**Margin of Error**
Total	29,394	±974	15,983	±907	11,221	±841	13,411	±980
Less than $10,000	6.9%	±1.5	5.5%	±1.9	2.6%	±1.5	8.7%	±2.2
$10,000 to $14,999	2.9%	±1.0	1.3%	±0.8	0.6%	±0.8	5.4%	±2.1
$15,000 to $24,999	7.5%	±1.4	4.4%	±1.2	2.6%	±1.1	11.3%	±2.6
$25,000 to $34,999	9.8%	±1.6	9.5%	±2.2	8.2%	±2.6	11.1%	±2.4
$35,000 to $49,999	13.6%	±1.8	12.0%	±1.9	9.5%	±2.0	15.9%	±3.1
$50,000 to $74,999	17.9%	±1.9	17.2%	±2.7	16.7%	±3.4	20.5%	±3.1
$75,000 to $99,999	13.6%	±1.8	14.2%	±2.5	15.2%	±2.8	10.6%	±2.0
$100,000 to $149,999	16.9%	±1.8	21.0%	±2.8	24.7%	±3.3	11.4%	±2.6
$150,000 to $199,999	5.8%	±1.7	7.0%	±2.8	9.5%	±3.9	3.7%	±1.2
$200,000 or more	5.1%	±1.1	8.0%	±2.0	10.4%	±2.8	1.3%	±0.6
Median income (dollars)	61,781	±4,135	75,146	±5,281	90,931	±5,008	46,999	±4,632
Mean income (dollars)	78,980	±3,887	92,296	±6,001	106,637	±7,719	59,297	±4,175
PERCENT ALLOCATED								
Household income in the past 12 months	35.6%	(X)	(X)	(X)	(X)	(X)	(X)	(X)
Family income in the past 12 months	(X)	(X)	36.6%	(X)	(X)	(X)	(X)	(X)
Nonfamily income in the past 12 months	(X)	(X)	(X)	(X)	(X)	(X)	33.5%	(X)

https://data.census.gov/table?q=below+poverty+level&g=0400000US47_0500000US47037,47187_860XX00US37013,37027,37135,37211&tid=ACSST5Y2021.S1701

	Tennessee						Davidson County, Tennessee						Williamson County, Tennessee				
	Total		Below poverty level		Percent below poverty level		Total		Below poverty level		Percent below poverty level		Total		Below poverty level		Percent below pov
Label	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate
Population for whom poverty status is determined	6,692,912	±2,085	955,929	±14,385	14.3%	±0.2	686,677	±1,511	98,412	±4,401	14.3%	±0.6	241,355	±281	9,420	±1,409	3.9%
AGE																	
Under 18 years	1,503,865	±2,123	299,021	±7,363	19.9%	±0.5	143,583	±800	32,207	±2,462	22.4%	±1.7	64,800	±286	1,983	±529	3.1%
Under 5 years	396,215	±1,326	88,155	±2,998	22.2%	±0.8	45,069	±344	9,324	±975	20.7%	±2.2	13,754	±62	501	±244	3.6%
5 to 17 years	1,107,650	±1,842	210,866	±5,411	19.0%	±0.5	98,514	±688	22,883	±1,978	23.2%	±2.0	51,046	±268	1,482	±453	2.9%
Related children of householder under	1,497,576	±2,262	293,219	±7,283	19.6%	±0.5	142,656	±916	31,392	±2,433	22.0%	±1.7	64,712	±297	1,901	±516	2.9%
18 to 64 years	4,095,943	±1,244	550,175	±8,884	13.4%	±0.2	456,901	±1,287	57,288	±2,834	12.5%	±0.6	144,650	±75	6,182	±1,034	4.3%
18 to 34 years	1,474,377	±1,641	243,014	±4,828	16.5%	±0.3	196,795	±1,148	28,327	±1,857	14.4%	±0.9	40,716	±115	2,595	±693	6.4%
35 to 64 years	2,621,566	±1,907	307,161	±6,411	11.7%	±0.2	260,106	±363	28,961	±1,954	11.1%	±0.8	103,934	±141	3,587	±663	3.5%
60 years and over	1,535,896	±4,602	160,632	±3,860	10.5%	±0.2	123,431	±1,195	12,902	±1,002	10.5%	±0.8	46,618	±713	1,848	±399	4.0%
65 years and over	1,093,104	±1,051	106,733	±2,888	9.8%	±0.3	86,193	±305	8,917	±838	10.3%	±1.0	31,905	±183	1,255	±323	3.9%
SEX																	
Male	3,266,324	±2,499	420,717	±7,330	12.9%	±0.2	331,174	±1,150	41,530	±2,347	12.5%	±0.7	118,852	±276	3,770	±643	3.2%
Female	3,426,588	±2,283	535,212	±8,646	15.6%	±0.3	355,503	±815	56,882	±2,649	16.0%	±0.7	122,503	±229	5,650	±962	4.6%
RACE AND HISPANIC OR LATINO ORIGIN																	
White alone	5,086,104	±5,649	603,165	±11,417	11.9%	±0.2	421,315	±3,052	44,350	±2,692	10.5%	±0.6	207,273	±1,168	7,068	±1,175	3.4%
Black or African American alone	1,090,429	±3,516	256,872	±6,832	23.6%	±0.6	181,779	±2,060	39,086	±2,961	21.5%	±1.6	9,598	±497	1,300	±530	13.5%
American Indian and Alaska Native alone	14,096	±1,108	3,277	±657	23.2%	±4.1	1,111	±332	104	±98	9.4%	±8.6	480	±415	0	±31	0.0%
Asian alone	122,774	±1,977	11,574	±1,293	9.4%	±1.0	23,893	±1,202	3,456	±876	14.5%	±3.4	11,879	±565	754	±372	6.3%
Native Hawaiian and Other Pacific Islander	4,018	±927	834	±277	20.8%	±6.8	284	±106	155	±93	54.6%	±23.0	74	±112	74	±112	100.0%
Some other race alone	121,227	±4,111	31,008	±2,675	25.6%	±1.8	24,637	±1,997	5,658	±1,108	23.0%	±4.1	2,454	±816	107	±83	4.4%
Two or more races	254,264	±5,470	49,199	±3,368	19.3%	±1.2	33,658	±2,194	5,603	±1,592	16.6%	±4.3	9,597	±1,043	117	±71	1.2%
Hispanic or Latino origin (of any race)	386,626	±958	89,799	±3,525	23.2%	±0.9	71,519	±581	15,234	±1,641	21.3%	±2.3	12,060	±6	1,025	±529	8.5%
White alone, not Hispanic or Latino	4,895,073	±3,545	559,662	±11,050	11.4%	±0.2	384,034	±1,300	36,051	±2,080	9.4%	±0.5	201,041	±697	6,400	±1,048	3.2%
EDUCATIONAL ATTAINMENT																	
Population 25 years and	4,633,381	±1,612	542,888	±8,772	11.7%	±0.2	487,435	±579	53,796	±2,408	11.0%	±0.5	157,998	±425	5,586	±812	3.5%
Less than high school graduate	505,744	±6,981	139,387	±3,788	27.6%	±0.7	47,588	±2,229	13,510	±1,560	28.4%	±2.9	6,544	±752	963	±309	14.7%
High school graduate (includes	1,452,724	±10,095	216,830	±4,466	14.9%	±0.3	102,544	±2,647	16,078	±1,079	15.7%	±1.1	20,309	±1,187	1,796	±539	8.8%
Some college, associate's degree	1,312,316	±8,888	128,409	±3,579	9.8%	±0.3	118,992	±3,208	12,530	±1,141	10.5%	±0.9	33,092	±1,409	1,170	±284	3.5%
Bachelor's degree or	1,362,597	±11,608	58,262	±2,488	4.3%	±0.2	218,311	±3,697	11,678	±1,283	5.3%	±0.6	98,053	±1,553	1,657	±442	1.7%
EMPLOYMENT STATUS																	
Civilian labor force 16 years and over	3,357,725	±9,166	258,336	±4,341	7.7%	±0.1	407,057	±2,332	32,765	±2,184	8.0%	±0.5	127,211	±1,544	3,338	±834	2.6%
Employed	3,180,664	±9,495	200,638	±3,973	6.3%	±0.1	387,853	±2,566	27,023	±1,987	7.0%	±0.5	124,301	±1,680	2,802	±813	2.3%
Male	1,664,127	±6,015	88,344	±2,617	5.3%	±0.2	198,743	±1,917	11,977	±1,093	6.0%	±0.6	68,115	±995	1,088	±338	1.6%
Female	1,516,537	±6,451	112,294	±2,790	7.4%	±0.2	189,110	±1,927	15,046	±1,284	8.0%	±0.7	56,186	±1,293	1,714	±642	3.1%
Unemployed	177,061	±4,183	57,698	±2,108	32.6%	±0.9	19,204	±1,539	5,742	±921	29.9%	±3.6	2,910	±485	536	±285	18.4%
Male	89,664	±2,899	26,104	±1,465	29.1%	±1.3	9,597	±1,068	2,413	±594	25.1%	±5.3	1,449	±308	184	±110	12.7%
Female	87,397	±2,936	31,594	±1,663	36.1%	±1.4	9,607	±995	3,329	±572	34.7%	±5.2	1,461	±324	352	±229	24.1%
WORK EXPERIENCE																	
Population 16 years and	5,367,274	±2,104	685,185	±9,673	12.8%	±0.2	558,070	±1,459	68,940	±2,976	12.4%	±0.5	185,587	±491	7,727	±1,120	4.2%
Worked full-time, year-round in the	2,355,628	±9,531	66,302	±2,029	2.8%	±0.1	288,062	±3,373	7,738	±826	2.7%	±0.3	90,048	±1,694	730	±219	0.8%
Worked part-time or part-year in the past	1,136,149	±9,166	196,221	±4,182	17.3%	±0.4	132,948	±3,367	26,404	±1,765	19.9%	±1.3	43,957	±1,527	2,707	±751	6.2%
Did not work	1,875,497	±10,450	422,662	±7,844	22.5%	±0.4	137,060	±2,050	34,798	±1,755	25.4%	±1.2	51,582	±1,645	4,290	±651	8.3%
ALL INDIVIDUALS WITH INCOME BELOW THE FOLLOWING POVERTY RATIOS																	
50 percent of poverty	423,669	±9,797	(X)	(X)	(X)	(X)	46,451	±3,061	(X)	(X)	(X)	(X)	4,305	±739	(X)	(X)	(X)
125 percent of poverty	1,269,653	±16,410	(X)	(X)	(X)	(X)	127,390	±4,613	(X)	(X)	(X)	(X)	12,622	±1,506	(X)	(X)	(X)
150 percent of poverty	1,581,425	±18,099	(X)	(X)	(X)	(X)	156,409	±5,066	(X)	(X)	(X)	(X)	16,011	±1,801	(X)	(X)	(X)
185 percent of poverty	2,020,544	±20,142	(X)	(X)	(X)	(X)	195,442	±4,812	(X)	(X)	(X)	(X)	23,446	±2,410	(X)	(X)	(X)
200 percent of poverty	2,219,991	±20,581	(X)	(X)	(X)	(X)	214,321	±4,965	(X)	(X)	(X)	(X)	28,406	±2,802	(X)	(X)	(X)
300 percent of poverty	3,418,409	±20,494	(X)	(X)	(X)	(X)	326,656	±5,283	(X)	(X)	(X)	(X)	52,159	±3,253	(X)	(X)	(X)
400 percent of poverty	4,393,882	±18,680	(X)	(X)	(X)	(X)	423,820	±5,157	(X)	(X)	(X)	(X)	81,232	±3,750	(X)	(X)	(X)
500 percent of poverty	5,088,168	±16,815	(X)	(X)	(X)	(X)	491,612	±4,506	(X)	(X)	(X)	(X)	111,665	±3,732	(X)	(X)	(X)
UNRELATED INDIVIDUALS FOR WHOM POVERTY STATUS IS DETERMINED	1,301,908	±10,552	338,196	±5,416	26.0%	±0.3	200,076	±4,417	38,626	±2,332	19.3%	±1.0	26,163	±1,895	4,303	±831	16.4%
Male	628,330	±6,752	145,863	±3,763	23.2%	±0.5	96,584	±2,650	16,085	±1,367	16.7%	±1.2	11,206	±1,335	1,419	±411	12.7%
Female	673,578	±5,984	192,333	±3,760	28.6%	±0.5	103,492	±2,523	22,541	±1,570	21.8%	±1.4	14,957	±997	2,884	±667	19.3%
15 years	1,901	±459	1,889	±456	99.4%	±1.0	438	±354	426	±352	97.3%	±5.8	13	±24	13	±24	100.0%
16 to 17 years	3,798	±549	3,635	±541	95.7%	±2.3	384	±155	344	±146	89.6%	±10.7	69	±66	69	±66	100.0%
18 to 24 years	143,861	±2,982	64,954	±2,346	45.2%	±1.4	21,857	±1,114	8,692	±997	39.8%	±3.9	3,162	±735	1,235	±540	39.1%
25 to 34 years	259,746	±4,270	50,028	±1,930	19.3%	±0.7	66,556	±2,400	8,316	±1,062	12.5%	±1.5	4,698	±662	338	±191	7.2%
35 to 44 years	150,243	±4,115	34,698	±1,850	23.1%	±1.0	26,044	±1,466	3,743	±528	14.4%	±2.0	3,259	±541	422	±193	12.9%
45 to 54 years	176,185	±3,635	46,163	±1,976	26.2%	±0.9	24,963	±1,356	4,411	±713	17.7%	±2.5	3,220	±532	617	±284	19.2%
55 to 64 years	222,802	±4,113	66,949	±2,542	30.0%	±1.0	26,067	±1,100	6,038	±687	23.2%	±2.5	3,977	±535	694	±223	17.5%
65 to 74 years	189,378	±3,418	38,346	±1,535	20.2%	±0.8	20,650	±1,082	4,010	±667	19.4%	±2.9	4,075	±627	258	±136	6.3%
75 years and over	153,994	±2,459	31,534	±1,321	20.5%	±0.8	13,117	±772	2,646	±523	20.2%	±3.6	3,690	±446	657	±251	17.8%
Mean income deficit for unrelated individuals (dollars)	7,288	±77	(X)	(X)	(X)	(X)	7,549	±269	(X)	(X)	(X)	(X)	8,180	±775	(X)	(X)	(X)
Worked full-time, year-round in the past 12 months	561,733	±7,398	21,801	±1,406	3.9%	±0.2	112,230	±3,637	2,540	±515	2.3%	±0.5	12,838	±1,303	290	±159	2.3%
Worked less than full-time, year-round in the past 12	259,260	±4,548	97,995	±3,055	37.8%	±1.0	44,602	±2,212	15,447	±1,481	34.6%	±2.8	5,082	±834	1,485	±623	29.2%
Did not work	480,915	±6,030	218,400	±4,566	45.4%	±0.7	43,244	±1,672	20,639	±1,379	47.7%	±2.3	8,243	±867	2,528	±524	30.7%
Population in housing units for whom poverty status is determined	6,679,518	±2,087	946,670	±14,387	14.2%	±0.2	684,370	±1,610	96,710	±4,398	14.1%	±0.6	241,316	±286	9,391	±1,410	3.9%

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		ZCTA5 37013						ZCTA5 37027						ZCTA5 37135			
	erty level	Total		Below poverty level		Percent below poverty level		Total		Below poverty level		Percent below poverty level		Total		Below poverty level	
Label	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Population for whom poverty status is determined	±0.6	101,455	±4,752	17,317	±2,270	17.1%	±2.2	60,439	±1,528	2,156	±621	3.6%	±1.0	21,126	±1,613	161	±132
AGE																	
Under 18 years	±0.8	28,855	±2,216	7,273	±1,335	25.2%	±4.3	15,074	±876	422	±224	2.8%	±1.5	6,247	±739	20	±33
Under 5 years	±1.8	8,709	±1,019	2,044	±562	23.5%	±6.1	2,493	±455	115	±94	4.6%	±4.0	1,490	±368	0	±25
5 to 17 years	±0.9	20,146	±1,711	5,229	±1,115	26.0%	±5.1	12,581	±850	307	±201	2.4%	±1.6	4,757	±738	20	±33
Related children of householder under	±0.8	28,754	±2,221	7,221	±1,339	25.1%	±4.3	15,040	±872	394	±222	2.6%	±1.5	6,227	±739	0	±25
18 to 64 years	±0.7	65,862	±3,072	9,255	±1,295	14.1%	±1.9	36,111	±1,462	1,398	±499	3.9%	±1.3	13,165	±1,339	102	±112
18 to 34 years	±1.7	28,064	±1,850	4,075	±833	14.5%	±2.9	9,955	±895	767	±419	7.7%	±4.0	3,628	±727	73	±100
35 to 64 years	±0.6	37,798	±2,062	5,180	±980	13.7%	±2.5	26,156	±1,049	631	±275	2.4%	±1.0	9,537	±956	29	±49
60 years and over	±0.9	11,287	±883	1,246	±325	11.0%	±2.8	13,483	±997	385	±136	2.9%	±1.0	2,555	±527	68	±82
65 years and over	±1.0	6,738	±612	789	±257	11.7%	±3.6	9,254	±757	336	±129	3.6%	±1.4	1,714	±436	39	±65
SEX																	
Male	±0.5	49,913	±3,075	7,605	±1,269	15.2%	±2.5	30,133	±965	875	±276	2.9%	±0.9	10,408	±836	47	±58
Female	±0.8	51,542	±2,447	9,712	±1,292	18.8%	±2.4	30,306	±1,245	1,281	±465	4.2%	±1.5	10,718	±1,018	114	±111
RACE AND HISPANIC OR LATINO ORIGIN																	
White alone	±0.6	47,493	±3,668	8,125	±1,678	17.1%	±3.2	51,599	±1,603	1,696	±567	3.3%	±1.1	17,607	±1,773	161	±132
Black or African American alone	±5.4	36,507	±3,066	4,943	±1,117	13.5%	±3.1	2,383	±782	312	±214	13.1%	±7.4	1,518	±563	0	±25
American Indian and Alaska Native alone	±8.0	376	±252	0	±31	0.0%	±10.1	50	±70	0	±31	0.0%	±46.5	0	±25	0	±25
Asian alone	±3.1	5,076	±996	1,159	±649	22.8%	±10.6	4,244	±651	93	±110	2.2%	±2.7	900	±389	0	±25
Native Hawaiian and Other Pacific Islander	±38.2	0	±31	0	±31	-	**	0	±31	0	±31	-	**	0	±25	0	±25
Some other race alone	±3.7	5,410	±1,527	1,482	±677	27.4%	±10.6	315	±162	24	±28	7.6%	±9.3	282	±297	0	±25
Two or more races	±0.7	6,593	±1,426	1,608	±1,052	24.4%	±12.9	1,848	±531	31	±38	1.7%	±2.1	819	±314	0	±25
Hispanic or Latino origin (of any race)	±4.4	17,506	±1,886	5,159	±1,290	29.5%	±6.5	2,191	±555	49	±53	2.2%	±2.3	1,040	±399	15	±28
White alone, not Hispanic or Latino	±0.5	37,378	±3,013	4,877	±1,079	13.0%	±2.6	50,285	±1,651	1,660	±556	3.3%	±1.1	17,013	±1,766	146	±129
EDUCATIONAL ATTAINMENT																	
Population 25 years and	±0.5	63,306	±2,652	8,578	±1,125	13.6%	±1.7	40,671	±1,532	1,435	±497	3.5%	±1.2	13,014	±1,057	68	±82
Less than high school graduate	±4.4	8,555	±968	2,488	±692	29.1%	±7.1	688	±221	64	±66	9.3%	±9.0	372	±163	0	±25
High school graduate (includes	±2.5	16,964	±1,550	2,534	±530	14.9%	±3.0	3,217	±491	230	±121	7.1%	±3.7	1,555	±346	29	±49
Some college, associate's degree	±0.9	18,893	±1,789	2,182	±536	11.5%	±2.9	6,280	±729	203	±95	3.2%	±1.5	2,293	±487	39	±65
Bachelor's degree or	±0.5	18,894	±1,410	1,374	±534	7.3%	±2.7	30,486	±1,252	938	±437	3.1%	±1.4	8,794	±1,064	0	±25
EMPLOYMENT STATUS																	
Civilian labor force 16 years and over	±0.7	56,758	±2,837	5,604	±813	9.9%	±1.5	33,023	±1,445	1,057	±427	3.2%	±1.3	11,658	±1,259	15	±28
Employed	±0.6	53,173	±2,753	4,569	±724	8.6%	±1.4	32,377	±1,469	1,012	±429	3.1%	±1.3	11,228	±1,092	15	±28
Male	±0.5	28,902	±2,007	2,279	±418	7.9%	±1.5	17,430	±966	449	±180	2.6%	±1.0	6,039	±609	0	±25
Female	±1.1	24,271	±1,343	2,290	±555	9.4%	±2.2	14,947	±1,053	563	±363	3.8%	±2.3	5,189	±657	15	±28
Unemployed	±8.6	3,585	±861	1,035	±374	28.9%	±9.0	646	±165	45	±26	7.0%	±4.4	430	±334	0	±25
Male	±7.3	1,976	±602	562	±377	28.4%	±15.7	333	±107	39	±25	11.7%	±8.1	293	±311	0	±25
Female	±13.6	1,609	±512	473	±197	29.4%	±11.9	313	±121	6	±9	1.9%	±2.8	137	±161	0	±25
WORK EXPERIENCE																	
Population 16 years and	±0.6	75,576	±3,458	10,650	±1,375	14.1%	±1.8	48,578	±1,620	1,836	±518	3.8%	±1.0	15,626	±1,450	161	±132
Worked full-time, year-round in the	±0.2	39,657	±2,341	1,694	±442	4.3%	±1.1	22,438	±1,015	282	±128	1.3%	±0.6	8,432	±980	0	±25
Worked part-time or part-year in the past	±1.7	18,609	±1,539	4,272	±726	23.0%	±3.5	12,694	±1,024	815	±375	6.4%	±2.8	3,586	±746	15	±28
Did not work	±1.3	17,310	±1,226	4,684	±836	27.1%	±4.3	13,446	±730	739	±192	5.5%	±1.4	3,608	±608	146	±129
ALL INDIVIDUALS WITH INCOME BELOW THE FOLLOWING POVERTY RATIOS																	
50 percent of poverty	(X)	6,185	±1,434	(X)	(X)	(X)	(X)	1,189	±433	(X)	(X)	(X)	(X)	161	±132	(X)	(X)
125 percent of poverty	(X)	23,467	±2,408	(X)	(X)	(X)	(X)	2,554	±617	(X)	(X)	(X)	(X)	753	±742	(X)	(X)
150 percent of poverty	(X)	29,299	±3,113	(X)	(X)	(X)	(X)	2,989	±666	(X)	(X)	(X)	(X)	940	±753	(X)	(X)
185 percent of poverty	(X)	37,180	±3,484	(X)	(X)	(X)	(X)	3,875	±746	(X)	(X)	(X)	(X)	1,413	±830	(X)	(X)
200 percent of poverty	(X)	40,296	±3,581	(X)	(X)	(X)	(X)	4,113	±771	(X)	(X)	(X)	(X)	1,557	±846	(X)	(X)
300 percent of poverty	(X)	59,732	±4,034	(X)	(X)	(X)	(X)	9,133	±1,155	(X)	(X)	(X)	(X)	3,737	±1,133	(X)	(X)
400 percent of poverty	(X)	75,253	±4,409	(X)	(X)	(X)	(X)	14,891	±1,510	(X)	(X)	(X)	(X)	6,940	±1,615	(X)	(X)
500 percent of poverty	(X)	85,654	±4,198	(X)	(X)	(X)	(X)	22,013	±1,672	(X)	(X)	(X)	(X)	10,018	±1,731	(X)	(X)
UNRELATED INDIVIDUALS FOR WHOM POVERTY STATUS IS DETERMINED	±2.7	19,758	±1,487	3,272	±615	16.6%	±2.8	7,540	±975	1,160	±420	15.4%	±4.5	1,135	±429	122	±118
Male	±3.0	10,731	±1,272	1,557	±512	14.5%	±4.2	2,818	±569	404	±186	14.3%	±6.5	363	±174	29	±49
Female	±4.0	9,027	±946	1,715	±383	19.0%	±3.5	4,722	±870	756	±375	16.0%	±6.0	772	±393	93	±107
15 years	±91.2	0	±31	0	±31	-	**	0	±31	0	±31	-	**	0	±25	0	±25
16 to 17 years	±39.6	52	±57	52	±57	100.0%	±45.6	28	±41	28	±41	100.0%	±62.2	20	±33	20	±33
18 to 24 years	±13.9	2,534	±469	742	±327	29.3%	±11.2	800	±286	291	±163	36.4%	±19.5	103	±108	73	±100
25 to 34 years	±4.0	6,508	±980	937	±392	14.4%	±5.3	1,986	±495	321	±373	16.2%	±16.1	177	±123	0	±25
35 to 44 years	±5.8	3,202	±605	441	±228	13.8%	±6.8	883	±267	221	±161	25.0%	±17.2	171	±105	0	±25
45 to 54 years	±7.8	3,013	±523	283	±146	9.4%	±5.0	1,038	±413	54	±67	5.2%	±6.5	54	±45	0	±25
55 to 64 years	±4.9	2,400	±390	503	±189	21.0%	±6.6	867	±269	5	±7	0.6%	±0.8	190	±119	29	±49
65 to 74 years	±3.4	1,462	±256	269	±133	18.4%	±8.0	1,164	±472	97	±69	8.3%	±6.2	357	±337	0	±25
75 years and over	±6.3	587	±163	45	±41	7.7%	±7.4	774	±143	143	±72	18.5%	±8.7	63	±59	0	±25
Mean income deficit for unrelated individuals (dollars)	(X)	7,839	±1,007	(X)	(X)	(X)	(X)	8,236	±1,009	(X)	(X)	(X)	(X)	N	N	(X)	(X)
Worked full-time, year-round in the past 12 months	±1.2	12,303	±1,147	257	±141	2.1%	±1.2	4,018	±640	125	±82	3.1%	±2.0	470	±184	0	±25
Worked less than full-time, year-round in the past 12	±9.2	4,199	±726	1,546	±550	36.8%	±9.8	1,843	±475	674	±365	36.6%	±14.6	227	±147	15	±28
Did not work	±5.1	3,256	±568	1,469	±376	45.1%	±8.4	1,679	±288	361	±134	21.5%	±7.2	438	±349	107	±113
Population in housing units for whom poverty status is determined	±0.6	101,352	±4,759	17,237	±2,268	17.0%	±2.2	60,423	±1,528	2,140	±622	3.5%	±1.0	21,126	±1,613	161	±132

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			ZCTA5 37211					
	Percent below poverty level		Total		Below poverty level		Percent below poverty level	
Label	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error	Estimate	Margin of Error
Population for whom poverty status is determined	0.8%	±0.6	72,721	±2,989	11,329	±1,665	15.6%	±2.2
AGE								
Under 18 years	0.3%	±0.5	15,958	±1,343	3,424	±799	21.5%	±4.7
Under 5 years	0.0%	±2.6	5,866	±869	950	±295	16.2%	±5.3
5 to 17 years	0.4%	±0.7	10,092	±1,081	2,474	±717	24.5%	±6.0
Related children of householder under	0.0%	±0.6	15,901	±1,347	3,367	±784	21.2%	±4.6
18 to 64 years	0.8%	±0.8	48,823	±2,220	6,760	±1,049	13.8%	±2.0
18 to 34 years	2.0%	±2.8	23,372	±1,913	4,029	±782	17.2%	±3.0
35 to 64 years	0.3%	±0.5	25,451	±1,308	2,731	±543	10.7%	±2.1
60 years and over	2.7%	±3.1	11,534	±827	1,369	±375	11.9%	±3.0
65 years and over	2.3%	±3.7	7,940	±639	1,145	±348	14.4%	±4.0
SEX								
Male	0.5%	±0.6	35,990	±1,757	5,058	±861	14.1%	±2.3
Female	1.1%	±1.1	36,731	±1,840	6,271	±1,028	17.1%	±2.6
RACE AND HISPANIC OR LATINO ORIGIN								
White alone	0.9%	±0.8	46,486	±2,477	6,748	±1,124	14.5%	±2.2
Black or African American alone	0.0%	±2.6	11,847	±1,414	1,747	±572	14.7%	±4.7
American Indian and Alaska Native alone	-	**	144	±101	31	±55	21.5%	±30.8
Asian alone	0.0%	±4.3	4,468	±764	733	±347	16.4%	±7.4
Native Hawaiian and Other Pacific Islander	-	**	86	±92	80	±93	93.0%	±15.5
Some other race alone	0.0%	±13.2	5,166	±1,133	811	±429	15.7%	±7.1
Two or more races	0.0%	±4.8	4,524	±1,215	1,179	±960	26.1%	±16.9
Hispanic or Latino origin (of any race)	1.4%	±2.8	15,322	±1,615	2,970	±804	19.4%	±5.0
White alone, not Hispanic or Latino	0.9%	±0.8	38,446	±2,199	4,924	±997	12.8%	±2.4
EDUCATIONAL ATTAINMENT								
Population 25 years and	0.5%	±0.6	50,323	±2,012	5,872	±776	11.7%	±1.5
Less than high school graduate	0.0%	±10.2	7,869	±976	1,804	±472	22.9%	±5.3
High school graduate (includes	1.9%	±3.1	10,910	±1,279	1,448	±292	13.3%	±2.7
Some college, associate's degree	1.7%	±2.8	11,320	±941	1,526	±482	13.5%	±3.9
Bachelor's degree or	0.0%	±0.5	20,224	±1,454	1,094	±308	5.4%	±1.5
EMPLOYMENT STATUS								
Civilian labor force 16 years and over	0.1%	±0.2	43,381	±2,093	4,047	±892	9.3%	±2.0
Employed	0.1%	±0.3	41,005	±1,942	3,296	±604	8.0%	±1.5
Male	0.0%	±0.7	22,623	±1,228	1,493	±295	6.6%	±1.3
Female	0.3%	±0.6	18,382	±1,204	1,803	±447	9.8%	±2.4
Unemployed	0.0%	±8.9	2,376	±614	751	±368	31.6%	±11.8
Male	0.0%	±12.7	1,257	±417	342	±195	27.2%	±12.3
Female	0.0%	±24.9	1,119	±462	409	±256	36.6%	±19.9
WORK EXPERIENCE								
Population 16 years and	1.0%	±0.8	58,297	±2,334	8,434	±1,226	14.5%	±2.0
Worked full-time, year-round in the	0.0%	±0.5	31,167	±1,719	1,449	±405	4.6%	±1.3
Worked part-time or part-year in the past	0.4%	±0.8	13,468	±1,128	2,782	±512	20.7%	±3.5
Did not work	4.0%	±3.4	13,662	±1,077	4,203	±813	30.8%	±4.7
ALL INDIVIDUALS WITH INCOME BELOW THE FOLLOWING POVERTY RATIOS								
50 percent of poverty	(X)	(X)	5,430	±1,226	(X)	(X)	(X)	(X)
125 percent of poverty	(X)	(X)	16,176	±1,662	(X)	(X)	(X)	(X)
150 percent of poverty	(X)	(X)	20,333	±2,180	(X)	(X)	(X)	(X)
185 percent of poverty	(X)	(X)	25,032	±2,807	(X)	(X)	(X)	(X)
200 percent of poverty	(X)	(X)	27,228	±2,877	(X)	(X)	(X)	(X)
300 percent of poverty	(X)	(X)	39,345	±2,745	(X)	(X)	(X)	(X)
400 percent of poverty	(X)	(X)	49,571	±2,793	(X)	(X)	(X)	(X)
500 percent of poverty	(X)	(X)	56,476	±3,106	(X)	(X)	(X)	(X)
UNRELATED INDIVIDUALS FOR WHOM POVERTY STATUS IS DETERMINED	10.7%	±10.4	21,017	±1,434	4,366	±815	20.8%	±3.3
Male	8.0%	±14.0	10,923	±1,041	1,874	±491	17.2%	±3.8
Female	12.0%	±14.2	10,094	±1,018	2,492	±601	24.7%	±5.2
15 years	-	**	0	±31	0	±31	-	**
16 to 17 years	100.0%	±73.6	24	±27	24	±27	100.0%	±67.2
18 to 24 years	70.9%	±50.8	2,739	±607	1,296	±514	47.3%	±11.8
25 to 34 years	0.0%	±20.1	7,525	±947	928	±349	12.3%	±4.1
35 to 44 years	0.0%	±20.7	2,792	±449	404	±182	14.5%	±6.0
45 to 54 years	0.0%	±44.8	2,341	±492	364	±154	15.5%	±6.1
55 to 64 years	15.3%	±23.5	2,241	±415	380	±150	17.0%	±6.4
65 to 74 years	0.0%	±10.6	2,350	±450	654	±271	27.8%	±9.9
75 years and over	0.0%	±41.5	1,005	±298	316	±243	31.4%	±17.6
Mean income deficit for unrelated individuals (dollars)	(X)	(X)	7,419	±865	(X)	(X)	(X)	(X)
Worked full-time, year-round in the past 12 months	0.0%	±8.2	12,010	±1,006	544	±291	4.5%	±2.3
Worked less than full-time, year-round in the past 12	6.6%	±12.8	4,894	±697	1,663	±404	34.0%	±6.8
Did not work	24.4%	±30.4	4,113	±637	2,159	±500	52.5%	±7.2
Population in housing units for whom poverty status is determined	0.8%	±0.6	72,588	±2,991	11,219	±1,663	15.5%	±2.2

Attachment 4N-1

Financial Assistance Policies

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 1 of 13	**REPLACES POLICY DATED:** 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	**EFFECTIVE DATE:** 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	**REFERENCE NUMBER:** PARA.PP.OPS.015

SCOPE:
All Self-Pay patient accounts, excluding elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients will be given an Uninsured Discount.

The following also qualify for the Uninsured Discount::

- Accounts where insurance benefits have been exhausted or terminated
- Medicare outpatient self-administered drugs

NOTE: If a Parallon Client chooses to participate in the uninsured discount process and the processes are different a client specific policy should be developed using this policy as the guideline and making changes as applicable. Use the reference number identifying the client as defined in the Policy and Procedure Development policy PARA.PP.GEN.001.

PURPOSE:
To define the process for selecting the appropriate Self-Pay IPLAN, providing patients with information regarding available discounts and processing discounts for patients assigned one of the Uninsured Discount IPLANS.

POLICY:
All Self-Pay patient accounts will receive an uninsured discount, with the exception of elective cosmetic procedures; facility designated self-pay flat rate procedures, scheduled/discounted procedures for International patients and accounts meeting the charity guidelines. Uninsured discounts will also be applied to accounts where insurance benefits have been exhausted or terminated. Medicare outpatient self-administered drugs will also receive the uninsured discount. Accounts will be assigned one of the following Uninsured Discount IPLANS.

IPLAN	IPLAN Description	LOG ID	IP Proc Code	OP Proc Code
099-40	Uninsured Discount Plan	UINS	920970	920980
099-41	Uninsured Discount Plan – Burn Unit	UINB	920971	920981
099-42	Uninsured Discount Plan – Transplant	UINT	920972	920982
099-44	Uninsured State Specific	(local)	(local)	(local)
099-45	Uninsured ESP – Left or Ref	(local)	(local)	(local)

099-46	Uninsured ESP - Treated	(local)	(local)	(local)
099-47	Uninsured Discount Plan – Patient Non-Compliance	UINS	920970	920980
099-49	Uninsured – Partially Exhausted Benefits	N/A	(local)	(local)
N/A	Uninsured – Medicare Self-Administered Drugs	N/A	N/A	957983

The discount amounts will be provided to each facility in a formal rate schedule document. The patient will receive the Uninsured Discount unless the patient qualifies for a Charity Discount as outlined in the existing Charity Financial Assistance Policy for Uninsured and Underinsured Patients (PARA.PP.OPS.016).

Refer to Uninsured Discount FAQ for more information.

Patient Notification at the time of Registration:
If it is determined the patient is uninsured at the time of registration, the patient/responsible party will be presented with an Uninsured Patient Information document (PARA.FT.OPS.015) that provides information on the Uninsured Discount Policy and other available discounts and payment options. This document will outline the process for uninsured discounts and inform the patient of additional account resolution options (i.e. monthly payments). The patient/responsible party will be asked to sign and date the document. The document will then be scanned into the imaging system and be placed in the imaging Patient Folder document type, as a validation that information regarding discounts has been communicated to all uninsured patients.

Patient Access Responsibilities at the Time of Registration:
Patient Access will be responsible for determining the appropriate IPLAN assignment from the table above and for presenting the Uninsured Patient Information Document (PARA.FT.OPS.015) to the patient/responsible party. Patient Access will explain the process as documented, answering questions related to the document and obtaining a signature from the patient/responsible party documenting that the information regarding available discounts was provided.

All requests for payment will be based on total estimated charges less the uninsured discount.

Patient Access will be responsible for requesting from the patient/responsible party the expected patient liability amount by using a facility specific deposit schedule which has been updated to reflect the Uninsured Discount.

Patient Access will be responsible for asking the patient/responsible party for payment in full or monthly payment arrangements on the patient liability amount.

Inpatient and Outpatient self-pay patients who are able to make payment in full or monthly payment arrangements.

- Assign the appropriate Uninsured Discount IPLAN
- The Uninsured Discount IPLAN should reflect proration of 100% of the total charges for the patient
- A facility/SSC specific prompt pay discount may be applied in addition to the Uninsured Discount as set forth in the PARA.PP.SS.035 Discount Policy for Patients

Inpatient self-pay patients who are not able to make payment in full or monthly payment arrangements and Outpatient self-pay patients will be considered for Medicaid eligibility.

- Assign the facility designated Pending Medicaid IPLAN as the primary payer
    - The Pending Medicaid IPLAN should reflect proration of 100% of the total charges for the patient
- Assign the Pending Charity IPLAN (099-50) as the secondary payer
    - Present the patient with a Financial Assistance Application for Charity consideration; (Note: Patients who are elective will not qualify for Charity, so the Pending Charity I-plan does not need to be added)
- Assign the appropriate Uninsured Discount IPLAN as the tertiary payer

Outpatient self-pay patients who are not able to make payment in full or monthly payment arrangements and do not meet the Medicaid eligibility threshold.

- Assign the Pending Charity IPLAN (099-50) as the primary payer
    - The Pending Charity IPLAN should reflect proration of 100% of the total charges for the patient
    - Present the patient with a Financial Assistance Application for Charity consideration; (Note: Patients who are elective will not qualify for Charity, so the Pending Charity I-plan does not need to be added)
- Assign the appropriate Uninsured Discount IPLAN as the secondary payer

All Inpatient and Outpatient self-pay patients registered for elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients.

- Assign the facility/SSC designated IPLAN for the discounted/flat rate procedure

Emergency Department self-pay patients who opt out to an ESP process will be assigned an Uninsured ESP IPLAN.

- Assign the Uninsured ESP –Left or Referred IPLAN (099-45) as the primary payer if the patient elects to Leave or be Referred during the ESP process
- Assign the Uninsured ESP – Treated IPLAN (099-46) as the primary payer if the patient receives treatment via the ESP process

The default of Self-Pay IPLAN 000-00, due to the absence of an IPLAN, should be avoided once this policy is implemented. All accounts that are not assigned an IPLAN and systematically assigned Self-Pay 000-00 should be reviewed and moved to the appropriate IPLAN. All accounts excluding Client/Industrial accounts must be registered with an appropriate IPLAN for the third party payer, Medicaid Pending, Charity Pending, elective cosmetic/facility designated flat rate plan or an Uninsured Discount Plan. A Business Objects script has been developed to assist in identifying accounts without an IPLAN assignment.

Financial Counselor/ CSO/Collector Responsibilities:
If at any time it is determined that the patient is covered for these services by a health plan, the Uninsured Discount IPLAN should be removed and the Uninsured Discount reversed. The Uninsured Discount is limited to patients who have no third party payer source of payment. The IPLAN assignment of the third party payer should be assigned to the account in place of the Uninsured Discount IPLAN.

Retroactive consideration for Medicaid eligibility or Charity Discount:
Uninsured Discount Plan patients that retroactively are considered for Medicaid eligibility or Charity discounts will have the appropriate Pending Medicaid eligibility and Pending Charity IPLANS assigned as outlined in the Patient Access process above. The Uninsured Discount will be reversed until determination of Medicaid eligibility and Charity can be ruled out.

Insurance Denials for Partially Exhausted Benefits:
Accounts where a denial is applied due to partially exhausted benefits, the Uninsured – Partially Exhausted Benefits IPLAN (099-49) should be applied to the secondary position, after the payer with

partially exhausted benefits. A manual p-line must be performed to adjust the exhausted benefit portion of the account by the facility Uninsured Discount percentage.

Guidelines to determine if an uninsured discount qualifies based on Partially Exhausted Benefits (All three guidelines must be met):

- The remit indicates a Final Denial, or verbiage used on the remit such as “Exhausted Benefits” or “Maximum Coverage Exceeded” and
- The patient was considered for Charity for the remaining balance and not approved and
- Days being considered for the uninsured discount were not covered by insurer; Also, no insurance payment or contractual adjustment was received or posted for a portion of the day’s charges

Medicare Outpatient Accounts containing Self-administered Drugs:
Self-administered drugs (SADs) provided to Medicare outpatients are considered a non-covered service by Medicare. SADs will not be tracked using an IPLAN. Charges for SADs will be uniformly discounted 100% for all HCA facilities. Non-HCA will be discounted based on facility Uninsured Discount percentage. A manual p-line using procedure code 957983 must be performed to adjust the SAD portion of the account. Click here for more information.

Insurance Denials for no coverage including pre-existing:
Accounts where the insurance remits a denial of coverage including pre-existing conditions and there are no other insurance coverage’s on file will be considered self-pay accounts. The IPLAN for the insurance denial should be removed and the Pending Medicaid IPLAN added as primary (if the account meets local screening guidelines), Pending Charity IPLAN assigned as secondary and the Uninsured Discount IPLAN assigned as tertiary. A Financial Assistance Application will need to be forwarded to the patient/responsible party.

