HEALTH FACILITIES COMMISSION
JANUARY 28, 2026
APPLICATION REVIEW

NAME OF PROJECT:	Parkridge Medical Center
PROJECT NUMBER:	CN2511-026
ADDRESS:	The northeast corner of the intersection of Blackburn Road SE, including the parcel addressed as 2375 Blackburn Road SE, and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74 Cleveland (Bradley County), TN 37311
LEGAL OWNER:	Parkridge Medical Center, Inc. 2333 McCallie Avenue Chattanooga (Hamilton County), TN 37404
OPERATING ENTITY:	N/A
CONTACT PERSON:	Chris Cosby, President and CEO, Parkridge Health System (423) 493-1772
DATE FILED:	December 1, 2025
PROJECT COST:	$17,409,082
PURPOSE FOR FILING:	Establishment of a Freestanding Emergency Department (FSED)

Note to Commission members: This staff review is an analysis of the statutory criteria of Need, Consumer Advantage Attributed to Competition, and Quality Standards, including data verification of the original application and, if applicable, supplemental responses submitted by the applicant. Any Health Facilities Commission Staff comments will be presented as a "Note to Commission members" in bold italic.

PROJECT DESCRIPTION:

This application is for the establishment of a freestanding emergency department (FSED) located on the northeast corner of the intersection of Blackburn Road SE, including the parcel addressed as 2375 Blackburn Road SE, and Appalachian Highway also known as

APD 40, US Route 64 Bypass and US Route 74, Cleveland (Bradley County), Tennessee 37311.

Executive Summary

- If approved, the applicant projects the proposed project will open for service in February 2028.
- The host hospital - Parkridge Medical Center - is a 275-bed hospital (186 staffed beds) located in western Hamilton County, approximately 28 miles southwest of the proposed satellite FSED site.
- There is one community hospital located in the proposed service area – Bradley Medical Center, a 251-bed hospital which reports staffing 152 beds. BMC's emergency department operates a 41-bay emergency room.
- The proposed FSED will be located approximately 3.5 miles / 10 minutes to the south of Bradley Medical Center.
- The proposed FSED will be a full-service hospital ED able to care for all acuity levels of ED patients. The facility will have isolation and behavioral health capabilities.
- The service area includes ZIP Codes located within Bradley County encompassing south Cleveland, McDonald and Old Fort (ZIP codes 37311, 37323, 37353 and 37362) and within the Polk County communities of Benton, Ocoee and Conasauga (ZIP codes 37307, 37361 and 37316).
- The Parkridge Cleveland FSED will be staffed by approximately 30.1 FTEs, consisting of physicians, RNs, EMT/Paramedics, radiology, a lab supervisor, and nonclinical support staff.
- Please see application Item 1E. on Pages 6 - 8 for the applicant's executive summary overview that includes project description, ownership, service area, existing similar service providers, project cost, and staffing.

Consent Calendar: □ Yes √ No

- Executive Director's Consent Memo Attached: □ Yes √ Not applicable

Facility Information

- The applicant has included a purchase and sale agreement and warranty deed for the proposed site as Attachment 9A-1 and 9A-2. The single-story facility will be approximately 10,860 square feet with 11 exam rooms including 1 trauma room, lab, imaging department, and nurse's station.
- The FSED will have a CT, X-ray, and ultrasound as well as lab and pharmacy support equipment. All equipment will be available 24/7. The Emergency Department room configurations are detailed in Attachment 10A – Floor Plan.
- The proposed tract for the project site sits on approximately 5 acres.

- The nearest drop-off point for public transit to the proposed site is located less than 1 mile - Cleveland Urban Area Transit System (CUATS) which operates weekdays from 6:00AM to 7:00 PM. See Attachment 11A for a transit map.

Ownership

- Parkridge Medical Center, Inc. is ultimately owned by HCA Healthcare, Inc. See Attachment 7A-3 for the applicant's organizational chart and Attachment 7A-4 for a listing of Parkridge Medical Center's directors and officers.

Project Cost Chart

- The total project cost is $17,409,082. Of this amount, the highest line-item costs of the project are Construction Costs ($8,308,000), Site Preparation ($2,000,000), Moveable Equipment ($1,900,000), and Fixed Equipment ($1,200,000).
- For additional information, please refer to the Project Cost Chart on Page 12 of the original application.

NEED

The applicant provided the following supporting the need for the proposed project**:**

- The need to increase emergency department capacity in Bradley County as there are fewer emergency departments per population than other large counties in the state as detailed in the following tables:

Emergency Departments per 1,000 Population

County	Total	2025 Population	EDs per 1,000 Population
Bradley	1	113,913	0.88
Hamilton	10	385,843	2.59
Rhea	1	33,948	2.95
Marion	1	29,265	3.42
McMinn	2	55,752	3.59
Bledsoe	2	15,248	13.12
Tennessee	**126**	**7,242,733**	**1.74**
Bradely County with Parkridge Cleveland FSED	**2**	**113,913**	**1.76**

Source: CN2511-040, Attachment 1N, Exhibit 1N-8, Page 10.

- The applicant states that the service area is geographically isolated citing a 35% outmigration rate for emergency services from Bradley and Polk Counties. The applicant also cites projected time savings (5 – 7 minutes) for residents accessing the proposed FSED site vs. the existing ED at BMC.
- The applicant states that the FSED will improve access to patients through (i) shorten wait times, lower the rates of patients who leave without being seen and improve turnaround time on CT scan results. The applicant cites the historical

data for Parkridge Medical Center as favorable compared to these outcomes for Bradley Medical Center.

- The applicant cites the capacity challenges faced by its own emergency departments at the host hospital and Parkridge North, both operating between 18%-30% above recommended ED visit volume guidelines published by the American College of Emergency Physicians. The presence of an FSED in Bradley County will decompress patient volume at these Hamilton County emergency departments and reduce outmigration from Bradley County.
- The applicant cites the need to respond to the population growth of the service area population age 65+ projected to increase by 17.6% by 2030.
- The applicant states that it will represent a higher quality option for emergency services than the existing hospital, citing its host-hospital's superior performance ranking in the top quartile of the state for of median wait time, percentage of patients receiving CT results within 45 minutes, and percentage of patients who left the emergency department without being treated.

(For applicant discussion, see the Original Application, Item 2.E., Pages 9 & 10 as well as the responses to Item 1N through 4N)

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

Freestanding Emergency Departments:
All applicable criteria and standards were met except for the following which appear to be partially met:

- ***Criteria #1-Determination of Need in the Service Area: The applicant is required to demonstrate that the population in the proposed service area has inadequate access to emergency services due to Geographic Isolation, Capacity Challenges, or Low-Quality of Care. The applicant has requested consideration under Geographic Isolation and Low Quality of Care and not under Capacity Challenges. The applicant has provided data under Other Applicable Data Related to Need and Capacity demonstrating the level of higher acuity patients, behavioral health patients and patients over age 65 served in the Service Area.***

The applicant is requesting consideration under Low Quality of Care under which it provides the following support:

- ***Low Quality of Care:*** *Existing emergency facilities should be in the bottom quartile of the state in the measures listed below to demonstrate low quality of care.*

  CMS OP18 "Median Time from ED Arrival to ED Departure for Discharged ED Patients" *scores per CMS are detailed in the table below:*

OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Emergency Department	ED Time/Score	Tennessee Avg.	National Avg.
Parkridge Medical Center (Host Hospital)	110	190	195
Bradley Medical Center	203	196	210

Source: CN2511-040, Attachment 1N, Exhibit 1N-13B, Page 20.

OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients
(High Volume Hospitals)

Emergency Department	ED Time/Score	<25th Percentile	25th – 50th Percentile	50th – 75th Percentile	>75th Percentile
Bradley Medical Center	203		x		

Source: CN2511-040, Attachment 1N, Exhibit 1N-15, Page 20.

- *Bradley Medical Center does not rank in the bottom quartile for OP 18B. Therefore, this portion of the criterion appears to not be met when the standard of other "high volume hospitals" is applied.*

OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients
(All Hospitals)

Emergency Department	ED Time/Score	<25th Percentile	25th – 50th Percentile	50th – 75th Percentile	>75th Percentile
Bradley Medical Center	203	x			

Source: CN2511-040, Attachment 1N, Exhibit 1N-14, Page 20.

- *Based on consideration of "all hospitals" in Tennessee including emergency departments ranging from "low volume" to "very high volume" emergency departments, Bradley Medical Center ranks in the bottom quartile for OP 18B. Therefore, this portion of the criterion appears to be met when the "all hospitals" standard is applied.*

Note to Commission members: The additional table based on Exhibit 1N-14 from the application (in red) has been added for member consideration. Because the language of the Freestanding Emergency Department Criteria and Standards does not explicitly state whether "bottom quartile" is to be evaluated against other similarly classified emergency departments, i.e. "low volume" vs. "very high volume" or against the state as

a whole across all emergency department volume classifications, both methods are being presented for member consideration. The standard appears to be met when applied "all hospitals" regardless of ED volume classification but not met when applied against all other "high volume only" emergency departments.

CMS OP22 "Left Without Being Treated" *scores per CMS are detailed in the table below:*

OP-22 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Emergency Department	LWOT Score	<25th Percentile	25th – 50th Percentile	50th – 75th Percentile	>75th Percentile
Bradley Medical Center	4%	X			

Source: CN2511-040, Attachment 1N, Exhibit 1N-13B, Page 20.

- *Bradley Medical Center ranks in the bottom quartile for OP 22. Therefore, this criterion appears to be met.*

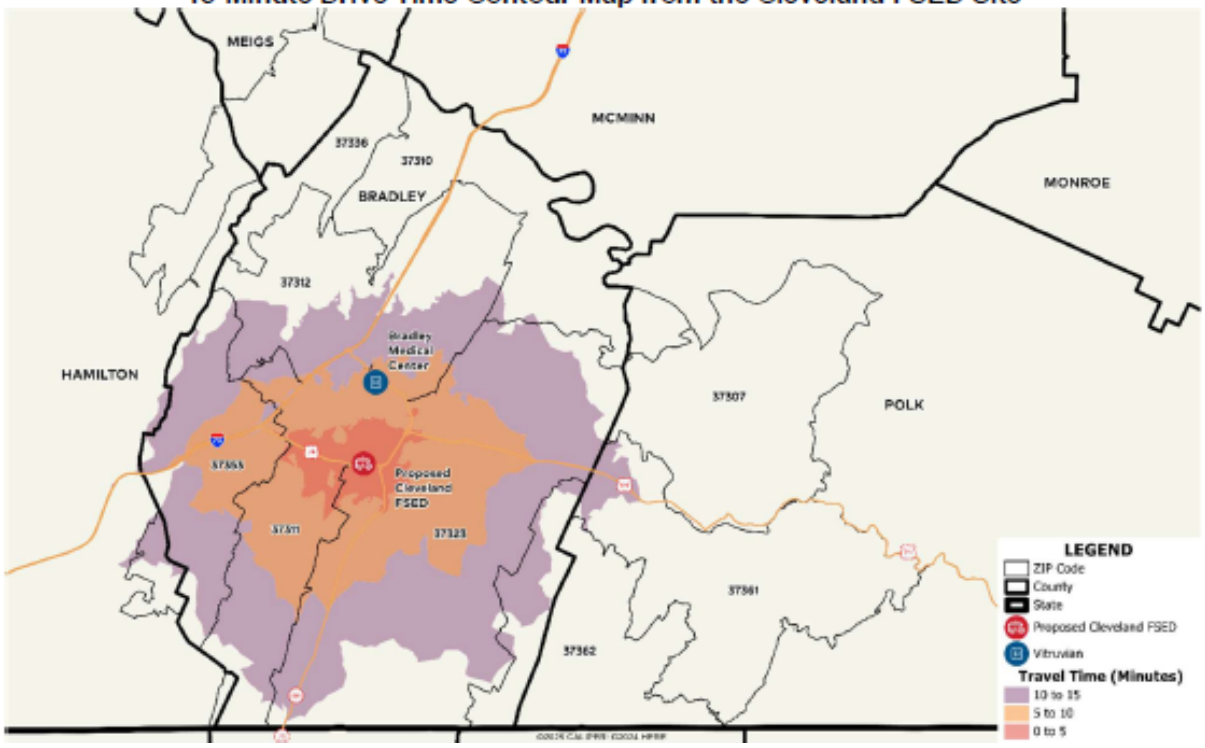
CMS OP23 "Percent of Patients with Stroke Symptoms Receiving Results within 45 Minutes" *scores per CMS were not available on in the most recent data release.*

Note to Commission members: The applicant highlights the fact that while OP23 is not available in the latest data release, the August 2025 data release reflected Bradley Medical Center in the lowest quartile. See Attachment 1N, Exhibit 1N-22, Page 25.

The applicant is requesting consideration under Geographic Isolation. Due to the lack of objective standards regarding what constitutes Geographic Isolation, an analysis of the standard being met is not provided by staff. The relevant data included in the applicant's response is detailed below:

Geographic Isolation*: There is no objective measurement of geographic isolation defined by the Criteria and Standards for Freestanding Emergency Departments. The applicant states that Need is supported with the following statement along with additional data provided in its response – Attachment 1N, Pages 1-13: "Parkridge Medical Center asserts that service area residents are geographically isolated because there is a significant population base of more than 70,000 residents in this area, which is growing and aging, without access to emergency services within a 15-minute drive. The closest provider is located between 16 and 22 minutes away from Bradley service area residents, and 26 to 32 minutes for Polk service area residents. With the continued growth and aging of the population, residents need access to an emergency care provider in the service area. Moreover, residents have no choice in provider with BMC being the only emergency provider; accordingly, approximately 35 percent of the service area residents currently opt to travel outside the county." The applicant has provided data on distances and travel times to support this portion of the criteria being met.*

Exhibit 1N-10
15-Minute Drive Time Contour Map from the Cleveland FSED Site



Source: CN2511-040, Attachment 1N, Exhibit 1N-10, Page 13

Driving Distances and Times for ZIP Codes and City Centroids to Bradley Medical Center and Proposed Parkridge Cleveland FSED

From Zip Code Centroid to Bradley Medical Center			
Service Area ZIP Code	**Time (Minutes)**	**Distance (Miles)**	**Location**
Bradley County Service Area			
SE Cleveland - 37323	17	9.8	South
Cleveland – 37311	16	8.1	South
McDonald - 37353	17	9.9	Southwest
Old Fort - 37362	22	14.4	Southeast
Polk County Service Area			
Benton – 37307	26	17.9	East
Conasauga – 37316	26	17.2	Southeast
Ocoee – 37361	32	18.8	East
From Zip Code Centroid to Parkridge Cleveland FSED			
Bradley County Service Area			
SE Cleveland - 37323	12	6.7	South
Cleveland – 37311	9	5.2	South
McDonald - 37353	12	8.0	Southwest
Old Fort - 37362	17	11.2	Southeast
Polk County Service Area			
Benton – 37307	24	17.9	East
Conasauga – 37316	21	14.2	Southeast
Ocoee – 37361	29	18.6	East
Difference in Time and Distance to BMC vs Parkridge FSED			
Bradley County Service Area			
SE Cleveland - 37323	5	3.1	South
Cleveland – 37311	7	2.9	South
McDonald - 37353	5	1.9	Southwest
Old Fort - 37362	5	3.2	Southeast
Polk County Service Area			
Benton – 37307	2	0.0	East
Conasauga – 37316	5	3.0	Southeast
Ocoee – 37361	3	0.2	East

Source: CN2511-040, Attachment 1N, Exhibit 1N-9, Page 11

- *The improvements in travel time and driving distances from service area ZIP Code centroids for Bradley Medical Center vs. the proposed Parkridge Cleveland FSED site range from 0.2 miles to 3.2 miles or 2 to 7 minutes.*
- *The FSED will be located 3.5 miles from the existing emergency department at BMC.*
- *The applicant states the following regarding its conception of geographic isolation: "Parkridge Medical Center believes a 15-minute drive time is appropriate given studies that show that patients drive an average of 8 miles and 17.3 minutes to access ED services. As such, if a patient's drive times to an ED exceeds these distances and times, that indicates the patient's barriers to accessing care exceed the average. While not every town, ZIP code or service area can support a FSED, Parkridge believes that the data and analysis included in this CON Application present compelling evidence that this service area is in need of additional emergency room services from both geographic and quality (discussed next) perspectives and that a FSED can be supported by the service area population."*
- *The establishment of the proposed Cleveland FSED would potentially reduce the drive-times exceeding 15 minutes for ZIP Codes 37311 – Cleveland, 37323 – SE Cleveland, and*

37353 – McDonald. All other ZIP Code centroids would remain more than 15 minutes from any emergency department.

The applicant is not requesting consideration under Capacity Challenges at Bradley Medical Center.

- ***The applicant provides data relevant to these considerations in the "Other Applicable Data" portion of the response as detailed below:***

- ***Other Applicable Data Related to Need and Capacity:*** *The applicant has provided data demonstrating the percentage of behavioral health visits, the percentage of Level I or Level II (lower acuity patients), and the percentage of patients over the age of 65.*

Service Area Behavioral Health, Level I & II and Patients 65+ (All ED Visits)

Emergency Services Provider	% of Behavioral Health	Statewide Avg. 2023	% of Patients Level I or Level II	Statewide Avg. 2023	% of Patients Ages 65+	Statewide Avg. 2023
37311 – Cleveland	2.6%	1.7%	33.3%	41.5%	18.0%	22.5%
37323 – SE Cleveland	2.0%		29.5%		22.8%	
373 Truncated	1.5%		19.3%		27.0%	
Service Area Total	1.9%		25.3%		23.9%	
Bradley County	2.2%		31.1%		23.2%	
Polk County	1.9%		42.1%		25.4%	

Source: CN2511-040, Attachment 1N, Exhibit 1N-24, Page 27. HDDS data by ZIP code, county and state, CY 2023. State and County from data request 35551101: ZIP codes from data request 35552215. Low acuity computed by taking 99281 plus 99282 divided by 99281 through 99285. Other CPT codes are not defined by acuity. Data from 373 truncated represents all ZIP Codes starting with 373 due to TDH data suppression.

- *The patients residing in the two service area counties are a higher percentage of behavioral health, a lower percentage of lower acuity patients (CPT 99281 & 99282 representing the lowest level ED Evaluation and Management Codes) in Bradley County, and higher percentage in Polk County than the statewide average, and higher percentages of individuals aged 65+ than the statewide average.*

Additional Parkridge and Parkridge North Data

Factor	% of Behavioral Health	% of Patients Level I or II (Low Acuity)	% of Patients 65+
Parkridge Medical Center	4.2%	7.1%	22.8%
ACEP Metric	Mid-Range	High-Range	High-Range
Parkridge North	5.4%	8.1%	7.9%
ACEP Metric	Mid-Range	High-Range	Low-Range

Source: CN2511-040, Attachment 1N, Exhibit 1N-23, Page 26. Internal Parkridge Data

- *The applicant's internal data reflects higher percentages of behavioral health patients, lower percentages of low-acuity patients and a similar percentage of individuals aged 65+ at Parkridge Medical Center, but a lower percentage at Parkridge North.*

Please see Attachment 1N for a full listing of the criteria and standards and the applicant's responses.

Service Area Demographics

- The service area is defined as the following ZIP codes: 37311 (Cleveland), 37323 (SE Cleveland), 37353 (McDonald), 37362 (Old Fort), and three Polk County ZIP codes, 37307 (Benton), 37361 (Ocoee) and 37316 (Conasauga). The first three are within Bradley County. Old Fort is assigned to Bradley County although it is also partially located within Polk County, a rural county without hospital or emergency facilities. (*see Attachment 2N for a ZIP Code level map*).
- The target population is the total population of the service area. (*See Attachment 3N).* The proposed project is located within ZIP code 37311.

Service Area County	2025 Population	2029 Population	% Change	Median Household Income	% Living Below Poverty Level	TennCare %
37311 Cleveland	30,345	30,999	2.2%	$46,827	20.9%	
37323 SE Cleveland	32,595	33,491	2.7%	$67,538	9.7%	
37353 McDonald	5,278	5,432	2.9%	$66,186	10.8%	
37362 Old Fort	3,921	4,039	3.0%	$49,432	14.7%	
37307 Benton	5,238	5,363	2.4%	$74,953	11.0%	
37361 Ocoee	1,800	1,907	6.0%	$79,167	10.3%	
Service Area Total	**79,177**	**81,231**	**2.6%**		14.4%	
Bradley County	113,913	117,682	3.3%	$72,455	16.8%	19.9%
Polk County	18,244	18,556	1.7%	$60,227	13.3%	21.3%
Tennessee Total	**7,242,733**	**7,462,831**	**3.0%**	**$67,097**	**14.0%**	**19.5%**

Source: CN2511-040, Attachment 3NB, The University of Tennessee Center for Business and Economic Research Population Projection Data Files

- The proposed service area projects a 4-year growth rate of (2.6%) compared to a statewide rate of (3.0%).
- The percentage of service area residents enrolled in the TennCare program is higher in both Bradley County (19.9%) and Polk County (21.3%) than the statewide rate of (19.5%).
- Bradley County has a higher median household income than the statewide median household income while Polk County is below the state average. Of the two ZIP Codes projected to serve the most patients – 37311 Cleveland, and 37323 SE Cleveland, there is a significant difference in the median household income with SE Cleveland ($67,538) being higher than Cleveland ($46,827).
- Among service area ZIP Codes 37311 – Cleveland has the highest percentage of residents living below the poverty level (20.9%), while 37323 – SE Cleveland has the lowest (9.7%).
- The applicant provides ZIP Code level service area population data as detailed in the following table:

Service Area Population by Age Group (2025-2030)

Zip Code	2020	2025	2030	2020	2025	2030
Total Population						
37311 Cleveland	29,762	30,345	31,162	38.9%	38.3%	38.1%
37323 SE Cleveland	31,238	32,595	33,715	40.8%	41.2%	41.2%
37353 McDonald	5,052	5,278	5,470	6.6%	6.7%	6.7%
37362 Old Fort	3,757	3,921	4,069	4.9%	5.0%	5.0%
37307 Benton	5,082	5,238	5,400	6.6%	6.6%	6.6%
37361 Ocoee	1,666	1,800	1,927	2.2%	2.3%	2.4%
Service Area Total	**76,557**	**79,177**	**81,743**	**100.0%**	**100.0%**	**100.0%**
Population 65+						
37311 Cleveland	4,217	4,760	5,470	33.3%	33.5%	32.7%
37323 SE Cleveland	5,407	6,052	7,159	42.7%	42.6%	42.9%
37353 McDonald	1,026	1,181	1,398	8.1%	8.3%	8.4%
37362 Old Fort	658	741	914	5.2%	5.2%	5.5%
37307 Benton	1,013	1,088	1,283	8.0%	7.7%	7.7%
37361 Ocoee	350	388	482	2.8%	2.7%	2.9%
Service Area Total	**12,671**	**14,210**	**16,706**	**100.0%**	**100.0%**	**100.0%**

Source: CN2511-040, Attachment 1N, Exhibit 1N-5, Page 7

- The proposed service area is projected to experience (3.2%) growth overall from 2025-2030 with higher growth coming from the population aged 65+ (17.5%).

Service Area - Historical Utilization

- The following table indicates the utilization of the existing Emergency Department in Bradley County.

Historical Utilization of EDs by Bradley County Residents 2021-2023

County	Facility	FY2021 ED Visits	FY2022 ED Visits	FY2023 ED Visits	Change FY2021-2023
Bradley	Bradley Medical Center	32,329	31,622	34,324	6.2%
	All Other Out of County	14,441	15,343	16,405	13.6%
	Bradley County Residents	46,770	46,965	50,729	8.5%
	% to Bradley Medical Center	**69.1%**	**67.3%**	**67.7%**	**-2.1%**

Source: CN2511-040, Attachment 1N, Exhibit 1N-39, Page 42, BMC from TDOH data request 35551101; total visits are from THA data files since TDOH file excludes some visits which are truncated volume by hospital.

- Approximately (67.7%) of emergency department utilization by Bradley County residents occurred at Bradley Medical Center in 2023, The remaining (33.3%) of visits occurred at an out-of-county emergency department. There are no emergency departments in Polk County.
- Overall, ED utilization increased from residents of Bradley County increased by (8.5%) from 2021-2023.

Bradley Medical Center ED Visits 2019-2024

County	Facility	2019 ED Visits	2020 ED Visits	2021 ED Visits	2022 ED Visits	2023 ED Visits	2024 ED Visits	% Change 2019-2024
Bradley	Bradley Medical Center	50,876	41,584	41,262	40,097	43,574	45,500	-10.6%

Source: TDH Joint Annual Reports. Note: These are total ED visits at BMC regardless of patient origin (county of residence).

- The total number of emergency department visits (all counties) served at Bradley Medical Center has decreased by (10.6%) from 50,876 in 2019 to 45,500 in 2024. ED visits greatly from 2019 to 2022 and have rebounded annually since 2022.
- The 2019 ED visits were included to represent pre-COVID utilization for comparative purposes.

Applicant's Historical and Projected Utilization

The following tables indicate the applicant's historical and projected Emergency Department utilization by ZIP Code of patient residence.

Parkridge Medical Center (Host Hospital) Patient Origin by ZIP Code

ZIP Code	ER Visits	% Distribution
30741 - Rossville	8,835	8.5%
30736 - Ringgold	8,327	8.0%
37412 - Chattanooga	8,038	7.7%
37421 - Chattanooga	7,662	7.4%
37411 - Chattanooga	6,540	6.3%
37404 - Chattanooga	5,634	5.4%
37406 - Chattanooga	5,541	5.3%
37363 - Ooltewah	4,715	4.5%
37379 - Soddy Daisy	4,473	4.3%
37407 - Chattanooga	3,231	3.1%
37416 - Chattanooga	2,802	2.7%
37343 - Hixson	2,474	2.4%
37410 - Chattanooga	2,211	2.1%
30707 - Chickamauga	2,049	2.0%
30742 - Fort Oglethorpe	1,826	1.8%
37402 - Chattanooga	1,704	1.6%
30728 - La Fayette	1,587	1.5%
37341 - Harrison	1,504	1.4%
30752 - Trenton	1,186	1.1%
37415 - Chattanooga	1,049	1.0%
37405 - Chattanooga	1,013	1.0%
37311 - Cleveland	952	0.9%
30755 - Tunnel Hill	856	0.8%
37403 - Chattanooga	817	0.8%
37323 - SE Cleveland	750	0.7%
37312 - Cleveland	715	0.7%
30739 - Rock Spring	693	0.7%
37347 - Jasper	680	0.7%
All Other (1800+ zip codes)	16,014	15.%
Total	**103,878**	**100%**

Source: CN2511-040, Attachment 1N, Table 9A-1, Page 56, Applicant internal data CY2024

- Approximately (1.6%) of ED visits to the host hospital – Parkridge Medical Center (Hamilton County), in CY 2023 were from the ZIP Codes in the proposed service area.
- ZIP code 37311 is the ZIP code where the proposed project will be located within.

CY 2023 Service Area ZIP Code Utilization by Hospital

County	Service Area EDs	Out of County EDs						
	#1 Bradley Medical Center	#2 Erlanger Baroness	#3 Erlanger East	#4 Parkridge	#5 Parkridge West	#6 Erlanger Bledsoe	Other Hospitals	Total
37311 Cleveland	12,133	1,848	931	569	9	-	1,351	16,832
37323 SE Cleveland	9,716	1,742	970	473	7	-	1,421	14,322
37353 McDonald	-	-	-	213	-	-	291	1,915
37362 Old Fort	-	-	-	51	-	-	399	1,767
37307 Benton	-	-	-	23	-	-	1,172	2,422
37361 Ocoee	-	-	-	12	-	-	210	677
Total Service Area	**21,849**	**3,590**	**1,901**	**1,341**	**16**	**-**	**4,844**	**37,935**
% Distribution Patients	**57.6%**	**9.5%**	**5.0%**	**3.5%**	**0.0%**	**-**	**12.8%**	**100%**

Source: CN2511-040, Attachment 1N, Page 57, Source: Hospital Discharge Data System (HDDS) CY 2023, provided by TDOH October 2025 for ZIP codes 37311 and 37323. 37353, 37362, 37307 and 37361 from THA data, limited to totals and TriStar data due to masking policy.

- The highest number of ED visits (21,849) from proposed service area ZIP Codes (37311 - Cleveland and 37323 – SE Cleveland) were treated at Bradley Medical Center in CY2023 followed by Erlanger Baroness (3,590), Erlanger East (1,901), Parkridge Medical Center (1,341), and Parkridge West (16). Patient volumes from ZIP Codes outside of the two primary Bradley County ZIP Codes are not available through TDOH reporting due populations being under 20K. Data from other service area ZIP Codes is provided by the applicant for the host hospital from THA data.

Parkridge Medical Center – Satellite EDs Transfers to Hospital Locations

Parkridge FSEDs	CY2022	CY2023	CY2024
Transfers			
Admitted to Host	1.9%	1.5%	2.1%
Observed at Host	0.2%	0.2%	0.2%
Transferred to Other TriStar	0.3%	0.8%	0.3%
All Other Hospitals	0.8%	1.1%	1.2%
Total Transfers	3.2%	3.5%	3.8%
Total ER Discharges	96.8%	96.5%	96.2%
Total ER Encounters	100.0%	100.0%	100.0%
Percent of Transfers OUT	24.2%	30.5%	30.8%
Percent of Transfers to HCA	75.8%	69.5%	69.2%

Source: CN2511-040, Attachment 6N, Page 33, Source: Parkridge Medical Center Internal Data

- The applicant details the historical utilization and transfer patterns for emergency department patients served at the host hospital and other Parkridge affiliated hospitals and FSEDs in the region.
- The applicant transferred approximately (3.8%) of emergency department patients to an acute hospital, with (2.1%) being admitted to the host hospital, and (1.2%) transferred to a non-HCA affiliated hospital.

Projected ED Utilization – Parkridge Medical Center (Cleveland FSED)
Year 1 – 2028 and Year 2 - 2029

Service Area ZIP Codes	Projected Utilization - Cleveland FSED (2028)	% of Total	Projected Utilization - Cleveland FSED (2029)	% of Total
Cleveland – 37311	3,191	36.5%	3,926	36.5%
SE Cleveland – 37323	2,707	30.9%	3,340	31.0%
McDonald – 37353	319	3.6%	386	3.6%
Old Fort – 37362	285	3.3%	345	3.2%
Benton – 37307	382	4.4%	468	4.3%
Ocoee – 37361	117	1.3%	145	1.3%
Service Area	7,001	80.0%	8,609	80.0%
All Other (Out of Area)	1,750	20.0%	2,152	20.0%
Total	**8,751**	**100%**	**10,762**	**100%**

Source: CN2511-040, Application, Page 33

- In Year One projections, the applicant projects that (67.4%) of the patient visits to the new Cleveland FSED will be residents of ZIP Code 37311 – Cleveland (36.5%), or 37323 – SE Cleveland (30.9%). Approximately (20%) of ED visits are project to originate from outside of the service area.
- The applicant details the projected utilization by acuity level of the Parkridge Cleveland FSED in the table below.

Projected Acuity Level at Cleveland FSED

Acuity Level	% of Total
CPT Code 99281 (non-urgent)	2.6%
CPT Code 99282 (less urgent)	6.6%
CPT Code 99283 (urgent)	52.6%
CPT Code 99284 (emergent)	28.9%
CPT Code 99285 (resuscitation)	9.1%
ER Critical Level – CPT 99291	0.1%
TOTAL	**100%**

Source: CN2511-040, Attachment 1N, Page 34

- The applicant's projected utilization for the Cleveland FSED reflects a majority utilization of acuity levels 99283 (Urgent), and 99284 (Emergent) with a combined percentage of (81.5%).

Note to Commission members: The Current Procedural Terminology (CPT) code range for Emergency Department Services 99281-99285 is a medical code set maintained by the American Medical Association. CPT® Code range 99281- 99285 represents New or Established Patient Emergency Department Services with 99281 representing least acute and 99285 representing most acute.

- To project utilization for the Cleveland FSED, the applicant applies historical ED use rates by age cohort to the projected population growth through 2030. This results in projected utilization among service area residents of 40,356 ED visits in 2028, 40,690 ED visits in 2029, and 41,025 ED visits in 2030.
- The applicant projects that between 17.3%-21.2% of these ED visits will be served at the proposed FSED from 2028 - 2030 resulting in 7,001 service area-based ED visits in Year 1 – 2028 and 8,609 visits in Year 2 – 2029. An additional 20% of total visits to the Cleveland FSED are projected to come from outside of the service area ZIP Codes.
- The applicant identifies its top five diagnosis types (10.7% of total patients) served through Parkridge affiliated emergency departments as: acute upper respiratory infections (unspecified), viral infections (unspecified), urinary tract infections (site not specified), other chest pain, and nausea with vomiting, (unspecified). The states that more than 5,100 principal diagnoses were treated overall.

CONSUMER ADVANTAGE ATTRIBUTED TO COMPETITION

The applicant identifies the following consumer benefits of this project:

- The introduction of an additional provider choice for emergency care in a county with only one emergency department will improve access, travel times (5-7 minute reductions), treatment capacity and turnaround times for residents of the service area closer to the proposed project.
- The quality of care represented by the applicant and its affiliates when compared to the existing emergency care provider is cited as supporting patient satisfaction and clinical outcomes for service area residents.
- The applicant cites its charity / indigent care policies as the most generous in the region. See Attachment 4N-1 for a copy of Uninsured Discount and Charity Write-Off Policies.

Charges
In Year One and Two of the proposed project, the average patient charges per visit for the proposed FSED are as follows:

	Projected Data Chart	
	Year 1 (2028)	**Year 2 (2029)**
Gross Charges	$6,398.58	$6,910.52
Deduction from Revenue	$5,671.92	$6,161.03
Average Net Charges	$726.66	$749.49

Source: CN2511-040, Application, Page 25

- The applicant's proposed average net charges per visit are projected to increase from $726 in Year 1 (2028) and $749 in Year 2 (2029). The applicants' proposed total charges are listed on Page 25.
- The applicant also states that the No Suprises Act limits emergency providers to billing patients the cost-sharing, deductibles, and out-of-pocket maximum that they would have paid if they had sought services through an in-network provider.

Average of Standard Gross Charges by CPT Codes (Current)

Facility	**99281**	**99282**	**99283**	**99284**	**99285**
Bradley Medical Center	$742	$1,142	$1,886	$2,513	$3,686
Parkridge Medical Center (Host Hospital)	$583	$795	$1,550	$1,695	$2,278

Source: CN2511-040, Application, Page 25
Hospital Chargemasters, 2025

- The host hospital's public chargemaster gross charges are lower than those listed by Bradley Medical Center for CPT Codes 99281- 99285.

Project Payor Mix
The applicant's projected payor mix for Year 1 (FY2028) total gross operating revenue of $55,994,000 is as follows:

	Percentage of Gross Operating Revenue (FSED Project Only)						
	Medicare	**Medicaid**	**Commercial**	**Self-Pay**	**Other**		**Charity Care**
Year 1	23.6%	25.4%	31.6%	13.5%	5.9%		10.4%

Source: CN2511-040, Application, Page 27.

- Medicaid (TennCare) and Self-Pay are projected to represent a combined (38.9%) of gross operating revenue for the project. The applicant projects Charity Care will be equivalent to approximately (10.4%) of Gross Operating Revenue in Year 1 (2028) of the project. Please refer to Item 10C. in the Consumer Advantage section on Page 27 of the application for additional Payor Mix information.
- The applicant is contracted with all TennCare Managed Care Organizations.

- The applicant states that it offers a prompt pay discount of 20% for patients paying estimated deductible and co-pays at the time of service.
- The applicant states that its charity care policy applies to patients on a sliding scale up to 400% of the federal poverty level. See Attachment 4N-1 for the applicant's Uninsured Discount, Charity Care Write-Off Policies and Discount Policy for Patients.
- The applicant states that in CY 2024, Parkridge Medical Center (overall system) wrote off $125 million in charity care and uninsured discounts.
- The table below represents payor sources for patients in service area ZIP Codes. It is included in Attachment 1N-Page 54.

Payor Mix for Service Area (Bradley and Polk County) and Host Hospital CY2024

Payor	37311 Cleveland		37323 SE Cleveland		37353 McDonald*		37362 Old Fort*		37307 Benton*		37361 Ocoee*		Total Service Area**	
	Total ED Patients	% of Total	Total ED Patients	% of Total	Total ED Patients	% 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	4,422	26.3%	4,049	28.3%	585	28.4%	451	24.5%	818	30.9%	253	32.6%	10,758	27.5%
TennCare/Medicaid	5,607	33.3%	4,027	28.1%	395	19.2%	486	26.4%	656	24.7%	168	21.6%	11,339	29.5%
Commercial	5,839	34.7%	5,593	39.1%	861	41.9%	720	39.1%	889	33.5%	265	34.1%	14,167	36.8%
Self-Pay	643	3.8%	380	2.7%	204	9.9%	182	9.9%	283	10.7%	89	11.5%	1,781	4.6%
Medically Indigent/Free	49	0.3%	31	0.2%	12	0.2%	3	0.2%	5	0.2%	1	0.1%	101	0.3%
Other	272	1.6%	242	1.7%	0	0.1%	1	0.1%	0	0.0%	0	0.0%	515	1.3%
Total	**16,832**	**100%**	**14,322**	**100%**	**2,057**	**100%**	**1,843**	**100%**	**2,651**	**100%**	**776**	**100%**	**38,481**	**100%**

Source: CN2511-040, Attachment 1N Page 54, TDH 2023 HDDS data request 35552215 for zip codes 37311 and 37323.
*Tennessee Hospital Association (THA) data. 37316 excluded from table due to low volume and sizing considerations.
**Total Service Area represents combined data from HDDS and all remaining THA data for service area ZIP Codes including 37316.

- Of the two primary ZIP Codes where patients are projected to reside, 37311 – Cleveland and 37323 – SE Cleveland, the latter has a lower historical percentage of TennCare patients, (28.1% vs. 33.3%), and a higher percentage of Commercial payor patients (39.1% vs. 34.7%).
- The westernmost Bradley County ZIP Code 37353 – McDonald has the highest percentage of Commercial patients (41.9%) and the lowest percentage of TennCare (19.2%).

Payor Mix for Host Hospital

Payor	Parkridge Medical Center (Host Hospital)	
	Total ED Patients	% of Total
Medicare/Medicare Advantage	17,419	29.6%
TennCare/Medicaid	13,043	22.2%
Commercial	19,333	32.9%
Self-Pay	6,118	10.4%
Medically Indigent/Free	2,901	4.9%
Other	0	0.0%
Total	**58,814**	**100%**

Source: CN2511-040, Attachment 1N Page 54, Applicant internal data

- The host hospital – Parkridge Medical Center reports a lower percentage of TennCare (22.2%), and higher percentages of Self-Pay (10.4%) and Medically Indigent / Free (4.9%) patients being served than the service area overall.

Agreements

- A list of healthcare providers with transfer agreements with the applicant is included in Attachments 1C-1, 1C-2, and 1C-3.
- A list of community partners is included in response to Attachment 1N, Criterion 18, pages 66-67.
- The applicant does not identify any affiliated urgent care or walk-in clinic locations in the proposed service area ZIP Codes. There are two non-affiliated facilities - MinuteClinic at CVS (37311) Fast Access Healthcare (37361) and Bradley/Polk Walk-In Clinic (37361).
- The applicant states that it refers patients in need of inpatient behavioral health services to Parkridge Health System facilities in the Chattanooga area include three behavioral health facilities with a total of 200 inpatient psychiatric beds. For patients requiring psychiatric consultation, referrals will be processed through the TriStar Health Behavioral Health Transfer Center and consultations are scheduled and managed using the InTouch tele-psychiatry virtual platform. Once medically cleared, patients requiring in-patient or follow-up behavioral health care can be transferred to any available bed in the region.

Staffing

The applicant's Year One proposed direct patient care staffing includes the following:

	Year One
Direct Patient Care Positions	21.9
Non-Patient Care Positions	4.0
Contractual Staff	4.2
Total	**30.1**

Source: CN2511-040, Application, Page 31

- Direct Care positions include the following: Nurses (15.2 FTEs); Radiology Techs (4.2 FTEs); Emergency Room Manager (1.0 FTE) Lab Supervisor (0.5 FTE); Ultrasonographer (0.5 FTE); and Pharmacist (0.5 FTE).
- Non-Patient Care positions include the following: Security (2.1 FTEs) and Environmental Services (1.9 FTEs).
- Contractual staff includes the following: Physicians (4.2 FTEs).
- The Medical Director for the FSED will be Daniel A. Poor, MD, FACEP who currently serves as the Regional Medical Director of the Parkridge Emergency Departments. See Attachment 5C-2 for Dr. Poor's CV and letter of support.

- The applicant's parent company, HCA Healthcare operates 183 FSEDs nationally. The FSED will be staffed by HCA-EmCare Holdings, LLC d/b/a Valesco Ventures.
- The applicant states it has access to a Nurse Residency Program which will allow it to meet staffing needs of the proposed facility.
- The applicant has included a list of its clinical training affiliations as Attachment 4C-1.
- The applicant states it will staff at least one Board-Certified Emergency Physician and RN at all times, 24/7/365 staffing with RN's.
- The applicant states that it will be able to staff the proposed hospital through Parkridge Medical Center's extensive network of affiliations.
- The applicant highlights its opening of the Galen College of Nursing in 2021 which operates campuses in Tennessee, Kentucky, Ohio, Virginia, South Carolina, Florida and Texas and is currently enrolling approximately 700 new students annually in either its Bachelor of Science in Nursing (BSN), Associate Degree of Nursing (ADN), Licensed Practical Nurse (LPN) to ADN Bridge Programs. The applicant states that approximately 55% of graduates have chosen to join an HCA affiliated hospital for employment.
- The applicant also highlights the recent opening of the Thomas F. Frist, Jr. College of Medicine at Belmont University in Nashville, which is a new medical school, whose first class commenced in Fall of 2024.
- Please refer to Item 8Q. on Page 31 of the application for additional details regarding project staffing.

QUALITY STANDARDS

The applicant commits to maintaining the following:

Licensure	Certification	Accreditation
Health Facilities Commission	Medicare/TennCare	The Joint Commission

Source: CN2511-040, Application, Page 29.

- The applicant maintains Licensure through the Tennessee Health Facilities Commission, Certification through Medicare and TennCare, and Accreditation through The Joint Commission (TJC). A full list of major accreditations and recognitions for Parkridge Medical Center are included in the Attachment 2Q-1.
- The host hospital maintains Joint Commission accreditation; accreditation as a TJC Chest Pain Center and Advanced Primary Stroke Center; Primary Heart Attack Center Certification by the American Heart Association; Zero Harms Award for CAUTI and CLABSI by the Tennessee Hospital Association; and Blue Distinction for knee and hip replacement and spine surgery from Blue Cross Blue Shield,

Commission on Cancer and American Association of Cardiovascular and Pulmonary Rehabilitation.

- The applicant has provided a copy of its Emergency Medical Treatment and Labor Act ("EMTALA") policy as Attachment 4C-2, a copy of its Plan for Improvement of Organizational Performance and Clinical Excellence as Attachment 5C-3 and a copy of its Staff Education Policies as Attachment 5C-4.
- All physicians working at the FSED will be required to have PALS (Pediatric Advanced Life Support) certification.
- See Item 5C, Pages 20-22 of the main application for the applicant's description of its clinical leadership, plan for improvement of organization performance and clinical excellence, and clinical staff training and requirements.

Application Comments
Application Comments may be filed by the Department of Health, Department of Mental Health, and Substance Abuse Services, and the Department of Disability and Aging. The following department(s) filed comments with the Commission and are attached:

☐ Department of Health
☐ Department of Mental Health and Substance Abuse Services
☐ Department of Disability and Aging
☒ **No comments were filed**

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

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:
There are no other Letters of Intent or for this applicant.

There are no other Letters of Intent on file for this applicant.

HCA Healthcare, Inc. has ownership interest in this proposed project and also in the following pending or outstanding applications or projects:

Denied Applications:

Project Name	**TriStar Hendersonville Medical Center – Gallatin Freestanding Emergency Department CN2305-012D**
Project Cost	$16,704,501
Denied Date	9/27/2023
Description	The establishment of a freestanding emergency department ("FSED") in the city of Gallatin in Sumner 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 a tract of vacant land that is approximately 2.3 acres in size and is located at the northeast corner of Harris Lane and Green Lea Boulevard in Gallatin (Sumner County), TN and being part of a larger parcel having Parcel ID Number 125 034.00 000. The service area includes ZIP Codes (37066, 30748, and 37075) within Hendersonville, Gallatin, and Cottontown TN in Sumner County. The applicant is owned by HCA Health Services of Tennessee, Inc.
Reasons for Denial	This project denied for failing to satisfy the need criteria.

Project Name	**TriStar Summit Medical Center, CN2511-040**
Project Cost	$18,060,545
Denied Date	September 24, 2025 (Simultaneous Review with CN2506-020 Sumner Regional Medical Center).
Description	The establishment of a freestanding emergency department ("FSED") in Lebanon, Tennessee, located on a portion of the property identified as Lot 3 of Parcel No. 095081-00215. The FSED will contain 11 exam rooms, including 1 trauma room, a lab, imaging department, a nurse station, and associated support spaces. The address of the project will be an approximate two and one-half (2.5) acre tract of unaddressed vacant land located near 125 Willard Hagan Drive, approximately 400 feet north of the intersection of Willard Hagan Drive and S. Hartman Drive, Lebanon, Wilson County, Tennessee, 37090. The service area is defined as Wilson County. The applicant is owned by HCA Health Services of Tennessee, Inc.
Reason for Denial	Did not satisfy the need standard.

Outstanding Applications:

Project Name	**TriStar Stonecrest Medical Center, CN2505-016A**
Project Cost	$18,885,948
Approval Date	September 24, 2025
Description	The establishment of a freestanding emergency department (FSED) located at 2490 S. Church Street, Murfreesboro, (Rutherford County), Tennessee 37127. The FSED will consist of approximately 11,500 square feet on 2.87 acres with 11 exam rooms, including 1 trauma room, lab, imaging department, nurse station, and associated support spaces. The service area is defined as zip codes 37037 (Christiana), 37127 (Murfreesboro), and 37128 (Murfreesboro), all in Rutherford County. TriStar StoneCrest Medical Center ("TriStar StoneCrest") is owned by HCA Health Services of Tennessee, Inc. The Applicant is ultimately owned by HCA Healthcare, Inc. through several wholly owned subsidiary corporations.
Project Status	This project was recently approved.
Expiration Date	November 1, 2028

Project Name	**TriStar Centennial Medical Center, CN2508-031**
Project Cost	$25,082,059
Approval Date	October 22, 2025
Description	To establish a 15-bed hospital-based inpatient rehabilitation unit on its campus, which will be operated and reimbursed as an Inpatient Rehabilitation Facility ("IRF"). The address of the project will be 2410 Patterson St., Nashville, Davidson, Tennessee, 37203. The service area is defined as Davidson, Cheatham, Dickson, Hickman, Marshall, Maury, Montgomery, Robertson, Rutherford, Sumner, Williamson, and Wilson. The applicant is owned by HCA Health Services of Tennessee, Inc.
Project Status	This project was recently approved.
Expiration	December 1, 2028

Project Name	**TriStar Clarksville Hospital, CN2505-018**
Project Cost	$286,048,000
Approval Date	July 23, 2025
Description	The establishment of a 69-bed full service acute care hospital located at an unaddressed site on Tiny Town Road, approximately 1,000 feet to the west of the intersection of Tiny Town Rd and Sandpiper Dr., Clarksville, (Montgomery County), Tennessee 37042. The project also seeks to initiate diagnostic and therapeutic cardiac catheterization services, magnetic resonance imaging services (MRI), and will include a Level II neonatal intensive care unit (NICU). The service area for the project includes Montgomery and Stewart Counties. The applicant is owned and will be operated by Clarksville Health Services, LLC, whose ultimate parent company is HCA Healthcare, Inc.
Project Status	Project Status Update August 2025 - TriStar Clarksville Hospital was approved by the HFC on July 23, 2025, to establish a 68-bed acute care hospital in Clarksville.
Expiration	September 1, 2028

Project Name	Lebanon Center for Outpatient Surgery, CN2504-013A
Project Cost	**$15,870,573**
Approval Date	June 25, 2025
Description	The establishment of a multi-specialty ambulatory surgical treatment center (ASTC) located at 125 Willard Hagan Drive, Lebanon (Wilson County), TN 37090. The ASTC will consist of approximately 17,350 square feet with two (2) operating rooms and one (1) procedure room. The surgical specialties to be offered at the ASTC will be General Surgery, ENT surgery, GI/Endoscopy, Orthopedic Surgery, Total Joint Replacement, Orthopedic Spine Surgery, Podiatry, and Pain Management Procedures. The facility will replace the existing TriStar Summit Hospital Outpatient Department. The service area is defined as Wilson County. The applicant will be wholly owned by Lebanon Surgicenter, LLC, whose ultimate parent is HCA Healthcare, Inc. Following approval of the CON, the physicians on the medical staff at LCOS will have the opportunity to collectively own up to 49% of Lebanon Surgicenter, LLC, not to exceed 5% ownership individually.
Project Status	Project Status Update – This project was recently approved.
Expiration	August 1, 2027

Project Name	TriStar Hendersonville White House Freestanding Emergency Department, CN2407-020A
Project Cost	**$17,832,032**
Approval Date	October 23, 2024
Description	The establishment of a freestanding emergency department (FSED) located at an unaddressed site on an approximate three (3) +/- acre tract of vacant land on the north side of TN-258/Raymond Hirsch Parkway, located approximately 650 +/- feet west of the intersection of Raymond Hirsch Parkway and Highway 31W, White House (Robertson County), Tennessee 37188. The service area is defined by the ZIP codes of White House (37188), Greenbrier (37073), Cross Plains (37049), and Cottontown (37048). Zip codes 37188 (White House), 37073 (Greenbrier), and 37049 (Cross Plains) are located primarily in Robertson County, and Cottontown (37048) primarily in Sumner County.
Project Status	Project Status Update May 2025 – Groundbreaking has occurred and the projected opening date is in 2026.
Expiration	December 1, 2027

Project Name	TriStar Spring Hill Hospital, CN2404-010A
Project Cost	**$250,000,000**
Approval Date	6/26/2024
Description	The establishment of a full-service acute care hospital with 68 licensed beds. The project also seeks to initiate diagnostic and therapeutic cardiac catheterization services, magnetic resonance imaging (MRI) services, and will include a Level II neonatal intensive care unit (NICU). The facility will encompass the existing TriStar Spring Hill Emergency Room. The address of the project will be 3001 Reserve Boulevard, Spring Hill (Maury County), Tennessee 37174. The proposed service area consists of three ZIP codes: 37174 (Spring Hill) in both Maury and Williamson Counties, 38401 (Columbia) in Maury County, and 37179 (Thompson's Station) in Williamson County. The applicant is owned by Spring Hill Hospital, Inc.
Project Status	Project Status Update May 2025: TriStar Spring Hill Hospital was approved for a CON for a new hospital on June 26, 2024. Vanderbilt University Medical Center and Williamson Medical Center commenced contested case proceedings on June 28, 2024. VUMC dismissed its opposition on April 24, 2025. Both VUMC and WMC dismissed their challenges in May 2025, and on May 14, 2025, the Administrative Procedures Divisions entered its Initial Order of Dismissal dismissing the challenge to the CON. Accordingly, TriStar Spring Hill Hospital is proceeding with the planning and development of this hospital.
Expiration	August 1, 2027

Project Name	**TriStar Southern Hills Medical Center – Nolensville Freestanding Emergency Department CN2304-010A**
Project Cost	$16,995,153
Approval Date	6/28/2023
Description	The establishment of a freestanding emergency department ("FSED") located at an unaddressed site on Ava Place near the intersection of Burkitt Place Drive and Nolensville Road, Nolensville (Williamson County), TN 37135. The entrances to the proposed FSED are expected to be accessible from Ava Place. The proposed project will be located on approximately 2.8 acres 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 service area includes the following ZIP Codes in Davidson County, Tennessee: 37013 and 37211, and the following ZIP Codes in Williamson County, Tennessee: 37135 and 37027. The applicant is owned by HCA Health Services of Tennessee, Inc.
Project Status	Project Status Update May 2025: TriStar Southern Hills Nolensville FSED was approved for a new FSED in Nolensville, Williamson County, Tennessee on June 28, 2023. Construction plans are in development, and construction is expected to begin in February 2025 with a October 2025 opening.
Expiration	August 1, 2026

Project Name	TriStar Skyline Medical Center – East Nashville Freestanding Emergency Department, CN2302-006A
Project Cost	**$20,876,000**
Approval Date	4/26/2023
Description	The establishment of a freestanding emergency department (FSED) in the East Nashville community in Metropolitan Nashville (Davidson County), Tennessee. The FSED will consist of approximately 11,900 square feet with 11 exam rooms including 1 trauma room, a lab, an imaging department, a nurse's station, and associated support spaces. The proposed project will be located on seven combined parcels located generally at the intersection of Dickerson Pike and Whites Creek Pike. Nashville, TN 37207 on approximately 1.32 acres. The proposed service area consists of four ZIP codes in Davidson County including: 37206, 37207, 37213, and 37216. The applicant is owned by is owned by HTI Memorial Corporation, whose ultimate parent company is HCA Healthcare, Inc.
Project Status	Project Status Update May 2025 - TriStar Skyline East Nashville FSED was approved on April 26, 2023. The CON has been issued and is valid through June 1, 2026. The project has been delayed by the inability to acquire the land for the project due to litigation between a tenant and the current owner. Relocation of the CON was approved March 25, 2025 and development of the new site is now underway.
Expiration	June 1, 2026

Project Name	Chattanooga East Surgicenter, LLC, CN2308-020A
Project Cost	**$23,203, 827**
Approval Date	10/25/2023
Description	This application is for the establishment of a multi-specialty ASTC in Hamilton County, Chattanooga Tennessee with 5 operating rooms and 4 procedure rooms. The ASTC will provide General Surgery, ENT, GYN Surgery, Orthopedic Surgery, Plastics, Podiatry, Urology, Spinal/Neurosurgery, GI/Endoscopy, and Pain Procedures. The address of the project will be 3745 Jenkins Road, Chattanooga (Hamilton County), Tennessee, 37421. The proposed service area consists of Bradley, Hamilton, and Marion Counties. The applicant is wholly owned by Surgicare of Chattanooga East, LLC, which is wholly owned by Medical Care America, LLC, whose ultimate parent company is HCA Healthcare, Inc. The applicant states that pending CON approval, (49%) of the applicant's parent company, Surgicare of Chattanooga East, LLC, will be owned by Erlanger Health Inc., and (49%) of the applicant entity, Chattanooga East Surgicenter, LLC, will be owned by local physician owners, while (51%) is to be owned by the parent company (HCA Healthcare, Inc.).
Project Status	Project Status Update May 2025: Chattanooga East Surgicenter was approved on October 25, 2023. It is currently in the development phase.
Expiration	December 1, 2025

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied applications, pending or outstanding Certificates of Need for other health care organizations proposing a related service type.