Patient Statements:
Statements should not be sent out until the uninsured discount has been posted. Letters to a Self-Pay patient/responsible party should not include the account balance until the Uninsured Discount has been posted. If you use letters in your Medicaid Pending or Charity Pending process, you will need to remove the account balance reflected on them.

Late Charges:
Accounts with the Uninsured Discount IPLAN as the primary payer should not have late charges posted. If late credits are posted to the account, the Uninsured Discount should be recalculated to

reflect the correct patient liability. The Bill Code master file on Patient Accounting should be modified to reflect no posting of late charges. Late charges after the Late Charge Days have elapsed should be NPST (not posted) from the Late Charge Report.

State Specific requirements

Each SSC should evaluate whether this policy complies with the applicable State regulations regarding Uninsured Discounts, and if it does not, clearly document exceptions to this policy in either a State specific policy or an addendum to this policy.

HCA Trauma Facilities

After all efforts to identify funding for Uninsured patients have been exhausted, the trauma activation charge will be discounted at 100% and then the standard uninsured discount will be applied to the remainder of the account. The discount will be applied automatically when the uninsured IPLAN is applied.

PROCEDURE:

Responsible Party	Action
Self-Pay – Inpatient and Outpatient (able to pay)	
Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. Determines the patient can make payment or establish arrangements for payment. Assigns the Uninsured IPLAN as the primary payer. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Calculates deposit from facility deposit schedule. Collects deposit and documents account.

Self-Pay – Inpatient (unable to pay)

Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. Determines the patient cannot make payment or establish arrangements for payment. Assigns the Medicaid Pending IPLAN as the primary payer. Assigns the Charity Pending IPLAN as the secondary payer. Assigns the Charity Pending IPLAN as the secondary payer. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Presents the Financial Assistance Application to the patient or responsible party. Documents account.

Self-Pay – Inpatient and Outpatients for an Elective Cosmetic Procedure, Facility Flat Rate or a scheduled/discounted International Patients

Patient Access	Assigns the facility/SSC designated IPLAN for the elective cosmetic procedure, facility flat rate procedure or scheduled/discounted International Patient procedure. Collects payment for elective cosmetic or facility flat rate procedure. Documents account.

Self-Pay – Non Inpatient (unable to pay and for services that exceed the facility Medicaid Eligibility threshold)

Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. Determines the patient cannot make payment or arrangements for payment.

	Determines the charges will be over the Medicaid eligibility threshold. Assigns the Medicaid Pending IPLAN as the primary payer. Assigns the Charity Pending IPLAN as the secondary payer. Assigns the Uninsured Discount IPLAN as the tertiary payer. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Presents the Financial Assistance Application to the patient or responsible party. Documents account.
Self-Pay – Non Inpatient (unable to pay and charges for services that may not exceed Medicaid eligibility threshold)	
Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. Determines the patient cannot make payment or arrangements for payment. Determines the complete charges for services cannot be made at time of registration or Determines the charges will not be over the Medicaid eligibility threshold. Assigns the Charity Pending IPLAN as the primary payer. Assigns the Uninsured Discount IPLAN as the secondary payer.

	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Presents the Financial Assistance Application to the patient or responsible party. Documents account.
Self-Pay – Emergency Department Registrations	
Patient Access	EMTALA guidelines must be adhered to for all ED patients. Assign the Charity Pending IPLAN as the primary payer. Assign the Uninsured Discount IPLAN as the secondary payer. Documents account accordingly.
Self-Pay – Emergency Department Departures (able to pay)	
Patient Access	Determines the patient can make payment or arrangements for payment. Removes the Charity Pending IPLAN (if assigned at time of registration) Assigns the Uninsured IPLAN as the primary payer. If the patient opts out for the ESP process, assign the appropriate ESP IPLAN. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Calculates deposit from facility deposit schedule. Collects deposit and documents account.
Self-Pay – Emergency Department Departures (unable to pay)	

Patient Access	Determines the patient cannot make payment or arrangements for payment.
	Ensures the Charity Pending IPLAN is the primary payer
	Ensures the Uninsured IPLAN is the secondary payer.
	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.
	Documents account.
Monitoring Inpatient and Outpatient Uninsured Discounts	
Operations Support	Reviews Self-Pay accounts with the Uninsured Discount Plan as the primary payer for appropriate posted discount.
	Notifies Payment Compliance of accounts with Uninsured Discount Plan as the primary payer that are final billed and do not reflect an Uninsured Discount.
	Ensures that all Statements are held until the Uninsured Discount is posted for patients who have the Uninsured Discount Plan as the primary payer.
	Ensures that all Letters to a Self-Pay patient/responsible party do not include the account balance until the Uninsured Discount has been posted
Self-Pay - Medicaid Eligibility Denied	
Operations Support staff	Determines the patient IS NOT eligible for Medicaid Coverage.

Deletes the Medicaid Pending IPLAN and the system will automatically move the Charity Discount IPLAN to the primary position and the Uninsured Discount IPLAN to the secondary position.

Considers the patient for a Charity Discount based on PARA.PP.OPS.016 Discount Charity Policy for Patients.

Self-Pay – Charity Discount Denied

Operations Support Staff — Determines the patient IS NOT eligible for a Charity Discount

Deletes the Charity Pending IPLAN and the system will automatically move the Uninsured Discount Plan to the primary position

Non-Concuity facilities processes an IZ transaction to ensure that the Uninsured Discount IPLAN Log ID performs discount calculation

Insurance Denials – No Coverage or Pre-existing

Collections and/or CSO — Third Party payer denies coverage due to no coverage or pre-existing.

Remove Third Party IPLAN from account.
Add Pending Medicaid as primary payer and Charity Pending 099-50 as secondary payer.
Send Financial Assistance Application to patient/RP

Insurance Denials – Partially Exhausted Benefits

Collections and/or CSO	Third Party Payer denies for partially exhausted benefits. Adds the Uninsured – Partially Exhausted Benefits IPLAN (099-49) into the secondary position following the partially exhausted benefits payer IPLAN. Processes a manual p-line for the facility approved Uninsured Discount on the portion of the account partially denied due to exhausted benefits and re-prorates to patient liability.
Medicare - Self-administered Drugs	
MSC Process	Will identify billed claims from the billing database that require a SADs uninsured discount. Charges for SADs will be uniformly discounted 100% for all HCA facilities. Non-HCA will be discounted based on facility Uninsured Discount percentage. A p-line using procedure code 957983 will be entered in eTran. The p-line follows the standard approval process defined in eTran. Once the uninsured discount is posted to the account; the accounts follow the normal MSC collection process. Click here for more information. **NOTE: Encounters reaching a zero balance will be moved to zero balance status and will not require an uninsured discount.**

REFERENCE:

PARA.FT.OPS.015 Uninsured Patient Information Document
Facility Specific Uninsured Discount Plan Deposit Schedule
Facility Specific Cosmetic Procedure Plan Policy and Procedure
PARA.PP.SS.035 Discount Policy for Patient
PARA.PP.OPS.016 Discount Charity Policy for Patients
PARA.PP.GEN.001 Policy and Procedure Development
PARA.PP.COLL.053 Non-Compliant COB Policy
Self-Administered Drug Discount effective 04/01/2016

Self-Administered Drugs 04012016.doc

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 13 of 13	**REPLACES POLICY DATED:** 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	**EFFECTIVE DATE:** 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	**REFERENCE NUMBER:** PARA.PP.OPS.015

QHP- denial code 8X addendum

QHP denial code 8X
specific to collectior

Uninsured Discount FAQ 04/01/2016

Uninsured Discount
Plan FAQ 04012016.c

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 1 of 6	**REPLACES POLICY DATED:** 11/01/2017
APPROVED: 09/29/2020	**EFFECTIVE DATE:** 10/1/2020
ANNUAL REVIEW DATE: 09/29/2020	**REFERENCE NUMBER:** PARA.PP.OPS.016

SCOPE:

All SSC and Facility areas responsible for requesting and evaluating Financial Assistance Applications ("FAA") for the purposes of processing a charity write-off for certain patients receiving services at HCA-affiliated, non-partnership, acute-care hospitals ("Hospitals").

PURPOSE:

To define the policy for providing partial or full financial relief to patients who (i) have received emergency services, (ii) meet certain income requirements, (iii) do not qualify for state or federal assistance for the date of service, (iv) are uninsured or underinsured, and (v) are unable to make partial or full payment on outstanding balances. In addition, with respect to the FAA and income validation, to establish protocols and supporting documentation requirements.

POLICY:

The following types of patients may qualify for a charity write-off based on the patient's total household income, supporting income verification documentation or processes, as required, and the amount of the patient liability:

1) To be eligible for a charity write-off review, a patient must have incurred emergent, non-elective services.

2) To be eligible for a charity write-off, a patient must be (a) uninsured or underinsured and (b) have an out-of-pocket patient responsibility of $1,500 or more for an individual account. Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than $1,500 may be reviewed and a charity write-off applied if Federal Poverty Guidelines/Level ("FPL") thresholds are met as set forth in Section 9, below.

3) For purposes of this policy, an uninsured patient is one (i) with no third party payer coverage for emergent health care services, (ii) who provides documentation that the patient is unable to pay for some or all of the provided non-elective hospital services and (iii) who satisfies the financial eligibility criteria set forth herein.

4) For purposes of this policy, an underinsured patient is one with some form of third party payer coverage for health care services, but such coverage is insufficient to pay the current bill such that the patient retains a patient liability that they are unable to pay.

5) A validation will be completed, as required in this Policy, to ensure that if any portion of the patient's medical services can be paid by any federal or state governmental health care program (e.g., Medicare, Medicaid, Tricare, Medicare secondary payer), private insurance company, or other private, non-governmental third-party payer, that the payment has been

received and posted to the account. No charity write-off can be applied to any account with any outstanding payer liability.

6) Supporting Income Verification Documentation & Review:

A. Medicare Accounts

i. All Medicare patients (i.e., inpatients and/or outpatients) must submit supporting income verification documentation. Electronic validation of patient income, e.g., Experian, alone is not sufficient. Medicare requires independent income and resource verification for a charity care determination with respect to Medicare beneficiaries (PRM-I § 312).

ii. In addition to the FAA, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement:

- State Income Tax Return for the most current year
- Supporting W-2
- Supporting 1099's
- Copies of all bank statements for last 3 months
- Most recent bank and broker statements listed in the Federal Tax Return
- Current credit report

iii. Dual-Eligible Beneficiaries: A Medicare beneficiary who also qualifies for Medicaid (dual-eligible beneficiary) may be deemed indigent as long as the "Must Bill" requirements are met. That these requirements are met must be supported by a State Medicaid remittance advice. When claiming an amount as Medicare Bad Debt for a dual-eligible beneficiary, Medicaid must be billed. In addition, the remittance advice showing non-payment must be maintained as supporting documentation for the Medicare Bad Debt adjustment. Charity write-offs for Medicaid Exhausted beneficiaries may be less than $1,500.

iv. Patients who qualify for a Medicare Savings Program (Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), Qualified Disabled and Working Individuals (QDWI)) will be eligible for a full charity write-off. Charity write-offs for Medicare Savings Program qualified patients may be less than $1,500.

B. Non-Medicare Accounts

i. Generally, for all non-Medicare Accounts, the following will be acceptable supporting documentation: (i) the documentation listed in A. above, (ii) or any one of the following:

- Most Recent Employer Pay Stubs
- Written documentation from income sources
- Proof of Medicaid Eligibility
- Electronic validation of patient income and family size, such as Experian

ii. Supporting income verification documentation through an electronic validation of patient information/income, such as Experian, shall be obtained where no other income verification is obtained.

iii. To the extent required by state law, a complete FAA shall be obtained for any dollars reported as charity to the state.

iv. Review of assets may take place during the application process where required by state law or regulation.

C. Patients/Responsible Party Deemed Eligible.

The patient/responsible party may be deemed to meet the charity guidelines if:

- the patient/responsible party is determined to be eligible by a local clinic under poverty and income guidelines similar to the ones in this policy; or
- the patient/responsible party presents with Medicaid, and Medicaid does not pay.

D. Charity Processing Based on Extenuating Circumstances, i.e., Potential Charity Write-off Absent Full Documentation.

There may be extenuating circumstances where resource testing cannot be completed because the patient/responsible party does not/cannot (i) complete the FAA, or (ii) provide supporting documentation listed in A or B, above. In those circumstances, a manager may waive the required documentation and extend a charity care write-off, consistent with this Policy. The following may be considered by the manager to be extenuating circumstances:

i. *Patients identified as an undocumented residents or homeless through*:

- Medicaid Eligibility screening
- Registration process

- Discharge to a shelter
- Clinical or Case Management documentation
- Absence of a credit report

ii. *Patients that expire* - if it is determined through family contact and/or courthouse records that an estate does not exist, it may be considered for a charity write-off (even if the patient had a spouse) upon documentation and with the manager's review and approval of a policy exception.

iii. *Medically Indigent* – In addition to the above, if a patient/responsible party meets the medically indigent status based upon state guidelines or requirements, a charity write-off may be applied after the manager completes a resource testing process for the patient/responsible party.

7) Pending Medicaid Effect on Charity Write-off:

The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Pending Charity.

8) Health Insurance Marketplace for Qualified Health Plans:

Pending qualification in the Health Insurance Marketplace may take place concurrently with the Pending Charity process. The QHP enrollment is not retroactive. Rather, the coverage becomes effective for future dates of service. Therefore, it is necessary to continue with the Pending Charity process for visits occurring prior to QHP effective dates.

9) Charity Processing based on Federal Poverty Guidelines:

A. Patients with individual or household incomes of between 0-200% of Federal Poverty Guidelines:

Patients with more than a $1,500 patient liability that fall within 0-200% of the FPL will have the entire patient balance processed as charity write-off. Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than $1,500 may be reviewed and a charity write-off applied.

B. Patients with individual or household incomes of between 201- 400% of Federal Poverty Guidelines:

Patients with incomes between 201% and 400% of FPL will have their balances capped at a percentage of their income according to the table below. This percentage will be determined using the patient's FPL.

- 201% - 300% - balances capped at 3% of annual household income
- 301% - 400% - balances capped at 4% of annual household income

Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than $1,500 may be reviewed and a charity write-off applied.

C. Insured Accounts with emergency services only: Additional financial relief will be available for insured patients with emergent services only. These patients will be identified by having one of the following emergency Evaluation and Management (E/M) codes on their account: 99281,99282,99283,99284,99285, or 99291, and NOT in inpatient status.

After all managed care payments, contractuals and/or discounts have been applied, patients will have their balance capped to a fixed amount depending on their income and corresponding FPL. The patient balance caps are as follows:

E/M Levels 1-3
201% - 300% - balance capped at $1500
301% - 400% - balanced capped at $1750

E/M Levels 4 +
201% - 300% - balance capped at $2500
301% - 400% - balanced capped at $2750

In the event that **Section 9A** or B above provides more relief to the patient, then Section 9)A or B will be used to determine patient responsibility.

10) Patients Who Are Uninsured:

Notwithstanding 9)A. and B. above, patients who are uninsured and who provide the supporting income verification documentation and otherwise meet the requirements of this Policy, will have their patient balance capped at the lesser of the amount calculated under 9)A. or 9)B. above, or the amount calculated pursuant to the uninsured discount model.

Balances from multiple accounts for the same patient may be considered together to determine out-of-pocket responsibility minimums and for calculating the cap.

The write-off will be applied to the entire outstanding patient balance.

11) Refunds on Charity Accounts:

    The general expectation is that all patients pay for services rendered if they are not fully covered by a third party. Therefore, any amount paid by the patient (even if the patient subsequently meets the charity write-off guidelines for their balance due), will be retained. Only amounts paid by the patient that exceed the amount that patient would have paid had they received the uninsured discount, or that exceed their out of pocket responsibility per their insurance, will be refunded. For those patients that do meet the charity write-off criteria and have made a partial payment, the charity write-off will be posted on the remaining patient balance.

12) Patient Dispute Process:

    In the event a patient wishes to file a dispute and appeal their eligibility for a Charity write-off under this policy, the patient may seek review from the Operations Support Director, Hospital Chief Financial Officer or an SSC Executive as defined in the Charity Review Appeal Process policy (PARA.PP.VCM.020).

13) Compliance with State regulations:

    Each SSC should evaluate whether this Policy complies with the applicable state law and regulations regarding charity care, e.g., California, Florida. If this Policy does not comply with state law and regulations, each SSC must clearly document exceptions to this policy in either a State specific policy or an addendum to this Policy.

14) Liens:

    Under no circumstances will liens be considered on properties less than $300,000 in value.

REFERENCE:

- **PARA.FT.VCM.606 Federal Charity Guidelines**
- **PARA.FT.VCM.638 Financial Assistance Application**
- **PARA.MF.VCM.804 Collection Charity Letters**
- **PARA.PARS.PP.009 Medicare Bad Debt and Recovery Logs Policy**
- **PARA.PP.VCM.019 Utilizing the Artiva Charity Process**

Attachment 4N-2

Non-Discrimination Policy

Status Active PolicyStat ID 8834207

TriStar Southern Hills MEDICAL CENTER

Effective	3/1/1998	Owner	Amit Parmar: Asst Administrator
Last Reviewed	5/20/2021	Policy Area	Patient Rights & Ethics
Last Revised	5/20/2021	Applicability	TriStar Southern Hills Medical Center
Next Review	5/20/2023		

Patient Rights

Effective: 07/01/2020

SCOPE:

All Company-affiliated facilities including both inpatient and outpatient settings not limited to, hospitals, ambulatory surgery centers, home health centers, home health agencies, physician practices, outpatient imaging centers, service centers and all Corporate departments, Groups, Divisions and Markets.

PURPOSE:

The commitment to treat all patients with respect and dignity is an obligation of every HCA Healthcare colleague and a fundamental principle of being part of HCA Healthcare. We recognize the diverse backgrounds and cultural needs of our patients and strive to foster an inclusive environment through the provision of culturally-competent care. It is, therefore, the purpose of this policy to:

- Ensure that there is no harassment, discrimination or distinction in:
  - the availability of services;
  - the admission, transfer or discharge of patients; or
  - in the care provided
    based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.
- Ensure that all patients receiving care and/or patient representatives are informed of their rights.

- Ensure that this policy is in alignment with federal, state and local regulations, HCA Healthcare Code of Conduct, and pursuant to The Joint Commission (TJC) and other accreditation standards.

POLICY:

All Company-affiliated facilities will not tolerate harassment or discrimination or make a distinction in the availability of services; the admission, transfer or discharge of patients; or in the care provided based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

All Company-affiliated facilities must provide each patient with a written statement of patient rights at the time of registration, and again at the time any patient or patient's representative has questions regarding their rights. The written statement of patient rights must be provided to the patient in their preferred language or manner that can be understood. When necessary, interpreter services must be provided to ensure the patient and/or patient's representative receive patient rights notification in a language and/or manner they understand. A model Statement is available on Atlas Connect.

DEFINITIONS

Family (TJC glossary): A person or persons who play a significant role in an individual's life. A family is a group of two or more persons united by blood or adoptive, marital, domestic partnership, or other legal ties. The family may also be a person or persons not legally related to the individual (such as a significant other, friend, or caregiver) whom the individual personally considers to be family. A family member may be the surrogate decision-maker if authorized to make care decisions for the individual should he or she lose decision-making capacity or choose to delegate decision making to another.

Patient Representative (CMS terminology): The patient's representative is the individual who is legally responsible for making medical decisions on the patient's behalf.

Patient Support Person (**CMS terminology**): The patient's support person does not necessarily have to be the same person as the patient's representative. A support person could be a family member, friend or other individual who supports the patient during the course of the hospital stay.

Surrogate Decision Maker (**TJC glossary**): Someone legally appointed to make decisions on behalf of another. This individual can be a family member or someone not related to the individual. A surrogate decision-maker makes decisions when the individual is without decision-making capacity or when the individual has given permission to the surrogate to make decisions. Such an individual is sometimes referred to as a legally responsible representative. See also family.

PROCEDURE:

All patients are to be treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights and involvement in their own care.

The patient rights notification at a minimum will address the following patient rights as well as all

additional federal, state or local requirements. These statements include but are not limited to:

- The right to receive considerate and respectful care, including consideration of cultural, spiritual, psychosocial and personal values, beliefs and preferences.
- The right to receive individualized care that fosters the patient's comfort and dignity, and is delivered in a setting that is free from abuse, discrimination and harassment.
- The right and authority to designate who may or may not visit, including, but not limited to, a spouse, domestic partner (including a same-sex domestic partner), another family member, or a friend. Facilities must not use the age, race, color, national origin, religion, gender, gender identity, sexual orientation, or disability of either the patient (or the patient's support person or representative, where appropriate) or the patient's visitors (including individuals seeking to visit the patient) as a basis for limiting, restricting, or otherwise denying visitation privileges.
- The right to access patient advocate and chaplaincy services without discrimination.
- The right to take part in religious and/or social activities and to exercise civil freedom while in the hospital as long as these do not interfere with the patient or others' treatment.
- The right to effective communication for persons who are deaf or hard of hearing, and for persons with limited English proficiency (LEP) at no cost to the patient, including use of interpreters and translation of written materials.
- The right to be accompanied by a service animal. Each facility maintains policies regarding these rights, which include specific procedures for accommodation.

In addition to their rights, the patient also has the responsibility to be considerate of the rights of other patients and hospital personnel.

All Company-affiliated facilities must have a written Statement of Patient Visitation Rights to ensure the visitor experience is a positive one for patients, patients' representatives, family and friends. This statement must be provided at the time of registration, and the patient must acknowledge receipt through the registration process. A model Statement is on Atlas Connect.

Company-affiliated facilities should post their Statements of Patient Rights and Patient Visitation Rights on their external website.

All Company-affiliated facilities must have and follow processes for prompt resolution of patient grievances which include informing patients of whom to contact regarding grievances and informing patients of the grievance resolution process.

All Company-affiliated facilities will provide role specific education addressing patient rights at the time of hire to all employees as applicable. Competencies will be established for employees as required by job description. Annual updates will occur to support compliance with all elements of this policy.

REFERENCES:

1. HCA Healthcare Code of Conduct, Patient Rights Section
2. Centers for Medicare and Medicaid (CMS) Condition of participation: Patient's rights: 42 CFR §482.13(a); 42 CFR §482.13(b); and 42 CFR §482.13(h)
3. Title VI of the Civil Rights Act of 1964

4. The Joint Commission (TJC), Comprehensive Accreditation Manual for Hospitals, 2014, Rights and Responsibilities of Individuals (RI) : Standards: RI.01.01.01; RI.01.01.03; and RI.01.02.01

All Revision Dates

5/20/2021, 2/19/2015, 2/4/2015, 3/1/2013, 9/1/2012, 1/1/2012, 5/1/2011, 2/1/2011, 2/1/2010, 3/1/2004, 1/1/2001, 8/1/2000, 2/1/2000

Attachments

Model Statement of Patient Rights Sep 2018.doc

Model Statement of Patient Rights SPANISH Sep 2018.doc

Approval Signatures

Step Description	Approver	Date
Board of Trust	Joe White: COO Southern Hills Med Ctr	5/20/2021
Medical Executive	Mary Ellen Brill: VP Quality/ Risk Mgmt	5/19/2021
Facility Ethics and Compliance	Joe White: COO Southern Hills Med Ctr	4/22/2021

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Attachment 4N-3

Discount Policy for Patients

DEPARTMENT: Support Services	POLICY DESCRIPTION: Discount Policy for Patients
PAGE: 1	**REPLACES POLICY DATED:** 01/01/2015
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 05/26/2016	**REFERENCE NUMBER: PARA.PP.GEN.043**

SCOPE:
All SSC (including Specialty Services) and Facility areas responsible for offering discounts at the time of service, or settlements after services are rendered, for the sole purpose of expediting collection efforts.

PURPOSE:
To define the policy for providing discounts and/or settlement offers to patients with outstanding patient liable amounts for the purposes of liquidating receivables. All discounts will be offered in an effort to liquidate receivables and not to induce incremental volume.

POLICY:
Discounts as defined below may be provided to uninsured and insured patients receiving non-elective and elective care based on the patient liable amount as courtesy type discounts. Discounts cannot be considered for Medicare Bad Debt and should not be included in the Medicare Bad Debt Log. Discounts cannot be advertised and are to be offered only in an effort to liquidate receivables. The following outlines the associated discount types:

Uninsured Patients

- **Prompt Pay –** Prompt pay discounts may be offered at the time of service. The discount should be offered contingent on payment of the remaining balance. The maximum prompt payment discount should be no more than 20%.
- **Settlement Offers** – Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the collection process to settle a delinquent account.

Insured Patients

- **Prompt Pay –** Prompt pay discounts may be offered at the time of service provided the patient liable portion has been determined and, provided that the prompt pay discount is in accordance with payer contract provisions and state law. The maximum prompt payment discount should be no more than 20%. A written notification that the provider may have offered a prompt payment discount to the patient liable portion will be included in the remarks section of the UB claim form in FL-80.
- **Out of Network Discounts** – Out of Network discounts may be applied provided the Payer has been notified in advance that the facility intends to waive the out-of-network penalty.
- **Out of Network Medicare and Medicaid PPO/HMO -** Waiving the difference between out-of-network charges and in-network charges for beneficiaries is prohibited. For example, a facility cannot tell a physician that the facility will accept the in-network charge of $300 instead of the out-of-network charge of $700, when the facility is an out-of-network provider. Refer to Compliance Alert #15 (attached) for information regarding permissible waivers.
- **Out of Network PPO/HMO with Medicare as Secondary/Tertiary Payer-** Discounts may not be offered to reduce or waive an Out Of Network penalty when Medicare is also listed as a payer on the account. For example, if the account lists an OON Payer as primary and Medicare as secondary, you may not offer a discount to offset the primary payer's penalty.

DEPARTMENT: Support Services	**POLICY DESCRIPTION:** Discount Policy for Patients
PAGE: 2	**REPLACES POLICY DATED:** 01/01/2015
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 05/26/2016	**REFERENCE NUMBER: PARA.PP.GEN.043**

- **Settlement Offers –** Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the patient liability collection process to settle a delinquent account.

The Division and SSC management teams will work together to establish the allowable discount percent for their respective facilities. The maximum prompt payment discount should be no more than 20%.

PROCEDURE:

Responsible Party	**Action**
Registrar/Financial Counselor/Collection and Support Services Staff	Identifies that the patient/responsible party collection efforts could be shortened if a discount would be provided.
Registrar/Financial Counselor/Collection and Support Services Staff	Determines the appropriate type of discount to offer in accordance with the list of discounts previously approved by the facility, Division and SSC.
Registrar/Financial Counselor/Collection and Support Services Staff	Offers discount to patient/responsible party. If patient/responsible party is contacted by phone, the Verification of Requestors policy should be followed. (SSD.PP.PRI.103)
Registrar/Financial Counselor/Collection and Support Services Staff	Documents the account.

REFERENCE:
Compliance Alert #15: Beneficiary Inducement Prohibition (updated 06/01/2012)
http://atlas2.medcity.net/portal/site/ethics
Select Compliance Alerts and choose Alert #15
Attachment Q

Attachment 6N
Letters of Support

HCT/11 Nolensville FSER - List of Letters of Support Submitted with Original CON

Number	Author	Title and Organization
6N-1	Kermy Dairphone	Antioch Resident
6N-2	Victor Torres	Nolensville Resident
6N-3	Kyle Sparkman	Nolensville Resident
6N-4	Daniel Christian	Brentwood Resident
6N-5	Caleb Hemmer	Tennessee State Representative, District 59
6N-6	Nicole Campbell	Nolensville Resident
6N-7	Heidi Campbell	Tennessee State Senator, District 20
6N-8	Erich Chadwick	Nolensville Resident
6N-9	Kyla Edsell	Brentwood Resident
6N-10	Kelena Baller	Nolensville Resident
6N-11	Melissa Cortenbach	Nolensville Resident
6N-12	Cary Pierce	Nolensville Resident
6N-13	Tiffany Copeland	Antioch Resident
6N-14	Chrissie Hinton	Brentwood Resident
6N-15	John Strack	Nolensville Resident
6N-16	Robert Binford	Nolensville Resident
6N-17	John Rutherford	Metro Nashville District 31 Councilman
6N-18	Sam Killingsworth	Fire Captain/Paramedic for the Town of Nolensville
6N-19	Neischa Alexander	Nolensville Resident
6N-20	Eric Clapp	Brentwood Resident
6N-21	Hala Alaw	Nolensville Resident
6N-22	David E Windrow	Fire Chief for the Town of Nolensville
6N-23	Nina Mothershed, AEMT	General Manger on behalf of Ambulnz TN, LLC
6N-24	Jeff Glick	Nolensville Resident
6N-25	Derrick Jensen	Nolensville Resident
6N-26	Janis Bogda	Nolensville Resident
6N-27	Mike Yedlicka	Nolensville Resident
6N-28	Mohamad Alaw	Nolensville Resident
6N-29	Nerissa Rollins	Nolensville Resident
6N-30	Ashok Patel	Brentwood Resident
6N-31	Darcy West	Brentwood Resident
6N-32	Shaker Cherukuri	Brentwood Resident

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

The ER proposed by TriStar Southern Hills will provide lifesaving support services to our area. There are scant emergency medical services in our area. Please open this ER in Nolensville for critical access for all emergency needs in our community since the population has tremendously increased.

Our entire neighborhood has been affected by the current lack of emergency services. My neighbor needed emergency services and since Cane Ridge is considered Davidson County, the services were all too far away. This is unacceptable. What is someone is having a stroke or heart attack? Every minute is crucial for brain and heart tissue to survive. Please open this facility!

Countless new communities in Nolensville, Burkitt Ridge, Brentioch, and Cane Ridge will all benefit greatly from this emergency service. This should be a no brainer for approval and for the leaders in the surrounding cities.

Nolensville's growing population is the perfect example of why we need emergency services. That's why I'm offering my full support for this project and want to see it approved.

Sincerely,

Kemry Dariphone
1000 Clover Glen Way
Cane Ridge, TN 37013

March 15, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Mr. Grant,

The ER that TriStar Southern Hills is proposing would be an excellent addition to Nolensville and it has my support. Our area sits between locations that are not easy to get to in an emergency setting. The community has grown so much that having an ER facility will bring a better well-being to our area.

In a life-or-death situation, there may not be much time to get someone to an ER, so having one in town would help save lives and keep families safe. Right now, we have to take back roads to get to existing facilities and the roads are dark and windy. We need easily accessible emergency care to support our town.

Our community has grown so much, and this ER would benefit the elderly and kids when accidents arise. I hope to see this ER built for Nolensville.

Sincerely,

Victor Torres
1509 Halsey Dr.
Nolensville, TN 37135

March 8, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

As a Nolensville resident, I was excited to hear about TriStar's proposed emergency room. The town is growing quickly and it's time that we had our own emergency services.

Currently, Nolensville does not have emergency services close-by, and it is always safe to have an emergency room closer than driving 30 minutes away. In an emergency, you don't always have that much time to get care. I think this emergency room will be a great addition to the community and save lives.

I am writing this letter as a show of my support because this is definitely something we need. I hope you will approve the project.

Sincerely,

Kyle Sparkman

856 Nolenmeade Court

Nolensville, TN 37135

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

The south Brentwood/Nolensville area is in need of emergency services. I commute daily from that area to downtown. When sitting in the growing traffic areas, I often think, "what if myself or family needed emergency services?" The commute wait time could be life or death. As this area and others outside grow, emergency care access is crucial to our community, and this proposed ER won't take away from the small-town feel.

Nolensville is a growing area and middle point for areas like Brentwood and College Grove which are also seeing immense growth. This ER proposed by Southern Hills is needed and will provide necessary services for our community. That's why I am happy to offer my support.

Sincerely,

Daniel Christian

9010 Carnival Dr.

Brentwood, TN 37027

April 5, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Executive Director Grant,

As the State Representative for the 59th legislative district, I have the distinct honor of serving our state and advocating for the health and well-being of Tennesseans. I express my full support for TriStar Southern Hills plans to develop a freestanding emergency room in the Nolensville community and respectfully ask for you to grant the required Certificate of Need.

I have spent most of my life in and around Davidson County. I have witnessed the growth of not only Nashville, but the surrounding communities in Williamson County as well. I know the struggles that these communities have faced as the result of their growth, and an emerging issue is timely access to healthcare. Nolensville is home to over 15,000 residents and currently has no dedicated emergency room. The nearest emergency rooms can be upwards of 20 minutes away depending on traffic and EMS availability. That is also assuming that only one emergency arises at a time, which is unrealistic for a growing community like Nolensville.

This FSER's impact would also be felt in the surrounding communities in East Brentwood, Cane Ridge, and Davidson County. My constituents would have somewhere to go in an emergency that is not as far away as downtown Nashville. This freestanding emergency department will allow Nolensville and the surrounding communities to continue to grow safely with the access to the healthcare they deserve.

Please consider this letter my full support of TriStar Southern Hills plan to develop a freestanding emergency room in Nolensville.

Sincerely,

Caleb Hemmer

Caleb Hemmer

Tennessee State Representative, District 59

3/10

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

As a Nolensville resident, I support building an ER in the area and think it would be a great asset to the community. While there are many hospitals and TriStar hospitals around, none are very close. With additional traffic and the smaller country roads, it takes longer to get to these services and even dangerous in some cases depending on time of day or weather conditions. Recently my husband had to visit the ER via an ambulance during the icy conditions over the holiday and it took over 30 mins to go straight up Nolensville Rd. late at night with no traffic. For emergency situations that may be life or death this is an extremely long time and having something closer would be a huge benefit to our community.

As I stated previously, my husband had to visit the ER via an ambulance during the icy conditions over the holiday and it took over 30 mins to go straight up Nolensville Rd. late at night with no traffic. For emergency situations that may be life or death this is an extremely long time and having something closer would be a huge benefit to our community.

This would be a great location that could serve multiple areas, but especially help in long commute times for those that live in southern Nolensville. Again, the country roads to access services in Smyrna and other areas are often dangerous during various weather situations and this would be a great service that would be closer during those times. I think that a new ER would allow people to get care quickly and potentially save lives.

Sincerely,

Nicole Campbell
3224 Bradfield Dr
Nolensville, TN 37135

HEIDI CAMPBELL
20TH SENATORIAL DISTRICT

425 JOHN LEWIS WAY NORTH
CORDELL HULL BUIDLING, SUITE 770
NASHVILLE, TENNESSEE 37243
615-741-6679

COMMITTEES:

ENERGY, AGRICULTURE AND
NATURAL RESOURCES

TRANSPORTATION

FISCAL REVIEW

April 10, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Executive Director Grant,

It is my honor to serve the community as Tennessee's State Senator for District 20. As such, I fully support TriStar Southern Hills Medical Center's proposed plan to construct a freestanding emergency room in Nolensville.

As a State Senator for the neighboring district, I recognize the importance of expanding emergency care services in this area to ensure that all residents have access to quality care when they need it most. Currently, many constituents in my district have limited resources for life-saving care and must travel long distances or endure growing wait times. The proposed facility would enhance the overall capacity to provide emergency care and reduce the strain on nearby hospitals and healthcare centers. Most importantly, this additional resource will save lives.

This project will have a transformative impact on our community. The health and wellbeing of my constituents is a top priority, and an additional healthcare facility is incredibly beneficial for our greater community. I urge you to give this proposal your full support and approve the Certificate of Need application. Thank you for your consideration.

Sincerely,

Heidi Campbell
Tennessee State Senator, District 20

March 8, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

Right now, access to emergency services in Nolensville is currently 20-40 minutes away depending on the traffic. My daughter had a bad cut on an artery in her hand and we had to take her all the way to Stonecrest in Smyrna. If we had an option in Nolensville, she would have received treatment much faster.

Nolensville has seen tremendous growth which makes the need for additional emergency services twofold.

1) The population can support it

2) The growth has led to increased traffic which makes the current emergency service options even further away in terms of travel time.

That's why I'm happy to offer my support for the Nolensville ER and hope to see it approved.

Sincerely,

Erich Chadwick

711 Delamotte Pass

Nolensville, TN 37135

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

Growth in our communities means infrastructure updates, and one could not be more vital than healthcare. Additional healthcare outlets that provide emergency care are especially vital to impacting patient outcomes. That's why I am offering my full support for TriStar's plan to build an emergency room in Nolensville.

With traffic being a consistent issue in Nolensville, this adds an additional barrier when getting to emergency care. Not only should the distance/milage be taken into account, but the additional external factors that increase the duration and delays the time it takes to travel from place to place, due to traffic congestion, construction, other road hazards, etc.

I hope that Nolensville is just the starting point, that these ERs will be in each area because our community could greatly benefit from access to healthcare. That's why I hope to see this project approved.

Sincerely,

Kayla Edsell
601 Old Hickory Blvd
Brentwood, TN 37027

March 15, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am writing this letter to show my support for the ER Southern Hills is planning to build in Nolensville. I think a new ER would be an asset to the community and is necessary with all of the growth in Nolensville over the last several years.

It takes us 25-30 minutes to get to the closest ER now. In an emergency, that is way too long. Having an ER close by could make people safer and potentially save lives in a situation where someone needs care quickly. We have lots of large subdivisions in Nolensville and they need to have emergency services nearby to care for all of the families that live there. I think the ER Southern Hills has proposed would be great for them.

For these reasons, I am happy to support this ER.

Sincerely,

Kelena Bellar

3156 Bradfield Dr.

Nolensville, TN 37135

March 16, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

This ER that is being proposed for Nolensville is needed in our community. Right now, there is nothing open past 7-8 pm and we have to drive to Franklin for the nearest ER. That is a 20-minute drive. A standalone ER, in my opinion, is way more efficient and desperately needed here.

One time, I was experiencing panic attacks that felt like a heart attack. I had to take a 20 min drive to an ER in Franklin, wait at check in. By the time I was seen, I had waited for an hour. Then, after hours of monitoring, I could barely find an uber home at 3am. No one should have to go through that, and an ER in town would help us get care more quickly.

I hope this ER is approved as it would be great for everyone in Nolensville.

Sincerely,

Melissa Cortenbach
124 Asher Downs Cir.
Nolensville, TN 37135

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

Nolensville has grown dramatically, and with it the need to all manner of healthcare. With traffic and rush hour, the need for closer emergency services grows every day. That's why I am supporting the ER that TriStar Southern Hills has proposed for Nolensville.

When my son cut his finger very badly, the closest location was over 30 minutes away, and luckily this was after rush hour. Had traffic been bad or the bleeding much worse, we very well might have had to call an ambulance for a simple laceration.

Nolensville is only going to grow from here. With it, Nolensville is already having to plan for greater fire and ambulance service, and an emergency room will make the people doing those jobs that much easier. That's why we need this ER, I hope you will see that and approve this project.

Sincerely,

Cary Pierce

6049 Christmas Dr.

Nolensville, TN 37135

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant,

Nolensville needs additional emergency services because of increased development of subdivisions and town homes on Nolensville Road from Lenox Village to Nolensville. The increased population growth in that area also drives the need for emergency services. Going to Smyrna or Centennial Medical Center is too far to have to go for urgent emergency care from that area.

TriStar Southern Hills Medical Center's proposed emergency room will help in providing timely and immediate medical care for patients in emergency situations. Instead of the possibility of going to a hospital emergency room that could be at full capacity, this ER could give the emergency care a patient needs.

Nolensville is only going to keep growing. That's why I'm offering my full support for this project and hope to see it approved.

Sincerely,

Tiffany Copeland
3660 Coles Branch Drive
Antioch, TN 37013

March 13, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

As a resident of Nolensville, I can tell you that Nolensville definitely needs this freestanding ER that Southern Hills plans to build. Traveling to Smyrna or way down to Nolensville is very difficult and could be a matter of life and death in an emergency. People may not have that much time, having something nearby could save lives.

Nolensville is growing quickly, and we need emergency services for all of the new people moving here. Many of these new residents are families with children, and we need to keep them safe. It would give everyone some peace of mind to know that care was nearby.

The sheer amount of new residents is enough to support this ER, that's why I am happy to offer my full support and hope to see this project passed.

Sincerely,

Chrissie Hinton

9656 Brass Valley Dr.

Brentwood, TN 37027

April 18, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant,

My family and I moved to Nolensville, TN on January 2nd of 2022. We love the town and are very excited to watch it grow into a version of the community that has been portrayed by the Mayor and Board of County Commissioners. A safe, family friendly town that offers all the amenities to it's residents.

As Nolensville grows, additional life safety facilities serving our town must also be built. That includes:

- Fire Stations
    - Fire Station # 1, was approved to be built on Thursday April 6, 2023.
    - Fire Station # 2, land has been purchased.
- Police Station, planning is underway.
- Hospitals, (well planning is underway, will it be approved?)

Did you know that projections show Nolensville doubling from 16,000 people to 32,000 people in the next 10 years? The vast majority of residents in Nolensville are families. The residents like me chose a small town that was safe to raise their children in. As parents we have all been in that panic moment rushing to get our children treatment. Or when we ourselves / loved ones experience other emergency health concerns that have us in fear for our well-being. Adding an Emergency Room to Nolensville makes sense! Why should a resident be forced to drive to another town for life saving treatment? Will driving the additional distance cause a loss of life?

It is our hope that you will permit the new ER to be built in our growing community.

Should you have any questions, my contact information can be found below.

Thank you,

John Strack
3029 Jada Way
Nolensville, TN 37135
615-572-3742

Subject: Stand Alone Emergency Room Facility in Nolensville, Tennessee

To Whom It May Concern:

I would like to offer my support for the proposed TriStar Health standalone emergency room in Nolensville, Tennessee. Currently, it takes a long time to get to an ER from this area in an emergency.