TPP
(1/21/2026) REVISED

CRITERIA AND STANDARDS

Freestanding Emergency Department (FSED) Standards and Criteria – Application Guide

As required, Parkridge Medical Center ("Parkridge" or "Parkridge Medical Center") 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 box is 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 the county 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 Need Standard.

The Project

The Project is a proposed freestanding emergency department ("FSED") known as Parkridge Cleveland FSED. It will be located at the northeast intersection of Blackburn Road SE, including the parcel addressed as 2375 Blackburn Road SE, and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74. This site is located in zip code 37311 on its east side, just 100 yards from zip code 37323. Both zip codes are associated with Cleveland, Tennessee.

The approximate 2-acre site fronts Blackburn Road SE on its west from which the public will access the FSED. The south side of the site is bordered by Appalachian Highway. Zip code 37323 is on the other side of Appalachian Highway. The north and west side of the sites are adjacent parcels owned by unrelated third parties.

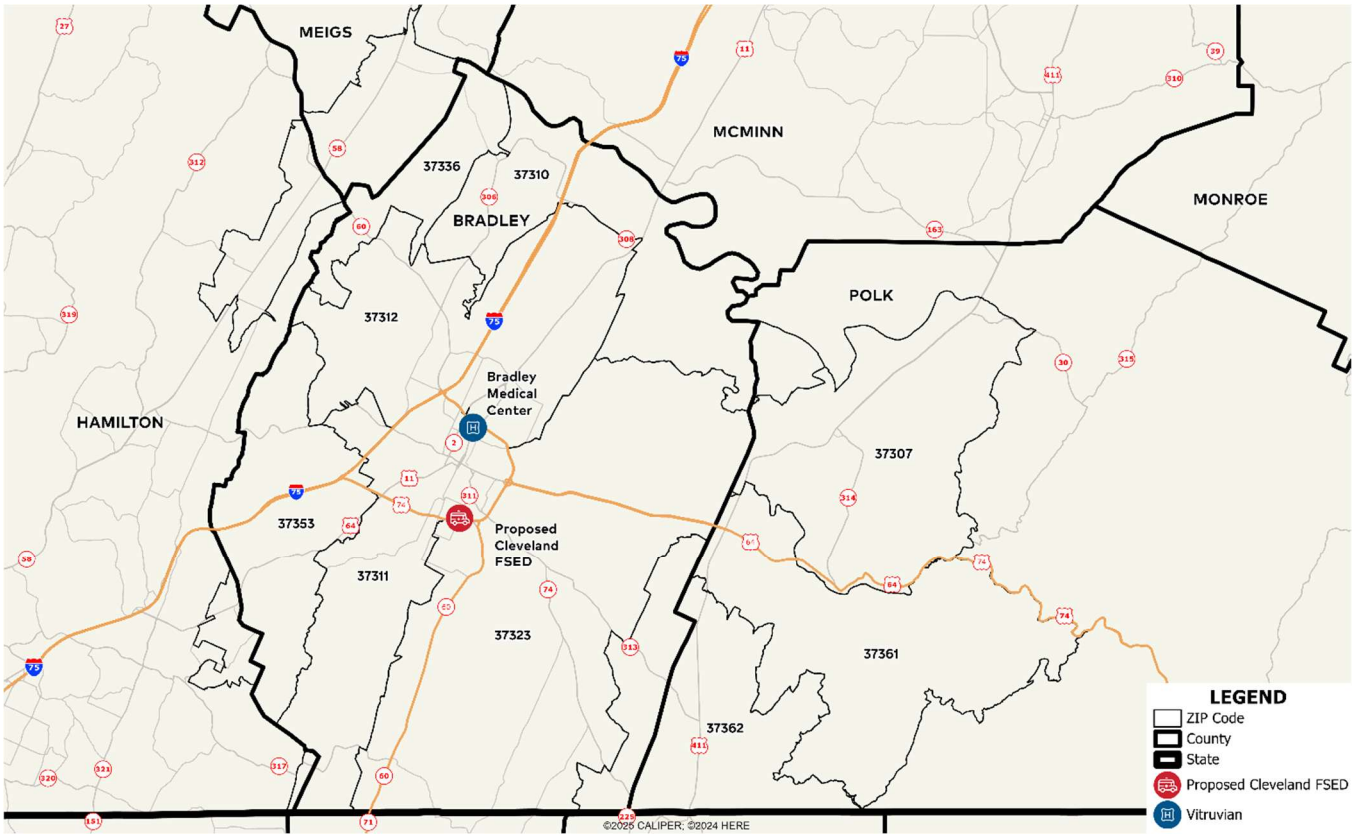
The Applicant, Parkridge Medical Center, operates its host hospital in Chattanooga, Hamilton County, approximately 28 travel miles from the proposed FSED. The proposed FSED will enhance access for southern Bradley and western Polk County residents by establishing a new ED access point, and, thus, (i) reducing geographic isolation, (ii) providing residents with choice, (iii) providing residents with an alternative model of care, (iv) offering enhanced quality care as to what is currently available, (v)

increasing the number of ED treatment rooms, (vi) improving travel times, (vii) shortening wait times, (viii) reducing the percentage of patients leaving without being seen, and (ix) improving CT results available for suspected stroke victims. The need for this project is multi-faceted and described in detail herein.

There are generally six populated zip codes assigned to Bradley County and two post office boxes.[1] Of the six populated zip codes, 37310 (Charleston) and 37312 (Cleveland) largely dominate the northern half of the county and are situated along Interstate 75. Bradley Medical Center ("BMC"), the only acute care hospital in Bradley County, is located in northern 37311, very near to 37312. Conversely, Polk County – with its 8 populated zip codes and 1 post office box, has no acute care hospital.

The zip codes that traverse the southern half of Bradley County include 37311 and 37323, both Cleveland zip codes, 37353 (McDonald) and 37362 (Old Fort). The proposed site is in the southern part of Bradley County along APD 40, US Route 64 Bypass and US Route 74, the primary east-west corridor in the community. The site is 5.4 miles from BMC along the normal travel route.[2]

Exhibit 1N-1
Site Location



The Service Area

To define the proposed service area for the Parkridge Cleveland FSED, the evaluation considered geographic distribution of zip codes within and outside Bradley County, location of the only emergency

[1] Zip code 37336 which is partially in northern Bradley County is assigned to Meigs County.
[2] The shorter route from the site to BMC is 3.8 miles along secondary roads and takes longer to travel than the normal route.

room in the county, roadway systems, travel distances and patient migration patterns. Polk County's proximity, geography and potential access was also considered as Polk County has no emergency room or hospital resources.

Based on this detailed analysis discussed throughout this CON Application, the service area is defined as the following zip codes:

- 37311 (Cleveland), the home zip code for the Parkridge Cleveland FSED covering central and southern Cleveland;
- 37323 (SE Cleveland), the zip code immediately to the east of the home zip code traversing southeast Cleveland;
- 37353 (McDonald), the zip code to the west of 37311 situated in the southwest of the county;
- 37362 (Old Fort), immediately to the east of 37323 and situated in southeast Bradley and southwest Polk County;
- 37307 (Benton) east of Cleveland in west Polk County; and
- 37361 (Ocoee) east of Cleveland in southwest Polk County.

Parkridge Cleveland FSED is an access enhancement to each of these six zip codes due to proximity for the residents of this defined service area.[3] This enhancement is not only based on the time required to access BMC but also the times required to access all other hospitals these patients are regularly utilizing for emergency services, including those in Hamilton County, McMinn County and out of state.

The proposed Parkridge Cleveland FSED is well positioned within the defined service area of 37311 (Cleveland), 37323 (SE Cleveland), 37353 (McDonald), 37362 (Old Fort), 37307 (Benton) and 37361 (Ocoee). The service area encompasses southern Bradley and western Polk with the first three zip codes located within the Bradley County limits. The fourth zip code, 37362 (Old Fort), is split between Bradley County and Polk County. The last two zip codes, 37307 (Benton) and 37361 (Ocoee) are located in western Polk County.

Of particular note, Polk County is geographically unique and has no emergency room facilities – requiring all Polk County residents to leave their home county to access an emergency room. It is largely a rural county, with Cherokee National Forest covering 80 percent of its land area. Areas to the west of the Cherokee National Forest include Old Fort, Ocoee, Benton and Conasauga.[4] Delano and Reliance extend to the north of Cherokee National Forest, and areas to the east of the Cherokee National Forest, include Farner, Turtletown, Ducktown and Copperhill.

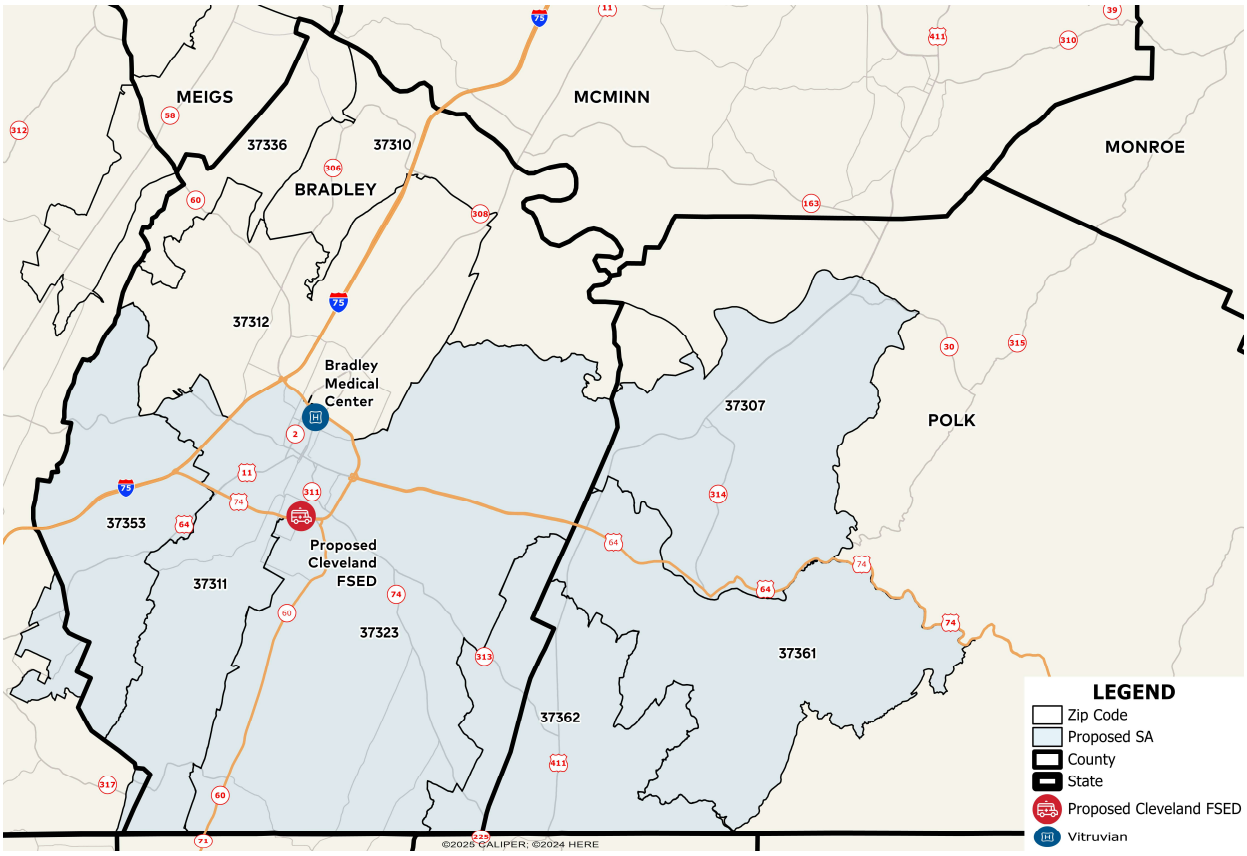
Those in the east side of Polk County primarily access ER services out-of-state, with just 15 or so percent traveling to BMC and others to McMinn County hospitals. The McMinn County hospitals treat the largest share of Delano and Reliance residents.

Conversely, those in western Polk County and proximate to Bradley County generally access commercial resources (retail, healthcare, etc.) in either Bradley County or further west in Hamilton County. US Route 64 is the primary route leading from west Polk County into Bradley County. The proposed Cleveland FSED site is located on this primary route; therefore, the implementation of Parkridge Cleveland FSED will enhance access for western Polk County residents, with Old Fort, Benton and Ocoee being included in the service area and other towns in Polk County included in the 20 percent out-of-service-area patient draw.

[3] A seventh zip code when appropriate is referenced herein, 37316 (Conasauga); it is a postal box with no population although it accounts for some emergency room visits.
[4] Geographically, Conasauga is located within zip code 37362, although it is assigned zip code 37316; 37316 is designated by the postal service as a PO Box with no population.

The defined service area is highlighted in **Exhibit 1N-2** below.

Exhibit 1N-2
Service Area Map



The proposed FSED is located at the intersection of Blackburn Road Southeast and Appalachian Highway. This latter roadway is also known as APD 40, US Route 64 Bypass and US Route 74. Route 64 travels east through zip code 37323 (SE Cleveland); and Route 74 travels west through 37323 (SE Cleveland), 37311 (Cleveland) and 37353 (McDonald), accessing Interstate 75 to the west of the proposed FSED site. Route 60, which also connects to these routes, travels south along the 37311 (Cleveland) and 37323 (SE Cleveland) border. Additionally, US Route 64 extends into and throughout Polk County, being the primary access road for western Polk County residents to access Bradley County resources (shopping, healthcare, etc.) and such resources further west in Hamilton County. This location is optimally situated to enhance access to southern Bradley County and western Polk County residents residing in the service area zip codes.

In emergency care where timeliness of care can determine medical outcomes, the proposed FSED not only saves time to treatment but also eliminates the need for patients to travel further north to BMC or further west into Hamilton County, which experiences significant and increasing migration from Bradley County.

Parkridge's objectives in this project are to improve the quality of care available in Bradley County, offer residents a choice of providers, and 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. Both lack of available quality care and geographic isolation

are confirmed by community members who have expressed frustration with their current lack of nearby options.

The Applicant

The Applicant is Parkridge Medical Center, a 275-bed acute care hospital located at 2333 McCallie Avenue, Chattanooga, Hamilton County, Tennessee. Parkridge Medical Center has been serving Hamilton, Bradley and adjacent rural counties since 1971 and has continued to evolve to meet the needs of its community. The hospital's numerous accreditations and distinctions include: accreditation by The Joint Commission; accreditation as a Chest Pain Center; Advanced Primary Stroke Center; Primary Heart Attack Center Certification by the American Heart Association; Zero Harms Award for CAUTI and CLABSI by the Tennessee Hospital Association; and Blue Distinction for knee and hip replacement, and spine surgery. Its key services include: comprehensive heart care including heart failure treatment, arrhythmia services, and heart/vascular surgery; critical care; emergency; gastroenterology; gynecology; joint replacement; sports medicine; orthopedics; oncology; rehabilitation; pulmonology; radiation oncology; trauma; and urology. Surgical services span general surgery, colorectal, gynecologic, neurosurgery, vascular, spine, minimally invasive and robot-assisted surgery. Its cancer treatment services are affiliated with the nationally recognized Sarah Cannon Cancer Institute.

Parkridge Medical Center is part of Parkridge Health System. Parkridge Health System includes 5 hospitals, 6 emergency rooms, 4 imaging centers, 12 physician offices with 63 specialty care providers and approximately 2,300 associates. It is regularly recognized for its outstanding quality; please see **Question 1N Criterion 22** below for a listing of Parkridge's quality achievements. In addition to the key services of Parkridge Medical Center listed above, Parkridge Health System also provides gynecology, obstetrics, Level III NICU, and behavioral health services for adults, adolescents, and children. The referenced hospitals and emergencies rooms include the following:

- Parkridge Medical Center, includes an emergency room
- Parkridge Medical Center East, includes an emergency room
- Parkridge Valley Adult and Adolescent Hospital, includes an emergency room known as Parkridge North
- Parkridge Valley Child Residential Hospital
- Soddy Daisy FSED, operates under the Parkridge Medical Center license
- Camp Jordan FSED, operates under the Parkridge East license
- Parkridge Medical Center West, includes an emergency room (Marion County)

The closest facility identified above to the proposed Cleveland FSED is Parkridge Valley Adult and Adolescent Hospital and its Parkridge North emergency room. These facilities are 22 minutes and 18 drive miles, respectively, from the proposed Cleveland FSED. For those Bradley County patients accessing this hospital as well as Parkridge Medical Center, the new FSED will minimize travel time and enhance access, offering significant relief – the ability to receive care closer to home, eliminating the need for travel out of the county. This convenience is a key factor in improving patient experience and reducing stress during emergencies, providing peace of mind and a sense of reassurance in times of need.

Need for the Proposed Parkridge Cleveland FSED

As will be demonstrated throughout this CON Application, the need for the proposed Parkridge Cleveland FSED is demonstrated by a series of planning metrics. These include:

- Relieving geographic isolation and enhancing access as each of the service area zip codes are closer to the proposed FSED, an improvement of 5 to 7 minutes depending on the zip code and,

importantly, largely reducing access to 12 minutes or less for the majority of service area residents; time to access from zip codes in Polk County will remain above 15 minutes but will improve by 2 to 5 minutes.

- Reducing out-migration which approximates 35 percent of service area patients accessing emergency services outside the county at, involving significant time and travel distances;
- Providing residents of the service area an alternative model for emergency services delivery, which are currently unavailable in Bradley or Polk County;
- Ensuring ED services are more readily available to the 65 and older population, which is expected to represent more than 20 percent of the service area's population by 2030;
- Offering consumers with a choice in emergency care providers;
- Improving the quality of ED services available in the service area and Bradley County and western Polk County;
- Delivering quality ED services to its patients, with shorter wait times and lower rates of people left without treatment ("LWOT"), closer to where they live; and
- Addressing the ED treatment needs of this underserved population through increased availability and improved accessibility to ED services.

Overview of the Area

The Parkridge Cleveland FSED service area comprises the four zip codes situated in the southern half of Bradley County and the two zip codes in western Polk County. These zip codes include the two southern Cleveland zip codes of 37311 and 37323, 37353 (McDonald), 37362 (Old Fort), 37307 (Benton) and 37361 (Ocoee).

Three of the zip codes are wholly located within Bradley County. The fourth zip code (37362), while assigned to Bradley County, traverses into Polk County, the southeasternmost county in the State. The last two zip codes (37307 (Benton) and 37361 (Ocoee) are fully contained within western Polk County. To the south of both counties is the Georgia state line.

Bradley County's current population is 113,913 and is forecasted to exceed 118,500 people in the next five years – an approximate increase of 4 percent. Notably, Bradley County's elderly population is expected to increase nearly 10 percent in the next five years. Because the elderly are the largest utilizers of healthcare services, their population growth is expected to have an outsized impact on demand. Bradley County population by age cohort is shown in **Exhibit 1N-3.**

Exhibit 1N-3
Bradley County Population by Age Cohort

	Population Count			Population Distribution			Population % Change	
Bradley	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	23,649	24,344	25,219	21.7%	21.4%	21.3%	2.9%	3.6%
18 to 44	37,300	38,934	40,200	34.2%	34.2%	33.9%	4.4%	3.3%
45 to 64	28,789	29,470	29,887	26.4%	25.9%	25.2%	2.4%	1.4%
65 to 74	11,155	12,151	12,987	10.2%	10.7%	11.0%	8.9%	6.9%
75 to 84	6,182	6,841	7,624	5.7%	6.0%	6.4%	10.7%	11.4%
85+	1,996	2,173	2,638	1.8%	1.9%	2.2%	8.9%	21.4%
Total	109,071	113,913	118,555	100.0%	100.0%	100.0%	4.4%	4.1%
65+	19,333	21,165	23,249	17.7%	18.6%	19.6%	9.5%	9.8%

Source: Tennessee Boyd Center, TN_2022 Projection

Western Polk County is included in the service area based on travel patterns of this population, healthcare access and that it is an acute and emergency care desert. Indeed, the only hospital in Polk County (Copper Basin Medical Center) closed in 2017. Accordingly, all its residents must out-migrate for emergency and other hospital services. As discussed above, western Polk County communities of

Benton, Ocoee and Conasauga with access via US Route 64 are included in the service area. Other portions of Polk County as well as other areas are expected to comprise a portion of the out-of-service-area patients being treated. **Exhibit 1N-4** provides Polk County population by age cohort.

Exhibit 1N-4
Polk County Population by Age Cohort

	Population Count			Population Distribution			Population % Change	
Polk	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	3,178	3,330	3,320	18.9%	18.3%	17.8%	4.8%	-0.3%
18 to 44	4,987	5,392	5,428	29.6%	29.6%	29.2%	8.1%	0.7%
45 to 64	5,033	5,434	5,404	29.9%	29.8%	29.0%	8.0%	-0.6%
65 to 74	2,124	2,377	2,540	12.6%	13.0%	13.7%	11.9%	6.9%
75 to 84	1,144	1,307	1,446	6.8%	7.2%	7.8%	14.2%	10.6%
85+	369	404	467	2.2%	2.2%	2.5%	9.5%	15.6%
Total	16,835	18,244	18,605	100.0%	100.0%	100.0%	8.4%	2.0%
65+	3,637	4,088	4,453	21.6%	22.4%	23.9%	12.4%	8.9%

Source: Tennessee Boyd Center, TN_2022 Projection

With respect to the service area, today the four Bradley zip codes comprise 63 percent of the Bradley County population and the two Polk zip codes comprise 40 percent of Polk County population. The service area population was 76,557 in 2020 and increased to 79,177 in 2025, representing a 3.4 percent increase. It is forecasted to increase an additional 3.2 percent to 81,743 by 2030. In total, from 2020 through 2030, the service area is projected to increase more than 6.7 percent. **Exhibit 1N-5** provides the service area population total and 65+ by zip code and service area total.

Exhibit 1N-5

Population Distribution by Service Area Zip Code						
Total Population	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**
37311 Cleveland	29,762	30,345	31,162	38.9%	38.3%	38.1%
37323 SE Cleveland	31,238	32,595	33,715	40.8%	41.2%	41.2%
37353 McDonald	5,052	5,278	5,470	6.6%	6.7%	6.7%
37362 Old Fort	3,757	3,921	4,069	4.9%	5.0%	5.0%
37307 Benton	5,082	5,238	5,400	6.6%	6.6%	6.6%
37361 Ocoee	1,666	1,800	1,927	2.2%	2.3%	2.4%
Service Area Total	76,557	79,177	81,743	100.0%	100.0%	100.0%
65+ Population	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**
37311 Cleveland	4,217	4,760	5,470	33.3%	33.5%	32.7%
37323 SE Cleveland	5,407	6,052	7,159	42.7%	42.6%	42.9%
37353 McDonald	1,026	1,181	1,398	8.1%	8.3%	8.4%
37362 Old Fort	658	741	914	5.2%	5.2%	5.5%
37307 Benton	1,013	1,088	1,283	8.0%	7.7%	7.7%
37361 Ocoee	350	388	482	2.8%	2.7%	2.9%
Service Area Total	12,671	14,210	16,706	100.0%	100.0%	100.0%

Source: Claritas

Overall, the 65+ population in Bradley County has increased from 16.6 percent to 17.7 percent and is expected to grow disproportionately to more than 20 percent by 2030. **Exhibit 1N-6** provides the service area population by age cohort and zip code.

Exhibit 1N-6
Service Area Population by Age Cohort, 2020 to 2030

	Population by Zip Code			Population Distribution By Zip Code			Population % Change	
37311 Cleveland	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	6,449	6,397	6,398	21.7%	21.1%	20.5%	-0.8%	0.0%
18-44	12,274	12,143	12,211	41.2%	40.0%	39.2%	-1.1%	0.6%
45-64	6,822	7,045	7,083	22.9%	23.2%	22.7%	3.3%	0.5%
65-74	2,531	2,835	3,021	8.5%	9.3%	9.7%	12.0%	6.6%
75-84	1,244	1,463	1,883	4.2%	4.8%	6.0%	17.6%	28.7%
85+	442	462	566	1.5%	1.5%	1.8%	4.5%	22.5%
Total	29,762	30,345	31,162	100.0%	100.0%	100.0%	2.0%	2.7%
65+	4,217	4,760	5,470	14.2%	15.7%	17.6%	12.9%	14.9%
37323 SE Cleveland	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	7,033	6,968	7,023	22.5%	21.4%	20.8%	-0.9%	0.8%
18-44	10,169	10,689	10,987	32.6%	32.8%	32.6%	5.1%	2.8%
45-64	8,629	8,886	8,546	27.6%	27.3%	25.3%	3.0%	-3.8%
65-74	3,352	3,577	4,038	10.7%	11.0%	12.0%	6.7%	12.9%
75-84	1,633	1,986	2,450	5.2%	6.1%	7.3%	21.6%	23.4%
85+	422	489	671	1.4%	1.5%	2.0%	15.9%	37.2%
Total	31,238	32,595	33,715	100.0%	100.0%	100.0%	4.3%	3.4%
65+	5,407	6,052	7,159	17.3%	18.6%	21.2%	11.9%	18.3%
37353 McDonald	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	1,037	951	911	20.5%	18.0%	16.7%	-8.3%	-4.2%
18-44	1,461	1,583	1,677	28.9%	30.0%	30.7%	8.4%	5.9%
45-64	1,528	1,563	1,484	30.2%	29.6%	27.1%	2.3%	-5.1%
65-74	609	681	767	12.1%	12.9%	14.0%	11.8%	12.6%
75-84	339	404	511	6.7%	7.7%	9.3%	19.2%	26.5%
85+	78	96	120	1.5%	1.8%	2.2%	23.1%	25.0%
Total	5,052	5,278	5,470	100.0%	100.0%	100.0%	4.5%	3.6%
65+	1,026	1,181	1,398	20.3%	22.4%	25.6%	15.1%	18.4%
37362 Old Fort	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	782	791	809	20.8%	20.2%	19.9%	1.2%	2.3%
18-44	1,153	1,214	1,239	30.7%	31.0%	30.4%	5.3%	2.1%
45-64	1,164	1,175	1,107	31.0%	30.0%	27.2%	0.9%	-5.8%
65-74	427	447	528	11.4%	11.4%	13.0%	4.7%	18.1%
75-84	191	238	313	5.1%	6.1%	7.7%	24.6%	31.5%
85+	40	56	73	1.1%	1.4%	1.8%	40.0%	30.4%
Total	3,757	3,921	4,069	100.0%	100.0%	100.0%	4.4%	3.8%
65+	658	741	914	17.5%	18.9%	22.5%	12.6%	23.3%
37307 Benton	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	994	1,017	1,018	26.5%	25.9%	25.0%	2.3%	0.1%
18-44	1,542	1,590	1,678	41.0%	40.6%	41.2%	3.1%	5.5%
45-64	1,533	1,543	1,421	40.8%	39.4%	34.9%	0.7%	-7.9%
65-74	640	637	711	17.0%	16.2%	17.5%	-0.5%	11.6%
75-84	304	365	460	8.1%	9.3%	11.3%	20.1%	26.0%
85+	69	86	112	1.8%	2.2%	2.8%	24.6%	30.2%
Total	5,082	5,238	5,400	135.3%	133.6%	132.7%	3.1%	3.1%
65+	1,013	1,088	1,283	27.0%	27.7%	31.5%	7.4%	17.9%
37361 Ocoee	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	329	347	348	8.8%	8.8%	8.6%	5.5%	0.3%
18-44	520	576	610	13.8%	14.7%	15.0%	10.8%	5.9%
45-64	467	489	487	12.4%	12.5%	12.0%	4.7%	-0.4%
65-74	225	226	269	6.0%	5.8%	6.6%	0.4%	19.0%
75-84	92	121	165	2.4%	3.1%	4.1%	31.5%	36.4%
85+	33	41	48	0.9%	1.0%	1.2%	24.2%	17.1%
Total	1,666	1,800	1,927	44.3%	45.9%	47.4%	8.0%	7.1%
65+	350	388	482	9.3%	9.9%	11.8%	10.9%	24.2%
Service Area Total	**2020**	**2025**	**2030**	**2020**	**2025**	**2030**	**2020-2025**	**2025-2030**
<18	16,624	16,471	16,507	21.7%	20.8%	20.2%	-0.9%	0.2%
18-44	27,119	27,795	28,402	35.4%	35.1%	34.7%	2.5%	2.2%
45-64	20,143	20,701	20,128	26.3%	26.1%	24.6%	2.8%	-2.8%
65-74	7,784	8,403	9,334	10.2%	10.6%	11.4%	8.0%	11.1%
75-84	3,803	4,577	5,782	5.0%	5.8%	7.1%	20.4%	26.3%
85+	1,084	1,230	1,590	1.4%	1.6%	1.9%	13.5%	29.3%
Total	76,557	79,177	81,743	100.0%	100.0%	100.0%	3.4%	3.2%
65+	12,671	14,210	16,706	16.6%	17.9%	20.4%	12.1%	17.6%

Source: Claritas.

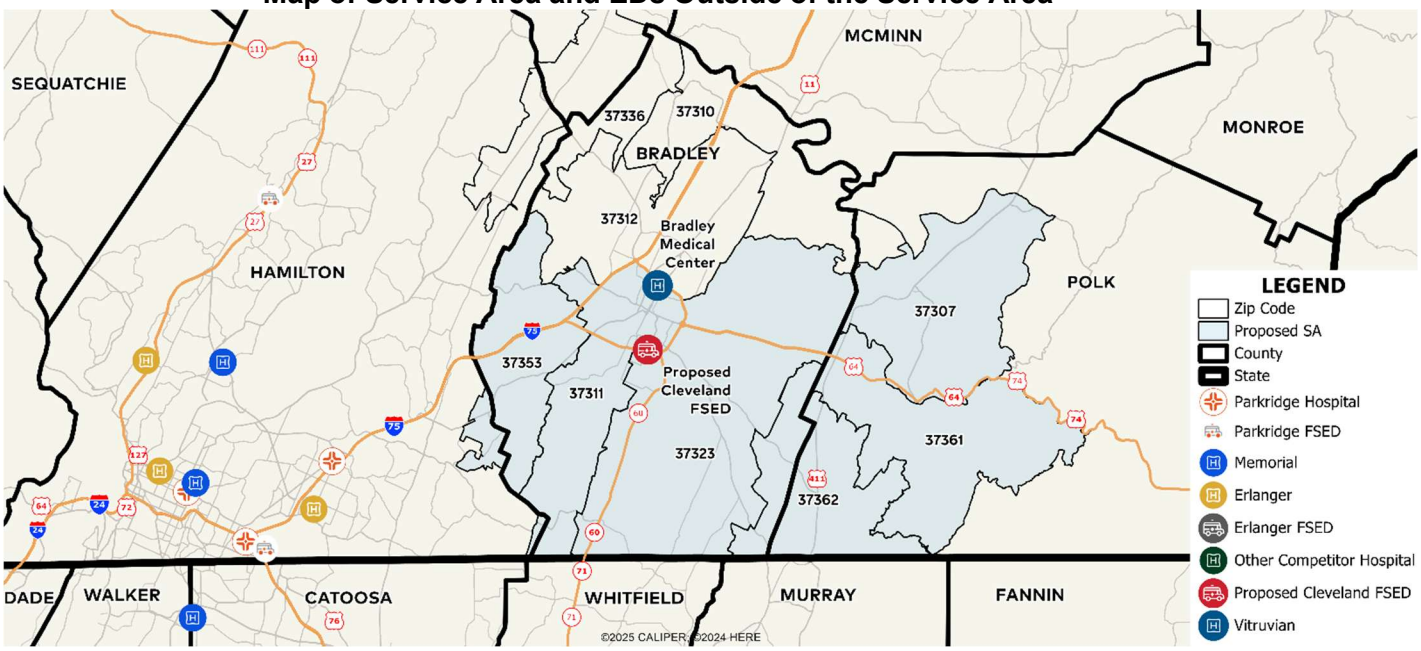
Reflected above, the individual zip codes increased between 2 and 8 percent in the most recent five years while the 65+ increased between 7.4 and 15.1 percent. During the next five years, the service area is expected to increase an additional 3.2 percent while 65+ will increase by 17.6 percent.

This growth and aging of the service area population will result in increased demand for healthcare services including emergency services, in part, because studies show that ED use rates increase with age.[5] In addition to published studies documenting that ED use rates increase as the population ages, analysis of use rates at the zip code level within the service area further confirms this. This information is provided in response to **Question 6N**.

The proposed Cleveland FSED will expand access for service area residents, including the elderly, upon its implementation. Given the forecasted continued growth of the service area, particularly the elderly, establishing the proposed FSED will decrease the distance and travel time service area residents must travel for emergency care.

Exhibit 1N-7 below presents a map that provides orientation to the one ED within the service area (BMC) and EDs outside of the service area to which approximately 35 percent of service area residents travel.

Exhibit 1N-7
Map of Service Area and EDs Outside of the Service Area



In the service area, BMC operates the sole emergency room. While reporting 41 ER treatment rooms in its 2024 JARs, it is unknown if all rooms are operational given its ER visit volume and the level of out-migration from the county. All other emergency rooms accessed by Bradley and Polk County residents are either outside Bradley County, with the closest to Cleveland being the Parkridge North ER, accessible via Interstate 75 as shown in the above **Exhibit 1N-7**, and for many, outside the state.

[5] 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.

With respect to available emergency rooms in Bradley County and the adjoining counties, Bradley County has the lowest number of emergency rooms per capita among all counties with an emergency room in southeast Tennessee. With nearly 114,000 people and one emergency room, its rate of ERs per 100,000 population is 0.88. This compares unfavorably to the statewide average of 1.74 emergency rooms per 100,000 population and is materially less than adjoining Hamilton County which operates 2.59 emergency rooms per 100,000. **Exhibit 1N-8** provides the comparative rates for Bradley County, Hamilton County and the other adjoining counties with emergency rooms.

Exhibit 1N-8
Emergency Rooms per 100,000 Population

County/State	Emergency Rooms	2025 Population	ERs/100,000 Population
Bradley	1	113,913	0.88
Hamilton	10	385,843	2.59
Rhea	1	33,948	2.95
Marion	1	29,265	3.42
McMinn	2	55,752	3.59
Bledsoe	2	15,248	13.12
Tennessee	*126*	*7,242,733*	*1.74*
Bradley With Parkridge Cleveland FSED	*2*	*113,913*	*1.76*

Notably, with the approval and implementation of the Parkridge Cleveland FSED, Bradley County's rate will increase to 1.76 ERs per 100,000 population, approximately the statewide average but still below any of the surrounding counties.

In terms of access to the proposed Parkridge Cleveland FSED, each of the service area zip codes are closer to the proposed location than to BMC. In fact, travel time from each zip code requires more than 15 minutes to access BMC. The time to reach Parkridge Cleveland FSED improves by between 5 and 7 minutes for Bradley service area zip codes, with three of the zip codes having travel times between 9 and 12 minutes, as opposed to times longer than 15 minutes. For the Polk service area zip codes, time improves by 2 to 5 minutes although it still remains greater than 15 minutes.

As required by the FSED Guide, **Exhibit 1N-9** below reflects the travel distance (miles) and travel time (minutes) to the center of each zip code in the service area from BMC and the proposed Parkridge Cleveland FSED. Travel time (minutes) is the most important consideration when considering geographic isolation.

Exhibit 1N-9

From Zip Code Centroid to BMC			
Service Area	**Time (Minutes)**	**Distance (Miles)**	**Location**
Bradley Portion			
SE Cleveland - 37323	17	9.8	South
Cleveland - 37311	16	8.1	South
McDonald - 37353	17	9.9	Southwest
Old Fort - 37362	22	14.4	Southeast
Polk Portion			
Benton - 37307	26	17.9	East
Conasauga - 37316	26	17.2	Southeast
Ocoee - 37361	32	18.8	East
From Zip Code Centroid to Parkridge Cleveland FSED			
Service Area	**Time (Minutes)**	**Distance (Miles)**	**Location**
Bradley Portion			
SE Cleveland - 37323	12	6.7	South
Cleveland - 37311	9	5.2	South
McDonald - 37353	12	8.0	Southwest
Old Fort - 37362	17	11.2	Southeast
Polk Portion			
Benton - 37307	24	17.9	East
Conasauga - 37316	21	14.2	Southeast
Ocoee - 37361	29	18.6	East

Difference in Time and Distance - "+" is Closer; "-" is Further			
Service Area	**Time (Minutes)**	**Distance (Miles)**	**Location**
Bradley Portion			
SE Cleveland - 37323	5	3.1	South
Cleveland - 37311	7	2.9	South
McDonald - 37353	5	1.9	Southwest
Old Fort - 37362	5	3.2	Southeast
Polk Portion			
Benton - 37307	2	0.0	East
Conasauga - 37316	5	3.0	Southeast
Ocoee - 37361	3	0.2	East

Source: Googlemaps. A plus sign indicates closer in time or distance to BMC; none of these zip codes have a "+" sign. The "-" sign indicates it is a shorter distance or time to the Parkridge Cleveland FSED of which each zip code in the service area is.

The State Health Plan Standards and Criteria for Freestanding Emergency Departments ("FSED Criteria and Standards") does not define "geographic isolation." It is up to the Applicant to determine what constitutes an isolated area or region. Parkridge Medical Center asserts that service area residents are geographically isolated because there is a significant population base of more than 70,000 residents in this area, which is growing and aging, without access to emergency services within a 15-minute drive.

The closest provider is located between 16 and 22 minutes away from Bradley service area residents, and 26 to 32 minutes for Polk service area residents. With the continued growth and aging of the population, residents need access to an emergency care provider in the service area. Moreover, residents have no choice in provider with BMC being the only emergency provider; accordingly, approximately 35 percent of the service area residents currently opt to travel outside the county.

When it comes to life-threatening conditions such as heart attacks or strokes, time is of the essence, and every minute counts. There is a common saying related to strokes that "Time is Brain." Similarly, there is a common saying related to cardiac events that “Time is Muscle.” The sooner a patient gets medical attention, the better their chances of surviving, recovery, and regaining their quality of life. As the population continues to increase in the area, patients can miss the “golden hour” for life-saving and disability preventing treatment, such as thrombolytics and other medications that can limit the damage done by a stroke or heart attack even when transported by EMS. 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, in 2024, Parkridge and its TriStar Division Satellite EDs cared for the following patients with common time-sensitive conditions:

Condition	Clinical Outcomes	# of Patients in Satellite EDs
Cardiac Arrest	Survival Rates:	134
	22% at 0 Minutes	
	8% at 10 Minutes	
	3% at 20 Minutes	
Stroke	1.9 million neurons die every	161
	minute a stroke goes untreated	
Sepsis	1-year mortality risk increases	1,012
	10% every hours delay in	
	antibiotic administration	

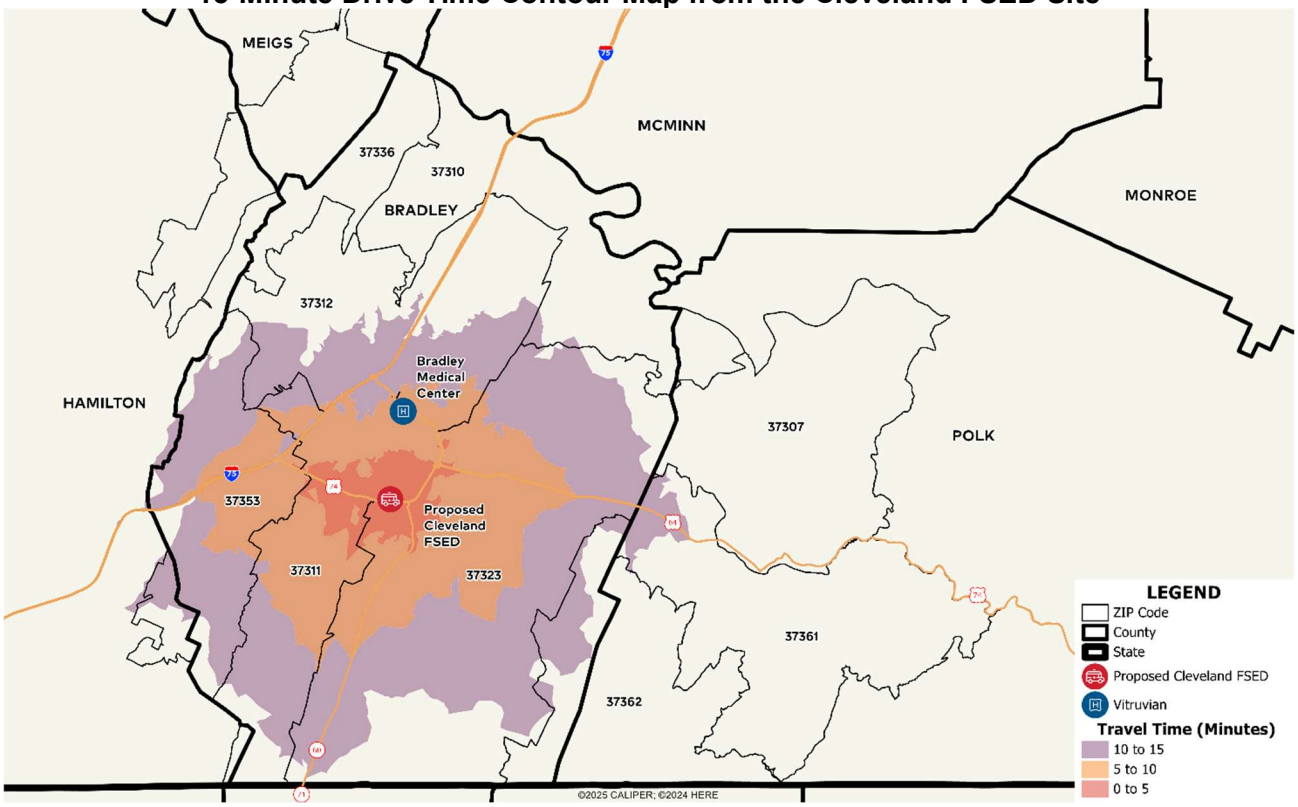
As confirmed in the above chart[6], the sooner a patient gets medical attention, the better their chances of surviving, recovery, and regaining their quality of life. This proposed FSED will offer a vital access point to emergency care for residents of the service area in an easily accessible location and with improved quality.

To address this geographic isolation and quality concerns, Parkridge proposes to develop its Parkridge Cleveland FSED at the northeast intersection of Blackburn Rd Southeast and Appalachian Highway near to the border of zip code 37311 (Cleveland) and 37323 (SE Cleveland). **Exhibit 1N-10** presents a 15-minute drive time contour map from the proposed Cleveland FSED site. This drive time is without traffic, indicating that heavy traffic, congestion and other road incidents will reduce the contour. As

[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

shown in the map, portions of 37311 (Cleveland) and 37323 (SE Cleveland) are within five minutes, larger portions of those two zip codes and 37353 (McDonald) are within 10 minutes, and the majority of 37353 (McDonald) (37311(Cleveland) and 37323 (SE Cleveland) are within 15 minutes. While most of 37362 is outside this 15-minute contour, it takes 22 minutes, or 5 minutes longer, for those service area residents to access BMC versus the proposed Parkridge Cleveland FSED.[7] This further demonstrates the proposed FSED will enhance emergency room access for service area residents. It will also be the closest emergency room to western Polk County residents who have no emergency services in their county.

Exhibit 1N-10
15-Minute Drive Time Contour Map from the Cleveland FSED Site



While the FSED Criteria and Standards do not provide a recommended drive time, Parkridge Medical Center believes a 15-minute drive time is appropriate given studies that show that patients drive an average of 8 miles and 17.3 minutes to access ED services.[8] As such, if a patient's drive times to an ED exceeds these distances and times, that indicates the patient's barriers to accessing care exceed the average. While not every town, zip code or service area can support a FSED, Parkridge believes that the data and analysis included in this CON Application present compelling evidence that this service area is in need of additional emergency room services from both geographic and quality (discussed next) perspectives and that a FSED can be supported by the service area population.

Additionally, to assure prompt transfers of patients needing higher acuity of care, Parkridge Medical Center will work with Bradley County EMS and Parkridge's third party ambulance company, Puckett Emergency Medical Services, to ensure timely transfers with minimal burden to EMS.

[7] Additionally, the western Polk service area zip codes are also outside the 15-minute contour; yet these residents have improved travel times to emergency care of 2 to 5 minutes.
[8] Tolpadi, A., Elliott, M.N., Waxman, D. et al., National travel distances for emergency care. BMC Health Serv Res 22, 388 (2022). https://doi.org/10.1186/s12913-022-07743-7.

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.

Not Applicable.

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.

Not Applicable.

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 be in 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 is defined as including all of any county included in a ZIP Code area.

The Applicant is applying under a Low Quality of Care at Existing Emergency Department in the Service Area criteria. Per the instructions above, for the purposes of this analysis, service area is defined as Bradley County and Polk County as it includes the designated service area zip codes. Residents of the service area lack timely access to quality emergency care. The only ED in the service area operates in the lower quartile of CMS metrics. The other hospitals outside the service area are outside the county and take significantly longer to access. Conversely, the proposed FSED will be accessible to residents of the Bradley part of the service area within 10 to 15 minutes, and shorter access time for all service area residents, which could significantly impact patient access to critical emergency care in a timely manner. Residents of the service area deserve to have more timely, local access to life-saving care from a high-quality provider.

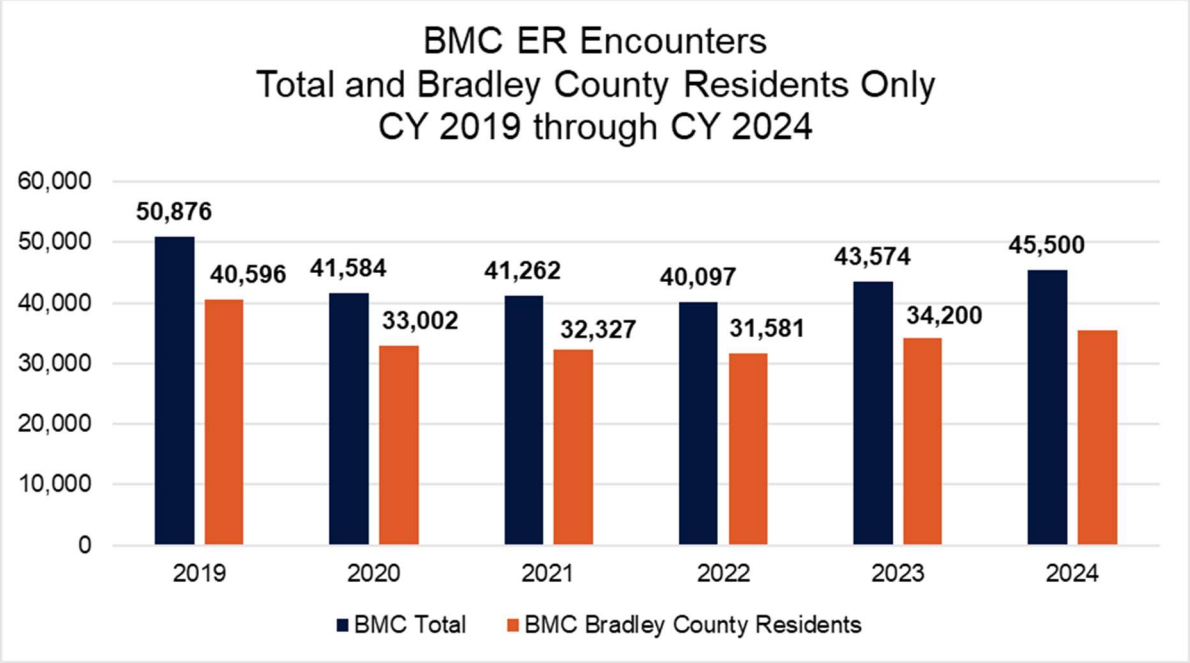
There is only one hospital and one emergency room in Bradley County. The hospital – now known as BMC – previously operated under the name Tennova Healthcare – Cleveland. On August 1, 2024, Vitruvian Health (formerly known as Hamilton Health Care System) completed its acquisition of the hospital. The acquisition included not only the acute-care hospital but also related businesses — physician clinics, outpatient services, medical office buildings and ancillary operations. Vitruvian Health is based in northwest Georgia primarily serving that area and with the acquisition, began serving southeast Tennessee

BMC, located at 2305 Chambliss Ave NW, Cleveland, TN 37311, is on the border of zip codes 37311 and 37312. It is licensed for 251 beds but only staffs 152 beds; in its last JARs (ending December 31, 2024), it indicated the unstaffed 99 beds could not be converted to licensed beds within 24 to 48 hours. Of the 152 beds, 24 are intensive care, 110 are med/surg, 15 are obstetrics and 3 are NICU.[9] BMC reports on its JARs that it operates a 41-bay emergency department which is accredited as a Chest Pain Center.[10]

[9] This is the same number of beds by type and operational as prior years.
[10] It is unclear if all 41 emergency treatment rooms are operational given its approximate 45,000 annual visit volume.

BMC's emergency room historical utilization has shown a decline since 2019. Indeed, unlike many facilities in the state, it has yet to re-bound to pre-COVID levels and its most recent annual encounters of nearly 45,500 remain 10.6 percent less than its 50,000+ encounters in 2019, although there has been an increase in the past few years. **Exhibit 1N-11A** below is the BMC 2019 through 2024 ER encounters by year. Also included are the ER visits for Bradley County residents as a subset of total. Notably, in terms of serving Bradley County residents, those visits have decreased 12.4 percent since 2019, nearly 2 points more than total decline confirming out-migration continues to increase.

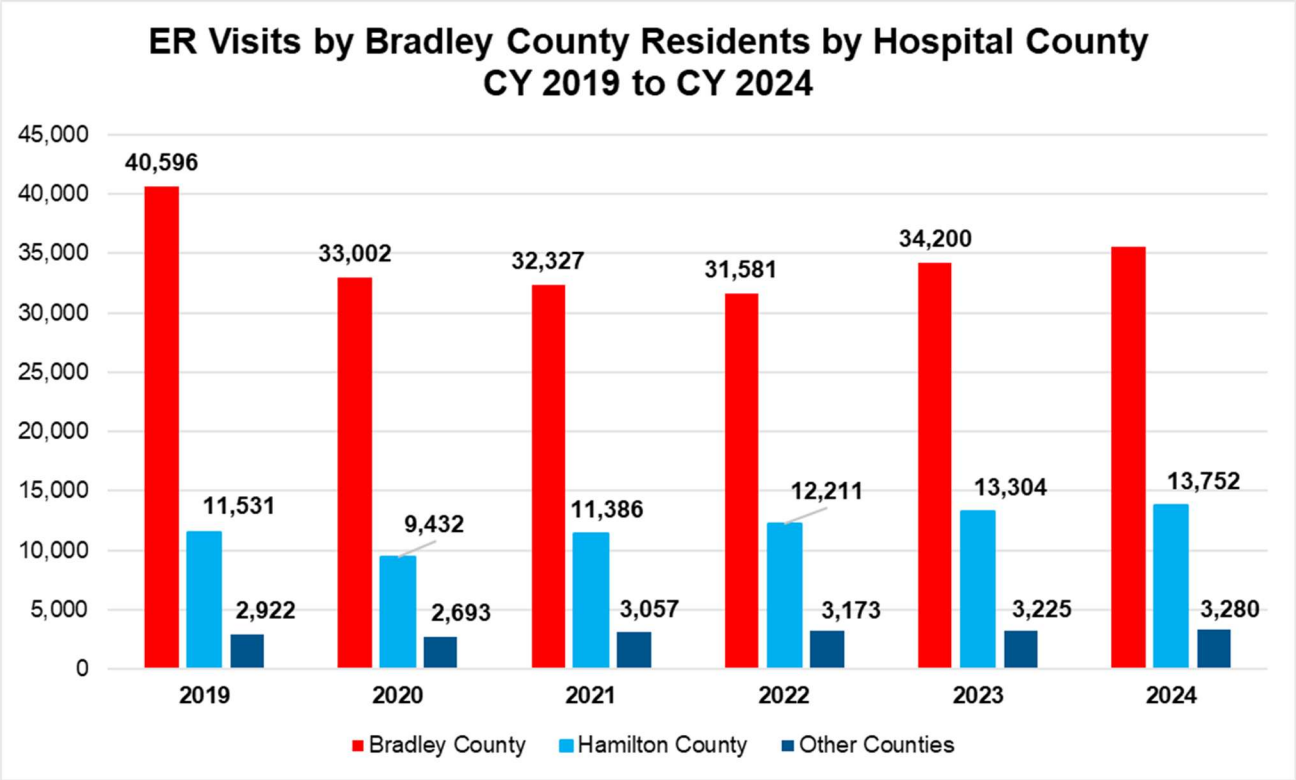
Exhibit 1N-11A



Source: 2019 through 2024, JARs and THA data for Bradley County resident visits.

BMC remains the only option for emergency services for Bradley County residents. Yet, while BMC ER visits by Bradley County residents have decreased, those out-migrating have increased, and specifically to Hamilton County. By destination, following are the number of visits leaving Bradley County for Hamilton County as well as other locations; notably both have increased to levels greater than 2019, a combined total of approximately 18 percent, whereas those remaining in Bradley County are 12.4 percent less.

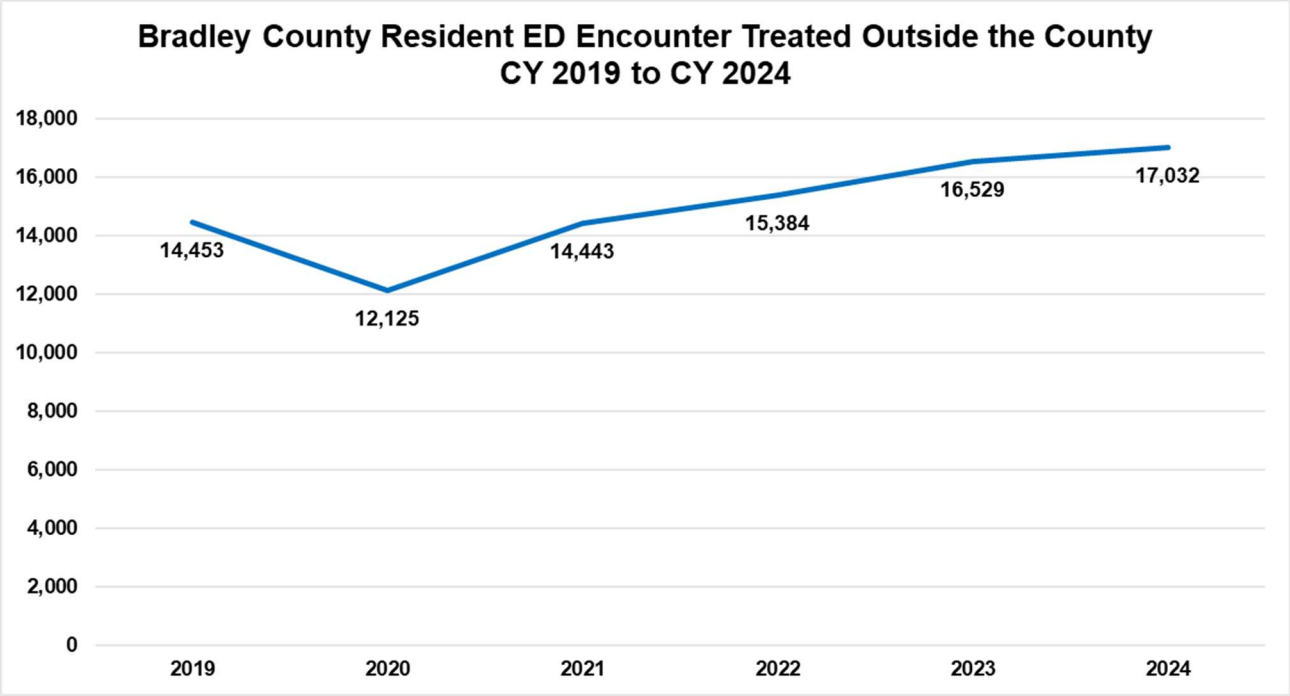
Exhibit 1N-11B



Source: THA data

These figures demonstrate that Bradley County residents are increasingly leaving their home county to seek emergency medical care – in other words, they are voting with their feet when choosing an emergency care provider. Bradley County resident ED visits outside the county have increased by approximately 18 percent since 2019 with those being treated in Hamilton County increasing by 19.3 percent. With BMC treating a smaller portion of Bradley County emergency patients, out-migration has steadily increased since 2019. The next chart, **Exhibit 1N-12**, shows out-migration from Bradley County by year through 2024. Q1 2025 continues to increase on an annualized basis with total outmigration during the first three months representing 33.4 percent of total Bradley County resident ED visits contrasted with just 26.9 percent in 2019.

Exhibit 1N-12



Source: THA data

From a quality perspective, BMC has unfavorable rankings. Of the initial quality measures considered by the HFC in the Freestanding Emergency Department Standards and Criteria, only two or three remain, depending upon the hospital and its reporting. The only remaining measures are as follows:

- Median Time Spent in the Emergency Department (CMS OP 18B);
- Left Before Being Seen (CMS OP 22), also known as left without treatment (LWOT); and
- CT Results Within 45 Minutes (CMS OP 23).

Each of these three quality criteria are discussed next in the context of BMC. Parkridge Medical Center and its corresponding measures are also provided to assure the HFC that the new provider will introduce a level of quality -- and top-quartile care -- not currently available within Bradley County.

Median Time Spent in the Emergency Department

BMC's median time patients spent in the emergency department before leaving from the visit was 203 minutes based on the most recent CMS release dated November 26, 2025.[11] This compares overall to a statewide average of 159 minutes and a national average of 161 minutes. When considering all 89 hospitals with reported minutes statewide, BMC ranks 73 of the 89. This is reflected in **Exhibit 1N-13A** on the next page.[12]

[11] The initial presentation (1N) on December 1, 2025 was prepared prior to this date and incorporated the CMS release dated August 6, 2025. In that release, BMC median time was 196 minutes, ranked 71 of 88 reported hospitals and was operational under new ownership for 2 months. This updated data incorporates new ownership for five months, almost half of the time period evaluated, with the median time increasing by 7 minutes and ranked 2 positions lower at 73 of 88.
[12] The full listing is included in the 1N Attachments; for presentation purposes just the top quartile and bottom quartile are shown in the Exhibit.

As shown, Parkridge Medical Center ranks number 8 of the 89 hospitals and is in the top quartile of all hospitals regardless of volume classification; notably it is "very high" volume and the only hospital that is not "low or n/a" volume in the 10 best performers statewide. This contrasts with BMC's ranking at 73 of 89; with 43,000+ visits, it is considered "high" volume.

Exhibit 1N-13A
Median Time Spent in the Emergency Department (CMS OP 18B)

Hospital	Volume	ED Time	Rank	Quartile
HIGHPOINT HEALTH-TROUSDALE WITH ASCENSION SAINT	Low	80	1	Top Quartile
STONES RIVER HOSPITAL	Low	80	2	Top Quartile
HIGHPOINT HEALTH-RIVERVIEW WITH ASCENSION SAINT TH	Low	88	3	Top Quartile
DEKALB COMMUNITY HOSPITAL	Low	95	4	Top Quartile
ERLANGER BLEDSOE HOSPITAL	Low	100	5	Top Quartile
HAWKINS COUNTY MEMORIAL HOSPITAL	Low	108	6	Top Quartile
MARSHALL MEDICAL CENTER	Low	108	7	Top Quartile
PARKRIDGE MEDICAL CENTER	Very High	110	8	Top Quartile
BAPTIST MEMORIAL HOSPITAL - CARROLL COUNTY	Low	111	9	Top Quartile
LAUDERDALE COMMUNITY HOSPITAL	Not Available	111	10	Top Quartile
SOUTHERN TENNESSEE REGIONAL HEALTH SYSTEM PULASKI	Low	112	11	Top Quartile
UNITY MEDICAL CENTER	Low	113	12	Top Quartile
WEST TENNESSEE HEALTHCARE BOLIVAR HOSPITAL	Low	114	13	Top Quartile
TRISTAR CENTENNIAL MEDICAL CENTER	Very High	115	14	Top Quartile
WEST TENNESSEE HEALTHCARE CAMDEN HOSPITAL	Low	115	15	Top Quartile
LIVINGSTON REGIONAL HOSPITAL	Low	116	16	Top Quartile
HANCOCK COUNTY HOSPITAL	Low	118	17	Top Quartile
MACON COMMUNITY HOSPITAL	Low	123	18	Top Quartile
VANDERBILT BEDFORD HOSPITAL	Medium	124	19	Top Quartile
JOHNSON COUNTY COMMUNITY HOSPITAL	Low	128	20	Top Quartile
SOUTHERN TENNESSEE REGIONAL HEALTH SYSTEM LAWRENCE	Low	128	21	Top Quartile
TRISTAR SOUTHERN HILLS MEDICAL CENTER	High	129	22	Top Quartile
: :	: :	: :	: :	: :
: :	: :	: :	: :	: :
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	High	185	68	Bottom Quartile
SAINT THOMAS HICKMAN HOSPITAL	Low	189	69	Bottom Quartile
CUMBERLAND MEDICAL CENTER	Medium	191	70	Bottom Quartile
METHODIST MEDICAL CENTER OF OAK RIDGE	Medium	195	71	Bottom Quartile
MORRISTOWN HAMBLEN HOSPITAL ASSOCIATION	High	200	72	Bottom Quartile
AFFILIATE OF VITRUVIAN HEALTH	High	203	73	Bottom Quartile
BLOUNT MEMORIAL HOSPITAL	High	203	74	Bottom Quartile
JOHNSON CITY MEDICAL CENTER	Very High	204	75	Bottom Quartile
LECONTE MEDICAL CENTER	High	204	76	Bottom Quartile
PHYSICIANS REGIONAL MEDICAL CENTER	Medium	204	77	Bottom Quartile
MAURY REGIONAL HOSPITAL	High	206	78	Bottom Quartile
ASCENSION SAINT THOMAS HOSPITAL	Very High	214	79	Bottom Quartile
JACKSON-MADISON COUNTY GENERAL HOSPITAL	Very High	218	80	Bottom Quartile
WELLMONT HOLSTON VALLEY MEDICAL CENTER	High	224	81	Bottom Quartile
MEMORIAL HEALTHCARE SYSTEM, INC	Very High	231	82	Bottom Quartile
COOKEVILLE REGIONAL MEDICAL CENTER	High	233	83	Bottom Quartile
METHODIST HOSPITALS OF MEMPHIS	Very High	248	84	Bottom Quartile
UNIVERSITY HEALTH SYSTEM, INC	Very High	248	85	Bottom Quartile
FORT SANDERS REGIONAL MEDICAL CENTER	High	250	86	Bottom Quartile
VANDERBILT UNIVERSITY MEDICAL CENTER	Very High	255	87	Bottom Quartile
PARKWEST MEDICAL CENTER	High	256	88	Bottom Quartile
REGIONAL ONE HEALTH	High	290	89	Bottom Quartile

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release; data for the period January 2024 through December 2024.

The median time for the State of Tennessee was 159 minutes during this time period while the National rate was 161 minutes. By emergency department volume grouping, **Exhibit 1N-13B** provides this information for Tennessee and at the national level. Notably, the very high volume for Tennessee of 190 minutes exceeds Parkridge Medical Center's 110 minutes by 80 minutes, or 73 percent.

Exhibit 1N-13B
Median Time Spent in the Emergency Department (CMS OP 18B)

ED Volume	Tennessee	National
Average	159	161
Low	127	121
Medium	161	175
High	196	210
Very High	190	195

Source: CMS Time and Effective Care-State and National, November 26, 2025 release.

Placing BMC on the specific 1N chart for the OP-18 Median Time from ED Arrival to Departure based on the above data results in the following presentation:

Exhibit 1N-14
BMC Ranking Amongst All Tennessee Hospitals

Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients						
Emergency Department	Timeframe	ED Time	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
BMC	CY 2024	203	X			

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release.

When one considers only high-volume hospitals of which BMC is considered, BMC ranks 11 of 19 which results in the 25th to 50th percentile, shown next.

Exhibit 1N-15
BMC Ranking Amongst Tennessee High Volume Hospitals

Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients						
Emergency Department	Timeframe	ED Time	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
BMC	CY 2024	203		X		

Source: CMS Time and Effective Care-Hospital, August 6, 2025 release.

In contrast, whether considering all 89 hospitals, or just the very high volume hospitals, Parkridge Medical Center ranks in the top quartile. Notably, there are 14 very high volume hospitals in the state. Of those 14 hospitals, Parkridge Medical Center ranks #1 with the lowest median time. This is shown next, followed by the 1N table reflecting it being in the top quartile.

Exhibit 1N-16
Median Time Spent in the Emergency Department (CMS OP 18B): Very High Volume Hospitals

PARKRIDGE MEDICAL CENTER	110	1	Top Quartile
TRISTAR CENTENNIAL MEDICAL CENTER	115	2	Top Quartile
TRISTAR SUMMIT MEDICAL CENTER	153	3	Top Quartile
TENNOVA HEALTHCARE-CLARKSVILLE	160	4	Top/2nd
ERLANGER MEDICAL CENTER	164	5	2nd Quartile
SAINT THOMAS RUTHERFORD HOSPITAL	166	6	2nd Quartile
BAPTIST MEMORIAL HOSPITAL	185	7	2nd Quartile
JOHNSON CITY MEDICAL CENTER	204	8	3rd Quartile
ASCENSION SAINT THOMAS HOSPITAL	214	9	3rd Quartile
JACKSON-MADISON COUNTY GENERAL HOSPITAL	218	10	3rd Quartile
MEMORIAL HEALTHCARE SYSTEM, INC	231	11	3rd/Bottom
METHODIST HOSPITALS OF MEMPHIS	248	12	Bottom Quartile
UNIVERSITY HEALTH SYSTEM, INC	248	13	Bottom Quartile
VANDERBILT UNIVERSITY MEDICAL CENTER	255	14	Bottom Quartile

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release; data for the period January 2024 through December 2024.

Exhibit 1N-17
Parkridge Medical Center Ranking Amongst All Tennessee and Very High Volume Hospitals

Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients						
Emergency Department	**Timeframe**	**ED Time**	**Check (X) Applicable Quartile**			
			≤25th Percentile	**25th-50th Percentile**	**50th-75th Percentile**	**≥75th Percentile**
Parkridge Medical Center	CY 2024	110				X

With the only hospital in Bradley County performing in the lower quartiles, the availability of Parkridge Cleveland FSED – a top quartile performer regardless of the ER volume classification -- will enhance quality in the service area (County).

Left Before Being Seen/Left Without Treatment (LWOT)

BMC's percentage of patients who LWOT is 4 percent. This compares overall to a statewide average of 2 percent and a national average of 2 percent. In terms of this scoring, there are 90 hospitals with reported LWOT scores statewide. BMC ranks 79th of the 90, again in the lowest quartile. This is reflected in **Exhibit 1N-18** on the next page. Only 12 of the hospitals statewide perform at 4 percent or less; BMC is one of these hospitals.

When considering 4 percent of ER encounters leave without being seen, this equates to 1,742 ER patients not treated at the BMC ER. Introducing Parkridge Medical Center into Bradley County means introducing a 1 percent LWOT rate. Had BMC performed at this level, over 1,300 fewer patients would have left BMC without being seen. This is a meaningful quality enhancement for those residents who went to BMC and either decided not to seek treatment elsewhere or had to travel long distances to reach another provider.

Exhibit 1N-18
Left Without Being Seen (CMS OP 22)

Hospital	Volume	LWOT Score	Rank	Quartile
BAPTIST MEMORIAL HOSPITAL TIPTON	Medium	0	1	Top Quartile
BAPTIST MEMORIAL HOSPITAL UNION CITY	Low	0	2	Top Quartile
HANCOCK COUNTY HOSPITAL	Low	0	4	Top Quartile
HAWKINS COUNTY MEMORIAL HOSPITAL	Low	0	5	Top Quartile
HAYWOOD COUNTY COMMUNITY HOSPITAL	Low	0	6	Top Quartile
HIGHPOINT HEALTH-RIVERVIEW WITH ASCENSION SAINT TH	Low	0	7	Top Quartile
HIGHPOINT HEALTH-TROUSDALE WITH ASCENSION SAINT	Low	0	8	Top Quartile
INDIAN PATH COMMUNITY HOSPITAL	Medium	0	9	Top Quartile
SAINT FRANCIS BARTLETT MEDICAL CENTER	Medium	0	10	Top Quartile
ST FRANCIS HOSPITAL	High	0	11	Top Quartile
TRISTAR HORIZON MEDICAL CENTER	High	0	12	Top Quartile
TRISTAR SOUTHERN HILLS MEDICAL CENTER	High	0	13	Top Quartile
TRISTAR STONECREST MEDICAL CENTER	High	0	14	Top Quartile
TRISTAR SUMMIT MEDICAL CENTER	Very High	0	15	Top Quartile
VANDERBILT WILSON COUNTY HOSPITAL	Medium	0	16	Top Quartile
WELLMONT HOLSTON VALLEY MEDICAL CENTER	High	0	17	Top Quartile
PARKRIDGE MEDICAL CENTER	Very High	1	18	Top Quartile
TRISTAR CENTENNIAL MEDICAL CENTER	Very High	1	19	Top Quartile
TRISTAR HENDERSONVILLE MEDICAL CENTER	High	1	20	Top Quartile
TRISTAR NORTHCREST MEDICAL CENTER	Medium	1	21	Top Quartile
TRISTAR SKYLINE MEDICAL CENTER	High	1	22	Top Quartile
BAPTIST MEMORIAL HOSPITAL - CARROLL COUNTY	Low	1	23	Top/2nd
DEKALB COMMUNITY HOSPITAL	Low	1	24	2nd Quartile
ERLANGER MEDICAL CENTER	Very High	1	25	2nd Quartile
FORT SANDERS REGIONAL MEDICAL CENTER	High	1	26	2nd Quartile
FRANKLIN WOODS COMMUNITY HOSPITAL	Medium	1	27	2nd Quartile
GREENEVILLE COMMUNITY HOSPITAL	Medium	1	28	2nd Quartile
HARDIN MEDICAL CENTER	Low	1	29	2nd Quartile
HIGHPOINT HEALTH-SUMNER WITH ASCENSION SAINT THOMA	High	1	30	2nd Quartile
::		::	::	::
::		::	::	::
AFFILIATE OF VITRUVIAN HEALTH	High	4	79	Bottom Quartile
BAPTIST MEMORIAL HOSPITAL	Very High	4	80	Bottom Quartile
HENDERSON COUNTY COMMUNITY HOSPITAL	Low	4	81	Bottom Quartile
JACKSON-MADISON COUNTY GENERAL HOSPITAL	Very High	4	82	Bottom Quartile
LECONTE MEDICAL CENTER	High	4	83	Bottom Quartile
PARKWEST MEDICAL CENTER	High	4	84	Bottom Quartile
PHYSICIANS REGIONAL MEDICAL CENTER	Medium	4	85	Bottom Quartile
UNITY MEDICAL CENTER	Low	4	86	Bottom Quartile
LIVINGSTON REGIONAL HOSPITAL	Low	5	87	Bottom Quartile
MEMORIAL HEALTHCARE SYSTEM, INC	Very High	5	88	Bottom Quartile
METHODIST HOSPITALS OF MEMPHIS	Very High	7	89	Bottom Quartile
CUMBERLAND MEDICAL CENTER	Medium	8	90	Bottom Quartile

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release; data for CY 2023.

When considering just the high-volume hospitals, BMC continues to perform in the bottom quartile. Both results are presented in the next table, **Exhibit 1N-19**.

Exhibit 1N-19
BMC Ranking Among All Tennessee Hospitals and High-Volume Hospitals

Measure: OP-22 Left Without Being Seen						
Emergency Department	**Timeframe**	**ED Score**	**Check (X) Applicable Quartile**			
			≤25th Percentile	**25th-50th Percentile**	**50th-75th Percentile**	**≥75th Percentile**
BMC	1/1/23-12/31/23	4	**X**			

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release.

In contrast, when just considering the very high-volume hospitals, Parkridge Medical Center performs in the top quartile. This is reflected in the next exhibit which presents the very high-volume hospitals.

Exhibit 1N-20
LWOT (CMS OP 22): Very High-Volume Hospitals

Hospital	LWOT Score	Rank	Quartile
TRISTAR SUMMIT MEDICAL CENTER	0	1	Top Quartile
PARKRIDGE MEDICAL CENTER	1	2	Top Quartile
TRISTAR CENTENNIAL MEDICAL CENTER	1	2	Top Quartile
ERLANGER MEDICAL CENTER	1	2	Top/2nd
JOHNSON CITY MEDICAL CENTER	1	2	2nd Quartile
SAINT THOMAS RUTHERFORD HOSPITAL	1	2	2nd Quartile
TENNOVA HEALTHCARE-CLARKSVILLE	1	2	2nd Quartile
UNIVERSITY HEALTH SYSTEM, INC	1	2	3rd Quartile
ASCENSION SAINT THOMAS HOSPITAL	2	9	3rd Quartile
VANDERBILT UNIVERSITY MEDICAL CENTER	3	10	3rd Quartile
BAPTIST MEMORIAL HOSPITAL	4	11	3rd/Bottom
JACKSON-MADISON COUNTY GENERAL HOSPITAL	4	11	Bottom Quartile
MEMORIAL HEALTHCARE SYSTEM, INC	5	13	Bottom Quartile
METHODIST HOSPITALS OF MEMPHIS	7	14	Bottom Quartile

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release; data for CY 2023.

With the only hospital in Bradley County performing at a very high 4 percent LWOT rate, the availability of Parkridge Cleveland FSED, with a 1 percent LWOT rate, means 75 percent less patients will be classified as LWOT. This will also enhance quality in the service area.

CT Results Within 45 Minutes

The third CMS measure which has available data is the percentage of patients who presented with stroke symptoms and received CT results within 45 minutes (CMS OP 23).[13] BMC's percent of patients who presented with stroke symptoms and received CT results within 45 minutes was not available in this most recent release; three months prior in the August 6, 2025 release, BMC measured at 42 percent. This compares unfavorably to a statewide average of 72 percent and a national average of 70 percent. Of hospitals in Tennessee that have reported percentage of patients presenting with stroke symptoms who received Head CT results within 45 minutes, the updated range is between 50 percent (lowest) to 96 percent (highest). BMC previously reported value of 42 percent is less than the lowest currently reported. Parkridge Medical Center ranks in the top quartile with 83 percent. This is reflected in **Exhibit 1N-21** below.

Exhibit 1N-21
Percent of Patients with Stroke Symptoms Receiving Results within 45 Minutes (CMS OP 23)

Hospital	Head CT results	Rank	Quartile
WELLMONT HOLSTON VALLEY MEDICAL CENTER	96	1	Top Quartile
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	91	2	Top Quartile
BLOUNT MEMORIAL HOSPITAL	89	3	Top Quartile
UNIVERSITY HEALTH SYSTEM, INC	86	4	Top Quartile
PARKRIDGE MEDICAL CENTER	83	5	Top Quartile
MEMORIAL HEALTHCARE SYSTEM, INC	82	6	Top Quartile
TENNOVA HEALTHCARE - NEWPORT MEDICAL CENTER	82	7	Top Quartile
MAURY REGIONAL HOSPITAL	81	8	Top/2nd
TRISTAR NORTHCREST MEDICAL CENTER	81	9	2nd Quartile
DYERSBURG REGIONAL MEDICAL CENTER	79	10	2nd Quartile
METHODIST HOSPITALS OF MEMPHIS	79	11	2nd Quartile
TRISTAR STONECREST MEDICAL CENTER	79	12	2nd Quartile
LINCOLN MEDICAL CENTER	76	13	2nd Quartile
TRISTAR SOUTHERN HILLS MEDICAL CENTER	75	14	2nd Quartile
TRISTAR HORIZON MEDICAL CENTER	74	15	2nd Quartile
PHYSICIANS REGIONAL MEDICAL CENTER	73	16	3rd Quartile
SAINT FRANCIS BARTLETT MEDICAL CENTER	73	17	3rd Quartile
WILLIAMSON MEDICAL CENTER	73	18	3rd Quartile
TENNOVA HEALTHCARE-CLARKSVILLE	72	19	3rd Quartile
JACKSON-MADISON COUNTY GENERAL HOSPITAL	69	20	3rd Quartile
SOUTHERN TENNESSEE REGIONAL HEALTH SYSTEM WINCHEST	69	21	3rd Quartile
WEST TENNESSEE HEALTHCARE HENRY COUNTY HOSPITAL	69	22	3rd Quartile
CUMBERLAND MEDICAL CENTER	67	23	3rd/Bottom
HIGHPOINT HEALTH-SUMNER WITH ASCENSION SAINT THOMA	67	24	Bottom Quartile
STARR REGIONAL MEDICAL CENTER ATHENS	67	25	Bottom Quartile
SWEETWATER HOSPITAL ASSOCIATION	67	26	Bottom Quartile
TRISTAR HENDERSONVILLE MEDICAL CENTER	63	27	Bottom Quartile
ROANE MEDICAL CENTER	55	28	Bottom Quartile
COOKEVILLE REGIONAL MEDICAL CENTER	53	29	Bottom Quartile
GREENEVILLE COMMUNITY HOSPITAL	50	30	Bottom Quartile

Source: CMS Time and Effective Care-Hospital, November 2, 2025 release; data for the period January 2024 through December 2024. BMC not available in this 12-month period, but was scored at 42 percent in the 12-month period of October 2023 through September 2024.

[13] Only 30 hospitals in Tennessee have this CMS measure reported in the most recent release dated November 26, 2025. While the count increased from 28 hospitals in the August 6, 2025 release, the group of hospitals measured changed. Most notably, BMC results were not available for CY 2024 in this latest release. They were however available in the August 6, 2025 release where BMC performed at 42 percent, the lowest of all 28 hospitals reported in that data set.

In terms of the required charts reflecting the placement by quartile, next is the chart presenting OP 23 results for Parkridge Medical Center.

Exhibit 1N-22
BMC and Parkridge Medical Center: Quartile Ranking

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 Score**	**Check (X) Applicable Quartile**			
			≤25th Percentile	**25th-50th Percentile**	**50th-75th Percentile**	**≥75th Percentile**
BMC	CY 2024	n/a	**(*)**			
Parkridge Medical Center	CY 2024	83				**X**

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release for calendar year 2024. In the August 6, 2025 release, BMC ranked in the lowest quartile at 42.

Implementing the Parkridge Cleveland FSED in Bradley County will improve this quality metric to greater than 80 percent. This will enhance the available quality for emergency room stroke patients in the service area and county.

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.

Highly Utilized Quality Emergency Room

The table below provides the percentage of behavioral health, high acuity, and elderly ED patients treated by Parkridge Medical Center and Parkridge North during the most recent year. Each of the metrics informs that Parkridge operates in the mid to high range in accordance with American College of Emergency Physicians ("ACEP") guidelines. Parkridge North operates in the low range although each of these three criteria result in one per category (low, mid and high).

Exhibit 1N-23
Additional Parkridge and Parkridge North Data

Factor	% of Behavioral Health	% Patients Level I or II (Low Acuity)	% of Patients 65+
Parkridge Medical Center	4.2%	7.1%	22.8%
ACEP Metric	Mid-Range	High-Range	High-Range
Parkridge North	5.4%	8.1%	7.9%
ACEP Metric	Mid-Range	High-Range	Low-Range

Source: Internal Parkridge data

When contrasting Parkridge Medical Center and Parkridge North with the service area experience in these three categories, it is evident that the proposed Parkridge Cleveland FSED will be well equipped to accommodate the service area patients and clinical needs. **Exhibit 1N-24** contrasts the above with service area 2023, the two counties and the State using HDDS data. Notably, four service area zip codes (37353, 37362, 37307 and 37361) are grouped into '373 truncated'.

Exhibit 1N-24
Service Area 2023 and the State

Service Area	% of Behavioral Health	Statewide	% Patients Level 1 or II (Low Acuity)	Statewide	% of Patients 65+	Statewide
37311 Cleveland	2.6%	1.7%	33.3%	41.5%	18.0%	22.5%
37323 SE Cleveland	2.0%		29.5%		22.8%	
373 Truncated	1.5%		19.3%		27.0%	
Service Area Total	1.9%		25.3%		23.9%	
Bradley County	2.2%		31.1%		23.2%	
Polk County	1.9%		42.1%		25.4%	

Source: HDDS data by zip code, county and state, CY 2023. State and County from data request 35551101; zip codes from data request 35552215. Low acuity computed by taking 99281 plus 99282 divided by 99281 through 99285. Other CPT codes are not defined by acuity.

A high percentage of medically complex patients and behavioral health patients can contribute to capacity constraints for area EDs. Both Parkridge Medical Center and Parkridge North have a high percentage of higher acuity patients (92+ percent) and behavioral health patients in the 4 to 6 percent range, double the area wide average. The proposed FSED will also have a behavioral health room to help address demand. Parkridge Medical Center with a high percentage of high acuity patients, displays indicators consistent with a high-range ED as defined by ACEP, resulting in longer treatment time and a lower number of visits per ED treatment room. Yet, Parkridge Medical Center has one of the lowest times for treatment (OP 18B) in the state despite documented capacity challenges at its facilities. These capacity challenges at both Parkridge Medical Center and Parkridge North are discussed next.

Capacity Challenges at Host Hospital and Hospital Closest to Service Area

Parkridge Medical Center has continuously operated above the ACEP Guidelines. It exceeded the range by 23.7 percent in 2022, increasing to 33 percent in 2025.

Furthermore, Parkridge North has an increasing visit volume such that in 2023 it exceeded ACEP guidelines by 6 percent, 13.6 percent in 2024, and itis on track to exceed the guidelines by more than 18 percent in 2025. These capacity measurements are presented in **Exhibit 1N-25**.

Exhibit 1N-25
Visits per Treatment Room at Parkridge Medical Center and Parkridge North
Calendar Years 2022 through Current

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Range	Percent Over (Under) Range
Parkridge Medical Center					
				Mid-Range	
2022	32,572	19	1,714	1,386	23.7%
2023	33,525	19	1,764	1,386	27.3%
2024	34,361	19	1,808	1,386	30.5%
2025Ann	35,037	19	1,844	1,386	33.0%
Parkridge North					
				Low-Range	
2022	12,657	11	1,151	1,364	-15.6%
2023	15,926	11	1,448	1,364	6.1%
2024	17,855	11	1,623	1,429	13.6%
2025Ann	18,596	11	1,691	1,429	18.3%

Source: JARs for respective years; 2025 internal data for 9 months annualized.

An additional advantage of the implementation of the proposed Parkridge Cleveland FSED is that some of the capacity overages identified above will be relieved through a re-direction of a portion of the ER visits at each of the above emergency rooms. Specifically, it is expected that approximately 1,100 patients currently being treated at Parkridge Medical Center and Parkridge North will re-direct to the proposed Cleveland FSED. The majority of these are being treated at Parkridge North. Based on this estimate, the above visits per room will decrease by nearly 100 visits per room at Parkridge North, reducing the capacity overage from the current 18 percent to approximately 12 percent.

Reducing Out-Migration

Out-migration from the service area to another county has increased from 28 percent in 2019 to 35 percent. Stated another way, more than one-third of emergency room patients out-migrated in 2024. While reasons for out-migration could be multi-fold including seeking a higher quality provider, historical relationship with a provider, perceived specialty nature of the condition, the reality is that since 2019, the number out-migrating has continuously increased cumulatively by 7 percentage points.

Out-migrating from the service area delays emergency treatment which, as previously discussed, could impair outcomes. The top emergency rooms treating service area patients and the time required to access those ERs from the service area zip codes are provided in **Exhibit 1N-26**.

Exhibit 1N-26
Time in Minutes from Service Area Zip Codes to Out of County Hospitals

Service Area	Parkridge	Parkridge North	Erlanger Baroness	Erlanger East	CHI Memorial
37311 Cleveland	38	24	42	32	38
37323 SE Cleveland	45	32	50	40	46
37353 McDonald	32	18	36	26	32
37362 Old Fort	51	37	56	45	51
37307 Benton	60	44	63	52	59
37316 Conasauga	54	41	59	49	56
37361 Ocoee	65	50	69	57	64
Parkridge Cleveland FSED	32	20	38	28	34

Source: Googlemaps.

As evident above, the closest out-of-county emergency room to Parkridge Cleveland FSED is Parkridge North ER at 20 minutes travel time. The other ERs are between 28 and 38 minutes from the proposed Cleveland FSED. In terms of travel time from the four service area zip codes to these Hamilton County hospitals, Parkridge North is again the closest to each of the service area zip codes ranging between 18 and 37 minutes from the Bradley zip codes and 41 to 50 minutes from the Polk County zip codes. Erlanger Baroness times range between 36 and 69 minutes while Erlanger East ranges between 26 and 57 minute travel time. CHI Memorial is further at between 32 and 64 minutes which is similar to Parkridge Medical Center.

Reducing out-migration is a planned benefit of the proposed Cleveland FSED. This reduction will improve access to emergency room care for service area residents while simultaneously enhancing the quality of care received in Bradley County.

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 Applicant is not seeking approval based on its need to decompress its emergency room. Notwithstanding, an additional advantage of the implementation of the proposed Parkridge Cleveland FSED is that some of the capacity overages identified above will be relieved through a re-direction of a portion of the ER visits at each of the above emergency rooms.

Parkridge Medical Center has been determined to be a Mid-Range emergency room using the ACEP guidelines whereas Parkridge North has been determined to be a Low-Range emergency room per the guidelines. **Exhibit 1N-27** provides the ACEP criteria and ranking for each of these two emergency rooms.

Exhibit 1N-27
ACEP Guidelines Designation for Parkridge Medical Center and Parkridge North

Factor	Parkridge Medical Center	Parkridge North	Metric
% Emergency Department Patients Admitted as Inpatients	Mid-Range	Low-Range	Less than 8% is low range; between 12% to 20% is mid range. PMC is 14.3%; Parkridge North is 3.1%.
Length of Stay (Hours) in ED	Mid-Range	Low-Range	Less than 2.25 is low range; 2.5 to 3.75 hours is mid range. PMC is 2.75 hours; Parkridge North is 103 minutes.
% of ED Patients seen in Private Rooms	Mid-Range	High-Range	Determination that the majority will be seen in private rooms with some flexibility.
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	High-Range	High-Range	Patients remain in provide rooms for stay; only 5% do not.
% of observation and extended stay patient remaining in ED	Low-Range	Low-Range	No patients remain in ER for this level of service.
# Average Minutes an ED patient admitted as an inpatient remains in ED	High-Range	High-Range	Patients to be admitted remain more than 150 minutes after order to admit.
Average turnaround time (minutes) for results for lab and imaging studies	Mid-Range	Mid-Range	High range is >90 minutes; mid range is 60+ minutes. PMC is 89 minutes; Parkridge North is 54 minutes.
% of behavioral health ED patients	Mid-Range	Mid-Range	4% to 6% is mid-range; PMC is 4.2%; Parkridge North is 5.4%.
% of ED patients either ESI 4 or 5 (Percent of Non-Urgent Patients)	High-Range	High-Range	Under 25% = high-range; Parkridge is 7.1%: Parkridge North is 8.1%.
% of ED patients Age 65+	High-Range	Low-Range	High range is >20%; low range is under 10%. PMC is 22.8%; Parkridge North is 7.9%.
% of imaging studies performed in ED	Mid-Range	Mid-Range	Limited radiology and CT in ER is mid-range which is the situation.
Provisions in ED for family consult/grieving rooms	Mid-Range	Mid-Range	Limited consulting or family grieving areas.
Availability of geriatric specialty area	Low-Range	Low-Range	No specialty area.
Availability of pediatric specialty area	Low-Range	Low-Range	No specialty area.
Availability of prisoner/detention patient specialty area	Low-Range	Low-Range	No special provisions.
Availability of administrative/teaching specialty area	Low-Range	Low-Range	No support for teaching programs.
The Range Where Majority of Above Factors Fall, i.e. Low, Mid or High Range	**Mid-Range**	**Low-Range**	PMC: 7 of 16 are Mid; 5 are Low; and 4 are High. Parkridge North: 7 of 16 are low range, 5 are mid and 4 are high

Both Parkridge Medical Center and Parkridge North exceed the relevant ACEP guidelines for their utilization. Specifically, Parkridge Medical Center has continuously operated above the ACEP Guidelines. It exceeded the range by 23.7 percent in 2022, increasing to 33 percent in 2025. Parkridge North has an increasing visit volume such that in 2023 it exceeded ACEP guidelines by 6 percent, in 2024 by 13.6 percent and in 2025 is on track to exceed the guidelines by more than 18 percent. These capacity measurements are presented in **Exhibit 1N-28**.

Exhibit 1N-28
Visits per Treatment Room at Parkridge and Parkridge North
Calendar Years 2022 through Current

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Range	Percent Over (Under) Range
Parkridge Medical Center					
				Mid-Range	
2022	32,572	19	1,714	1,386	23.7%
2023	33,525	19	1,764	1,386	27.3%
2024	34,361	19	1,808	1,386	30.5%
2025Ann	35,037	19	1,844	1,386	33.0%
Parkridge North					
				Low-Range	
2022	12,657	11	1,151	1,364	(15.6%)
2023	15,926	11	1,448	1,364	6.1%
2024	17,855	11	1,623	1,429	13.6%
2025Ann	18,596	11	1,691	1,429	18.3%

Source: JARs for respective years; 2025 internal data for 9 months annualized.

An additional advantage of the implementation of the proposed Parkridge Cleveland FSED is that some of the capacity overages identified above will be relieved through a re-direction of a portion of the ER visits at each of the above emergency rooms. Specifically, it is expected that approximately 1,100 patients currently being treated at Parkridge Medical Center and Parkridge North will re-direct to the proposed Cleveland FSED. The majority of these are being treated at Parkridge North. Based on this estimate, the above visits per room will decrease by nearly 100 visits per room at Parkridge North, reducing the capacity overage to approximately 12 percent rather than the current 18 percent.

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 acuitylevels, 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.

This CON Application is being submitted for the HFC criteria related to quality and geographic isolation. An additional benefit to be derived is from the fact that two of Parkridge Medical Center's emergency rooms treating patients from the proposed service area are over capacity relative to the ACEP guidelines. These hospitals are outside the service area; the proposed Parkridge Cleveland FSED will reduce out-migration and simultaneously address Parkridge capacity constraints.

Parkridge Health System operates five high quality emergency rooms in adjoining Hamilton County and one additional emergency room in Marion County. The host hospital, Parkridge Medical Center, is located 28 miles and 32 minutes from the proposed Cleveland FSED. Parkridge North ER is the closest emergency room to Bradley County of any Hamilton County emergency room provider. It is 18 miles and 20 minutes from the proposed FSED. Both of these emergency rooms treat patients residing in the service area. Both existing emergency rooms are well utilized operating above ACEP guidelines. **Exhibit 1N-29** provides the number of visits and visits per treatment room at each of these Parkridge emergency rooms.

Exhibit 1N-29
ED Visit Trend at Host Hospital and Parkridge North

ER Visits		
	Parkridge Medical Center	Parkridge North
2021	32,056	9,973
2022	32,572	12,657
2023	33,525	15,926
2024	34,361	17,855
ER Treatment Rooms		
2021-- 2024	19	11
Visits/Per ER Treatment Room		
2021	1,687	907
2022	1,714	1,151
2023	1,764	1,448
2024	1,808	1,623

Source: JARs for the respective years.

Both emergency rooms experience robust activity that exceeds the ACEP guidelines for the respective facilities. To determine which ACEP range (low, mid or high) to compare the above activity against and conclude how over capacity each of the ERs is, an evaluation of each of these two emergency rooms was conducted. The evaluation considered the 16 ACEP criteria outlined in Emergency Department Design, A Practical Guide to Planning for the Future utilizing tables 5.1 and 5.2. The characteristics of Parkridge Medical Center, host hospital, reflect a blend of each range under the ACEP criteria. The largest group is mid-range with 7 of the 16 characteristics; the balance are 5 low-range and 4 high-range. Those factors resulting in mid-range include length of stay, admission rate, private rooms, turnaround time, behavioral health patients, imaging and support space. This scoring is reflected in **Exhibit 1N-30** presented next.

Exhibit 1N-30
ACEP Criteria with Parkridge Medical Center Metrics and Result

Factor	Result/Range	Metric
% Emergency Department Patients Admitted as Inpatients	Mid-Range	Less than 12% to 20% is mid range; PMC is 14.3%.
Length of Stay (Hours) in ED	Mid-Range	2.5 to 3.75 hours is mid range; PMC is 2.75 hours.
% of ED Patients seen in Private Rooms	Mid-Range	Determination that the majority will be seen in private rooms with some flexibility.
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	High-Range	Patients remain in provide rooms for stay; only 5% do not.
% of observation and extended stay patient remaining in ED	Low-Range	No patients remain in ER for this level of service.
# Average Minutes an ED patient admitted as an inpatient remains in ED	High-Range	Patients to be admitted remain more than 150 minutes after order to admit.
Average turnaround time (minutes) for results for lab and imaging studies	Mid-Range	High range is >90 minutes; mid range is 60+ minutes. PMC is 89 minutes.
% of behavioral health ED patients	Mid-Range	4% to 6% is mid-range; PMC is 4.2%.
% of ED patients either ESI 4 or 5 (Percent of Non-Urgent Patients)	High-Range	Under 25% = high-range; Parkridge is 7.1%.
% of ED patients Age 65+	High-Range	High range is >20%; PMC is 22.8%.
% of imaging studies performed in ED	Mid-Range	Limited radiology and CT in ER is mid-range which is the situation.
Provisions in ED for family consult/grieving rooms	Mid-Range	Limited consulting or family grieving areas.
Availability of geriatric specialty area	Low-Range	No specialty area.
Availability of pediatric specialty area	Low-Range	No specialty area.
Availability of prisoner/detention patient specialty area	Low-Range	No special provisions.
Availability of administrative/teaching specialty area	Low-Range	No support for teaching programs.
The Range Where Majority of Above Factors Fall, i.e. Low, Mid or High Range	**Mid-Range**	7 of 16 are Mid; 5 are Low; and 4 are High.

Parkridge Medical Center is the host hospital and therefore relevant to this assessment. It is located 28 miles and approximately 32 minutes from the proposed Parkridge Cleveland FSED. As noted previously, also operating under Parkridge Medical Center's license is its Parkridge North ER, which is the emergency room associated with Parkridge Valley Adult and Adolescent Hospital, located at 7402 Lee Highway. Of all Hamiton County emergency rooms, this emergency room is the closest to Bradley County. It is located 20 minutes and 18 miles from the proposed Cleveland FSED. Given this proximity of Parkridge's emergency rooms, Parkridge North has the greatest number of Bradley County emergency room encounters. Furthermore, its emergency room visits demonstrate capacity challenges based on ACEP guidelines. The ACEP criteria for Parkridge North are presented next in **Exhibit 1N-31**. These characteristics present a diverse range at Parkridge North depending on the criteria with the largest group of factors classified as low range (7 of 16).

Exhibit 1N-31
ACEP Criteria with Parkridge North Metrics and Result

Factor	Result/Range	Metric
% Emergency Department Patients Admitted as Inpatients	Low-Range	Less than 8% is low range; Parkridge North is 3.1%.
Length of Stay (Hours) in ED	Low-Range	Less than 2.25 hours is low range; Parkridge North is 103 minutes.
% of ED Patients seen in Private Rooms	High-Range	90+% seen in private rooms.
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	High-Range	Patients remain in provide rooms for stay; only 5% do not.
% of observation and extended stay patient remaining in ED	Low-Range	No patients remain in ER for this level of service.
# Average Minutes an ED patient admitted as an inpatient remains in ED	High-Range	Patients to be admitted remain more than 150 minutes after order to admit.
Average turnaround time (minutes) for results for lab and imaging studies	Mid-Range	Low range is <45 minutes; mid range is 60 minutes. Parkridge North is 54 minutes.
% of behavioral health ED patients	Mid-Range	4% to 6% is mid-range; Parkridge North is 5.4%.
% of ED patients either ESI 4 or 5 (Percent of Non-Urgent Patients)	High-Range	Under 25% = high-range; Parkridge North is 8.1%.
% of ED patients Age 65+	Low-Range	Low range is <10%; Parkridge North is 7.9%.
% of imaging studies performed in ED	Mid-Range	Limited radiology and CT in ER is mid-range which is the situation.
Provisions in ED for family consult/grieving rooms	Mid-Range	Limited consulting or family grieving areas.
Availability of geriatric specialty area	Low-Range	No specialty area.
Availability of pediatric specialty area	Low-Range	No specialty area.
Availability of prisoner/detention patient specialty area	Low-Range	No special provisions.
Availability of administrative/teaching specialty area	Low-Range	No support for teaching programs.
The Range Where Majority of Above Factors Fall, i.e. Low, Mid or High Range	**Low-Range**	7 of 16 are Low; 5 are Mid; and 4 are High.

Exhibit 1N-32 provides Parkridge Medical Center and Parkridge North ER visit volume versus ACEP Ranges.

Exhibit 1N-32
Visits per Treatment Room at Parkridge and Parkridge North
Calendar Years 2022 through 2024 and Annualized 2025

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Range	Percent Over (Under) Range
Parkridge Medical Center					
				Mid-Range	
2022	32,572	19	1,714	1,386	23.7%
2023	33,525	19	1,764	1,386	27.3%
2024	34,361	19	1,808	1,386	30.5%
2025Ann	35,037	19	1,844	1,386	33.0%
Parkridge North					
				Low-Range	
2022	12,657	11	1,151	1,364	(15.6%)
2023	15,926	11	1,448	1,364	6.1%
2024	17,855	11	1,623	1,429	13.6%
2025Ann	18,596	11	1,691	1,429	18.3%

Source: JARs for respective years; 2025 internal data for 9 months annualized.

Based on the proximity of both emergency rooms and the number of patients each treat at their respective ERs, Parkridge expects some redirection of its Parkridge Medical Center and Parkridge North patients to the Parkridge Cleveland FSED. As a result, implementation of the Parkridge Cleveland FSED will benefit the capacity challenges at both emergency rooms.

Additional information and metrics which support this CON Application and further demonstrate the need for expansion are provided below. These factors will contribute to consumer advantages in a meaningful way.

Consumer Advantages Resulting from Parkridge Cleveland FSED's Implementation

Consumers will benefit from the proposed Cleveland FSED through having a choice of provider as there is currently only one ER, and a new type of emergency provider, currently unavailable in the service area. Consumer access to an ER will also be enhanced by providing a more proximate ED access point, improving quality in the service area and county, offering lower wait times than the other ED, improving the LWOT statistics, enhancing treatment time for suspected stroke victims and shortening travel times to access the proposed Cleveland FSED. OP-18 previously presented for the hospitals has been reformatted below to specifically demonstrate the consumer advantages achieved with having access to Parkridge within Bradley County. **Exhibit 1N-33** contrasts the Bradley County hospital ED relative to both Tennessee and national averages.

Exhibit 1N-33
OP-18B, OP -22 and OP-23
Median Time from ED Arrival to ED Departure for Discharged Patients, LWOT and Percent of Patients with Stroke Systems Receiving CT Results within 45 Minutes
Deviation from Tennessee and National Averages

Metric	BMC	Tennessee	National
Median Time (Minutes)	203	159	161
Left without Being Seen	4%	2%	2%
Percent with Stroke Symptions Who Received Head CT Results within 45 Minutes	n/a	72%	70%

Source: CMS Medicare Compare, November 26, 2025 release, CY 2024 for median time and CT results, CY 2023 for left without being seen (LWOT). In the November 26, 2025 release, BMC Head CT Results were not published; in the August 6, 2025 release for the 12 months ending September 30, 2024, BMC results were reported at 42 percent, lower than any other reported hospital in the state.

With 43,000+ visits identified on the CMS data set, a 4 percent LWOT versus 2 percent impacts 871 additional patients (4 percent is 1,742, 2 percent is 871). Had BMC performed at the same level of Parkridge Medical Center at its 1 percent level, the number of LWOT patients would have been reduced by more than 1,300 per year.