My family moved to Nolensville about 30 years ago. Since that time, we've had several incidences that caused us to go to an emergency room. These include and may not be limited to:

1. One of our sons had a head injury when sledding down a long, steep icy hill. We made a rushed trip to the Williamson Medical Center ER. Due to poor road conditions, we traveled Nolensville Road south to Triune and then Highway 96 to Williamson Medical. These roads are maintained during periods of ice and snow. Nolensville Road north at least to Concord Road is also maintained during periods of ice and snow and If the proposed ER had been there, it would have considerably reduced travel time.
2. We took one of our children to the ER in the middle of the night due to croup.
3. I was born with a bicuspid aortic valve, that has been replaced 3 times.
   a. Between the first and second heart valve replacement surgery, I tore a leaflet in the aortic valve. With the symptom, my wife took me to the Vanderbilt ER. A transesophageal echocardiogram later determined a leaflet tore, and it was "flapping in the breeze."
   b. After my second heart surgery, medication dropped my blood pressure to the point that blood pressure would not register on the EMT's blood pressure cuff. I was transported to the Vanderbilt ER in an ambulance with lights and sirens. It is a long way from Nolensville to the ER when you are in bad shape.
4. I had a freak accident and broke about 3 bones in my foot. I passed out twice. Passing out with heart issues, I was again taken to an ER.

Thank you for allowing me to submit this and to offer my support.

Robert A. Binford
2256 Rolling Hills Drive
Nolensville, TN 37135
Andy.Binford@comcast.net

Robert A Binford

April 11, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant,

As the Metro Nashville Councilman for District 31, Southern Hills Medical Center's proposed freestanding emergency room will serve my district. I am writing you to express my full support of this project.

There is no emergency room in Nolensville. As a result, families in Nolensville, east Brentwood and south Nashville have very limited options for emergency services. This rapidly growing area relies on large and crowded hospitals over 15 minutes away for their ER services. This requires patients and first responders to travel 15-20 or more minutes through the traffic headaches of I-65, Clovercroft Road, Concord Road, Nolensville Pike, Kidd Road/McFarlin Road, and/or Rocky Springs Road to access emergency services.

With the rapid growth of Nolensville and the traffic that is accompanying it, my constituents have an increasing need for access to emergency services. The existing emergency care options are much too far away for residents experiencing time-sensitive medical emergencies. The 15,000+ residents of Nolensville will benefit from this proposed emergency room within the community. The proposed ER will provide residents and workers access to needed care closer to their homes and work.

I am eager to express my support for TriStar Southern Hills Medical Center's proposed freestanding emergency room to serve my constituents and those of the surrounding areas.

Thank you,

John Rutherford

Metro Nashville District 31 Councilman

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am a fire captain/ paramedic for the town of Nolensville. A free standing ED would greatly cut down transport times for critical patients in the Nolensville area. It would also help alleviate ED congestion at surrounding hospitals.

The exponential growth in Nolensville makes it the perfect place to put a new ED. It will help the community and I hope to see it built.

Sincerely,

Sam Killingsworth

2729 Water Lane

Nolensville, TN

March 13, 2022

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

With Nolensville being such a family community, it would be helpful to have an ER where easy fixes like broken bones can be taken care of. It might also help save lives in cases of heart attacks, high blood pressure or strokes. I've had to visit an ER several times and it seemed like the drive took forever. Even car accident victims could at least start out there. I think it would be a great asset to Nolensville.

I'm happy to support this ER and I think it will provide a lot of value to the Nolensville community; I hope to see it approved.

Sincerely,

Neischa Alexander

1100 Hibiscus Lane

Nolensville, TN 37135

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I think the ER that Southern Hills has proposed for Nolensville would be a great thing to have in our community. I've lived in the Brentwood/Nolensville area for the past 10 years and given the growth that this area has experienced, it would be great to have something like this in the Nolensville community, so we don't have to travel to the Williamson County MC or up to Nashville when we need to visit the ER.

I had a friend that experienced cardiac arrest and he had to be transported up to Nashville for care. In some emergencies, that long drive can cost someone their life. Time is important and Nolensville needs an ER so that people can get care quickly and efficiently.

There are so many homes being built in Nolensville, as well as new businesses popping up, it only makes sense to make sure the that residents of the Nolensville area have an ER facility within minutes of their homes, rather than having to commute 15-20 minutes away, which that amount of time could be really important to the person that needs emergency care. I hope this ER is approved.

Sincerely,

Eric Clapp
2021 Valleybrook Dr.
Brentwood, TN 37027

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

As a resident of Nolensville, I am happy to support the new Southern Hills freestanding emergency room because there are no emergency services in Nolensville only walk-in clinics. We need an emergency room here in Nolensville that can serve this area.

There was a medical emergency involving my niece and when my brother called 911, they took her all the way to Nashville VUMC children's hospital. There is no ED location in Nolensville, so all of the options are far away which can cost someone their life if the problem is very serious.

I hope you will approve this ER, I think it will be great for Nolensville and save lives.

Sincerely,

Hala Alaw
1419 Winding Creek Dr.
Nolensville, TN 37135

March 31, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center FSER CON Application

Dear Mr. Grant:

As the Municipal Fire Chief for the Town of Nolensville, I am writing in support of TriStar Southern Hills proposed freestanding emergency room in Nolensville. Prior to my role in Nolensville, I served Brentwood Fire and Rescue for 24 years. Given my experience in Williamson County, I know the difficulties we face in getting patients to the emergency room in a timely manner. Increased emergency services in Nolensville will improve patient outcomes and allow EMS teams to work more efficiently.

Our community is growing at a rapid rate. The addition of an ER in Nolensville will reduce travel times for patients and provide relief for our existing emergency rooms, which are often operating at or near capacity. I think it will be an excellent quality of life addition to our community and I hope you approve this ER.

On a personal level I have broken bones, needed stitches and suffered minor burns throughout my career. It would be a major relief if there was an emergency room in town if our fire fighters or police officers needed care. I have also been in critical condition due to multiple myeloma. I had partial renal failure. Rapid intervention by the ER staff allowed me to be here today.

Sincerely,

David E Windrow
Fire Chief
7218 Nolensville Road
Nolensville TN 37135

March 30, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deadrick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant,

I am writing to you on behalf of Ambulnz TN, LLC. We have served the Middle Tennessee area for five years and have first-hand knowledge of the long travel times for our first responder and EMS crews taking patients to hospitals in Davidson and Williamson County.

The Nolensville community has seen a tremendous amount of growth over the last three (3) years and their need for urgent medical care has significantly increased. Without access to an FSER, this creates further delays to definitive care and potentially damages patient outcomes. The addition of an FSER in Nolensville would greatly reduce our travel times while allowing our EMS and first responders to have a more efficient return time to our respective zones and be available for community members who need emergency services.

Thank you for your consideration.

Best Regards,

Nina Mothershed, AEMT
General Manager
TN Division

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am happy to support this ER because every minute is critical in emergency care intervention. With limited road infrastructure and an increasingly high traffic volume, transit times to the three closest ER facilities (Tristar Southern Hills, Tristar StoneCrest, and Williamson Medical Center) are getting longer. An ER facility in the Nolensville, SE Davidson and East Brentwood area would provide just-in-time medical intervention.

A dog attacked my 86-year-old mother-in-law in her hand and arms. She was bleeding profusely, with tears to skin and flesh. She required medical intervention that was beyond the scope of an urgent clinic. We had to travel almost a half-hour with no ER nearby to receive initial medical intervention. Eventually, she was transported to Nashville for specialist care. It was a close call. We were lucky. Others facing time and distance delays might not be as lucky.

Nolensville is at the epicenter of exponential residential and commercial growth where Brentwood city, Nashville city, and Rutherford County all meet. Nolensville Road is the main transportation artery for the corridor. This makes this a perfect place for this ER, I hope to see it approved.

Sincerely,

Jeff Glick
420 Marlowe Court
Nolensville, TN 37135

March 18, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am writing in support of this ER because the Nolensville community needs an ER that is close as opposed to traveling to an ER that is 20 or 30 minutes away. Time is of the essence in an emergency situation, and when it's a matter of life and death, the ER should be within close driving distance.

The proposed location is central to lots of the neighborhoods and schools, and would be able to provide care to everyone in Nolensville in a timely manner. That's I support this project and I hope you will approve it.

Sincerely,

Derrick Jensen
606 Mer Rouge Dr.
Nolensville, TN 37135

4/5/2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant,

I know firsthand the need that Nolensville has for emergency care. I was a patient at TriStar Southern Hills in Antioch last month at my doctor's recommendation and it was quite far from my home. I also received treatment at Williamson Medical with a highly contagious medical condition, and both facilities were a good way away from home.

Thankfully my medical issues were not so emergent that I could not reach care in time, but it worries me that if I or one of my neighbors were to fall, or even get in a car accident, it would take a dangerous amount of time for them to get medical attention.

Nolensville is a growing, blossoming community with young families, senior citizens, and professionals interested in its proximate location to Nashville. We not only need emergency care in our community, but we deserve the peace of mind that it would bring.

Thank you,

Janis Bogda

9698 Clovercroft Rd, Nolensville TN 37135

janisbog@gmail.com

(708) 638-2530

3/31/2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am a resident of Nolensville and I wanted to write to you to show my support for the ER that TriStar Southern Hills has proposed for Nolensville. Right now, the closest ER to us is Stonecrest and I would like a closer option for me and my family. Nolensville is a growing town, and depending on where you live the closest ER is either Williamson Medical in Franklin, Southern Hills in South Nashville, or Stonecrest in Smyrna. In a true emergency, seconds count and a closer ER will give patients quicker care.

We need an ER close to home to give people in Nolensville better access to an ER so that they can get quicker care in an emergency. For these reasons, an ER would be great for Nolensville and should be approved.

Thanks,

Mike Yedlicka
2724 Cortlandt Ln.
Nolensville, TN 37135

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I support TriStar Southern Hills and their proposed ER in Nolensville because there is nothing close by, and as a father of two kids I would like to have something close to our home rather than driving to Franklin. It's a long drive to the emergency room, and it's important to have those services nearby for all of the families in Nolensville.

Nolensville is growing fast, but there are no proper ER services close by to support this growth. We need something in Nolensville to take care of patients here in the community. For these reasons, I hope you approve this ER.

Sincerely,

Mohamad Alaw

648 Riverdene Dr.

Nolensville, TN 37135

3-9-23

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

As a Nolensville resident, I think that there is a need for an ER here in town. Right now, we don't have emergency care close by. It is very necessary to have that kind of care where you can get to it.

The closest hospitals to me are Stonecrest and Williamson medical which are too far away. We need this ER in Nolensville.

Thank you,

Nerissa Rollins

Nerissa Rollins
PO Box 1133
Nolensville, TN 37135

4/13/2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

My name is Ashok Patel and I am writing to you to show my support for an ER in Nolensville. We live in this area and there is no place to go if there was an emergency. There needs to be a place in Nolensville for people to go and receive care when they need it. Thankfully, I have not had an emergency in which myself or a loved one had to go to one of the ERs downtown, but if we did, I'd much rather have something nearby and convenient.

This area is growing so much and residents do not have a place close by for emergency services. This is a necessity for the community and I hope you approve this project for Nolensville and the surrounding areas.

Thank you,

Ashok Patel
1883 Tradition Court
Brentwood, TN 37027

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am a resident of Brentwood and I am writing in support of the ER that TriStar has proposed for Nolensville. Population density has increased, and fast access to emergency services is impeded by traffic, leading to an increased number of residents that need access to emergency services.

The area has grown rapidly over the past several years and the traffic is getting worse. A new ER would help drive down the time it takes for people to get to the ER and get care. Please approve this ER for Nolensville, it will have a positive impact on Brentwood and Nolensville.

Sincerely,

Darcy West
909 Bluff Rd.
Brentwood, TN 37027

3/9/2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am writing this letter to express my support for TriStar's proposed ER in Nolensville.

The exponential growth of the Nolensville area and Williamson County with limited and far distance between urgent care facilities makes this a much-needed service to the community. The nearest emergency rooms are a long drive away, and we need something close by to be prepared for emergencies. A new ER would help get care quickly to the people of Nolensville and fill the need for emergency services. I urge you to approve this ER.

Sincerely,

Shaker Cherukuri
1532 Copperstone Dr.
Brentwood, TN 37027

March 9, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am a Nolensville resident, and I am writing to show my support for the ER that TriStar Southern Hills has proposed for Nolensville.

Right now, the closest ER Hospital is 8 miles or more from Nolensville. My Dad and Mom at different times in their lives suffered from medical emergencies and were sent to Stonecrest/Southern Hills then had to have emergency surgery and sent Centennial. I felt if we had a closer Hospital at the time, my Dad would not have had to end up on dialysis and would have lived a better life for the last few years before his passing.

Nolensville is growing every day and we have a large variety of age groups here. Being here for 27 years we are entering the senior years. To have something closer would be more peace of mine and to have other services there as well such as yearly check ups, scans and x-rays. This would be a great convenience for all ages in Nolensville and in close by Neighborhoods in Nashville, Arrington, Triune and Antioch.

Sincerely,

DJ Jensen
606 Mer Rouge Dr
Nolensville, TN 37135

4/13/2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

My name is Dr. Prakash Patel and I am writing to you today to show my support for the FSER that TriStar has proposed for Nolensville. Nolensville is growing rapidly growing community. Although we have many urgent care facilities available for urgent primary care need, having dedicated emergency services could help our families have access to emergency care for heart problems, stroke, and trauma. Having an ED in Nolensville will make our community safer.

Our neighbor had a stroke, which required him to be transferred to hospital in Nashville. Having local ED access would have improved his care. The same can be said for many in Nolensville, many of whom are miles from the nearest ED.

Due to rapid growth, it is taking longer to access the ER at Williamson Medical Center or any other ER. Access to emergency care is important for the community, and for that reason, this facility should be approved.

Sincerely,

Prakash Patel
9691 Brass Valley Dr.
Brentwood, TN 37027

March 28, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

As a Family Medicine Practitioner with 25 years of practice experience in the Nolensville area, I am happy to offer my support for TriStar Southern Hills proposed freestanding emergency room in Nolensville. I strive for excellent care for my patients locally, and with the growth in the community and the lack of access to ER services, additional emergency services are needed and will provide a valuable service to Nolensville.

TriStar is an excellent Hospital group with access to a network of highly skilled medical specialties across Middle Tennessee. I have no doubt that the TriStar physicians will be able to provide excellent local care for this community. Nolensville is a unique community that is growing quickly, and it will benefit from services in the community as opposed to services that are up to 30 minutes away. In patient care, there are times when local services have not been available and referral to ER has been a challenge. Time is one of most significant factors in emergency care and the ability to treat patients quickly can be lifesaving.

This FSER will undoubtedly make for a healthier community by bringing a higher level of care locally. Nolensville is growing rapidly; it needs its own ER to support the population into the future. For these reasons, and many others, I offer my support for this freestanding emergency room and hope to see it approved for the Nolensville community.

Sincerely,

Steve Johnson, MD
Board-certified Family Medicine

Engage Health
9002 Gasserway Circle
Brentwood, TN 37027

Mr. Logan Grant
Executive Director, Tennessee Health Facilities Commission

Subject: ER in Nolensville, TN

Dear Mr. Logan Grant,

My name is Melissa Doyle-Wenger and I am writing to ask you to approve an emergency room in Nolensville. I moved here from central Ohio, where there were emergency centers conveniently located in nearly each city or town. I am also an RN and know how important it is to have emergency services close to get help immediately and not wasting time and energy driving further to find one.

Long waits for emergency care can cost lives. Convenient ER access can help make the community safer and is needed in Nolensville.

Because there is not an emergency department located in Nolensville. This has become a heavily populated area of all age groups and emergency care is important. We need an ER and I hope you will approve it.

Thank you,

Melissa Doyle-Wanger
1548 Little Leaf Way
Nolensville, TN 37135

3/10/2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I am resident of Nolensville and I am in favor of a new ER for the Nolensville area. If you live in Nolensville, you know how fast this area is growing. More people are coming every year, with new homes and subdivisions popping up all over the place. The closest ER IS 17-22 minutes away which is unacceptable. We need closer emergency services with our town that keeps expanding in size of citizens.

Our friend's son passed away and the closest hospital was in Smyrna. A closer ER may have saved him. A facility like this one could save lives Nolensville, and that is reason enough for it to be built.

We are full of people and children and need an emergency center closer to the community to protect and treat our citizens. Having an ER nearby is important for the health of our community and the surrounding areas. I hope this facility is approved and can begin treating people in Nolensville.

Sincerely,

Tara Diffie
1504 Halsey Dr.
Nolensville, TN 37135

March 10, 2023

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Southern Hills Medical Center's FSER CON Application

Dear Mr. Grant:

I witnessed an accident on 3/8/2023. One of the cars involved had injuries. It took emergency vehicles over 30 minutes to arrive at the scene. With the way Nolensville is growing along with the number of elderly individuals, it is unacceptable to wait 30 minutes to receive help. Nolensville is no longer a small sleepy suburb of Nashville and it needs its own ER in order to take care of this growing population.

I had to call for an ambulance for my mother. She lives with me in Burkitt Place. It took 35 minutes for the ambulance to arrive. This almost certainly would not have happened with an ER in Nolensville. Taking that long can cost lives and shouldn't happen when there is an opportunity to put a facility in Nolensville that can respond quickly to emergencies. Nolensville and the surrounding areas will continue to grow and this facility can service a greater area of Davidson/Williamson County.

Having an ER in Nolensville is important, and even though no one wants to use the ER, you want it to be there if you ever do need it. I hope you approve this ER.

Thank you,

Miranda Kirk

Miranda Kirk
724 Meadowcroft Ln
Nolensville, TN 37135

Mr. Logan Grant
Executive Director, Tennessee Health Facilities Commission

Subject: ER in Nolensville, TN

Dear Mr. Logan Grant,

I am writing this letter to you because there is a definite need for an ER here in Nolensville. We are not in close proximity to an ER, everything is over 20 minutes away and through lots of traffic. An ER should be in a convenient location, closer to where people live so that they can get to an emergency quickly.

Nolensville is also growing quickly, so the proximity issue could become greater as traffic increases. Emergency services are needed in Nolensville, they will benefit our community as well as nearby communities like Brentwood and Antioch.

I hope that you choose to approve this ER and bring valuable emergency care to the people of Nolensville.

Sincerely,

Janet Lynch

Janet Lynch
709 Westcott Ln
Nolensville, TN 37135

Attachment 1C-1

Transfer Agreements

FACILITY TRANSFER AGREEMENT (Revised 04-2011)

This Transfer Agreement (the "Agreement") is made as of this **30** day of **April**, 20**22**, by and between:
HCA Health Services of Tennessee, Inc., doing business as
TriStar Southern Hills Medical Center and
HCA Health Services of Tennessee, Inc. d/b/a Centennial Medical Center,
each individually referred to herein as "facility," or "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

W I T N E S S E T H:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities;

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. **Transfer of Patients.** In the event any patient of either facility is deemed by that facility (the "Transferring Facility") as requiring the services of the other facility (the "Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. **Responsibilities of the Transferring Facility.** The Transferring Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer;

(B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;

(C) Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;

(D) Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;

(E) Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

(F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

(G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

(H) Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed

consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

(I) Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

(J) Notify the Receiving Facility of the estimated time of arrival of the patient;

(K) Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(N) Recognize the right of a patient to refuse consent to treatment or transfer;

(O) Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred;

(P) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

(Q) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. **Responsibilities of the Receiving Facility.** The Receiving Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within **Thirty (30)** minutes after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

(B) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred and maintain a call roster of physicians at the Receiving Facility;

(C) Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

(D) Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

(E) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

(F) Provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

(G) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

(H) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

(I) Provide for the return transfer of patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to the Transferring Facility, provide the items and services specified in Section 2 of this Agreement;

(J) Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(K) Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Complete, execute, and return the memorandum of transfer form to the Transferring Facility; and,

(N) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. **Billing.** All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. *In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made at* **NA** *% of charges or in accordance with the payment fee schedule, labeled as Exhibit* **NA**, *attached hereto and incorporated herein by this reference.* In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. **Transfer Back; Discharge; Policies.** At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the agreed upon location. If the patient is to be transferred back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility. Such transfers shall be conducted in accordance with HCA Healthcare Corporation Ethics and Compliance Policies and Procedures (*e.g., Discharge Planning and Referrals of Patients to Post Discharge Providers Policy, LL.HH.016 and EMTALA – Transfer Policy, EM.003*).

6. **Compliance with Law.** Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. **Indemnification; Insurance.** The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. **Term; Termination.** The term of this Agreement shall be a minimum of one (1) year, commencing on the **1** day of **May**, 20**22**, and ending on the **30** day of **April**, 20**24**, unless sooner terminated as provided herein. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. In addition, this Agreement may be terminated immediately upon the occurrence of any of the following events:

(A) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or

(B) Either facility loses its license, or Medicare certification.

This Agreement may be renewed for subsequent one (1) year terms upon the mutual written consent of the parties.

9. **Arbitration**. Any dispute or controversy arising under, out of or in connection with, or in relation to this Agreement, or any amendment hereof, or the breach hereof shall be determined and settled by arbitration in **Davidson County**, **Tennessee**, in accordance with the rules of the American Health Lawyers Association Alternative Dispute Resolution Services and applying the laws of the state specified in section 11 below. Any award rendered by the arbitrator shall be final and binding upon each of the parties, and judgment thereof may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both parties. During the pendency of any such arbitration and until final judgment thereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated provided hereunder.

10. **Entire Agreement; Modification**. This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

11. **Governing Law**. This Agreement shall be construed in accordance with the laws of the State of **Tennessee** in which the facility affiliated with HCA is located.

12. **Partial Invalidity**. If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

13. **Notices**. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to: **HCA Health Services of Tennessee, Inc. d/b/a**
TriStar Southern Hills Medical Center
391 Wallace Road
Nashville, TN 37211
Attention: Chief Executive Officer

Copy to: One Park Plaza, P.O. Box 550
Nashville, Tennessee 37202-0550
Attention: **John Bradford**, Operations Counsel

If to: **HCA Health Services of Tennessee, Inc. d/b/a**
TriStar Centennial Medical Center
2300 Patterson Street
Nashville, Tn 37203
Attention: Chief Executive Officer

or to such other persons or places as either party may from time to time designate by written notice to the other.

14. **Waiver**. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

15. **Assignment; Binding Effect**. Each facility shall not assign or transfer, in whole or in part, this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

16. **Change in Law**. Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within thirty (30) days after said notice was given, this Agreement shall terminate as of midnight on the thirtieth (30th) day after said notice was given.

17. **Warranty of Non-Exclusion.** Each party represents and warrants to the other that the party, its officers, directors and employees (i) are not currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. §1320a-7b(f) (the "federal healthcare programs"), (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services but have not yet been excluded, debarred, or otherwise declared ineligible to participate in the federal healthcare programs, and (iii) are not, to the best of its knowledge, under investigation or otherwise aware of any circumstances which may result in the party or any such individual being excluded from participation in the federal healthcare programs. This shall be an ongoing representation and warranty during the term of this Agreement and each party shall immediately notify the other of any change in the status of the representations and warranty set forth in this section. Any breach of this section shall give the other party the right to terminate this Agreement immediately for cause.

18. **HIPAA Compliance Requirements.** To the extent applicable to this Agreement, Contractor agrees to comply with the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d through d-8 ("HIPAA") and any current and future regulations promulgated under either the HITECH Act or HIPAA, including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162 and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transactions Regulations"), all as may be amended from time to time, and all collectively referred to herein as "HIPAA Requirements." Contractor agrees to enter into any further agreements as necessary to facilitate compliance with HIPAA Requirements.

19. **Access To Records.** Pursuant to the requirements of 42 CFR §420.300 et seq., each party agrees to make available to the Secretary of Health and Human Services ("HHS"), the Comptroller General of the Government Accounting Office ("GAO") or their authorized representatives, all contracts, books, documents and records relating to the nature and extent of costs hereunder for a period of four (4) years after the furnishing of Services hereunder for any and all Services furnished under this Agreement. In addition, each party hereby agrees to require by contract that each subcontractor makes available to the HHS and GAO, or their authorized representative, all contracts, books, documents and records relating to the nature and extent of the costs thereunder for a period of four (4) years after the furnishing of Services thereunder.

20. **Execution of Agreement.** This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

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

HCA Health Services of Tennessee, Inc. d/b/a
TriStar Southern Hills Medical Center

By: Joanna J Conley

Its: **Joanna Conley - Chief Executive Officer**

HCA Health Services of Tennessee, Inc d/b/a
TriStar Centennial Medical Center

By: Cynthia Lockyear CNO

Its: Cynthia Lockyear, Chief Nursing Officer

Monroe Carell Jr. Children's Hospital at Vanderbilt University Medical Center
Comprehensive Regional Pediatric Center (CRPC) Network
Pediatric Educational Agreement

This Agreement is entered into the __14th______day of ___ December_____________, 2016 (the "Effective Date"), between Tristar Southern Hills Medical Center (hereinafter called "Hospital") and Vanderbilt University Medical Center through its Monroe Carell Jr. Children's Hospital (hereinafter called "Center").

WHEREAS, the Center is certified as a Comprehensive Regional Pediatric Center by the State of Tennessee ("State"), and serves as a regional referral center for the specialized care of pediatric patients or in special circumstances provides safe and timely transfer of children to other resources for specialized care; and

WHEREAS, as part of such certification, Center is responsible for organizing and implementing a network of educational support to the hospitals in its region, including Hospital, that trains instructors, including physicians, nurses, and emergency medical personnel, to teach pediatric pre-hospital, nursing and physician-level emergency care to all hospitals and healthcare providers in the region and that promotes family-centered care in relation to policies, programs and environments for children treated in emergency departments; and

WHEREAS, Hospital and Center would like to enter into an arrangement whereby Center provides continuing education courses regarding pediatric skills and training to Hospital's employees and staff designed to improve the care of pediatric patients in the region.

NOW, THEREFORE, in consideration of the mutual covenants hereinafter set forth and intending to be legally bound hereby, it is agreed by and between the parties hereto as follows:

I. Services

A. Center will offer educational courses addressing pediatric pre-hospital emergency care to area physicians, nurses, and emergency technicians, including employees or agents of Hospital, at times and dates as determined by Center or as may be specifically requested by Hospital ("Courses");
B. Upon notice of a Course or Courses being offered, Hospital shall be responsible for registering its employees or other personnel who participate in such Course or Courses (each, a "Participant" and together, the "Participants");
C. Hospital shall be responsible to the Center for any fees that Center incurs related to training provided by third parties. Center and Hospital agree that third party training shall only be provided upon the request of Hospital and the cost of such training shall be communicated in advance.
D. Center shall prepare all course materials and shall send such materials to Hospital after registration and payment of fees.
E. Hospital shall forfeit fees if Hospital fails to cancel a Participant within seventy-two (72) hours of commencement of the Course for Participant's inability to attend. Hospital shall give Center notice of cancellation in writing or by phone.

II. Term of Agreement

This Agreement shall be in effect from the Effective Date and shall continue for a period of three (3) years. Thereafter, it shall be renewed automatically for successive periods of one (1) year each, unless sooner terminated by either party giving at least sixty (60) days notice at any time during the initial or

any renewal term to the other party of their interest not to continue the contractual relationship. This Agreement may be amended at any time by a written agreement signed by both parties.

III. Continuing Education Efforts

Both Hospital and Center will work together to make available to healthcare workers and Participants continuing education intended to maintain and update their skills in recognizing and stabilizing pediatric emergencies. Center reserves the right to remove from participation in any of the Courses any Participant who is disruptive, non-cooperative, or presents any threat to the health, safety, or well-being of Center's employees, agents, patients, or the other participants.

IV. Notices

All notices, requests, demands or other communications under this Agreement shall be in writing and shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the third day after mailing if mailed to the party to whom notice is to be given, by first class mail, registered or certified, postage prepaid, and properly addressed as follows:

Hospital: Tri Star Southern Hills Medical Center

Center: Monroe Carell Jr. Children's Hospital at Vanderbilt
3401 West End Avenue
Nashville, Tennessee 37203
Attn: CRPC Coordinator

With a copy to: Vanderbilt University Medical Center
Office of Contracts Management
3319 West End Avenue, Suite 100
Nashville, TN 37203-6869
Attn: Director

Either party may change its address indicated above by giving the other party written notice of the new address in the manner set forth above.

V. Media

The parties agree they will not use each other's name or programs in any advertising, promotional material, press release, publication, public announcement, or through other media, written or oral, whether to the press, to holders of publicly owned stock without the prior written consent of the party whose name is to be used.

VI. Materials

All materials, documents, and information furnished by Center and prepared or developed by Center shall be the sole and exclusive property of Center and shall not be copied, reproduced,

distributed, or republished in any way without the express written consent of Center.

VII. Headings Not Binding

The headings used in this Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement.

VIII. Non-Exclusivity

Each party shall have the right to enter into similar agreements with other parties to the extent such other agreements will not prohibit either party from meeting its obligations hereunder.

IX. Entire Agreement

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter herein and supersedes any other agreements, restrictions, representations, or warranties, if any, between the parties hereto with regard to the subject matter herein.

IN WITNESS WHEREOF, Hospital and Center have caused the Agreement to be executed on the day and first above written.

Hospital Name: TriStar Southern Hills Medical Center

By: [signature]
Printed Name: Richard Tumlin
Title: Interim CEO
Date: 3/3/17

By: [signature]
Printed Name: Greta H. Walsh
Title: Director Emergency/Cardiovascular Services
Date: 3-3-17

Center: Vanderbilt University Medical Center, by and through its Monroe Carell Jr. Children's Hospital

Recommended by:

By: [signature]
Name: Luke Gregory, FACHE
Title: CEO
Date: 5/9/17

Approved by:

By: [signature]
Name: C. Wright Pinson, MBA, MD
Title:
Date:

Monroe Carell Jr. Children's Hospital at Vanderbilt University Medical Center
Comprehensive Regional Pediatric Center (CRPC) Network
Pediatric Educational Agreement

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WHEREAS, as part of such certification, Center is responsible for organizing and implementing a network of educational support to the hospitals in its region, including Hospital, that trains instructors, including physicians, nurses, and emergency medical personnel, to teach pediatric pre-hospital, nursing and physician-level emergency care to all hospitals and healthcare providers in the region and that promotes family-centered care in relation to policies, programs and environments for children treated in emergency departments; and

WHEREAS, Hospital and Center would like to enter into an arrangement whereby Center provides continuing education courses regarding pediatric skills and training to Hospital's employees and staff designed to improve the care of pediatric patients in the region.

NOW, THEREFORE, in consideration of the mutual covenants hereinafter set forth and intending to be legally bound hereby, it is agreed by and between the parties hereto as follows:

I. Services

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B. Upon notice of a Course or Courses being offered, Hospital shall be responsible for registering its employees or other personnel who participate in such Course or Courses (each, a "Participant" and together, the "Participants");
C. Hospital shall be responsible to the Center for any fees that Center incurs related to training provided by third parties. Center and Hospital agree that third party training shall only be provided upon the request of Hospital and the cost of such training shall be communicated in advance.
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any renewal term to the other party of their interest not to continue the contractual relationship. This Agreement may be amended at any time by a written agreement signed by both parties.

III. Continuing Education Efforts

Both Hospital and Center will work together to make available to healthcare workers and Participants continuing education intended to maintain and update their skills in recognizing and stabilizing pediatric emergencies. Center reserves the right to remove from participation in any of the Courses any Participant who is disruptive, non-cooperative, or presents any threat to the health, safety, or well-being of Center's employees, agents, patients, or the other participants.

IV. Notices

All notices, requests, demands or other communications under this Agreement shall be in writing and shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the third day after mailing if mailed to the party to whom notice is to be given, by first class mail, registered or certified, postage prepaid, and properly addressed as follows:

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Center: Monroe Carell Jr. Children's Hospital at Vanderbilt
3401 West End Avenue
Nashville, Tennessee 37203
Attn: CRPC Coordinator

With a copy to: Vanderbilt University Medical Center
Office of Contracts Management
3319 West End Avenue, Suite 100
Nashville, TN 37203-6869
Attn: Director

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The headings used in this Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement.

VIII. Non-Exclusivity

Each party shall have the right to enter into similar agreements with other parties to the extent such other agreements will not prohibit either party from meeting its obligations hereunder.

IX. Entire Agreement

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter herein and supersedes any other agreements, restrictions, representations, or warranties, if any, between the parties hereto with regard to the subject matter herein.

IN WITNESS WHEREOF, Hospital and Center have caused the Agreement to be executed on the day and first above written.

Hospital Name: TriStar Southern Hills Medical Center

By: [signature]
Printed Name: Richard Tumlin
Title: Interim CEO
Date: 3/3/17

By: [signature]
Printed Name: Greta H. Walsh
Title: Director Emergency/Cardiovascular Services
Date: 3-3-17

Center: Vanderbilt University Medical Center, by and through its Monroe Carell Jr. Children's Hospital

Recommended by:

By: [signature]
Name: Luke Gregory, FACHE
Title: CEO
Date: 5/9/17

Approved by:

By: [signature]
Name: C. Wright Pinson, MBA, MD
Title:
Date:

MUTUAL AGREEMENT FOR EMERGENCY PATIENT TRANSFER BY AND BETWEEN PARTICIPATING HOSPITALS

PARTICIPANT'S SIGNATORY PAGE

We, the undersigned, agree to abide by the MUTUAL AGREEMENT FOR EMERGENCY PATIENT TRANSFER BY AND BETWEEN PARTICIPATING HOSPITALS.

Name of Facility: Southern Hills Medical Center

Name of President/CEO/Director or Designee: Thomas H. Ozburn

Authorized Signature: [signature]

Title: Chief Executive Officer

Date: 9/27/10

Revised: 05/09

MUTUAL AGREEMENT FOR EMERGENCY PATIENT TRANSFER BY AND BETWEEN PARTICIPATING HOSPITALS

LIST OF PARTICIPATING FACILITIES

Facility	Address
Baptist Hospital	2000 Church Street Nashville, TN 37236
Centennial Medical Center	2300 Patterson Street Nashville, TN 37203
Centennial Medical Center at Ashland City	313 North Main Street Ashland City, TN 37015
Gateway Health Systems	1771 Madison Street Clarksville, TN 37043
Hendersonville Medical Center	355 New Shackle Island Road Hendersonville, TN 37075
Horizon Medical Center	111 Highway 70 East Dickson, TN 37055
Metropolitan Nashville Bordeaux Hospital	1414 County Hospital Road Nashville, TN 37218
Metropolitan Nashville General Hospital	1818 Albion Street Nashville, TN 37208
Middle Tennessee Medical Center	400 N. Highland Avenue Murfreesboro, TN 37130
Northcrest Medical Center	100 Northcrest Drive Springfield, TN 37172
Select Specialty Hospital	2021 Church Street Suite #202 Nashville, TN 37203
Skyline Medical Center	3441 Dickerson Pike. Nashville, TN 37207
Skyline Medical Center – Madison	500 Hospital Drive Madison, TN 37115

Saint Thomas Hospital	4220 Harding Road (Box 380) Nashville, TN 37202
Southern Hills Medical Center	391 Wallace Road Nashville, TN 37211
StoneCrest Medical Center	200 StoneCrest Blvd Smyrna, TN 37167
Summit Medical Center	5655 Frist Boulevard Nashville, TN 37076
Sumner Regional Medical Center	555 Hartsville Pike Gallatin, TN 37066
University Medical Center	1411 Baddour Parkway Lebanon, TN 37087
Vanderbilt Medical Center	1161 21st Ave. South Nashville, TN 37232
Veterans Administration Medical Center	1310 24th Ave. South Nashville, TN 37212
Williamson Medical Center	P.O. Box 681600 Franklin, TN 37068

MUTUAL AGREEMENT FOR EMERGENCY PATIENT TRANSFER

BY AND BETWEEN

PARTICIPATING HOSPITALS - 2009

In consideration of the needs of the residents of the area serviced by the institutions listed below, this Agreement is entered into by the hospitals that are listed on the Participants' Signatory Page. In the event of a natural or human-related disaster, as defined under the Davidson County Comprehensive Emergency Management Plan and comparable state and Federal agencies, in which a participating institution's ability to provide continuity of care is prohibited, the participating institutions mutually agree to provide hospitalization, when possible, for patients of the other institutions named in this agreement should the emergency require evacuation of patients. In the event of a national emergency declared by the President of the United States, the United States Congress, or a presidentially declared natural or technological disaster, a Federal party to this agreement must abide by its Federal Department policy and directives, and applicable Federal statutes on, including but not limited to, emergency preparedness and information disclosure.

To the extent possible, under all the circumstances, emergency patient transfers shall be conducted in compliance with COBRA regulations, 42 USC 1395dd et seq. and any amendments thereto and such other requirements as may be imposed by the Secretary of Health and Human Services. This provision does not apply to any Federal party not subject to such statute or Health and Human Services Regulations.

In this agreement, the institution requiring evacuation of patients is hereafter referred to as "TRANSFERRING INSTITUTION" and the institution receiving patients is referred to as "RECEIVING INSTITUTION".

Now therefore, the parties agree as follows:

1. When the need exists for the evacuation of patients from the TRANSFERRING INSTITUTION to the RECEIVING INSTITUTION, the RECEIVING INSTITUTION agrees to facilitate prompt admission of such evacuated patients subject to availability of appropriate space and the ability to provide the services needed by the patients, and to the extent permitted by laws applicable to the participant. (VA's ability to participate in this Agreement is limited by certain obligations that may take precedence over this agreement to assist local non-VA facilities during a disaster, including the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. Sections 5121, et seq. (the Stafford Act); The National Disaster Medical System (NDMS); 38 U.S.C. Section 1785, 38 U.S.C. Section 8111A; and /or where provision of resources to non-Veterans would deny or delay care to eligible Veterans. Determinations by the VA concerning the availability of services and/or other resources to be provided by the VA pursuant to this

Agreement are conclusive, binding on the parties to this Agreement, and non-reviewable. The decision of the VA not to provide any service or other resources called for by this Agreement because of its unavailability does not constitute a breach of the Agreement and is not considered a cause for termination of this Agreement in whole or part.)

2. A patient may only be admitted for inpatient care by a physician who has medical staff privileges at the RECEIVING INSTITUTION. If a patient's attending physician does not have medical staff privileges at the RECEIVING INSTITUTION, he must be granted temporary privileges pursuant to Section 6 below before he can admit his patient. Should such privileges be denied, or should the attending physician choose not to admit his patient himself, the patient must be admitted by another member of the RECEIVING INSTITTTION'S medical staff through a referral by the attending physician. The TRANSFERRING INSTITUTION is responsible for notifying family members of the new location of the patient.

3. When a patient has been transferred to the RECEIVING INSTITUTION from the TRANSFERRING INSTITUTION and it is determined that the need no longer exists to retain the patient at the RECEIVING INSTITUTION but the patient does require further hospitalization and/or follow-up, the TRANSFERRING INSTITUTION agrees to readmit that patient for the appropriate hospitalization and/or follow-up and to provide or arrange for transportation back to the TRANSFERRING INSTITUTION. The RECEIVING INSTITUTION may discharge patients per physician's order. The TRANSFERRING INSTITUTION will be notified of the discharge.

4. The TRANSFERRING INSTITUTION and RECEIVING INSTITUTION agree to provide each other with information regarding the type of resources and services the patient needs, the health conditions of the patient, and other needs of the patient, and any and all other information necessary to provide care for the patient, subject to any applicable release of information requirements imposed by the Privacy Act, 5 U.S.C. 552a, HIPAA, 38 U.S.C. 7332, and 38 U.S.C. Sections 5701 and 5705 if governed there under and applicable thereto.

5. The RECEIVING INSTITUTION and the TRANSFERRING INSTITUTION agree to send with each patient, at the time of transfer or, in case of disaster, as promptly as possible after the transfer, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption together with essential, identifying and administrative information, subject to any applicable release of information requirements imposed by the Privacy Act, 5 U.S.C. 552a, HIPAA, 38 U.S.C. 7332, and 38 U.S.C. Sections 5701 and 5705 if governed there under and applicable thereto.

6. The RECEIVING INSTITUTION agrees to grant temporary reciprocity to those members of the medical staff of the Transferring Institution in certain specialties or departments if permitted by the Receiving Institution's governing handbooks, policies, bylaws or directives. The Receiving Institution reserves the right to deny temporary reciprocal privileges to any member of the medical staff of the Transferring Institution, for any or no reason in its sole discretion. As soon as possible the TRANSFERRING

INSTITUTION will provide a current listing of all credentialed medical staff seeking reciprocal privileges to the credentialing offices of the RECEIVING INSTITUTION, along with such credentialing documentation as is required and reasonably requested by the receiving Institution.

7. The RECEIVING INSTITUTION agrees to grant temporary reciprocity to licensed professional patient care providers employed by the TRANSFERRING INSTITUTION if permitted by its governing handbooks, policies, bylaws or directives. The Receiving Institution reserves the right to deny temporary reciprocity to any such licensed professional patient care providers for any or no reason in its sole discretion. As soon as possible, the TRANSFERRING INSTITUTION will provide a listing of licensed professional patient care providers to be granted reciprocity in order to work at the RECEIVING INSTITUTION, including pertinent licensing and certification information and documentation as required and reasonably requested by the Receiving Institution. Prior to such individuals' commencing work at the Receiving Institution, they shall report to the designated Administrator of the receiving Institution, and shall thereafter comply with all appropriate directives of the administration of the Receiving Institution. Such individuals remain on the payroll of the TRANSFERRING INSTITUTION which will continue normal insurance and workers compensation insurance coverage, unless other arrangements have been made.

8. The RECEIVING INSTITUTION and the TRANSFERRING INSTITUTION agree to notify the other institution promptly and in writing of any incident, occurrence, or claim arising out of or in connection with the transfer or medical treatment of a patient transferred from one facility to another under this Agreement, and to the extent permitted by laws applicable to the participant to cooperate with the other institution in this investigation of said incident, occurrence or claim, including provision of any medical records and information the other institution should request.

9. The INSTITUTIONS named on this Agreement carry general liability, including broad form contractual and professional liability insurance in a minimum amount of $1,000,000 /$3,000,000 and shall provide a certificate of said coverage with this Agreement. This does not apply to governmental agencies as prohibited/restricted or otherwise provided by law.