Comparing Bradley Medical Center on a ranking basis against Parkridge Medical Center, the following is noted:

- Of the 89 Tennessee hospitals with ER median times, Parkridge Medical Center ranks 8th (top/best quartile) whereas BMC ranks 73rd (lowest quartile).
- Parkridge Medical Center's left without being seen (LWOT) rate is 1 percent, compared to BMC's 4 percent. Only 12 hospitals of the 90 Tennessee hospitals with LWOT scores have 4 percent or worse LWOT rates, placing BMC in the lowest quartile of this ranking.
- Of hospitals in Tennessee that have reported percentage of patients presenting with stroke symptoms who received Head CT results within 45 minutes, the range is between 50 percent (lowest) to 96 percent (highest). BMC is currently not ranked but ranked the lowest of any hospital in the State in the last release, at 42 percent. Parkridge Medical Center ranks in the top quartile.
- Parkridge Medical Center is considered very high volume with more than 100,000 visits yet far exceeds BMC metrics; BMC is considered high volume with 43,571 visits.
- For very high volume hospitals, Parkridge Medical Center ranks 1st of the 14 Tennessee hospitals in this grouping with the shortest median time, 110 minutes (top position/top quartile).
- Comparing BMC to other high volume hospitals of which there are 19 in the state, BMC ranks 11th of the 19, placing it in the lower half.

From a quality assessment using metrics cited by the HFC in its freestanding emergency room standards and criteria, BMC demonstrates low quality. Parkridge Medical Center demonstrates high quality and will be able to introduce its high quality, top quartile service to Bradley and Polk County residents who currently must travel out of county to receive improved care.

3. Relationship to Existing Similar Services in the Area

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.

Historical Utilization of Existing Providers Serving the Service Area

Historical utilization of the existing Bradley County provider serving the service area is presented below. **Exhibit 1N-33 and 1N-34** provide relative percent of emergency care services provided in the service area in CY 2023.[14] BMC is the only hospital located in the county and in the proposed service area.

The FSED Guide requires that the Applicant use HDDS data. The HDDS data provided is not limited to the service area for this project, truncates data from small zip codes, and suppresses data from lesser used EDs. Regarding truncating data, where the zip codes are smaller than 20,000 people, the HDDS does not report the numbers separately. Accordingly, the zip code estimates for four of the service area zip codes (37362, 37353, 37307 and 37361) are combined into "373 zip codes", which is all 373 zip codes with less than 20,000 people. This means that the numbers will include visits for zip code 37353, 37362, 37316, 37307, 37361 in the service area along with other non-service area zip code such as 37352 (Lynchburg – Moore County), 37375 (Sewanee – Franklin County), and 37301 (Altamont – Grundy County). In 2023, 37353 (McDonald) had 1,915 visits, 37362 (Old Fort) had 1,767 ED visits, 37307 (Benton) had 2,636 ED visits, 37316 (Conasauga) had 28 ED visits and 37361 (Ocoee) had 775 ED visits. The HDDS ED visits for this truncated 373 totals 36,779 ED visits, an increase of nearly more than 30,000 visits, or four-fold. **Exhibit 1N-34** below shows the utilization using the HDDS data:

[14] This represents the most current year of publicly available data.

Exhibit 1N-34
Historical Utilization of Existing Providers by Service Area ED Visits, CY 2023

Hospital ED	Service Area	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 %
BMC	Yes	Bradley	25,997	67,953	38.3%
Erlanger Baroness	No	Hamilton	9,000	67,953	13.2%
Erlanger Bledsoe	No	Bledsoe	8,172	67,953	12.0%
Parkridge West Hospital	No	Marion	4,406	67,953	6.5%
Erlanger East	No	Hamilton	3,942	67,953	5.8%
Parkridge Medical Center	No	Hamilton	3,375	67,953	5.0%
CHI Memorial Chattanooga	No	Hamilton	3,327	67,953	4.9%
CHI Memorial Hixson	No	Hamilton	2,431	67,953	3.6%
Erlanger North	No	Hamilton	1,755	67,953	2.6%
Parkridge East Hospital	No	Hamilton	1,191	67,953	1.8%
Other TN Hospitals	No	**All Other TN Counties**	4,357		
Total			67,953		
Satellite ED Visits YR 1			8,751		

Source: HDDS data request 35552215. Note: Where the zip codes are smaller than 20,000 people, the HDDS does not report the numbers separately. Accordingly, the zip code estimates are for 373 zip codes, which is a combined number of all 373 zip codes with less than 20,000 people. This means that the numbers will include visits for zip code 37353, 37362, 37316, 37307, 37361 in the service area along with other non-service area zip code.

Using THA data for the more recent time period (2024), a more accurate picture of historical ED utilization is shown in **Exhibit 1N-35** because that data reports all zip codes and does not suppress smaller hospital reported data.

Exhibit 1N-35
Hospital ED Utilization in the Proposed Service Area – 2024

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 %
BMC	Bradley	Masked	39,078	Masked
Erlanger Baroness	Hamilton	Masked	39,078	Masked
Erlanger East	Hamilton	Masked	39,078	Masked
Parkridge Medical Center	Hamilton	1,638	39,078	4.2%
Other TN Hospitals	**All Counties**	5,239		
Total		39,078		
Satellite ED Visits YR 1		8,751		

Source: THA Data, 2023. Masking required by THA Data Use Policy. Satellite ED Visits Year 1 are total volume, with 7,001 from the service area and 1,750 outside the service area.

It should be noted that THA data is available through the first quarter of 2025. Since 2023, the patients seeking care at Parkridge Medical Center as shown above has increased even further, to 4.7 percent, while, BMC has decreased.

Similarly, the FSED Application Guide requires **Exhibit 1N-36** to report the HDDS data for the service area. But, as noted, due to truncation of zip code data, the Applicant acknowledges the data does not present an accurate picture of the service area in **Exhibit 1N-36**, with exception of zip codes 37311 and 37323.

Exhibit 1N-36
Ranking of ED Providers Using HDDS Data

Service Area	% Highest Market Share –	% 2nd Highest Market Share –	% 3rd Highest Market Share –	% 4th Highest Market Share –
37311 - Cleveland	BMC - 72.1%	Erlanger Baroness - 11%	Erlanger East - 5.5%	Parkridge Medical Center - 3.4%
37323 - SE Cleveland	BMC - 67.8%	Erlanger Baroness - 12.2%	Erlanger East - 6.8%	Parkridge Medical Center - 4.0%
373 - Truncated	Erlanger Bledsoe - 22.2%	Erlanger Baroness - 14.7%	Parkridge West Hospital - 12%	BMC - 11.3%
Service Area Total	BMC- 38.3%	Erlanger Baroness - 13.2.%	Erlanger Bledsoe - 12%	Parkridge West Hospital - 6..5%

Source: HDDS data request 35552215. Where the zip codes are smaller than 20,000 people, the HDDS does not report the numbers separately. Accordingly, the zip code estimates are for 373 zip codes, which is a combined number of all 373 zip codes with less than 20,000 people. This means that the numbers will include visits for zip code 37353, 37362, 37316, 37307, and 37361 in the service area along with other non-service area zip code. In 2023, 37353 (McDonald) had 1,915 visits, 37362 (Old Fort) had 1,767 ED visits, 37307 (Benton) had 2,636 ED visits, 37316 (Conasauga) had 28 ED visits and 37361 (Ocoee) had 775 ED visits. The HDDS ED visits for this truncated 373 totals 36,779 ED visits, an increase of nearly 30,000, or four-fold.

A more accurate version of the requested data for the service area in this matter is shown in **Exhibit 1N-37** below. That data is reported by zip code without truncation and does not suppress visits to lesser used EDs.[15] Hospitals that are not TriStar Division affiliates are masked per THA policy.

Exhibit 1N-37
Ranking of ED Providers Using THA Data for Most Recent Period (Q1 2025)

Service Area Zip Code	% Highest Market Share	% 2nd Highest Market Share	% 3rd Highest Market Share	% 4th Highest Market Share	Sutotal Market Share
37311 - Cleveland	BMC	Erlanger Baroness	Erlanger East	Parkridge Medical	Top 4
	Masked	Masked	Masked	4.1%	90.9%
37323 - SE Cleveland	BMC	Erlanger Baroness	Erlanger East	Parkridge Medical	Top 4
	Masked	Masked	Masked	4.2%	88.9%
37353 - McDonald	BMC	Erlanger East	Parkridge Medical	Erlanger Baroness	Top 4
	Masked	Masked	15.7%	Masked	81.6%
37362 - Old Fort	BMC	Erlanger Baroness	Starr - Etowah	Erlanger East	Top 4
	Masked	Masked	Masked	Masked	82.3%
37307 - Benton	BMC	Starr - Etowah	Erlanger Baroness	Starr - Athens	Top 4
	Masked	Masked	Masked	Masked	88.5%
37361 - Ocoee	BMC	Starr - Etowah	Erlanger Baroness	CHI Memorial	Top 4
	Masked	Masked	Masked	Masked	79.5%
Grand Total	BMC	Erlanger Baroness	Erlanger East	Parkridge Medical	Top 4
	Masked	Masked	Masked	4.5%	86.6%

Source: THA Data. Masking required by THA Data Use Policy

Utilization trends of the EDs used by the proposed service area patients are provided in response to **Question 6N** in the main application, which requests historical utilization data (see **Exhibit 1N-38** below). From 2019 through 2024, the total ED visits at the single provider in Bradley County decreased from 50,876 in 2019 to 45,500 in 2024. This is notable, as most hospitals throughout Tennessee have rebounded to pre-pandemic levels due to population growth, use rates, and an aging population. (See **Question 5N**).

Exhibit 1N-38
Historical Utilization of the Single ED in the Proposed Service Area and County Latest 5 Years

County	Facility	2019 ED Visits	2020 ED Visits	2021 ED Visits	2022 ED Visits	2023 ED Visits	2024 ED Visits	% Change
Bradley	BMC	50,876	41,584	41,262	40,097	43,574	45,500	-10.6%

Source: JARs, page 41. Note: These are total ED visits at BMC regardless of patient origin (county of residence).

Bradley Medical Center is the only operational emergency room in the service area and Bradley County. There is no such facility in Polk County. Per HDDS data, the proportion of patients seeking treatment in Bradley County has decreased since 2019. **Exhibit 1N-39** provides this information through 2023, the latest available TDOH data. THA data confirms this continuing proportionate decrease patients through Q1 2025.

[15] This data is the most recent period available demonstrating the growth in patients seeking care at Parkridge during the past two years.

Exhibit 1N-39
Bradley County Resident ED Visits to BMC and Out of County

ER	CY 2021	CY 2022	CY 2023	% Change
BMC	32,329	31,622	34,324	6.2%
All Other: Out of County	14,441	15,343	16,405	13.6%
Bradley County Residents	46,770	46,965	50,729	8.5%
Percent to BMC	69.1%	67.3%	67.7%	-2.1%

Source: BMC from TDOH data request 35551101; total visits are from THA data files since TDOH file excludes some visits which are truncated volume by hospital.

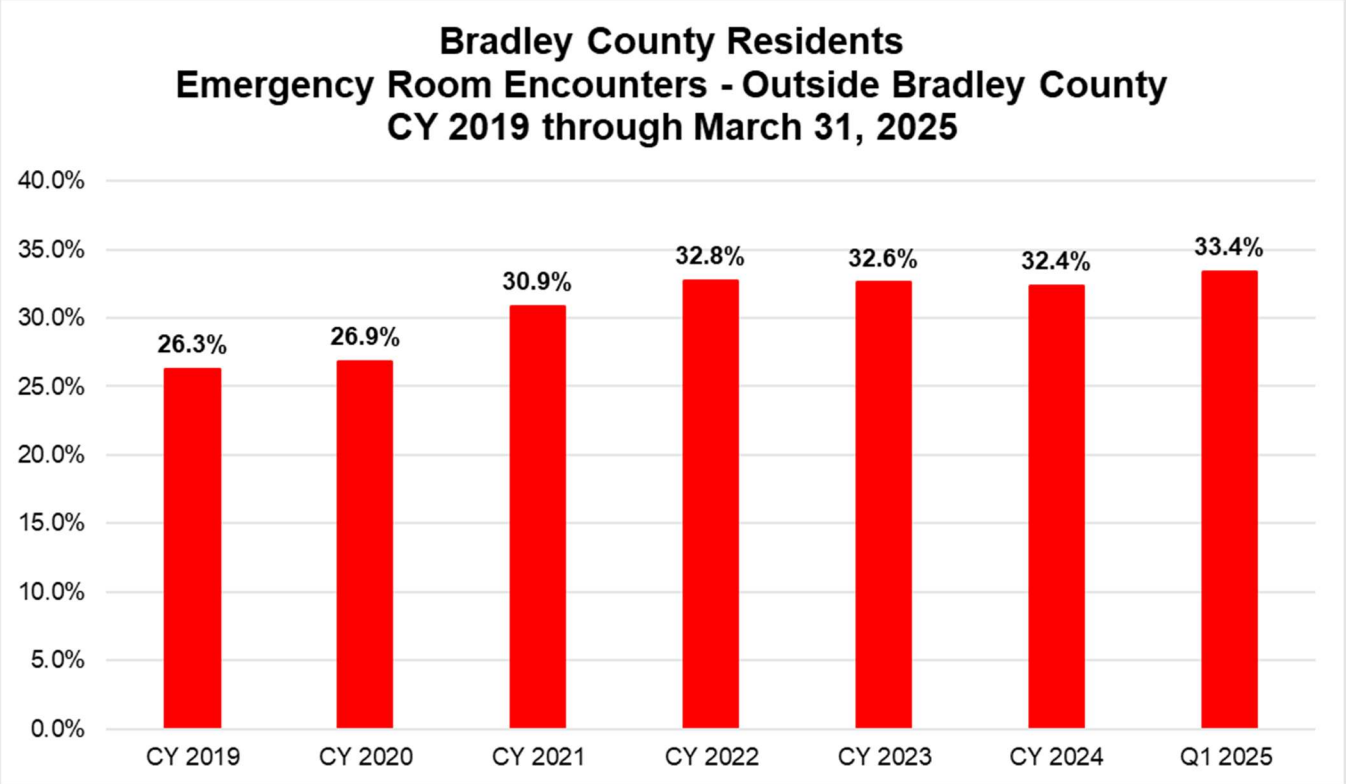
Utilizing the full ER visit data set for the county from THA data, the increase in outmigration is more evident in observing data from pre-pandemic levels to date. **Exhibit 1N-40** provides this larger data set, followed by **Exhibit 1N-41** which graphically shows the trend in out-migration for this period.

Exhibit 1N-40
Bradley County Resident ED Visits to BMC and Out of County, 2019 to Date

Bradley County Resident ER Visits	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	Q1 2025
BMC	40,596	33,002	32,327	31,581	34,200	Masked	Masked
All Other: Out of County	14,453	12,125	14,443	15,384	16,529	Masked	Masked
Bradley County Resident ER Visits	55,049	45,127	46,770	46,965	50,729	52,598	13,106
Percent BMC	73.7%	73.1%	69.1%	67.2%	67.4%	Masked	Masked

Source: THA Data; recent periods masked due to THA policy.

Exhibit 1N-41



Source: THA Data

Service area trends for out-migration are like the county trends, showing an increase in out-migration since 2019. The Parkridge Cleveland FSED will have a significant impact on out-migration through the introduction of a high quality provider into the Bradley County hospital landscape.

Parkridge Medical Center and Parkridge North Increase in ED Demand

During the three years from 2021 to 2024, Parkridge Medical Center experienced a 7.2 percent increase in emergency room visits. Parkridge North experienced a 79 percent increase during this same time period. Likewise, its visits per ED bed increased at the same rate. Accordingly, both EDs now exceed their respective mid and low range capacity per ACEP guidelines. **Exhibit 1N-42** provides the ED visits and resulting increase.

Exhibit 1N-42
Parkridge Medical Center and Parkridge North ED Visits
CY 2021-2024 and ACEP Range

ER Visits		
Year	Parkridge Medical Center	Parkridge North
2021	32,056	9,973
2022	32,572	12,657
2023	33,525	15,926
2024	34,361	17,855
Change	7.2%	79.0%
ER Treatment Rooms		
2021-- 2024	19	11
Visits/Per ER Treatment Room		
2021	1,687	907
2022	1,714	1,151
2023	1,764	1,448
2024	1,808	1,623
Change	7.2%	79.0%
ACEP Range	**Mid-Range**	**Low-Range**
ACEP Value	1,386	1,429
Over ACEP Range	30%	14%

Source: Hospital Joint Annual Report for the respective year and ACEP Tables 5.1 and 5.2

An added advantage of this CON Application is that some decompression of this overage will occur given that Parkridge Medical Center and Parkridge North treat Bradley and Polk County residents.

Impact on Existing Providers

The projected utilization for the proposed FSED is based on a combination of improving quality of care in the service area, re-direction of patients accessing other Parkridge emergency rooms, reduction in out-migration, enhancing access to service area residents and the impending future growth. The basis for the projection is discussed in detail in **Question 6N.** It is not anticipated that the Parkridge Cleveland FSED will have a meaningful impact on existing providers. Rather, growth anticipated in the service area

is expected to generate more than 3,400 incremental visits by the proposed FSED's third year of operation (2030). This projection also includes an expected redirection of more than 1,100 patients from Parkridge Medical Center and Parkridge North emergency rooms, which in turn reduces out-migration to Parkridge. Combined, these two factors represent approximately 53 percent of the projected service area visit volume of the proposed FSED by Project Year 3. This impact analysis is described in detail in application form **Question 6N** and shown in **Exhibit 1N-43** below. The balance of the Parkridge Cleveland FSED visits will be from service area residents seeking improved quality and enhanced access to emergency services which will result in further reduction in out-migration.

Exhibit 1N-43
FSED Projected Utilization and Impact on Existing Providers

CY 2023 Service Area Visits	37,588
Projected Year 3 Service Area Visits	41,024
Incremental Visits from Service Area Population Growth/Aging	3,436
Projected Shift from Parkridge and Parkridge North	1,139
Combined Total of Growth and Shift	4,575
Projected FSED Service Area Volume Year 3	8,679

The above demonstrates that more than half of the service area patients at the proposed Cleveland FSED will be derived from service area growth and shift from Parkridge Medical Center and Parkridge North. Consistent with the Consumer Advantage criteria, the proposed project will better serve the growing and aging service area population by providing a choice in provider and an emergency access point closer to the homes of many patients in the service area while improving quality of care in the service area.

Differentiation of the Proposed Service from Existing Services

The Parkridge Cleveland FSED will provide high-quality healthcare to the patients in the service area using a vehicle that is not currently available to patients. Providing a more proximate ED access point, improving quality in the service area, offering lower wait times than the other ED, improving the LWOT statistics, enhancing treatment time for suspected stroke patients and shortening travel times to access the proposed Cleveland FSED is different than currently exists in the service area.

Moreover, FSEDs serve patients of all acuity levels. The proposed Cleveland FSED will enable service area residents who need emergency care for high-risk conditions and require prompt and often specialized medical intervention improved access to such services through the establishment of an access point in southern Bradley County. Geographically, this access point will be the furthest south in the county, and near to the exit of well-traveled Route 64 and most proximate to western Polk County. Improved time to emergency care will benefit the residents of the service area through quicker access to emergency care, reduced waiting times for all patients, reduced rates of leaving without treatment, quicker access to CT results and top quartile quality of care.

Adding a new ED access point for residents of the service area and one that is a non-hospital-based emergency department will be a significant consumer advantage. While the same services are provided, FSEDs combine speed and convenience with the expertise and equipment of a hospital, making them an increasingly popular choice for emergency medical services. They reduce wait times, expand access to underserved areas, and provide high-quality care in a more comfortable setting. A summary of similarities and differences is shown in **Exhibit 1N-44** below

Exhibit 1N-44
Hospital Based Emergency Department vs Freestanding Emergency Department

Factor	Hospital Based Emergency Department	Freestanding Emergency Department
Acuity Levels Treated	All	All
Hours of Operation	24/7	24/7
Emergency Room Physicians	24/7	24/7
ER Nurses	24/7	24/7
Laboratory Capability	Yes	Yes
Ultrasound Capability	Yes	Yes
X-Ray Capability	Yes	Yes
CT Capability	Yes	Yes
Seamless Admission	Yes	Yes
Wait Times	Longer	Shorter
Lab Turnaround Time	Longer	Shorter
Diagnostic Turnaround Time	Longer	Shorter
Environment	More crowded	Less crowded
Physical Access	Less accessible	More accessible
Cost	Same	Same
Insurances	All Accepted	All Accepted
Location	Inside or Connected to Hospital	Standalone, Often Close Proximity to Where Patients Live

While there are some urgent care and primary care providers in and around the service area, these 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 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, a laboratory, or a pharmacy.

Furthermore, travel time will be shortened by the presence of the proposed Cleveland FSED in the community closer to where service area patients live.

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 southern Bradley County and western Polk County. Bradley County is not rural, while the portion of the service area in Polk County is rural. Accordingly, this criterion does not apply. However, 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						
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.

Of the 8 CMS Quality of Care measures, only 3 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-22 Left Without Being Seen/Left Without Treatment
- 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.

For OP-18, Parkridge Medical Center scored within top quartile as shown below and discussed previously. It is important to note that CMS Measure OP-18 is not meant to be compared across all hospitals, rather it is to be compared amongst like hospitals (i.e. high volume, geography, etc.). In the case of comparing Parkridge to like hospitals (very high volume), it ranks #1 with the lowest median time, thus also placing it atop the top quartile. For OP-22, Parkridge Medical Center also placed in the top quartile with 1 percent LWOT rate.

For OP-23, only 28 of the Tennessee hospitals have reported data. While this is less than 30 percent of all hospitals, one might look at the reporting hospitals on a scale. On this scale, Parkridge scored second highest across the State, again placing it among the best performing facilities within the top quartile. It also ranked well above State and National averages.

Exhibit 1N-45
Parkridge Medical Center: Quartile Ranking

Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients						
Emergency Department	**Timeframe**	**ED Score**	**Check (X) Applicable Quartile**			
			≤25th Percentile	**25th-50th Percentile**	**50th-75th Percentile**	**≥75th Percentile**
Parkridge Medical Center	CY 2024	110				**X**

Measure: OP-22 LWOT						
Emergency Department	**Timeframe**	**ED Score**	**Check (X) Applicable Quartile**			
			≤25th Percentile	**25th-50th Percentile**	**50th-75th Percentile**	**≥75th Percentile**
Parkridge Medical Center	1/1/23-12/31/23	1				**X**

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 Score**	**Check (X) Applicable Quartile**			
			≤25th Percentile	**25th-50th Percentile**	**50th-75th Percentile**	**≥75th Percentile**
Parkridge Medical Center	CY 2024	83				**X**

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release.

Parkridge Medical Center is in the "Very High Volume" category of emergency departments as assigned by CMS based on total visit volume. As a result, Parkridge's peers also include other Very High-Volume Hospitals within Tennessee. Very High-Volume Hospitals have longer wait times as they typically serve more high acuity patients. Among the 14 Very High-Volume emergency departments in the state, Parkridge has the lowest wait time. Notably, after Parkridge Medical Center, the 2nd and 3rd lowest times for very high volume EDs in the state are Parkridge's affiliates in Middle Tennessee. **Exhibit 1N-46** presents the minutes by hospital for the Very High Volume Hospitals.

Exhibit 1N-46
Median Time Spent in the Emergency Department (CMS OP 18B): Very High Volume Hospitals

PARKRIDGE MEDICAL CENTER	110	1	Top Quartile
TRISTAR CENTENNIAL MEDICAL CENTER	115	2	Top Quartile
TRISTAR SUMMIT MEDICAL CENTER	153	3	Top Quartile
TENNOVA HEALTHCARE-CLARKSVILLE	160	4	Top/2nd
ERLANGER MEDICAL CENTER	164	5	2nd Quartile
SAINT THOMAS RUTHERFORD HOSPITAL	166	6	2nd Quartile
BAPTIST MEMORIAL HOSPITAL	185	7	2nd Quartile
JOHNSON CITY MEDICAL CENTER	204	8	3rd Quartile
ASCENSION SAINT THOMAS HOSPITAL	214	9	3rd Quartile
JACKSON-MADISON COUNTY GENERAL HOSPITAL	218	10	3rd Quartile
MEMORIAL HEALTHCARE SYSTEM, INC	231	11	3rd/Bottom
METHODIST HOSPITALS OF MEMPHIS	248	12	Bottom Quartile
UNIVERSITY HEALTH SYSTEM, INC	248	13	Bottom Quartile
VANDERBILT UNIVERSITY MEDICAL CENTER	255	14	Bottom Quartile

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release.

Parkridge Medical Center is also lower than the National and Tennessee average for its peer group hospitals by significant margins. Indeed, Parkridge Medical Center's median time is below the State and National average by 80 and 85 minutes, respectively. This is shown below in **Exhibit 1N-47.**

Exhibit 1N-47
Median Time Spent in the Emergency Department: Parkridge, Tennessee and U.S.

Factor	Parkridge	Tennessee	National
Very High Volume Hospitals	110	190	195
Benefit of Parkridge Compared to Peers	--	80	85

Source: CMS Time and Effective Care-Hospital, November 26, 2025 release.

Further as shown previously, in terms of actual minutes, Parkridge Medical Center performs 93 minutes better than the only existing emergency room in Bradley County. Its introduction into the service area will improve the quality of emergency medical care available in Bradley County.[16]

Parkridge is Recognized as a High Quality Hospital

In addition to its favorable ED time, LWOT score and CT scan result time, Parkridge Medical Center has a number of other quality recognitions. These include, but are not limited to, the following:

- Joint Commission Accreditation
- Advanced Primary Stroke Center (TJC)
- Advanced Chest Pain Center (TJC)
- Primary Heart Attack Center Certification by the American Heart Association
- Accredited Cardiac Rehabilitation Program – American Association of Cardiovascular and Pulmonary Rehabilitation
- Zero Harms Award, CAUTI and CLABSI, Tennessee Hospital Association
- Blue Distinction Center for knee and hip replacement by Blue Cross Blue Shield
- Blue Distinction Center for spine surgery by Blue Cross Blue Shield
- Center for Excellence in Cardiac Care and Heart Rhythm Disorders – United Health Premium
- Fortune/Merative® 100 Top Hospitals, 2022
- High Performing Hospitals, U.S. News, 2023 -2024
- Fortune/PINC AI 100 Top Hospitals, 2023
- Fortune/PINC AI 50 Top Cardiovascular Hospitals, 2023
- Healthgrades Patient Safety Excellence Award, 2024-2025
- Healthgrades, America's 250 Best Hospitals, 2023-2025
- Healthgrades, America's 50 Best Hospitals for Surgical Excellence Award, 2025-2026
- Healthgrades Stroke Care Excellence Award, 2024, 2026
- Healthgrades Critical Care Excellence Award, 2024
- Healthgrades Spine Surgery Excellence Award, 2022 – 2024
- Healthgrades Pulmonary Excellence Award, 2024
- American Heart Association, Stroke 2025 Gold Plus, Stroke Honor Roll Elite Plus and Type 2 Diabetes Honor Roll
- Commission on Cancer
- Aetna Institutes of Quality
- Designated by the American College of Radiology as a Lung Cancer Screening Center

[16] Parkridge Medical Center average is 110 minutes compared to BMC at 203 minutes.

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.

FSEDs differentiate themselves from on-campus hospital EDs in terms of patient experience; hospital EDs have a reputation for long wait times, busy staff, crowded waiting rooms, and frequent diversion status. According to *The Journal of Urgent Care Medicine*, patients experience an average of 3-hour wait times in the nation's hospital-based EDs, whereas FSEDs see patients in a few minutes and focus on getting patients out within 60 to 90 minutes.[17]

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 or required 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.

In addition, based on TriStar Division affiliates' experience operating 183 FSEDs nationally, 70 to 80 percent of FSED patients reside within 15 minutes of its FSEDs. This is informative and relevant to the proposed Cleveland FSED. As shown in the 15-minute drive time map above (**Exhibit 1N-10**), given the proposed FSED location in southern Bradley County and the drive time studies presented in **Exhibit 1N-9**, access for service area residents will be enhanced. The service area portion within Bradley County will be reduced to 9 to 12 minute travel time. The ability of service area residents to access emergency care within 15 minutes or less will be a consumer advantage. Those areas in western Polk County part of the service area will be closer to the proposed Cleveland FSED.

The proposed FSED is an extension of emergency care provided by Parkridge Medical Center and will offer a much-needed alternative access point to emergency care for service area residents. The proposed 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 TriStar Cleveland FSED because it is closer, which in turn will alleviate some of the emergency service volume present at other Parkridge emergency rooms in the region.

FSEDs are very appropriate models for establishing an access point in populated growth areas and enhancing accessibility to emergency services for those growth areas. A secondary benefit is that it will also decompress hospitals with capacity constraints. FSEDs are also known for reduced wait times and having shorter lengths of stay from arrival through departure time. Over the past decades, the healthcare industry has seen the decentralization and dissemination of healthcare access points to provide high quality care in a sustainable manner. The appropriateness of the FSED model is evident in the success of the FSEDs operated by Parkridge Health System and other TriStar Division affiliates. Parkridge Health System operates 2 FSEDs in Hamilton County and the TriStar Division operates an additional 6 FSEDs in greater Nashville and the surrounding Middle Tennessee area. TriStar Division also has four CON approvals which are in the process of implementation; these are in the Nolensville area, East Nashville, White House and Murfreesboro. EMS providers, which work with Parkridge Medical Center and other TriStar Division FSEDs, have recognized the value and appropriate model of FSEDs thus bringing patients in need of emergency care.

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. **Exhibit 1N-48** summarizes the CY 2022 through CY

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

2024 transfers from Parkridge Health System's FSEDs to a higher level of care. As noted, between 3.2 and 3.8 percent of patients were transferred for admission or observation. Of those, the percentage to Parkridge Medical Center and its affiliates has decreased from 76 percent to 69 percent.

Patients will be transferred based on choice and clinical needs. Based on Parkridge Health System's experience, it anticipates a similar transfer pattern at the proposed Cleveland FSED.

Exhibit 1N-48
Summary of Parkridge Satellite EDs Transfers to Hospital Locations

Parkridge FSEDs	**CY 2022**	**CY 2023**	**CY 2024**
Transfers			
Admitted to Host	1.9%	1.5%	2.1%
Observed at Host	0.2%	0.2%	0.2%
Transferred to Other TriStar	0.3%	0.8%	0.3%
All Other Hospitals	0.8%	1.1%	1.2%
Total Transfers	3.2%	3.5%	3.8%
Total ER Discharges	96.8%	96.5%	96.2%
Total ER Encounters	100.0%	100.0%	100.0%
Percent of Transfers OUT	*24.2%*	*30.5%*	*30.8%*
Percent of Transfers to HCA	*75.8%*	*69.5%*	*69.2%*

Source: Internal Parkridge data, CY 2022 through CY 2024.

The proposed Cleveland FSED will play a significant role in providing increased access to patients needing to be served at a higher level of care or to be admitted to a hospital setting by increasing the availability of emergency medical care for the increasing service area population.

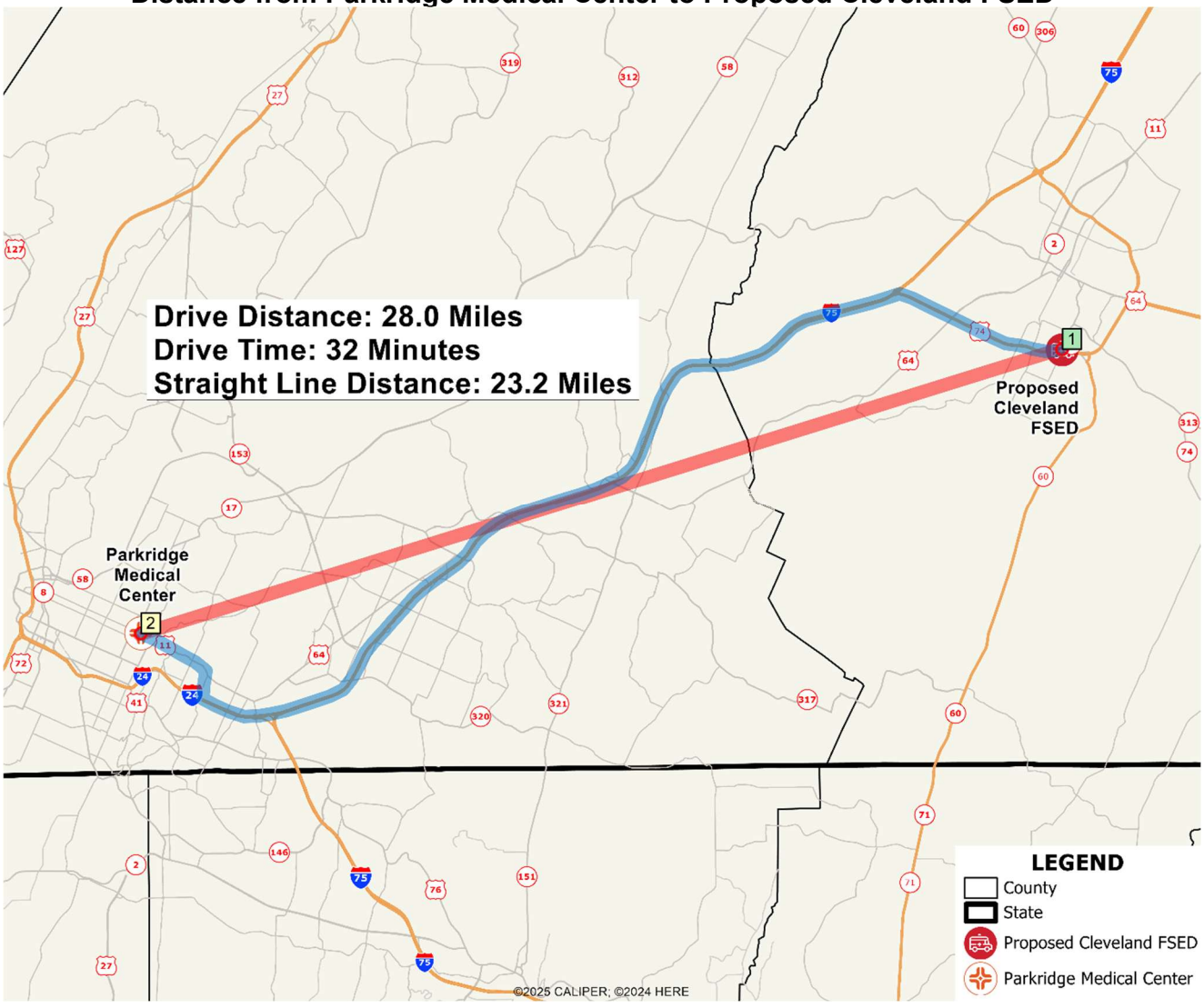
6. Geographic Location

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 28 driving miles (or 23 miles as the crow flies) northeast of the host hospital, Parkridge Medical Center. The below map, **Exhibit 1N-48,** demonstrates that the proposed FSED is located within a 35-mile radius of the hospital, Parkridge Medical Center.

Exhibit 1N-48
Distance from Parkridge Medical Center to Proposed Cleveland FSED



7. Access

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 the FSED as proposed here, must serve all who seek care as shown in its policies and procedures and based on EMTALA. Parkridge Medical Center 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 Parkridge Medical Center (see the Applicant's response to **Criterion 8** below). Further, in CY 2024, Parkridge Medical Center wrote off approximately $125 million in charity care dollars.[18]

Parkridge Medical Center makes allowances for all persons who have income at less than 400 percent of the poverty level. And for those who are below 200 percent of the poverty level, personal responsibilities are written off in their entirety. Furthermore, 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 care, or any other discount program the facility offers.

As demonstrated by Parkridge Medical Center's historical provision of emergency services for all patients, including medically indigent patients, and its historical provision of charity care overall, the proposed FSED will equitably serve all of the proposed service area.

Further, Parkridge Medical Center complies with the No Surprises Act, effective January 1, 2022, which fully protects patients from any cost differential between services provided by in-network or out-of-network providers by holding the patients harmless from any such difference and this same policy/application of the law applies to the physician services to be provided in the proposed FSED.

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 Parkridge Medical Center ED serves – and will continue to serve at each of its existing and proposed locations – a significant number of uninsured and low-income patients presenting with emergency care needs. In CY 2024, 37.4 percent of Parkridge Medical Center's ED patients were uninsured and/or low-income patients, with 21.9 percent being designated as TennCare/Medicaid patients.[19] This rate is comparable to the aggregate of the proposed FSED service area. Additionally, the latest available HDDS data is CY 2023 although truncated. Therefore, THA data is also utilized. Both sets of information are provided on the next page, **Exhibit 1N-50**. 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.

[18] Charity care and uninsured discounts for Parkridge Medical Center are from the 2024 Joint Annual Report, Schedule E, page 22.
[19] Including TennCare/Medicaid and medically indigent/charity care patients.

Exhibit 1N-50
Service Area and Parkridge Medical Center ED Services to High Need Populations by Payor
Calendar Year 2024

	Cleveland - 37311		SE Cleveland - 37323		McDonald - 37353		Old Fort - 37362		Benton - 37307		Conasauga - 37316		Ocoee - 37361		Service Area		Host Hospital	
Payor	Total ED Patients	% of Total	Total ED Patients	% of Total	Total ED Patients	% of Total	Total ED Patients	% of Total	Total ED Patients	% 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	4,566	26.0%	4,116	28.1%	585	28.4%	451	24.5%	818	30.9%	9	32.1%	253	32.6%	10,798	27.3%	17,419	29.6%
TennCare/Medicaid	4,925	28.1%	3,192	21.8%	395	19.2%	486	26.4%	656	24.7%	2	7.1%	168	21.6%	9,824	24.8%	13,043	22.2%
Commercial/Commercial Other	5,287	30.1%	5,715	39.0%	861	41.9%	720	39.1%	889	33.5%	11	39.3%	265	34.1%	13,748	34.8%	19,333	32.9%
Self Pay	2693	15.4%	1,598	10.9%	204	9.9%	182	9.9%	283	10.7%	6	21.4%	89	11.5%	5,055	12.8%	6,118	10.4%
Uncompensated	63	0.4%	35	0.2%	12	0.6%	3	0.2%	5	0.2%	0	0.0%	1	0.1%	119	0.3%	2,901	4.9%
Other	2	0.0%	1	0.0%	0	0.0%	1	0.1%	0	0.0%	0	0.0%	0	0.0%	4	0.0%	0	0.0%
Total	17,536	100.0%	14,657	100.0%	2,057	100.0%	1,843	100.0%	2,651	100.0%	28	100.0%	776	100.0%	39,548	100.0%	58,814	100.0%
TennCare/Medicaid/Uncompensated	4,988	28.4%	3,227	22.0%	407	19.8%	489	26.5%	661	24.9%	2	7.1%	169	21.8%	9,943	25.1%	15,944	27.1%

Source: THA data for zip codes; internal data for Host Hospital (Parkridge Medical Center)

Service Area and Parkridge Medical Center ED Services to High Need Populations by Payor
Calendar Year 2023

	37311 Cleveland		37323 SE Cleveland		373 Truncated		Service Area		Host Hospital	
Payor	Total ED Patients	% 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	4,422	26.3%	4,049	28.3%	11,806	32.1%	20,277	29.8%	17,419	29.6%
TennCare/Medicaid	5,607	33.3%	4,027	28.1%	10,332	28.1%	19,966	29.4%	13,043	22.2%
Commercial/Commercial Other	5,839	34.7%	5,593	39.1%	11,264	30.6%	22,696	33.4%	19,333	32.9%
Self Pay	643	3.8%	380	2.7%	2,936	8.0%	3,959	5.8%	6,118	10.4%
Uncompensated	49	0.3%	31	0.2%	326	0.9%	406	0.6%	2,901	4.9%
Other	272	1.6%	242	1.7%	115	0.3%	629	0.9%	0	0.0%
Total	16,832	100.0%	14,322	100.0%	36,779	100.0%	67,933	100.0%	58,814	100.0%
TennCare/Medicaid/Uncompensated	5,656	33.6%	4,058	28.3%	10,658	29.0%	20,372	30.0%	15,944	27.1%

Source: HDDS data request 35552215 for zip codes including truncated 373, October 2025; internal data for Host Hospital (Parkridge Medical Center)

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.

To define the proposed service area for the Parkridge Cleveland FSED, the evaluation considered (i) geographic distribution of zip codes within and outside Bradley County, (ii) location of the only emergency room in the service area, (iii) roadway systems, (iv) travel distances and (v) patient migration patterns. Polk County's proximity, geography and potential access was also considered as Polk County has no emergency room or hospital resources. Based on this detailed analysis discussed throughout this CON Application, a reasonable service area was determined to include the following zip codes:

- 37311 (Cleveland), the home zip code for the Parkridge Cleveland FSED covering central and southern Cleveland;
- 37323 (SE Cleveland), the zip code immediately to the east of the home zip code traversing southeast Cleveland;
- 37353 (McDonald), the zip code to the west of 37311 situated in the southwest of the county;
- 37362 (Old Fort), immediately to the east of 37323 and situated in southeast Bradley and southwest Polk County;
- 37307 (Benton) east of Cleveland in west Polk County; and
- 37361 (Ocoee) east of Cleveland in southwest Polk County.

Parkridge Cleveland FSED is an access enhancement to each of these six zip codes due to proximity for the residents of this defined service area. This enhancement is not only based on the drive time required to access BMC but also the drive times required to access all other hospitals these patients are regularly utilizing for emergency services, including those in Hamilton County, McMinn County and out of state.

Table 9A1 below provides patient origin by zip code for the aggregate of the six Parkridge Medical Center emergency rooms; as reflected on the table, Parkridge ERs treat more than 2,100 service area patients annually. **Table 9A2** follows presenting market share information per the HDDS data set.

Table 9A1: Patient Origin, Ranked Highest to Lowest
Parkridge Health System EDs, CY 2024

Zip Code and City	ED Visits	% Distribution	Cumulative %
30741 - Rossville	8,835	8.5%	8.5%
30736 - Ringgold	8,327	8.0%	16.5%
37412 - Chattanooga	8,038	7.7%	24.3%
37421 - Chattanooga	7,662	7.4%	31.6%
37411 - Chattanooga	6,540	6.3%	37.9%
37404 - Chattanooga	5,634	5.4%	43.4%
37406 - Chattanooga	5,541	5.3%	48.7%
37363 - Ooltewah	4,715	4.5%	53.2%
37379 - Soddy Daisy	4,473	4.3%	57.5%
37407 - Chattanooga	3,231	3.1%	60.6%
37416 - Chattanooga	2,802	2.7%	63.3%
37343 - Hixson	2,474	2.4%	65.7%
37410 - Chattanooga	2,211	2.1%	67.9%
30707 - Chickamauga	2,049	2.0%	69.8%
30742 - Fort Oglethorpe	1,826	1.8%	71.6%
37402 - Chattanooga	1,704	1.6%	73.2%
30728 - La Fayette	1,587	1.5%	74.8%
37341 - Harrison	1,504	1.4%	76.2%
30752 - Trenton	1,186	1.1%	77.3%
37415 - Chattanooga	1,049	1.0%	78.3%
37405 - Chattanooga	1,013	1.0%	79.3%
37311 - Cleveland	952	0.9%	80.2%
30755 - Tunnel Hill	856	0.8%	81.1%
37403 - Chattanooga	817	0.8%	81.9%
37323 - SE Cleveland	750	0.7%	82.6%
37312 - Cleveland	715	0.7%	83.3%
30739 - Rock Spring	693	0.7%	83.9%
37347 - Jasper	680	0.7%	84.6%
All Other (1800+ zip codes)	16,014	15.4%	15.4%
Total	103,878	100.0%	--
Service Area Subtotal	*2,193*	2.1%	--

Source: Internal Parkridge data, CY 2024

Table 9A2
ED Patient Destination by Hospital ED, 2023

	Service Area ED		Out of County EDs						
	Patient ED 1	Subtotal of	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital	
Service Area Zip Code	BMC	County EDs	Erlanger Baroness	Erlanger Bledsoe	Parkridge West	Erlanger East	Parkridge	ED Patients	Total
37311 Cleveland	12,133	12,133	1,848	*	*	931	569	1,351	16,832
37323 SE Cleveland	9,716	9,716	1,742	*	*	970	473	1,421	14,322
373 Truncated	4,148	4,148	5,410	8,172	4,406	2,041	2,333	10,269	36,779
Total Service Area	25,997	25,997	9,000	8,172	4,406	3,942	3,375	13,041	67,933
Distribution by % of Patients	38.3%	38.3%	13.2%	12.0%	6.5%	5.8%	5.0%	19.2%	100.0%

Source: Hospital Discharge Data System (HDDS) CY 2023, provided by TDOH October 2025; data request 35552215. 373 Truncated includes 37353 (McDonald), 37362 (Old Fort), 37307 (Benton), 37316 (Conasauga) and 37361 (Ocoee).

With the distortion created by 373 Truncated line above, the following table provides information for zip code 37353, 37362, 37307 and 37361 with that data limited to totals and TriStar Division hospitals.

	Service Area ED		Out of County EDs						
	Patient ED 1	Subtotal of	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital	
Service Area Zip Code	BMC	County EDs	Erlanger Baroness	Erlanger Bledsoe	Parkridge West	Erlanger East	Parkridge	ED Patients	Total
37311 Cleveland	12,133	12,133	1,848	*	9	931	569	1,351	16,832
37323 SE Cleveland	9,716	9,716	1,742	*	7	970	473	1,421	14,322
37353 McDonald					0		213	291	1,915
37362 Old Fort					0		51	399	1,767
37307 Benton					0		23	1,172	2,422
37361 Ocoee					0		12	210	677
Total Service Area	21,849	21,849	3,590	0	16	1,901	1,341	4,844	37,935
Distribution by % of Patients	57.6%	57.6%	9.5%	0.0%	0.0%	5.0%	3.5%	12.8%	100.0%

Source: Hospital Discharge Data System (HDDS) CY 2023, provided by TDOH October 2025 for 37311 and 37323. 37353, 37362, 37307 and 37361 from THA data, limited to totals and TriStar data due to masking policy.

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 groups shall be a significant consideration. Complete the following table of federally designated areas in the proposed service area to address this portion of the standards.

The proposed Cleveland FSED will be in zip code 37311. At this location, it will improve access to underserved populations, including low-income and Medicaid-eligible residents. Bradley County is not considered a rural area, although adjacent Polk County is considered rural including western Polk County which is within the proposed service area with Parkridge Cleveland FSED being the closest emergency room to western Polk County.

Bradley County is identified as having (i) a medically underserved population, (ii) a professional shortage for primary care for the whole county low-income population, and (iii) a professional shortage for mental health for the whole county low-income population. Polk County is also identified as medically underserved geographically as well as having a low-income population and being a professional shortage area. This is shown in **Exhibit 1N-51** below.

Exhibit 1N-51

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
Bradley County	--	X	X	X
Polk County	X	X	X	X

https://www.tn.gov/health/health-program-areas/division-of-health-disparities-elimination-/rural-health/federal-shortage-areas.html

Polk County, as a whole, is underserved; this is due in part to having no acute or emergency providers. Being a low-income health professional shortage here (HPSA) means that there is a lack of primary care and mental health services in both Bradley and Polk Counties for specific underserved populations, including low-income and Medicaid-eligible people. For these populations in particular, access to geographically accessible emergency services is essential, as they have an identified lack of

access to primary care and mental health.

The primary objective of the project is to increase access to care for those in the service area, including those who are low-income and Medicaid-eligible.

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 Parkridge Cleveland FSED will have all required medical services in-house. See **Table 11** below.

Table 11
Composition of Services

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

**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 ED is classified as Basic Level pediatric care.[20] Its medical staff and department staff are therefore trained and qualified to serve pediatric patients and do so daily. The number of pediatric patients receiving treatment at Parkridge Medical Center is consistently growing and is expected to

[20] This classification does not require a separate Pediatric emergency department. The qualifications of an emergency department to care for pediatric patients are classified as Basic, Primary, General and Comprehensive, based on staff training, availability of certain equipment, and so forth. Parkridge's physicians and nurses are suitably trained to care for pediatric patients and to maintain the "Basic" Pediatric Emergency Facility qualification.

exceed 5,000 this year having increased from 2,000 in CY 2021. As a percentage of total visits, pediatric patients have also shown tremendous growth during the past five years. **Exhibit 1N-52** provides pediatric ED visits as a percentage of total visits at Parkridge Medical Center since 2021.

Exhibit 1N-52
Parkridge Medical Center: Pediatric ED Visits as a Percent of Total

Age Group	CY 2021	CY 2022	CY 2023	CY 2024	YTD 2025
<18	4.9%	5.4%	6.5%	7.5%	8.0%

Source: Internal Parkridge Medical Center records.

Notably the percentage of service area pediatric patient visits has increased steadily during this same time frame. **Exhibit 1N-53** provides pediatric ED visits as a percentage of service area visits also since CY 2021.

Exhibit 1N-53
Pediatric ED Visits by Zip as a Percent of Total Proposed Service Area

Zip Code	CY 2021	CY 2022	CY 2023	CY 2024
Cleveland - 37311	16.0%	17.1%	16.8%	17.3%
SE Cleveland - 37323	15.6%	15.8%	15.9%	16.7%
McDonald - 37353	12.7%	13.6%	14.7%	15.6%
Old Fort - 37362	14.3%	17.9%	16.4%	18.8%
Benton - 37307	15.3%	15.1%	15.8%	16.3%
Ocoee -37361	16.1%	16.5%	15.4%	12.1%
Service Area	15.5%	16.3%	16.3%	16.9%

Source: THA Data

The proposed Cleveland FSED will be staffed by the same Emergency Physician group that covers Parkridge's main campus ED. All ER physicians are required to have PALS (Pediatric Advanced Life Support) certification. As reflected in **Exhibit 1N-53,** 17 percent of the ED patient visits in calendar year 2024 from the proposed service area were children and adolescents. Given Parkridge Medical Center's experience reflected above, and the fact is it is now treating 5,000+ children/adolescents per year, Parkridge's physicians are well-qualified to treat pediatric patients who present to the proposed FSED.

Patients of the proposed FSED needing a higher level of pediatric care will be transferred to Children's Hospital at Erlanger, as is the practice of Parkridge's main campus ED. Please see **Attachment 1C-3** for a copy of the Parkridge Medical Center and Erlanger transfer agreement.

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.

Parkridge Medical Center fully commits to develop and maintain the facility resources, equipment, and staffing needed to provide the appropriate emergency services. The letter of support is no longer required as it is a relic of a previous statutory framework which included consideration of Economic Feasibility.

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 Parkridge Cleveland FSED is summarized in **Exhibit 1N-53** below.

Exhibit 1N-53
Staffing Patterns

Position Type	FTEs Needed for Proposed FSED	FTEs Currently Employed	FTEs that will be Recruited
Physicians	4.2	0	4.2
ER Manager	1.0	0	1
Registered Nurses	15.2	0	15.2
EVS Tech	1.9	0	1.9
Radiology Tech	4.2	0	4.2
Pharmacist	0.5	0	0.5
Ultrasonographer	0.5	0	0.5
Laboratory	0.5	0	0.5
Other	2.1	0	2.1
Total	30.1	0	30.1

The FSED physician services will be staffed by HCA-EmCare Holdings, LLC d/b/a Valesco Ventures. Valesco provides a variety of physician services to approximately 100 healthcare facilities nationwide. Parkridge Medical Center contracts with Valesco for Emergency Medicine physician services. A letter confirming this from the Parkridge Regional Emergency Room Director is included in **Attachment 5C-2**.

Parkridge Medical Center, its TriStar Division of which it is a part and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. In 2021, HCA Healthcare opened the Galen College of Nursing in Nashville, 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. It graduated 45 nurses in its first year (2023) and is currently enrolling 700 new students each year. It expects estimated enrollment to increase 5 to 10 percent each year. This year, Galen College of Nursing expects to graduate approximately 250 graduates. It is HCA Healthcare's experience that 55 percent of graduates join an HCA hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Division including recruitment for the proposed Cleveland FSED. TriStar Division is also committed to increasing its nursing residency programs.

In addition to Galen College of Nursing, Parkridge Medical Center offers clinical training programs with other schools in Tennessee and out-of-State. The Parkridge Cleveland FSED will benefit from these

extensive nurse training relationships. The entire list is included in **Attachment 4C-1**. Schools with which it has nurse training programs include the following:

- University of Tennessee at Chattanooga
- University of Tennessee Health Science Center
- University of Tennessee Knoxville
- University of Tennessee Martin
- Austin Peay State University
- Belmont University
- Cumberland University
- Lipscomb University
- Maryville University
- Middle Tennessee State University
- Tennessee State University
- Tennessee Technological University
- Auburn University
- Azusa Pacific University
- Bethel University
- Chamberlain University
- Dalton State College
- Emory University School of Nursing
- Fortis Institute
- Freed-Hardeman University
- Georgia Northwestern Technical College
- Georgia State University
- Herzing University
- Lee University
- Madisonville Community College
- Marian University
- Marshall University
- Mary Baldwin University
- Murray State University
- Shenandoah University
- Southcentral Kentucky Community and Technical College
- Southern Adventist University
- Spring Arbor University
- Union University
- United States University
- University of Alabama at Birmingham
- University of Alabama at Huntsville
- University of North Alabama
- University of South Alabama
- University of South Carolina Aiken
- University of West Georgia
- Walden University
- Western Governors University

Parkridge Medical Center is confident it will be able to fill each of the positions identified to staff the proposed Cleveland FSED. Its current track record lends credibility to this statement based on the fact its emergency services vacancy rate is just 6.25 percent on a year-to-date basis. The metric reflects Parkridge Medical Center's successful employment experience as a significant employer in Hamilton and surrounding counties. Its expertise in recruitment and retention will be extended to the Parkridge Cleveland FSED.

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 physicians and nurses. Each FSED is required to be staffed by at least one physician and at least one registered nurse at all times (24/7/365). Physicians staffing the FSED should be board certified or board eligible emergency 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 nurses certified 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: staff 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 Regional Medical Director of the Parkridge Emergency Departments is Daniel A. Poor, MD, FACEP. A copy of Dr. Poor's letter of support is attached as **Attachment 5C-2**. Additionally, the FSED will be staffed by HCA-EmCare Holdings, LLC d/b/a Valesco Ventures. Valesco provides a variety of physician services to approximately 100 healthcare facilities nationwide. Parkridge Health System contracts with Valesco for Emergency Medicine physician services.

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.

15. Medical Records

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 main campus 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 (including FSEDs) operated within the TriStar Division.

16. Stabilization and Transfer Availability for Emergent Cases

The applicant shall demonstrate the ability of the proposed FSED to perform stabilizing treatment within the FSED and demonstrate a plan for the rapid transport of patients from the FSED to the most 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 host hospital, Parkridge Medical Center, has a helipad. Given its location and site dimensions, at this initial planning stages, the Parkridge Cleveland FSED is not expected to have an on-site helipad.

Parkridge Medical Center will work with Bradley EMS and Parkridge's its third-party ambulance company, Puckett Emergency Medical Services, to ensure patients at the FSED who require transport will have ready access to this ambulance service. Coordination with both Bradley County EMS and Puckett EMS will ensure timely transfers with minimal burden to EMS.

The proposed Cleveland FSED will serve as an extension of Parkridge Medical Center and will use the experience of the host hospital's ED to provide emergency services to the service area. The proposed 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.

Parkridge Medical Center will educate the community regarding the availability of emergency care at the Parkridge Cleveland FSED. The community will be educated through the development of written brochures available at the proposed FSED, social media messages, website information, and mailings. The community will be educated about services provided at the proposed FSED and the facilitation of transfers for inpatient care. Parkridge Medical Center will provide further education of service area residents through involvement in community activities and community boards.

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.

Parkridge Health System facilities in the Chattanooga area include three behavioral health facilities with a total of 200 inpatient psychiatric beds. Behavioral health services provided at these three facilities include Adult, Senior, Child, Adolescent and Residential care. The Parkridge Valley Mental Health and Wellness Adult and Adolescent Acute Campus connects to an emergency room referred to as Parkridge North, the closest accessible emergency room outside Bradley County. These facilities are approximately 20 minutes west of the proposed Cleveland FSED. Additionally, these hospitals operate an outpatient behavioral health program in Cleveland 37312, approximately 7 miles north of the proposed FSED.

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 the InTouch tele-psychiatry virtual platform. Based on recommendations from the tele-psychiatrist and in consultation with the Emergency Room physician, the patient is dispositioned 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 Parkridge or non-Tri-Star facility.

In addition to behavioral programs, Parkridge Medical Center works with other area providers and community access points to ensure that all patients have adequate access to needed care. Below is a list of healthcare entities with which Parkridge Medical Center has ongoing relationships:

Home Health:
- Amedisys of Chattanooga
- Accent Care Home Health
- Adoration Home Health
- Centerwell Home Health
- CHI Memorial Home Health
- Enhabit Home Health
- Erlanger Continucare Home Health
- Home Care Solutions
- Maxim Healthcare Services
- NHC Homecare
- Suncrest Home Health
- Tennessee Home Health

Rehabilitation Hospitals:
- Parkridge Medical Center – Acute Rehab
- Siskin Hospital for Physical Rehab
- Encompass Health Rehabilitation Hospital

Skilled Nursing Facilities:
- Bradley Health Care & Rehab
- Ascension Living Alexian Village
- Bledsoe County Nursing Home
- Chattanooga Health and Rehab Center
- Health Center at Standifer Place
- Laurelbrook Nursing Home
- Life Care Center of Cleveland
- Life Care Center of Collegedale
- Life Care Center of East Ridge
- Life Care Center of Hixson
- Life Care Center of Ooltewah
- Life Care Center of Red Bank
- Life Care Center of Rhea County
- NHC Healthcare – Chattanooga
- NHC Healthcare – Sequatchie
- Signature Healthcare of Cleveland
- Soddy Daisy Health Care Center
- Tennessee State Veterans Home Cleveland

In addition to healthcare entity relationships, Parkridge works closely with social services agencies and other similar organizations in southeast Tennessee. These organizations include:

- Adult Protective Service
- AIM Center
- American Cancer Society
- American Heart Association
- American Red Cross
- Autism Society of Chattanooga
- CADAS (Council for Alcohol and Drug Abuse Services)

- Catoosa County Chamber of Commerce
- Chatt Foundation
- Chattanooga Area Chamber of Commerce
- Chattanooga Area Food Bank
- Chattanooga State Community College
- Chattanooga Women's Leadership Institute
- Chattanooga Police Department
- Chattanooga Fire Department
- City of Chattanooga
- City of East Ridge
- City of South Pittsburg
- Depression and Bipolar Support Alliance
- Dr. Carol B Berz Family Justice Center
- Dr. Deanna Duncan Foundation
- Family Visitation Center of Chattanooga
- Girls, Inc. of Chattanooga
- Greater Chattanooga Colon Cancer Foundation (GCCCF)
- Green Spaces Chattanooga
- Habitat for Humanity
- Hamilton County Coalition (Multi-agency/business opioid abuse task force)
- Hamilton County Emergency Communications District
- Hamilton County EMS
- Hamilton County Medical Society
- Homeless Health Clinic
- Kidney Foundation of the Greater Chattanooga Area
- La Paz
- March of Dimes
- Marion County Chamber of Commerce
- Marion County Partnership for Economic Development
- National Alliance on Mental Illness (NAMI) - Tennessee
- Orchard Knob Collaborative
- Project Access
- Pulsepoint Community CPR Alert Initiative
- Salvation Army of Greater Chattanooga
- Scenic City Friends
- Tennessee Donor Services
- Tennessee Recovery
- Tennessee Voices for Children – Nurture the Next
- The Partnership
- TN Choice
- United Way of Greater Chattanooga
- University of Tennessee at Chattanooga
- Volunteer Behavioral Health
- Welcome Home
- YMCA of Greater

Parkridge Medical Center also works with a network of physician practices to ensure continuity of care for patients. Parkridge Medical Center is open to establishing new relationships as appropriate to better serve patients in the proposed service area.

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 and/or the Health Facilities Commission 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 proposed Cleveland FSED will be included in Parkridge's 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.

Parkridge Medical Center 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.

Parkridge Medical Center is in full compliance with the above standard. Evidence of accreditation and licensure is provided in **Attachment 2Q-1 and Attachment 5C-1**. In addition to its favorable ED time (107 minutes), 1 percent LWOT score, and 88 percent suspected strokes receiving CT results within 45 minutes, Parkridge Medical Center has other quality recognitions. These include, but are not limited to, the following:

- Joint Commission Accreditation
- Advanced Primary Stroke Center (TJC)
- Advanced Chest Pain Center (TJC)
- Primary Heart Attack Center Certification by the American Heart Association
- Accredited Cardiac Rehabilitation Program – American Association of Cardiovascular and Pulmonary Rehabilitation
- Zero Harms Award, CAUTI and CLABSI, Tennessee Hospital Association
- Blue Distinction Center for knee and hip replacement by Blue Cross Blue Shield
- Blue Distinction Center for spine surgery by Blue Cross Blue Shield
- Center for Excellence in Cardiac Care and Heart Rhythm Disorders – United Health Premium
- Fortune/Merative® 100 Top Hospitals, 2022
- High Performing Hospitals, U.S. News, 2023 -2024
- Fortune/PINC AI 100 Top Hospitals, 2023
- Fortune/PINC AI 50 Top Cardiovascular Hospitals, 2023
- Healthgrades Patient Safety Excellence Award, 2024-2025
- Healthgrades, America's 250 Best Hospitals, 2023-2025
- Healthgrades, America's 50 Best Hospitals for Surgical Excellence Award, 2025-2026
- Healthgrades Stroke Care Excellence Award, 2024, 2026
- Healthgrades Critical Care Excellence Award, 2024
- Healthgrades Spine Surgery Excellence Award, 2022 – 2024
- Healthgrades Pulmonary Excellence Award, 2024
- American Heart Association, Stroke 2025 Gold Plus, Stroke Honor Roll Elite Plus and Type 2 Diabetes Honor Roll
- Commission on Cancer
- Aetna Institutes of Quality
- Designated by the American College of Radiology as a Lung Cancer Screening Center

Please refer to **Attachment 1C-2** for a summary of Parkridge Health System community impact.

LETTER OF INTENT

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

LETTER OF INTENT

The Publication of Intent is to be published in the Chattanooga Times Free Press and Cleveland Daily Banner which are both newspapers of general circulation in Bradley County, Tennessee, on or before 11/15/2025 for one day.

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 Parkridge Medical Center, a/an Hospital owned by Parkridge Medical Center, Inc. with an ownership type of Corporation (For Profit) and to be managed by itself intends to file an application for a Certificate of Need for the establishment of a freestanding emergency department (FSED) in Cleveland, Bradley County, Tennessee. The FSED will consist of approximately 10,860 square feet with 11 exam rooms including 1 trauma room, lab, imaging department, nurse station and associated support spaces. The FSED will have two covered canopies (2,000 square feet), one designated for emergency vehicles and one designated for general public. The address of the project will be the northeast corner of the intersection of Blackburn Road SE, including the parcel addressed as 2375 Blackburn Road SE, and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74, Cleveland, Bradley County, Tennessee, 37311. The estimated project cost will be $17,409,083.

The anticipated date of filing the application is 12/01/2025

The contact person for this project is President and CEO Chris Cosby who may be reached at Parkridge Health System - 2333 McCallie Avenue, Chattanooga, Tennessee 37404 – Contact No. 423-493-1772.

Chris Cosby	11/14/2025	chris.cosby@hcahealthcare.com
Signature of Contact	**Date**	**Contact's Email Address**

The Letter of Intent must be received between the first and the fifteenth day of the month. If the last day for filing is a Saturday, Sunday, or State Holiday, filing must occur on the next business day. Applicants seeking simultaneous review must publish between the sixteenth day and the last day of the month of publication by the original applicant.

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. Written notice of opposition may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov .

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

PUBLICATION OF INTENT

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than two (2) columns by two (2) inches.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health 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 Parkridge Medical Center, a/an Hospital owned by Parkridge Medical Center, Inc. with an ownership type of Corporation (For Profit) and to be managed by itself intends to file an application for a Certificate of Need for the establishment of a freestanding emergency department (FSED) in Cleveland, Bradley County, Tennessee. The FSED will consist of approximately 10,860 square feet with 11 exam rooms including 1 trauma room, lab, imaging department, nurse station and associated support spaces. The FSED will have two covered canopies (2,000 square feet), one designated for emergency vehicles and one designated for general public. The address of the project will be the northeast corner of the intersection of Blackburn Road SE, including the parcel addressed as 2375 Blackburn Road SE, and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74, Cleveland, Bradley County, Tennessee, 37311. The estimated project cost will be $17,409,083.

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ORIGINAL APPLICATION

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

Parkridge Medical Center
Name

the northeast corner of the intersection of Blackburn Road SE, including the parcel addressed as 2375 Blackburn Road SE, and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74 | Bradley County
Street or Route | **County**

Cleveland | Tennessee | 37311
City | **State** | **Zip**

www.parkridgehealth.com
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

Chris Cosby | President and CEO
Name | **Title**

Parkridge Health System | chris.cosby@hcahealthcare.om
Company Name | **Email Address**

2333 McCallie Avenue
Street or Route

Chattanooga | Tennessee | 37404
City | **State** | **Zip**

Executive | 423-493-1772
Association with Owner | **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: 11/14/25

Date LOI was Published: 11/14/25

RESPONSE: See attached 3A Proof of Publication affidavits and tear sheets.

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

- ☐ Establish New Health Care Institution
- ☐ Relocation
- ☐ Change in Bed Complement
- ☐ Addition of a Specialty to an Ambulatory Surgical Treatment Center (ASTC)
- ☐ Initiation of MRI Service
- ☐ MRI Unit Increase
- ☑ Satellite Emergency Department
- ☐ Addition of Therapeutic Catheterization
- ☐ Positron Emission Tomography (PET) Service
- ☐ Initiation of Health Care Service as Defined in §TCA 68-11-1607(3)

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 documentation as 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
- ☐ 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

Other -

Hospital -
General Medical and Surgical

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

Parkridge Medical Center, Inc.

Name

2333 McCallie Avenue		423-493-1772
Street or Route		**Phone Number**
Chattanooga	Tennessee	37404
City	**State**	**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: Parkridge Medical Center, Inc. owns, manages and operates Parkridge Medical Center ("Parkridge"), the Applicant and facility for which the proposed freestanding emergency department ("FSED") will function as a satellite emergency department. Parkridge Medical Center is ultimately owned by HCA Healthcare, Inc. ("HCA Healthcare") through several wholly owned subsidiary corporations. Please see Attachments 7A-1 and 7A-2 for Parkridge Medical Center's corporate status from the Tennessee Division of Business Services Department of State, Charter, Amended Charter and Certificate of Good Standing, respectively. Attachment 7A-3 contains a copy of Parkridge Medical Center, Inc.'s organizational chart. Attachment 7A-4 contains a listing of Parkridge Medical Center, Inc.'s directors and officers.

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

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.
- ☐ Letter of Intent, or other document showing a commitment to lease the property - attach reference document
- ☑ Other (Specify)

Real Estate Purchase and Sale Agreement and Trust Agreement

RESPONSE: Please see Attachment 9A-1 for real estate purchase and sale agreement for the proposed site. Attachment 9A-2 includes the warranty deed for the property which confirms the seller has site control.

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 of the single-story structure.

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: The site is at the northeast intersection of Blackburn Rd Southeast and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74, Cleveland, Bradley County, TN. The approximate 2-acre site is located in zip code 37311 (Cleveland) approximately 100 yards from zip code 37323 (SE Cleveland). Route 64 travels east through zip code 37323; into Polk County. Route 74 travels west through 37323 (SE Cleveland), 37311 (Cleveland) and 37353 (McDonald), accessing Interstate 75 to the west of the proposed FSED. Route 60, which also connects to these routes, travels south along the 37311 and 37323 border. The highway and secondary road infrastructure confirms the site is easily accessible by car, ambulance, and other ground transportation. Cleveland Urban Area Transit System (CUATS) operates Monday through Friday 6AM to 7PM. There are five bus routes with all buses leaving the transit center at 165 Edwards Street on an hourly basis. The red and blue lines travel to Southern Cleveland with the end stop for both being Walmart on Treasure Drive, enabling passengers to transfer from one route to another. The blue route passes the site at the intersection of Bower Lane SE and Blackburn Road SE. Screenshots of the blue and red routes are included as Attachment 11A.

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 parcel is located at the northeast intersection of Blackburn Rd Southeast and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74, Cleveland, Bradley County, TN. The site fronts Blackburn Road SE on its west from which the public will access the FSED. The south side of the site is bordered by Appalachian Highway. The north and west side of the sites are adjacent parcels owned by unrelated third parties. Please see the plot plan included in Attachment 12A for the site, location of the structure on the site and the names of all adjacent roads.

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 (Provide signed USPS green-certified mail receipt card for each official notified.)
  - ☐ Notification in process, attached at a later date
  - ☐ Notification not in process, contact HFC Staff
  - ☑ 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 (Provide signed USPS green-certified mail receipt card for each official notified.)
  - ☐ Notification in process, attached at a later date
  - ☐ Notification not in process, contact HFC Staff
  - ☐ 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.

RESPONSE:

Parkridge Medical Center proposes to establish a FSED (referred to as "Parkridge Cleveland FSED," "proposed Cleveland FSED," or "proposed FSED") to be operated as a satellite location of its Emergency Department ("ED") and located at the northeast intersection of Blackburn Rd SE and Appalachian Highway, Cleveland, TN, approximately 28 miles from its main hospital facility. The Parkridge Cleveland FSED will be a full-service emergency department with the capability to care for emergency patients of all acuity levels. The proposed FSED will consist of approximately 10,860 square feet, including 11 treatment/exam rooms (including 1 trauma room), lab, imaging department, nursing station, and associated support space. It will have isolation and behavioral health/holding capabilities. The proposed FSED will serve the defined service area within Bradley County encompassing south Cleveland, McDonald and Old Fort (zip codes 37311, 37323, 37353 and 37362) and within the Polk County communities of Benton, Ocoee and Conasauga (zip codes 37307, 37361 and 37316).[1] The proposed FSED will enhance access for southern Bradley and western Polk County residents by establishing a new ED access point thus (i) reducing geographic isolation, (ii) providing residents with choice, (iii) providing residents with an alternative model of care, (iv) offering enhanced quality care as to what is currently available, (v) increasing the number of ED treatment rooms, (vi) improving travel times, (vii) shortening wait times, (viii) reducing the percentage of patients leaving without being seen, and (ix) improving CT results available for suspected stroke victims. The proposed FSED is needed to address:

Geographic Isolation: The defined service area is geographically isolated from emergency services. The only existing ED in the service area is Bradley Medical Center ("BMC"), a hospital in Cleveland, TN, owned by Vitruvian Health System. Given its location, the county's roadway infrastructure and perceived lower quality, approximately 35 percent of ED patients out-migrate from the service area. With the exception of Old Fort at 17 minutes, each of the Bradley County service area zip codes are within 9 to 12 minutes of the proposed Parkridge Cleveland FSED; none are within 15 minutes of BMC. Reduced time represents an improvement of between 5 and 7 minutes depending on zip code. Additionally, while the Polk County service area zip codes are further than 15 minutes, the proposed FSED will be nearer to that portion of the service area than BMC thereby shortening access time for all areas within the service area. Notably, with 35 percent of the patients out-migrating for emergency services, their travel times range between 18 and 56 minutes (12 to 42 miles) for southern Bradley County residents and 41 to 69 minutes (32 to 49 miles) for western Polk County residents to access out of county ED services including Parkridge EDs. The proposed FSED will enhance access for this patient population.

Access/Availability: Bradley County has one emergency room serving its nearly 114,000 population. Statistically this represents 0.88 emergency rooms per 100,000 population. Comparing this to statewide averages, it is approximately one half the state average of 1.74 emergency rooms per 100,000 population. It is materially less than each of the surrounding counties with ED services, including adjoining Hamilton County which has 2.59 ERs per 100,000 population. Parkridge Cleveland FSED will address the ED treatment needs of this underserved population through increased availability and improved accessibility to ED services. The proposed FSED will serve to: (i) shorten wait times by 93 minutes, (ii) lower the rates of LWOT patients and (iii) improve turn time on CT results.

Quality: There is only one emergency department in the service area, BMC, which is located at the hospital in Cleveland. BMC's ED performs in the lowest quartile statewide for median wait time, left without being seen/left without treatment ("LWOT") and lowest quartile of percent of suspected stroke victims receiving CT results within 45 minutes; these are the only three CMS criteria available for the service area. BMC performs substantially lower in these three metrics than the

Tennessee statewide and national averages. Conversely, the proposed Parkridge Cleveland FSED will introduce a high quality provider to the service area that performs in the top quartile of median wait time, receiving CT results within 45 minutes, and LWOT.

ED Capacity Challenges: Both Parkridge Medical Center and Parkridge North - the closest ED outside Bradley County - have capacity challenges, being between 18 and 30 percent over ACEP guidelines. Reducing out-migration to Hamilton County from the service area will not only expedite access to ED services but will also reduce the capacity challenges experienced by Parkridge EDs, and particularly Parkridge North ED.

Population Growth: Bradley County's population is estimated at approximately 114,000, having increased from 109,000 in 2020. Polk County population is estimated at 18,200, having increased from 16,800 in 2020. The Boyd Center for Business and Economic Research forecasts that the population will reach 118,555 and 18,605, respectively, by 2030. The defined service area is approximately 60 percent of the two-county population total, at 79,177 currently and expected to increase to 81,743 by 2030. While the overall service area population is increasing at 3.2 percent, the 65+ population is increasing at more than 5 times that rate, 17.6 percent. As a result, seniors will comprise more than 20 percent of the service area population by 2030. The increase in Bradley and Polk County population will generate 5,800 additional ED visits between 2023 and 2030, 3,400 of those visits will involve residents of the service area. Southern Bradley, western Polk and surrounding areas require expanded access to more proximate, high quality ED services.

[1] Zip code 37316 (Conasauga) is a postal box within 37362 (Old Fort) and has no population; however, it has ED visits identified in this zip code. While incorporated into the service area analysis, references to the service area throughout focuses on the six populated service area zip codes. Where appropriate, information on this zip code is provided throughout the CON Application.

- Ownership structure

RESPONSE: Parkridge Cleveland FSED will be a satellite of Parkridge Medical Center, whose ultimate parent company is HCA Healthcare. Please see the response to Question 7A and Attachment 7A. Parkridge is part of Parkridge Health System which operates 6 emergency rooms in southeast Tennessee including 2 FSEDs, while nationally, HCA Healthcare operates 189 FSEDs.

- Service Area

RESPONSE: The service area is defined as the following zip codes: 37311 (Cleveland), 37323 (SE Cleveland), 37353 (McDonald), 37362 (Old Fort), and three Polk County zip codes, 37307 (Benton), 37361 (Ocoee) and 37316 (Conasauga). The first three are within Bradley County. Old Fort is assigned to Bradley County although it is also partially located within Polk County, a rural county without hospital or emergency facilities.

- Existing similar service providers

RESPONSE: BMC, a 251-bed hospital which staffs 152 beds, currently operates the sole ED in Bradley County and the service area. Its 41-bay emergency room had approximately 45,500 ER encounters last year, a 10.6 percent decrease since 2019. As noted, BMC's ED performs in the lowest quartile statewide for median wait time, LWOT and percent of suspected stroke victims receiving CT results within 45 minutes; these are the only three CMS criteria available for the service area. Parkridge Cleveland FSED will introduce a high quality provider to the service area. See the response to Question 5N for information on BMC and its operating statistics. Additionally, the proposed FSED will introduce a new service into the service area. Freestanding EDs combine speed and convenience with the expertise and equipment of a hospital.

- Project Cost

  RESPONSE: The estimated capital cost of the project is $17,409,083.

- Staffing

  RESPONSE: The proposed FSED will be staffed by approximately 30.1 FTEs, consisting of physicians, RNs, EMT/Paramedics, radiology, and lab supervisor, as well as non-clinical support staff to provide all acuity levels of ED services. Parkridge's successful recruitment and retention experience is provided in Attachment 1N, Criterion 14.

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

  RESPONSE: The Parkridge Cleveland FSED is needed, as the proposed service area is geographically isolated and underserved relative to emergency care, with its out-migration representing 35 percent of resident ED visits traveling up to 50+ minutes (42 miles) from the Bradley portion of the service area and greater distances from the Polk portion (up to 69 minutes and 49 miles). The one existing ED in the service area performs in the lowest quartile, confirming the need to provide the service area with an alternative, high-quality provider that is more proximate to where the residents live. The Old Fort part of the service area includes a portion of western Polk County which is an acute care desert, devoid of hospital and emergency services. The proposed FSED will also provide the other service area communities in western Polk County (Ocoee, Conasauga and Benton) with a more accessible emergency room. With just one ED in Bradley County, this equates to 0.88 ERs per 100,000 population. Comparing this to statewide averages, it is approximately one half the state average of 1.74 emergency rooms per 100,000 population. It is materially less than each of the surrounding counties with ER services, including adjoining Hamilton County which has 2.59 ERs per 100,000 population. An additional advantage is that through some reduction in out-migration to the Parkridge EDs, their capacity challenges will be partially mitigated. The service area population had more than 37,500 emergency room visits in CY 2023; with population increases and aging, this is expected to reach 41,000 in 2030, an increase of 3,448 visits in the service area. Given that southern Bradley and western Polk are geographically isolated with respect to emergency care, various criteria support the need to add capacity at the proposed location, including operational practices resulting in shorter wait times, lower LWOT and other improved quality metrics, and simultaneously enhancing access for the service area.

- Quality Standards

  RESPONSE: The proposed Cleveland FSED will serve all ED acuity levels and operate under the same quality standards as the Parkridge main campus ED and its affiliates. The proposed Cleveland FSED will provide high quality care that is accessible for all patients in the service area. As part of Parkridge Medical Center, the proposed FSED will be accredited by the Joint Commission. In addition, the proposed FSED will be part of its robust Quality Assurance and Performance Improvement (QAPI) and Utilization Review Program to maintain and ensure quality of care and patient safety. Parkridge Cleveland FSED will address the ED treatment needs of this underserved population through increased availability and improved accessibility to ED services. The proposed FSED will bring a high-quality: (i) shorten wait times from 203 minutes to 110 minutes, or by 93 minutes, (ii) lower the rates of LWOT patients from 4 to 1 percent and (iii) improve turn time on CT results to 83 percent. Parkridge Medical Center, is accredited by The Joint Commission, Commission on Cancer and American Association of Cardiovascular and Pulmonary Rehabilitation; it has certifications and distinctions in Primary Stroke, Chest Pain, Primary Heart Attack, Cardiac Care and Heart Rhythm Disorders, Spine Surgery, Hip and Knee Joint Replacement; and Zero Harms Award (CAUTI and CLABSI) and many other high quality recognitions. See Attachment 1N, Criterion #22.

- Consumer Advantage
  - Choice

    RESPONSE: The proposed Cleveland FSED will introduce an additional choice of provider of emergency care in Bradley County. This is consistent with the BMC Community Health Needs Assessment 2025-2028 findings confirming need for ‘access to providers’.[2] The existing ED is hospital-based, performs below average in the

CMS metrics and is more than 15 minutes from each of the service area zip codes. Allowing Parkridge Medical Center to alleviate geographic isolation for the proposed service area residents will provide consumers with a choice of providers and a different mode of care, locally, to experience shorter wait times (a decrease of 93 minutes), lower LWOT rates, quicker CT and other diagnostic results, less congestion, access to alternate medical staff, and reduce travel. FSEDs differentiate themselves from on-campus hospital EDs in terms of patient experience; hospital EDs have a reputation for long wait times, busy staff, crowded waiting rooms, and frequent diversion status. According to The Journal of Urgent Care Medicine, patients experience an average of 3-hour wait times in the nation's hospital-based EDs, whereas FSEDs see patients in a few minutes and focus on getting patients out within 60 to 90 minutes.[3] [2] Bradley Medical Center Vitruvian Health Community Health Needs Assessment 2025 – 2028 Focus Groups identified access to providers (plural) as a significant health issue, most significant health needs and biggest health needs, concerns or issues for the community today (pages 21, 34 and 39). [3] https://www.jucm.com/understanding-the-freestanding-emergency-department-phenomenon/.

○ Improved access/availability to health care service(s)

RESPONSE: The proposed Cleveland FSED will enhance access for service area residents. Three of the service area zip codes will now be within 9 to 12 minutes of an ER when previous access times exceeded 15 minutes. The fourth Bradley zip code, partially located in western Polk County, will be closer to the proposed Cleveland FSED but only take 17 minutes to access, less than accessing BMC. Additionally, the western Polk service area zip codes will also have improved access with the establishment of the proposed FSED, although their travel times will still exceed 15 minutes. Parkridge Cleveland FSED will improve access by addressing geographic isolation for those residents of southern Bradley by bringing ED services geographically closer to patients' homes by between 5 and 7 minutes depending on the zip code and for residents of western Polk by 2 to 5 minutes; for the 35 percent of patients out-migrating, access times will be materially improved by up to 40 minutes. Reducing wait times by 93 minutes, reducing LWOT from 4 to 1 percent, and improving CT results within 45 minutes to 83 percent will improve the availability of ED services for residents in the service area when able to access the Parkridge Cleveland FSED. Improved ED operational efficiencies and access to timely emergency care are positively associated with enhanced quality of care, patient safety, and patient satisfaction, leading to potential reduction of healthcare costs.

○ Affordability

RESPONSE: The proposed Cleveland FSED will ensure access for all patients and will adhere to Non-Discrimination and Charity/ Indigent Care policies. These policies ensure access to healthcare by treating all patients regardless of race, ethnicity, or socioeconomic status and aim to reduce cost of care or provide free care to eligible patients. HCA Healthcare's TriStar Division is the largest TennCare provider in Tennessee and has the most generous charity care policy in the region. As part of Parkridge Health System, the proposed Cleveland FSED will accept all government payors, including Medicare and TennCare, and will treat all patients regardless of their ability to pay. The proposed FSED, like Parkridge, will also comply with the No Surprises Act, by holding the patients harmless from any between in-network or out-of-network insured status. See Attachment 4N-1 for a copy of Uninsured Discount and Charity Write-Off Policies.

3E. Consent Calendar Justification

☐ Letter to Executive Director Requesting Consent Calendar (Attach Rationale that includes addressing the 3 criteria)

☑ Consent Calender NOT Requested

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.

4E. PROJECT COST CHART

A. Construction and equipment acquired by purchase:	
1. Architectural and Engineering Fees	$764,000
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$150,000
3. Acquisition of Site	$1,200,000
4. Preparation of Site	$2,000,000
5. Total Construction Costs	$8,308,000
6. Contingency Fund	$300,000
7. Fixed Equipment (Not included in Construction Contract)	$1,600,000
8. Moveable Equipment (List all equipment over $50,000 as separate attachments)	$1,900,000
9. Other (Specify): Inflation, Testing, Inspection, Escalation, & Building Fees	$1,148,000
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	
2. Underwriting Costs	
3. Reserve for One Year's Debt Service	
4. Other (Specify):	
D. Estimated Project Cost (A+B+C)	$17,370,000
E. CON Filing Fee	$39,082
F. Total Estimated Project Cost (D+E) **TOTAL**	$17,409,082

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 completion 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 (Attachment 1N)

RESPONSE:

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

2N. Identify the proposed service area and provide justification for its reasonable ness. 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)

RESPONSE:

See attached PDF response to **Question 2N**.

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

PROJECTED UTILIZATION

Unit Type: ☐ Procedures ☐ Cases ☐ Patients ☑ Other Emergency Room Visits

Service Area Counties	Projected Utilization Recent Year 1 (Year = 2028)	% of Total
Bradley	319	3.65%
Polk	117	1.34%
Other not primary/secondary county	1,750	20.00%
Bradley	3,191	36.46%
Polk	382	4.37%
Bradley	2,707	30.93%
Bradley	285	3.26%
Total	8,751	100%

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

RESPONSE:

See attached PDF response to **Question 3N**.

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).

RESPONSE:

See attached PDF response to **Question 3N**.

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.

RESPONSE:

See attached PDF response to **Question 4N**.

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.

RESPONSE:

See attached PDF response to **Question 5N**.

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.

RESPONSE:

See attached PDF response to **Question 6N**.

7N. Complete the chart below 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 the applicant, and the percentage of ownership that is shared with the applicant's owners.

RESPONSE:

Parkridge does not have any outstanding CON applications. The Applicant's TriStar Division affiliates have several approved CONs as noted in the chart. The status of each is summarized below.

CON Number	Project Name	Date Approved	Expiration Date
CN2407-020	TriStar Hendersonville White House FSED	10/23/2024	12/1/2027
CN2404-010	TriStar Spring Hill Hospital	6/26/2024	8/1/2027
CN2304-010	TriStar Southern Hills Nolensville FSED	6/28/2023	8/1/2026
CN2504-013	Lebanon Center for Outpatient Surgery	6/25/2025	8/1/2027
CN2505-016	TriStar StoneCrest Murfreesboro FSED	9/24/2025	11/1/2028
CN1707-023	TriStar StoneCrest Surgery Center	10/25/2017	5/31/2026
CN2302-006	TriStar Skyline East Nashville FSED	4/26/2023	3/25/2028
CN2505-018	TriStar Clarksville Hospital	7/23/2025	9/1/2028
CN2308-020	Chattanooga Surgery Center	10/25/2023	12/1/2026
CN2508-031	TriStar Centennial Rehabilitation Bed Project	10/22/2025	1/1/2029

CONSUMER ADVANTAGE ATTRIBUTED TO COMPETITION

The responses to this section of the application helps 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.

RESPONSE: Please see Attachment 1C-1 and 1C-2 for copies of Parkridge Medical Center transfer agreements and Parkridge Health System Annual Community Report. See Question 1N, Criterion 18 for a list of Parkridge's community linkages including post acute facilities and services.

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

- [x] Aetna Health Insurance Company
- [x] Ambetter of Tennessee Ambetter
- [x]

Blue Cross Blue Shield of Tennessee

- [x] Blue Cross Blue Shield of Tennessee Network S
- [x] Blue Cross Blue Shiled of Tennessee Network P
- [x] BlueAdvantage
- [ ] Bright HealthCare
- [x] Cigna PPO
- [ ] Cigna Local Plus
- [ ] Cigna HMO - Nashville Network
- [x] Cigna HMO - Tennessee Select
- [ ] Cigna HMO - Nashville HMO
- [x] Cigna HMO - Tennessee POS
- [x] Cigna HMO - Tennessee Network
- [ ] Golden Rule Insurance Company
- [x] HealthSpring Life and Health Insurance Company, Inc.
- [x] Humana Health Plan, Inc.
- [x] Humana Insurance Company
- [ ] John Hancock Life & Health Insurance Company
- [ ] Omaha Health Insurance Company
- [ ] Omaha Supplemental Insurance Company
- [ ] State Farm Health Insurance Company
- [x] United Healthcare UHC
- [x] UnitedHealthcare Community Plan East Tennessee
- [ ] UnitedHealthcare Community Plan Middle Tennessee
- [ ] UnitedHealthcare Community Plan West Tennessee
- [x] WellCare Health Insurance of Tennessee, Inc.
- [x] Others

RESPONSE: Coventry Healthcare; First Health/Coventry National; HCA Employee Benefit Plan; Alliance; Magellan Health Service; MultiPlan/PHCS; Ambetter Exchange; Oscar; Amerigroup; WellPoint.

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.

RESPONSE:

Positive Effects

Adding a new ED access point for residents of the service area and one that is a non-hospital-based emergency department will be a significant consumer advantage. Caring for emergency patients in a FSED versus a hospital-based emergency department provides several consumer advantages. While the same services are provided, an FSED offers generally easier access, quicker treatment times, quicker turn times for diagnostics, and more accessible environment. A summary of similarities and differences s shown in **Exhibit 20** below

Exhibit 20

Hospital Based ED vs Freestanding ED

Factor	Hospital Based Emergency Department	Freestanding Emergency Department
Acuity Levels Treated	All	All
Hours of Operation	24/7	24/7
Emergency Room Physicians	24/7	24/7
ER Nurses	24/7	24/7
Laboratory Capability	Yes	Yes
Ultrasound Capability	Yes	Yes
X-Ray Capability	Yes	Yes
CT Capability	Yes	Yes
Seamless Admission	Yes	Yes
Wait Times	Longer	Shorter
Lab Turnaround Time	Longer	Shorter
Diagnostic Turnaround Time	Longer	Shorter
Environment	More crowded	Less crowded
Physical Access	Less accessible	More accessible
Cost	Same	Same
Insurances	All Accepted	All Accepted
Location	Inside or Connected to Hospital	Standalone, Often Close Proximity to Where Patients Live

In addition to the programmatic differences and benefits identified above, the proposed FSED will have several other positive effects including:

· Providing consumers with a choice;

· Relieving geographic isolation and enhancing access as 3 of the Bradley service area zip codes are within 9 to 12 minutes of the proposed FSED, an improvement of between 5 and 7 minutes to BMC depending on the zip code and importantly largely reducing access to 15 minutes or less for service area residents;

· Old Fort is in Bradley and Polk Counties and therefore will be 5 minutes closer to the proposed FSED;

· The proposed FSED will also be more proximate for western Polk service area residents including those residing in Ocoee, Conasauga and Benton;

· Introducing a new ED to the service area by a host hospital with significant consumer quality benefits including shorter wait times, lower LWOT scores, significantly quicker diagnostic results reporting, more accessible, less crowded and quicker diagnostic turnaround time, among other quality metrics presented throughout the CON application;

· Improving the quality of ED services available in the service area;

· Delivering quality ED services to its patients, with shorter wait times and lower LWOTs, closer to where they live;

· Addressing the ED treatment needs of this underserved population through increased availability and improved accessibility to ED services;

· Reducing out-migration, which approximates 35 percent of service area patients accessing emergency services outside the county at significant time and distances;

· Ensuring ED services are more readily available to the 65 and older population, which is expected to increase to more than 20 percent by 2030;

· Increasing the number of emergency rooms from 1 to 2 thereby increasing ERs per 100,000 population from half the statewide average to 1.76 which is still well below the rate of surrounding counties;

· Addressing the future ED demands by zip code, which results in a 3,448 visit increase between 2023 and 2030;

· Provide service area residents with an alternative mode to receive their emergency care, which is currently not available in the area; and

· Providing service area residents with an accessible alternate ER provider with top quartile high quality metrics.

Negative Effects

There are no material negative impacts for consumers. Top quartile quality ED services provided by Parkridge Medical Center will be made more readily available in Bradley County. This will reduce time for this population to access Parkridge Medical Center and its affiliates which currently ranges between 18 and 56 minutes, as well as other providers in Hamilton County, depending on zip code and emergency room. Furthermore, 3 of the Bradley service area zip codes will now have access to an emergency room within 9 to 12 minutes versus longer than 16 minutes or more to the existing provider.

The impact of some patients choosing to go to an ED closer to their homes will be positive for consumers because: (a) patient access is enhanced as has been noted before and (b) the other facility faces longer wait times and higher rates of leaving without treatment. The availability of the proposed Cleveland FSED access point will help those facilities to manage their patient flow better. Further, Parkridge EDs have a strong track record of transferring patients, currently averaging 3.8 percent, who need to be admitted or require more complex services to other providers, to the extent necessary.

Approximately half of the projected service area ED visits to Parkridge Cleveland FSED are anticipated to be from population growth, aging of the service area population and re-direction from Parkridge affiliates in Hamilton County. The balance will include a reduction in out-migration to other providers and re-direction of service area residents to a closer, top quartile quality provider – all to the benefit of service area consumers.

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.

RESPONSE:

See attached PDF of **Question 4C** response.

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.

RESPONSE:

Licensure and Certifications

Parkridge Medical Center is licensed by the Health Facilities Commission / Licensure Division and the license is in good standing. Parkridge Medical Center is certified to participate in the Medicaid and Medicare programs and currently meets all requirements of certification. Parkridge Medical Center's numerous accreditations and distinctions include:

Joint Commission accreditation; accreditation as a Chest Pain Center and Advanced Primary Stroke Center; Primary Heart Attack Center Certification by the American Heart Association; Zero Harms Award for CAUTI and CLABSI by the Tennessee Hospital Association; and Blue Distinction for knee and hip replacement and spine surgery. See **Attachment 5C-1** and **Attachment 2Q** for Parkridge Medical Center's Hospital License and The Joint Commission Accreditation.

Clinical Leadership

Medical direction at the proposed Cleveland FSED will be provided by Daniel Poor, MD, FACEP. Currently, Dr. Poor is the Regional Medical Director for the Parkridge Health System's EDs. Dr. Poor is board certified by the American Board of Emergency Medicine and has been providing emergency services for more than 7 years. See **Attachment 5C-2** for Dr. Poor's letter of support for the proposed FSED.

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 Parkridge Medical Center, the proposed Cleveland FSED will be part of Parkridge's existing methods to ensure and maintain quality of care. At Parkridge Medical Center, 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. Parkridge 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. Parkridge Medical Center's 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.

The proposed Cleveland FSED will be an extension of the ED at Parkridge Medical Center and a licensed department of Parkridge Medical Center and will therefore adhere to its 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. Parkridge Medical Center addresses methods to ensure and maintain patients' quality of care.

Parkridge Medical Center is dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. As a satellite ED to Parkridge Medical Center, the proposed Cleveland FSED will maintain the highest standards and quality of care, consistent with the high standard that Parkridge Medical Center has sustained throughout its history of providing patient care. In this regard, Parkridge Medical Center 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, Parkridge Medical Center 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 Division's Plan for Improvement of Organizational Performance and Clinical Excellence.

Clinical Staff Training and Requirements

The proposed Cleveland FSED will be operationally integrated with Parkridge's main ED. As such, it will comply with all 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 Parkridge Medical Center's emergency department is Dr. Poor, who will serve as Medical Director of the FSED.

In its dedication to enhance quality assurance and performance improvement, Parkridge Medical Center 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, Parkridge Medical Center will continue to require all clinical staff members to attend continuing education programs, and receive annual in-services on HIPAA, Medicare Compliance, and OSHA. Parkridge 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 Staff Education Policies. See **Attachment 4C-1** for List of Clinical Affiliations.

Proposed Cleveland FSED

All equipment at the proposed Cleveland FSED will be available 24/7. The FSED will have a CT, X-ray and ultrasound as well as lab and pharmacy support equipment. Please see the major equipment list provided in **Attachment 4E-1**. Also see page 27 for an image and equipment list for each treatment room.

HISTORICAL DATA CHART

☑ Total Facility
☐ Project Only

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

	Year 1	Year 2	Year 3
	2022	2023	2024
A. Utilization Data			
Specify Unit of Measure Other : Admissions	9851	9692	11435
B. Revenue from Services to Patients			
1. Inpatient Services	$1,074,946,689.00	$1,146,064,528.00	$1,360,712,508.00
2. Outpatient Services	$661,791,024.00	$726,821,040.00	$889,212,335.00
3. Emergency Services	$0.00	$0.00	$0.00
4. Other Operating Revenue (Specify) Virtual DSH, Statutory DSH, GME, Cafeteria, Other	$23,736,759.00	$25,303,523.00	$21,442,549.00
Gross Operating Revenue	$1,760,474,472.00	$1,898,189,091.00	$2,271,367,392.00
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$1,382,391,928.00	$1,515,284,198.00	$1,841,303,566.00
2. Provision for Charity Care	$114,981,413.00	$103,009,017.00	$125,768,862.00
3. Provisions for Bad Debt	$4,537,432.00	$11,765,811.00	$3,067,092.00
Total Deductions	$1,501,910,773.00	$1,630,059,026.00	$1,970,139,520.00
NET OPERATING REVENUE	$258,563,699.00	$268,130,065.00	$301,227,872.00

PROJECTED DATA CHART

☑ Project Only
☐ Total Facility

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

	Year 1	Year 2
	2028	2029
A. Utilization Data		
Specify Unit of Measure Other : ER Visits	8751	10762
B. Revenue from Services to Patients		
1. Inpatient Services	$0.00	$0.00
2. Outpatient Services	$0.00	$0.00
3. Emergency Services	$55,994,000.00	$74,371,000.00
4. Other Operating Revenue (Specify)	$0.00	$0.00
Gross Operating Revenue	$55,994,000.00	$74,371,000.00
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$42,102,000.00	$56,294,000.00
2. Provision for Charity Care	$5,848,576.00	$7,772,480.00

3. Provisions for Bad Debt		$1,684,424.00	$2,238,520.00
	Total Deductions	$49,635,000.00	$66,305,000.00
NET OPERATING REVENUE		$6,359,000.00	$8,066,000.00

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	Most Recent Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	$0.00	$0.00	$6,398.58	$6,910.52	0.00
Deduction from Revenue *(Total Deductions/Utilization Data)*	$0.00	$0.00	$5,671.92	$6,161.03	0.00
Average Net Charge *(Net Operating Revenue/Utilization Data)*	$0.00	$0.00	$726.66	$749.49	0.00

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.

RESPONSE:

The average ED charges per visit for the proposed Cleveland FSED are projected to be $6,399 and $6,910 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 Parkridge Medical Center. The proposed FSED is not expected to have any impact on the charges for ED services at Parkridge Medical Center or any affiliate.

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. In reality, the average net charge is what patients and/or payors pay in aggregate for the ED services received. As reflected in the above chart, the average net charge at Parkridge Cleveland FSED is $727 in year one and $749 in year two. This net amount is for all services provided during the ED visit including the visit, treatment and ancillaries. This net amount is based on Parkridge Medical Center's experience.

9C. Compare the proposed project charges to those of similar facilities/services in the service area/adjoining services 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 schedule by common procedure terminology (CPT) code(s).

RESPONSE:

The proposed charges are based on the existing charges of Parkridge's ED, which are comparable throughout Parkridge Health System. 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 21 provides a comparison of gross charges by CPT Code for Codes 99281-99285 for the ED provider in Bradley County compared with Parkridge Medical Center.

Exhibit 21

Bradley County ED Patient Level Gross Charges by CPT Code

CPT Code:	99281	99282	99283	99284	99285
BMC	$742	$1,142	$1,886	$2,513	$3,686
Parkridge Medical Center	$583	$795	$1,550	$1,695	$2,278

As noted above, Parkridge Medical Center charges for each CPT code are less than that reported by BMC in its chargemaster.

10C. 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.

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

Applicant's Projected Payor Mix

Project Only Chart

Payor Source	Year-2028		Year-2029	
	Gross Operating Revenue	**% of Total**	**Gross Operating Revenue**	**% of Total**
Medicare/Medicare Managed Care	$13,211,000.00	23.59	$17,547,000.00	23.59
TennCare/Medicaid	$14,200,000.00	25.36	$18,860,000.00	25.36
Commercial/Other Managed Care	$17,680,000.00	31.57	$23,482,000.00	31.57
Self-Pay	$7,592,000.00	13.56	$10,084,000.00	13.56
Other(Specify)	$3,311,000.00	5.91	$4,398,000.00	5.91
Total	$55,994,000.00	100%	$74,371,000.00	100%
Charity Care	$5,848,576.00		$7,772,480.00	

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

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.

RESPONSE: See attached narrative response to Question 10C.

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.

- [x] Yes
- [ ] No

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 in its CON application?
  - [x] Yes
  - [ ] No
- Does the applicant commit to obtaining and maintaining all applicable state licenses in good 3tanding?
  - [x] Yes
  - [ ] No

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

  - [x] Yes
  - [ ] No

3Q. Please complete the chart below on accreditation, certification, and licensure plans. Note: if the applicant does not plan to participate in these type 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	Active	66
Certification	☑ Medicare ☑ TennCare/Medicaid ☐ Other _____	Active Active	44-0156 44-0156
Accreditation(s)	TJC - The Joint Commission	Active	7815

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

- ☑ AMERIGROUP COMMUNITY CARE- East Tennessee
- ☐ AMERIGROUP COMMUNITY CARE - Middle Tennessee
- ☐ AMERIGROUP COMMUNITY CARE - West Tennessee
- ☑ BLUECARE - East Tennessee
- ☐ BLUECARE - Middle Tennessee
- ☐ BLUECARE - West Tennessee
- ☑ UnitedHealthcare Community Plan - East Tennessee
- ☐ UnitedHealthcare Community Plan - Middle Tennessee
- ☐ UnitedHealthcare Community Plan - West Tennessee
- ☑ TENNCARE SELECT HIGH - All
- ☑ TENNCARE SELECT LOW - All
- ☑ PACE
- ☐ KBB under DIDD waiver
- ☐ Others

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.

  - ☑ Yes
  - ☐ No
  - ☐ N/A

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

  ☐ Yes
  ☑ No
  ☐ N/A

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

Has any of the following:

- 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.

Been subject to any of the following:

- Final Order or Judgement in a state licensure action;

  ☐ Yes
  ☑ No

- Criminal fines in cases involving a Federal or State health care offense;

  ☐ Yes
  ☑ No

- Civil monetary penalties in cases involving a Federal or State health care offense;

  ☐ Yes
  ☑ No

- Administrative monetary penalties in cases involving a Federal or State health care offense;

  ☐ Yes
  ☑ No

- 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;

  ☐ Yes
  ☑ No

- Suspension or termination of participation in Medicare or TennCare/Medicaid programs; and/or

  ☐ Yes
  ☑ No

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

  ☐ Yes
  ☑ No

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) positions for these positions.

☑ Existing FTE not applicable (Enter year)

Position Classification	Existing FTEs(enter year)	Projected FTEs Year 1
A. Direct Patient Care Positions		
Nurses - RN	0.00	15.20
Emergency Room Manager	0.00	1.00
Radiology Tech	0.00	4.20
Ultrasonographer	0.00	0.50
Lab Supervisor	0.00	0.50
Pharmacist	0.00	0.50
Total Direct Patient Care Positions	N/A	21.9
B. Non-Patient Care Positions		
Security	0.00	2.10
Environmental Services	0.00	1.90
Total Non-Patient Care Positions	N/A	4
Total Employees *(A+B)*	0	25.9
C. Contractual Staff		
Contractual Staff Position	0.00	4.20
Total Staff *(A+B+C)*	0	30.1

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 decision whether to grant an extension is within the sole discretion of the Commission, 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		01/28/26
2. Building Construction Commenced	314	12/07/26
3. Construction 100% Complete (Approval for Occupancy)	646	11/04/27
4. Issuance of License	706	01/03/28
5. Issuance of Service	736	02/02/28
6. Final Project Report Form Submitted (Form HR0055)	856	06/01/28

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

Attachment 3A

Proof of Publication

Form v1.55

Chattanooga Times Free Press

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Before me personally appeared Samara Swafford, who being duly sworn that she is the Legal Sales Representative of the CHATTANOOGA TIMES FREE PRESS, and that the Legal Ad of which the attached is a true copy, has been published in the above named newspaper and on the corresponding newspaper website on the following dates, to-wit:

Times Free Press 11/14/25; TimesFreePress.com 11/14/25

And that there is due or has been paid the CHATTANOOGA TIMES FREE PRESS for publication the sum of $239.32.

Samara Swafford

Sworn to and subscribed before me this date:14th day of November, 2025

SHENIQUA HAMBRICK
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY
MY COMMISSION EXPIRES DECEMBER 14, 2026

Sheniqua Hambrick

My Commission Expires 12/14/2026

Chattanooga Times Free Press

400 EAST 11TH ST
CHATTANOOGA, TN 37403

Families sue ByHeart over recalled formula

BY EMIL ALENTA
THE ASSOCIATED PRESS

The parents of at least two babies sickened in an infantile botulism outbreak are suing the makers of the ByHeart baby formula at the heart of a nationwide recall.

Stephen and Yanney Iverson, of Flagstaff, Arizona, said their 4-month-old daughter, Rose, had to be flown by air ambulance to a children's hospital two hours from home and treated for several weeks this summer.

Michael and Hanna Everett, of Richmond, Kentucky, said their daughter, Piper, also 4 months, was rushed to a hospital New York with worsening symptoms of the rare and potentially deadly disease.

The lawsuits, filed in federal courts in two states, allege that the ByHeart formula the babies consumed was defective and that the company was negligent in selling it. They seek financial payment for medical bills, emotional distress and other harm.