10. The RECEIVING INSTITUTION and the TRANSFERRING INSTITUTION hereby agree to indemnify and hold the other institution harmless from any and all liability and claims of liability arising out of the sole negligence of the other institution's staff, employees, representative, and authorized agents alleged to have occurred during the other institution's care and treatment of patients transferred pursuant to this Agreement. However, to the extent permitted by law and not inconsistent with the doctrine of sovereign immunity, government agencies only accept responsibility for negligent acts and omissions of its employees and damages proximately caused thereby.

11. Neither the TRANSFERRING INSTITUTION, any of its employees or medical staff is to be construed as an agents or employees of the RECEIVING INSTITUTION. Neither the RECEIVING INSTITUTION, nor any of its employees or medical staff is to be construed as agents or employees of the TRANSFERRING INSTITUTION. Each party to this Agreement shall be considered to be an independent party and shall not be construed to be an agent or representative of any of the other parties, and therefore, has no liability for the acts or omissions of any of the other parties.

12. The TRANSFERRING INSTITUTION agrees that it will be responsible for payment of transportation services incurred when transferring patients to the RECEIVING INSTITUTION from the TRANSFERRING INSTITUTION. It is agreed that the services rendered by the TRANSFERRING INSTITUTION or the RECEIVING INSTITUTION shall be charged to the patient and that the TRANSFERRING INSTITUTION will not be held responsible for payment for services rendered to a patient by RECEIVING INSTITUTION nor shall the RECEIVING INSTITUTION be held responsible for services rendered to a patient by the TRANSFERRING INSTITUTION.

13. No party entering this Agreement shall use the name of any other party in this Agreement in any promotional or advertising material unless review and specific written approval of the material and intended use shall first be obtained from the party whose name is to be used.

14. Nothing in this Agreement shall be construed as limiting the right of any party entering into this Agreement to affiliate or contract with any other party on either a limited or general basis, while this Agreement is in effect.

15. The individual governing bodies of the institutions entering this Agreement shall have the exclusive control of the management, assets and affairs of their respective institutions.

16. By agreeing to admit an individual pursuant to the terms of this Agreement, the RECEIVING INSTITUTION does not assume legal responsibility for the individual until it assumes physical custody and control over said individual. Any responsibility incurred thereby shall terminate when the individual ceases to be a patient in said institution except for the results of the quality of care dispensed during the tenure of stay at the institution.

17. All institutions entering this Agreement shall comply with all federal and state laws or regulations applicable to this Agreement. If any provision of this Agreement shall at any time, conflict with any state or federal laws applicable thereto or shall conflict with any regulation of any regulatory agency having jurisdiction with respect thereto, the state or federal law shall govern except that a Federal party hereto does not waive any sovereign immunity except as specifically provided by act of Congress.

18. This agreement shall be reviewed on an annual basis, and revised if necessary. This Agreement will automatically renew itself. However, an institution may elect to terminate its participation in this Agreement. In that event, that institution shall terminate its participation in this Agreement by written notification to the other institutions at least ninety (90) days prior to the desired date of termination. However the termination of one institution shall not void this Agreement, and the terms and conditions of this Agreement shall remain effective and in force with the remaining institutions. An institution shall automatically be terminated from this Agreement should it fail to maintain licensure or certification as provided by law or regulation.

19. No revision in or amendment to this Agreement shall be valid unless such revision or amendment is in writing and executed by all parties hereto.

20. This agreement constitutes the entire understanding and agreement among the parties hereto with respect to the subject matter hereof and contains all the Agreements among the parties with respect to the subject matter and supersedes and replaces all agreements, both oral and written. There are no arrangements, understandings, restrictions, representations, or warranties among any of the parties hereto, except as provided herein this Agreement.

21. This Agreement cannot be amended, modified, supplemented or rescinded except in writing by the parties hereto. No waiver of any provision of this Agreement shall be valid unless such waiver is in writing signed by the parties hereto.

22. Each party hereby irrevocably consents to the jurisdiction of all state and federal courts sitting in Davidson County, Tennessee, agree that venue for any such action shall lie exclusively in such courts and agree that such courts shall be the exclusive forum for any legal actions brought in connection with this Agreement or the relationships among the parties hereto except that a Federal party hereto does not waive any sovereign immunity except as specifically provided by act of Congress.

23. The headings used in the Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement.

24. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors or assigns, provided that appropriate written evidence of such assignment, signed by the assignor, is duly received by the other parties hereto.

25. This Agreement shall be governed in all respects by, and be construed in accordance with, the laws of the State of Tennessee and of the Federal government except that a Federal party hereto does not waive any sovereign immunity except as specifically provided by act of Congress.

26. The failure by any party to enforce at any time any of the provisions of this agreement or any rights with respect thereto, or to exercise any election herein provided, shall in no way be considered to be a waiver of such provisions, rights, or elections, or in any way affect the validity of this Agreement. The exercise by any party of any rights or elections under the terms or covenants of this Agreement shall not preclude or prejudice any party form exercising the same or any other right it may have under this Agreement, irrespective of any previous action or proceeding taken by the parties.

27. In compliance with federal law, including provisions of Title IX of the Education Amendments of 1972, Section 503 and 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, the parties hereto will not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military

service in its administration of its policies, programs, or activities; its admissions policies; other programs; or employment.

28. This Agreement may be executed in one or more counterparts (facsimile transmission or otherwise), each of which counterpart shall be deemed an original Agreement and all of which shall constitute but one Agreement.

29. It is mutually agreed that any duty, obligation or liability of all parties assumed by this Agreement or any subsequent extensions or revisions thereto should continue until such time as the duty, obligation, or liability ceases to exist.

Attachment 1C-3

Community Benefit Report

TriStar Southern Hills

Nashville, TN | Additional location: TriStar Century Farms ER

TriStar Southern Hills has served the South Nashville, Brentwood and Antioch communities for more than 40 years. Our 24/7 ER is an accredited chest pain center and primary stroke center. The Joint and Spine Center is a 20-bed boutique center dedicated to the wellness of patients who require any type of spine, orthopedic or neurosurgery procedure.

Our cardiovascular team is equipped to provide fast, life-saving treatment for heart attacks and other heart-related conditions. Our TriStar Southern Hills Center for Surgical Weight Loss offers the latest in minimally invasive techniques for patients seeking to decrease their risk of obesity-related health conditions.

Drew Tyrer
Chief Executive Officer

Key Services:

- Emergency
- Neurosurgery
- Bariatrics
- Orthopedics
- Cardiology
- Neurology
- Surgical Care
- Wound Care

5,479
Patient Admissions

46,129
Total Annual ER Visits

646
Colleagues

136
Licensed Beds

All data based on 2021 annual results.

Attachment 2C

List of Contracted Managed Care Organizations

The Health Care Consumer Right-to-Know Act of 1998 which was signed by Governor Sundquist in May, 1998 requires hospitals to report to the Department of Health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently - as of the last day of this reporting period - have a valid contract. List each plan separately not just the name of the Company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield of Tennessee.

Plans:

Aetna - TennesseeAmbetter Nashville
American Health Advantage HOS - TN
Amerigroup MCD TNCare - TNAmerigroup MCR TNCare - TN
Apex Health - TNATRIO (Golden Times) - TNBCBS MCR - TN
BCBS TN Network PBeech Street - TN
BGFH SingleSource - Southern HillsBright Health - TN
Buyers Healthcare - HorizonCenturion of TN - Tristar
Cigna - Southern HillsCorVel Corporation - Tristar
Employers Health Network - TN
HCA Employee Benefit Plan - TNHealthspring Southern Hills
Humana ChoiceCare Network - TNHumana Tricare - TN
Kentucky Labor Cabinet - Tristar Workers Comp
Multiplan - TNNovaNET TNOdom's TN Pride Sausage - TN
Odyssey Healthcare - TristarOscar - TN
Plumbers and Pipefitters Local 572 - Tristar
Prime Health COMM - TristarPrime Health WC - SAD, Tristar
Pruitt Health (AllyAlign) - Tristar TNRhythm Health - TN
Sarah Cannon Research - TriStar
Signature Advantage, LLC - TNUnited - TennCare
United - TN HOSUnited HOS - TNUnited VA CCN HOS - TN
VHP TennCare - TristarWellCare - TN

Attachment 4C-1

Clinical Training Affiliations

School	Program Name
Academy of Allied Health	Advanced EMT
Academy of Allied Health	Phlebotomy Technician Program
Albany College of Pharmacy and Health Sciences	Pharmacy
Andrew College	Respiratory Therapy
Andrews University	Medical Laboratory Science
Arcadia University	Masters in Medical Science
Auburn University	BSN
Auburn University	MSN
Auburn University	DNP
Augusta University	Medical Laboratory, Imaging, & Radiologic Sciences
Augusta University	Health Informatics
Augusta University	Occupational Therapy
Augusta University	Physical Therapy
Augusta University	Respiratory Therapy
Augusta University	Physician Assistant
Augusta University	College of Nursing
Augusta University	Clinical and Digital Health Sciences
Aurora University	School of Education
Aurora University	Social Work
Austin Peay State University	BSN
Austin Peay State University	Radiography
Austin Peay State University	Radiation Therapy
Austin Peay State University	Medical Lab Science
Austin Peay State University	Phlebotomy Technician Program
Austin Peay State University	Social Work
Austin Peay State University	MSN
Austin Peay State University	BSN
Azusa Pacific University	BSN
Azusa Pacific University	MSN
Azusa Pacific University	DNP
Bellarmine University	Physical Therapy
Belmont University	BSN
Belmont University	MSN
Belmont University	APN
Belmont University	DNP
Belmont University	Physical Therapy
Belmont University	Occupational Therapy
Belmont University	Social Work
Belmont University	Pharmacy
Belmont University	Music Therapy
Belmont University	Mental Health Counseling
Bethel University	BSN
Bethel University	Physician Assistant
Calvin University	Speech Language Pathology
Capella University	Clinical Mental Health Counseling
Capella University	DNP
Capella University	Social Work
Capella University	MSN
Cardiac & Vascular Institute of Ultrasound	Cardiac and Vascular Ultrasound

Chamberlain College of Nursing	BSN
Chamberlain College of Nursing	MSN
Chamberlain College of Nursing	APN
Chamberlain College of Nursing	DNP
Clarkson University	Occupational Therapy
Concorde Career College	Occupational Therapy Assistant
Concordia University	Diagnostic Medical Sonogrophy
Cumberland University	BSN
Cumberland University	MSN
Cumberland University	APN
Cumberland University	DNP
Dalton State College	Assoc Degree in Nursing
Dalton State College	BSN
Dalton State College	Respiratory Therapy
Dalton State College	Medical Laboratory Technology
Dalton State College	Radiologic Technology
Dalton State College	Social Work
Dalton State College	Phlebotomy
Duke University	MSN
East Tennessee State University	Nursing
East Tennessee State University	Exercise Science
Emory University	BSN
Emory University	MSN
Emory University	APN
Emory University	DNP
Emory University	Ph.D. in Nursing
Emory University	Anesthesiology Assistant
Emory University	Human Genetics
Emory University	Medical Imaging
Emory University	Physical Therapy
Emory University	Physician Assistant
Faithful Guardian Training Center	Paramedic
Faulkner University	Speech Language Pathology
Faulkner University	Physical Therapy
Faulkner University	Occupational Therapy
Faulkner University	Physician Assistant
Fortis Institute	Surgical Technology
Fortis Institute	Radiologic Technology
Fortis Institute	Cardiovascular Technology
Fortis Institute	Medical Laboratory Technology
Fortis Institute	Assoc Degree in Nursing
Fortis Institute	BSN
Fortis Institute	Pharmacy Technician
Fortis Institute	EMT - Paramedic
Fortis Institute	Radiologic Technology
Fortis Institute	Cardiovascular Technology
Fortis Institute	Medical Laboratory Technology
Fortis Institute	Assoc Degree in Nursing
Fortis Institute	BSN
Fortis Institute	Pharmacy Technician

Fortis Institute	Emergency Medical Services
Fortis Institute	Medical Assisting
Freed-Hardeman University	BSN
Freed-Hardeman University	MSN
Freed-Hardeman University	APN
Freed-Hardeman University	DNP
Frontier Nursing University	MSN
Frontier Nursing University	DNP
Frontier Nursing University	Nurse Practitioner
Frontier Nursing University	Certified Nurse Midwife
Galen College of Nursing	BSN
Galen College of Nursing	Assoc Degree in Nursing
Galen College of Nursing	MSN
Gannon University	Physical Therapy
Gannon University	Occupational Therapy
Gannon University	Physician Assistant
Gannon University	Speech Language Pathology
George Washington University	Medical Lab Science
Georgetown University	Nursing and Health Studies
Georgia Highlands College	Assoc Degree in Nursing
Georgia Highlands College	BSN
Georgia Highlands College	Business Administration
Georgia Highlands College	Health Information Management
Georgia Highlands College	Dental Hygiene
Georgia Northwestern Technical College	Assoc Degree in Nursing
Georgia Northwestern Technical College	Central Sterile Supply Processing Technician
Georgia Northwestern Technical College	Dental Assisting
Georgia Northwestern Technical College	Diagnostic Medical Sonography
Georgia Northwestern Technical College	Adult Echocardiography
Georgia Northwestern Technical College	Emergency Medical Technician
Georgia Northwestern Technical College	Health Information Management
Georgia Northwestern Technical College	Lactation Education
Georgia Northwestern Technical College	Mammography
Georgia Northwestern Technical College	Medical Assisting
Georgia Northwestern Technical College	Medical Scribe
Georgia Northwestern Technical College	Patient Care Assistant
Georgia Northwestern Technical College	Paramedic Technology
Georgia Northwestern Technical College	Phlebotomy Technician Program
Georgia Northwestern Technical College	Radiologic Technology
Georgia Northwestern Technical College	Respiratory Care
Georgia Northwestern Technical College	Surgical Technology
Georgia Northwestern Technical College	Vascular Technology
Georgia Northwestern Technical College	Practical Nursing
Georgia Southern University	Communication Science and Disorders
Georgia Southern University	Health Services Administration
Georgia Southern University	Health Informatics
Georgia Southern University	Medical Lab Science
Georgia Southern University	BSN
Georgia Southern University	MSN
Georgia Southern University	DNP

Georgia Southern University	Nutrition and Food Science
Georgia Southern University	Radiologic Sciences
Georgia Southern University	Respiratory Therapy
Georgia Southern University	Nurse Practitioner
Georgia Southern University	Nuclear Medicine
Georgia Southern University	Physical Therapy
Georgia Southern University	Radiation Therapy
Grand Canyon University	Nursing and Health Care
Gulf Coast Dietetic Internship	Dietetic Internship
Gwinnett Technical College	Echocardiography
Harding University	Physical Therapy
Harding University	Social Work
Herzing University	BSN
Herzing University	MSN
Herzing University	Health Information Management
Herzing University	Healthcare Management
Hopkinsville Community College	Nursing
Illinois State University	Dietetics
Indiana Wesleyan University	Social Work
Indiana Wesleyan University	Occupational Therapy
Indiana Wesleyan University	Physical Therapy
Indiana Wesleyan University	Exercise Science
Indiana Wesleyan University	BSN
Indiana Wesleyan University	MSN
Indiana Wesleyan University	DNP
Indiana Wesleyan University	APN
Indiana Wesleyan University	Music Therapy
Indiana Wesleyan University	Public Health
Indiana Wesleyan University	Social Work
Lee University	BSN
Lee University	DNP
Lenoir-Rhyne University	Dietetic Internship
Lenoir-Rhyne University	Nursing
Lenoir-Rhyne University	Occupational Therapy
Lenoir-Rhyne University	Exercise Science
Lenoir-Rhyne University	Public Health
Lincoln Memorial University	Physician Assistant
Lincoln Memorial University	MSN Nurse Anesthesia Concentration
Lindsey Wilson College	School of Professional Counseling
Lindsey Wilson College	BSN
Lipscomb University	BSN
Lipscomb University	MSN
Lipscomb University	APN
Lipscomb University	DNP
Lipscomb University	Pharmacy
Lipscomb University	Physician Assistant
Lipscomb University	College of Pharmacy & Health Sciences
Lipscomb University	Dept. of Psychology, Counseling, & Family Science
Madisonville Community College	Assoc Degree in Nursing
Madisonville Community College	Medical Laboratory Technology

Madisonville Community College	Physical Therapy Assistant
Madisonville Community College	Occupational Therapy Assistant
Madisonville Community College	EMS - Paramedic
Madisonville Community College	Radiography
Madisonville Community College	Respiratory Therapy
Madisonville Community College	Surgical First Assistant
Madisonville Community College	Surgical Technology
Marian University	BSN
Marian University	Doctor of Nurse Anesthesia Practice
Marian University	MSN
Maryville University	BSN
Maryville University	MSN
Maryville University	APN
Maryville University	DNP
Massachusetts College of Pharmacy and Health Scienc	Pharmacy
Massachusetts College of Pharmacy and Health Scienc	Nursing
Massachusetts College of Pharmacy and Health Scienc	Physician Assistant
Massachusetts College of Pharmacy and Health Scienc	Physical Therapy
Massachusetts College of Pharmacy and Health Scienc	Occupational Therapy
Massachusetts College of Pharmacy and Health Scienc	Medical Imaging and Radiation Therapy
Medaille College	Clinical Mental Health Counseling
MedCerts	Phlebotomy
Meridian Institute of Surgical Assisting	Surgical First Assistant
Middle Tennessee School of Anesthesia	MSN
Middle Tennessee School of Anesthesia	Nurse Practitioner
Middle Tennessee School of Anesthesia	Doctor of Nurse Anesthesia Practice
Middle Tennessee State University	Professional Counseling
Middle Tennessee State University	BSN
Middle Tennessee State University	MSN
Middle Tennessee State University	Social Work
Middle Tennessee State University	Health Care Informatics
Milligan University	Master of Science on Occupational Therapy
Mississippi University for Women	Music Therapy
Murray State University	Speech Language Pathology
Murray State University	Occupational Therapy
Nashville General Hospital	Radiologic Technology
National Institute of First Assisting	First Assisting
NHC/LP	Dietetic Internship
North Carolina Central University	Kinesiology and Recreation Administration
North Georgia Nursing Academy	Nursing Radiology
Northeast Alabama Community College	Practical Nursing
Northeast Alabama Community College	Assoc Degree in Nursing
Northern Kentucky University	FNP
Northern Kentucky University	A/G Primary
Northern Kentucky University	DNP
Northern Kentucky University	A/G Acute
Northern Kentucky University	NED
Northern Kentucky University	NEL
Northern Kentucky University	P/M Health
Northern Kentucky University	Social Work

Oakwood University	Distance dietetic Internship
Old Dominion University	BSN
Old Dominion University	MSN
Old Dominion University	DNP
Old Dominion University	Anesthesia
Puckett EMS Training Academy	EMT - Paramedic
Puckett EMS Training Academy	Emergency Medical Technician
Pulse Radiology	American Registry of Radiologic Technologists
Reinhardt University	BSN
Richmont Graduate University	Counseling
Saint Francis University	Physician Assistant
Saint Francis University	Physical Therapy
Saint Francis University	Occupational Therapy
Saint Francis University	Nursing
Saint Francis University	Exercise Physiology
Saint Francis University	Social Work
Saint Mary of the Woods College	Art Therapy
Saint Mary of the Woods College	Music Therapy
Saint Mary of the Woods College	Music Therapy
Samford University	Doctor of Pharmacy
Samford University	School of Health Professions
Samford University	Nursing
Samford University	Public Health
South College	Physical Therapy
South College	Pharmacy
South College	Nursing
South College	Physician Assistant
South College	Health & Therapy Programs
South College	Imaging Science
South College	Doctor of Nurse Anesthesia Practice
Southcentral Kentucky Community and Technical Colle	Assoc Degree in Nursing
Southcentral Kentucky Community and Technical Colle	Radiography
Southcentral Kentucky Community and Technical Colle	Respiratory Therapy
Southcentral Kentucky Community and Technical Colle	Sonography
Southcentral Kentucky Community and Technical Colle	Surgical Technology
Southcentral Kentucky Community and Technical Colle	EMT - Paramedic
Southern Adventist University	Assoc Degree in Nursing
Southern Adventist University	BSN
Southern Adventist University	MSN
Southern Adventist University	APN
Southern Adventist University	DNP
Southern Adventist University	Social Work
Southern Adventist University	Clinical Mental Health Counseling
Southern Adventist University	Physical Therapy Assistant
Southern Methodist University	Music Therapy
Stephens College	Physician Assistant

Attachment 4C-2
EMTALA Policy

Status **Active** PolicyStat ID **9669480**

Effective	2/1/2010	Owner	Timothy Danford: Dir Emergency Svcs FSED
Last Reviewed	5/10/2021	Policy Area	Emergency Services
Last Revised	10/2/2019	Applicability	TriStar Southern Hills Medical Center
Next Review	5/9/2024		

TriStar Southern Hills MEDICAL CENTER

Tennessee EMTALA – Transfer

DATE: 03/2019

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

PURPOSE: To establish guidelines for either accepting an appropriate transfer from another facility or providing an appropriate transfer to another facility of an individual with an emergency medical condition ("EMC"), who requests or requires a transfer for further medical care and follow-up to a receiving facility as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY: Any transfer of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf or by a physician order with the appropriate physician certification as required under EMTALA. EMTALA obligations regarding the appropriate transfer of an individual determined to have an EMC apply to any emergency department ("ED") or dedicated emergency department ("DED") of a hospital whether located on or off the hospital campus and all other departments of the hospital located on hospital property.

A hospital with specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural

areas) shall accept from a transferring hospital an appropriate transfer of an individual with an EMC who requires specialized capabilities if the receiving hospital has the capacity to treat the individual. The transferring hospital must be within the boundaries of the United States.

The transfer of an individual shall not consider age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law, except to the extent that pre-existing medical condition or physical or mental handicap is significant to the provision of appropriate medical care to the individual.

The CEO must designate in writing an administrative designee by title responsible for accepting transfers in conjunction with a receiving physician. The CEO designee in conjunction with the ED physician has authority to accept the transfer if the hospital has the capability and capacity to treat the individual.

Note: Movement of an individual to another part of the same hospital is not considered a transfer for EMTALA purposes.

1. **Transfer of Individuals Who Have Not Been Stabilized**

a. If an individual who has come to the emergency department has an EMC that has not been stabilized, the hospital may transfer the individual only if the transfer is an appropriate transfer and meets the following conditions:

i. The individual or a legally responsible person acting on the individual's behalf requests the transfer, after being informed of the hospital's obligations under EMTALA and of the risks and benefits of such transfer. The individual must have received complete and accurate information about matters pertaining to the transfer decision, including: medical necessity of the movement; availability of appropriate services at both the transferring and receiving hospitals; the availability of indigent care at the hospital initiating the transfer and the facility's legal obligations to provide medical services without regard to the patient's ability to pay; and any obligation of the hospital through its participation in government medical assistance programs to accept such program's reimbursement as payment in full for needed medical care. The request must be in writing and indicate the reasons for the request as well as indicate that the individual is aware of the risks and benefits of transfer; or

ii. A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of the woman in labor, to the woman or the unborn child, from being transferred. The certificate must contain a written summary of the risks and benefits upon which it is based; or

iii. If a physician is not physically present in the DED at the time the individual is transferred, a qualified medical person ("QMP") has signed a certification after a physician in consultation with the QMP, agrees with the certification and subsequently countersigns the certification. The certification must contain a written summary of the risks and benefits upon which it is based.
Note: The date and time of the physician or QMP certification should match the date and time of the transfer.

a. A transfer will be an appropriate transfer if:
    i. The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
    ii. The receiving facility has available space and qualified personnel for the treatment of the individual and a physician at the receiving facility has agreed to accept the transfer and to provide appropriate medical treatment;
    iii. The transferring hospital sends the receiving hospital copies of all medical records related to the EMC for which the individual presented that are available at the time of transfer as well as the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
    iv. The transfer is effected through qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transport.
    Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized EMCs that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the necessary capability and capacity to care for the unstabilized EMC.

b. **Higher Level of Care**. A higher level of care should be the more likely reason to transfer an individual with an EMC that has not been stabilized. The following are examples of a higher level of care:
    i. A receiving hospital with **specialized capabilities or facilities** that are not available at the transferring hospital (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) must accept an appropriate transfer of an individual with an EMC who requires specialized capabilities or facilities if the hospital has the capacity to treat the individual.
    ii. If there is a local, regional or state plan for hospital care for designated populations such as individuals with psychiatric disorders or high risk neonates, the transferring hospital must still provide an MSE and stabilizing treatment prior to transferring to the hospital so designated by the plan.

1. **Additional Transfer-Related Situations**
    a. **Diagnostic Facility**. If an individual is moved to a diagnostic facility located at another hospital for diagnostic procedures not available at the transferring hospital and the hospitals arrange to return the individual to the transferring hospital, the transfer requirements must still be met by the sending hospital. The receiving hospital is not obligated to meet the EMTALA transfer requirements when implementing an appropriate transfer back to the transferring hospital. The recipient hospital will send or communicate the results of the tests performed to the transferring hospital.
    b. **Off-Campus hospital-based facilities to nonaffiliated hospital**. A transfer from a hospital-based facility located off-campus to a nonaffiliated hospital must still

comply with the requirements of an appropriate transfer as defined by EMTALA. A Memorandum of Transfer must be used in such situations.
Note: Off-Campus Provider-based EDs or DED. A movement of a patient from an off-campus provider-based ED or DED to the main hospital ED is a movement and not a transfer.

c. **Pre-Existing Transfer Agreements**. Appropriate transfer agreements should be in place and in writing between the hospital, including any outpatient or other off-campus departments where care is provided and other hospitals in the area where the outpatient or off-campus departments are located. Even if there are pre-existing transfer agreements between transferring and receiving hospitals, a physician certification is required for any medically indicated transfer for an unstable individual. Transfer Agreements shall not include financial provisions for transfer but may include reciprocal provisions for transferring the individual back to the original transferring hospital when the higher level of care is no longer required.

d. **Transfers for High Risk Deliveries**. A hospital that is not capable of handling the delivery of a high-risk woman in labor must still provide an MSE and any necessary stabilizing treatment as well as meet the requirements of an appropriate transfer even if a transfer agreement is in place. In addition, a physician certification that the benefits of transfer outweigh the risks of transfer is required for the transfer of the woman in labor.

e. **Diversion/Exceeded Capacity**. If the transferring hospital has the capability but lacks the capacity to treat the individual, then the individual would likely benefit from the transfer and it would be permissible if all other conditions of an appropriate transfer are met. In addition, the hospital may transfer an individual due to bed shortage or overcrowding, if it has exhausted all its capabilities, even if the individual does not require any specialized capabilities of the receiving hospital. The receiving hospital must accept the transfer of the individual if it has the capacity and capability to do so. In communities with a community-wide emergency services system, the receiving hospital must accept the individual being transferred from a hospital on diversionary status if it has the capacity and capability. After acceptance, the receiving hospital may attempt to validate that the transferring hospital has, in fact, exhausted all its capabilities prior to transfer.

f. **Lateral Transfers**. Transfers between hospitals of comparable resources and capabilities are not permitted unless the receiving facility would offer enhanced care benefits to the patient that would outweigh the risks of the transfer. Examples of such situations include a mechanical failure of equipment or no ICU beds available.

g. **Women in Labor**. For a woman in labor, a transfer may be made only if the woman in labor or her representative requests the transfer, or if a physician signs a certification that the benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual or the unborn child. A hospital cannot cite State law or practice as the basis for transfer. A woman in labor who requests transfer to another facility may not be discharged against medical advice to go to the other facility. The risks associated with such a disposition must be thoroughly explained to the patient and documented. If the patient still insists on leaving to go to another facility, the facility should take all

reasonable steps to obtain the patient's request in writing and take all reasonable steps to have the patient transported using qualified personnel and transportation equipment. Transporting a woman in labor by privately-owned vehicle is not an appropriate form of transportation.

h. **Observation Status**. An individual who has been placed in observation status is not an inpatient, even if the individual occupies a bed overnight. Therefore, an individual placed in an observation status who came to the hospital's DED for example, does not terminate the EMTALA obligations of that hospital or a recipient hospital toward an individual who remains in unstable condition at the time of transfer. The EMTALA obligation does not end until the patient has been stabilized, appropriately transferred, or discharged. Therefore, any transfer of a patient in observation status who initially presented to a DED must meet all the requirements of an EMTALA transfer.

2. **Authority to Decline a Transfer Request**
   The ED physician, working in conjunction with the CEO, Administrator-on-Call (AOC), or a hospital leader who routinely takes administrative call has the authority to decline a transfer request based on a determination that the facility does not have the capability and/or capacity to accept such transfer. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor, or other similarly titled position is not considered to be an equivalent of the AOC.
3. **Authority to Conduct a Transfer**
   The transferring physician is responsible for determining the appropriate mode of transportation, equipment and attendants for the transfer in such a manner as to be able to effectively manage any reasonably foreseeable complication of the individual's condition that could arise during the transfer. Only qualified personnel, transportation and equipment, including those life support measures that may be required during transfer shall be employed in the transfer of an individual with an unstabilized EMC. If the individual refuses the appropriate form of transportation determined by the transferring physician and decides to be transported by another method, the transferring physician is to document that the individual was informed of the risks associated with this type of transport and the individual should sign a form indicating the risks have been explained and the individual acknowledges and accepts the risks. All additional requirements of an appropriate transfer are to be followed by the transferring hospital.
4. **Transfer Center Use**
   Hospitals may utilize a Transfer Center to facilitate the transfer of any individual from or to the Emergency Department of the transferring facility to the receiving facility. The transferring physician, after discussion with the individual patient or his or her legally authorized representative, determines the appropriate receiving facility for providing the care necessary to stabilize and treat the individual's emergent condition. The Transfer Center then facilitates the transfer from the transferring facility to the facility selected by the transferring physician and/or the patient. Transfer Centers do not: 1) diagnose or determine treatment for medical conditions; 2) make independent decisions regarding the feasibility of transfer; 3) make independent decisions as to where the individual will be transferred; or 4) determine how a transfer shall be effected.

At the ED Physician's request, the Transfer Center must facilitate a discussion between the ED Physician and the on-call physician of the receiving facility. The on-call physician **does not have the authority** to refuse an appropriate transfer on behalf of the facility.

The Transfer Center may, at the transferring ED Physician's request, provide a list of the receiving facilities with capability and capacity for accepting the individual in need of transfer. The list should include geographic distances and specific capabilities of the receiving facilities. The ED Physician and the individual to be transferred then make the decision on the receiving facility.

The Transfer Center may, at the request of the transferring facility, provide information on the availability of EMS or transport options for transfer of an individual. However, the Transfer Center does NOT select the level of care provided by the transferring facility. The transfer acceptance cannot be predicated upon the transferring facility using a mode of transportation chosen by the receiving facility or a Transfer Center.

6.**Bed Management/Transfer Center Facility**

If the Transfer Center has real time access to necessary data elements documenting capability and capacity, the facility, the ED physician, and the Transfer Center representatives may develop criteria and algorithms for allowing the Transfer Center to accept a transfer request on behalf of the facility and the ED physician in order to expedite the transfer process. Such documents allowing a Transfer Center to accept a patient on behalf of a facility shall be in writing in the ED and on file in the Transfer Center. However, prior to completing the transfer process, the Transfer Center should validate the acceptance with the receiving ED and notify the facility of the transfer to ensure that the capability and capacity status has not changed and that the on-call physician is available when needed. A Transfer Center may not make any independent decisions to refuse a transfer request, except that a bed management Transfer Center may refuse a request with respect to capacity.

PROCEDURES:

1. **Transfers of Individuals Who Are Not Medically Stable**
   Requirements Prior to Transfer. After the hospital has provided medical treatment within its capability to minimize the risks to the health of an individual with an EMC who is not medically stable, the hospital may arrange an appropriate transfer for the individual to another more appropriate or specialized facility. Evaluation and treatment shall be performed and transfer shall be carried out as quickly as possible for an individual with an EMC which has not been stabilized or when stabilization of the individual's vital signs is not possible because the hospital does not have the appropriate equipment or personnel to correct the underlying process. The following requirements must be met for any transfer of an individual with an EMC that has not been stabilized:
    a. Minimize the Risk. Before any transfer may occur, the transferring hospital must first provide, within its capacity and capability, medical treatment to minimize the risks to the health of the individual or unborn child.
    b. Individual's Request or Physician's Order. Any transfer to another medical facility of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf

or by a physician order with the appropriate physician or QMP and Physician certification as required under EMTALA. Any written request for a transfer to another medical facility from an individual with an EMC or the legally responsible person acting on the individual's behalf shall indicate the reasons for the request and that he or she is aware of the risks and benefits of the transfer. The individual must have received complete and accurate information about matters pertaining to the transfer decision, including: medical necessecity of the movement; availability of appropriate services at both the transferring and receiving hospitals; the availability of indigent care at the hospital initiating the transfer and the facility's legal obligations to provide medical services without regard to the patient's ability to pay; and any obligation of the hospital through its participation in government medical assistance programs to accept such program's reimbursement as payment in full for needed medical care.

c. Request To Transfer Made to Receiving Facility. The transferring hospital must call the receiving hospital or the Transfer Center if the facility is part of a Transfer Center network to verify the receiving hospital has available space and qualified personnel for the treatment of the individual. A physician at the receiving hospital must agree to accept the transfer and provide appropriate treatment. The transferring hospital must obtain permission from the receiving hospital to transfer an individual. This may be facilitated by a Transfer Center. Such permission should be documented on the medical record by the transferring hospital, including the date and time of the request and the name and title of the person accepting transfer. The transferring physician shall ensure that a receiving hospital has appropriate services and has accepted responsibility for the individual being transferred. If utilizing the services of a Transfer Center, the Transfer Center may assist in determining whether the receiving hospital has the appropriate services.

d. Document the Request. The transferring hospital must document its communication with the receiving hospital, including the request date and time and the name of the person accepting the transfer.

e. Send Medical Records. The transferring hospital must send to the receiving hospital copies of all medical records available at the time of transfer related to the EMC and continuing care of the individual. The transferring hospital may provide the Face Sheet with the appropriate information to the Transfer Center to assist Transfer Center in facilitating the transfer. But, the Transfer Center generally may not provide any information to, or respond to questions from, to the receiving facility or physician at the receiving facility, from the Face Sheet regarding whether or not the patient has insurance, or the type of insurance, or other information regarding the patient's ability to pay for services prior to acceptance of the patient except as required by a state or local plan for providing care to certain patient populations where insurance coverage is a determining factor in where the patient may receive care. Documentation sent to the receiving hospital must include:

   - Copies of the available history, all records related to the individual's EMC, observations of signs or symptoms, patient's condition at the time of transfer, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests, monitoring and assessment data, any other pertinent information, and the informed

written consent for transfer of the individual or the certification of a physician or QMP.

- The name and address of any on-call practitioner who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
- The individual's vital signs which should be taken immediately prior to transfer and documented on the Memorandum of Transfer Form.
- Copies of available records must accompany the individual; and
- Copies of other records not available at the time of transfer must be sent to the receiving hospital as soon as practical after the transfer.

Medical and other records related to individuals transferred to or from the hospital must be retained in their original or legally reproduced form in hard copy, microfilm, or electronic media for a period of five years from the date of transfer.

f. **Physician Certification of Risks and Benefits**. A physician must sign an express written certification that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the unborn child, from being transferred. The certification should meet the following requirements:
    - The certification must state the reason for transfer. The narrative rationale need not be a lengthy discussion of the individual's medical condition as this can be found in the medical record but should be specific to the condition of the patient upon transfer.
    - The certification must contain a complete picture of the benefits to be expected from appropriate care at the receiving facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer.
    - The date and time of the physician certification should closely match the date and time of the transfer.
    - Certifications may not be backdated.

g. **QMP Certification**. If a physician is not physically present at the time of the transfer, a QMP may sign the certification, after consultation with a physician, and transfer the individual as long as the medical benefits expected from transfer outweigh the risks. If a QMP signs the certification, a physician shall countersign it within 24 hours or a reasonable time period specified by the hospital bylaws, rules or regulations.

h. **Send Memorandum of Transfer**. A Memorandum of Transfer must be completed for every patient who is transferred to another separately licensed hospital. The Memorandum of Transfer and the patient's medical record must be sent with the patient at the time of the transfer. A copy of the Memorandum of Transfer shall be retained by the transferring hospital and incorporated into the patient's medical record.

2. **Transfers that are requested by the individual but not medically indicated**
   If a medically unstable individual, or the legally responsible person, requests a transfer to another hospital that is not medically indicated, the individual or the legally responsible person must first be fully informed of the risks of the transfer; the alternatives (if any) to the transfer; and the hospital's obligations to provide further examination and treatment sufficient to stabilize the individual's EMC.

   Components of the Individual's Request for Transfer. The transfer is appropriate only when the request meets all of the following requirements:

   - is in writing and indicates the reasons for the request;
   - contains a statement of the hospital's obligations under EMTALA and the benefits and risks that were outlined to the person signing the request;
   - indicates the individual is aware of the availability of appropriate services at both the transferring and receiving hospitals, the availability of indigent care at the transferring hospital, and any obligation of the hospital to accept government medical assistance program reimbursement as payment in full;
   - indicates that the individual is aware of the risks and benefits of the transfer;
   - is made part of the individual's medical record, and a copy of the request should be sent to the receiving facility when the individual is transferred; and
   - is not made through coercion or by misrepresenting the hospital's obligations to provide an MSE and treatment for an EMC or labor.
     Note: Once the transfer is accepted, the Memorandum of Transfer and the patient's medical record must be sent with the patient.

3. **Refusal to Consent to Transfer**
   If an individual, or the legally responsible person acting on the individual's behalf, refuses to consent to the hospital's offer to transfer the individual to another facility for services the hospital does not provide and informs the individual, or the legally responsible person, of the risks and benefits to the individual of the transfer, all reasonable steps must be taken to secure a written refusal from the individual or the person acting on the individual's behalf. The individual's medical record must contain a description of the proposed transfer that was refused by the individual or the person acting on the patient's behalf, a statement that the individual was informed of the risks and benefits and the reason for the individual's refusal to consent to the transfer.

4. **Transfer of Individuals Who Are Medically Stable**
   EMTALA does not apply to an individual who has been medically stabilized. The hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized or who has been admitted as an inpatient.
   a. Any individual who has been medically stabilized may be transferred upon request or pursuant to a physician's order via a pre-arranged transfer or treatment plan according to hospital policy.
   b. **Document Stable Condition**. The stability of the individual is determined by the ED physician or QMP in consultation with the physician. After it is determined that the

individual is medically stable, the physician or QMP must accurately and thoroughly document the parameters of such stability.

i. A woman who is in labor is considered to be stabilized only after she has been delivered of the child and the placenta.

ii. An individual presenting with psychiatric symptoms is considered to be stabilized when he/she is protected and prevented from harming self or others.

iii. If there is a disagreement between the treating physician and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual is stable for transfer, the medical judgment of the physician who is treating the individual at the transferring facility DED takes precedence over that of the off-site physician.

5. **Recipient Hospital Responsibilities**

a. A participating hospital that has specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) may not refuse to accept an appropriate transfer from a transferring hospital within the boundaries of the United States, of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

b. The requirement to accept an appropriate EMTALA transfer applies to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a DED. All licensed hospitals in Tennessee are required to accept appropiate transfers from other hospitals if the receiving hospital has space and capability, without regard to the patient's source of payment or ability to pay.

c. The recipient hospital's EMTALA obligations do not extend to individuals who are inpatients at another hospital.

d. If an individual arrives through the DED as a transfer from another hospital or health care facility, the hospital has a duty to have a physician or QMP, not a triage nurse, perform an appropriate MSE to determine whether the patient's condition deteriorated during the transport. The MSE must be documented in the medical record.

e. A recipient hospital with specialized capabilities that delays the treatment of an individual with an EMC who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances of the delay.

f. An individual on an EMS stretcher in the DED must be provided an MSE without delay. EMTALA regulations apply as soon as the individual arrives on the facility's campus even if the EMS service has not formally turned the individual over to the DED care providers.

g. The receiving hospital may handle the receipt and subsequent assessment of the transferred emergency patient in a number of ways, including:

i. For example, the transferring facility may contact the individual or department designated by the CEO as the coordinator for transfers such

as the House Supervisor or the Transfer Center. After the receiving hospital's designated transfer coordinator is contacted, this individual or Transfer Center will then coordinate any transfer requests with the Administrator On-Call and the ED Physician as necessary. Once it has been determined that the receiving facility has agreed to accept the patient, the patient may be transferred directly to a designated specialty unit such as a SICU, PICU, Cardiac Catheterization Lab, Burn Center, or other Specialty Unit if there is capacity and a physician with the appropriate specialty credentials is available to assess the patient within a reasonable timeframe (generally, within 30 minutes). Upon acceptance into the specialty unit as an inpatient, the Conditions of Participation govern the patient's care, including the history and physical and establishment of a plan of care.

ii. If the receiving facility participates in a community wide cardiac or stroke alert system inclusive of pre-hospital patient management by EMS Services under the direction of a qualified physician that allows for diagnosis of an emergent medical condition prior to arrival at the receiving facility, the EMS service may take the patient directly to the Interventional Radiology Suite or the Cardiac Catheterization Lab if the stroke or cardiac alert team, including the appropriately credentialed physician, is present upon arrival of the patient. The awaiting physician in the Unit would perform the additional evaluation and treatment and document such findings in the medical record. The Interventional Radiology Suite or Cardiac Cath Lab would be responsible for ensuring the registration as an emergency patient thus ensuring the patient appears on the Central/ EMTALA log.

iii. If a facility's transfer coordinator receives a request from a transferring hospital and no specialty bed is available but the DED has capacity and capability to further treat and stabilize the individual and an on-call physician is available, the receiving facility should accept the transfer as an ED to ED transfer. If the Emergency Department of the receiving hospital has exceeded its capacity and capability with individuals waiting to be seen and patients being held on stretchers in the hallways because no beds are available, then the receiving ED can refuse the transfer based upon no capacity and capability if that has been their practice in the past based on the same capacity.

iv. Each specialty unit shall be responsible for entering the transferred patient's name and pertinent data into the appropriate log as per hospital policy.