Both families said they bought the organic formula to provide what they viewed as a natural, healthier alternative to traditional baby formulas, and that they were shocked and angered by the suffering their children endured.

"I wouldn't guess that a product designed for a helpless, developing human in the United States could cause something this severe," said Stephen Denzer, 44.

"She's so little and you're just helplessly watching this," said Hanna Everett, 28. "It was awful."

OUTBREAK IN AUGUST

Rose Denzer and Piper Everett are among at least 15 infants in a dozen states who have been sickened in the outbreak that began in August, according to federal and state health officials. No deaths have been reported.

Both received the interventions available for botulism in children: rare shots a year old an IV medication called BabyBIG, made from the blood plasma of people immunized against the neurotoxins that cause the illness.

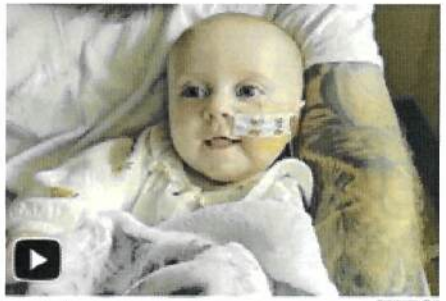
Investigations into more potential botulism cases are pending after ByHeart, the New York-based formula manufacturer, recalled all of its formula nationwide on Sunday. At least 84 U.S. babies have been treated for infantile botulism since August, including those in the outbreak, California officials said.

The company sells about 200,000 cans of formula per month. It can take up to 30 days for signs of infantile botulism infection to appear, medical experts said.

California officials confirmed that a sample from an open can of ByHeart formula fed to an infant who fell ill contained the type of bacteria that can lead to illness.

The lawsuits filed Wednesday could be the first of many legal actions against ByHeart, said Bill Marler, a Seattle food safety lawyer who represents Denzer.

"This company potentially faces an existential crisis," he said.



Four-month-old Piper Everett is treated Monday for infantile botulism in a Kentucky hospital.

ELAINE CHAMBERS/AP

ByHeart officials didn't respond to questions about the new lawsuits but said they would "address any legal claims in due course."

"We remain focused on ensuring that families using ByHeart products are aware of the recall and have factual information about steps they should take," the company said in a statement.

BABIES GROW SICKER

In Rose Denzer's case, she received ByHeart formula within days of her birth in July after breast milk was insufficient, her father said. Stephen Denzer said he went to Whole Foods to find a "natural option."

"I'm a little concerned with things that are so food that one would expect to be safe," he said. "We do our best to buy something that says it's organic."

Piper Everett, who was healthy at birth, didn't thrive on the formula. She had trouble feeding and was fussy and fretful as she got sicker. On Aug. 31, when she was 8 weeks old, her parents couldn't wake her.

Rose was flown by air ambulance to Phoenix Children's hospital, where she stayed for nearly two weeks.

Hanna Everett said she used ByHeart to supplement breastfeeding starting when Piper was 6 weeks old.

"It's supposed to be similar to breast milk," she said.

Last weekend, Piper started showing signs of illness. Everett said she became more wearied when a friend told her ByHeart had recalled two lots of its Whole Nutrition Infant Formula. Whereas family members checked the recipe's cans, they matched the recalled lots.

"I was like, 'Oh my god, we need to go to the ER,'" Everett recalled.

At Kentucky Children's Hospital, Piper's condition worsened rapidly. Her pupils stopped dilating correctly and she had lost gag reflex. Her head and arms became limp and floppy.

Doctors immediately ordered doses of the BabyBIG medication, which had to be shipped from California, Everett said. In the meantime, Piper had to have a feeding tube and IV fluids inserted.

In both cases, the babies improved after receiving treatment. Rose went home in September and the 20 pounds Piper required a feeding tube. Piper went home this week.

They appear to be doing well on different formulas, the families said.

Britain gives OK to smaller nuclear reactor in Wales

BY STANLEY REED
NEW YORK TIMES NEWS SERVICE

LONDON — Britain will back a modular nuclear power station for Anglesey Island in northern Wales, ending years of uncertainty over the fate of what is considered the country's best nuclear site.

The decision, which was announced Thursday morning in London, appears to be an effort to create a British nuclear champion and a move to increase the government's role in the economy, especially the energy sector.

The Wales plant would also be the first of this type of nuclear plant to be built in Britain. Modular designs are promoted as cheaper and quicker to construct.

Rolls-Royce SMR, an affiliate of the jet engine maker that is one of Britain's few remaining large industrial companies, will design the power station at Wylfa, a rocky headland on the island that overlooks the Irish Sea.

Rolls-Royce is trying to parlay its experience designing and building the reactors for Britain's nuclear submarines into a new business line. It has brought in investors, including the Qatar Investment Authority, the Persian Gulf emirate's sovereign wealth fund, Czech Holdco, an American utility, and Exor, a Czech Republic's power company.

The Wales plant will consist of three units, known as small modular reactors, or SMRs, whose power output will add up to a little less than half that of one of the newest generation of giant power stations.

These "mini-nuclear reactors are smaller and quicker to build" than some larger ones, the government said in a news release. The plan is to lower costs through assembling modules from components in factories and then setting them up on site.

The government is betting that these smaller reactors will give Britain a technology with low carbon emissions and "global export opportunities." It has pledged 2.5 billion pounds ($3.3 billion) for preliminary work on the site and other preparations. The additional cost of completing the plant may be financed through charges on electric bills, a strategy the government is using to draw investors to another plant, Sizewell C, being built in eastern England.

The government said the plant would support 3,000 local jobs and power 3 million homes. By comparison, Sizewell C is projected to create 9,000 jobs at peak construction and light 6 million homes.

The government, though, is taking something of a gamble. Small modular reactors like the one proposed for Rolls-Royce are relatively new in the global nuclear industry. Such leadership could bring both advantages and unexpected problems.

Britain, which is trying to construct nuclear plants after a long hiatus, has already been badly burned by delays and cost overruns at a giant plant being built on the west coast of England at Hinkley Point.

In addition, some critics say the government is making a mistake by not building a larger plant at Wylfa that would generate more electricity and create more jobs. The nuclear industry considers Wylfa the most advantageous of potential British sites because of its bedrock location and easy access to deep waters for cooling.

In a statement Wednesday, Unite, a large trade union, said that "[u]sing the small modular plant at Wylfa was "a missed opportunity."

The union said that although the smaller plant would generate "some employment opportunities," those from a larger model would be "far greater."

In addition, the choice is likely to disappoint Washington, an important ally and the American nuclear industry, which has been courting Britain. The United States recently signed an ambitious nuclear cooperation deal with Britain.

In an article in The Telegraph in October, Warren Stephens, the U.S. ambassador to Britain, urged the government to designate Wylfa as the site for what he called a "gigawatt-scale nuclear project." He also said private investors were prepared "to fund the majority" of the facility.

The British government, though, is eager to move forward with small nuclear reactors and may have calculated that lining up an American giant would take years.

Kate Sumner, the prime minister, also probably wanted something to happen quickly at Wylfa, whose future has been in doubt since Hitachi walked away from building a power station there in 2020 after spending around 2 billion pounds. A Hitachi-era plant at Wylfa closed in 2015.

"It might simply be that Wylfa is in the wrong size they can possibly bring online for SMRs, so they're gone for that," said Adam Bell, a former senior British energy official who is now director of policy at Stonehaven, a consulting firm.

Edward T. Jones, a senior lecturer in economics at Bangor University in North Wales, said the local community, which was stunned by Hitachi's departure, might not be prepared to cash in on the opportunities offered by the new plans. "They've been burnt once and don't want to be burnt again," he said.

The Wylfa nuclear power plant, a 1960s-era facility shut down in 2015, is seen in 2018 on Anglesey Island in northern Wales. Britain will back a modular nuclear power station for Anglesey Island, ending years of uncertainty over the fate of what is considered the country's best nuclear site.

STEFAN ROUSSEAU/PA VIA ASSOCIATED PRESS

Lodge

CONTINUED FROM C1

An iron-clad plan is in place at Lodge to mark the nation's historical milestone, according to the South Pittsburg plant's chief executive officer.

"Since you're celebrating 250 years of the U.S., this is literally one of the first off the line of cannonballs, the new technology we just put in, next door," Lodge chief executive Mike Overman told Lee in his presentation of the company's commemorative skillets. "We're able to create any design we want."

Overman couldn't provide more details on the new line, but company officials offered a tease.

"Lodge is celebrating American's 250th anniversary with a special edition cast iron skillet featuring American icons and landscapes from across the country," Lodge spokesperson Jay Hirt said in a follow-up email. "Seasoned with 100% vegetable oil, the cast iron skillet is made without PFAS for a naturally nonstick experience, proudly made in South Pittsburg since 1896. The line is scheduled to launch in early 2026."

PFAS, short for per- and polyfluoroalkyl substances, are chemicals that contain a strong carbon-fluorine bond that allows them to accumulate over time in the environment and in the bodies of animals and people, posing health risks, according to the Environmental Health News website.

During the tour, Lee and his wife asked questions about the process, the employees and where the basic iron used comes from — it is sourced from Brazil. They asked how long it takes to make a single skillet — about 2.5 hours — and what happens to rejects — bad seasoning is blasted clean and re-seasoned, but defective pieces are melted down again for a new product.

"Tennessee, we know, is the best state in the country, and companies like this, communities like this, are what make Tennessee unique. This has been a great opportunity to actually see the process and see what happens, and this is a great American iconic company."

— TENNESSEE GOV. BILL LEE

minister. That foundry burned down in May 1981, according to the company.

Three months later, the foundry was rebuilt under the Lodge manufacturing name.

The Marion County industry celebrated 129 years in operation in 2025, a testament to company and family historical accounts. Lodge is the oldest continuously operating cast iron cookware foundry and the oldest family-owned cookware company in the United States.

In the coming year, Tennessee will celebrate the outset of its birthday by interpreting and preserving the unique Tennessee stories, objects, landmarks and places "that have defined what we are as Tennessean and Americans," according to the press release from Lee's office.

The Tennessee Commission for the United States Semiquincentennial is charged with planning, and additional information will be announced as they are scheduled, officials said in the release. Tennessee residents are invited to sign up for the Lee Report from the Museum's Voices and Volunteers newsletter to learn more about upcoming events and share personal stories at

The commission is also offering grant opportunities for organizations and communities centered around Tennessee's unique stories, including project support grants and community support grants, officials said. Twenty-two will be awarded to applicants who propose projects that support the mission of Tennessee's America 250 Celebration by highlighting Tennessean and events that have shaped American democracy from the Revolutionary era to the present. More information regarding eligibility and application deadlines may be found at

Contact Stephanie Desmon at sdesmon@timesfreepress.com or

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Kelly said named the union's proposals would significantly alter Starbucks' operations, such as giving workers the ability to shut down mobile ordering if a store has more than five orders in the queue.

Kelly said Starbucks remained ready to talk, and "believes we can move quickly to a reasonable deal." Kelly also said surveys showed that most employees like working for the company and its barista hourly rates are half the industry average.

HIGH VISIBILITY

Unionized workers have gone on strike at Starbucks locations in 2022 and 2023. workers walked off the job on Red Cup Day. Last year, a five-day strike ahead of Christmas closed 50 U.S. stores. Each time, Starbucks said the disruption to its operations was minimal. Starbucks Workers United said the new strike is open-ended and could spread to many more unionized locations.

The number of Starbucks unionized stores dwarfs the number of unionized ones. But Todd Vachon, a union expert at the Kheel School of Management and Labor Relations, said any strike could be highly visible and educate the public on barista concerns.

Unlike manufacturers, Vachon said, retail industries depend on the connection between their employees and their customers. That makes sharing a potentially powerful weapon in the union's arsenal, he said.

IMPROVING SALES

Starbucks' same-store sales, or sales at locations open at least a year, rose 1% in the July-September period. It was the first time in nearly two years that the chain's results two years that the company had posted an increase. It is first year at the company. Niccol set new hospitality standards, redesigned stores to be more welcoming and spacious, and adjusted staffing levels to better handle peak hours.

Starbucks also is trying to prioritize in-store orders over mobile ones. Last week, the company's holiday drink rollout to the U.S. was so successful that it almost immediately sold out of the plan. Starbucks cup. Starbucks said demand for the cup exceeded its expectations, but it wouldn't say if the Reusable will return before the holidays are over.

HIGHER PAY, BETTER HOURS

Workers say they're seeking better hours and improved staffing in stores, where they say long customer wait times are typical time. They also want higher pay, pointing out that executives like Niccol are making millions and the company spent $81 million in June on a conference in Las Vegas for 14,000 store managers and regional leaders.

Doris Spalmer, a barista from Pittsburgh, said in a union conference call Thursday that it's hard for workers to be assigned more than 15 hours per week, which lowers their chances of the 20 hours they would need to be eligible for Starbucks' benefits. Spalmer said she makes $16 per hour.

"I want Starbucks to succeed. My livelihood depends on it," Spalmer said. "We're proud of our work, but we're tired of being treated like we're disposable."

The union also wants the company to resolve hundreds of unfair labor practice charges filed by workers, who say the company has fired baristas in retaliation for unionizing and has failed to bargain over changes in policy that workers said disrupted the its decision earlier this year to limit customers use to paying customers.

WAGES AND BENEFITS

Starbucks says it offers the best wage and benefit package in retail, with workers making up of $30 per hour. Among the company's benefits are up to 18 weeks of paid family leave and 100% tuition coverage for a bachelor college degree. In a letter to employees last week, Starbucks' Chief Partner Officer Sara Kelly said the union walked away from the bargaining table on the spring.

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TVA

CONTINUED FROM C1

CEO will be just over $6 million, placing him on the bottom of CEO pay for a

TVA uses for comparison.

The four other current top executives filling out the leadership under Mood are Chief Financial Officer Tom Rice, Chief Nuclear Officer Jeff Lyash, Executive General Counsel Rebecca Tolene and Chief Business Officer Jeremy Fisher.

The nuclear chief oversees three nuclear plants that together supply around 40% of TVA electricity, which is purchased by 10 million people in seven states through their local utilities. Rasmussen is based in Chattanooga, where the Knoxville-based utility has more employees than anywhere city.

None of the executives are new to TVA. They are at the top of a team of 14 managers who have a

of experience at the utility.

MIXED PAY

Compensation for each of the current executives is lower than that of their predecessors, though it is pro-rated with a mix of their previous and current pay based on their time in each role, TVA spokesperson Scott Fiedler said in an email.

Most of the departed executives, including former Chief Financial Officer John Thomas and former General Counsel David Fountain, did not receive pay for the full year. A majority of compensation for executives came from performance-based incentives.

Mood's compensation includes more than $900,000 from a one-year offset to cut $650 million of planned spending, which officials said at a board meeting in May was on track for completion by Sept. 30, 2026.

The spending cuts come as TVA plans to invest $50 billion over the next three years in its system of power plants to

and improve the reliability of existing ones, Mood told the board.

While the spending cuts are largely related to TVA's supply chain, the utility looked to its labor costs as well. Around

took a voluntary buyout this year related to the effort, which TVA calls its "enterprise transformation."

The workforce reduction was officially tallied in the annual report on Thursday. TVA had 10,010 employees as of Sept. 30, down from 11,362 employees in 2024.

The slimmer workforce increased the percentage of TVA employees represented by

to 58% from 57% and increased the average tenure of employees to 13 years from 12 years.

Some of the spending cuts relate to the executive team, which has a smaller headcount and lower compensation compared to last year.

Rice was previously senior vice president of finance before becoming chief financial officer in January. Tolene was previously a vice president and chief of staff before becoming the top lawyer in April. Jeremy Fisher was previously senior vice president of commercial energy solutions before becoming chief executive and customer officer in April. He title changed to chief business officer in August.

Rasmussen was previously senior vice president of nuclear operations before becoming chief nuclear officer in October. He took on the duties of the role beginning in August.

Contact business reporter Daniel Johnson at

or

at

TVA executive compensation in 2023

- Jeff Lyash, former CEO: $6.8 million
- Don Moul, CEO: $5.7 million
- John Thomas, former chief financial officer: $4.4 million
- Tim Rausch, former chief nuclear officer: $3.2 million
- David Fountain, former general counsel: $2.6 million
- Tom Rice, chief financial officer: $2 million
- Matt Rasmussen, chief nuclear officer: $1.6 million
- Rebecca Tolene, general counsel: $1.5 million
- Jeremy Fisher, chief business officer: $1.3 million

Source: TVA report to U.S. Securities and Exchange Commission

TVA executive compensation in 2024

- Jeff Lyash, CEO: $10.5 million
- John Thomas, chief financial officer: $6.3 million
- Don Moul, chief operating officer: $5 million
- David Fountain, general counsel: $3.1 million
- Tim Rausch, chief nuclear officer: $3.1 million

Source: TVA report to U.S. Securities and Exchange Commission

AI

CONTINUED FROM C1

year, amounting to more than 20 gigawatts of energy, more than all of last year combined.

Oracle was securing the most capacity during the time frame, much of it supporting AI workloads for Anthropic's chief rival OpenAI, maker of ChatGPT. Google was second and Facebook came in third, ahead of Meta, Amazon, CoreWeave and Microsoft.

Anthropic said its projects will create about 800 permanent jobs and 2,400 construction jobs. It said in a statement that the "scale of this investment is necessary to meet the growing demand for Claude from hundreds of thousands of businesses while keeping our research at the frontier."

Microsoft has founded its own story. Atlanta data center as it increase 2 and said it will be connected across a "high-speed network" with the original Fairwater complex being built south of Milwaukee, Wisconsin. The company said the facility's densely packed Nvidia chips will help power Microsoft's own AI technology, along with OpenAI's and other AI developers.

Microsoft was, until earlier this year, OpenAI's exclusive cloud computing provider before the two companies amended their partnership. OpenAI has since announced more than $1 trillion in infrastructure obligations, much of it tied to its Stargate project with partners Oracle and SoftBank. Microsoft, in turn, spent nearly $35 billion in the July-September quarter on capital expenditures to support its AI and cloud demand, nearly half of that on computers and chips.

Anthropic has made its own computing partnerships with Amazon and, more recently, Google.

The tech industry's big spending on computing infrastructure for AI startups that generate no profitable has fueled concerns about an AI investment bubble.

Investors have closely watched a series of circular deals over recent months between AI developers and the companies building the costly chips and data centers needed to power their AI products. Anthropic said it will announce "prioritize cost-effective, capital-efficient approaches" to scaling up its computing.

OpenAI hadn't backtrack last week after its chief financial officer, Sarah Friar, made comments at a tech conference suggesting the U.S. government could help in financing chips needed for data centers. The White House's top AI official, David Sacks, responded on social media that there "will be no federal bailout for AI" and if one of the leading companies fails, "others will take its place," though he also added he didn't think "anyone was actually asking for a bailout."

OpenAI CEO Sam Altman later confirmed in a lengthy statement that "we do not have or want government guarantees" for the company's data centers and that it sought to address concerns about whether it will be able to pay for all the infrastructure it has signed up for.

"We are looking at expenditures of about $13 trillion over the next 8 years," Altman wrote. "Obviously this requires enormous revenue growth, and each dwindling is a lot of work that we are finding good about our prospects then."

AFFP

Notification of Intent

Affidavit of Publication

STATE OF TN }
COUNTY OF BRADLEY } SS

Heather Brown, being duly sworn, says:

That she is Legal Clerk of the Cleveland Daily Banner, a daily newspaper of general circulation, printed and published in Cleveland, Bradley County, TN; that the publication, a copy of which is attached hereto, was published in the said newspaper and on the newspaper website, and for foreclosure notices, on the third-party website, www.foreclosuretn.com, on the following dates:

November 15, 2025

That said newspaper was regularly issued and circulated on those dates.

SIGNED:

Heather Brown

Legal Clerk

Subscribed to and sworn to me this 15th day of November 2025.

Joyce Taylor

Joyce Taylor, Notary Public, Bradley County, TN

My commission expires: December 10, 2025

70149149 71360169

HCA Healthcare / TriStar Division
1000 Healthcare Dr.
Bldg. 3, Ste. 500
BRENTWOOD, TN 37027

JOYCE TAYLOR
STATE OF TENNESSEE
NOTARY PUBLIC
BRADLEY COUNTY

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 Parkridge Medical Center, a/an Hospital owned by Parkridge Medical Center, Inc. with an ownership type of Corporation (For Profit) and to be managed by itself intends to file an application for a Certificate of Need for the establishment of a freestanding emergency department (FSED) in Cleveland, Bradley County, Tennessee. The FSED will consist of approximately 10,860 square feet with 11 exam rooms including 1 trauma room, lab, imaging department, nurse station and associated support spaces. The FSED will have two covered canopies (2,000 square feet), one designated for emergency vehicles and one designated for general public. The address of the project will be the northeast corner of the intersection of Blackburn Road SE, including the parcel addressed as 2375 Blackburn Road SE, and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74, Cleveland, Bradley County, Tennessee, 37311. The estimated project cost will be $17,409,083.

The anticipated date of filing the application is 12/01/2025

The contact person for this project is President and CEO Chris Cosby who may be reached at Parkridge Health System - 2333 McCallie Avenue, Chattanooga, Tennessee 37404 - Contact No. 423-493-1772.

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. Written notice may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov.

10500 Merchandise

Artificial Christmas trees, ornaments, skirts, lights, and garland for sale - **(423) 584-0556**

Handmade baby afghans, hooded sweaters, booties, and bunnings for sale - **(423) 584-0556**

Legos for sale and accompanying free instruction books - **(423) 584-0556**

10600 Real Estate For Rent

1 BEDROOM.
Clean, convenient. Appliances, blinds. No pets/ smoking. References. $435
423-479-2174

2 Rivers Camping
RV Park, Cabin Rentals, directly on the river at junction of Hiwassee & Ocoee Rivers.
423-338-7208

RUSTIC VILLA STEEPLECHASE APARTMENTS
2 bedroom ($829 - $1029). Appliances furnished. Duplexes 423-472-7788.

Siegel Select Cleveland.
Move in and earn free rent today! We offer fully furnished studio apartments with free utilities. "Stay where YOU are appreciated! Call Now! **423-401-6341.**

Nice upstairs and basement apartments in North Cleveland. TV/ Internet and all bills paid. **(423) 665-3304**

10900 Legals

REQUEST FOR PROPOSALS (RFP)
Cleveland Land Bank Authority (CLBA)
Re: Redevelopment of 1660 Blythe Ave SE, Cleveland, TN
The Cleveland Land Bank Authority (CLBA) is seeking proposals from qualified developers, nonprofit organizations, or other eligible entities to acquire and redevelop the property located at **1660 Blythe Ave SE** in the Blythe Oldfield neighborhood of Cleveland, Tennessee.
Proposal details, evaluation criteria, and submission requirements are available online at: https://www.clevelandtn.gov/753/Cleveland-Land-Bank-Authority
Submission instructions:
Submit: Electronically (PDF) to dtommey@clevelandtn.gov
Deadline: December 15, 2025
Questions: Dustin Tommey, Redevelopment Coordinator, 423-284-622
November 15, 2025

LEGAL PUBLICATION
The following vehicles will be for sale at public auction **December 4th, 2025 @ 1:00 PM at Titan Towing, 2410 Guthrie Ave NW, Cleveland, TN 37311.**
14 MAZDA
JM1GJ1W67E1131330
DRHANN K THOMAS, SHNEKA JONES
14 CHEVROLET
2G1WB5E36E1185126
LARRY MCKINNEY
18 CHRYSLER
2C3CCABG3JH269547
E AND K AUTO SALES
97 DODGE
1D7HA18K37J503496
JACK MCCOSH
15 FORD
3FA6P0H96FR149068
GILBERT L ARMS, BETH OLIVER
08 FORD
1FAHP28W88G115983
TREVOR MARKET, CASSANDRA STARNES
00 CHEVROLET
3GNEC16T0YG174413
TREVIN W PRIDMORE
12 FORD
1FTFW1CF6CKD78167
MICHAEL OR ELIZABETH MCGEE
00 TOYOTA
4T1BG22KXYU694498
SHARON THORNTON
06 HONDA
2HGFG12819H533936
BRUCE W DAVIS
03 CHEVROLET
1GCEC14X03Z103324
OTIS ROSS, JERRY D GRAHAM
07 HYUNDAI
5NPD74LFXHH126000 J AYLAND ISAIAH RIVERS
94 JAGUAR
SAJAD13M3FJ99926
ERIKA DENISE WILLIAMS
16 JEEP
1C4NJCBB6GD514605
ELDRIDGE F JOHNSON JR, HANNAH DRU JOHNSON
13 NISSAN
1N6AD0ER7DN720725
RAMONA SILVERS
93 JEEP
1J4FT78S5PL521059
RICKY THOMPSON
14 FORD
3FA6P0HDXER181886
DANIKA P JOHNSON
99 NISSAN
JN1CA21D0XT813020
KELSEY LONG
November 15, 2025

BRADLEY COUNTY SCHOOLS
Charleston Elementary School – Outdoor Sign
Bradley County Schools is accepting proposals from qualified vendors for the replacement of the outdoor sign at Charleston Elementary School, 8797 Hiwassee St, Charleston, TN 37310. The bids are due on Friday, November 21, 2025, at 9:00 AM. Bids will be publicly opened and read on Friday, November 21, 2025, at 9:00 AM. A copy of the bid specifications may be seen by visiting the Bradley County Schools website at www.bradleyschools.org.
Bradley County Schools is an equal-opportunity employer.
November 13, 15, 2025

10900 Legals

LEGAL PUBLICATION
NOTICE TO CREDITORS
Estate of Falisa Porter, Deceased
No. 2025-PR-115
Chancery Court of Bradley County, Tennessee
Notice is hereby given that on July 16, 2025, Letters of Administration in respect of the estate of Falisa Porter, deceased, were issued to Lindsay Porter, Administrator, by the Chancery Court of Bradley County, Tennessee.
All persons, resident and non-resident, having claims, matured or unmatured, against the estate are required to file the same with the Clerk and Master of the said court at her office at the Bradley County Courthouse, 155 N. Ocoee Street, Cleveland, TN 37311, within the earlier of four (4) months from the date of the first publication of this notice or twelve (12) months from the decedent's date of death, otherwise their claims will be forever barred.
All persons indebted to the estate are requested to make immediate payment.
This 4th day of November, 2025.
Lindsay Porter, Administrator
Estate of Falisa Porter, Deceased
Frank Ousmanno
(BPR #039953)
Acuity Law Group, PLLC
1510 Stuart Rd NE, Suite 202B
Cleveland, TN 37312
(423) 331-0888
Attorney for the Estate
November 8, 15, 2025

ADVERTISEMENT FOR BIDS
Owner: Boys & Girls Club of the Ocoee Region
The Contractor shall provide separate sealed Bids for furnishing of all materials, labor, tools and equipment necessary for the TN Copper Company Office Building to be renovated into the Copper Basin Unit for the Boys & Girls club located at 385 3rd Street SW, Cleveland, TN 37311.
A mandatory pre-bid meeting will be held on November 18, 2025 at 10:00am at the job site located at 242 Boys and Girls Club Way in Copperhill Tennessee to review bidding requirements, to ask questions and to inspect the existing building conditions. Bids will be received by the Owner on December 16th, 2025 at 2:00pm at the office of Boys and Girls Club at 385 3rd Street SW, Cleveland, TN 37311. Bid opening will be public. The envelopes containing the bids must be sealed, addressed to Wyatt Bevis at 385 3rd Street SW, Cleveland, TN 37311 Boys & Girls Club of the Ocoee Region and designated as bid for Copper Basin Boys & Girls Club Building Renovation.
This project is an existing office building built in 1949 and turning it into a Boys and Girls Club (Alteration Level 2). The building is concrete columns and floor slab and roof slab with brick veneer and interior plaster walls. The funding is from state agencies thru grants and is required certain state historic regulations. The basement is not in the scope except for adding a double door for access. The first floor will be partially for the club and partially for public agencies. The second floor is entirely for the club. The main corridors are staying and the rooms will be adjusted by demo and new walls.
Bidding documents and requirements may be obtained by contacting LDI plan room and AGC of East Tennessee plan room and the Architect, Mr. David Delcamp at Rardin & Carroll Architects, 423-894-3242 or david@rc-architects.com. There is no charge for digital copies of the bidding documents.
No bid may be withdrawn within 60 days after the scheduled time for receipt of bids.
All questions should be directed to Mr. David J. Delcamp with Rardin & Carroll Architects, 423-894-3242.
Boys & Girls Club of the Ocoee Region reserves the right to waive informalities and to reject any and all bids.
It is the policy the Boys and Girls Club to ensure compliance with Title VI of the Civil Rights Act of 1964; 49 CFR, Part 21; related statutes and regulations to that end that no person shall be excluded from participation in or be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or any other funding source on the grounds of race, color, sex, national origin, or ancestry. By virtue of submitting a response to this solicitation, bidders agree to comply with the same non- discrimination policy. See Specifications for further requirements due to Grant funding.
11/13/25 - 11/27/25

PUBLIC NOTICE
The regular monthly meeting of the Bradley County Planning Commission will be held on Thursday, November 20th at 12:00 PM. The meeting will be held at the Bradley County Courthouse Commission Room.
November 15, 2025

10900 Legals

SPRING BRANCH INDUSTRIAL PARK SITE PREP
Industrial Development Board for Bradley County and the City of Cleveland
Separate sealed bids for the Mass Grading and Site Prep for Lots 8 and 9 of the Spring Branch Industrial Park will be received by Douglas Berry at the office of the Cleveland – Bradley County Chamber of Commerce until 2 P.M. Thursday, December 11th, 2025, and then at said office publicly opened and read aloud.
The Information for Bidders, Bid Form, Contract, Plans, Specifications, and Bid, Performance and Payment Bond, and other documents may be examined at the following:
Cleveland – Bradley County Chamber of Commerce
225 Keith Street
Cleveland, TN 37311
Copies may be obtained at the Industrial Development Board for Bradley County and the City of Cleveland located at 225 Keith Street, Cleveland, TN 37311 upon payment of $300.00 per set. Any unsuccessful bidder, upon returning each set promptly and in good condition, will be refunded his payment, and any non-bidder upon so returning such a set will be refunded $300.00.
The owner reserves the right to waive any informalities or to reject any or all bids.
Each bidder must deposit with their bid, security in the amount, form and subject to the conditions provided in the Information for Bidders.
Attention of bidders is particularly called to the requirements as to conditions of employment to be observed and minimum wage rates to be paid under the contract.
No bidder may withdraw his bid within 60 days after the actual date of the opening thereof.

SUBSTITUTE TRUSTEE'S NOTICE OF SALE
Sale at public auction will be on **January 15, 2026 at 2:00PM local time**, on the east door, Bradley County Courthouse, 155 N. Ocoee Street, Cleveland, Tennessee pursuant to Deed of Trust executed by Angella M. Brewer and Ricky S. Brewer, to Matt B. Murfree, Trustee, as trustee for Guaranty Trust Company on April 12, 2006 at Book 1633, Page 148, Instrument No. 06007186;and modified by agreement recorded February 16, 2022 in Book 2881, Page 819 conducted by LLG Trustee TN LLC, having been appointed Substitute or Successor Trustee, all of record in the Bradley County Register's Office. Default has occurred in the performance of the covenants, terms, and conditions of said Deed of Trust and the entire indebtedness has been declared due and payable.
Party Entitled to Enforce the Debt: Wells Fargo Bank, NA, its successors and assigns.
The real estate located in Bradley County, Tennessee, and described in the said Deed of Trust will be sold to the highest call bidder. The terms of the said Deed of Trust may be modified by other instruments appearing in the public record. Additional identifying information regarding the collateral property is below and is believed to be accurate, but no representation or warrant is intended.
Street Address: 123 Northeast Puente Drive, Cleveland, Tennessee 37323
Parcel Number: 059K B 015.00
Current Owner(s) of Property: Angella M. Brewer
This sale is subject to all matters shown on any applicable recorded Plat or Plan; any unpaid taxes and assessments; any restrictive covenants, easements or setback lines that may be applicable; rights of redemption, equity, statutory or otherwise, not otherwise waived in the Deed of Trust, including rights of redemption of any government agency, state or federal; and any and all prior deeds of trust, liens, dues, assessments, encumbrances. Including those created by a fixture filing or any applicable homeowners' association dues or assessments; any defects, adverse claims and other matters that may take priority over the Deed of Trust upon which this foreclosure sale is conducted or are not extinguished by this Foreclosure Sale; all claims or other matters, whether recorded or not, which may encumber the purchaser's title and any matter that an accurate survey of the premises might disclose.
The following parties may claim an interest in the above-referenced property to be affected by the foreclosure: any judgment creditor or lien holder with an interest subordinate to the said Deed of Trust or any party claiming by, though, or under any of the foregoing. Such parties known to the Substitute Trustee may include: Secretary of Housing and Urban Development; Cleveland Tennessee Hospital Company, LLC dba Tennova Healthcare-Cleveland.
Terms of Sale will be public auction, for cash, free and clear of rights of homestead, redemption and dower to the extent disclaimed or inapplicable, and the rights of Angella M. Brewer and Ricky S. Brewer, and those claiming through him/her/it/them.
Any right of equity of redemption, statutory and otherwise, and homestead are waived in accord with the terms of said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.
The right is reserved to postpone or adjourn the sale to another time certain or to another specified date, time, and location certain, without further newspaper publication upon announcement by posting with the third-party internet posting company and announcing on the date, time, and location of each sale set forth above or any subsequent postpone or adjourned date, time, and location of sale; provided, however if the sale is postponed or adjourned for less than five (5) days after the original sale, announcement by internet posting is not required.
If you purchase a property at the foreclosure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified/bank check made payable to or endorsed to LOGS Legal Group LLP. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the lender and any other bidders. Insufficient funds will not be accepted. Amounts received in excess of the winning bid will be refunded to the successful purchaser at the time the foreclosure deed is delivered.
This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded only by the Substitute Trustee at any time. If the Substitute Trustee rescinds the sale, the purchaser shall only be entitled to a return of any money paid towards the purchase price and shall have no other recourse.
Once the purchaser tenders the purchase price, the Substitute Trustee may deem the sale final in which case the purchaser shall have no remedy.
The real property will be sold AS IS, WHERE IS, with no warranties or representations of any kind, express or implied, including without limitation, warranties regarding condition of the property or marketability of title.
THE PROPERTY IS SOLD WITHOUT ANY REPRESENTATIONS OR WARRANTIES, EXPRESSED OR IMPLIED, RELATING TO TITLE, MARKETABILITY OF TITLE, POSSESSION, QUIET ENJOYMENT OR THE LIKE AND FITNESS FOR A GENERAL OR PARTICULAR USE OR PURPOSE. The title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.
This Notice of Sale can be viewed online by Better Choice Notice Solutions at HTTPS://BetterChoiceNotices.com
LLG Trustee TN LLC
Substitute Trustee
8520 Cliff Cameron Dr., Suite 330
Charlotte, NC 28269
Phone (704) 333-8107
Fax (704) 333-8156
File No, 13-049775
November 15, 22, 2025

SUBSTITUTE TRUSTEE'S SALE
Sale at public auction will be on **January 20, 2026 on or about 10:00AM local time**, at the Bradley County Courthouse, Cleveland, Tennessee, conducted by the Co-Substitute Trustees as identified and set forth herein below, pursuant to Deed of Trust executed by SETH MICHAEL HOUSEHOLDER AND BREANNA R. HOUSEHOLDER, to Frank Alvstad, Trustee, on November 13, 2021, of Record Book 2857, Page 401-414 as Instrument No. 21019679 in the real property records of Bradley County Register's Office, Tennessee.
Owner of Debt: The Secretary of Veterans Affairs, an officer of the United States
The following real estate located in Bradley County, Tennessee, will be sold to the highest call bidder subject to all unpaid taxes, prior liens and

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 Parkridge Medical Center, a/an Hospital owned by Parkridge Medical Center, Inc. with an ownership type of Corporation (For Profit) and to be managed by itself intends to file an application for a Certificate of Need for the establishment of a freestanding emergency department (FSED) in Cleveland, Bradley County, Tennessee. The FSED will consist of approximately 10,860 square feet with 11 exam rooms including 1 trauma room, lab, imaging department, nurse station and associated support spaces. The FSED will have two covered canopies (2,000 square feet), one designated for emergency vehicles and one designated for general public. The address of the project will be the northeast corner of the intersection of Blackburn Road SE, including the parcel addressed as 2375 Blackburn Road SE, and Appalachian Highway also known as APD-40. US Route 64 Bypass and US Route 74, Cleveland, Bradley County, Tennessee. 37311. The estimated project cost will be $17,409,083.

The anticipated date of filing the application is 12/01/2025

The contact person for this project is President and CEO Chris Cosby who may be reached at Parkridge Health System - 2333 McCallie Avenue, Chattanooga, Tennessee 37404 - Contact No. 423-493-1772.

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. Written notice may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov

Attachment 7A-1

Charter And Amendments

BOOK 4431 PAGE 988

State of Tennessee

Department of State

CERTIFICATE

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of PARKRIDGE HOSPITAL, 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 NINTH, *19* 70.

Secretary of State

CHARTER BOOK 4431 PAGE 989

OF

PARKRIDGE HOSPITAL, 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 Parkridge Hospital, 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 242 25th Avenue, North, Nashville, County of Davidson.

4. The corporation is for profit.

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

(a) To own, manage and operate hospitals, nursing homes, clinics, and all other types of health-care or medically oriented facilities.

(b) To buy, sell and lease articles of commerce, and, in connection therewith, to own, manage and operate wholesale and retail sales outlets.

(c) To buy, sell, develop, and lease real estate.

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

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

PM 2 52

6. The maximum number of shares which the corporation shall have the authority to issue is One Hundred Thousand (100,000) 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.

(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 members of the entire Board of Directors, or by the holders of a majority of the outstanding shares of capital stock.

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

Dated July 9 , 1970.

Robert G. McCullough

Maclin P. Davis, Jr.

William E. Martin

BOOK 4431 PAGE 991

State of Tennessee

THE GREAT SEAL OF THE STATE OF TENNESSEE
XVI
AGRICULTURE
COMMERCE
1796

A 83929

IDENTIF. REFERENCE

JUL 16 4 01 PM '70

FELIX Z. WILSON II REGISTER
DAVIDSON COUNTY, TENN.

JL 16 MISC A* 5.00 * 5.00

CHARTER
OF
PARKRIDGE HOSPITAL, INC.

RECEIVED FEE, $ 10.00

RECEIVED TAX, $ 10.00

TOTAL, $ 20.00

Secretary of State.

BOOK 4431 PAGE 988

State of Tennessee

Department of State

CERTIFICATE

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

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Secretary of State

CHARTER BOOK4431 PAGE 989

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(c) To buy, sell, develop, and lease real estate.

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

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

PM 2 52

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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 members of the entire Board of Directors, or by the holders of a majority of the outstanding shares of capital stock.

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

Dated July 9 , 1970.

Robert G. McCullough

Robert G. McCullough

Maclin P. Davis, Jr.

Maclin P. Davis, Jr.

William E. Martin

William E. Martin

BOOK 4431 PAGE 991

State of Tennessee

CHARTER

OF

PARKRIDGE HOSPITAL, INC.

A 83929

IDENTIF. REFERENCE

JUL 16 4 01 PM '70

FELIX Z. WILSON II REGISTER
DAVIDSON COUNTY, TENN.

JUL 16 MISC * 5.00 ** 5.00

RECEIVED FEE, $ 10.00

RECEIVED TAX, $ 10.00

TOTAL, $ 20.00

Secretary of State.

Secretary of State
Corporations Section
James K. Polk Building, Suite 1800
Nashville, Tennessee 37219

DATE: 08/01/88
REQUEST NUMBER: 898-1016
TELEPHONE CONTACT: (615) 741-0537
FILE DATE/TIME: 08/01/88 1130
EFFECTIVE DATE/TIME: 08/01/88 1130
CONTROL NUMBER: 0023600

TO: mail
HOSPITAL CORPORATION OF AMERICA
P O BOX 550

NASHVILLE, TN 37202

RE:
PARKRIDGE HOSPITAL, INC.
RESTATEMENT OF CHARTER

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.

FOR: RESTATEMENT OF CHARTER

RECEIVED: $10.00

ON DATE: 08/01/88

FROM:
HOSPITAL CORPORATION OF AMERICA
P O BOX 550

NASHVILLE, TN 37202

RECEIPT NUMBER: 000000813028
ACCOUNT NUMBER: 00001308

Gentry Crowell

GENTRY CROWELL
SECRETARY OF STATE

AMENDED AND RESTATED CHARTER

OF

PARKRIDGE HOSPITAL, INC.

PURSUANT TO THE PROVISIONS OF SECTION 48-20-107 OF THE TENNESSEE BUSINESS CORPORATION ACT, THE FOLLOWING AMENDED AND RESTATED CHARTER WAS ADOPTED BY UNANIMOUS WRITTEN CONSENT OF THE SHAREHOLDERS AND BOARD OF DIRECTORS OF PARKRIDGE HOSPITAL, INC. (THE "CORPORATION") ON THE 22ND DAY OF JULY, 1988:

PART ONE:

ARTICLE ONE: The name of the Corporation is PARKRIDGE HOSPITAL, INC.

ARTICLE TWO: The duration of the Corporation is perpetual.

ARTICLE THREE: The address of the principal office of the Corporation in the State of Tennessee shall be 2333 McCallie Avenue, Chattanooga, County of Hamilton, Tennessee 37404-3206.

ARTICLE FOUR: The Corporation is for profit.

ARTICLE FIVE: The purposes for which the Corporation is organized are:

(a) To own, manage and operate hospitals, nursing homes, clinics, and all other types of health-care or medically oriented facilities.

(b) To buy, sell and lease articles of commerce, and, in connection therewith, to own, manage and operate wholesale and retail sales outlets.

(c) To buy, sell, develop, and lease real estate.

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

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

ARTICLE SIX: The maximum number of shares which the Corporation shall have the authority to issue is One Hundred Thousand (100,000) shares of Common Stock, par value of $1.00 per share.

ARTICLE SEVEN: The Corporation will not commence business until the consideration of One Thousand Dollars ($1,000) has been received for the issuance of shares.

ARTICLE EIGHT:

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

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

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

ARTICLE NINE: The Registered Office of the Corporation in the State of Tennessee shall be One Park Plaza, Nashville, Davidson County, Tennessee 37203 and the Registered Agent at that address shall be Donald W. Fish.

ARTICLE TEN: No director of the Corporation shall be personally liable to the Corporation or its shareholder for monetary damages for breach of fiduciary duty as a director; provided that this provision shall not eliminate or limit the liability of any director (i) for any breach of the director's duty of loyalty to the Corporation or its shareholders, (ii) for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law or (iii) under Section 48-18-304 of the Tennessee Business Corporation Act. If, after approval of this provision by the Board of Directors, the Tennessee Business Corporation Act is amended to authorize corporate action further eliminating or limiting the personal liability of directors, then the liability of directors of the Corporation shall be eliminated or limited to the fullest extent permitted by the Tennessee Business Corporation Act as so amended from time to time. Any repeal or modification of this Article shall not adversely affect any right or protection of a director of the Corporation existing at the time of such repeal or modification with respect to acts or omissions occurring prior to such repeal or modification.

PART TWO:

The Corporation hereby certifies that this Amended and Restated Charter contains one or more amendments requiring shareholder approval and that the Board of Directors and the shareholder of the Corporation have duly approved and adopted this Amended and Restated Charter.

DATED: July 22, 1988

PARKRIDGE HOSPITAL, INC.

John O. Colton, President

ATTEST:

Bettye D. Daugherty, Secretary

D 9 2 1 8

IDENTIFICATION REFERENCE

08/08/88 MISC 5.00 **5.00

AUG 8 11 05 AM '88

SARAH P. DE GRIESE
REGISTER
HAMILTON COUNTY
STATE OF TENNESSEE

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

DATE: 12/07/99
REQUEST NUMBER: 3776-0218
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 12/06/99 0914
EFFECTIVE DATE/TIME: 12/06/99 1630
CONTROL NUMBER: 0023600

TO:
COLUMBIA HCA
%LEGAL DEPT
P O BOX 750
NASHVILLE, TN 37202-0750

RE:
PARKRIDGE HEALTH SYSTEM, INC.
ARTICLES OF AMENDMENT TO THE CHARTER

THIS WILL ACKNOWLEDGE THE FILING OF THE ATTACHED DOCUMENT WITH AN EFFECTIVE DATE AS INDICATED ABOVE.

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

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.

FOR: ARTICLES OF AMENDMENT TO THE CHARTER ON DATE: 11/18/99

FROM:
COLUMBIA/HCA HEALTHCARE CORP/NASHVILLE
PO BOX 550

NASHVILLE, TN 37202-0550

	FEES	
RECEIVED:	$20.00	$0.00
TOTAL PAYMENT RECEIVED:		$20.00

RECEIPT NUMBER: 00002573710
ACCOUNT NUMBER: 00187233

Riley C Darnell

RILEY C. DARNELL
SECRETARY OF STATE

SS-4458

ARTICLES OF AMENDMENT TO THE CHARTER OF PARKRIDGE HOSPITAL, INC.

Pursuant to the provisions of Section 48-20-106 of the Tennessee Business Corporation Act, the undersigned domestic corporation adopts the following Articles of Amendment to its Charter:

1. The name of the corporation is Parkridge Hospital, Inc.

2. Article 1 is amended to delete the name "Parkridge Hospital, Inc." and the name of the corporation is changed to "Parkridge Health System, Inc." which is inserted in lieu thereof.

3. The corporation is a for-profit corporation.

4. The Amendments were duly adopted on the 29th day of November, 1999, by the Shareholders and the Board of Directors of the corporation.

5. The Amendments shall be effective when these Articles are filed by the Secretary of State of Tennessee.

Date: November 29, 1999

PARKRIDGE HOSPITAL, INC.

John M. Franck II
Vice President and Secretary

Instr:200007240072866 Page: 1 OF 1
REC'D FOR REC 07/24/2000 12:04:40PM
RECORD FEE: $7.00
M. TAX: $0.00 T. TAX: $0.00

S:\Corporate\CONKLIN KACEE\CORP\TN\DOCS\Parkridge amend.doc

PICK-UP

BX14

Secretary of State
Division of Business Services
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

DATE: 09/12/02
REQUEST NUMBER: 4596-0695
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 09/12/02 1223
EFFECTIVE DATE/TIME: 09/12/02 1630
CONTROL NUMBER: 0023600

TO:
CFS
8161 HWY 100 172

NASHVILLE, TN 37221

RE:
PARKRIDGE MEDICAL CENTER, INC.
ARTICLES OF AMENDMENT TO THE CHARTER

THIS WILL ACKNOWLEDGE THE FILING OF THE ATTACHED DOCUMENT WITH AN EFFECTIVE DATE AS INDICATED ABOVE.

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

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.

Davidson County CHARTER
Recvd: 09/13/02 13:54 2pgs
Fees:7.00 Taxes:0.00

20020913-0111768

FOR: ARTICLES OF AMENDMENT TO THE CHARTER ON DATE: 09/12/02

		FEES	
FROM:	RECEIVED:	$20.00	$0.00
CFS			
8161 HIGHWAY 100	TOTAL PAYMENT RECEIVED:		$20.00
#172			
NASHVILLE, TN 37221-0000	RECEIPT NUMBER: 00003143050		
	ACCOUNT NUMBER: 00101230		

Riley C Darnell

RILEY C. DARNELL
SECRETARY OF STATE

SS-4458

4596 0695

State of Tennessee

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

ARTICLES OF AMENDMENT
TO THE CHARTER
(For-Profit)

For Office Use Only
FILED
SEP 12 PM 12: 23
SECRETARY OF STATE

CORPORATE CONTROL NUMBER (IF KNOWN) 0023600

PURSUANT TO THE PROVISIONS OF SECTION 48-20-106 OF *THE TENNESSEE BUSINESS CORPORATION ACT*, THE UNDERSIGNED CORPORATION ADOPTS THE FOLLOWING ARTICLES OF AMENDMENT TO ITS CHARTER:

1. PLEASE INSERT THE NAME OF THE CORPORATION AS IT APPEARS OF RECORD:
Parkridge Health System, Inc.
IF CHANGING THE NAME, INSERT THE NEW NAME ON THE LINE BELOW:
Parkridge Medical Center, Inc.

2. PLEASE MARK THE BLOCK THAT APPLIES:

☒ AMENDMENT IS TO BE EFFECTIVE WHEN FILED BY THE SECRETARY OF STATE.
☐ AMENDMENT IS TO BE EFFECTIVE, _____ (MONTH, DAY, YEAR)

(NOT TO BE LATER THAN THE 90TH DAY AFTER THE DATE THIS DOCUMENT IS FILED.) IF NEITHER BLOCK IS CHECKED, THE AMENDMENT WILL BE EFFECTIVE AT THE TIME OF FILING.

3. PLEASE INSERT ANY CHANGES THAT APPLY:

[**NOTE:** IF CHANGING THE PRINCIPAL OR REGISTERED AGENT ADDRESS, A COMPLETE STREET ADDRESS, INCLUDING CITY, STATE, ZIP CODE, AND COUNTY MUST BE PROVIDED.]

4. THE CORPORATION IS FOR PROFIT.

5. THE MANNER (IF NOT SET FORTH IN THE AMENDMENT) FOR IMPLEMENTATION OF ANY EXCHANGE, RECLASSIFICATION, OR CANCELLATION OF ISSUED SHARES IS AS FOLLOWS:

6. THE AMENDMENT WAS DULY ADOPTED ON September 6, 2002 (MONTH , DAY, YEAR)
BY (Please mark the block that applies):

☐ THE INCORPORATORS WITHOUT SHAREHOLDER ACTION, AS SUCH WAS NOT REQUIRED.
☐ THE BOARD OF DIRECTORS WITHOUT SHAREHOLDER APPROVAL, AS SUCH WAS NOT REQUIRED.
☒ THE SHAREHOLDERS.

Assistant Secretary
SIGNER'S CAPACITY

Dora A. Blackwood
SIGNATURE

September 6, 2002
DATE

Dora A. Blackwood
NAME OF SIGNER (TYPED OR PRINTED)

SS-4421 (Rev. 1/00) RDA 1678

TN005 - 8/03/00 C T System Online

Division of Business and Charitable Organizations
Department of State
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
sos.tn.gov/

Tre Hargett
Secretary of State

KRISTINA BAGWELL
ONE PARK PLAZA
NASHVILLE, TN 37203, USA

09/10/2025

Request Type: Certificate of Existence/Authorization

Issuance Date: 09/10/2025

Request #: C2025076984

Document Receipt

Order Number: C2025076984

Verification #: EAC8E8B9

Receipt #: 2025-651330

Filing Fee: $20.00

Payment: Credit Card - 3905859513 $20.00

Entity Name:	PARKRIDGE MEDICAL CENTER, INC.		
SOS Control #:	000023600	Initial Filing Date:	07/09/1970
Entity Type:	For-profit Corporation	Formation Locale:	TENNESSEE
Status:	Active	Duration Term:	Perpetual
Fiscal Year Close:	December	Annual Report Due:	04/01/2026
Business County:	DAVIDSON		
Shares of Stock:	100000		
Obligated Member Entity:	No		

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

PARKRIDGE MEDICAL CENTER, 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

Secretary of State
Division of Business Services
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

DATE: 09/12/02
REQUEST NUMBER: 4596-0693
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 09/12/02 1223
EFFECTIVE DATE/TIME:
CONTROL NUMBER: 0023600

TO:
CFS
8161 HWY 100 172

NASHVILLE, TN 37221

RE:
PARKRIDGE MEDICAL CENTER
APPLICATION FOR CANCELLATION OF ASSUMED
CORPORATE NAME

THIS WILL ACKNOWLEDGE THE FILING OF THE ATTACHED CANCELLATION OF THE ASSUMED CORPORATE NAME WITH AN EFFECTIVE DATE AS INDICATED ABOVE.