6. **Review Process for Any Refused Transfers**
   For those situations in which the hospital refuses to accept a transfer from another facility, the hospital and Transfer Center must have in place a procedure to review potential refusals and/ or to monitor any refusals of transfer from other facilities.

7. **Reporting Potential EMTALA Violations**
   Each Transfer Center employee working with the DED, medical staff member, house staff

member, hospital employee, or contracted individual who works in the DED or other area where EMTALA requirements are applicable and who has reason to believe that a potential violation of the law has resulted in an inappropriate transfer to the hospital as a receiving hospital or from the hospital as a transferring hospital must report the incident to the CEO or CEO's designee such as the Risk Manager or the ECO immediately for investigation.

a. **Receiving Hospitals**. Receiving hospitals have a duty to report any inappropriate transfer received from a transferring institution. A hospital that suspects it may have received an improperly transferred individual (transfer of an unstable individual with an EMC who was not provided an appropriate transfer according to 42 C.F.R. § 489.24(e)(2)), is required to promptly report the incident to the Centers for Medicare & Medicaid Services ("CMS") or the state agency within 72 hours of the occurrence. Failure to report within 72 hours may result in an EMTALA violation by the receiving facility.

b. **Transferring Hospitals**. A participating hospital may not penalize or take adverse action against a physician or a QMP because the physician or QMP refuses to authorize the transfer of an individual with an EMC that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of the EMTALA obligations.

8. **Declared Emergencies**
Sanctions under EMTALA for an inappropriate transfer during a national emergency do not apply to a hospital with a DED located in an area that has been declared a national emergency area. Please review the requirements for transfers during a National Emergency contained in the EMTALA – Definitions and General Requirements Policy, LL.EM.001, and consult with the hospital's Disaster and Emergency Preparedness Plan as well as Operations Counsel for additional guidance

   a. .**Waiver of Sanctions**. Sanctions under EMTALA for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site for the MSE during a national emergency do not apply to a hospital with a DED located in an emergency area if the following conditions are met:

      i. the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period;

      ii. the direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency ("PHE") that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan;

      iii. the hospital does not discriminate on the basis of an individual's source of payment or ability to pay;

      iv. the hospital is located in an emergency area during an emergency period; and

      v. there has been a determination that a waiver of sanctions is necessary.

   b. **Waiver Limitations**.

      i. An EMTALA waiver can be issued for a hospital only if:

- the President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act;
- the Secretary of HHS has declared a PHE; and
- the Secretary of HHS invokes his or her waiver authority including notifying Congress at least 48 hours in advance.

ii. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.

- In addition, in order for an EMTALA waiver to apply to the hospital and for sanctions not to apply: (i) the hospital must activate its disaster protocol; and (ii) the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan.
- Even when a waiver is in effect, there is still the expectation that everyone who comes to the DED will receive an appropriate MSE, if not in the DED, then at the alternate care site to which they are redirected or relocated.
- A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that if a PHE involves a pandemic infectious disease, the waiver will continue in effect until the termination of the application decision of a PHE or a limitation by CMS. However, the waiver may be limited to a date prior to the termination of the PHE declaration, as determined by CMS. If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital is located prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date. Likewise, if the hospital deactivates its disaster protocol prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date.
- All other EMTALA-related requirements continue to apply, as do similar State law requirements, even when a hospital is operating under an EMTALA waiver. For example, a hospital's obligation to accept an appropriate transfer of an individual under EMTALA cannot be waived if the hospital has the capabilities and capacity to accept such transfer (as discussed in this Policy).

Emergency Medical Condition (EMC) Identified: (Mark appropriate box; have physician certify if **I.c** or **I.d** selected and then go to Section II.)

I. **MEDICAL CONDITION:**
Diagnosis:____

a. **No Emergency Medical Condition Identified**: This patient has been examined and an EMC has not been identified.
Screening Physician Signature:____ *Date:* _____/_____/_____ *Time:*_______ *AM/PM*

b. **Unstable Patient, Request for Transfer**: The patient has been examined and an EMC has been identified and the patient is not stable. The hospital has the

capability and capacity to provide the care needed but the patient has specifically requested to be transferred to another facility after being notified that the hospital can and is willing to provide the care needed to stabilize and treat the EMC.
c. **Patient Stable For Transfer**: The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.
d. **Patient Unstable**: The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.
I.c and I.d Physician Certification: *I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.* **Physician Signature***:* ____ *Date:* _____/_____/_____ *Time:*_______ *AM/PM* **Signature applies to any checked boxes**.

II. **REASON FOR TRANSFER:**

Medically Indicated Patient Requested (see patient request documentation: Section VII)
On-call physician refused or failed to respond within a reasonable period of time
On-Call Physician Name: ______________________________ Address ____________________________________

III. **RISKS AND BENEFITS FOR TRANSFER**:

Medical Benefits:	**Medical Risks :**
Obtain level of care/ service unavailable at this facility. Service: __________________________________ Medical Benefits outweigh the risks. Other ____	Deterioration of condition in route Worsening of condition or death if you stay here. Risk of traffic delay/accident resulting in condition deterioration or death. Other ____

IV. **MODE/SUPPORT DURING TRANSFER AS DETERMINED BY PHYSICIAN:**

Mode of transportation for transfer: BLS ALS Helicopter Neonatal Unit
Other_________________________________
Agency: ______________________ Name/Title of accompanying hospital employee if required: _______________________________
Support/Treatment during transfer: Cardiac Monitor Oxygen: ______________ IV Pump
IV Fluid: __________Rate: ___________ Restraints – Type: ________ Other: ____________________________ None
Transferring Physician Signature if different from Certifying Physician:________________________ Date: ___/___/___ Time: ____ AM/PM
If no physician immediately available, transfer authorized by Qualified Medical Provider per Dr.

____

QMP Signature ____ Date: ___/___/___ Time: ____ AM/PM

Authorizing PhysicianSignature ____ Date: ___/___/___ Time: ____ AM/PM

V. **NURSING**

RECEIVING FACILITY AND INDIVIDUAL: The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility: __________________ Person accepting TXFR: ____________________ _

Date: ___/___/___ Time: ____ AM/PM

Receiving MD____ Date: ___/___/___ Time: ____ AM/PM

Questions regarding Medication Reconciliation Information may be directed to _______________________or Transferring Physician.

VI. **ACCOMPANYING DOCUMENTATION** sent via: Patient/Responsible Party Fax Transporter

Documentation includes: Copy of Medical Record Lab/ EKG/ X-Ray Copy of Transfer Form Medication Reconciliation Information Advanced Directive Other

____

Report given to: (Person/title):

____

Time of Transfer: ____________ Date: __________ Nurse Signature: ____________________Transferring Unit:______________

Vital Signs Just Prior to Transfer: Temp: ______ Pulse______ R______ BP______ spO2%______ FHT______ Time:____ AM/PM

VII. **PATIENT CONSENT TO MEDICALLY INDICATED TRANSFER or PATIENT REQUEST FOR TRANSFER (Mark appropriate box a. or b.):**

a. I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits of this transfer.

b. I hereby **REQUEST TRANSFER** to _______________________________. I understand and have considered the hospital's EMTALA responsibilities that have been explained to me, the availability of appropriate care, the medical risks and benefits of transfer and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician or anyone associated with the hospital. I agree to accept the risks associated with my decision.

The reason I request transfer is:

____

Signature of: Patient Responsible Person____________________________ Relationship to patient____________________

Witness_______________________________ Title _________________________ Date: ___/___/___ Time: ____ AM/PM

All Revision Dates

10/2/2019, 9/7/2018, 11/7/2016, 2/4/2016, 7/31/2015, 7/1/2013, 5/1/2013, 2/1/2013, 7/1/2012, 9/1/2010

Attachments

A - EMTALA Memorandum of Transfer

B - Patient's Information

D - Waiver Of Right To Medical Screening Examination

EMTALA - Memorandum of Movement Form.docx

EMTALA Informed Refusal and AMA form EnglishSpanish.doc

EMTALA MOT EnglishSpanish.doc

FINAL SIGN-IN and WAIVER Form.doc

Memo Of Transfer 2010.doc

Approval Signatures

Step Description	Approver	Date
Policy & Procedure	Laura Reed: CNO Southern Hills Med Ctr	5/10/2021

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Status Active PolicyStat ID 10026130

TriStar Southern Hills MEDICAL CENTER

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Next Review	5/17/2025

Owner	Timothy Danford: Dir Emergency Svcs FSED
Policy Area	Emergency Services
Applicability	TriStar Southern Hills Medical Center
References	LL.EM.001

Tennessee EMTALA - Medical Screening Examination and Stabilization

Effective Date: May 2017

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

PURPOSE:

To establish guidelines for providing appropriate medical screening examinations ("MSE") and any necessary stabilizing treatment or an appropriate transfer for the individual as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY:

An EMTALA obligation is triggered when an individual comes to a dedicated emergency department ("DED") and:

1. the individual or a representative acting on the individual's behalf requests an examination or treatment for a medical condition; or
2. a prudent layperson observer would conclude from the individual's appearance or behavior that the individual needs an examination or treatment of a medical condition.

Such obligation is further extended to those individuals presenting elsewhere on hospital property requesting examination or treatment for an emergency medical condition ("EMC"). Further, if a prudent layperson observer would believe that the individual is experiencing an EMC, then an appropriate MSE, within the capabilities of the hospital's DED (including ancillary services routinely available and the availability of on-call physicians), shall be performed. The MSE must be completed by an individual (i) qualified to perform such an examination to determine whether an EMC exists, or (ii) with respect to a pregnant woman having contractions, whether the woman is in labor and whether the treatment requested is explicitly for an EMC. If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as defined by and required by EMTALA. Stabilization treatment shall be applied in a non-discriminatory manner (*e.g.*, no different level of care because of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law).

PROCEDURE:

1. **When an MSE is Required:**

   A hospital must provide an appropriate MSE within the capability of the hospital's emergency department, including ancillary services routinely available to the DED, to determine whether or not an EMC exists: (i) to any individual, including a pregnant woman having contractions, who requests such an examination; (ii) an individual who has such a request made on his or her behalf; or (iii) an individual whom a prudent layperson observer would conclude from the individual's appearance or behavior needs an MSE. An MSE shall be provided to determine whether or not the individual is experiencing an EMC or a pregnant woman is in labor. An MSE is required when:

   a. The individual ***comes to a DED*** of a hospital and a request is made by the individual or on the individual's behalf for examination or treatment for a medical condition, including where:

      i. The individual requests medication to resolve or provide stabilizing treatment for a medical condition.

      ii. The individual arrives as a transfer from another hospital or health care facility. Upon arrival of a transfer, a physician or qualified medical person ("QMP") must perform an appropriate MSE. The physician or QMP shall provide any additional screening and treatment required to stabilize the EMC. The MSE of the individual must be documented. This type of screening cannot be performed by the triage nurse. If an EMC is determined to exist and the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under EMTALA ceases.

Note: The MSE and other emergency services need not be provided in a location specifically identified as a DED. The hospital may use areas to deliver emergency services that are also used for other inpatient or outpatient services. MSEs or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the DED.

b. The individual arrives on the ***hospital property other than a DED*** and makes a request or another makes a request on the individual's behalf for examination or treatment for an EMC.

   i. **Screening where the individual presented**: If an individual is initially screened in a department or location on-campus other than the DED, the individual may be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being a transfer. The hospital shall not move the individual to an off-campus facility or department (such as an urgent care center or satellite clinic) for an MSE.

   ii. **Transporting to the DED**: The hospital may determine that movement of an individual to the hospital's DED may be necessary for screening. However, common sense and individual judgment should prevail. When determining how best to transport the individual to the DED (means of transport, accompanying qualified personnel, equipment, etc.), the following factors should be taken into account but shall not be determinative:

      - Whether the hospital DED has the personnel and resources necessary to render adequate medical treatment to all existing patients in the DED,
      - Whether responding to the emergency could send hospital personnel into harm's way or unreasonably endanger or jeopardize the lives or health of such personnel, and
      - Whether non-hospital paramedics, emergency medical technicians, or other qualified personnel are more appropriate to respond.

   iii. **Transporting to other hospital property**: The facility may direct individuals to other hospital-based facilities that are on hospital property and operated under the hospital's provider number. However, the hospital should not move an individual to a hospital-based facility located off-campus, such as a rural health clinic or physician office, for an MSE or other emergency services. Individuals should only be moved to the hospital-based on-campus facility when the following conditions are met:

      - all persons with the same medical condition are moved to this location regardless of their ability to pay for treatment,
      - there is a bona fide medical reason to move the individual, and
      - QMP accompany the individual.

Note: Unless outpatient testing is associated with an individual presenting to the DED with a request for an emergency medical screening, it should not be performed in the emergency department. Individuals presenting for outpatient testing should be registered as outpatients and not as emergency patients.

Note: Anyone may make the request for an MSE or treatment described in both a. and b. above. Specifically,

- A minor (child) can request an examination or treatment for an EMC. Hospital personnel should not delay the MSE by waiting for parental consent. If, after screening the minor, it is determined that no EMC is present, the staff may wait for parental consent before proceeding with further examination and treatment. **Note:** For additional information regarding treatment of minors, please consult your operations counsel.
- Emergency Medical Services (EMS) personnel may request an evaluation or treatment on an individual's behalf.

  Example: If an individual is on a gurney or stretcher or in an ambulance or on a helipad at the hospital and EMS personnel, the individual, or a legally responsible person acting on the individual's behalf, requests examination or treatment of an EMC from hospital staff, an MSE must be provided.

c. The individual arrives ***on the hospital property***, either in the DED or property other than the DED, ***and no request is made*** for evaluation or treatment, but the appearance or behavior of the individual would cause a prudent layperson observer to believe that the individual needed such examination or treatment.

d. An individual is in a ***ground or air ambulance*** for purposes of examination and treatment for a medical condition at a hospital's DED, and the ambulance is either:

   i. *owned and operated by the hospital,* even if the ambulance is not on hospital grounds, or

   ii. neither owned nor operated by the hospital, but *on hospital property*.

e. A ***community-wide plan*** exists for specific hospitals to treat certain EMCs (*e.g.*, psychiatric, trauma, physical or sexual abuse). Prior to transferring the individual to the community plan hospital, an MSE must be performed and any necessary stabilizing treatment rendered.

f. If a ***law enforcement official*** requests hospital emergency personnel to provide ***medical clearance*** for incarceration, the Hospital has an EMTALA obligation to provide an MSE to determine if an EMC exists. If an EMC is found to exist and is stabilized, the Hospital has met its EMTALA obligations and additional requests for assessment or testing are not required. All facilities must remain in compliance with

federal and state HIPAA regulations.

g. If a ***law enforcement official*** brings a person who is exhibiting behavior that suggests that he or she is intoxicated to the DED for ***drawing of the blood alcohol*** and asks for an MSE, or if a prudent layperson observer would believe that the individual needed examination or treatment for a possible EMC, then an MSE must be performed. This is required because some medical conditions could present behaviors similar to those of an inebriated individual.

h. If an individual presents to a facility which does not have the capability to perform a rape kit when one is needed, the hospital's obligation is to provide an appropriate MSE without disturbing the evidence and transfer the individual to a hospital that has the capability to gather the evidence. Transfer must occur only in compliance with hospital policies and procedures that are Medicare Hospital Conditions of Participation (CoP) and licensure compliant.

i. ***Born Alive Infant***. When an infant is born alive in the DED, if a request is made on the infant's behalf for screening for a medical condition or if a prudent layperson would conclude based on the infant's appearance or behavior that the infant needed examination or treatment for a medical condition, the hospital and physician must provide an MSE. If the infant is born alive elsewhere on the hospital's campus and a prudent layperson observer would conclude based on the born alive infant's appearance or behavior that the infant was suffering from an EMC, the hospital and medical staff must perform an MSE to determine whether or not an EMC exists. If an EMC exists, the hospital must provide for stabilizing treatment or an appropriate transfer.

j. ***Off-Campus Provider-Based Emergency Department*. An off-campus provider based- emergency department is a department of the hospital, located no more than 35 miles from the main hospital, that meets all the provider-based requirements, holds the same Medicare provider number as the main hospital and either is (i) licensed by the state as an Emergency Department, (ii) is advertised as providing care for emergency medical conditions on an urgent basis without appointment, or (iii) provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring previously scheduled appointments.** If an individual presents to an off-campus provider-based emergency department (should not be referred to as a "free-standing" emergency department), he or she must be provided an appropriate MSE just as he or she would if the presentation was at the main campus emergency department. Should the individual require additional screening for stabilizing care by a physician specialist, he or she will be moved to the main campus or another non-HCA facility for the additional care required. Such movement would be via an appropriate transport vehicle as designated by the ED Physician with appropriate equipment and personnel as determined by the ED Physician.

2. **When an MSE is NOT Required**

    a. If an individual **presents to a DED** in the following circumstances only**, no MSE is required by EMTALA:**

        i. ***The individual requests services that are NOT examination or treatment for***

an EMC, *such as preventive care services or drugs that are not required to stabilize or resolve an EMC**;***

Example: An individual presents to the DED and tells the clerk that he needs a flu shot because it is now flu season. The hospital is not obligated to provide an MSE under EMTALA because the request for a flu vaccine is a preventive care service.

ii. ***The individual requests services that are NOT for an EMC such as gathering of evidence for criminal law cases*** (sexual assault, blood alcohol). When the request made is only to collect evidence, not to analyze the results or otherwise examine or treat the individual, no EMTALA obligation exists;

iii. ***When an individual appears for non-emergency tests*** or pursuant to a previously scheduled visit. The hospital must ensure and document that no EMC was present or that no request was made to examine or treat the individual for an EMC.

1. **When an individual presents to the DED for medical care that is, by its nature, clearly unlikely to involve an EMC, the individual's statement that he or she is not seeking emergency care, together with brief questioning by QMP, is sufficient to establish that there is no EMC.**
2. **A QMP is not required to question or examine the individual if the individual presents to the DED solely to fill a physician's order for a non-emergency test. The QMP should, however, question the individual to confirm that no EMC exists if the individual requests treatment for a non-emergency condition unrelated to the physician's order.**

   Example: A physician refers an individual to the emergency department for occupational medicine testing.

b. If the individual is in a ***ground or air ambulance*** which is:

i. *owned and operated* by the hospital and *operated under community-wide EMS protocols or EMS protocols "mandated by State law" that direct it to transport* the individual to a hospital other than the hospital that owns the ambulance (i.e., to the closest appropriate facility). In this case, the individual is considered to have "come to the emergency department of the hospital" to which the individual is transported, at the time the individual is brought onto hospital property; or

ii. *not owned by the hospital and not on the hospital's property* even if the ambulance personnel contact the hospital by telephone or telemetry communications and inform the hospital that they want to transport the individual to the hospital for examination and treatment; or

iii. *owned but not operated by the hospital* as where a physician who is not employed or otherwise affiliated with the hospital that owns the

ambulance directs its operation and the ambulance is not on hospital property.

Note: A hospital may deny access to individuals when it is in "official diversionary" status because it does not have the capability or capacity to accept any additional emergency individuals at the time. The hospital shall develop and adopt written criteria that describe the conditions under which any or all of the hospital's emergency services are deemed to be at maximum capacity.

Caution: If the ambulance staff disregards the hospital's instructions and brings the individual on to hospital property, the individual has come to the emergency department and the hospital must perform an appropriate MSE. Should a hospital which is not in official diversionary status fail to accept a telephone or radio request for transfer or admission, the refusal could represent a violation of other Federal or State regulations.

Note: The hospital shall maintain written records documenting the date and time of the start and end of each period of diversionary status.

c. ***Use of hospital-owned helipad on hospital property for patient transport.*** No MSE is required for individuals being transported by local ambulance services or other hospitals to tertiary hospitals throughout the state through use of a ***hospital-owned helipad on the hospital's property*** by local ambulance services or other hospitals **as long as the sending hospital conducted the MSE prior to transporting the individual** to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an EMC exists and implementing stabilizing treatment or conducting an appropriate transfer.

   Caution: If the individual's condition deteriorates while being transported to the helipad or while at the helipad, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity if requested by medical personnel accompanying the individual.

   If, as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital with the helipad does not have an EMTALA obligation if they are not the recipient hospital, unless a request is made by EMS personnel, the individual, or a legally responsible person acting on the individual's behalf for the examination or treatment of an EMC.

d. ***Off campus, non-DED.*** If an individual requests emergency care in a hospital department off the hospital's main campus that does not meet the definition of a DED, EMTALA does not apply and the hospital department is not obligated to perform an MSE. However, the off-campus department must have policies and procedures in place as to how to handle patients in need of immediate care.

3. **Extent of the MSE**

a. **Determine if an EMC exists.** The hospital must perform an MSE to determine if an EMC exists. It is not appropriate to merely "log in" or triage an individual with a medical condition and not provide an MSE. Triage is not equivalent to an MSE. Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital in order to prioritize when the individual will be screened by a physician or other QMP.

b. **Definition of MSE.** An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. It is not an isolated event. The MSE must be appropriate to the individual's presenting signs and symptoms and the capability and capacity of the hospital.

c. **An on-going process.** The individual shall be continuously monitored according to the individual's needs until it is determined whether or not the individual has an EMC, and if he or she does, until he or she is stabilized or appropriately admitted or transferred. The medical record shall reflect the amount and extent of monitoring that was provided prior to the completion of the MSE and until discharge or transfer.

d. **Judgment of physician or QMP.** The extent of the necessary examination to determine whether an EMC exists is generally within the judgment and discretion of the physician or other QMP performing the examination function according to algorithms or protocols established and approved by the medical staff and governing board.

e. **Extent of MSE varies by presenting symptoms.** The MSE may vary depending on the individual's signs and symptoms:

    i. Depending on the individual's presenting symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans and other diagnostic tests and procedures.

    ii. *Pregnant Women:* The medical records should show evidence that the screening examination includes, at a minimum, on-going evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of membranes (*i.e.,* ruptured, leaking and intact), to document whether or not the woman is in labor. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife or other QMP acting within his or her scope of practice as defined by the hospital's medical staff bylaws and State medical practice acts, certifies in writing that after a reasonable time of observation, the woman is in false labor. The recommended timeframe for such physician certification of the QMP's determination of false labor should be within 24 hours of the MSE, however, the medical staff bylaws, rules and regulations can provide guidance on the timeframe.

    iii. *Individuals with psychiatric or behavioral symptoms:* The medical records should indicate both medical and psychiatric or behavioral components of the MSE. The MSE for psychiatric purposes is to determine if the

psychiatric symptoms have a physiologic etiology. The psychiatric MSE includes an assessment of suicidal or homicidal thoughts or gestures that indicates danger to self or others.

Non-discrimination. The hospital must provide an MSE and necessary stabilizing treatment to any individual regardless of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law.

4. **Who May Perform the MSE**
   a. Only the following individuals may perform an MSE:
      i. A qualified physician with appropriate privileges;
      ii. Other qualified licensed independent practitioner (LIP) with appropriate competencies and privileges; or
      iii. A qualified staff member who:
         - is qualified to conduct such an examination through appropriate privileging and demonstrated competencies;
         - is functioning within the scope of his or her license and in compliance with state law and applicable practice acts (*e.g.*, Medical or Nurse Practice Acts);
         - is performing the screening examination based on medical staff approved guidelines, protocols or algorithms; and
         - is approved by the facility's governing board as set forth in a document such as the hospital bylaws or medical staff rules and regulations, which document has been approved by the facility's governing body and medical staff. It is not acceptable for the facility to allow informal personnel appointments that could change frequently.
   b. **Qualified Medical Personnel.** QMPs may perform an MSE if licensed and certified, approved by the hospital's governing board through the hospital's bylaws, and only if the scope of the EMC is within the individual's scope of practice.
      i. The designation of QMP is set forth in a document approved by the governing body of the hospital. Each individual QMP approved to provide an MSE under EMTALA must be appropriately credentialed and must meet the requirements for annual evaluations set forth in the protocol agreements with physicians and the State's medical practice act, nurse practice act or other similar practice acts established to govern health care practitioners. Only appropriately credentialed APRNs, PAs and physicians may perform MSEs in the DED.
      ii. **Psychiatric QMP.** The ED physician shall consult the QMP providing the behavioral assessment for psychiatric purposes but shall remain the

primary decision-maker with regard to transfer and discharge of the individual presenting to the DED with psychiatric or behavioral emergencies. Should an individual with a psychiatric or behavioral emergency present to a behavioral department of a hospital that meets the requirements of a DED, that department is responsible for ensuring that the individual has the appropriate MSE, including any behavioral examination, and providing necessary stabilizing treatment.

iii. **Labor and Delivery QMP.** QMPs in the labor and delivery DED may be appropriately-approved RNs and must communicate their findings as to whether or not a woman is in labor to the obstetrician on call, the laborist, or the ED physician.

iv. **Limitations.** The hospital has established a process to ensure that:

1. a physician examines all individuals whose conditions or symptoms require physician examination;
2. an ED physician on duty is responsible for the general care of all individuals presenting themselves to the emergency department; and
3. the responsibility remains with the ED physician until the individual's private physician or an on-call specialist assumes that responsibility, or the individual is discharged.

5. **No Delay in Medical Screening or Examination**

a. **Reasonable Registration Process.** An MSE, stabilizing treatment, or appropriate transfer will not be delayed to inquire about the individual's method of payment or insurance status, or conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered. The facility may follow reasonable registration processes for individuals for whom examination or treatment is required. Reasonable registration processes may include asking whether the individual is insured, and if so, what that insurance is, as long as these procedures do not delay screening or treatment or unduly discourage individuals from remaining for further evaluation. The hospital may seek non-payment information from the individual's health plan about the individual, such as medical history. In the case of an individual with an EMC, once the hospital has conducted the MSE and has initiated stabilizing treatment, it may seek authorization for all services from the plan as long as doing so does not delay completion of the stabilizing treatment.

b. **Managed Care.** For individuals who are enrolled in a managed care plan, prior authorization from the plan shall NOT be required or requested before providing an appropriate MSE and initiating any further medical examination and necessary stabilizing treatment.

c. **EMS.** A hospital has an obligation to see the individual once the individual presents to the DED whether by EMS or otherwise. A hospital that delays the MSE or stabilizing treatment of any individual who arrives via transfer from another facility, by not allowing EMS to leave the individual, could be in violation EMTALA and the Hospital CoP for Emergency Services. Even if the hospital cannot immediately

complete an appropriate MSE, the hospital must assess the individual's condition upon arrival of the EMS service to ensure that the individual is appropriately prioritized based on his or her presenting signs and symptoms to be seen for completion of the MSE.

d. **Contacting the individual's physician.** An ED physician or non-physician practitioner may contact the individual's personal physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to medical treatment and screening of the individual, so long as this consultation does not inappropriately delay services.

e. **Financial Responsibility Forms.** The performance of the MSE and the provision of stabilizing treatment will NOT be conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered.

f. **Financial Inquiries.** Individuals who inquire about financial responsibility for emergency care should receive a response by a staff member who has been well trained to provide information regarding potential financial liability. The staff member who provides information on potential financial liability should clearly inform the individual that the hospital will provide an MSE and any necessary stabilizing treatment, regardless of his or her ability to pay. Individuals who believe that they have an EMC should be encouraged to remain for the MSE.

   Note: There is no delay in the provision of an MSE or stabilizing treatment if: (i) there is not an open bed in the DED; (ii) there are not sufficient caregivers present to render the MSE and/or stabilizing treatment; and (iii) the individual's condition does not warrant immediate screening and treatment by a physician or QMP.

6. **Refusal to Consent to Treatment**

   a. **Written Refusal – Partial Refusal of Care or Against Medical Advice.** If a physician or QMP has begun the MSE or any stabilizing treatment and an individual refuses to consent to a test, examination or treatment or refuses any further care and is determined to leave against medical advice, after being informed of the risks and benefits and the hospital's obligations under EMTALA, reasonable attempts shall be made to obtain a written refusal to consent to examination or treatment using the form provided for that purpose or document the individuals refusal to sign the Partial Refusal of Care or the Against Medical Advice Form (see Partial Refusal of Care or Against Medical Advice Form). The medical record must contain a description of the screening and the examination, treatment, or both if applicable, that was refused by or on behalf of the individual.

   b. **Waiver of Right to Medical Screening Examination.** If an individual refuses to consent to examination or treatment and indicates his or her intention to leave prior to triage or prior to receiving an MSE or if the individual withdrew the initial request for an MSE, facility personnel must request that the individual sign the Waiver of Right to Medical Screening Examination Form that is part of the Sign-In Sheet or document on the Sign-In Sheet the individual's refusal to sign the Waiver of Right to Medical Screening Examination Form.

c. **Documentation of Information.** If an individual refuses to sign a consent form, the physician or nurse must document that the individual has been informed of the risks and benefits of the examination and/or treatment but refused to sign the form.

d. **Documentation of Unannounced Leave.** If an individual leaves the facility without notifying facility personnel, this must be documented upon discovery. The documentation must reflect that the individual had been at the facility and the time the individual was discovered to have left the premises. Triage notes and additional records must be retained. If the individual leaves prior to transfer or leaves prior to an MSE, the information should be documented on the individual's medical record. If an individual has not completed a Sign-In Sheet, an ED staff member should complete a sheet and if the individual's name is not known a description of the individual leaving should be entered on the form. All individuals presenting for evaluation or treatment must be entered into the Central Log.

7. **Stabilizing Treatment Within Hospital Capability**

The determination of whether an individual is stable is not based on the clinical outcome of the individual's medical condition. An individual has been provided sufficient stabilizing treatment when the physician treating the individual in the DED has determined, within reasonable clinical confidence, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an EMC of a woman in labor, that the woman has delivered the child and placenta; or in the case of an individual with a psychiatric or behavioral condition, that the individual is protected and prevented from injuring himself/ herself or others. For those individuals who are administered chemical or physical restraints for purposes of transfer from one facility to another, stabilization may occur for a period of time and remove the immediate EMC, but the underlying medical condition may persist and, if not treated for longevity, the individual may experience exacerbation of the EMC. Therefore, the treating physician should use great care when determining if the EMC is in fact stable after administering chemical or physical restraints.

a. **Stable.** The physician or QMP providing the medical screening and treating the emergency has determined within reasonable clinical confidence, that the EMC that caused the individual to seek care in the DED has been resolved although the underlying medical condition may persist. Once the individual is stable, EMTALA no longer applies. (The individual may still be transferred; however, the "appropriate transfer" requirement under EMTALA does not apply.)

b. **Stabilizing Treatment Within Hospital Capability and Transfer.** Once the hospital has provided an appropriate MSE and stabilizing treatment within its capability, an appropriate transfer may be effected by following the appropriate transfer provisions. (See Transfer Policy.) If there is a disagreement between the physician providing emergency care and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual has been provided sufficient stabilized treatment to effect a transfer, the medical judgment of the transferring physician takes precedence over that of the off-site physician.
Refer to the hospital's Transfer Policy for additional directions regarding transfers of those individuals who are not medically stable. If a hospital has exhausted all its

capabilities and is unable to stabilize an individual, an appropriate transfer should be implemented by the transferring physician.

c. **Stabilizing Treatment and Individuals Whose EMCs Are Resolved.** An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his or her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions. The EMC that caused the individual to present to the DED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/ provide discharged individuals the necessary information to secure follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.

8. **When EMTALA Obligations End**

The hospital's EMTALA obligation ends when a physician or QMP has made a decision:

a. That no EMC exists (even though the underlying medical condition may persist);
b. That an EMC exists and the individual is appropriately transferred to another facility; or
c. That an EMC exists and the individual is admitted to the hospital for further stabilizing treatment; or
d. That an EMC exists and the individual is stabilized and discharged.

Note: A hospital's EMTALA obligation ends when the individual has been admitted in good faith as an inpatient, whether or not the individual has been stabilized.* An individual is considered to be an inpatient when the individual is formally admitted to the hospital by a physician's order. A hospital continues to have a responsibility to meet the patient's emergency needs in accordance with hospital CoPs. A patient in observation status is not considered admitted as an inpatient, therefore, EMTALA obligations continue.

*Case law provides that EMTALA does apply to inpatients who have not been stabilized in Kentucky, Tennessee, Ohio and Michigan. *Moses v. Providence Hospital and Medical Centers, Inc. and Paul Lessem, 6th Circuit Court of Appeals, April 6, 2009*.

9. ***EMTALA Waivers and Requirements During Pandemics and Other Declared Emergencies.***

a. Alternative Screening Sites on Campus for Screening during a Pandemic (No Waiver Required.) For the screening of influenza like illnesses, the hospital may establish an alternative screening site(s) on campus. Individuals may be redirected to these sites AFTER being logged in. The redirection and logging can take place outside the entrance to the DED. However, the person doing the directing must be qualified (*e.g.*, an RN or QMP) to recognize individuals who are obviously in need of immediate treatment in the DED. The MSEs must be conducted by qualified personnel.
b. Alternative Screening Site Off-Campus (No Waiver Required.) The hospital may

encourage the public to go to an off-campus hospital-controlled site **for the screening of influenza like illness**. However, the hospital may NOT tell an individual who has already come to the DED to go to the off-site location for the MSE. The off-campus site for influenza like illnesses should not be held out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis.

c. EMTALA Waivers.

    i. A hospital operating under an EMTALA waiver will not be sanctioned for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site, for the MSE if the following conditions are met:

        1. The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period (as those terms are defined in the hospital's EMTALA Transfer Policy);

        2. The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan;

        3. The hospital does not discriminate on the basis of an individual's source of payment or ability to pay;

        4. The hospital is located in an emergency area during an emergency period; and

        5. There has been a determination that a waiver of sanctions is necessary.

    ii. An EMTALA waiver can be issued for a hospital only if:

        1. The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act; and

        2. The Secretary of HHS has declared a Public Health Emergency (PHE); and

        3. The Secretary invokes his or her waiver authority including notifying Congress at least 48 hours in advance; and

        4. The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.

d. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.

e. In addition, in order for an EMTALA waiver to apply to the hospital and for sanctions not to apply, (i) the hospital must activate its disaster protocol, and (ii) the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan.

f. Even when a waiver is in effect, there is still the expectation that everyone who comes to the DED will receive an appropriate MSE, if not in the DED, then at the alternate care site to which they are redirected or relocated.

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's disaster protocol. In the case of a PHE involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, the waiver may be limited to a date prior to the termination of the PHE declaration, as determined by CMS. If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital is located prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date. Likewise, if the hospital deactivates its disaster protocol prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date.

All Revision Dates

5/18/2022, 8/14/2017, 3/25/2017, 11/7/2016, 2/4/2016, 7/31/2015, 2/1/2013, 9/1/2012, 3/1/2012, 2/1/2010, 2/1/2004, 12/1/2003, 7/1/2001

Attachments

EMTALA Informed Refusal and AMA form EnglishSpanish.doc

EMTALA MOT EnglishSpanish.doc

FINAL SIGN-IN and WAIVER Form.doc

FINALPartial Refusal of Care and AMA Form.doc

Its The Law

LL.EM.001 EMTALA - Definitions and General Requirements.doc

Memo Of Transfer 2010.doc

Patient Information

Approval Signatures

Step Description	Approver	Date
Policy & Procedure	Jeff Dykes: Dir Emergency Svcs	5/18/2022

Policy & Procedure	John Baldwin: COO Southern Hills Med Ctr	5/11/2022

Status Active PolicyStat ID 10026132

TriStar Southern Hills MEDICAL CENTER

Effective	2/1/2010
Last Reviewed	5/18/2022
Last Revised	5/18/2022
Next Review	5/17/2025
Owner	Timothy Danford: Dir Emergency Svcs FSED
Policy Area	Organization Wide
Applicability	TriStar Southern Hills Medical Center
References	LL.EM.001

Tennessee EMTALA - Signage Policy

Effective Date: 2/1/2016

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

PURPOSE:

To establish guidelines for providing all individuals with the opportunity to be aware of and view their right to medical screening examination ("MSE") and stabilization for an emergency medical condition ("EMC") as required of any hospital with an emergency department by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY:

All emergency departments and any other place likely to be noticed by all individuals entering the emergency department and those individuals waiting for examination and treatment in areas of the hospital other than the traditional emergency department such as the entrance area, admitting areas, waiting rooms, and treatment areas located on hospital property must post conspicuously, appropriate

signage notifying individuals of their right to an MSE and stabilization or treatment for an EMC and required services for women in labor as specified under EMTALA as well as information indicating whether or not the hospital participates in the Medicaid program. The entrance to the emergency department shall be clearly marked.

PROCEDURE:

All hospitals must post signage that, at a minimum, meets the following requirements:

- signage must be conspicuously posted in any place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than the traditional emergency department (*e.g.*, entrance, admitting area, waiting room, labor and delivery, and other treatment areas located on hospital property):
    - signage must be readable from anywhere in the area
    - wording on signage must be clear and in simple terms in a language(s) that is (are) understandable by the population the hospital serves

      The contents of the signage must:
        - indicate whether or not the hospital participates in a Medicaid program approved under a State plan under Title XIX;
        - specify the rights of individuals with EMCs to receive an MSE and necessary stabilization and treatment for any EMC regardless of the ability to pay; and
        - specify the rights of women in labor who come to the emergency department for health care services.

The signage content must include the following language:

IT'S THE LAW!

If you have a medical emergency or are in labor, even if you cannot pay or do not have medical insurance or you are not entitled to Medicare or Medicaid, you have the right to receive, within the capabilities of this hospital's staff and facilities:

- An appropriate medical screening examination;
- Necessary stabilizing treatment (including treatment for an unborn child); and
- If necessary, an appropriate transfer to another facility.

This hospital (does/does not) participate in the Medicaid program.

All Revision Dates

5/18/2022, 8/23/2018, 11/7/2016, 2/4/2016, 7/31/2015, 4/1/2012

Attachments

EMTALASignageEng-Spanish.doc

LL.EM.001 EMTALA - Definitions and General Requirements.doc

Signage

Approval Signatures

Step Description	Approver	Date
Policy & Procedure	Jeff Dykes: Dir Emergency Svcs	5/18/2022
Policy & Procedure	John Baldwin: COO Southern Hills Med Ctr	5/11/2022

Status **Active** PolicyStat ID **10026128**

Effective	2/1/2010	Owner	Timothy Danford: Dir Emergency Svcs FSED
Last Reviewed	5/18/2022	Policy Area	Organization Wide
Last Revised	5/18/2022	Applicability	TriStar Southern Hills Medical Center
Next Review	5/17/2025	References	LL.EM.001

TriStar Southern Hills MEDICAL CENTER

EMTALA Provision of On-Call Coverage

Effective Date: 8/1/2016

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be easily identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

PURPOSE:

To establish guidelines for the hospital, including a specialty hospital, and its personnel to be prospectively aware of which physicians, including specialists and sub-specialists, are available to provide additional medical evaluation and treatment necessary to stabilize individuals with emergency medical conditions ("EMCs") in accordance with the resources available to the hospital as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal and State regulations and interpretive guidelines promulgated thereunder.

POLICY:

The hospital must maintain a list of physicians on its medical staff who have privileges at the hospital or, if it participates in a community call plan, a list of all physicians who participate in such plan. Physicians on the list must be available after the initial examination to provide treatment necessary to stabilize

individuals with EMCs who are receiving services in accordance with the resources available to the hospital. The cooperation of the hospital's medical staff members with this policy is vital to the hospital's success in complying with the on-call provisions of EMTALA. The hospital should make its privileged physicians aware of their legal obligations as reflected in this policy and the Medical Staff Bylaws and should take all necessary steps to ensure that physicians perform their obligations as set forth herein and in each document.

PROCEDURE:

Develop an On-Call Schedule

The facility's governing board must require that the medical staff be responsible for developing an on-call rotation schedule that includes the name and direct telephone number or direct pager of each physician who is required to fulfill on-call duties. Practice group names and general office numbers are not acceptable for contacting the on-call physician. Individual physician names with accurate contact information, including the direct telephone number or direct pager where the physician can be reached, are to be put on the on-call list. The hospital MUST be able to contact the on-call physician with the number provided on the list. If the on-call physician decides to list an answering service number as the preferred method of contact, his/her mobile phone number must be provided to the hospital as a backup number to reach the on-call physician. The backup number will be used by hospital and Transfer Center personnel when the On-Call Physician does not respond to calls in a timely manner. Each physician is responsible for updating his or her contact information as necessary. Each hospital shall provide a copy of the daily on-call schedule to the Transfer Center.

The on-call schedule may be by specialty or sub-specialty (*e.g.*, general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the hospital and implemented by the relevant department chairpersons. The Medical Executive Committee ("MEC") shall review the on-call schedule and make recommendations to the CEO when formal changes are to be made or when legal and/or operational issues arise.

The hospital shall keep local Emergency Medical Services advised of the times during which certain specialties are unavailable.

Only physicians that are available to physically come to the ER may be included on the on-call list. A physician available via telemedicine does not satisfy the on-call requirements under EMTALA.

Specialty Hospital Call

A specialty hospital such as a psychiatric, orthopedic, or heart hospital that does not operate an emergency department is still subject to EMTALA requirements, and must maintain an on-call list and accept appropriate transfers when requested to do so.

Records

The hospital must keep a record of all physicians on-call and on-call schedules for at least five years. Any on-call list must reflect any and all substitutions from the time of first posting of the list. These

records may be in electronic or hardcopy format.

Maintain a List

Each hospital must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The Medical Staff Bylaws or appropriate policy and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with an EMC. Factors to consider in developing the on-call list include: the level of trauma and emergency care afforded by the hospital; number of physicians on the medical staff who are holding the privileges of the specialty; other demands on the physicians; frequency with which the physician's services are required; and the provisions the hospital has made for situations where the on-call physician is not available or not able to respond due to circumstances beyond his or her control. The hospital is expected to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available.