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

FOR: APPLICATION FOR CANCELLATION OF ASSUMED CORPORATE NAME

ON DATE: 09/12/02

FROM:
CFS
8161 HIGHWAY 100
#172
NASHVILLE, TN 37221-0000

	FEES	
RECEIVED:	$20.00	$0.00
TOTAL PAYMENT RECEIVED:		$20.00

RECEIPT NUMBER: 00003143047
ACCOUNT NUMBER: 00101230

Riley C Darnell

RILEY C. DARNELL
SECRETARY OF STATE

SS-4458

State of Tennessee

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

APPLICATION FOR CANCELLATION OF ASSUMED CORPORATE NAME

For Office Use Only

FILED

Pursuant to the provisions of Section 48-14-101(e) of the Tennessee Business Corporation Act or Section 48-54-101(e) of the Tennessee Nonprofit Corporation Act, the undersigned corporation hereby submits this application:

1. The true name of the corporation is Parkridge Health System, Inc.

2. The state or country of incorporation is Tennessee.

3. The corporation intends to cease transacting business under an assumed corporate name by cancelling it.

4. The assumed corporate name to be cancelled is Parkridge Medical Center

September 6, 2002
Signature Date

Assistant Secretary
Signer's Capacity

Parkridge Health System, Inc.
Name of Corporation

Dora A. Blackwood
Signature

Dora A. Blackwood
Name (typed or printed)

SS-4405 (Rev. 6/00)

RDA 1678

Attachment 7A-2

Corporate Existence

Division of Business and Charitable Organizations
Department of State
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
sos.tn.gov/

Tre Hargett
Secretary of State

KRISTINA BAGWELL
ONE PARK PLAZA
NASHVILLE, TN 37203, USA

09/10/2025

Request Type: Certificate of Existence/Authorization

Issuance Date: 09/10/2025

Request #: C2025076984

Document Receipt

Order Number: C2025076984

Verification #: EAC8E8B9

Receipt #: 2025-651330

Filing Fee: $20.00

Payment: Credit Card - 3905859513 $20.00

Entity Name:	PARKRIDGE MEDICAL CENTER, INC.		
SOS Control #:	000023600	Initial Filing Date:	07/09/1970
Entity Type:	For-profit Corporation	Formation Locale:	TENNESSEE
Status:	Active	Duration Term:	Perpetual
Fiscal Year Close:	December	Annual Report Due:	04/01/2026
Business County:	DAVIDSON		
Shares of Stock:	100000		
Obligated Member Entity:	No		

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

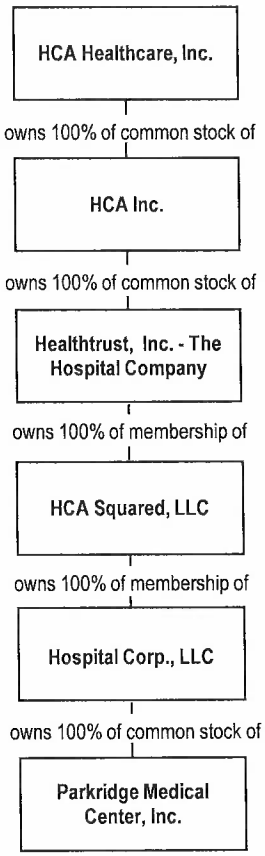
PARKRIDGE MEDICAL CENTER, INC.

* 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

Attachment 7A-3

Organizational Chart


HCA Healthcare, Inc.
owns 100% of common stock of
HCA Inc.
owns 100% of common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of membership of
HCA Squared, LLC
owns 100% of membership of
Hospital Corp., LLC
owns 100% of common stock of
Parkridge Medical Center, Inc.

Attachment 7A-4

Officers and Directors

September 5, 2025

OFFICERS AND DIRECTORS
OF
PARKRIDGE MEDICAL CENTER, INC.

* **Samuel N. Hazen**	**President**	**One Park Plaza Nashville, TN 37203**
Monica Cintado	Senior Vice President	One Park Plaza Nashville, TN 37203
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 A. Marks	Senior Vice President	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
* **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
Natalie H. Cline	Vice President and Secretary	One Park Plaza Nashville, TN 37203
Chris Cosby	Vice President	2333 McCallie Avenue Chattanooga, TN 37404
Jaime DeRensis	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Matthew R. Favicchio	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
Todd Maxwell	Vice President	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
Wilson Robinson	Vice President	One Park Plaza Nashville, TN 37203
Peter Rossell	Vice President	One Park Plaza Nashville, TN 37203
Brad Spicer	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

***Directors**

Persons employed in the capacity of Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Administrator or 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 (each such partnership or limited liability company referred to as a "Managed Entity"), are hereby authorized to, subject to applicable policies and procedures, (a) manage the facilities and all employees and agents of the Company or any Managed Entity 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 facility, 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 or any Managed Entity entered into pursuant to applicable policies and procedures) which with the advice of legal counsel shall be deemed appropriate and advisable.

Attachment 8A

Management Agreement

NOT APPLICABLE

Attachment 9A-1

Purchase and Sale Agreement

REAL ESTATE PURCHASE AND SALE AGREEMENT

THIS REAL ESTATE PURCHASE AND SALE AGREEMENT ("***Agreement***") is made and entered into effective as of the calendar date after the date the last of the Parties executes this Agreement ("***Effective Date***"), by and between **MABLE GEREN** ("***Seller***"), and **CROSLAND BARNES GROUP, LLC**, a South Carolina limited liability company, its successors and assigns ("***Purchaser***"). Seller and Purchaser are sometimes referred to in this Agreement individually as a "***Party***" and collectively as the "***Parties.***"

Seller owns certain real property, including any buildings or improvements located thereon, situated in Bradley County, Tennessee, consisting of a portion of Bradley County Parcel ID Number 065D F 018.00 which portion consists of all of such tax parcel that is located adjacent to APD 40 and/or Blackburn Road SE being generally depicted on Exhibit A attached to this Agreement (collectively, the "***Land***"). The description of the Land as prepared by Purchaser's Survey and/or the Subdivision Plat, as applicable (both defined below) will govern. The Land, including all easements, rights-of-way, water rights, mineral rights and appurtenances relating to said 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/SUBDIVISION. 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, (iii) without change from the Contingency Date with respect to all other physical conditions of the Property other than ordinary wear and tear, and (iv) subdivided as contemplated pursuant to the below paragraph.

2. PURCHASE PRICE. The purchase price ("***Purchase Price***") for the Property is $1,200,000.00.

3. EARNEST MONEY. Purchaser shall deliver $25,000 ("***Initial Earnest Money***") to First American Title Insurance Company – National Commercial Services having an address of 511 Union Street, Suite 1600, Nashville, Tennessee 37219, Attn.: Stacey Denson-Palmer or another national title company reasonably acceptable to Purchaser and Seller ("***Title Company***") promptly after the Effective Date. The Initial Earnest Money and Extension Earnest Money (as applicable) are referred to in this Agreement collectively as the "***Earnest Money***", will be held and disbursed according to this Agreement, and applied toward the Purchase Price at Closing. Initial earnest money will become non-refundable (except in the event of a default by Seller under this Agreement or the termination of this Agreement by Purchaser pursuant to Section 9(a), 9(b), 9(c), 12, 13(a), 14 and/or 15 of this Agreement) after the first One Hundred Twenty (120) days of Due Diligence pass, but the same will remain applicable to the Purchase Price.

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, as well as any rollback taxes, look-back taxes or other similar taxes assessed in connection with a change in the use of the Property. 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 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. Seller will be responsible for coordinating the cessation of service and closure and payment of its accounts with respect to all utilities (*e.g.*, electricity, gas, water, sewer, telecommunications) serving the Property, if any (collectively, "***Utilities***") up to the Closing Date. Purchaser will be responsible for coordinating the provision of service and opening of accounts in its own name with respect to Utilities as of and after the Closing Date. Consequently, Utilities are not intended to be prorated or adjusted by the Parties at Closing. Any Utilities not actually addressed as provided in the preceding sentence 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. Seller will be solely responsible for obtaining the refund of any deposits which Seller may have on account with respect to any Utilities. Seller will not be credited for any such deposits at Closing.

(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) all real estate transfer taxes, documentary stamp taxes or similar charges or taxes, if any (iii) Seller's attorneys' fees, (iv) 1/2 of the customary escrow or closing fees charged by the Title Company, (v) a commission to Purchaser's Broker (defined below) at Closing in an amount equal to 3% of the Purchase Price, (vi) a commission to Seller's Broker (defined below) at Closing in an amount determined per the listing agreement or other separate agreement between Seller and Seller's Broker, (vii) the base title premium charged for the issuance of Buyer's extended coverage Owner's Policy of title insurance, in the insured amount of the Purchase Price hereunder (herein, the "Base Premium"), and specifically excluding: (a) any additional premiums or other charges in connection with any endorsements requested by Buyer or Buyer's lender to said policy will be paid by buyer; (b) any premiums in connection with any policy of title insurance requested by Buyer's lender will be paid by buyer; and (c) any abstract fees, copy costs and other fees, costs and expenses that may be incurred in connection with the title abstract of the Property and preparation and generation of the Commitment; and (viii) 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) Purchaser's expenses for tests, inspections and surveys, (iii) title fees, costs and premiums excluding only the Base Premium (defined above) and specifically including: (a) any additional premiums or other charges in connection with any endorsements requested by Buyer or Buyer's lender to Buyer's (or its lender's) title insurance policy; (b) any premiums in connection with any policy of title insurance requested by Buyer's lender; and (c) any abstract fees, copy costs and other fees, costs and expenses that may be incurred in connection with the title abstract of the Property and preparation and generation of the Commitment; (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. "***Property Information***" means any of the following with respect to the Property: (i) Seller's most recent title policy and survey, if available, and (ii) Seller's most recent environmental study, report or assessment, if available, and (iii) any wetlands delineations, determinations or similar wetlands reports including any drafts thereof, and (v) written notices from governmental authorities within the past 3 years of the Effective Date as to changes in zoning, road access or any environmental or wetlands matters.

6. INVESTIGATION OF THE PROPERTY BY PURCHASER. Seller grants to Purchaser and its agents and representatives the full right of access to the Property from and after the Effective Date, 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. 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 Purchaser's negligence or willful misconduct 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 120 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 (b), inclusive, of this Section 7. Purchaser has the right and option to postpone the Contingency Date for two (2) additional periods of 30 days each by providing written notice to Seller of such election prior to 6:00 p.m., local time where the Property is situated, on the then-current Contingency Date. Concurrently with any postponement of the Contingency Date by Purchaser pursuant to the foregoing sentence, Purchaser will deliver to Title Company the sum of $25,000 for each such postponement (each, and collectively if more than one postponement is exercised, referred to as "***Extension Earnest Money***"). Upon deposit with the Title Company of each Extension Earnest Money deposit, such Extension Earnest Money will be treated as part of the "Earnest Money" hereunder, and all Extension Earnest Money Deposits shall be applicable to the Purchase Price. 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 Purchaser pursuant to this Section 7 without any further consent or authorization from Seller. Seller agrees to fully cooperate with and assist Purchaser in Purchaser's attempt to satisfy the contingencies in this Agreement, and in connection with such cooperation, Seller agrees 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. All monies paid per extension will be deemed nonrefundable (except in the event of a default by Seller under this Agreement or the termination of this Agreement by Purchaser pursuant to Section 9(a), 9(b), 9(c), 12, 13(a), 14 and/or 15 of this Agreement) but applicable to the purchase price.

(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 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"***). 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, and (iii) Seller Encumbrances (defined below). Seller will have 10 days from receipt of the Objection Notice to cure or commit to cure the Title & Survey Objections. If Seller does not cure or commit to cure the Title & Survey Objections within said 10 day period or if Seller notifies Purchaser that it will not attempt to cure, Purchaser may elect to (i) terminate this Agreement up to the Closing Date, or (ii) accept title as it then is without any reduction in the Purchase Price

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 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 solicit, initiate or negotiate a sale of all or any portion of the Property with any person other than Purchaser. 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 take any other action which would cause any representation, warranty or covenant 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 permit any new title matters not caused by Purchaser to affect the Property after the Effective Date.

(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 encumbrances affecting the Property which were not caused by Purchaser (***"Seller Encumbrances"***), to be satisfied and released. The proceeds due at Closing may be applied by Seller to satisfy and release any Seller Encumbrances.

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), inclusive, 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 Section 13(a) below shall govern. 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. In addition, without waiving Purchaser's option to terminate this Agreement for the failure of any such conditions, Purchaser may postpone the Closing Date as Purchaser deems reasonably necessary so as to allow an opportunity for such conditions to be satisfied in Purchaser's 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.

(b) Documents and Covenants. All documents, instruments and assurances required to be delivered on or before the Closing to Purchaser or Title Company shall have been duly and timely delivered in form, substance and execution satisfactory to Purchaser and Title Company and all covenants and agreements of Seller in this Agreement must have been duly and timely performed and satisfied.

(c) Delivery Condition. Purchaser must be satisfied that the Property is in 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 vested in Purchaser, insuring the Property and all easements and other rights benefiting the Property in a condition approved by Purchaser with such coverage and including such endorsements as Purchaser may require (***"Owner's Policy"***).

(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.

(f) Re-Zoning. The Property shall be fully rezoned to such zoning as is necessary to allow for Purchaser's intended use of the Property (which, for the avoidance of doubt, shall be at Purchaser's sole expense).

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, as extended ("***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 general warranty deed, in a form acceptable to Purchaser, conveying to Purchaser or its designee fee simple title to the Property as described in Purchaser's Survey, subject only to real estate taxes for the current year, not yet due or payable.

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

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

(iv) Bring-Down Certificate. A certificate, in a form approved by Purchaser, certifying that the representations of Seller in this Agreement are true and correct as of the Closing Date.

(v) 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.

(vi) Keys and Combinations. Keys or combinations to all locks at the Property, to the extent in Seller's possession. Purchaser acknowledges and agrees that Seller is permitted to make such items available to Purchaser at the Property in lieu of delivering them to Title Company.

(vii) Miscellaneous. Any other documents reasonably required by this Agreement or the Title Company to be executed or delivered by Seller or necessary to implement and effectuate the Closing hereunder and 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 Purchaser and 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 be effective as of the Closing Date and will survive Closing.

(a) Representations and Warranties – Seller. Seller is a citizen and resident of the State in which the Property is located. 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.

(b) Representations and Warranties – Property. Seller is the sole owner of the Property and has good and marketable fee simple title to the Property. No other party 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 best knowledge and belief 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. All documents, instruments and other information being delivered by Seller to Purchaser pursuant to this Agreement, including the Property Information, are materially true, accurate and complete. There are no easements, leases, licenses or other rights to use or occupy the Property which are not recorded in the land records of the county in which the Property is situated. 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 quasigovernmental 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 the best of Seller's knowledge, prior to, Seller's ownership of the Property, (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 quasigovernmental 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, byproducts 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 quasigovernmental authority or body having jurisdiction over the Property.

(d) Representations and Warranties – 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 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.

12. BREACH OF REPRESENTATIONS, WARRANTIES OR COVENANTS. If any of Seller's representations or warranties are true and accurate as of the Effective Date but become untrue or inaccurate on or before the Closing Date and such representation or warranty is not made untrue or inaccurate due to an act, omission or misrepresentation of Seller, 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 under this Agreement. If any of Seller's representations or warranties (i) are untrue or inaccurate as of the Effective Date, or (ii) become untrue or inaccurate on or before the Closing Date and such representation or warranty becomes untrue or inaccurate due to an act, omission or misrepresentation of Seller, then Section 13(a) below shall govern and Seller shall indemnify, protect, defend and hold Purchaser harmless from and against all claims, demands, causes of action, losses, damages, liabilities, costs, expenses (including reasonable attorneys' fees and litigation costs) and charges arising or resulting from, or in connection with, such breach. The provisions of this Section 12 will survive the Closing, expiration or earlier termination of this Agreement.

13. DEFAULTS AND REMEDIES.

(a) Default by Seller. If Seller fails to timely perform any of its obligations, covenants or agreements contained in this Agreement or if any of Seller's representations or warranties are untrue or inaccurate as of the Effective Date or become untrue or inaccurate on or before the Closing Date and such representation or warranty is made untrue or inaccurate due to an act, omission or misrepresentation of Seller, then Purchaser, at its option and in addition to all other remedies available at law or in equity, may: (i) close the purchase of the Property pursuant to the terms of this Agreement, (ii) specifically enforce the provisions of this Agreement, and (iii) cancel and terminate this Agreement and receive the Earnest Money and retain all rights against Seller for damages arising out of Seller's default, and (iv) without waiving Purchaser's other remedies in this Section, forbear the exercise of such remedies and extend the Contingency Date or Closing Date, as applicable, as Purchaser deems reasonably necessary so as to allow an opportunity to cure such failure or breach in a manner satisfactory to Purchaser in Purchaser's sole and absolute discretion.

(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.

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 quasipublic 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 of such proceeding, 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 of cancellation to Seller, 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, 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 assign this Agreement and its rights under this Agreement without the necessity of obtaining the prior consent, written or otherwise, of Seller.

17. BROKERS' COMMISSIONS. Purchaser represents and warrants to Seller that no third-party broker or finder has been engaged or consulted by Purchaser or through Purchaser's actions is entitled to compensation as a consequence of this transaction except for Purchaser's Broker. Seller represents and warrants to Purchaser that no third-party broker or finder has been engaged or consulted by Seller or through Seller's actions is entitled to compensation as a consequence of this transaction except for Seller's Broker. "***Purchaser's Broker***" means Andrew Holt / Merchant Real Estate Group, representing Purchaser only. "***Seller's Broker***" means SVN Second Story / John Markley and Hunter Myers, representing Seller only. 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. NOTICE IS HEREBY GIVEN THAT THE FOLLOWING LICENSED REAL ESTATE BROKERS/AGENTS MAY ALSO HAVE AN OWNERSHIP INTEREST IN BUYER: EDWARD C. BARNES (LICENSED UNDER THE LAWS OF SOUTH CAROLINA, NORTH CAROLINA AND GEORGIA).

18. NOTICES. Any notice, request, approval, demand, instruction or other communication to be given to either Party under this Agreement (each, a "***Notice***") must be in writing and addressed to the addresses of the receiving Party 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. A Notice will be conclusively deemed to be delivered when either (i) personally delivered, (ii) hand-delivered, (iii) deposited for prepaid overnight delivery with an overnight courier such as Federal Express, UPS, or other national overnight courier service, (iv) if the receiving Party's address for Notices is a P.O. Box, then when deposited with U.S. Mail, or (v) sent by email if an email address for said part is provided on the signature page to this Agreement. All Notices will be effective upon being delivered 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, 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 or be required to join or execute any documents in connection with the Exchange except for an acknowledgement of an assignment of this Agreement to a qualified intermediary. 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.

22. 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.

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

SELLER SIGNATURE PAGE TO REAL ESTATE PURCHASE AND SALE AGREEMENT

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

SELLER:

Mable Geren

Mable Geren

Date: 10/31/2025, 2025

Seller's Notice Address:

Mable Geren

Email: 10/31/2025

SELLER'S NOTICE ADDRESS:

782 BEECH CIR NW

CLEVELAND, TN 37312

PURCHASER SIGNATURE PAGE TO REAL ESTATE PURCHASE AND SALE AGREEMENT

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

PURCHASER:

CROSLAND BARNES GROUP, LLC,

a South Carolina limited liability company

By: DocuSigned by: Edward C. Barnes 5024C20A58D8462...
Edward C. Barnes, its Manager

Date: 11/4/2025, 2025

Purchaser's Notice Address:

Crosland Barnes Group
Attn.: Ned Barnes
6 Calendar Court, Suite 3
Columbia, SC 29206
Email: ned@croslandbarnesgroup.com

With a copy to:

Crosland Barnes Group
Attn: Mary Dameron Milliken
6 Calendar Court, Suite 3
Columbia, SC 29206
Email: mary.milliken@croslandbarnesgroup.com

EXHIBIT A TO REAL ESTATE PURCHASE AND SALE AGREEMENT

TRUST AGREEMENT

The undersigned CROSLAND BARNES GROUP, LLC, a South Carolina limited liability company (hereinafter called "**Trustee**"), whose address is 6 Calendar Court, Suite 3, Columbia, South Carolina 29206, and PARKRIDGE MEDICAL CENTER, INC., a Tennessee corporation, or its assigns (hereinafter called "**Beneficiary**"), whose address is c/o HCA Healthcare, Inc., One Park Plaza, Nashville, Tennessee 37203, each intending to be legally bound, agree as follows with respect to that certain parcel of real property located at 2375 Blackburn Road SE, Cleveland, Bradley County, Tennessee, being Tax Parcel Number: 065D F 018.00 (such tract or parcel of land hereinafter the "**Property**").

1. Trustee shall enter, or has entered, into a binding contract (the "**Contract**") to purchase the Property from Mable Geren, the owner thereof ("**Seller**"), for a purchase price of not more than $1,200,000.00 ("**Purchase Price**"), and such Contract shall be, or has been, entered into by Trustee solely as the nominee, agent or trustee for Beneficiary.

2. Trustee agrees to do all things requested by Beneficiary and as necessary, appropriate or desirable to enter into the Contract, but shall execute and deliver only such options to purchase, option agreements, offers to purchase, contracts, agreements, commitments and other documents which implement, effect or otherwise relate to the purchase of the Property (collectively, including the Contract, the "**Contract Documents**") as are prepared by or approved by Beneficiary or its counsel. No other contracts, agreements or other documents signed or delivered or other acts or things done by Trustee shall be binding upon Beneficiary. Beneficiary shall furnish Trustee with, or reimburse Trustee for, all funds to pay any option money or earnest money deposits required under the terms of the Contract Documents.

3. Beneficiary shall be and always remain the owner of the entire beneficiary interest in the Property and contracts and rights to purchase or acquire the Property held by Trustee, and Trustee does hereby, and shall, upon request of Beneficiary (or in any event prior to the date required for closing under the applicable Contract if no prior request is made by Beneficiary), assign, remise, release and quitclaim to Beneficiary all right, title and interest, if any, which it has or may hereafter acquire in and to any and all of the Property and any contracts on or rights to purchase or acquire the same or any part thereof, including, but not limited to all Contract Documents. Likewise, Beneficiary hereby accepts assignment of all obligations and liabilities incurred by Trustee on behalf of Beneficiary through the execution of the Contract Documents by Trustee, and Beneficiary agrees to accept assignment of all right, title, obligations and interest of Trustee under the Contract Documents prior to the date required for closing under the applicable Contract or Contract Document.

4. Reserved.

5. Trustee declares that all rents, issues, profits and earnings issuing from or out of the Property do not belong to it and that any of which come into its possession are the property of Beneficiary and shall be held in trust for Beneficiary, subject to Beneficiary's order, disposition and control.

6. Trustee shall have no duties or responsibility with respect to the Property or the Contract Documents except as specifically provided in this Agreement and as may be reasonably requested by Beneficiary and consistent with the terms, spirit and scope of this Agreement.

7. Beneficiary shall provide to Trustee all funds and other things necessary or proper for Trustee to perform any obligations required to be performed of Trustee under the Contract Documents.

8. Beneficiary shall defend, indemnify and hold Trustee harmless from all claims, demands, actions, liabilities, losses, costs and expenses, including, but not limited to reasonable attorney's fees, incurred by or to which Trustee shall be subject by reason of this Agreement, any acts or omissions of Beneficiary and any act or thing done or omitted to be done by Trustee as Beneficiary's nominee and trustee under this Agreement, absent bad faith, or gross negligence on the part of Trustee or Trustee's failure to comply with the terms of this Agreement or follow Beneficiary's instructions.

9. Trustee will not voluntarily, intentionally or negligently disclose the identity of Beneficiary or that it is acting on behalf of Beneficiary without the prior written consent of Beneficiary; provided, however, that Trustee shall be allowed to disclose such information as may be required by applicable laws and/or as may be required by court order.

10. Trustee shall receive from Beneficiary as compensation for the performance of Trustee's duties and obligations under this Agreement, a sum in the amount of Ten Dollars and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged by Trustee. Furthermore, Beneficiary shall reimburse Trustee for the reasonable costs and expenses which Trustee incurs in the performance of his duties under this Agreement, including any attorneys' fees and other legal costs reasonably incurred by Trustee for services of outside legal counsel (but excluding attorney's fees incurred by Trustee with respect to in-house legal counsel of Trustee).

11. This Agreement shall inure to the benefit of and bind the parties hereto, their heirs, devisees, personal representatives, successors and assigns; provided that Trustee shall not assign his rights or delegate the performance of any of his duties or obligations hereunder without the prior written consent of Beneficiary.

12. This Agreement shall be deemed to be an agency agreement and shall not be deemed to create a trust for federal income tax purposes.

13. This Agreement may be executed in any number of counterparts, each of which when taken together shall constitute an original. Signature pages transmitted electronically (via email or fax) shall be accepted as originals.

[Signature page follows.]

Dated as of the 21st day of November, 2025.

TRUSTEE:

CROSLAND BARNES GROUP, LLC

DocuSigned by:

By: Ed Barnes
5024C20A58D8462...

Name: Edward C. Barnes

Title: Manager

BENEFICIARY:

PARKRIDGE MEDICAL CENTER, INC.

Signed by:

By: Todd Maxwell
7F6C535A271C48A...

Name: Todd Maxwell

Title: Vice President

Attachment 9A-2

Warranty Deed Showing Seller Ownership

THIS INSTRUMENT PREPARED BY
WINSTON H. PRINCE, JR.
BROWN BUILDING
CLEVELAND, TENNESSEE

D E E D 65-D.F.18

FOR AND IN CONSIDERATION of the sum of Five ($5.00) Dollars cash in hand paid, and other good and valuable considerations, the receipt of which is hereby acknowledged, we, LILLIAN JONES KELLEY, LOUISE JONES McCOY, RUTH JONES McLEOD, DAVID JONES, BEULAH DELASHMITT, MARTHA CLARK, PATSY HARPER, JANIE WILLIAMS OGLE, KENNEY WILLIAMS, BETTY McCOY HOWERTON, RALPH WILLIAMS, DWIGHT WILLIAMS, CAROLYN WILLIAMS FARMER, RANDY WILLIAMS, DAVID WILLIAMS, GWEN HAILE, SHARON COYNER, PHYLLIS NORMAN (formerly Phyllis Arthur), GREG JONES, RITA COCHRAN and WAYNE STONECIPHER, have bargained and sold and by these presents do transfer and convey unto BARKLEY GEREN and wife, MABLE GEREN, their heirs and assigns forever, the following described real estate in the First Civil District of Bradley County, Tennessee to-wit:

BEGINNING at the point of intersection of the eastern right-of-way line of Blackburn Road (formerly Home Drive - See plat book 1, page 39) and the Southern right-of-way line of Home Drive (not opened); thence with the southern and western right-of-way line of Home Drive (not opened) as follows: South 77 deg. 09 min. East, 126.8 feet to a point, Delta = 99 deg. 54 min R = 100, 148.2 feet to a point and South 22 deg. 45 min. West, 392.14 feet to a point in the northern right-of-way line of State of Tennessee Highway Project No. APD-40; thence with the Northern right-of-way of APD-40 as follows: North 89 deg. 38 min. 40 seconds West, 93.84 feet to a point; North 28 deg. 42 min. West, 120.6 feet to a point; North 19 deg. 04 min. EAst, 115.4 feet to a point; North 10 deg. 57 min. East, 100.9 feet to a point; and North 70 deg. 18 min. West 12.5 feet to a point in the eastern right-of-way of said Blackburn Road; thence North 20 deg. 43 min. East with the eastern right-of-way of said Blackburn Road, 161.6 feet to a point, the place of beginning, containing 1.9 acres, more or less, and being designated as Tract 5 on Plat of survey prepared by Richmond Surveying Company dated August 23, 1988.

SUBJECT to an existing sewer line easement and right-of-way in the southwest corner area as shown on said Plat.

Also quitclaimed and not included in the warranties in this Deed to the Grantee is all of our right, title and interest in and to the right-of-way for Home Drive as shown on said Plat and Plat Book 1, page 39, Register's Office, Bradley County, Tennessee.

Mail to:
For tax purposes
Route 8, Box 11
Cleveland, TN 37311

1027

SUBJECT to controlled access by the State of Tennessee to APD-40 and permit requirements if applicable.

Being part of the real estate conveyed to Herbert Williams and wife, Minnie Lee Williams, by deed from Homer Green and wife, Lillian Green dated January 27, 1943, and recorded in the Register's Office of Bradley County, Tennessee in deed book 68, page 353. Herbert Williams predeceased Minnie Lee Williams, leaving her surviving tenant by the entirety. Minnie Lee Williams is now deceased and the Grantors herein take by virtue of her Will recorded in Will Book 7, page 351, in the Office of the Clerk and Master of Bradley County, Tennessee.

TO HAVE AND TO HOLD the above described real estate unto the said BARKLEY GEREN and wife, MABLE GEREN, their heirs and assigns forever.

We covenant that we are lawfully seized and possessed of the said real estate, that we have a good and lawful right to sell and convey the same; that the title so conveyed is clear, free and unencumbered, and we will forever warrant and defend the title thereto against the lawful claims of all persons, whomsoever.

WITNESS our signature this 22nd day of September 1988.

Lillian Jones Kelley
LILLIAN JONES KELLEY

Louise Jones McCoy
LOUISE JONES McCOY

Ruth Jones McLeod
RUTH JONES McLEOD

Beulah DeLashmitt
BEULAH DELASHMITT

Martha Clark
MARTHA CLARK

1028

Patsy Harper
PATSY HARPER

Janie Williams Ogle
JANIE WILLIAMS OGLE

Kenney Williams
KENNEY WILLIAMS

Betty McCoy Howerton
BETTY McCOY HOWERTON

Ralph Williams
RALPH WILLIAMS

Dwight Will
DWIGHT WILLIAMS

Carolyn Williams Farmer
CAROLYN WILLIAMS FARMER

Randy Williams
RANDY WILLIAMS

David Williams
DAVID WILLIAMS

Gwen Haile
GWEN HAILE

Sharon Coyner
SHARON COYNER

Phyllis Norman
PHYLLIS NORMAN.

1029

Greg Jones
GREG JONES

Rita Cochran

RITA COCHRAN

Wayne Stonecipher

WAYNE STONECIPHER

David Jones

DAVID JONES

1030

STATE OF Tennessee:

COUNTY OF Bradley :

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared JANIE WILLIAMS OGLE, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that she executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 14th day of ~~September~~ October, 1988.

Winston H. Sivley Jr.
NOTARY PUBLIC

My commission expires: 6-26-89.

STATE OF TENNESSEE :

COUNTY OF BRADLEY :

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared KENNEY WILLIAMS, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that he executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 14th day of ~~September~~ October, 1988.

Winston H. Sivley Jr.
NOTARY PUBLIC

My commission expires: 6-26-89.

1031

STATE OF TENNESSEE :

COUNTY OF BRADLEY :

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared LILLIAN JONES KELLEY, LOUISE JONES McCOY, MARTHA CLARK, RALPH WILLIAMS, DWIGHT WILLIAMS, CAROLYN WILLIAMS FARMER, DAVID WILLIAMS, PHYLLIS NORMAN (formerly Phyllis Arthur), GREG JONES, RITA COCHRAN AND WAYNE STONECIPHER, some of the within named bargainors with whom I am personally acquainted, and who acknowledged that they executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 14th day of October, 1988.

Winston H. Shea, Jr.
NOTARY PUBLIC

My commission expires: 6-26-89

1032

STATE OF TENNESSEE :
COUNTY OF Bradley

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared DAVID JONES, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that he executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 13th day of October, 1988.

Winston H. Lucy Jr.
NOTARY PUBLIC

My commission expires: 6-26-89.

STATE OF TENNESSEE :
COUNTY OF Bradley

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared RUTH JONES McLEOD, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that she executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 13th day of October, 1988.

Winston H. Lucy Jr.
NOTARY PUBLIC

My commissionexpires: 6-26-89.

1033

STATE OF FLORIDA :

COUNTY OF ORANGE

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared GWEN HAILE, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that she executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 6th day of ~~September~~ October, 1988.

NOTARY PUBLIC

My commission expires:

NOTARY PUBLIC, STATE OF FLORIDA
MY COMMISSION EXPIRES APRIL 15, 1991.
BONDED THRU NOTARY PUBLIC UNDERWRITERS.

STATE OF FLORIDA :

COUNTY OF

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared PATSY HARPER, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that she executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 5th day of ~~September~~ October, 1988.

NOTARY PUBLIC

My commission expires:

NOTARY PUBLIC, STATE OF FLORIDA
My commission expires Oct. 28, 1988

1034

STATE OF CALIFORNIA:
COUNTY OF: San Diego

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared BEULAH DeLASHMITT one of the within named bargainors with whom I am personally acquainted, and who acknowledged that she executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 22 day of September, 1988.

OFFICIAL SEAL
CAROL M. MILLER
NOTARY PUBLIC-CALIFORNIA
PRINCIPAL OFFICE IN
SAN DIEGO COUNTY
My Commission Expires July 29, 1991

Carol M. Miller
NOTARY PUBLIC

My commission expires: 7-29-91

STATE OF COLORADO :
COUNTY OF Arapahoe

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared SHARON COYNER, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that she executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 3rd day of ~~September~~ October, 1988.

Dee Hefley
NOTARY PUBLIC

My commission expires: 1035

My Commission Expires June 29, 1992

STATE OF IDAHO :

COUNTY OF

Before me, the undersigned Notary Public in and for the State and County aforesaid, personally appeared BETTY McCOY HOWERTON, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that she executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 23rd day of September, 1988.

Michele Clark
NOTARY PUBLIC

My commission expires: 3-10-93

I, or we, hereby swear or affirm that the actual consideration for this transfer or value of the property transferred, whichever is greater is $26,500, which amount is equal to or greater than the amount when the property transferred would command at a fair voluntary sale.

Mable R. Coren
Affiant

Described and sworn to before me this the 2nd day of December, 19 88

STATE OF COLORADO :

COUNTY OF El Paso

Before me, the undersigned Notary ODELL SWAFFORD, Register, the State and County aforesaid, personally appeared RANDY WILLIAMS, one of the within named bargainors with whom I am personally acquainted, and who acknowledged that he executed the within and foregoing instrument for the purpose therein contained and expressed.

WITNESS my hand and notarial seal this 22 day of September, 1988.

Kathleen D. Nelson
NOTARY PUBLIC

STATE OF TENNESSEE, BRADLEY COUNTY
The foregoing instrument and certificate were noted in Note Book 1 Page 112 At 3:55 O'Clock P M 12-2 19 88 and recorded in DB Book 317 Page 1027 State Tax Paid $ 82.45 Fee .50 Recording Fee 40.00 Total $ 127.95 Witness my hand Receipt No. 1487

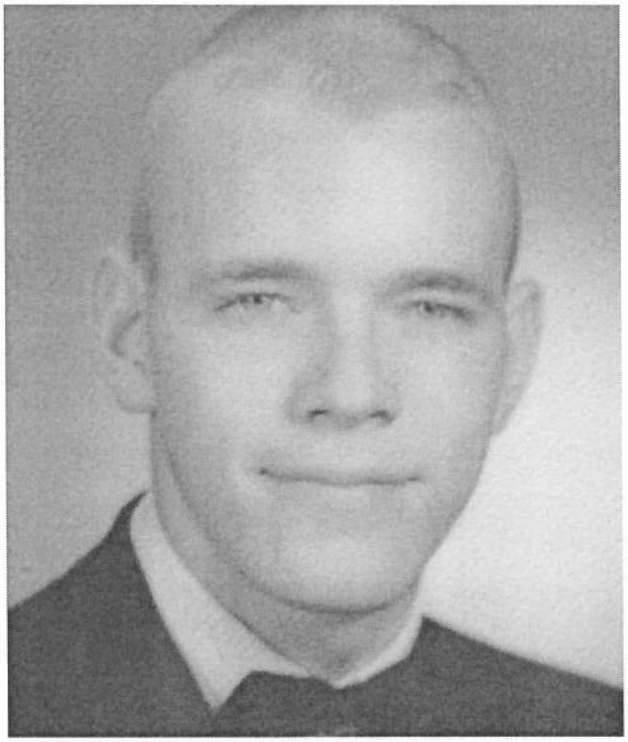
Odell Swafford, Register

My commission expires:

KATHLEEN D. NELSON
NOTARY PUBLIC
STATE OF COLORADO
My Commission Expires 3-28-91

3SSW/JA
PETERSON AFB, CO

1036



Barkley Geren

November 27, 1944 — February 7, 2017

SEND FLOWERS

SEND A GIFT

Listen to Obituary

Barkley Geren, 72, of Cleveland, TN passed away on February 7, 2017 at his home. He was born on November 27, 1944 to the late Kins Lee Geren and Mellie Loree Geren. Barkley was a lifelong resident of this area and the owner and operator of Geren Construction since 1970. In his free time,

Barkley loved to fish and watch his grandchildren's ballgames.

In addition to his mother and father, he is preceded in death by his brother Billy Don Geren.

He leaves behind to cherish his memory his wife of 53 years Mable Geren; sons Bryan Geren (Pam) and Kinny Geren (Cindy); daughters Cheryl Geren of Spring City, TN and Amy Geren McGowan (Scott); grandchildren: Walker Geren (Breanna), Bradlee Carter, Baylee Carter, Kellee Geren, Sydni Geren, Barkley "Kley" McGowan, Kinslee McGowan, Kason McGowan, Walker McGowan, and Baylor McGowan. In addition to these, Barkley leaves behind numerous extended family members and friends.

A memorial celebration of life will be held at 6:00pm on Saturday February 11, 2017 at Companion Funeral Home located at 2419 Georgetown RD NW, Cleveland, TN 37311. The family will receive friends from 3:00pm until 6:00pm at the funeral home prior to the service.

You are invited to share a personal memory of Barkley or your condolences with his family at his online memorial located at www.companionfunerals.com. Companion Funeral and Cremation Service and the Cody family are honored to assist the Geren family with these arrangements.

SERVICE SCHEDULE

PAST SERVICES

VISITATION

Saturday, February 11, 2017
3:00 - 6:00 pm (Central time)
Add to Calendar

Companion Funeral & Cremation Service - Cleveland Chapel
2415 Georgetown Road Northwest
Cleveland, TN 37311

DIRECTIONS

SERVICE

Saturday, February 11, 2017
Starts at 6:00 pm (Central time)
Add to Calendar

Companion Funeral & Cremation Service - Cleveland Chapel
2415 Georgetown Road Northwest
Cleveland, TN 37311

DIRECTIONS

Attachment 10A

Proposed Floor Plan

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

0' 4' 8' 16' 32'

HEREFORD · DOOLEY
ARCHITECTS
11 LEA AVE · SUITE 601
NASHVILLE · TENNESSEE · 37210
P · 615 · 244 · 7399
F · 615 · 244 · 6697
WWW.HDARCHITECTS.COM

PROJECT
00000.00

PROPOSED FSER
2375 BLACKBURN ROAD SE, CLEVELAND, TENNESSEE 37311
[INSERT FACILITY NAME]
[INSERT FACILITY ADDRESS]

STATUS
SCHEMATIC DESIGN 90

DATES OF ISSUANCE
William E. Hereford, III
AR # [xxxxx]
11.05.2025
△

TITLE
PRESENTATION FLOOR PLAN

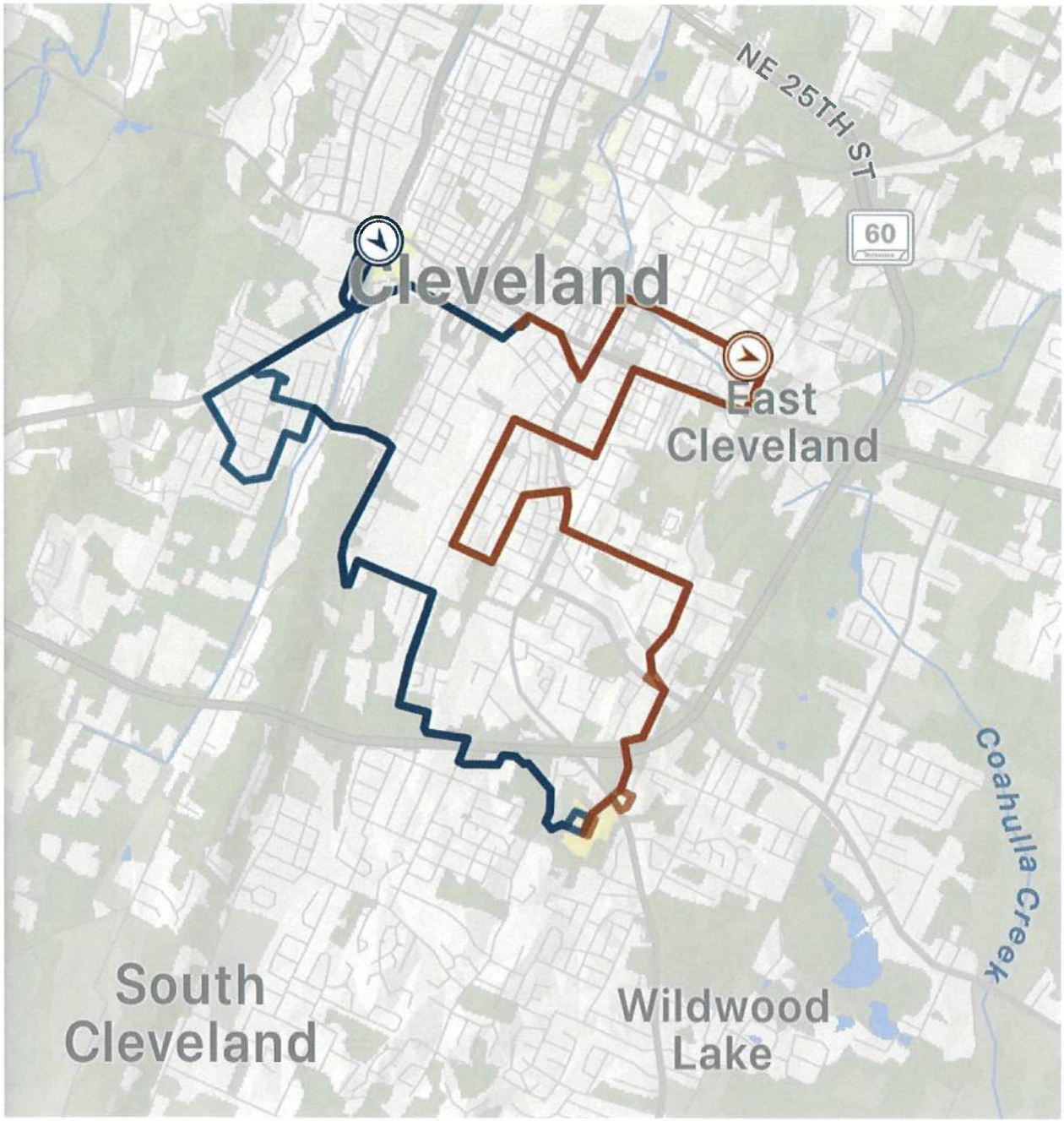
SHEET
A.0

Attachment 11A

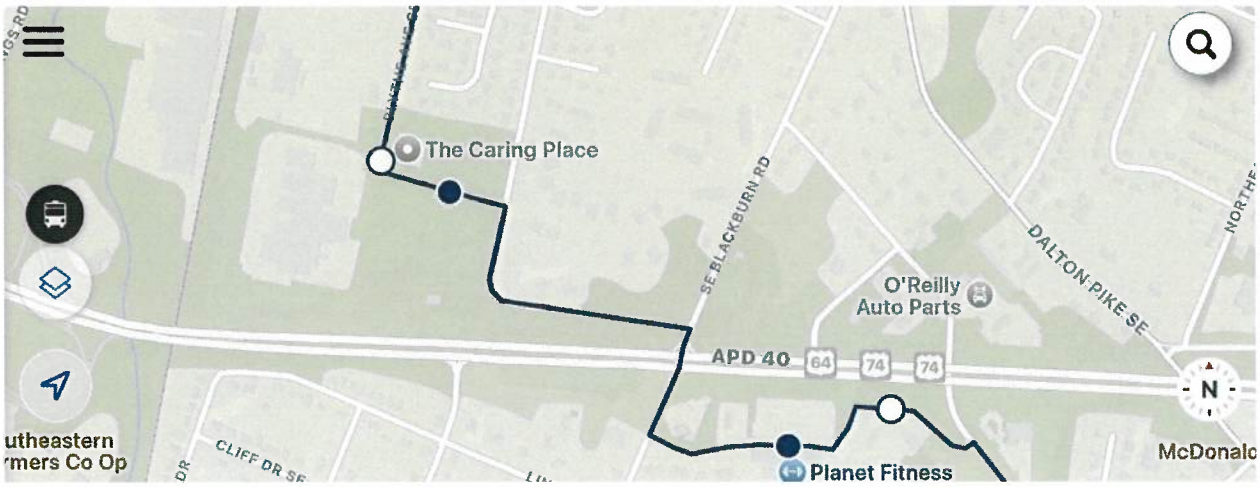
Public Transportation (Bus) Route

Cleveland Urban Area Transit System (CUATS) Red and Blue Routes

There are five bus routes in Cleveland all of which initiate at the Transit Center, 165 Edwards Street, Cleveland 37311. Three routes travel to northern Cleveland while two (Red and Blue) travel to southern Cleveland. The Red and Blue routes take two separate routes and ultimately converge in southern Cleveland at Walmart, Treasure Drive in southern Cleveland approximately 3 minutes and less than one mile from the Site.



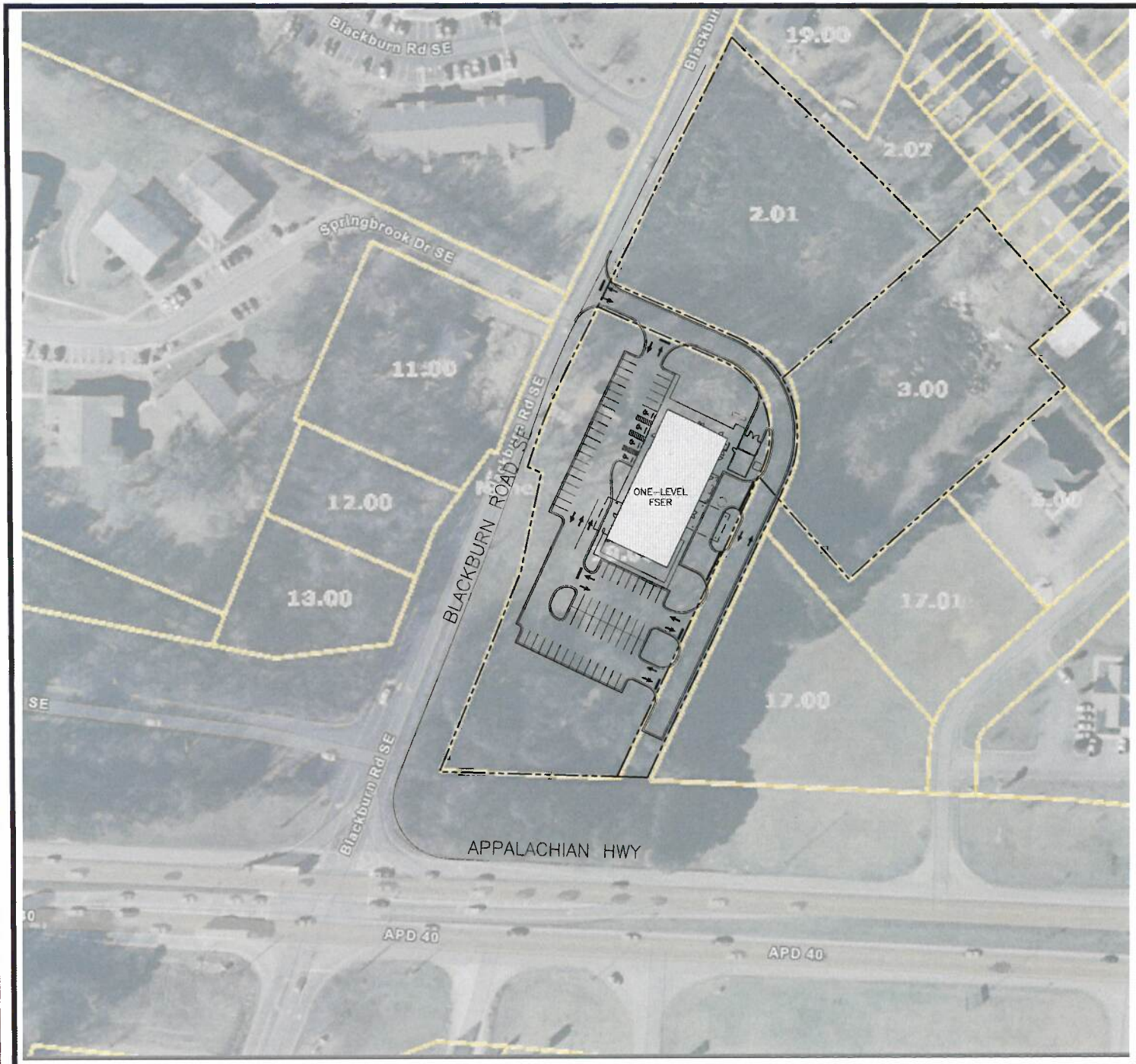
The Blue Route enters Blackburn Rd SE at Bower Lane SE at the northwest intersection of Blackburn Rd SE and Appalachian Highway, across from the proposed site.



The nearest bus stops to the site are at The Caring Place to the west of the site and Planet Fitness to the south of the site.

Attachment 12A

Plot Plan



SITE SUMMARY

1. **Address** – The site is comprised of three parcels. Two of the parcels have assigned addresses – 2375 Blackburn Road SE (Parcel ID: 065D F 01800 000), and 820 King Street SE (Parcel ID: 065D F 00300 000). The third parcel (Parcel ID: 065D F 00201 000) does not have an assigned address.
2. **Acreage** – The approximate combined acreage of the three parcels is 4.99 acres, according to the City of Cleveland GIS.
3. **Project** – The proposed building is a single story FSER of approximately 11,000 square feet.
4. **Land Use** –The southwest parcel currently contains a single-family residence. The north and northeast parcels are vacant.
5. **Zoning** – The southwest parcel is zoned CH – Highway Commercial. The north and northeast parcels are zoned R2 Low Density Single- and Multi-Family Residential
   The CH zoning designation permits all uses by right in the Professional Institutional (PI) designation. Medical offices or clinics are permitted within the PI designation and, therefore, should be permitted in the CH designation.
   Medical uses are not listed as permitted uses in the R2 zoning designation.
6. **Parking** Medical Offices require one space per 150 square feet.
7. **Building Dimensions** – The maximum building height is two stories in the CH designation.
8. **Floodplain** – The site is in the FEMA Flood Zone X – Area of Minimal Flood Hazard

205

Cleveland FSER Blackburn RD
PROJECT NAME

INGRAM CIVIL ENGINEERING GROUP
213 CHEEK-OAK CIRCLE, SUITE 105
SWANNANOA, NORTH CAROLINA 28778
(828) 575-0000 OFFICE
(828) 575-1072 FAX

124824.03
PROJECT NUMBER

11-04-2025
DATE

T100
SHEET NUMBER

TEST FIT
SHEET NAME

GRAPHIC SCALE

Attachment 4E

Equipment List > $50,000

HCA Healthcare

4/14/2025

FSER Template
Medical Equipment Summary:
$50,000 +

Vendor	Item	Cost
GE Healthcare	CT - REVOLUTION MAXIMA 32 CHANNEL, 64 SLICE	$387,772
GE Healthcare	X-RAY / RAD - DEFINIUM TEMPO PRO - 65KW GEN RAD	$153,000
GE Healthcare	PORTABLE X-RAY - AMX NAVIGATE	$113,257
GE Healthcare	PHYSIOLOGIC MONITORING SYSTEM - 1 FIXED, 4 PORTABLE, & CENTRAL STATION	$98,557

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)

The Parkridge Cleveland FSED will be located at the northeast intersection of Blackburn Road SE and Appalachian Highway also known as APD 40, US Route 64 Bypass and US Route 74. This site is located in 37311 on its east side, approximately 100 yards from 37323. Both zip codes are associated with Cleveland, Tennessee. The proposed FSED will enhance access for southern Bradley and western Polk County residents through establishing a new ED access point thus reducing geographic isolation, providing residents with choice, reducing the growing outmigration, offering enhanced quality care as to what is currently available, increasing the number of ED treatment rooms, improving travel times, shortening wait times, reducing LWOT scores, and improving CT results available for suspected stroke victims. There is only one hospital in Bradley County and the service area, BMC. The need for this project is multi-faceted and described in detail herein.