In addition, the on-call list requirement applies to any hospital with specialized capabilities that is participating in the Medicare program regardless of whether the hospital has a DED. Specialty Hospitals must have appropriate on-call specialists available for receiving those individuals transferred pursuant to EMTALA. Hospitals should verify that the privileges of each on-call physician are current as to the procedures that each on-call physician is able to perform and the services that each on-call physician may provide.

The on-call list maintained for the main hospital Emergency Department shall be the on-call list for the hospital, including any Off-Campus Provider-based Emergency Departments.

Physician's Responsibility

The hospital has a process to ensure that when a physician is identified as being "on-call" to the DED for a given specialty, it shall be that physician's duty and responsibility to assure the following:

A. Immediate availability, at least by telephone, to the ED physician for his or her scheduled "on-call" period, or to secure a qualified alternate who has privileges at the hospital if appropriate.
B. If a Transfer Center is being utilized to contact the on-call physician, the on-call physician must respond to the Transfer Center within a reasonable timeframe (generally, within 30 minutes).
C. Arrival or response to the DED within a reasonable timeframe (generally, response by the physician is expected within 30 minutes). The ED physician, in consultation with the on-call physician, shall determine whether the individual's condition requires the on-call physician to see the individual immediately. The determination of the ED physician or other practitioner who has personally examined the individual and is currently treating the individual shall be controlling in this regard.
D. The on-call physician has a responsibility to provide specialty care services as needed to any individual who comes to the Emergency Department either as an initial presentation or upon transfer from another facility.
E. The on-call physician has a responsibility to notify the Medical Staff Office of changes to the on-call schedule.

Authority to Decline Transfers

The on-call physician **does not have the authority** to refuse an appropriate transfer on behalf of the facility.

Only the CEO, Administrator-on-Call ("AOC"), or a hospital leader who routinely takes administrative call has the authority to verify that the facility does not have the capability and capacity to accept a transfer. Any transfer request which may be declined must first be reviewed with this individual before a final decision to refuse acceptance is made. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor or other similarly titled position is not considered to be an equivalent of the AOC.

Financial Inquiries

Medical Staff Members who are on-call and who are called to provide treatment necessary to stabilize an individual with an EMC may not inquire about the individual's ability to pay or source of payment before coming to the DED and no facility employee, including Transfer Center employees, may provide such information to a physician on the phone.

Physician Appearance Requirements

If a physician on the on-call list is called by the hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable timeframe, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Social Security Act. If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person within a reasonable amount of time. For those physicians who do not respond within a reasonable amount of time, the Chain of Command Policy should be initiated.

Note: Each facility should define a reasonable timeframe – generally that timeframe should not be greater than 30 minutes.

If, as a result of the on-call physician's failure to respond to an on-call request, the hospital must transfer the individual to another facility for care, the hospital must document on the transfer form the name and address of the physician who refused or failed to appear.

Call by Non-Physician Practitioners

The ED physician must be able to first confer with the on-call physician. Midlevel practitioners (usually physician assistants or advanced practice registered nurses) who are employed by and have protocol agreements with the on-call physician, may appear at the hospital and provide further assessment or stabilizing treatment to the individual only after the on-call physician and ED physician confer and the on-call physician so directs the licensed non-physician practitioner to appear at the hospital. The individual's medical needs and capabilities of the hospital, along with the State scope of practice laws, hospital bylaws, and rules and regulations, must be thoroughly reviewed prior to implementing this process. The designated on-call physician remains ultimately responsible for providing the necessary services to the

individual in the DED regardless of who makes the first in-person visit. If the ED physician does not believe that the non-physician practitioner is the appropriate practitioner to respond and requests the on-call physician to appear, the on-call physician must come to the hospital to see the individual.

Selective Call and Avoiding Responsibility

Medical Staff Members may not relinquish specific clinical privileges for the purpose of avoiding on-call responsibility. The Board of Trustees is responsible for assuring adequate on-call coverage of specialty services in a manner that meets the needs of the community in accordance with the resources available to the hospital. Exemptions for certain medical staff members (*e.g.*, senior physicians) would not per se violate EMTALA-related Medicare provider agreement requirements. However, if a hospital permits physicians to selectively take call ONLY for their own established patients who present to the DED for evaluation, then the hospital must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement.

Providing Elective Surgeries or Other Therapeutic or Diagnostic Procedures While On-Call

The hospital shall have in place policies and procedures to ensure that specialty services are available to meet the needs of any individual with an EMC if the hospital permits on-call physicians to schedule elective surgeries during the time that they are on-call. An on-call physician who undertakes an elective surgery while on-call must arrange for an appropriate physician with comparable hospital privileges to serve as back-up to provide on-call coverage and notify the facility of such determination. The facility will ensure that the DED is familiar with the back-up arrangement for any physician performing elective procedures.

Simultaneous Call

Physicians are permitted to have simultaneous call at more than one hospital in the geographic area; however, the physician must provide the hospital with the physician's on-call schedule so that the hospital can have a plan in place to meet its EMTALA obligation to the community. This plan could include back-up call by an additional physician or the implementation of an appropriate transfer. An on-call physician may not choose the hospital in which to treat a patient purely for the physician's convenience (*e.g.*, if a physician is on-call for both Hospitals A and B, is at Hospital B, but is requested to come to Hospital A by the Hospital A ED physician, the on-call physician is obligated to treat the patient at Hospital A).

Back-up Plans and Transfers

The hospital shall have in place a written plan for transfer and/or back-up call coverage by a physician of the same specialty or subspecialty for situations in which a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond the physician's control. The ED physician shall determine whether to attempt to contact another such specialist or immediately arrange for a

transfer. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.

Appropriate transfer agreements shall be in place for those occasions when an on-call specialist is not available within a reasonable period of time to provide care for those individuals who require specialty or subspecialty physician care and a transfer is necessary. A list of facilities with which the hospital has transfer arrangements and the specialties represented shall be available to the individual or Transfer Center responsible for facilitating the transfer. The transfer agreements shall not include financial provisions for EMTALA transfers.

Transfer to Physician's Office

When a physician who is on-call is in his or her office, the hospital may NOT refer individuals receiving treatment for an EMC to the physician's office for examination and treatment. The physician must come to the hospital to examine the individual if requested by the treating physician.

Community Call Plan

A community call plan is designed to meet the needs of the communities served utilizing the resources within the region. A community call plan facilitates appropriate transfers to the hospital providing the specialty on-call services pursuant to the plan, but does not relieve any hospital of any EMTALA obligations with respect to transfer. Even though a hospital may participate in a community call plan, the hospital must still accept appropriate transfers from non-participating hospitals.

Any community call plan must be approved by Operations Counsel and meet all applicable federal and state regulations and guidelines.

All Revision Dates

5/18/2022, 9/7/2018, 11/1/2016, 2/4/2016, 7/31/2015, 8/4/2014, 2/1/2013

Attachments

LL.EM.001 EMTALA - Definitions and General Requirements.doc

Approval Signatures

Step Description	Approver	Date
Policy & Procedure	Jeff Dykes: Dir Emergency Svcs	5/18/2022

Policy & Procedure	John Baldwin: COO Southern Hills Med Ctr	5/11/2022

Status Active PolicyStat ID 10026129

TriStar Southern Hills MEDICAL CENTER

Effective	10/1/1979
Last Reviewed	11/8/2021
Last Revised	8/16/2018
Next Review	11/7/2024

Owner	Timothy Danford: Dir Emergency Svcs FSED
Policy Area	Emergency Services
Applicability	TriStar Southern Hills Medical Center
References	LL.EM.001

EMTALA Central Log Policy

Tennessee EMTALA – Central Log Policy

DATE: 2/1/2016

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

Purpose: To establish guidelines for tracking the care provided to each individual seeking care in a dedicated emergency department ("DED") for a medical condition or seeking care in areas on hospital property other than a DED for an emergency medical condition ("EMC") as required of any hospital with an emergency department by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

Policy: The hospital will maintain a Central Log containing information on each individual who comes on the hospital campus requesting assistance or whose appearance or behavior would cause a prudent layperson observer to believe the individual needed examination or treatment, whether he or she left before a medical screening examination ("MSE") could be performed, whether he or she refused treatment, whether he or she was refused treatment, or whether he or she was transferred, admitted and

treated, stabilized and transferred or discharged.

The Central Log includes the patient logs from the traditional ED and, either by direct or indirect reference, patient logs from any other areas of the hospital that may be considered DEDs or where an individual may present for emergency services or receive an MSE, such as Labor and Delivery.

Procedure:

1. All hospitals must maintain the Central Log in an electronic format. An electronic template that includes all federal requirements for EMTALA is available on Meditech for each market or division to customize.
2. All ancillary logs maintained by all hospital departments, including the DEDs, labor & delivery, behavioral health, pediatric EDs, and catheterization labs, are incorporated by reference and become part of the facility's EMTALA Central Log.
3. The Central Log, including all additional logs incorporated into the Central Log by reference, shall be maintained in the same manner and with the same central core of information. The logs must contain at a minimum, the name of the individual, the date and time of arrival, the record number, and whether the individual:

- refused treatment,
- was refused treatment,
- was transferred,
- was admitted and treated,
- was stabilized and transferred,
- was discharged, or
- expired.

1. A log entry for all individuals who have come to the hospital seeking medical attention or who appear to need medical attention must be made by the appropriate individual. Further, in non-DED departments of the hospital where an individual may present with an EMC, the department will provide the necessary information from the point of contact to the DED for logging purposes.
2. The Central Log of individuals who have come to the hospital seeking medical attention or who appear to need medical attention will be available within a reasonable amount of time for surveyor review and must be retained for a minimum of five years from the date of disposition of the individual.
3. Duplicate accounts created for the same patient who visits the hospital on more than one occasion must be consolidated so that only one medical record number per patient exists in the Central Log.

All Revision Dates

8/16/2018, 11/7/2016, 2/4/2016, 7/31/2015, 9/1/2012, 4/1/2012, 2/1/2010, 2/1/2004, 2/1/1998, 11/1/1991, 3/1/1989, 12/1/1985, 7/1/1982

Attachments

LL.EM.001 EMTALA - Definitions and General Requirements.doc

Approval Signatures

Step Description	Approver	Date
Policy & Procedure	Amy Higgins: CNO Southern Hills Med Ctr	11/8/2021

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Attachment 5C-1

TriStar Southern Hills Medical Center License

Board for Licensing Health Care Facilities

State of Tennessee

License No. 0000000021
No. of Beds 0136

DEPARTMENT OF HEALTH

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

HCA HEALTH SERVICES OF TENNESSEE, INC. to conduct and maintain a

Hospital TRISTAR SOUTHERN HILLS MEDICAL CENTER

Located at 391 WALLACE ROAD, NASHVILLE

County of DAVIDSON, Tennessee.

This license shall expire JANUARY 01, 2024, 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 21ST day of DECEMBER, 2022.

In the Distinct Category(ies) of:
STROKE RELATED-PRIMARY
PEDIATRIC BASIC HOSPITAL
STEMI-RECEIVING CENTER
GENERAL HOSPITAL

By Jennifer L. Putnam, Esq.
ASST. COMMISSIONER, HEALTH LICENSURE & REGULATION

By Morgan McDonald
COMMISSIONER

Attachment 5C-2

Medical Director C.V. and Letter of Support

Brad W. Hoover, M.D.

Regional Medical Director - TriStar EDs
Envision Physician Services

EDUCATION

Sep '*82- May '85* Bachelor of Science; University of Tennessee, Martin
Sep '*85- Jun '89* Doctor of Medicine, University of Tennessee, Memphis

EMPLOYMENT

June '*17* - present: Regional Medical Director, TriStar (HCA) EDs.
Overseeing 16 Nashville-region EDs/FSEDs operations, leaders, and performance. Have also been regional director of 4 Chattanooga market and 3 greater Atlanta market HCA EDs (2017-2021)

June '19 - present: Medical Director, Mt Juliet Freestanding ED

Nov '21 - present: Interim Medical Director, Southern Hills ED

Jan '98 - present*:* Medical Staff Physician, ED. Summit Med Ctr Nashville
2005-2014: Medical Director, Emergency Dept

Oct/ '14 – Jul '17: Medical Director, Doctor's Hospital of Sarasota (FL)

Jul 96-Jun 98 U.S. Army Medical Staff Emergency Physician
Blanchfield Army Community Hospital
Ft. Campbell, KY
1997-1998: Chief of Emergency Services

Jul *93- Jun 96* Resident, Emergency Medicine, Brooke Army Medical Center Fort Sam Houston, TX
1996: Chief Resident

Jul *90- Jun 93* General Medical Officer, 1st Armored Division
Nuremberg, Germany
Jul '90- Apr'91: Chief, Troop Medical Clinic
Dec '90- Apr '91: Brigade Surgeon, 1st AD Artillery

Desert Shield/Storm
May ‘91- Jun ‘93: Staff ED Physician, 98th Gen Hospital

Jul 89 – Jun 90 Internship, Int. Medicine, Beaumont Army Medical Center El Paso, TX

CERTIFICATIONS

American Board of Emergency Medicine, 1997
Recertification, 2007 and 2017

LICENSURES

I currently hold active medical licenses in the states of Tennessee and Georgia.

PUBLICATION

Acute Bilateral Blindness *Academic Emergency Medicine*; Nov 1996

PROFESSIONAL ORGANIZATIONS

Tennessee Medical Association
**Graduate, Physician Leadership Council 2013*

AWARDS and RECOGNITION

Eagle Scout 1981

Bronze Star Medal - Desert Shield/Storm 1991

Meritorious Service Medal – U.S. Army 1998

Attendee, ACEP ED Directors Academy (parts 1-3) 2005-06

Frist Humanitarian Award – Summit Medical Center 2009

Board Member, Small World Ministries 2009 - 2021

Board President 2019 - 2021

Author, *A Hero in a Bandana* (Academy Park Press) 2014

PERSONAL

Spouse – Michelle Hoover (m. 1989). Children: Liam (b. 1993), Aubrey (b. 1997), and Gabriel (b. 2007).

Interests – cycling, hiking, travel.

Philanthropic focus – adoption awareness and champion, pediatric cancer research and support for families, missionary medical trips Haiti (2010) and Honduras (2011)

TriStar Southern Hills
MEDICAL CENTER

tristarsouthernhills.com
391 Wallace Road
Nashville, TN 37211
(615) 781-4000

March 29, 2023

Re: TriStar Nolensville FSED CON Application

Logan Grant, Exec Dir

Health Svcs and Development Agency

Nashville, TN

Dear Mr. Grant:

Hello. I serve as the ER medical director of the Southern Hills Medical Center and Summit Medical Center, both in Nashville. In addition, I have served as the medical director of the Mt Juliet freestanding ED (FSED) for the past 3+ years. I have been a resident of Williamson County since moving to this area (March 1998), and have witnessed the incredible growth of Nolensville in particular over the last 5 years.

The traffic congestion on Nolensville Road is significant, especially around the rush hours (AM and PM). Minutes (and seconds) count when a life/limb threat emergency presents, and a FSED can provide 24/7 emergency-physician-trained care to these patients just like an emergency department attached to a hospital. At the Mt Juliet FSED, where I am the medical director, we admit/transfer up to 12% of our patients on a monthly basis. We also are on a pace to see over 20,000 patients in 2023. I am certain a FSED in Nolensville can and will serve a similar purpose to the residents (and visitors) in the region.

As you know, a FSED is much more than an urgent care center. With CT and ultrasound capabilities, and full lab and pharmacy services, a FSED can meet any emergent need of any patient from ages 6 minutes to 106 years. The time spent in a FSED is much less than a full-facility ED, and the patient satisfaction is subsequently higher. Staff and physician satisfaction are also enhanced at a FSED, so it's a win-win for everyone.

I would be willing to come before the Agency board meeting and discuss this need for the Nolensville area in person, if that would be helpful. I appreciate your time in reading my letter, and ask for your support in the CON request for this much-needed facility.

Cordially,

Brad W. Hoover, MD

Regional Medical Director, TriStar EDs

Matthew R. Tincher, MD FACEP

EMERGENCY DEPARTMENT LEADERSHIP

Accomplished ED leader with 15+ years of success in improving patient outcomes and increasing patient safety through targeted strategies that streamline operational processes. Combines detailed process analysis, proven best practices, and solid leadership to consistently achieve hospital objectives.

PROFILE

Team building strategist with a focus on establishing a culture committed to excellence, efficiency, and compassionate care. Consistently strives to develop innovative operational strategies that improve clinical quality, increase patient satisfaction, and support growth.

LEADERSHIP SUMMARY

Operations Management
Medical Staff Leadership
Quality & Safety Initiatives
Policy/Protocol Development
EMR Implementation

PROFESSIONAL EXPERIENCE

ENVISION HEALTHCARE

Senior Vice President	4/2018 - Present
Alliance Operating Unit	
TriStar Division	
Regional Medical Director	10/2016-3/2018
Alliance Operating Unit	
TriStar Division	

TRISTAR HORIZON MEDICAL CENTER

Chief Medical Officer	5/2018- Present
Medical Director, Emergency Department	2007 - 2018
Chief-of-Staff	2012 - 2014
Vice Chief-of-Staff	2010 - 2012
Medical Director, Dickson Co EMS	2008 - 2019

OPERATIONS MANAGEMENT & STRATEGIC PLANNING EXPERIENCE

- Reduced Arrival-to-Greet, Discharged LOS, and Low Acuity LOS by >30% through process improvement designed to streamline workflow, accurately assess acuity, and positively impact patient throughput.
- Achieved gains in inpatient admissions by developing strategies to mitigate transfers.
- Implementation of a successful strategic plan to improve ED patient satisfaction.

TEAM MANAGEMENT & PATIENT CARE EXPERIENCE

- Development of a cohesive team driven by common goals through the establishment of clear expectations in the setting of a positive culture dedicated to quality care.
- Accurate identification of staff strengths, weaknesses, and motivators to promote growth and generate real-world gains in team productivity.
- Close collaboration with executive leadership teams to develop and implement strategic plans.

EDUCATION

RESIDENCY

Emergency Medicine, Emory University 1998-2001
Atlanta, GA

DOCTOR OF MEDICINE

University of Cincinnati 1994-1998
Cincinnati, OH

BACHELOR OF SCIENCE IN CHEMISTRY

Lipscomb University 1989-1994
Nashville, TN

AWARDS

EmCare Alliance Group	Emergency Medicine Excellence Award	2016
EmCare Alliance Group	Medical Director of the Year	2015

April 12, 2023

Mr. Logan Grant
Executive Director
Health Services and Development Agency
Andrew Jackson Building,
9th Floor 502 Deaderick Street
Nashville, Tennessee 37243

RE: TriStar Southern Hills Nolensville FSED CON Application

Dear Mr. Grant:

This letter is to convey my support for TriStar Southern Hills' Medical Center's CON Application to develop a new freestanding emergency department (FSED) in the Nolensville community. I have served as Tristar's regional lead of Envision Physician Services ("Envision") for 5 years, and I previously served as Emergency Department Medical Director at Tristar Horizon Medical Center and Tristar Natchez FSED. Accordingly, I am keenly aware of the operational needs of Southern Hills' ED and the emergency healthcare needs of our local communities.

Given the ongoing development in and around Nolensville, when other options are miles away a Free-Standing ED could save lives. I have seen this time-sensitive, life-saving treatment have tremendous impact for each Free-Standing ED which I serve, and I am certain a Free-Standing ED will serve a similar purpose for the residents (and visitors) of Nolensville.

Currently, TriStar Southern Hills is the closest existing ED for Nolensville residents, and as Southern Hills' diverse and high acuity patient base has created ED program growth, the hospital has seen an increase in wait times as well as longer-than-ideal ED boarding times as patients wait to be admitted. Despite its ED capacity issues, Southern Hills continues to provide high quality care to every patient that walks through its doors; however, the need for additional capacity is imminent for Southern Hills to continue to provide the care that its patients deserve.

Tristar Health's growing network of FSEDs provided emergency care to over 60,000 patients last year, when traditional hospital emergency rooms were not able to meet community needs. The Nolensville FSED is an opportunity for TriStar Southern Hills to enhance access to its patient base who currently have limited access to emergency care while simultaneously relieving Southern Hills' ED capacity constraints.

The Nolensville FSED will fill a critical gap in access to care and improve hospital operational efficiencies, and I strongly urge you to approve the proposed project. Thank you for your time and consideration.

Sincerely,

Matthew R. Tincher MD FACEP
Senior Vice President
Envision Physician Services

Attachment 5C-3

2022 QAPI Plan

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TriStar Southern Hills MEDICAL CENTER

Effective	9/24/2013	Owner	Mary Ellen Brill: VP Quality/Risk Mgmt
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2022 Quality/Patient Safety Plan

MISSION AND VALUES

Above all else, we are committed to the care and improvement of human life by caring for those we serve with integrity, compassion, a positive attitude, respect and exceptional quality.

In pursuit of our mission, we believe the following value statements are essential and timeless:

A. We recognize and affirm the unique and intrinsic worth of each individual.
B. We treat all those we serve with compassion and kindness.
C. We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
D. We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.

PHILOSOPHY/OBJECTIVES/SCOPE OF SERVICES

Philosophy:

Performance Improvement/Patient Safety Programs' underlying philosophy:

A. Utilizes a planned, systematic, hospital-wide approach to design, measurement, assessment and improvement in performance and processes.
B. Offers facility leaders, medical staff, and facility staff objective information, which they can use for purposes of review, patient management, and quality measurement.
C. Facilitates activities that are collaborative and interdisciplinary in order to respond to the needs of the patient, physician, staff and community.

D. Promotes integration and communication between hospital departments, medical staff, and Senior Leadership to continuously improve processes which affect patient care.

Objectives:

The objectives of this plan are to preserve/improve the quality of patient care, enhance appropriate utilization of resources, and to reduce or eliminate unnecessary risks and hazards within the facility by promoting:

A. The employment of qualified, competent, and effectively supervised personnel for patient care, utilizing clear channels of supervision, responsibility, and accountability.

B. Patient care which is appropriate to the ages and needs of patients that is delivered as follows:

   1. in a safe and timely manner
   2. within the range of available resources
   3. in as cost-efficient of a manner as possible
   4. consistent with achievable goals
   5. properly documented to facilitate evaluation and effective communication
   6. continuously evaluated and improved

C. A system in which the appropriate level of care is provided to all patients and is subject to periodic review (prospective or concurrent) with the use of pre-established objective indicators and documentation of findings.

D. A system in which the findings of patient care monitoring and evaluation are utilized by the hospital in concrete ways to fulfill the objectives of the Performance Improvement/Patient Safety Program.

E. The maintenance of a continuing education program utilizing, in part, results of patient care monitoring and evaluation.

F. Continuous evaluation and improvement of customer satisfaction (patients/family/community, physicians, employees).

Scope of Services:

The scope of this plan includes monitoring and evaluation activities which address patients of all ages served by the hospital and all services and settings owned by the hospital.

LEADERSHIP'S ROLE AND RESPONSIBILITY

Leadership plays a central role in improving both organizational performance and safety. Leadership includes the Board of Trustees, Medical Executive Committee, the Chief Executive Officer and senior leadership, department directors, and Nursing Officers/Managers/Supervisors. The leaders set expectations, develop plans, and manage processes to measure, analyze, and improve the quality and safety of the hospital's clinical and support activities. The leaders are responsible for adopting an approach to performance improvement which is utilized in reporting and in team activities. Leaders also are responsible for setting policy/procedure and priorities, as well as re-prioritizing priorities when there are sentinel events or unexpected adverse outcomes.

Leaders are responsible for establishing a policy and procedure for sentinel events, educating staff on sentinel events, and responding appropriately when they occur. The policy shall include a process for conducting a timely serious event analysis that focuses on processes and systems, and the development of risk reduction strategies and an action plan that incorporates evaluating the effectiveness of the actions taken.

Leaders set a positive Performance Improvement/Patient Safety culture in the organization through planning, education on tools, approaches, methods), providing support, such as time and resources (staff, information systems, etc), and empowering staff as appropriate. Leaders also actively participate in interdisciplinary performance improvement and patient safety activities, as appropriate.

The Performance Improvement/Patient Safety Program is the shared responsibility of the Board of Trustees, the Medical Staff, and the Senior Leadership of the hospital, with specific areas of the program delegated to each. The program involves the Board, medical and other professional staff, administrative, technical and all support services, and includes education concerning the approaches and methods of performance improvement.

Board of Trustees:

The Board shall require specific review and evaluation of activities to assess and improve the overall quality, safety and efficiency of patient care in the hospital. While maintaining overall responsibility, the Board delegates operational authority to the Medical Staff and Senior Leadership. In exercising its supervisory responsibility, the Board will:

A. Receive, review and accept or reject periodic reports on findings, conclusions, recommendations, actions and results of program activities.
B. Assess the program's effectiveness and efficiency and require modification in organizational structure and systems where necessary to improve program performance.
C. Provide for resources and support systems for performance improvement and functions related to patient care and safety.
D. Verify that the overall goal of patient care enhancement is being achieved.
E. Require a process designed to assure that all individuals responsible for the assessment, treatment or care of patients are competent.

Medical Executive Committee (MEC):

A. The Medical Executive Committee (MEC) of the Medical Staff is accountable to the Board of Trustees for oversight of the monitoring and evaluation functions to determine that the same level of medical care is rendered to all patients in the hospital through performance improvement monitoring, actions taken when indicated, and by reporting these activities to the Board of Trustees.
B. The MEC shares the responsibility for the operations of the monitoring and evaluation functions with the Medical Staff, Quality Council and the appropriate Medical Staff Committees. The Credentials Committee is delegated the responsibility for evaluation of the results of monitoring and evaluation functions at the time of reappointment to the Medical Staff.

Senior Leadership:

Senior Leadership, through the Chief Executive Officer (CEO) and Quality Council, is accountable to the Board of Trustees for the quality of care provided and patient safety. The CEO will:

A. Promote the participation of the appropriate members of professional and technical staffs and departments in the program through interdisciplinary monitoring and evaluation of patient care and patient safety activities through the Quality Council.

B. Establish and maintain operational linkages between Risk Management, Patient Safety, and Performance Improvement functions.

C. Assure that sufficient resources and personnel are provided to support Patient Safety and Performance Improvement activities, and that staff are provided adequate time to participate in these activities.

Quality/Risk Management Department:

Senior Leadership will provide adequate resources to conduct quality, performance improvement, and patient safety functions. These resources will be directed through the Quality/Risk Management Department. This department will provide at least the following services and functions:

A. Orientation and training on programs, functions and tools related to performance improvement and patient safety.

B. Reports of changes in regulations, laws, and accreditation standards to Senior Leadership, the Medical Staff Leaders and employees.

C. Conduct data retrieval functions.

D. Aggregate performance improvement findings for presentation to Leadership, Medical Staff, and hospital staff.

E. The Vice-President of Quality/Risk will be responsible for ensuring that appropriate actions are implemented within established time frames.

F. The Vice President of Quality/Risk or designee will be a member of Medical Staff Committees, Medical Executive Committee, Quality Council, Facility Ethics and Compliance, Environment of Care Committee, and Board of Trustees.

PLAN

TriStar Southern Hills Medical Center participates in collaborative, interdisciplinary monitoring of patient care activity processes and outcomes. Performance improvement activities include how the hospital designs, measures, assesses, and improves important processes and outcomes. All performance improvement activities are incorporated into a collaborative, interdisciplinary approach through interdisciplinary monitoring and performance improvement teams.

Performance Improvement Model:

TriStar Southern Hills Medical Center will utilize proven performance improvement tools and methodologies in its improvement efforts. Our primary improvement model is FOCUS PDCA.

- **F** ind a process to improve

- **O** rganize a team that knows the process
- **C** larify the current knowledge of the process
- **U** nderstand the causes of process variation
- **S** elect the process improvement
- **P** lan the improvement and continued data collections
- **D** o the improvement, data collection and analysis
- **C** heck and study the results
- **A** ct to hold the gain and to continue to improve the process

Leadership supports the use of data driven, scientific approaches to process improvement and the necessary hospital-wide planning and prioritization of resources required to achieve and sustain desired results. A variety of improvement tools are utilized. Opportunities involving large scale and complex inter-departmental processes are reviewed, prioritized and resourced through the Quality Council with representatives from Clinical Operations, Quality, Risk, Medical Staff and Senior Leadership. Additionally, the Corporate Performance Improvement (PI) Team partners with facilities utilizing an approach that is data-driven and organizationally structured to deliver solutions designed to assist hospitals in reducing costs, improving quality, and increasing efficiency. Teams of facility and PI resources are aligned to support improvements in the areas of patient care, surgical services, general support and ancillary services. Subject matter experts (SMEs) bring in-depth knowledge and best demonstrated practices to clinical and operational areas to drive change within the organization. This collaborative approach between facilities and the PI team supports the commitment to deliver high-quality, cost-effective healthcare in the communities that we serve. Activities from the Quality Council are reported through to the Medical Executive Committee and the Board of Trustees.

Hospital-Wide Priorities:

Priorities for hospital-wide performance improvement activities at the facility will be designed to improve processes and patient outcomes. These priorities will be developed by the Quality Council, with participation of all hospital disciplines, and approved by the MEC and Board of Trustees. High priority will be given to processes/outcomes which are:

A. High risk (including patient safety issues)

B. High volume/Low volume

C. Problem prone

2022 Patient Safety/Quality Improvement Priorities:

In addition to the ongoing improvement efforts outlined by the quality improvement/patient safety indicators, the organization has identified Patient Safety and Quality Improvement operational strategies. These strategic initiatives were developed from trends of quality improvement data, current industry literature, and proactive initiatives derived from our mission and values statements.

The hospital has prioritized the following for targeted focus:

ELEVATE CARE EXPERIENCE & CARE TEAM ENGAGEMENT	TIME PERIOD	GOAL
RN R12 Turnover	202201	19.80%
PCT R12 Turnover	202201	30.00%
Nurse Leader R12 Turnover	202201	15.00%
RN Engagement Meaningful Conversations	2021Q4	62
PCT Engagement Meaningful Conversations	2021Q4	68
ER Satisfaction (Top Box)	2021Q4	70.60%
IP HCAHPS (Top Box)	2021Q4	73.70%
Phys. Engagement - Place to Practice	2021Q1	48.80%
Phys. Engagement - Nursing Overall	2021Q1	42.90%
Hire to Core	202201	90.00%
Staff to Target	202201	99 - 104%

ELIMINATE HARM AND MITIGATE ORGANIZATIONAL RISK	TIME PERIOD	GOAL
CAUTI SIR	2021Q1-2021Q4	0.381
CLABSI SIR	2021Q1-2021Q4	0.471
CDIFF SIR	2021Q1-2021Q4	0.252
MRSA SIR	2021Q1-2021Q4	0.496
COLO SIR	2021Q1-2021Q4	0.306
HYST SIR	2021Q1-2021Q4	0.184

OPTIMIZE CARE EFFECTIVENESS & EFFICIENCY	TIME PERIOD	GOAL
% Door-to-Needle in 45 minutes	202102-202201	80.00%
NTSV C-Section Rate	202102-202201	25.00%
Sepsis Early Management Bundle (SEP-1)	2021Q2-2022Q1	71.00%
ESR Participation	202102-202201	75.00%
Complication Index	202102-202201	0.67
Mortality Index	202102-202201	0.65
PCI Mortality Rate (all patients)	2020Q3-2021Q2	1.71%

Service Line Specific Goals

Service Line	Goal
Cardiovascular Services Cath/PCI	Achieve goal of 80% of EKGs done/read within 10 minutes of arrival of any patient c/o symptoms of ACS (typical and atypical)
Cardiovascular Services Cath/PCI	Achieve median patient arrival to troponin resulted turnaround time to ≤ 60 minutes
Cardiovascular Services Cath/PCI	Maintain 100% door to balloon times for STEMI patients < 90 minutes
Cardiovascular Services Cath/PCI	Maintain AKI rate in 90th percentile (<2.6%)
Cardiovascular Services Cath/PCI	Maintain > 90% compliance of heart risk assessment in the ER (Heart Score) performed on all patients presenting with s/s of ACS
Cardiovascular Services Cath/PCI	Decrease LOS of cardiac observation patients
Cardiovascular Services Cath/PCI	Achieve/maintain > 90% compliance with discharge education

Re-prioritizing: The priorities may be reprioritized periodically in response to unusual or urgent events such as those identified through performance improvement monitoring and evaluation, changing regulatory requirements, significant patient/staff needs, changes in patient population, changes in the environment of care, changes in the community, or in response to sentinel events.

DESIGN

When a need or opportunity to establish new services, extend product lines, occupy a new facility, or significantly change existing functions or processes occurs, the following factors will be considered:

A. The process meets the needs of individuals served, staff and others.

B. It will incorporate the results of performance improvement activities, when available.

C. It will incorporate available information to minimize potential risks to patients affected by the new or redesigned process, function, or service.

D. Design or redesign of the service will be based on current knowledge and relevant information from literature and/or clinical guidelines.

E. Information about sentinel events will be considered, when available and relevant.

F. Testing/analysis will be done to determine if the proposed design/redesign is an improvement.

G. Leaders will collaborate with staff and appropriate stakeholders to design services.

H. The process will be consistent with the hospital's mission, vision, values, goals and plans.

Consideration of these factors will provide basic performance expectations that can be measured, assessed, and improved over time. All disciplines which will be involved in the new service, product line, function, or process will be included in the design.

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MEASURE

Measurement is the basis for determining the level of performance of existing processes and the outcomes resulting from these processes. Continuous and ongoing measurement activities will include:

A. Measurement of both processes and outcomes
B. Measurement of patient safety issues incorporated into the monitors
C. Measurement of high volume, high risk, and problem prone processes/outcomes
D. Measurement of areas identified for focused or targeted data collection
E. Establishment of a performance baseline
F. Comparison of outcomes to external databases, when available, as appropriate
G. Measurement will focus on sustaining improvement

Medical Staff Monitoring and Evaluation:

A. The Medical Staff is responsible for participating in interdisciplinary ongoing physician practice evaluation (OPPE) and focused physician practice evaluation (FPPE). Medical staff responsibilities include, but are not limited to:
    1. Participate in identification of interdisciplinary indicators, collection of data for each indication, reach conclusions, make recommendations and initiate actions.
    2. Communicate findings, conclusions, recommendations, actions, and effectiveness of actions taken to department members and MEC.
    3. Assess the effectiveness of actions and document improvement in patient care.
    4. Make recommendations to the Credentials Committee for clinical privileges.
    5. Participate on performance improvement teams.
    6. Work collaboratively to review and evaluate the performance improvement findings.

B. All performance improvement activities will be reported to the Medical Staff, as appropriate, and the MEC. The MEC is responsible for participating in and evaluation of performance improvement activities. All performance improvement activities are reported to the Board of Trustees

AGGREGATE AND ANALYZE

Process:

Aggregating and analyzing data allows the organization to use information to draw conclusions about the stability of a process or the predictability of an outcome in relation to performance expectations. Accumulated data are analyzed in such a way that current performance levels, patterns, or trends can be identified. This is supported by the following data use principles:

A. Collected data are aggregated and analyzed
B. Data are aggregated at the frequency appropriate to the activity or process being studied.

C. Statistical tools and techniques are used to analyze and display data
D. Data are analyzed and compared internally overtime and externally with other sources of information when available (benchmarking)
E. Comparative data are used to determine if there is excessive variability or unacceptable levels of performance when available.

Intensive Analysis:

Intensive analysis will be conducted when the following factors are identified:

A. Important single events, performance, and patterns or trends that vary significantly from expectations
B. If performance varies significantly and undesirably from other hospitals
C. If performance varies significantly and undesirably from recognized standards
D. When a sentinel event has occurred
E. Confirmed transfusion reactions
F. Significant adverse drug reactions
G. Significant medication errors and hazardous conditions
H. Major discrepancies between pre and post-operative diagnoses in pathology reports
I. Adverse events during anesthesia, moderate or deep sedation
J. Staffing effectiveness issues
K. Core measures data which identify the hospital as a negative outlier for three or more consecutive quarters

Analysis Findings Relevant to Individual Performance:

When the findings of the analysis process are relevant to an individual's performance, the following process will be followed:

A. **Credentialed Practitioners/Medical Staff Members:** The peer review process will be utilized for individual Medical Staff/Credentialed practitioner performance. The case will be referred to the Professional Practice Evaluation Committee and reviewed by a peer, as defined by the Professional Practice Evaluation policy and an improvement strategy, such as education, letter, etc., determined as necessary. Any recommended action on privileges and/or membership will be referred to the Medical Executive Committee which will make recommendations to the Board of Trustees. Professional Practice Evaluation findings are maintained in individual Medical Staff Quality Files.
B. **Hospital Staff:** The Department Manager will review information relevant to individual staff performance and an improvement strategy, such as education, determined as necessary. Documentation of this action will be maintained in individual employee files and utilized in the performance evaluation process.

Use of Dimensions of Performance and Scientific Tools:

The following definitions of dimensions of performance will be utilized in assessing how performance

was improved:

Dimensions of Performance

A. **Doing the Right Thing**

1. The **efficacy** of the procedure or treatment in relation to the patient's condition. Efficacy is the degree to which the care/intervention for the patient has been shown to accomplish the desired/projected outcome (s).
2. The **appropriateness** of a specific test, procedure, or service to meet a patient's needs. Appropriateness is the degree to which the care/intervention provided is relevant to the patient's clinical needs, given the current state of knowledge.

B. **Doing the Right Thing Well**

1. The **availability** of a needed test, procedure, treatment, or service to the patient who needs it. Availability is the degree to which appropriate care/intervention is available to meet the patient's needs.
2. The **timeliness** with which a needed test, procedure, treatment, or service is provided to the patient. Timeliness is the degree to which the care/intervention is provided to the patient at the most beneficial or necessary time.
3. The **effectiveness** with which tests, procedures, treatment, or service is provided to the patient. Effectiveness is the degree to which care/intervention is provided in the correct manner, given the current state of knowledge, in order to achieve the desired/ projected outcome for the patient.
4. The **continuity** of the services provided to a patient with respect to other services, practitioners, and providers, and over time. Continuity is the degree to which care/ intervention for the patient is coordinated among practitioners, among organizations, and over time.
5. The **safety** of the patient (and others) to whom the services are provided. Safety is the degree to which the risk of an intervention and risk in the care environment are reduced for the patient and others, including the health care provider.
6. The **efficiency** with which services are provided. Efficiency is the relationship between the outcomes (results of care) and the resources used to deliver patient care.
7. The **respect and caring** with which services are provided. Respect and caring is reflected by the degree to which the patient or a designee is involved in his/her own care decisions and to which those providing services do so with sensitivity and respect for patients' needs, expectations, and individual differences.

Various scientific tools may be used to assist in assessment, including flowcharts, Pareto charts (bar graphs), histograms, cause-and-effect diagrams (fishbone diagram), and run charts.

Reference Databases:

The hospital will utilize state and national patient outcome database reports (including CMS reports) to compare the hospital's performance with other facilities. In addition, the hospital provides data to external databases for comparative patient outcome studies, comparing our hospital to other peer

hospitals and national rates. This information will be utilized to determine areas for improvement.

Comparative databases used by TriStar Southern Hills Medical Center include, but are not limited to:

A. National Healthcare Safety Network (NHSN) with the CDC
B. Q-Source, Inc.
C. American College of Cardiology - Cath/PCI
D. Get with the Guidelines – Stroke
E. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) - Patient Satisfaction
F. GLINT
G. ORYX
H. Clinical Outcomes Measure Evaluation and Transmission (COMET) - core measures
I. American College of Radiology
J. American College of Pathology
K. American Association of Blood Banks
L. Leapfrog
M. Institute of Healthcare Improvement (IHI)
N. HCA Quality Review Data
O. National Quality Forum
P. Comprehensive Health Outcomes Information System (CHOIS)
Q. Agency for Healthcare Research and Quality (AHRQ)
R. Centers for Medicare and Medicaid Services
S. Professional Practice Manager (PPM)
T. NCDR

IMPROVE

Monitoring activities identify a variety of opportunities for improvement. These include improving existing processes, designing new processes, and/or reducing variation or eliminating undesirable variation in processes or outcomes. Improved changes which are made will be implemented into standard operating procedures and monitored for sustained improvement. Staff will be educated about redesigned processes or changes. The following reporting structure is utilized for performance improvement reporting:

Decisions for Improvements:

Decisions for making improvements are made by the Quality Council based on the following factors:

A. Opportunities to improve processes within the important functions.
B. Results of autopsies, risk management activities, and performance improvement activities.

C. Resources needed to improve, such as staffing, facilities, training, equipment, etc.
D. Organization's mission and priorities.

Opportunities to improve care may be referred to the Quality Council from the following sources:

A. Patients/families/community members
B. Board of Trustees
C. Medical Staff/Credentialed Practitioners
D. Employees/volunteers/students/vendors
E. Senior Leadership
F. Committees
G. Corporate or Divisional Office
H. Risk Management activities

Actions for Improvement:

Once results have been evaluated and the decision is made that improvement is necessary, the Quality Council will determine actions to be implemented for the improvement. When action is taken to improve a process:

A. The action may be tested on a trial basis
B. The action's effectiveness is evaluated using the dimensions of performance
C. When the initial action is not effective, a new action will be taken and may include the formation of a PI Team, if appropriate.
D. Successful actions are implemented

Quality Council Reporting:

Reports of findings, conclusions, recommendations and actions will be reported to the MEC and the Board of Trustees, as well as back to other Medical Staff/hospital committees and departments as appropriate.

SENTINEL EVENTS

Leaders of the organization will be responsible for defining the policy and procedure for responding to a sentinel event. If a sentinel event occurs, a serious event analysis (SEA) will be conducted in accordance with current policy and procedure. Once the SEA has been conducted, the team will develop an appropriate action plan to address any variations identified and establish measures for any changes made. Once resolved, performance improvement indicators may be continued to ensure that the problem remains corrected.

Proactive Risk Reduction:

At least every 18 months, one acute high-risk process is selected to perform a proactive risk assessment. The process is then reviewed using a Failure Mode and Effects Analysis (FMEA). The FMEA

process includes:

A. Identification of steps that could fail in a process and how
B. Identification of possible effects a process could have on patients
C. Prioritization of the potential process failures by severity
D. Determination of why priority failures could occur through the completion of a serious event analysis
E. Redesign of the process/system to manage the risk of effects on patients
F. Testing and implementation of the redesigned process
G. Monitoring the effectiveness of the redesigned process

MANAGEMENT OF INFORMATION

Information Systems:

The hospital utilizes a number of systems to assist in the management of information for the Performance Improvement/Patient Safety Program. Performance improvement data and reports will only be accessible to those participating in the performance improvement program and by those agencies responsible for ascertaining the existence of an ongoing and effective performance improvement program. All medical staff quality files and measurement/assessment data will be secured in the Quality/Risk Management department.

INTEGRATION OF RISK MANAGEMENT & PATIENT SAFETY

Risk Management:

In order for this Plan to be effective, it is essential that Risk Management functions be integrated with the performance improvement functions. Integration of Risk Management functions will be accomplished through the following:

A. Risk Management reports will be presented to the Quality Council at least quarterly.
B. Life Safety Data trends will be reviewed by the Environment of Care Committee as appropriate.

Patient Safety:

The purpose of the hospital Patient Safety program, which is an integral part of performance improvement monitoring, is as follows:

A. Promote a patient-safe environment that identifies mechanisms that contribute to patient safety, such as review of high risk patient care processes, collection and analysis of adverse patient incident data, and routine investigation of significant adverse events
B. Implement The Joint Commission (TJC) National Patient Safety Goals and recommendations from the Sentinel Event Alerts.
C. Develop proactive patient safety risk reduction strategies for minimizing the occurrence of

medical/health care errors using TJC sentinel event information and other published information related to medical/health care errors

D. Aggregate patient safety related data and information to improve professional and organizational performance

E. Learn about actual and potential medical and healthcare errors and utilize that knowledge to improve patient safety

Patient Safety monitoring will be incorporated into ongoing performance improvement monitors, including TJC National Patient Safety Goals and other published information. These will be monitored on an ongoing basis and reported to the Quality Council, Medical Executive Committee and Board of Trustees.

The Hospital will conduct patient safety activities with assistance and input from the HCA PSO, LLC.

CONFLICT OF INTEREST AND CONFIDENTIALITY

Conflict of Interest:

No physician/employee shall be responsible for reviewing his/her own care. When only one physician in a specialty is on the medical staff, practice will be reviewed within the expertise of the department. If practice is not within the expertise of the department, or is questioned, provision will be made to have cases evaluated by an outside expert in the same medical specialty.

Confidentiality:

Confidentiality shall be maintained, based on full respect of the patient's right to privacy and keeping with hospital policy and state and federal laws/regulations. All employees of TriStar Southern Hills Medical Center and outside agencies that are involved in the review process will be made aware of the responsibility. All data shall be considered the property of TriStar Southern Hills Medical Center, and the hospital shall ensure the maximum protection of all confidential data, including any findings, recommendations or actions.

The Plan for Improvement of Organizational Performance and Patient Safety of TriStar Southern Hills Medical Center is established based on the facilities' professional review function, and is designed to comply with The Joint Commission standards, applicable federal and state laws, including HIPAA regulations, Tennessee Peer Review Statute and the Healthcare Quality Improvement Act.

In order to safeguard the privacy of our patients and the rights of health care providers practicing within the facility, all information relative to the Plan for Improvement of Organizational Performance and Patient Safety is considered confidential and will be treated as such. Information which identifies individual patients or practitioners will be shared only with those who have a direct responsibility for measuring the performance or services provided by the individuals involved, or who can take direct action to resolve identified opportunities for improvement. All other communication regarding quality of services will contain only information which is pertinent to the maintenance of a general awareness of quality issues, the prevention of quality issues in the future and the identification of opportunities to

improve patient care and prevent adverse outcomes.

ANNUAL APPRAISAL

The Plan for Improvement of Organizational Performance and Patient Safety is evaluated annually to determine the effectiveness of the plan in meeting the objectives. A report of the evaluation is provided to the MEC and the Board of Trustees. The plan is revised when evaluation indicates need for revision, patient and/or staff expectation indicate a need for revision, performance improvement or patient safety indicates need for revision, or if there is a major change to the scope of services, patient population, change in technology or any factor that would have a direct impact on patient care services for which measurement of a process and outcomes would be required.

On an annual basis, leadership measures and assesses the effectiveness of their contribution to improving performance and patient safety by setting measurable objectives, assessing effectiveness and evaluating performance in support of sustained improvements.

All Revision Dates

5/17/2022, 3/31/2021, 3/27/2019, 12/5/2018, 1/4/2018, 5/18/2016, 6/22/2015, 9/24/2013

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee-Board of Trust	Sareda Nur: CMO - Southern Hills Med Ctr	5/17/2022
Medical Executive Committee-Board of Trust	Amy Higgins: CNO Southern Hills Med Ctr	5/17/2022
Medical Executive Committee-Board of Trust	Mary Ellen Brill: VP Quality/Risk Mgmt	5/17/2022
Quality Council	Mary Ellen Brill: VP Quality/Risk Mgmt	5/17/2022

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TriStar Southern Hills MEDICAL CENTER

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Risk Management Plan

PURPOSE:

The purpose of TriStar Southern Hills Medical Center's Risk Management Program is to provide an integrated and coordinated effort toward risk management which complies with Tennessee State Law, meets The Joint Commission Standards, meets requirements of regulatory agencies; and helps our facility to reduce risks and control losses related to professional, general, and workers' compensation liability.

POLICY:

The Vice President of Quality/Risk Management will develop, implement, and maintain a hospital-wide Risk Management Program consistent with state and federal regulations; HCA's risk management, patient safety, and loss prevention efforts; The Joint Commission; and the requirements of TriStar Southern Hills Medical Center's insurance carrier, Health Care Indemnity Inc. (HCI).

A. **Goals**

   1. Through the Risk Management Program, TriStar Southern Hills will minimize the number of adverse patient occurrences; minimize the number of losses (claims) relating to patients, employees, visitors and property; and minimize the number of work related employee injuries/illnesses; thereby maintaining the lowest insurance cost possible while assuring compliance with statutory regulations.

B. **Scope**

   1. The Risk Management Program includes all departments, services and health care professionals. The Risk Management Program is ongoing and includes effective mechanisms to measure and assess patient care, as well as, identify improvement, evaluate effectiveness, and determine the success of actions taken.

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C. **Objectives**

1. It is the responsibility of the Board of Trustees, through the medical staff and administration, to establish controls that will minimize risk exposures and maintain desirable standards of patient care. The objectives of this risk management program are:

    a. To provide ongoing surveillance for potential variances to hospital standards or policies in order to prevent their occurrence;

    b. To orient new employees to their responsibility in proper reporting of unusual occurrences or incidents and future prevention of those incidences;

    c. To integrate data received from HCA's Clinical Safety Improvement Program (CSIP) activities as it pertains to potential losses to the hospital, staff and patients, and make recommendations toward resolving issues causing losses;

    d. To investigate, categorize and analyze all occurrences or variances, in order to establish trends or patterns involving individuals, equipment, locations or types of incidents and to determine appropriate action and follow-up to prevent recurrence;

    e. To investigate and resolve all patient/family complaints promptly to ensure satisfaction with healthcare services;

    f. To provide in-service education on risk management and risk prevention periodically and when indicated to prevent losses;

    g. To communicate findings of Risk Management Program activities to appropriate departments of individuals, administration, medical staff, and Board of Trustees;

    h. To maintain a safe hospital environment for patients, employees and visitors;

    i. To comply with Health Care Indemnity, Inc.'s (HCI's) insurance coverage guidelines;

    j. To maintain confidentiality of all information pertaining to unusual occurrences within the hospital;

    k. To comply with medical device tracking/device problem reporting/product recalls and alerts with manufacturers and/or Food and Drug Administration (FDA);

    l. To comply with State of Tennessee Department of Health Facilities Licensing Standards, the Conditions of Participation for the Medicare and Medicare Program, and The Joint Commission Standards.

D. **Components**

1. **Risk Management**

    a. A system that identifies, evaluates, and analyzes potential loss sources for the purpose of preventing or reducing the consequences of events that

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can cause harm to patients, visitors, employees or property.

2. **Clinical Safety Improvement Program (CSIP)**
    a. The identification of opportunities to voluntarily develop and implement specific patient safety initiatives focused on issues identified by the evaluation of close calls, adverse events, and current hospital clinical performance metrics.
3. **Claims Management**
    a. To manage all professional and general liability claims to resolution in a fair, expedient and cost effective manner.
4. **Patient Grievance and Complaint Management**
    a. To establish a process for timely referral, prompt review, investigation and resolution of patient grievances and complaints.
5. **Patient Safety and Serious Event Analysis**
    a. To utilize the standardized HCA Patient Safety Organization (PSO) Serious Event Analysis (SEA) framework as the primary mechanism for serious event analysis. This process has been designed to produce a thorough and credible analysis. Patient-related SEAs are reported to the PSO as Patient Safety Work Product (PSWP) as defined in the Patient Safety and Quality Improvement Act (PSQIA) of 2005.
6. **Patient Event and Close Call Reporting**
    a. The Risk Manager will assure that Federal, State, and local requirements for event and close call reporting, review, and response are met. Reports related to patient events may be classified as Patient Safety Work Product (PSWP) by PSO provider members. These reports must be handled pursuant to TriStar Southern Hills' PSO Operating Policy and Procedure.
7. **Employee Safety and Security**
    a. The goal of the HCA's Employee Safety and Security Incentive Program is to focus on reducing the frequency and severity of employee injuries and security incidents and to comply with all aspects of HCA's Healthy Work Environment Model Safety and Security Program.
8. **Section 504/Section 1557/Americans with Disabilities Act/Title VI of the Civil Rights Act of 1964 and Executive Order 13166**
    a. The Ethics and Compliance Officer/designee is responsible to maintain the appropriate aspects of Section 504 of the Rehabilitation Act of 1973; Section 1557 of The Patient Protection and Affordable Care Act of 2010; The Americans with Disabilities Act, Sections III and IV; Title VI of the Civil Rights Act of 1964, and Executive Order 13166.
9. **Facility Ethics and Compliance**
    a. The Director of Patient Safety will work with the Ethics and Compliance

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Officer (ECO) to immediately notify the appropriate Operations Counsel and the Director CIA Implementation, of the discovery of any ongoing investigation or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that the facility or subsidiary has committed a crime or has engaged in fraudulent activity.

E. **Hospital Patient Safety Organization**

1. TriStar Southern Hills Medical Center ("Hospital") is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
2. Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. *(See 42 CFR § 3..204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*
3. The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes.
4. Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

F. **Data Sources**

1. The following materials and resources are some of the data sources used by Risk Management to identify, evaluate and analyze risk exposures.
    a. Patient Event and Close Call Reporting
    b. Work Related Injury/Illness Report Trends/Summaries
    c. Trending Reports of Number/Type Lawsuits
    d. Security Reports
    e. Data from Clinical Safety Improvement Program (CSIP) that pertains to Risk Management
    f. Patient Grievances and Complaints
    g. Employee Safety and Security Surveillance Rounds

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h. Joint Commission Surveys

i. State Licensure Surveys

G. **Retention of Records**
Medical/Facility records are retained in accordance to the HCA Facility Records Control Schedule. If not set forth in the HCA Facility Records Control Schedule, then in accordance to the State of Tennessee's Record Retention Schedule – Medical/Facility Records, or as set forth in Center for Medicare/Medicaid Services regulations. Regardless of HCA/State/Federal Records Control Schedules, medical records relating to any matter in litigation will not be destroyed until such litigation is completely and finally resolved.

H. **Confidentiality of Medical Records**
Requests for copies of the medical record from attorneys, patients and/or their legal guardian must be submitted in writing to the Health Information Management Department with the reason for the request indicated. The request must be accompanied by a release of information signed by the patient. Psychiatric records release will require a court order signed by a judge.

I. **Duties and Responsibilities**

1. **Board of Trustees**
The Board of Trustees (BOT) has the ultimate responsibility for the patient care quality provided at TriStar Southern Hills Medical Center. The Risk Management Program operates with the support and under the authority of the Board of Trustees through their approval of this plan.

2. **Hospital Administration**
The CEO is responsible for providing sufficiently qualified personnel to support the proper functioning of the risk management, patient safety, and loss prevention efforts and the operation of the Risk Management Program.

3. **Medical Staff**
The Medical Staff is responsible for participation in the review and evaluation of patient care through measurement and assessment activities. The Medical Executive Committee (MEC) of the Medical Staff shall review and act upon, as necessary; reports received relating to Risk Management Program activities.

4. **Nursing Departments**
Nursing Departments through the employee Patient Event and Close Call Reporting seek to identify problems, to take appropriate action to correct identified problems and to maintain communication with the Administration at TriStar Southern Hills Medical Center, so that patient safety/employee safety activities may be coordinated within the hospital-wide Risk Management Program.

5. **Ancillary Departments**
The Department Director shall identify a planned and systematic process for measuring and assessing functions, dimension of performance, and appropriateness of care/service provided, identifying adverse occurrences, resolving identified problems, assessing effectiveness of actions taken, and maintaining communication with the Vice President Quality/Risk Management, so that Ancillary Department activities may be coordinated within the hospital-wide Risk Management Program.

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6. **Vice President Quality/Risk Management (VPQ)**
    a. A hospital-wide Risk Management Program shall be designed, implemented and supported by the Vice President Quality/Risk Management (VPQ). The VPQ is an extension of Administration at TriStar Southern Hills Medical Center and has the authority to affect immediate correction(s) for any legal/regulatory matters.
    At TriStar Southern Hills, the Risk Management function is the responsibility of the VPQ and the Director of Patient Safety.
    b. Specific duties of these positions include:
        i. Coordinate training of hospital and medical staff members in the Risk Management Program components.
        ii. Monitor the ongoing Risk Management Program components for effectiveness of identification and correction of potential risk factors as they relate to the hospital-wide Risk Management Program.
        iii. Prepare information from the following sources in order to identify risk areas:
            a. Risk Management quarterly and annual reports
            b. Health Care Indemnity, Inc.'s (HCI) Issues in Review, HCA Risk and Patient Safety, and HCA Clinical Safety Improvement Program (CSIP).
        iv. Maintain resource information to provide for a current Risk Management Program.
        v. Prepare and provide a quarterly report to the Administrative Team regarding clinical Risk Management activities and closed/open litigation claims.
        vi. Complete an annual appraisal of the Risk Management Program. The appraisal should include a summary of problems and opportunities for improvement identified, success of actions taken and results of implemented risk reduction/prevention strategies. The programs, which need to be modified or instituted to improve effectiveness, must also be identified.
        vii. Maintain the Patient Event and Close Call Reporting system, personally investigate serious accidents, receive and review as well as oversee the follow-up on corrective action to eliminate accident causes.
        viii. Formulate, administer and make necessary changes in the Risk Management Program.
        ix. Maintain outside professional contacts to exchange information and keep the program up to date.
        x. Secure necessary assistance from Health Care Indemnity, Inc. (HCI), HCA Risk and Patient Safety, and HCA Clinical Services

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Group (CSG).

PROCEDURE:

A. **Risk Management Program**

1. **Loss Prevention/Control Activities**

a. **Professional/General Liability**

i. The Director of Patient Safety is a crucial member of the claims handling team, which also consists of the Health Care Indemnity's, Inc. (HCI) claims person, the defense attorney and the claims investigator. It is expected that the Director of Patient Safety will take an active role in the following areas:

a. *Notification of claim* – The Director of Patient Safety is to complete a Probable Claim Report (PCR) and send it to Health Care Indemnity's, Inc. (HCI). Pertinent documents, such as notice letters, lawsuits and the face sheet of the medical record should be attached.

b. *Retain and protect the pertinent medical records* – It is essential that the medical records relating to an injured claimant be protected from loss, alteration and all other types of damage.

c. *Early intervention* – Early intervention with potential claimants is always preferred. Time permitting; the Director of Patient Safety may take the lead in resolving claims within the authority granted by Health Care Indemnity's, Inc. (HCI).

d. *Advise Health Care Indemnity's, Inc. (HCI) claims professional of all sensitive operational issues* – Malpractice claims are very complex and often there are operational and "political" issues that could impact claim strategy.

e. *Participate in case evaluations* – It is helpful for the Health Care Indemnity's, Inc. (HCI) claims professional to receive input from the HCA facility staff on its evaluation of its own claims.

f. *Schedule facility-based witness interviews* – These interviews normally will be conducted at the facility by an outside investigator or defense counsel.

g. *Attend interviews if necessary* – Some witnesses are more comfortable being interviewed with the Director of Patient Safety present.

h. *Answer specific interrogatories* – The interrogatory is a pretrial discovery tool consisting of written questions

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about the case submitted by one party to the other party or a witness. A sworn statement must be signed indicating that the answers are true and accurate. This is usually done by the Director of Patient Safety.

i. *Obtain materials for specific requests for production* – This is a pretrial discovery tool that enables an opposing party to obtain documents or material from the other party.

j. *Attend key depositions* – It is desirable that the Director of Patient Safety attends depositions of nursing and other personnel. It may also be helpful to attend the depositions of the plaintiff and involved physicians.

k. *Represent HCA Entity at trial* – Having a local representative attend trial every day personalizes the defendant for the jury. It sends the message that the defendant is not just bricks and mortar, but a group of people whose mission in life is to care for patients.

b. **Automobile Claims**
Any automobile accident involving a hospital-owned or leased vehicle must be reported to the Director of Patient Safety and all information from involved person's insurance should be exchanged and a police report filed. Any potential claim resulting in injury or property damage to others should be reported to theDirector of Patient Safety as soon as possible. Representatives of adverse insurance companies should be referred to the Director of Patient Safety. No statements admitting fault or offers of a settlement will be made by hospital employees. Any accident resulting in bodily injury to an on-the-job employee should be reported through the applicable employee injury program. TriStar Southern Hills Medical Center does not insure or reimburse patients or visitors for the loss or damage of any vehicle on its property.

c. **Real Property Loss**
Real Property loss claims are reported, by TriStar Southern Hills Medical Center's Director of Patient Safety, to Health Care Indemnity, Inc. (HCI) by telephone, fax or on ATLAS as soon as possible. Health Care Indemnity, Inc. (HCI) will assist the facility in reporting, coordinating and negotiating the claims with the property insurers.

d. **Personal Property Loss**

i. **Patient/Visitor**
TriStar Southern Hills Medical Center maintains a safe for the safekeeping of money and valuables, and is not liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and is not liable for the loss

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or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the facility for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the patient. TriStar Southern Hills Medical Center is not responsible for the loss or damage of cell phones, glasses or dentures or personal valuables unless they are placed in the hospital safe in accordance with the terms stated above.

ii. **Employee**
TriStar Southern Hills Medical Center is not responsible for lost, damaged, or stolen employee personal property. Employees should arrange for their own personal, automobile, and/or homeowner's insurance coverage. Nevertheless, the manager may decide that there are extenuating circumstances, where it is appropriate to reimburse an employee for certain lost or damaged personal property. In these circumstances, the employee should complete an Expense Report, and submit it with supporting documentation, to their manager for consideration.

e. **Visitor Falls and/or Injuries**
TriStar Southern Hills Medical Center does not provide free medical care for any visitor who may have fallen or is injured on facility property. Any visitor who falls or is injured on facility property, and seeks medical care, in the Emergency Room or elsewhere, must pay for such medical care out of their own pocket or with their own medical insurance. The Director of Patient Safety will determine if TriStar Southern Hills Medical Center and/or its staff were responsible for the visitor fall or injury on its property before any adjustments can be made to the visitor (patient) account. Generally, such a determination can only be made retrospectively; therefore, the visitor must pay for such medical care out of their own pocket or with their own medical insurance.

f. **Payment for Risk Management Claims**

i. If an agreement for payment to patients, visitors, or other persons for the replacement of lost or damaged property items (including dentures, glasses, or hearing aids, etc.); the "Check Request Form" must be utilized. The Director of Patient Safety or designee will complete the form, provide a detailed explanation of why reimbursement is being requested, include the bills/invoices; and route to TriStar Southern Hills Medical Center's Chief Financial Officer (CFO) for approval. If approved, the facility's CFO will send to Accounts Payables for payment.

ii. If an agreement for payment to optometrists, dentists, other providers for the replacement of patient's, visitor's, or other

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individual's glasses, dentures, hearing aid, etc.; the Director of Patient Safety or designee will provide a detailed explanation of why reimbursement is being requested, include the bills/ invoices; and route to TriStar Southern Hills Medical Center's CFO for approval. If approved, the facility's CFO will send to Accounts Payables for payment.

iii. Any demands for future medical payments will be turned over to Health Care Indemnity, Inc. (HCI), for determination of responsibility/liability, and/or any payments.

iv. All administrative adjustments requested by TriStar Southern Hills Medical Center must be documented and approved by the facility's CFO. The Director of Patient Safety or designee will complete a detailed explanation of why the adjustment is being requested and route the request to the facility's CFO for approval.

v. All Check Requests submitted to the Accounting Department, where a manual check is requested, must have a vendor number issued by the Supply Chain. To obtain a vendor number, the Director of Patient Safety or designee will submit a Supply Chain POV Exempt Authorization Form, Vendor Add National Request Form, and a Vendor Add Approval Form, along with the Check Request, to the Supply Chain Manager. When the Supply Chain issues the vendor number, the Director of Patient Safety may then submit the Check Request to the Accounting Department.

2. **Other Legal Issues**

a. **Summons and Complaints/Suits**: Service of Notices/Summons and Complaints/Suits should be made through TriStar TriStar Southern Hills Medical Center's agent for service of process.

b. **Subpoenas**: Service of Subpoenas for employees should be directed to the Quality/Risk Management Department for guidance on their disposition.

c. **Warrants**: Service of Warrants for employees and/or patients should be directed to the Quality/Risk Management Department for guidance on their disposition.

d. **Subpoenas Duces Tecum**: Service of Subpoenas Duces Tecum for Medical Records should be directed to the Health Information Department and/or Custodian of Records for guidance on there disposition.

e. **Employees Witnessing Legal Documents**: HCA Corporate Legal does not permit TriStar Southern Hills Medical Center employees to act as witnesses for general legal documents. The only documents that TriStar Southern Hills Medical Center employees witness should be those related to providing care to our patients, e.g., Informed Consents, Advanced Directives (Living Wills, Advanced Care Plans, Durable Power of Attorney for Health Care, Appointment of Health Care Agent). That means, TriStar Southern Hills Medical Center employees should not act as witnesses for

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Wills, Codicils, General Power of Attorney, Trusts, Marriage Licenses, and/or Divorce Decrees.

f. Serious injuries resulting in death, brain damage, sensory damage, amputation, spinal cord injury, reproductive organ loss or impairment, substantial disfigurement or burns, potential claims with sensitive political or public relations issues should be called immediately to the Director of Patient Safety and a PCR will be completed and forwarded to HCI.

g. No statements admitting fault or offers of a settlement will be made by hospital employees. Employees will not discuss an incident with anyone not authorized to receive such information and should forward all requests/calls to the Director of Patient Safety. Employees of TriStar Southern Hills Medical Center will cooperate with the Director of Patient Safety.

3. **Confidentiality of Information**

   a. Risk Management data is highly confidential. The data, reports, and committee minutes generated by Risk Management activities is accessible to only those individuals who participate in the program, and those agencies responsible for ascertaining the existence of an ongoing and effective risk management program.

   b. These records are hospital property and are not available for review by anyone without the specific permission of the Director of Patient Safety. Patient Event and Close Call Reports will be copied only for the purpose of communicating with TriStar Southern Hills Medical Center's Patient Safety Evaluation System ("PSES").

   c. Information gathered through Risk Management activities about adverse patient occurrences is documented in the Patient Event and Close Call Reporting System. These reports are used to notify Health Care Indemnity Inc. (HCI) of situations that may result in allegations of hospital liability, so that preparations for potential litigation can be made. Employees who complete the Patient Event and Close Call Reports are acting in an agency capacity between the hospital and the hospital attorney. This report is protected from discovery by the attorney- client confidentiality privilege.

   d. Records [interviews and all reports, incident reports, statements, minutes, memoranda, charts, statistics, evaluations, critiques, test results, corrective actions, disciplinary actions, and any and all other documentation generated by or in connection with activities of TriStar Southern Hills Medical Center's Quality Council and any Patient Safety Work Product (PSWP) as defined at § 921 of the Patient Safety and Quality Improvement Act of 2005, P.L. 109-41] is protected from direct or indirect means of discovery, subpoena or admission into evidence in any judicial or administrative proceeding. *(See also 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)* Additionally, any person who supplies information, testifies or makes statements as part of TriStar Southern Hills Medical Center's

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Quality Council may not be required to provide information as to the information, testimony or statements provided to or made before such a committee or opinions formed by such person as a result of committee participation, as set forth in Tenn. Code Ann. § 68- 11-272 (Tennessee's Patient Safety and Quality Improvement Act of 2011).

References:

42 CFR § 3..204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product. CMS Interpretive Guidelines § 482.13 (a) (2), 2004, 42 CFR § 489, and 42 CFR § 482.13. Tenn. Code Ann. §§ 33-1-101, 53-10-304, 53-11-309, and 53-11-402. Tenn. Code Ann. § 63-6-204. Tenn. Code Ann. § 63-9-113. Tenn. Code Ann. Tenn. Code Ann. § 68-11-272 Patient Safety and Quality Improvement. P.L. 109-41, as amended, § 924 of the Patient Safety and Quality Improvement Act of 2005. 45 CFR Parts 160 and 164. Tenn. Code Ann. §§ 55-1-103, 55-1-122, 55-1-123, 55-4-111, 55-8-101, 55-8-191, and 55-50-102.

The Joint Commission (TJC) Comprehensive Accreditation Manual for Hospitals (CAMH), RI.2.120, EP 1-5. TJC EC.02.01.01.11 The hospital responds to product notices and recalls. TJC EC.02.04.01.5 The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

HCA Ethics & Compliance, Compliance Matters, Volume 14, Number 2, May 2013. HCA – Quality, Safety & Performance Improvement: Patient Grievance and Complaint Management Policy 3300.15. HCA – Automobile and Driver Safety Guidelines. HCA – Records Management Policy, EC.014. HCA Designated Record Set Policy. HCA – Clinical Safety Improvement Program. HCA – Employee Safety and Security Incentive Progream. Patient Property and Valuables, RI.108. Hospital Patient Safety Organization, PI.104. Patient Event and Close Call Reporting Policy, PI.105. Response to Regulatory Agency Requests for Patient Safety Work Product, PI.106. Patient Serious Event Analysis Policy, PI.107.

All Revision Dates

4/21/2022, 3/31/2021, 4/23/2019

Approval Signatures

Step Description	Approver	Date
Board of Trust	Mary Ellen Brill: VP Quality/ Risk Mgmt	4/21/2022
Medical Executive Committee	Mary Ellen Brill: VP Quality/ Risk Mgmt	4/21/2022

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Quality Council	Mary Ellen Brill: VP Quality/ Risk Mgmt	4/21/2022
Quality Council	Leah Connearney: Dir Patient Safety	3/8/2022

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Attachment 5C-4

Staff Education Policies

Question: What are the training and education regulatory requirements for 2023?

Answer: The following table outlines training and education requirements as defined by The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), Occupational Safety and Health Administration (OSHA), and HCA Healthcare.
Please note education requirements can vary by state, and educators should ensure compliance with local regulatory requirements. Individual state requirements are not addressed in this document.
Each organization is responsible for identifying and following any additional education and training defined within specific organization policies or any required expectations established as a part of plan(s) of correction related to external surveys.

New additions and significant revisions to listed requirements (summarized) are:
- Revised Emergency Management Standards are located in the Emergency Management, Environment of Care and Life Safety section.
- New and Revised Antibiotic Stewardship requirements are located in the Medication Management section.

Abbreviations used in the Detail of Standard/Regulations:
LIP Licensed Independent Practitioner (**Note: TJC intends to eliminate use of this term effective February 19, 2023 [https://www.jointcommission.org/-/media/tjc/documents/standards/prepublications/effective-2023/lip_hap_prepub_all.pdf]*); this will align TJC standards with changes CMS made in the 2020 version of State Operations Manual Appendix A. References included in COG.MI.003 and COG.MI.004 will be updated in the next update of those HCA Healthcare clinical policies.
LP Licensed Practitioner
QMP Qualified Medical Professional
APP Advanced Practice Professional
CSP Compounded Sterile Products
LCD Local Coverage Determination
DHP Dependent Healthcare Professional

General Education and Training Related to Assigned Task and Responsibilities

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
HR.01.04.01	HR.01.04.01: The hospital provides orientation to staff.	Orientation	Staff	HCA Healthcare Center for Clinical Advancement Atlas Connect https://connect.medcity.net/web/cca
EP 1	The hospital orients its staff to the key safety content (provision of care, treatment, and services; environment of care and infection control) it identifies before staff provides care, treatment, and services. **Completion of this orientation is documented.**			
EP 3	The hospital orients staff on the following: - Relevant hospital-wide and unit-specific policies and procedures - Their specific job duties, including those related to infection prevention and control and assessing and managing pain - Sensitivity to cultural diversity based on their job duties and responsibilities - Patient rights, including ethical aspects of care, treatment, and services and the process used to address ethical issues based on their job duties and responsibilities **Completion of this orientation is documented.**			
HR. 01.05.03	HR.01.05.03: Staff participate in ongoing education and training.	To maintain or increase competency, Ongoing	Staff and Licensed practitioners	
EP 1	Staff participate in ongoing education and training to maintain or increase their competency and, as needed, whenever staff responsibilities change. **Staff participation is documented.**			
EP 14	The hospital verifies and documents that individuals who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following: - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns - Safe procedures for operation of the types of CT equipment they will use. Information can be found at http://imagegently.org and http://www.imagewisely.org **Documentation is required.**	Annual	Individuals performing diagnostic computed tomography (CT) examinations	http://imagegently.org http://www.imagewisely.org
EP 25	The hospital verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education that includes annual training on safe MRI environment including the following: - Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF) - Proper patient and equipment positioning activities to avoid thermal injuries - Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional) - MRI safety response procedures for patients who require urgent or emergent medical care - MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures - Patient hearing protection - Management of patients with claustrophobia, anxiety, or emotional distress **Documentation is required.**	Annual	Technologists who perform magnetic resonance imaging (MRI) examinations	http://www.astm.org
EP 29	As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows: - What constitutes workplace violence - Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement - Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents	Upon hire, annually thereafter, and when changes occur		
IM.01.01.03	IM.01.01.03: The hospital plans for continuity of its information management processes.	Unspecified	Staff and Licensed practitioners	
EP 2	The hospital's plan for managing interruptions to information processes addresses the following: Scheduled and unscheduled interruptions of electronic information systems, training for staff and licensed independent practitioners* on alternative procedures to follow when electronic information systems are unavailable, and backup of electronic information systems.			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
MS.11.01.01	MS.11.01.01: The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners* which is separate from actions taken for disciplinary purposes.	Unspecified	Licensed practitioners, Staff	
EP 1	Process design addresses the following issues: Education of licensed independent practitioners* and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners (at-risk criteria).			
PC.02.02.13	PC.02.02.13: The patient's comfort and dignity receive priority during end-of-life care.	Unspecified	Staff	
EP 2	The hospital provides staff with education about the unique needs of dying patients and their families.			
CMS §482.13(b)(3)	§482.13(b)(3): The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers) and §489.104 (Effective dates).	Unspecified	Staff and Licensed practitioners	
	§489.102 also requires the hospital to: Provide for the education of staff concerning its policies and procedures on advance directives. The right to formulate advance directives includes the right to formulate a psychiatric advance directive (as allowed by state law)			
NPSG.06.01.01	NPSG.06.01.01: Improve the safety of clinical alarm systems.	Unspecified	Staff and Licensed practitioners	
EP 4	Educate staff and licensed independent practitioners* about the purpose and proper operation of alarm systems for which they are responsible.			
NPSG.15.01.01	NPSG.15.01.01: Reduce the risk for suicide.			HealthStream Courses offerings include: • Suicide Screening Overview: Behavioral Health • Suicide Screening Overview: Non-Behavioral Health (ED) • Suicide Screening Overview: Non-Behavioral Health (Nursing)
EP 5	Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for patients at risk for suicide - Guidelines for reassessment - Monitoring patients who are at high risk for suicide			
CLIA §493.1413 **CLIA §493.1451**	The technical consultant/supervisor is responsible for - Evaluating the competency of all testing personnel and assuring that the staff maintain their competency to perform test procedures and report test results promptly, accurately and proficiently. The procedures for evaluation of the competency of the staff must include, but are not limited to - (i) Direct observations of routine patient test performance, including patient preparation, if applicable, specimen handling, processing and testing; (ii) Monitoring the recording and reporting of test results; (iii) Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventive maintenance records; (iv) Direct observation of performance of instrument maintenance and function checks; (v) Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples; and (vi) Assessment of problem solving skills; **Documentation is required.**	Semiannually during first year of employment, at least annually thereafter	Laboratory testing personnel performing moderate-complexity testing	
CLIA §493.1413 **CLIA §493.1451**	The technical consultant/supervisor is responsible for - Evaluating and documenting the performance of individuals responsible for moderate complexity testing at least semiannually during the first year the individual tests patient specimens. Thereafter, evaluations must be performed at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individual's performance must be reevaluated to include the use of the new test methodology or instrumentation.	Semiannually during first year of employment, at least annually thereafter	Laboratory testing personnel performing moderate-complexity testing	
CAP GEN.55500	Non-waived testing: During the first year of an individual's duties, competency must be assessed at least semi-annually. After an individual has performed his/her duties for one year, competency must be assessed at least annually. Competency assessment must include all six elements described below for each individual on each test system during each assessment period, unless an element is not applicable to the test system.	During the first year of an individual's duties, competency must be assessed at least semiannually; Annually after one year of performing duties	Staff	

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
WT.03.01.01	Staff and licensed independent practitioners* performing waived tests are competent.	Orientation, Annually, Defined intervals per hospital policy	Staff and Licensed practitioners	
EP 1	The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments (CLIA) certificate, or a qualified designee, provides orientation and training and assesses the competency of, staff and licensed independent practitioners* who perform waived testing.			
EP 2	Staff and licensed independent practitioners* who perform waived testing have received orientation in accordance with the hospital's specific services. The orientation for waived testing is **documented.**			
EP 3	Staff and licensed independent practitioners* who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is **documented.**			
EP 4	Staff and licensed independent practitioners* who perform waived testing that requires the use of an instrument have been trained on its use and maintenance. The training on the use and maintenance of an instrument for waived testing is **documented.**			
EP 5	Competency for waived testing is assessed using at least two of the following methods per person per test: - Performance of a test on a blind specimen - Periodic observation of routine work by the supervisor - Monitoring of each user's quality control performance - Use of a written test specific to the test assessed			
EP 6	Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is **documented.**	Annual		
Infection Prevention and Control				
IC.02.04.01	IC.02.04.01: The hospital offers vaccination against influenza to licensed independent practitioners* and staff. Note: This standard is applicable to staff and licensed independent practitioners* only when care, treatment, or services are provided on site. When care, treatment or services are provided off site, such as with telemedicine or telephone consultation, this standard is not applicable to off-site staff and licensed independent practitioners*.	Unspecific, Annually with influenza vaccination	Licensed practitioners and Staff	
EP 2	The hospital educates licensed independent practitioners* and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.			https://www.cdc.gov/vaccines/hcp/vis/index.html
IC.02.05.01	Implement evidence-based practices to prevent healthcare–associated infections due to the following: - Multidrug-resistant organisms (MDRO) - Central line–associated bloodstream infections (CLABSI) - Catheter-associated urinary tract infections (CAUTI) - Surgical site infections (SSI)	Upon hire or granting of initial privileges, Periodically thereafter as determined by the organization	Staff and Licensed practitioners	HCA Healthcare Center for Clinical Advancement Atlas Connect https://connect.medcity.net/web/cca
CMS §482.42	§482.42(a) Standard: Organization and Policies. An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership;	Initially, Regular updates	Infection preventionist(s)	
	§482.42(c)(2) Standard: The infection preventionist(s)/infection control professional(s) is responsible for:] Competency-based training and education of hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of infection prevention and control guidelines, policies, and procedures.	Upon hire or granting of initial privileges, Periodically thereafter as determined by the organization	Staff, Anyone having contact with patients or medical equipment	

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
OSHA 1910.1030(g)(2)	OSHA 1910.1030 (g)(2) Bloodborne Pathogens: The employer shall train each employee with occupational exposure in accordance with the requirements of this section. Such training must be provided at no cost to the employee and during working hours. The employer shall institute a training program and ensure employee participation in the program.	Initial assignment, Annually, Ongoing	Staff	https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030
	Staff training shall be provided at the time of initial assignment to tasks where occupational exposure may take place and at least annually thereafter (annual training for all employees shall be provided within one year of their previous training).			
	Material should be appropriate in content and vocabulary to educational level, literacy and language of employees.			
	Training includes opportunity for interactive questions and answers with the person conducting the training session.			
	The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.			
	The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.			
	a. An accessible copy of the regulatory text of this standard and an explanation of its contents; b. A general explanation of the epidemiology and symptoms of bloodborne diseases; c. An explanation of the modes of transmission of bloodborne pathogens; d. An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan; e. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials; f. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment; g Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment; h. An explanation of the basis for selection of personal protective equipment; i. Information on the Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated and that the vaccine and vaccination will be offered free of charge; j. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials; k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available; l. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident; and m. An explanation of the signs and labels and/or color coding required for hazardous area.			
OSHA Standard 29 CFR 1910.132	1910.132(a) Protective equipment, including personal protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, shall be provided, used, and maintained in a sanitary and reliable condition wherever it is necessary by reason of hazards of processes or environment, chemical hazards, radiological hazards, or mechanical irritants encountered in a manner capable of causing injury or impairment in the function of any part of the body through absorption, inhalation or physical contact. 1910.132(f)(1) The employer shall provide training to each employee who is required by this section to use PPE. Each such employee shall be trained to know at least the following: 1910.132(f)(1)(i) When PPE is necessary; 1910.132(f)(1)(ii) What PPE is necessary; 1910.132(f)(1)(iii) How to properly don, doff, adjust, and wear PPE; 1910.132(f)(1)(iv) The limitations of the PPE; and, 1910.132(f)(1)(v) The proper care, maintenance, useful life and disposal of the PPE. 1910.132(f)(2) Each affected employee shall demonstrate an understanding of the training specified in paragraph (f)(1) of this section, and the ability to use PPE properly, before being allowed to perform work requiring the use of PPE. 1910.132(f)(3) When the employer has reason to believe that any affected employee who has already been trained does not have the understanding and skill required by paragraph (f)(2) of this section, the employer shall retrain each such employee.	Orientation, Ongoing	Staff	https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.132
OSHA Standard 29 CFR 1910.134 (c)(1)	OSHA Respiratory Protection Standard 29 CFR 1910.134 (c) (1) In any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory protection program with worksite-specific procedures. The program shall be updated as necessary to reflect those changes in workplace conditions that affect respirator use. The employer shall include in the program the following provisions of this section, as applicable:	Orientation, Ongoing	Staff	
	1910.134(c)(1)(vii) Training of employees in the respiratory hazards to which they are potentially exposed during routine and emergency situations; 1910.134(c)(1)(viii) Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance; and 1910.134(c)(4) The employer shall provide respirators, training, and medical evaluations at no cost to the employee.			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
OSHA 1910.134.(k)	OSHA 1910.134 (k) – Effective training must be provided to employees who are required to use respirators. The training must be comprehensive, understandable and recur annually and more often as necessary. The employer shall provide the training prior to requiring the employee to use a respirator in the workplace.	Annually, Ongoing as needed, Prior to assigned skill and/or task requiring use, and retraining occurs with changes in the workplace or the type of respirator render the previous training obsolete	Staff	https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134
	1910.134(k)(1)(i)-(vii): The employer shall ensure that each employee can demonstrate knowledge of at least the following: a. Why the respirator is necessary and how improper fit, usage or maintenance can compromise the protective effect of the respirator; b. What the limitations and capabilities of the respirator are; c. How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions; d. How to inspect, put on and remove, use and check the seals of the respirator; e. What the procedures are for the maintenance and storage of the respirator; f. How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators; and The training shall be conducted in a manner that is understandable to the employee. The employer shall provide the training prior to requiring the employee to use a respirator in the workplace.			
	Retraining shall be administered annually, and when the following situations occur: a. Changes in the workplace or the type of respirator render previous training obsolete; b. Inadequacies in the employee's knowledge or use of the respirator indicate that the employee has not retained the requisite understanding or skill; or c. Any other situation arises in which retraining appears necessary to ensure safe respirator use.			
OSHA 1910.1200(a)(1)	1910.1200(a)(1): The purpose of this section is to ensure that the hazards of all chemicals produced or imported are classified, and that information concerning the classified hazards is transmitted to employers and employees. The requirements of this section are intended to be consistent with the provisions of the United Nations Globally Harmonized System of Classification and Labeling of Chemicals (GHS), Revision 3. The transmittal of information is to be accomplished by means of comprehensive hazard communication programs, which are to include container labeling and other forms of warning, safety data sheets and employee training.	Ongoing as needed, Upon hire based on assigned task	Staff	https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1200
OSHA 1910.1200(a)(2)	1910.1200(a)(2): This occupational safety and health standard is intended to address comprehensively the issue of classifying the potential hazards of chemicals, and communicating information concerning hazards and appropriate protective measures to employees, and to preempt any legislative or regulatory enactments of a state, or political subdivision of a state, pertaining to this subject. Classifying the potential hazards of chemicals and communicating information concerning hazards and appropriate protective measures to employees, may include, for example, but is not limited to, provisions for: developing and maintaining a written hazard communication program for the workplace, including lists of hazardous chemicals present; labeling of containers of chemicals in the workplace, as well as of containers of chemicals being shipped to other workplaces; preparation and distribution of safety data sheets to employees and downstream employers; and development and implementation of employee training programs regarding hazards of chemicals and protective measures. Under section 18 of the Act, no state or political subdivision of a state may adopt or enforce any requirement relating to the issue addressed by this Federal standard, except pursuant to a Federally- approved state plan.			https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1200
	1910.1200(b)(4)(iii) Employers shall ensure that employees are provided with information and training in accordance with paragraph (h) of this section (except for the location and availability of the written hazard communication program under paragraph (h)(2)(iii) of this section), to the extent necessary to protect them in the event of a spill or leak of a hazardous chemical from a sealed container.			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
OSHA 1910.1200(h)	1910.1200(h): Employee information and training. 1910.1200(h)(1): Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment and whenever a new chemical hazard the employees have not previously been trained about is introduced into their work area. Information and training may be designed to cover categories of hazards (e.g., flammability, carcinogenicity) or specific chemicals. Chemical-specific information must always be available through labels and safety data sheets.			https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1200
	1910.1200(h)(2): *Information* . Employees shall be informed of: 1910.1200(h)(2)(i) The requirements of this section; 1910.1200(h)(2)(ii) Any operations in their work area where hazardous chemicals are present; 1910.1200(h)(2)(iii) The location and availability of the written hazard communication program, including the required list(s) of hazardous chemicals, and safety data sheets required by this section. 1910.1200(h)(3): Training. Employee training shall include at least: 1910.1200(h)(3)(i): Methods and observations that may be used to detect the presence or release of a hazardous chemical in the work area (such as monitoring conducted by the employer, continuous monitoring devices, visual appearance or odor of hazardous chemicals when being released, etc.); 1910.1200(h)(3)(ii): The physical, health, simple asphyxiation, combustible dust, and pyrophoric gas hazards, as well as hazards not otherwise classified, of the chemicals in the work area; 1910.1200(h)(3)(iii): The measures employees can take to protect themselves from these hazards, including specific procedures the employer has implemented to protect employees from exposure to hazardous chemicals, such as appropriate work practices, emergency procedures, and personal protective equipment to be used; and, 1910.1200(h)(3)(iv): The details of the hazard communication program developed by the employer, including an explanation of the labels received on shipped containers and the workplace labeling system used by their employer; the safety data sheet, including the order of information and how employees can obtain and use the appropriate hazard information.			
EC.03.01.01	EC.03.01.01: Staff and licensed independent practitioners* are familiar with their roles and responsibilities relative to the environment of care.	Unspecified	Staff and Licensed practitioners (LP)	
EP 1	Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials and waste are competent and receive continuing education and training.	Unspecified	Staff	
Emergency Management, Environment of Care and Life Safety				
EM.15.01.01	EM.15.01.01: The hospital has an emergency management education and training program ****The EM review and update requirements listed below may exceed current CMS and TJC standards. The review, update and training requirements listed below are the current HCA Healthcare EEOC requirements.****	Initial, Annual, Ongoing	Staff and Licensed practitioners	
EP 2	The hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedures manuals or equipment) **Documentation is required.**			
EP 3	The hospital provides ongoing education and training to all staff, volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency: - **Annually** - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training **Documentation is required.**			
EP 4	The hospital requires that incident command staff participate in education and training specific to their duties and responsibilities in the incident command structure.			
CMS §482.15(d)	The facility must develop and maintain an emergency preparedness training and testing program. The training and testing program must be reviewed and updated at least **annually**. (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least **annually**. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.			
Emergency Preparedness	**IS-100:** Introduction to Incident Command System **IS-700:** National Incident Management System, An Introduction (or equivalent course) **IS-800:** National Response Framework, An Introduction (or equivalent course) **IS-200:** Basic Incident Command System for Initial Response (or equivalent course) All training is available at: https://training.fema.gov/emiweb/is/icsresource/trainingmaterials/#item1		Staff with direct role in emergency planning, response, or recovery efforts.	FEMA. (2020). National Incident Management System Training Program. Retrieved from: https://www.fema.gov/sites/default/files/documents/fema_nims_training-program-may-2020_0.pdf

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
CMS §482.15(d)	CMS §482.15 Standard: Emergency Preparedness. The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. CMS §482.15(d) The training and testing program must be reviewed and updated **annually**. The hospital must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.		Staff, Individuals providing services under arrangement, and volunteers	
EC.02.03.01	EC.02.03.01: The hospital manages fire risks			
EP 9	The written fire response plan describes the specific roles of staff and licensed practitioners at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, how to evacuate to areas of refuge, and how staff and licensed practitioners will cooperate with firefighting authorities. Staff and licensed practitioners are periodically instructed on and kept informed of their duties under the plan, including cooperation with firefighting authorities. A copy of the plan is readily available with the telephone operator or security. **Documentation is required.**	Periodically instructed	Staff and Licensed practitioners	
EC.03.01.01	EC.03.01.01: Staff and licensed independent practitioners* are familiar with their roles and responsibilities relative to the environment of care.	Unspecified	Staff and Licensed practitioners	
EP 1	Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials and waste are competent and receive continuing education and training.			
EP 2	Staff and licensed independent practitioners* can describe or demonstrate actions to take in the event of an environment of care incident.			
LS.01.02.01	LS.01.02.01: The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.	Unspecified, Based on facility's ILSM policy		
EP 13	The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The need for education is based on criteria in the hospital's interim life safety measure (ILSM) policy.			
CMS §482.13(h)	§482.13(h) Standard: Patient visitation rights. A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. The hospital's policies and procedures are expected to address how hospital staff who play a role in facilitating or controlling visitor access to patients will be trained to assure appropriate implementation of the visitation policies and procedures and avoidance of unnecessary restrictions or limitations on patients' visitation rights.	Unspecified		

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
OSHA 29 CFR 1910.1200(h)	OSHA Hazard Communication Standard, 29 CFR 1910.1200(h): Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment and whenever a new physical or health hazard the employees have not previously been trained about is introduced into their work area. Information and training may be designed to cover categories of hazards (e.g., flammability, carcinogenicity) or specific chemicals. Chemical-specific information must always be available through labels and material safety data sheets.	Initial assignment Whenever a new physical or health hazard is introduced	Staff	https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1200
	Employees shall be informed of: The requirements of section 1910.1200(h) a. Any operations in their work area where hazardous chemicals are present b. The location and availability of the written hazard communication program, including the required list(s) of hazardous chemicals, and material safety data sheets c. Methods and observations that may be used to detect the presence or release of a hazardous chemical in the work area (such as monitoring conducted by the employer, continuous monitoring devices, visual appearance or odor of hazardous chemicals when being released, etc.) d. The physical and health hazards of the chemicals in the work area			
	e. The measures employees can take to protect themselves from these hazards, including specific procedures the employer has implemented to protect employees from exposure to hazardous chemicals, such as appropriate work practices, emergency procedures, and personal protective equipment to be used			
	NOTE: Under the General Industry standards, OSHA has training requirements listed in 15 subparts with a total of 95 topics that may or may not be applicable in a healthcare environment. Contact Environment and Employee Safety at the HCA Corporate Office (615-344-5856) for further information.			https://connect.medcity.net/web/safesecure/oshacompliance
Assessment and Reassessment/Management of Patient Care				
APR.09.02.01	APR.09.02.01: Any individual who provides care, treatment, and services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the hospital	Unspecified	Staff, Medical Staff, Individuals providing care, treatment and services	
EP 1	The hospital educates its staff, medical staff, and other individuals who provide care, treatment, and services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.			
EP 2	The hospital informs its staff and medical staff that it will take no disciplinary or punitive action because an employee, physician, or other individual who provides care, treatment, and services reports safety or quality-of-care concerns to The Joint Commission.			
PC.01.02.09	PC.01.02.09: The hospital assesses the patient who may be a victim of possible abuse and neglect.	Unspecified	Staff	HCA Healthcare Center for Clinical Advancement Atlas Connect https://connect.medcity.net/web/cca
EP 3	The hospital educates staff about how to recognize signs of possible abuse and neglect and about their roles in follow-up.			
CMS §482.13(c)(3)	CMS §482.13(c)(3): The patient has the right to be free from all forms of abuse or harassment.	Orientation	Staff	
CMS §482.24(c)(3)	CMS §482.24(c)(3): Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders	Orientation, annually, and upon changes to standing orders	Staff	
PC.02.01.11	PC.02.01.11: Resuscitation services are available throughout the hospital.		Staff	
EP 4	The hospital provides education and training to staff involved in the provision of resuscitative services. The hospital determines which staff complete this education and training based upon their job responsibilities and hospital policies and procedures. The education and training are provided at the following intervals: - At orientation - A periodic basis thereafter, as determined by the hospital - When staff responsibilities change Note 1: Topics may cover resuscitation procedures or protocols; use of cardiopulmonary resuscitation techniques, devices, or equipment; and the roles and responsibilities during resuscitation events. Note 2: The format and content of education and training are determined by the hospital (for example, a skills day, a mock code). (See also HR.01.01.01, EP 1; HR.01.05.03, EP 1)	Orientation, periodically, and upon changes to staff responsibilities		
PC.02.02.13	The patient's comfort and dignity receive priority during end of life.			
EP 4	The hospital provides staff with education about the unique needs of dying patients and their families.	Unspecified	Staff	
PC.06.01.01	PC.06.01.01: Reduce the likelihood of harm related to maternal hemorrhage.	Orientation Every two years or whenever changes occur.	Staff and Providers	
EP 4	Provide education to all staff and providers who treat pregnant and postpartum patients about hospital's hemorrhage procedures. Note: Education must be role specific.			
PC.06.03.01	PC.06.03.01: Reduce the likelihood of harm related to maternal severe hypertension/preeclampsia.	Orientation Every two years or whenever changes occur.	Staff and Providers	
EP 3	Provide specific education to all staff and providers who treat pregnant/postpartum patients about the hospital's evidence-based severe hypertension/preeclampsia procedure.			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
Restraint and Seclusion				
CMS §482.13(e)(10)	CMS §482.13 (e)(10): The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have completed the training criteria.	Orientation, Prior to utilization of restraint, Ongoing based upon hospital policy (Once initial training takes place, training must be provided frequently enough to ensure that staff possesses the requisite knowledge and skills to safely care for restrained or secluded patients in accordance with the regulations)	Physicians and other Licensed practitioners authorized to order restraint and seclusion, LPs authorized to order restraint and seclusion, Staff, Non-healthcare staff (as applicable), Trainer	HCA Healthcare Center for Clinical Advancement Atlas Connect https://connect.medcity.net/web/cca
CMS §482.13(e)(11)	CMS §482.13 (e)(11): Physician and other licensed practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.			
	Hospitals have the flexibility to identify training requirements above this minimum requirement based on the competency level of their physicians and other LPs, and the needs of the patient population(s) that they serve.			
CMS §482.13 (e)(12)	CMS §482.13 (e)(12): When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention-			
	(i) By a- (A) Physician or other licensed practitioner; or (B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. Training for an RN or PA to conduct the 1-hour face-to-face evaluation would include all of the training requirements at §482.13 (f) as well as content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition (documented training in conducting physical and behavioral assessment); and the need to continue or terminate the restraint or seclusion.			
CMS §482.13 (f)(1)	CMS §482.13 (f)(1): Restraint or seclusion: Staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.	Prior to performing, Orientation, Subsequently on a periodic basis per hospital policy		
	a. Training Intervals - Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion before performing any of the actions specified in this paragraph; as part of orientation; and subsequently on a periodic basis consistent with hospital policy.			
	b. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion.			
	c. All staff designated by the hospital as having direct patient care responsibilities, including contract or agency personnel, must demonstrate the competencies specified in standard (f) prior to participating in the application of restraints, implementation of seclusion, monitoring, assessment, or care of a patient in restraint or seclusion, monitoring, assessment, or care of a patient in restraint or seclusion. These competencies must be demonstrated initially as part of orientation and subsequently on a periodic basis consistent with hospital policy. Hospitals have the flexibility to identify a time frame for ongoing training based on the level of staff competency, and the needs of the patient population(s) served.			
	d. Training for an RN or PA to conduct 1-hour face-to-face evaluation would include all of the training requirements at CMS §482.13 (f) as well as content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion.			
	e. Once initial training takes place, training must be provided frequently enough to ensure that staff possesses the requisite knowledge and skills to safely care for restrained or secluded patients in accordance with the regulations.			
	f. If hospital security guards, or other non-healthcare staff, as part of hospital policy, may assist direct care staff, when requested, in the application of restraint or seclusion, the security guards, or other non-healthcare staff, are also expected to be trained and able to demonstrate competency in the safe application of restraint and seclusion.			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
CMS §482.13 (f)(2)(i)	CMS §482.13 (f)(2)(i): Training Content- The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following: Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.			
	All staff, including contract or agency personnel, designated by the hospital as having direct patient care responsibilities are required to receive training in the areas of clinical techniques used to identify patient and staff behaviors, events and environmental factors that may trigger circumstances that require the use of restraint or seclusion. This training should be targeted to the specific needs of the patient populations being served, and the competency level of staff.			
CMS §482.13 (f)(2)(ii)-(vii)	CMS §482.13 (f)(2)(ii)-(vii): The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following: ii. The use of nonphysical intervention skills. iii. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition. iv. The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia). v. Clinical identification of specific behavioral changes that indicated that restraint or seclusion is no longer necessary. vi. Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. vii. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.			
CMS §482.13 (f)(3)	CMS §482.13 (f)(3): Trainer Requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patient behaviors.			
	Individuals providing the training must be qualified as evidenced by education, training and experience in techniques used to address patients' behaviors for the patient populations being served. Trainers should demonstrate a high level of knowledge regarding all the requirements of these regulations as well as the hospital's policies and procedures that address these requirements.			
CMS §482.13 (f)(4)	CMS §482.13 (f)(4): Training Documentation. -The hospital **must document** in the staff personnel records that the training and demonstration of competency were successfully completed.			
PC.03.05.17	PC.03.05.17: The hospital trains staff to safely implement the use of restraint or seclusion.	Orientation, Before participation in the use of restraints and seclusion, On a periodic basis thereafter	Staff	
EP 2	The hospital trains staff on the use of restraint and seclusion and assesses their competence, at the following intervals: At orientation, before participating in the use of restraint and seclusion, and on a periodic basis thereafter			
EP 3	Based on the population, staff education, training and knowledge focus on: - Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint of seclusion - Use of nonphysical intervention skills - Methods for choosing the least restrictive intervention based on an assessment of the patient's medical or behavioral status or condition - Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia) - Clinical identification of specific behavioral changes that restraint or seclusion is no longer necessary - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint seclusion - Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.			
EP 4	Individuals providing staff training in restraint of seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.			
EP 5	The hospital **documents in staff records** that restraint and seclusion training and demonstration of competence were completed.			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
Medication Management and Transfusion				
MM.05.01.13	MM.05.01.13: The hospital safely obtains medications when the pharmacy is closed.	Prior to performing task/skill	Nurse, Prescribers	
EP 2	When non-pharmacist healthcare professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Only trained, designated prescribers and nurses are permitted access to approved medications.			
MM.09.01.01	The hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.	Upon hire Initial privileges and periodically thereafter	Staff and Licensed practitioners	
EP 12	The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leadership, and pharmacy leadership, as well as with the hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - **Providing competency-based training and education for staff, including medical staff, on the practical applications of antibiotic stewardship guidelines, policies, and procedures**		Staff and Licensed practitioners	
CMS §482.23 (c)	CMS §482.23 (c) Standard: Preparation and Administration of Drugs	Orientation, Ongoing, Continuing education	Staff	
	CMS §482.23 (c)(1) - Drugs and biologicals must be prepared and administered in accordance with federal and state laws, the orders of the practitioner or practitioners responsible for the patient's care and acceptable standards of practice			
	CMS §482.23 (c)(2) - All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.			
	a. Medication administration education and training is typically included in hospital orientation or other continuing education for nursing staff and other authorized healthcare personnel. Training or continuing education topics regarding medication preparation and administration may include but are not limited to the following: i. Safe handling and preparation of authorized medications; ii. Knowledge of the indications, side effects, drug interactions, compatibility, and dose limits of administered medications; iii. Equipment, devices, special procedures, and/or techniques required for medication administration; *Policies and procedures must address the required components of the training and if the training provided during hospital orientation imparts sufficient education or whether ongoing in-services or continuing education will be required to demonstrate competence .*			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
CMS §482.23 (c)(4)	CMS §482.23 (c)(4) - Blood transfusions and intravenous medications must be administered in accordance with state law and approved medical staff policies and procedures.	Orientation, Prior to performing skill and/or assigned task, Ongoing	Staff	[HCA Healthcare Center for Clinical Advancement Atlas Connect](https://connect.medcity.net/web/cca) https://connect.medcity.net/web/cca
	Intravenous (IV) medications and blood transfusions must be administered by qualified personnel, regardless of whether they are practitioners or non-practitioners. Generally intravenous (IV) medications and blood transfusions are administered to patients by registered nurses (RNs) consistent with state law governing scope of practice and approved medical staff policies and procedures. Among other things, personnel must be able to demonstrate competency in venipuncture, in accordance with state law and hospital policy. If other types of vascular access are utilized, staff must have demonstrated competency in appropriate usage, care, and maintenance. If other types of vascular access are utilized, staff must have demonstrated competency in the appropriate usage, care, and maintenance. Staff must also be trained in early detection of timely intervention for IV opioid-induced over-sedation and respiratory depression. Education and training regarding these procedures are typically included in the nurse's hospital orientation. Nursing staff who receive training for intravenous medication administration and/or blood transfusion administration during hospital orientation or during other continuing education programs would meet the requirements of this regulation. Content of the training must address each required component of the approved medical staff policies and procedures.			
CMS §482.25(b)(1)	CMS §482.25(b)(1) - All compounding, packaging, and dispensing of drugs and biologicals must be under the supervision of a pharmacist and performed consistent with state and federal laws.			
	Ensure that sterile compounding practices are consistent with USP <797> or equivalent/more stringent standards for the risk level(s) of CSPs being produced for/dispensed to hospital patients. Personnel training and competency assessment, including but not limited to accuracy/precision in identifying and measuring ingredients; cleansing and garbing; aseptic manipulation skills; environmental quality and disinfection; appropriate work practices within and adjacent to the direct compounding area; verification/calibration of equipment; sterilization; and post-production quality checks.			
	Organ Procurement			
TS.01.01.01	TS.01.01.01: The hospital, with the medical staff's participation, develops and implements written policies and procedures for donating and procuring organs and tissues.	Unspecified, Prior to performing skill and/or assigned task	Staff Individuals performing task/skill	
EP 4	The hospital works with the organ procurement organization (OPO) and tissue and eye banks to do the following: - Review death records in order to improve identification of potential donors. - Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant. - Educate staff about issues surrounding donation. - Develop a written donation policy that addresses opportunities for asystolic recovery that is mutually agreed upon by the hospital, its medical staff, and the designated OPO. When the hospital and its medical staff agree not to provide for asystolic recovery and cannot achieve agreement with the designated OPO, the hospital documents its efforts to reach an agreement with its OPO, and the donation policy addresses the hospital's justification for not providing for asystolic recovery. **Documentation is required.**			
EP 5	Staff who have been designated to discuss potential organ, tissue, or eye donations with families are educated and trained in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families.			
EP 7	The individual designated by the hospital to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor. (A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation.)			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
CMS §482.45(a)	CMS §482.45(a)(3) -The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation; a. Any individuals involved in a request for organ, tissue, and eye donation must be formally trained in the donation request process. b. The hospital must ensure that any —designated requestor for organs, tissues or eyes has completed a training course either offered or approved by the OPO, which addresses methodology for approaching potential donor families.	Unspecified, Prior to performing skill and/or assigned task	Staff Individuals performing task/skill	
CMS §482.45(a)(5)	CMS §482.45(a)(5) - Ensure that the hospital works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues; a. Appropriate hospital staff, including all patient care staff, must be trained on donation issues. The training program must be developed in cooperation with the OPO, tissue bank and eye bank, and should include, at a minimum: i. Consent process; ii. Importance of using discretion and sensitivity when approaching families; iii. Role of the designated requestor; iv. Transplantation and donation, including pediatrics, if appropriate; vi. Role of the organ procurement organization.	Training should be conducted with new employees annually, whenever there are policy/procedure changes, or when problems are determined through the hospital's QAPI program.		
	Those hospital staff who may have to contact or work with the OPO, tissue bank and eye bank staff must have appropriate training on donation issues including their duties and roles.			
Executive Leadership and Governance				
LD.01.03.01	LD.01.03.01: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.	Unspecified	Staff	
EP 13	The governing body consults directly with the individual assigned the responsibility for the organization and conduct of the hospital's medical staff, or his or her designee. At a minimum, this direct consultation occurs periodically throughout the fiscal or calendar year and includes a discussion of matters related to the quality of medical care provided to patients of the hospital.			
LD.02.01.01	LD.02.01.01: The mission, vision and goals of the hospital support the safety and quality of care treatment, and services.			
EP 3	Leaders communicate the mission, vision, and goals to staff and the population(s) the hospital serves.			
LD.04.01.05	LD.04.01.05: The hospital effectively manages its programs, services, sites, or departments.			
EP 25	Requirement regarding designation of a radiation safety officer and description of responsibilities.			
LD.04.03.13	Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital.	Unspecified	Staff and Licensed practitioners	HCA Healthcare Center for Clinical Advancement Atlas Connect https://connect.medcity.net/web/cca
EP 3	The hospital provides staff and licensed independent practitioners* with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.			
HCA Healthcare Expectations & Clinical Policy Training Requirements				
HCA Healthcare Patient Restraint/Seclusion Policy COG.001	Please refer to Appendix A: Training Requirements of the HCA Clinical Policy for Restraints/Seclusion.	Orientation, Before restraint/seclusion application, monitoring assessment	All staff designated as having direct patient care responsibility, security guards or non-healthcare staff that assist direct care staff	https://connect.medcity.net/web/clinical-services/patient-restraints
HCA Healthcare Radiation Safety		Dependent upon HCA Healthcare policy	Refer to HCA Healthcare clinical policies	https://connect.medcity.net/web/clinical-services/radiation-safety
Computed Tomography (CT) Policy for Improving and Monitoring Radiation Safety COG.MI.002	Ensure technologists possess fundamental knowledge necessary to promote ALARA principles as evidenced by: a. Advanced certification where the minimum recognized credential will be ARRT(R)(CT) or NMTCB(CT). In the case of multi-modality technologists, the aforementioned credential must be met when independently performing CT at or above the level of per diem staffing requirements. Facility-defined timeline for achieving certification will not exceed (6) months or the full-time hourly equivalent from the employee's date of hire or transfer. Where LCDs apply, certification is required prior to providing reimbursed CT services. b. Facility defined orientation and the provision of annual training and competency which includes dose optimization techniques and safe operation of CT equipment All training and competencies will be documented. c. Documented equipment-specific competencies provided either by the original equipment manufacturer (OEM) upon installation or training provided by a technologist having previously documented competency.	Orientation, Ongoing, Annual Radiation Safety training	CT technologists	
	Ensure all technologists demonstrate ongoing commitment to ALARA as evidenced by: a. Continued education to include but not limited to annual radiation safety training, annual review of dose optimization techniques and refresher training as required when responsibilities change. CE courses pertinent to the maintenance of primary license and advanced certification throughout the term of employment. b. Maintenance of equipment competency through appropriate refresher training as necessary at facility-defined intervals and whenever updates to equipment occur.			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
HCA Healthcare Radiation Right Fluoroscopy Policy COG.MI.003	Ensure physicians, technologists, nurses and supporting clinicians possess fundamental knowledge, skills and abilities necessary to promote ALARA principles as evidenced by: a. Physicians and other Licensed Independent Practitioners* are required to provide evidence of having completed minimum radiation safety education when requesting the clinical privilege to perform procedures in which fluoroscopy shall be used under their supervision. To be eligible to be granted this clinical privilege, the physician/LIP must first meet facility-defined requirements for radiation safety education. The performance of this clinical privilege shall be subject to Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). A practitioner's eligibility for the ongoing performance of this privilege, or the renewal of this privilege, shall be dependent upon favorable FPPE/OPPE results, or the satisfaction of any recommendations for improvement, as determined by the responsible department chairperson and the medical staff committees which oversee performance and recommend clinical privilege renewals. b. Clinical and Technical Staff will receive annual training on Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently and Image Wisely campaign: and safe procedures for the operation of the types of fluoroscopy equipment they will use. They will also be able to perform and speak to radiation safety, radiation dose indices, dose tracking and notifications as specified in this policy. All staff achieve advanced certifications where applicable within their primary discipline as required by accrediting organizations, local, state and/or federal law to include conditions of participation as outlined by all payers. c. No member of the clinical team is permitted to activate fluoro without minimum education requirements. This will be achieved in accordance with facility-defined clinical and equipment competencies under the guidance and approval of a Radiation Safety Officer (RSO) or other competent designee. Further, education and competency must meet all accrediting body requirements to include all applicable local, state or federal laws to operate ionizing equipment within the clinical team member's scope of practice.	Orientation, Ongoing, Annual Radiation Safety training	Licensed practitioners, technologists, nurses, supporting clinicians	https://connect.medcity.net/web/clinical-services/radiation-safety
	Ensure all staff demonstrate commitment to ALARA principles through: a. Continuing Education: All staff who routinely enter areas using active fluoroscopy will receive annual radiation safety training. Members will also maintain documentation of activities required for maintenance of credentials/privileges and licensing to include relevant education in maintaining doses ALARA. (e.g., dose savings techniques, radiation safety, managing occupational exposure, etc.). b. **Documented annual review** of dose optimization techniques and tools as provided by Image Gently® and Image Wisely® campaigns. c. Equipment Competency: Staff having equipment-specific competencies in the area of their primary discipline as evidenced by: i. **Documented education** and/or applications provided by the OEM upon installation of the equipment or ii. **Documented education** and/or applications provided by a staff member having previously established equipment competency and for whom documented competency exist or iii. **Documented education** by someone having an educational background, experience, and knowledge of the skills being assessed.			
Radiation Right Oncology Policy COG.MI.004	1. Ensure therapists, dosimetrists, physicists, and oncologists possess the fundamental knowledge, skills and abilities necessary to deliver safe, appropriate, high-quality radiation treatment by demonstrating and documenting the required clinical and technical competencies necessary to perform their job role. Current license, registration, and/or certification in their primary discipline as required by accrediting organizations, local, state and/or federal law to include conditions of participation as outlined by payers must be maintained. Role-specific qualifications are listed below: a. Oncologists and other Licensed Independent Practitioners* i. Board eligible with the American Board of Radiology or equivalent and certified within two years of privilege date. ii. Maintenance of delineated clinical privileges to perform radiation oncology procedures subject to Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). b. Radiation Therapists i. Registered by the American Registry of Radiologic Technologists (ARRT). It is acceptable to employ a recent graduate of an accredited school of radiation therapy who is registry eligible so long as this employee achieves registration by the American Registry of Radiologic Technologists within the first six months of their employment as a radiation therapist. ii. Hold an unrestricted state license in radiation therapy where applicable. c. Medical Dosimetrists i. Certified by the Medical Dosimetry Certification Board (MDCB), or possess the credentials for board eligibility. It is acceptable to employ a recent graduate of an accredited medical dosimetry program so long as this employee obtains certification within the first two years of their employment as a medical dosimetrist. 1) Non-certified dosimetrists may participate in the treatment planning only under the direct supervision of a certified medical dosimetrist or Qualified Medical Physicist (QMP).		Radiation Oncology practitioners and staff	

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
	d. Medical Physicists i. Board Certified in therapeutic radiologic physics or a certification including therapeutic radiologic physics, by the American Board of Radiology (ABR), American Board of Medical Physics (ABMP), or the Canadian College of Physicists in Medicine (CCPM) and hold an appropriate state license. ii. Board eligible medical physicists, referred to as Physicists in Training (PIT) may be employed under the appropriate supervision of a QMP, in addition: 1) PIT should be a person who is board eligible as defined by the ABR; namely, one who has completed a Commission on Accreditation of Medical Physics Education Programs (CAMPEP)-approved residency program or who has been approved to take Part 2 of the ABR initial certification examination, whichever comes first. Certification must be achieved within four years of hire. 2) The PIT shall not be the primary physicist at a radiation oncology center.			

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
HCA Healthcare Controlled Substance Monitoring Policy COG.MM.001	Staff, LPs and APPs who may access medication are responsible for reading this policy and understanding their role in preventing medication diversion.		Staff, Licensed practitioners, Advanced Practice Professionals	https://connect.medcity.net/web/clinical-services/medication-diversion
HCA Healthcare Substance Use in the Workplace HR.ER.060	To ensure all employees or students are aware of their role in supporting this policy, each facility shall prepare a plan for ensuring: a. The policy will be reviewed in orientation sessions for all employees and students. b. The policy will be reviewed annually by all employees and students. c. Leadership/designee will discuss the policy and organizational procedure during orientation of staff managers.		All colleagues and students	https://connect.medcity.net/web/clinical-services/medication-diversion
HCA Healthcare Safe Procedural and Surgical Verification Policy COG.PS.001	Staff who may participate in procedures and surgical cases are responsible for reading this policy and understanding their role.	Recommended upon hire and annually	Staff and Licensed practitioners	https://connect.medcity.net/web/clinical-services/safe-procedural-surgical-verification
HCA Healthcare Serious Safety Events Policy HCA.PSO.006	All new hires to the clinical departments will be oriented to this policy, identification and reporting of events, as well as chain of command and conflict resolution. Each facility will determine annual education needs for the local staff related to this Policy. "Just-in time" coaching will be available. Individuals selected to participate in the Patient Focus First Response Team, will have advanced education in the management of SSEs, including Patient and/or Patient's Representative/Family and/or Support Person Disclosure techniques.	Annual	Staff, Physician Leaders, Quality and Risk Departments, Senior Leadership	https://connect.medcity.net/web/clinical-services/serious-patient-adverse-events
	Code of Conduct – Refer to EC.004 for specific requirements			https://connect.medcity.net/web/coc
	Coding – Refer to REGS.COD.005, REGS.COD.006 and REGS.GEN.007 for specific requirements.			https://connect.medcity.net/web/ethicsandcomplianceoverview/regs-cod-policies https://connect.medcity.net/web/ethicsandcomplianceoverview/regs-gen-policies
	NHSN Reporting - Refer to COG.COM.004 for specific requirements		Facilities are required to maintain two trained NHSN users at all times.	https://connect.medcity.net/web/ip/clinical-reporting

Standard/Regulation	Detail Requirement	Frequency	Required For	Available Resources
HCA Healthcare Ethics and Compliance Policies	HIPAA - Refer to IP.PRI.001 and IP.PRI.002 for specific requirements			https://connect.medcity.net/web/ethicsandcomplianceoverview/ip-pri-policies
	Infant Security - Refer to IP.PS.005: Infant security specific training for all hospital employees is completed within the first seven days of hire. Additional training for employees involved in the care of newborns is completed before or during the employee's first shift in the patient care area. Educate staff regarding not allowing tailgating/piggy-backing onto secured units.	Within first seven days of hire, First shift	All hospital employees	https://connect.medcity.net/web/ethicsandcomplianceoverview/information-protection-and-security-physical-security-ipps-
	Pediatric Security - Refer to IP.PS.007: Pediatric specific training for all facility employees is completed within the first seven days of hire. Additional security training for employees involved in the care of pediatrics is completed prior to or during the employee's first shift in the patient care area. Refresher training should be conducted on an annual basis for all staff. Educate staff regarding not allowing tailgating/piggy-backing onto secured units. With technology, appropriate staff should receive formal system training during orientation.	Within first seven days of hire, First shift	All hospital employees	https://connect.medcity.net/web/ethicsandcomplianceoverview/information-protection-and-security-physical-security-ipps-
	Physical Security - Refer to IP.PS.001: f. All workforce members have responsibilities that contribute to a safe and secure environment and should be educated on the following: 1) How to contact Security or Security Administrator; 2) What and how to report security issues or incidents to Security or Security Administrator; 3) LiveSafe; The importance of displaying and checking identification; 4) Procedures for preventing and responding to emergency situations including, but not limited to, abductions, breaches and workplace violence; 5) Preventing, intervening, reporting and resolving workplace violence issues; and 6) Their role in crime prevention. g. Personal safety awareness. All workforce members must receive security education within thirty (30) days of employment. h. All workforce members must receive annual physical security education.	Within first thirty days of hire, Annually	All workforce members	https://connect.medcity.net/web/ethicsandcomplianceoverview/information-protection-and-security-physical-security-ipps-
The Joint Commission New Standards and Revised Requirements: Effective January 1, 2023				
New and Revised Requirements Addressing Antibiotic Stewardship				https://www.jointcommission.org/en/standards/prepublication-standards/
Regulatory and Accreditation Focus Areas				
Dialysis Services	Readily accessible documentation of staff skills with new dialysis equipment and equipment manufacturer's instructions for use.	Prior to use with patient care	Employed and DHP staff members responsible for direct care with dialysis patients	
Compounding Medications (Refer to CMS §482.25(b)(1) Pharmaceutical Services)	a. Didactic testing **and** visual observation of hand washing and donning of personal protective equipment (also known as "garbing" practices) b. Visual observation and validation of aseptic work practices during compounding and cleaning/disinfection procedures before/during/after compounding c. Initial gloved fingertip sampling (NOTE: This is a one-time-only competency. These must be retained as they demonstrate a unique, original competency process for pharmacy staff performing compounding.) d. Ongoing (annual) gloved fingertip sampling e. Aseptic media fill testing	Every 12 months plus or minus one month Note: With revisions to USP <797>, effective date November 1, 2023, this will become an **every six month** routine competency.	Pharmacy staff members responsible for preparing compounded sterile products (CSPs).	Download USP <797>

References

The Centers for Medicare and Medicaid Services (2021, February 21). State Operations Manual Appendix A. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

The Joint Commission (2023). Comprehensive Accreditation Manual for Hospitals. Oak Brook, IL: Joint Commission Resources

Occupational Safety and Health Administration (n.d.). Standards, Laws and Regulations. Retrieved from https://www.osha.gov/laws-regs

Clinical Services Group. HCA Clinical Policies. Retrieved from https://connect.medcity.net/web/clinical-services/clinical-policies

Updated January 2023

Status Active PolicySat ID 10435874

TriStar Southern Hills MEDICAL CENTER

Effective	2/1/1995	Owner	Lee Hanna: Clin Ed Prof Dev Educator
Last Reviewed	5/16/2022	Policy Area	Staff Development
Last Revised	5/16/2022	Applicability	TriStar Southern Hills Medical Center
Next Review	5/15/2025		

ACLS/ALS/BLS/PALS Training

COPY

SCOPE:

Applies to all employees, employees under an employment agreement and contract staff in a position requiring resuscitation certification.

PURPOSE:

To define Advanced Cardiac Life Support (ACLS) and Advanced Life Support (ALS), Basic Life Support (BLS), and Pediatric Advanced Life Support (PALS) training requirements.

POLICY:

See HCA Policy HR.ER.041 entitled Certification Verification and Renewal for scope, purpose, definitions, responsibilities, suspension, termination and disclosure directives (HCA hrAnswers).

All training (ACLS/ALS, BLS and PALS) must be from one of the following organizations: American Heart Association; American Red Cross; or the Military Training Network. A hands-on session for skills validation must be part of completion criteria (instructor or self-guided validation). ACLS and ALS both meet the requirement for advanced cardiac support for adults, are equally recognized and may be substituted for each other.

Light or Restricted Duty: If an employee is on light or restricted duty due to a work-related injury they must provide written proof they are cleared to participate in AHA activities. Written proof is defined as a Medical Status form from their treating Physician signed by Occupational Health, showing proof that they are able to participate in AHA activities.

FMLA or TAFW: If an employee is on FMLA or TAFW they will not be allowed to attend AHA courses as

they have not yet been released by their medical professional.

Employee records of ACLS/ALS, BLS and/or PALS are maintained by electronic employee file. Employees are responsible to provide the electronic employee file with current copies of their ACLS/ALS, BLS and/or PALS course completion cards.

All Revision Dates

5/16/2022, 4/16/2019, 12/3/2018, 11/1/2016, 3/1/2013, 8/1/2011, 1/1/2009, 11/1/2006, 9/1/2005, 3/1/2004, 10/1/2002, 9/1/2002, 10/1/2000, 2/1/1998, 10/1/1996, 11/1/1995

Approval Signatures

Step Description	Approver	Date
Nursing & Patient Care	Amy Higgins: CNO Southern Hills Med Ctr	5/16/2022
Quality Council	Mary Ellen Brill: VP Quality/ Risk Mgmt	11/22/2021

COPY

Attachment 2Q
Accreditation Certificates

TriStar Southern Hills Medical Center

Nashville, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

July 22, 2022

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #7890
Print/Reprint Date: 10/03/2022

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

CERTIFICATE OF DISTINCTION

has been awarded to

TriStar Southern Hills Medical Center

Nashville, TN

in the management of

Chest Pain

by

The Joint Commission

based on a review of compliance with national standards, clinical guidelines and outcomes of care.

March 23, 2022

Certification is customarily valid for up to 24 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #7890

Print/Reprint Date: 03/25/2022

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in certified organizations. Information about certified organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding certification and the certification performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

CERTIFICATE OF DISTINCTION

has been awarded to

TriStar Southern Hills Medical Center

Nashville, TN

for Advanced Certification as a

Primary Stroke Center

by

The Joint Commission

based on a review of compliance with national standards, clinical guidelines and outcomes of care.

November 13, 2021

Certification is customarily valid for up to 24 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #7890

Print/Reprint Date: 02/10/2022

Ana Pujols McKee, MD
Interim President & CEO

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in certified organizations. Information about certified organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding certification and the certification performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF ACCREDITATION

LABORATORY NAME AND ADDRESS

HCA HEALTH SERVICES OF TENNESSEE INC
DBA TRISTAR SOUTHERN HILLS MEDICAL CEN
391 WALLACE ROAD
NASHVILLE, TN 37211

CLIA ID NUMBER

44D0308808

EFFECTIVE DATE

01/03/2023

LABORATORY DIRECTOR

NITIN MARWAHA M.D.

EXPIRATION DATE

01/02/2025

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Monique Spruill

Monique Spruill, Director
Division of Clinical Laboratory Improvement & Quality
Quality & Safety Oversight Group
Center for Clinical Standards and Quality

414 Certs2_120622

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

LAB CERTIFICATION (CODE)	EFFECTIVE DATE
BACTERIOLOGY (110)	07/19/1995
PARASITOLOGY (130)	07/12/2000
VIROLOGY (140)	07/08/2014
GENERAL IMMUNOLOGY (220)	05/13/2004
ROUTINE CHEMISTRY (310)	07/19/1995
URINALYSIS (320)	07/19/1995
ENDOCRINOLOGY (330)	07/19/1995
TOXICOLOGY (340)	03/29/2003
HEMATOLOGY (400)	07/19/1995
ABO & RH GROUP (510)	07/19/1995
ANTIBODY TRANSFUSION (520)	07/19/1995
ANTIBODY NON-TRANSFUSION (530)	07/19/1995
ANTIBODY IDENTIFICATION (540)	07/19/1995
COMPATIBILITY TESTING (550)	07/19/1995
HISTOPATHOLOGY (610)	07/19/1995
CYTOLOGY (630)	05/13/2004

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER. PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

TRISTAR SOUTHERN HILLS CARDIAC REHAB
397 WALLACE ROAD
NASHVILLE, TN 37211

CLIA ID NUMBER

44D2160243

EFFECTIVE DATE

01/08/2023

LABORATORY DIRECTOR

PAUL DIGIOVANNI M.D.

EXPIRATION DATE

01/07/2025

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.

Gregg Brandush, Director
Division of Clinical Laboratory Improvement & Quality
Quality & Safety Oversight Group
Center for Clinical Standards and Quality

1236 Certs1_121322

- **If this is a Certificate of Registration, it represents only the enrollment of the laboratory in the CLIA program and does not indicate a Federal certification of compliance with other CLIA requirements. The laboratory is permitted to begin testing upon receipt of this certificate, but is not determined to be in compliance until a survey is successfully completed.**
- **If this is a Certificate for Provider-Performed Microscopy Procedures, it certifies the laboratory to perform only those laboratory procedures that have been specified as provider-performed microscopy procedures and, if applicable, examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.**
- **If this is a Certificate of Waiver, it certifies the laboratory to perform only examinations or procedures that have been approved as waived tests by the Department of Health and Human Services.**

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER. PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Laboratory Director Name Update

Brochu Summer <Summer.Brochu@hcahealthcare.com>
Wed 1/4/2023 1:35 PM
To: CLIA.health@TN.gov <CLIA.health@TN.gov>
Cc: Nitin Marwaha, MD <nimarwaha@pathgroup.com>;Parmar Amit <Amit.Parmar@hcahealthcare.com>;Baldwin John - Nashville <John.Baldwin2@hcahealthcare.com>

TN Healthcare Facilities,

Please update the name of the Laboratory Director for the following CLIAs

44D2160243
44D2160239

remove: Paul Digiovanni M.D.

New Director: Nitin Marwaha M.D.

Summer Brochu MBA, DLM (ASCP), MLS (ASCP)
Interim Laboratory Director
TriStar Southern Hills Medical Center
391 Wallace Rd. Nashville, TN 37211
HCA Healthcare | TriStar Division
P 615.781.3530 | M 864.621.1467

CENTERS FOR MEDICARE & MEDICAID SERVICES

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF WAIVER

LABORATORY NAME AND ADDRESS

ADVANCED WOUND CARE
397 WALLACE ROAD SUITE 309
NASHVILLE, TN 37211

CLIA ID NUMBER

44D2160239

EFFECTIVE DATE

01/08/2023

LABORATORY DIRECTOR

PAUL DIGIOVANNI M.D.

EXPIRATION DATE

01/07/2025

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