Service Area Definition

See **Attachment 2N** for the proposed county service area map. To define the proposed service area for the Parkridge Cleveland FSED, the evaluation considered geographic distribution of zip codes within and outside the county, location of the only emergency room in the county, roadway systems, travel distances and patient migration patterns. It also considered Polk County's proximity, geography and potential access as it has no emergency room or hospital resources.

In addition to these factors considered to identify the location of the proposed Cleveland FSED, Parkridge also considered the following factors in its determination of the proposed service area:

- Geographic proximity of zip codes to the proposed FSED;
- TriStar Division's experience that 70 to 80 percent of patients live within 15 minutes of an FSED; and
- FSEDs often pull from a narrower service area than on-campus hospital EDs as evidenced by Parkridge and its affiliates experience.

Based on this detailed analysis, the service area was defined as the following zip codes:[4]

- 37311 (Cleveland), the home zip code for the Parkridge Cleveland FSED covering central and southern Cleveland;
- 37323 (SE Cleveland), the zip code immediately to the east of the home zip code traversing southeast Cleveland;
- 37353 (McDonald), the zip code to the west of 37311 situated in the southwest of the county;
- 37362 (Old Fort), immediately to the east of 37323 and situated in southeast Bradley and southwest Polk County;
- 37307 (Benton) east of Cleveland in west Polk County; and
- 37361 (Ocoee) east of Cleveland in southwest Polk County.

Parkridge Cleveland FSED is an access enhancement to each of these zip codes due to proximity for the residents of this defined service area. This enhancement is not only based on the time required to access BMC but also the times required to access all other hospitals these patients are regularly utilizing for emergency services, including those in Hamilton County, McMinn County and out of state.

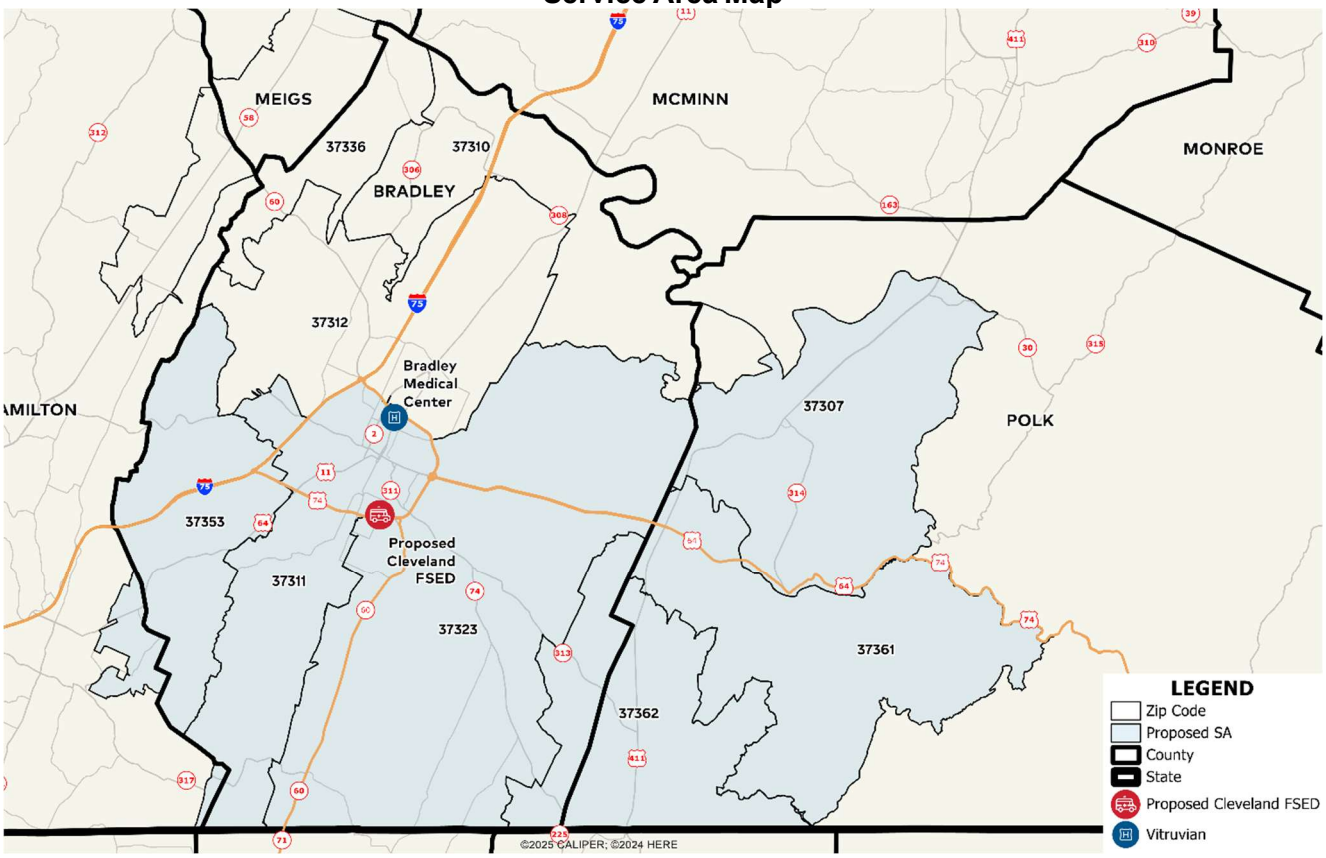
[4] Postal code 37316 (Conasauga), located within Old Fort, has no population but does have ED visits; it is included in the service area and identified in certain analyses where applicable.

The proposed Parkridge Cleveland FSED is well positioned within the defined service area of 37311 (Cleveland), 37323 (SE Cleveland), 37353 (McDonald), 37362 (Old Fort), 37307 (Benton) and 37361 (Ocoee). The service area encompasses southern Bradley and western Polk with the first three zip codes located within the Bradley County limits. The fourth zip code, 37362 (Old Fort), is split between Bradley County and Polk County. The last two zip codes, 37307 (Benton) and 37361 (Ocoee) are located in western Polk County.

Polk County is geographically unique and has no emergency room facilities – requiring all Polk County residents to leave their home county to access an emergency room. It is largely a rural county, with Cherokee National Forest covering 80 percent of its land area. Areas to the west of the forest include Old Fort, Ocoee, Benton and Conasauga.[5] Delano and Reliance extend to the north of the forest. Areas to the east of the Cherokee National Forest, include Farmer, Turtletown, Ducktown and Copperhill. Those on the east side of Polk County primarily access ED services out-of-state. The McMinn County hospitals treat the largest share of Delano and Reliance residents.

Generally, those in western Polk County and proximate to Bradley County access commercial resources (retail, healthcare, etc.) in Bradley County or further west in Hamilton County. US Route 64 is the primary route leading from west Polk County into Bradley County. The proposed Cleveland FSED site is located on this route; therefore, the implementation of Parkridge Cleveland FSED will enhance access for western Polk County residents, with Old Fort, Benton and Ocoee being included in the service area and other towns in Polk County included in the 20 percent out-of-service-area patient draw. **Exhibit 1** provides a map of the service area and its positioning within the counties.

Exhibit 1
Service Area Map



[5] Geographically Conasauga is located within zip code 37362, although assigned zip code 37316 which is designated by the postal service as a PO Box with no population.

The proposed FSED is located at the intersection of Blackburn Road Southeast and Appalachian Highway. This latter roadway is also known as APD 40, US Route 64 Bypass and US Route 74. Route 64 travels east through zip code 37323 (SE Cleveland); and Route 74 travels west through 37323 (SE Cleveland), 37311 (Cleveland) and 37353 (McDonald), accessing Interstate 75 to the west of the proposed FSED site. Route 60, which also connects to these routes, travels south along the 37311 (Cleveland) and 37323 (SE Cleveland) border. Additionally, US Route 64 extends into and throughout Polk County, being the primary access road for western Polk County residents to access Bradley County resources (shopping, healthcare, etc.) and such resources further west in Hamilton County. This location is optimally situated to enhance access to southern Bradley and western Polk County residents residing in the service area zip codes.

In emergency situations where timeliness of care can determine medical outcomes, the proposed FSED will not only save time to treatment but also eliminate the need for patients to travel further north to BMC or further west into Hamilton County, which is experiencing significant and increasing migration from Bradley County.

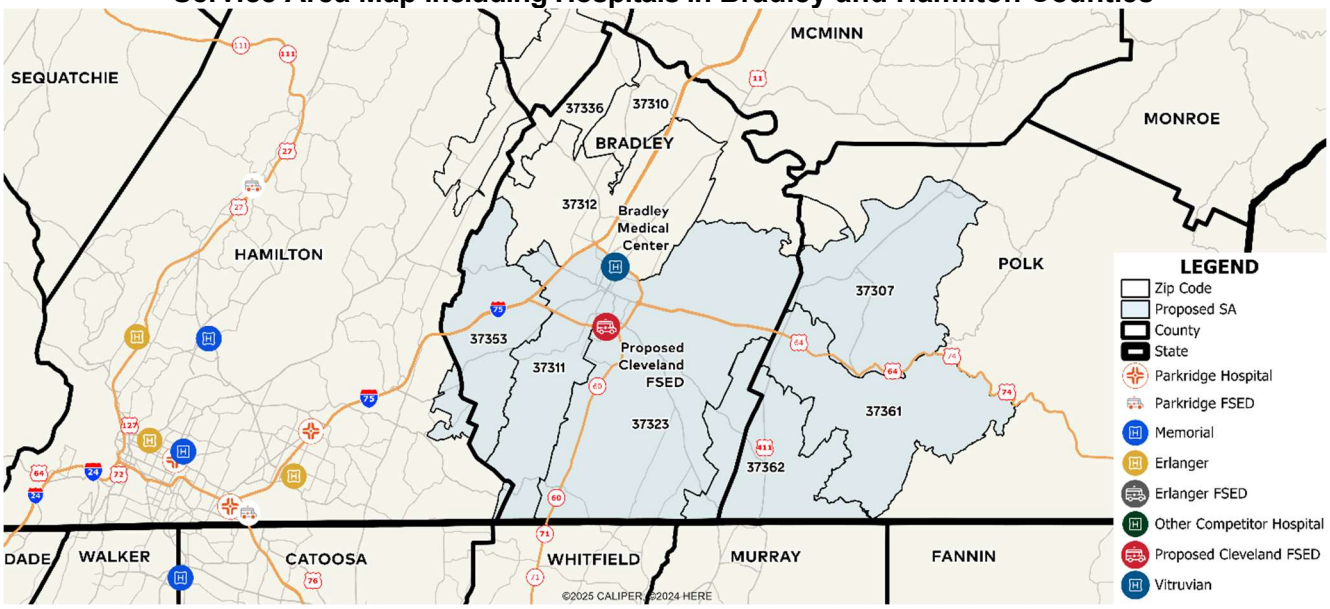
Parkridge Medical Center's objective in this project is to improve the quality of care available in and around Bradley County, offer residents a choice in providers and shorten service area residents' travel time to emergency care, thereby reducing the isolation experienced by patients during a critical time when every minute is important for an emergency intervention. The proposed FSED will enhance available quality of care and geographic access to emergency services for patients in the service area and thus improve outcomes for patients with life threatening conditions. Both lack of available quality care and geographic isolation are confirmed by community members. Implementing the Parkridge Cleveland FSED will accomplish the following:

- Improve the quality of ED services available in the service area including southern Bradley and western Polk County;
- Deliver quality ED services to its patients, with shorter wait times and lower LWOTs, closer to where they live;
- Address the ED treatment needs of this underserved population through increased availability and improved accessibility to ED services;
- Relieve geographic isolation and enhance access as each of the service area zip codes are closer to the proposed FSED, an improvement of 5 to 7 minutes depending on the zip code and importantly largely reducing access to 12 minutes or less for the majority of service area residents; time to access from zip codes in Polk County will remain above 15 minutes but will improve by 2 to 5 minutes;
- Reduce the growing out-migration, which accounts for 35 percent of service area patients accessing emergency services outside the county at significant time and travel distances;
- Ensure ED services are more readily available to the 65 and older population, which is expected to increase to more than 20 percent by 2030;
- Increase the number of emergency rooms from 1 to 2 thereby increasing ERs per 100,000 population from half the statewide average to 1.76;
- Address the future ED demands by zip code, which results in a 3,400 visit increase between 2023 and 2030;
- Provide service area residents with an alternative mode to receive their emergency care, which is currently not available in the area; and
- Provide service area residents with an accessible alternate ED provider with top quartile high quality metrics.

Based on the aforementioned factors, the proposed service area is reasonable and justified. **Exhibit 2** provides a map of the service area zip codes that are highlighted in blue. The map includes the existing

hospital within Bradley County. It also includes the major roadway infrastructure in the area. As noted, the only hospital in the service area and county is BMC, 3.8 to 5.4 miles north of the proposed Cleveland FSED depending on route taken. Residents traveling from the service area zip codes will travel on average between 16 and 22 minutes to access BMC. Those living further than the zip code centroids will have greater travel times. For reference purposes the surrounding counties are also shown along with their available hospitals and emergency rooms.

Exhibit 2
Service Area Map including Hospitals in Bradley and Hamilton Counties



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

As observed in the above map, the proposed FSED will be centrally located on an east-west plane and at the intersection of major roadways providing access from the south, east and west portions of the service area.

Forecasted Utilization of the Parkridge Cleveland FSED

Exhibit 3 provides forecasted utilization of the proposed FSED for its first two years of operation. For detailed projected utilization by zip code assumptions, refer to the response to **Question 6N** below.

Exhibit 3
Forecasted ED Visits at the Parkridge Cleveland FSED

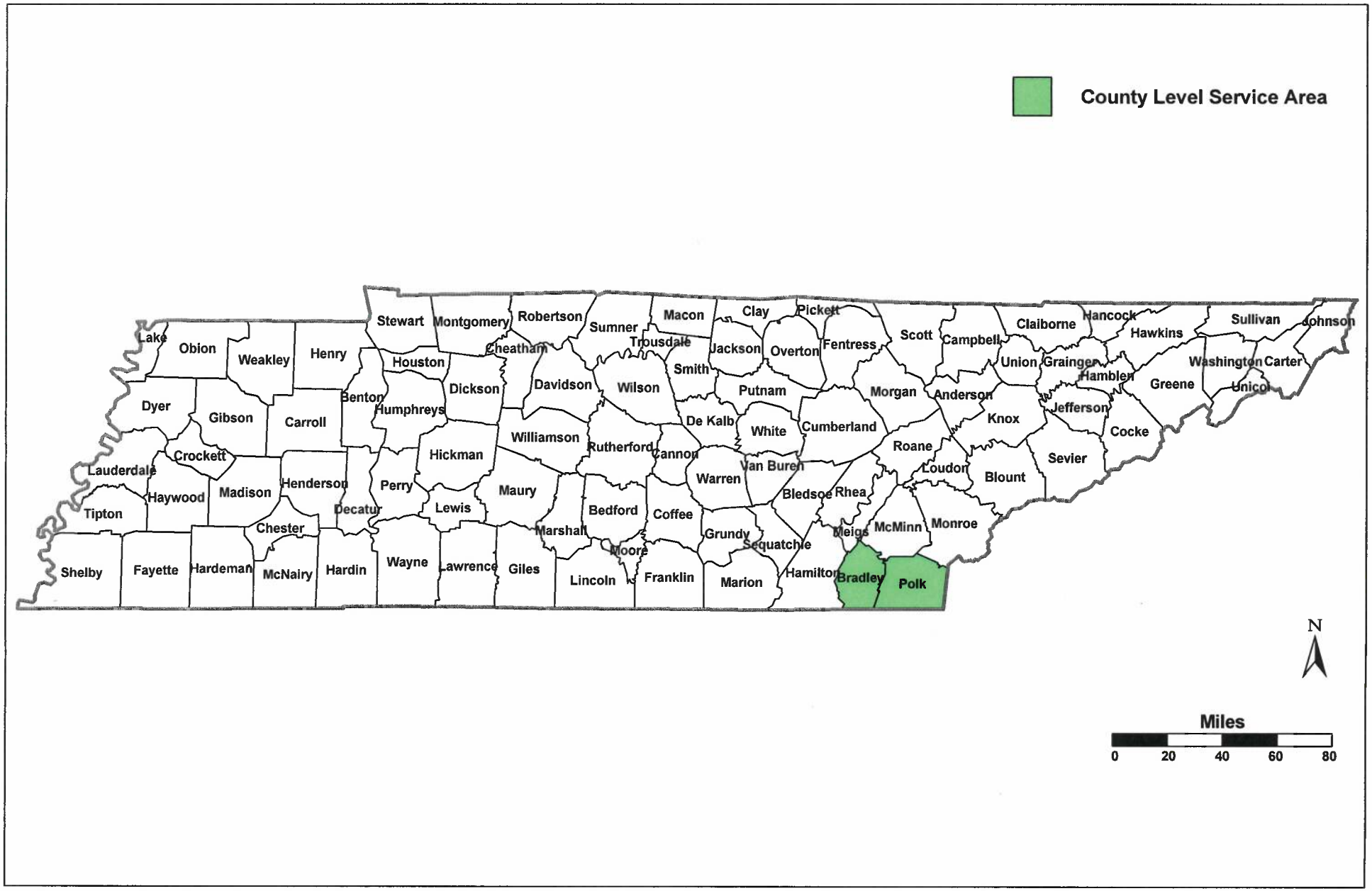
Zip Code	Year 1	% of Total	Year 2	% of Total
Cleveland - 37311	3,191	36.5%	3,926	36.5%
SE Cleveland - 37323	2,707	30.9%	3,340	31.0%
McDonald - 37353	319	3.6%	386	3.6%
Old Fort - 37362	285	3.3%	345	3.2%
Benton - 37307	382	4.4%	468	4.3%
Ocoee - 37361	117	1.3%	145	1.3%
Service Area	7,001	80.0%	8,609	80.0%
Out of Area	1,750	20.0%	2,152	20.0%
Total	8,751	100.0%	10,762	100.0%

Totals may not add due to rounding.

Attachment 2N

County Level Service Area Map

Parkridge Medical Center: Parkridge Cleveland FSED



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

The following section describes in detail the demographics of the population of the proposed service area.

Population

Bradley County, home to the proposed Parkridge Cleveland FSED, currently has a population of approximately 114,000 having increased from 109,000, or 4.4 percent since 2020. In 2010, its population was 99,086, resulting in a 15 percent increase between 2010 and current. It is forecasted to increase an additional 4 percent in the next five years. Adjacent Polk County, which the proposed Cleveland FSED will also serve, has a current population of 18,244 having increased 8.4 percent in the last five years. Its growth is slowing somewhat to approximately 2 percent to 2030. However, the population of both counites is aging which increases utilization and need for accessible and available healthcare, including emergency services. The proportion of elderly in Bradley County is expected to increase to 19.6 percent in the next five years whereas Polk County will near 24 percent. Population by age cohort in each of these counties is presented in **Exhibit 4** below.

Exhibit 4
Bradley and Polk Counties: Population by Age Cohort, 2020 to 2030

Bradley County	**0-17**	**18-44**	**45-64**	**65+**	**Total**	**% 65+**
2020	23,649	37,300	28,789	19,333	109,071	17.7%
2025	24,344	38,934	29,470	21,165	113,913	18.6%
2030	25,219	40,200	29,887	23,249	118,555	19.6%
% Change 2020 to 2025	2.9%	4.4%	2.4%	9.5%	4.4%	
% Change 2025 to 2030	3.6%	3.3%	1.4%	9.8%	4.1%	
Polk County	**0-17**	**18-44**	**45-64**	**65+**	**Total**	**% 65+**
2020	3,178	4,987	5,033	3,637	16,835	21.6%
2025	3,330	5,392	5,434	4,088	18,244	22.4%
2030	3,320	5,428	5,404	4,453	18,605	23.9%
% Change 2020 to 2025	4.8%	8.1%	8.0%	12.4%	8.4%	
% Change 2025 to 2030	-0.3%	0.7%	-0.6%	8.9%	2.0%	

Source: Boyd Center for Business and Economic Research.

In the service area, all ages, except those age 0-17 are expected to increase. The service area zip codes in the aggregate show a greater increase in the elderly than those in Bradley County and similar to Polk County at 12.1 percent versus 9.5 and 12.4 percent, respectively. Total population change however is similar in three zip codes and slightly lower in one zip code. **Exhibit 5** presents population by service area zip code area and age cohort for 2020 and 2025. Notably, 37353 (McDonald), 37362 (Old Fort), Benton (37307) and Ocoee (37361) have the highest percent elderly. 37353 (McDonald), 37362 (Old Fort) and Ocoee (37361) have the highest overall growth rates.

Exhibit 5
2020-2025 Service Area Population by Age Group

	2020					
Zip Code	**0-17**	**18-44**	**45-64**	**65+**	**Total**	**% 65+**
37311 Cleveland	6,449	12,274	6,822	4,217	29,762	14.2%
37323 SE Cleveland	7,033	10,169	8,629	5,407	31,238	17.3%
37353 McDonald	1,037	1,461	1,528	1,026	5,052	20.3%
37362 Old Fort	782	1,153	1,164	658	3,757	17.5%
37307 Benton	994	1,542	1,533	1,013	5,082	19.9%
37361 Ocoee	329	520	467	350	1,666	21.0%
Service Area	16,624	27,119	20,143	12,671	76,557	16.6%
	2025					
Zip Code	**0-17**	**18-44**	**45-64**	**65+**	**Total**	**% 65+**
37311 Cleveland	6,397	12,143	7,045	4,760	30,345	15.7%
37323 SE Cleveland	6,968	10,689	8,886	6,052	32,595	18.6%
37353 McDonald	951	1,583	1,563	1,181	5,278	22.4%
37362 Old Fort	791	1,214	1,175	741	3,921	18.9%
37307 Benton	1,017	1,590	1,543	1,088	5,238	20.8%
37361 Ocoee	347	576	489	388	1,800	21.6%
Service Area	16,471	27,795	20,701	14,210	79,177	17.9%
	Percent Growth: 2020 to 2025					
Zip Code	**0-17**	**18-44**	**45-64**	**65+**	**Total**	
37311 Cleveland	-0.8%	-1.1%	3.3%	12.9%	2.0%	
37323 SE Cleveland	-0.9%	5.1%	3.0%	11.9%	4.3%	
37353 McDonald	-8.3%	8.4%	2.3%	15.1%	4.5%	
37362 Old Fort	1.2%	5.3%	0.9%	12.6%	4.4%	
37307 Benton	2.3%	3.1%	0.7%	7.4%	3.1%	
37361 Ocoee	5.5%	10.8%	4.7%	10.9%	8.0%	
Service Area	-0.9%	2.5%	2.8%	12.1%	3.4%	

Source: 2025 Claritas Spotlight.

The service area population contains approximately 60 percent of the combined Bradley and Polk County population, so as expected, its relative changes and increases correspond with county changes as shown in **Exhibit 4.** Service area population estimates for 2025 through 2030 were obtained from Claritas. As shown in **Exhibit 6** below, the proposed Cleveland FSED's service area is projected to increase from 79,177 residents in 2025 to 81,743 residents by 2030, representing a 3.2 percent population growth. However, the elderly population is expected to grow 5.4 times the total service area's population growth rate. Specifically, from 2025 to 2030, the 65 and older population is projected to grow 17.6 percent. The increase is meaningful in each zip code area, ranging between 14.9 and 24.2 percent.

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.[6] This was also confirmed in our analysis of service area use rates by age cohort presented in response to **Question 6N**.

[6] 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

Exhibit 6
2025-2030 Service Area Population by Age Group

	2025					
Zip Code	**0-17**	**18-44**	**45-64**	**65+**	**Total**	**% 65+**
37311 Cleveland	6,397	12,143	7,045	4,760	30,345	15.7%
37323 SE Cleveland	6,968	10,689	8,886	6,052	32,595	18.6%
37353 McDonald	951	1,583	1,563	1,181	5,278	22.4%
37362 Old Fort	791	1,214	1,175	741	3,921	18.9%
37307 Benton	1,017	1,590	1,543	1,088	5,238	20.8%
37361 Ocoee	347	576	489	388	1,800	21.6%
Service Area	16,471	27,795	20,701	14,210	79,177	17.9%

	2030					
Zip Code	**0-17**	**18-44**	**45-64**	**65+**	**Total**	**% 65+**
37311 Cleveland	6,398	12,211	7,083	5,470	31,162	17.6%
37323 SE Cleveland	7,023	10,987	8,546	7,159	33,715	21.2%
37353 McDonald	911	1,677	1,484	1,398	5,470	25.6%
37362 Old Fort	809	1,239	1,107	914	4,069	22.5%
37307 Benton	1,018	1,678	1,421	1,283	5,400	23.8%
37361 Ocoee	348	610	487	482	1,927	25.0%
Service Area	16,507	28,402	20,128	16,706	81,743	20.4%

	Percent Growth: 2025 to 2030				
Zip Code	**0-17**	**18-44**	**45-64**	**65+**	**Total**
37311 Cleveland	0.0%	0.6%	0.5%	14.9%	2.7%
37323 SE Cleveland	0.8%	2.8%	-3.8%	18.3%	3.4%
37353 McDonald	-4.2%	5.9%	-5.1%	18.4%	3.6%
37362 Old Fort	2.3%	2.1%	-5.8%	23.3%	3.8%
37307 Benton	0.1%	5.5%	-7.9%	17.9%	3.1%
37361 Ocoee	0.3%	5.9%	-0.4%	24.2%	7.1%
Service Area	0.2%	2.2%	-2.8%	17.6%	3.2%

Source: 2025 Claritas Spotlight

Service Area Race and Ethnicity

The service area is the six contiguous zip codes and one PO Box zip code primarily in southern Bradley and western Polk. These zip codes include south Cleveland, McDonald, Old Fort, Ocoee and Benton. In terms of racial and ethnic composition, as shown in **Exhibit 7**, the service area is approximately 82 percent white and 18 percent non-white (minority). 37311, the home zip code for the Parkridge Cleveland FSED has a greater minority population than the service area at 28 percent. Furthermore, the census tract in which it is located has a 35 percent minority rate. Given this minority population presence, the proposed Cleveland FSED will improve access to minority populations in addition to non-minority population.

Exhibit 7
2025 Racial and Ethnic Demographics of the Service Area Population

Distribution by Race and Ethnicity								
Zip Code	American Indian	Asian	Black or African American	Native Hawaiian or Pacific Islander	White or Caucasian	Other Race	Total All Races	Hispanic
37311 Cleveland	0.6%	0.7%	8.9%	0.3%	71.8%	17.8%	100.0%	15.1%
37323 SE Cleveland	0.3%	0.5%	2.2%	0.1%	86.7%	10.2%	100.0%	6.3%
37353 McDonald	0.3%	0.9%	2.3%	0.1%	85.7%	10.7%	100.0%	6.5%
37362 Old Fort	0.2%	0.1%	0.9%	0.1%	93.3%	5.5%	100.0%	3.1%
37307 Benton	0.6%	0.1%	0.7%	0.0%	93.6%	4.9%	100.0%	1.9%
37361 Ocoee	0.3%	0.2%	1.3%	0.1%	92.6%	5.5%	100.0%	2.9%
Service Area	0.4%	0.5%	4.6%	0.2%	81.8%	12.4%	100.0%	9.2%

Source: 2025 Claritas Spotlight. Highlighted line is the location of the Parkridge Cleveland FSED.

Service Area Low Income and Uninsured Residents

A benefit of the proposed project is increasing access to care for those with lower income. As shown in **Exhibit 8,**11.4 percent of service area residents are below the poverty level. The zip code with the greatest proportion of poverty level persons is the home zip code for the proposed FSED, 37311 (Cleveland), at 15.7 percent.

Research shows that individuals with lower incomes and living in poverty consistently experience worse health outcomes than individuals with higher incomes. 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.[7] By adding a new access point, the proposed Cleveland FSED will increase access to patients who are more likely to need emergent care.

Exhibit 8
Service Area Poverty Level

Service Area	% of Persons Below Poverty Level
37311 Cleveland	20.9%
37323 SE Cleveland	9.7%
37353 McDonald	10.8%
37362 Old Fort	14.7%
37307 Benton	11.0%
37361 Ocoee	10.3%
Service Area Total	14.4%

Source: Census.Gov.

[7] https://www.aafp.org/about/policies/all/poverty-health.html

As a hospital emergency room operating under the Parkridge Medical Center license, the proposed Cleveland FSED will care for all who need emergency care. As previously established, the proposed Cleveland FSED will be part of the larger Parkridge Health System and TriStar Division 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 Financial Assistance Policy for Uninsured Patients Charity Financial Assistance Policy for Uninsured and Underinsured Patients and Discount Policy for Patients.[8] Further, Parkridge Medical Center complies with the No Surprises Act, which fully protects patients from any cost differential between services provided by in-network or out-of-network providers by holding the patients harmless from any such difference.

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 do not provide data on a zip code level. Parkridge Medical Center 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 (Bradley and Polk) as each service area zip code is located within Bradley or Polk County. The service area zip codes and aggregate are also provided with that information and metrics being derived from Claritas, Inc. and census.gov as noted. This enables comparison between the service area and the entirety of Bradley and Polk Counties.

[8] Uncompensated care includes charity care and self pay patients both of whom qualify for free or discounted care at TriStar Division facilities including Parkridge Medical Center. This represents the patient's payment classification and a count of visits by payor class. It does not represent the amount of write off or adjustments made for these patients. For the purposes of classification, charity care includes medically indigent/free care. Bad debt is not a patient payor classification. Bad debt is an expense taken at the total hospital level.

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Census Bureau				TennCare	
	Total Population-Current Year 2025	Total Population-Projected Year 2029	Total Population-% Change 2025-2029	*Target Population- All Ages Current Year 2025	Target Population- All Ages Project Year 2029	Target Population- % Change, 2025-2029	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
37311 Cleveland	30,345	30,999	2.2%	30,345	30,999	2.2%	100%	36.2	$46,827	6,342	20.9%		
37323 SE Cleveland	32,595	33,491	2.7%	32,595	33,491	2.7%	100%	41.7	$67,538	3,162	9.7%		
37353 McDonald	5,278	5,432	2.9%	5,278	5,432	2.9%	100%	46.7	$66,186	570	10.8%		
37362 Old Fort	3,921	4,039	3.0%	3,921	4,039	3.0%	100%	44.1	$49,432	576	14.7%		
37307 Benton	5,238	5,363	2.4%	5,238	5,363	2.4%	100%	45.2	$74,953	576	11.0%		
37361 Ocoee	1,800	1,907	6.0%	1,800	1,907	6.0%	100%	44.0	$79,167	185	10.3%		
Service Area Total	**79,177**	**81,231**	2.6%	**79,177**	**81,231**	2.6%	100%			**11,412**	14.4%		
Bradley County	113,913	117,682	3.3%	113,913	117,682	3.3%	100%	40.5	$72,455	19,137	16.8%	22,714	19.9%
Polk County	18,244	18,556	1.7%	18,244	18,556	1.7%	100%	46.2	$60,227	2,426	13.3%	3,887	21.3%
State of TN Total	7,242,733	7,462,831	3.0%	7,242,733	7,462,831	3.0%	100%	39.1	$67,097	1,013,983	14.0%	1,410,973	19.5%

Source: Tennessee Department of Health; Census.gov ACTS 1 year and 5 year, November 2025; Claritas, Inc. for zip code service area population and median age; census.gov for zip code service area median household income and poverty level; and Division TennCare, Enrollment as of September 2025 (latest available in November 2025).

Target Population is the population that the project will primarily serve, defined here as Total Population.
Persons Below Poverty Level computed from census.gov quick facts poverty level times Tennessee Department of Health current year population estimates for county and state; poverty level percent for zip code areas from census.gov times current year population estimates for zip code areas.

Attachment 4N-1

Financial Assistance Policies

PARALLON

DEPARTMENT: Vendor Collections Management	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 1 of 13	REPLACES POLICY DATED: 09/15/2016
APPROVED: 12/22/2014	RETIRED:
EFFECTIVE DATE: 11/01/2017	REFERENCE NUMBER: PARA.PP.VCM.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. (Example: PARA.PP.VCM.015L for LifePoint)

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

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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.VCM.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.VCM.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.VCM.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.

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- 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.

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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/Support Services/Collector/Early Out Agency 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 Patient Non-Compliance:
Accounts where a denial is applied due to the patient's lack of cooperation are considered "uninsured".

Based on the liability due from the payer, the following collection guidelines will be followed and approval obtained prior to releasing liability to the patient where the patient failed to provide the requested information timely. Once efforts to obtain required information is exhausted, the 09947 Uninsured Discount Iplan is assigned and remaining liability after the uninsured discount will become the patient's responsibility.

Threshold	Collection Guidelines	Approver
<$1,500 <$2000 (Atlanta SSC only)	1 Letter	15% audit sample
>$1,500 - <$10,000	1 Letter and 1 Call	Team Lead
>$10,000 - <$50,000	1 Letter and 1 Call	Manager
>$50,000 - <$100,000	2 Letters and 2 Calls	Director
>$100,000	2 Letters and 2 Calls	COO

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Artiva letters 1100 Request for Additional Information Request and 1153 Additional Insurance Information Request are available to send to the patient for 1st and 2nd letter attempts. The letters contain a dropdown to allow the requester to select the information required or enter free form text if not listed in the dropdown. The next follow-up should occur based on the next follow-up cycle after action is taken based on the standard liability stratification (top, high, etc.).

Once the appropriate collection activity and approval is completed, ensure both the Uninsured IPLAN 099-47 and discount is applied appropriately. No approval is required for insurance liability less than $1,500 ($2,000 ATL only); however; an audit must be performed monthly on 15 percent of the accounts to ensure liabilities are released appropriately. To retain the original insurance plan information, assign Uninsured IPLAN 099-47 as the primary payer and resequence the original insurance IPLAN as the secondary payer.

- Assign the 099-47 Uninsured Discount IPLAN and resequence to the primary payer retaining the original IPLAN as the secondary payer.
    - The Uninsured Discount IPLAN should reflect proration of 100% of the total charges.

Subsequently, if patient complies with the payer request, the uninsured IPLAN can be removed and the original IPLAN information will move to primary intact.

Document actions and approvals with user name and ID in a clear and concise manner in the account notes in Artiva.

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:

PARALLON

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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

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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 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.

PARALLON

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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.

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	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 <u>can</u> 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.

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	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	
Vendor Collections Management	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	
Vendor Collections Management staff	Determines the patient IS NOT eligible for Medicaid Coverage.

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	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.VCM.016 Discount Charity Policy for Patients.
Self-Pay – Charity Discount Denied	
Vendor Collections Management 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 – Patient Non-Compliance	
Collections and/or Support Services	Third Party payer denies coverage due to patient fails to comply with request for information or payment of premium (QHP 8X addendum). Sends the patient one or two letters and places one or two phone calls depending on the liability due. Obtains appropriate approval to release liability to the patient. Assigns the Uninsured IPLAN – Patient Non-Compliance (099-47) as the primary payer Resequence the original IPLAN to secondary payer. The system will post the uninsured discount. Keeping the original IPLAN on the account retains the insurance information in the event the patient subsequently complies with payer request. Documents Account. For accounts with liability due <$1000, perform an audit on a 15% sample to confirm one letter was sent and time allowed for the patient to respond before releasing liability to the patient.

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Insurance Denials – No Coverage or Pre-existing

Collections and/or Support Services	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 Support Services	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.VCM.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

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PARA.PP.VCM.016 Discount Charity Policy for Patients
PARA.PP.GEN.001 Policy and Procedure Development
Self-Administered Drug Discount effective 04/01/2016

Self-Administered Drugs 04012016.doc

QHP- denial code 8X addendum

QHP denial code 8X specific to collectior

Uninsured Discount FAQ 04/01/2016

Uninsured Discount Plan FAQ 04012016.c

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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

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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

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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

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- 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.

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- 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.

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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.OPS.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.

REFERENCE:

- **PARA.FT.OPS.606 Federal Charity Guidelines**
- **PARA.FT.OPS.638 Financial Assistance Application**
- **PARA.MF.OPS.804 Collection Charity Letters**
- **PARA.PARS.PP.009 Medicare Bad Debt and Recovery Logs Policy**
- **PARA.PP.OPS.019 Utilizing the Artiva Charity Process**

Uninsured Discount Plan FAQ

Who is eligible for the Uninsured Discount Plan?
All Self Pay patients, excluding patients seeking treatment for elective cosmetic or facility self pay flat rate procedure. International Patients traveling to the US for scheduled/discounted procedures are also eligible for the Uninsured Discount.

If the patient becomes eligible for health care coverage retroactively, will they retain the Uninsured Discount?
If the patient becomes eligible for health care coverage, the Uninsured Discount will be removed.

Are certain charges included in the facility detail charges, such as private room differences and facility based professional fees excluded from the Uninsured Discount?
No. All charges reflected on the account are subject to the Uninsured Discount Plan.

Are patients who receive an Uninsured Discount eligible for Charity consideration?
Yes. If it is determined that the patient should have been processed under the Charity policy, the Uninsured Discount will be removed and the Charity Discount processed.

Are patients who receive an Uninsured Discount eligible for Prompt Payment Discounts?
Yes. If the facility offers a prompt payment discount, the discount can be applied to the account. The calculation should be based on the account balance net of the uninsured discount.

When should the patient be told about the Uninsured Discount?
If it is determined at the point of registration that the patient is uninsured, the registrar should explain the Uninsured Discount Plan at the time of registration and the Uninsured Discount Information document should be given to the patient at this time. All EMTALA guidelines should be met prior to discussing the Uninsured Discount Plan in the ED setting.

What is the IPLAN for Uninsured Patients?

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)

Can additional Uninsured Discount IPLANS be established at the SSC, Market or Local level?
No. It is important for consolidated reporting that only the approved IPLANS be designated for the Uninsured Discount.

Uninsured Discount Plan FAQ

Can the facility modify the Uninsured Discount in order to remain competitive in the market?
No. The Uninsured Discount will be established for the local market and will be updated annually. If a facility wants to request an exception, this request should be sent to the SSC CEO who will work with the Financial Service Division to determine if an exception is warranted.

Can a patient file their own private insurance and still receive the Uninsured Discount?
No. The Uninsured Discount Plan is only available for patients who have no form of health care coverage. If you become aware of such activity, the discount should be reversed off the account.

Are Physicians and Non-US citizens who have no insurance coverage eligible for the Uninsured Discount?
Yes, as long as they have no form of health care coverage. International Patients traveling to the US for scheduled/discounted procedures are also eligible.

Can an Uninsured Patient obtain a copy of their UB92 and Detail Bill?
Yes. The UB04 and the Detail Bill may be given to the patient after it is determined the patient is not eligible for Medicaid or Charity so that the Uninsured Discount will be reflected on the claim.

Is the Uninsured Discount Plan available only for facilities associated with a SSC?
No. All HCA facilities participate in the Uninsured Discount Plan. Partnership facilities should take this policy to their board for approval as soon as possible.

Who is listed as the insured for the Uninsured Discount IPLAN?
The responsible party will also be the insured for the Uninsured Discount Plan.

Are required fields in the Uninsured Discount IPLAN different from other IPLANS?
No. All normally required fields including those for HIPAA, are still required for this IPLAN.

If the patient only has a Daily Benefit or Small healthcare policy, are they eligible for the Uninsured Discount Plan?
Yes. 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.

What is the purpose of IPLAN 099-49 Uninsured – Partially Exhausted Benefits?

- The purpose of IPLAN 099-49, Uninsured- Partially Exhausted Benefits is to provide an IPLAN that can reside in the secondary or tertiary position when insurance benefits, regardless of payer, are exhausted AND the patient does not qualify for any other program, such as Medicaid or Charity. In those instances where Medicaid or Charity coverage is available or the patient qualifies, then IPLAN 099-49 should not be applied.

Why must Patient Access list three IPLANS for patient accounts that are under consideration for Medicaid eligibility?

Uninsured Discount Plan FAQ

For accounts under consideration for Medicaid eligibility the account will reflect Pending Medicaid IPLAN as primary, Pending Charity IPLAN as secondary and Uninsured Discount Plan as tertiary. If Medicaid eligibility is not available, that IPLAN is removed which will set the account up for Charity discount review. If the patient is not eligible for Charity that IPLAN is removed which will set the account up for the Uninsured Discount. Setting these three payers up on the account is a safe guard for review of appropriate discounting and will ensure that the account financial class reflects the current status of the account.

It may be possible for the patient to access HPS to make payment prior to the Uninsured Discount being posted. How should this be addressed?
The Uninsured Patient Information document includes information regarding the Uninsured Discount process. It will explain that all charges are posted to the patient's account and after Medicaid and/or Charity eligibility have been ruled out, the patient will receive the Uninsured Discount.

It may be possible for the patient to obtain their account balance in IVR prior to the Uninsured Discount being posted. How should this be addressed?
Modification to the IVR process is under investigation. Details of the modification will be shared with the SSC when the final determination has been made.

If the insurance carrier denies the claim for no coverage or pre-existing, will the patient receive an Uninsured Discount?
Yes. If the insurance carrier denied the claim and remits no payment, then the insurance should be removed from the account and the Pending Charity IPLAN should be placed in the primary position with the Uninsured IPLAN assigned as the secondary payer.

If the insurance carrier applies the claim towards a deductible, will the patient receive an Uninsured Discount?
No. If the patient is covered by insurance then they will not be considered uninsured.

Are there any special considerations for self pay patients that are not eligible for the Uninsured Discount? (e.g. PIP – Personal Injury Protection, Elective Cosmetic, Flat Rates, scheduled International Patients, Medicaid Pending and Charity Pending)
Yes. All patient accounts must be assigned an IPLAN. Examples of IPLANS established at the local level for self pay patients who will not receive the Uninsured Discount are; PIP – Personal Injury Protection, Elective Cosmetic, Flat Rate (which could include International patient admissions), Medicaid Pending and Charity Pending.

If the patient is seeking treatment for an elective cosmetic procedure and the facility does not offer a flat rate or cosmetic procedure discount, do I still assign an IPLAN?
Yes. All patients, including all self pay patients, must be assigned an IPLAN. In this case, the facility would assign a locally defined IPLAN with 0% coverage. The Uninsured Discount IPLANS would not be considered for these type patients.

If the insurance carrier delays payment, can I still release tracking and bill the patient for total charges or should I apply an Uninsured Discount?
No. You must apply the uninsured discount before billing the patient. If the insurance later pays on the account, the uninsured discount should be reversed.

Uninsured Discount Plan FAQ

Are you required to attempt Medicaid eligibility for all Uninsured Patients?
No. You may set thresholds at your facility/SSC regarding the registration types or dollar minimums for accounts that are to be considered for Medicaid eligibility.

Are you required to consider Charity Care for all Uninsured Patients?
Yes. The Financial Assistance Application was recently modified. The form can now be easily completed by the patient/responsible party prior to leaving the facility. The simplified Financial Application form and Artiva make the process of reviewing, approving or denying Charity discounts easier for the Collections/Support staff.

Are special procedures/services such as bariatrics covered under the Uninsured Discount Plan?
Yes. If the facility has a flat/discounted rate for special procedures/services such as bariatrics, they can decide to continue to bill the flat/discounted rate or bill the Uninsured Discount rate.

How do I determine the patient liability?
The facility should update their existing deposit schedules by reducing the deposits based on the Uninsured discount.

Is the Uninsured Discount Plan different for Joint Venture facilities?
The uninsured discount plan must be approved by each board and the policy amended for any changes. The discount plan schedule is set at a market level, which would include facilities in a Joint Venture. However, approval by the local Joint Venture is required prior to beginning the Uninsured Discount process.

What if the patient does not have his insurance information available at the time of admission?
The patient would be considered Self Pay until insurance information can be obtained. The Uninsured Discount IPLAN should be assigned. Once the insurance information has been received, the Uninsured Discount IPLAN should be removed.

Should Late Charges be posted to Uninsured Discount accounts?
No. The Uninsured Discount is based on a discount of total charges at final bill. Posting additional charges would require coordination of holding statements until late charges could be discounting.

If the SSC suspects insurance coverage from a third party liability insurance such as auto or third party liability accident or an indemnity policy where the insurance company pays directly to the patient, should the uninsured discount be applied?
No. The SSC should pursue the insurance payment from the patient and thoroughly document the patient had received funds directly from the payer and then full charges can be billed to the patient.

If patient / guarantor are uncooperative in providing information necessary to process the claim, should the uninsured discount be applied?
Yes. Once all efforts are exhausted to obtain the information needed, the uninsured discount should be applied in primary position retaining the original Iplan in the secondary position. If the patient / guarantor subsequently provide the information, resequence the original iplan back to primary which will remove the uninsured discount.

Attachment 4N-2

Non-Discrimination Policy

Equal Employment Opportunity, Anti-Harassment, and Respectful Workplace Policy

Index

Equal Employment Opportunity, Anti-Harassment, and Respectful Workplace Policy - HR.ER.072

DEPARTMENT: Human Resources

POLICY DESCRIPTION: Equal Employment Opportunity, Anti-Harassment, and Respectful Workplace

PAGE: 1 of 5

REPLACES POLICY DATED: HR.ER.013 (7/1/21); HR.ER.024 (11/1/16); HR.ER.059 (8/1/18)

EFFECTIVE DATE: January 1, 2022

REFERENCE NUMBER: HR.ER.072

APPROVED BY: Ethics and Compliance Policy Committee

SCOPE: All Company-affiliated subsidiaries including, but not limited to hospitals, ambulatory surgery centers, outpatient imaging centers, physician practices, HealthTrust Workforce Solutions, Corporate Departments (Organization Units), Groups, and Divisions (collectively, "Affiliated Employers" and individually, "Affiliated Employer").

PURPOSE: To ensure all colleagues are treated in accordance with the mission and values of the organization in compliance with federal, state, and local laws addressing harassment and discrimination. By outlining responsibilities and requirements for behavior and conduct; ensuring that we act in accordance with our mission, values, and applicable laws; and clearly defining the obligations to identify and report potential violations of this policy, it is the purpose of this policy to create and sustain a safe, welcoming, and productive work environment for all colleagues, patients, and visitors.

POLICY:

A. Equal Employment Opportunity and Unlawful Harassment

1. HCA Healthcare and its Affiliated Employers are equal opportunity employers, committed to promoting an inclusive culture that embraces and nurtures our patients, colleagues, partners, physicians and communities. Equal employment opportunities are provided to all colleagues and applicants for employment without regard to race, color, religion, sex, gender, national origin, age, pregnancy, disability, sexual orientation, gender identity or expression, genetic information or protected veteran status, or status in any group protected by federal, state or local law. This policy applies to all terms and conditions of employment, including, but not limited to, hiring, placement, promotion, termination, layoff, transfer, leaves of absence, compensation, and training. Reasonable accommodations will be made to known qualified individuals with disabilities. As used within this paragraph, "genetic information":

a. includes information about an individual's genetic tests, genetic tests of a family member, and family medical history; and

b. does not include information about the sex or age of an individual or the individual's family members; information that an individual currently has a disease or disorder; or tests for alcohol or drug use.

2. Unlawful harassment is a form of discrimination and violates the policies of HCA Healthcare and its Affiliated Employers. This policy expressly prohibits any form of unlawful colleague harassment based on race, color, religion, sex, gender, national origin, age, pregnancy, disability, sexual orientation, gender identity or expression, genetic information, protected veteran status, or status in any group protected by federal, state or local law. Such harassment may include, but is not limited to, offensive comments, jokes, or innuendoes in printed material, material distributed through electronic media, or items posted on walls or communication boards. Improper interference with the ability of colleagues to perform their expected job duties is not tolerated. Harassment becomes unlawful where:

a. Enduring the offensive conduct becomes a condition of continued employment, or

b. The conduct is severe and pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive.

3. Examples of prohibited harassment or discrimination include, but are not limited to:

a. Degrading words or name calling used to describe an individual.

b. Displays of reading materials, objects, or pictures containing negative stereotypes in the workplace.

c. Using e-mail, voicemail, facsimile, instant messaging, or any other digital media or Affiliated Employer property for the transmission of discriminatory or otherwise inappropriate material.

d. Offensive jokes, pranks, vandalism, negative comments, threatening language toward others, or other conduct related to the characteristics identified in this policy under Section A.1.

4. Each member of management is responsible for creating an atmosphere free of discrimination and harassment. Further, colleagues are responsible for respecting the rights of their coworkers.

B. Sexual Harassment

1. Colleagues' right to work in an environment free of harassment and disruptive behavior includes the right to a work environment free from sexual harassment. Sexual harassment will not be tolerated. Sexual harassment includes, but is not limited to, unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual nature, especially where:

a. Submission to such conduct is made either explicitly or implicitly a term or condition of employment;

b. Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or

c. Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive working environment.

2. Behaviors that produce a hostile or offensive work environment will not be tolerated. These behaviors include but are not limited to:

a. unwelcome sexual remarks, advances, and/or propositions;

b. unwelcome touching or other physical contact;

c. unwelcome requests for dates or other social engagements;

d. offensive comments, jokes, innuendoes, and other sexually-oriented statements; or

e. sexually suggestive printed material, material distributed through electronic media, e-mail, voicemail, facsimile, instant messaging or any other digital media or Affiliated Employer property or items posted on walls or bulletin boards.

3. Each member of management is responsible for creating an atmosphere free of sexual harassment. Further, each colleague is responsible for respecting the rights of coworkers.

C. Respectful Workplace

1. Even when conduct does not rise to the level of unlawful harassment, relationships marred by disrespectful behavior have a negative impact on the quality and safety of care delivered. The establishment of positive, respectful relationships is crucial to preventing these behaviors. Respect is promoted through communication, collaboration, support, and fairness, each of which is foundational to establish healthy relationships with others.

2. Respectful individuals act and speak in a manner that preserves the safety, dignity, autonomy, self-esteem and civil rights of others. In doing so, they must consider the audience, setting, and tone prior to expressing their thoughts in words or actions. The goal is to do this in a constructive manner and in an appropriate setting so as not to impede providing the utmost quality of care to our patients and creating a safe, welcoming, and productive work environment.

3. Management is responsible for creating a workplace that promotes physical and mental well-being. When colleagues do not feel safe, the work environment is left vulnerable, and everyone's safety is compromised and serious problems in the workplace can occur.

4. Under Section 7 of the National Labor Relations Act, colleagues who are "employees" have the right to express their concerns, whether positive or negative, regarding their terms and conditions of employment. We expect such colleagues to exercise those rights in a respectful and courteous manner that does not negatively affect the delivery of safe, effective, efficient, and compassionate care to our patients. This furthers our goal of maintaining a safe, respectful, and productive work environment for colleagues, volunteers, students, contract staff, physicians or any other person doing business with or for our business entity.

5. Representative Examples of Prohibited Conduct, include, but are not limited to:

a. **Incivility**: the acts of rude and discourteous conduct, gossiping and spreading rumors, the use of profane or obscene language in a demeaning or offensive way, inappropriately refusing to assist a coworker, or similar acts.

b. **Bullying**: the combination of repeated, unwanted harmful actions intended to humiliate or offend the recipient by abusing or misusing power, creating feelings of defenselessness and

injustice, or undermining an individual's inherent right to dignity. Bullying can also include workplace mobbing, which is a form of bullying aimed at an individual from a work group.

c. **Violence**: the threat or use of verbal or physical harm or force against an individual that reduces or eliminates their sense of being safe or actual safety.

d. **Retaliation**: any adverse action or behavior that is seeking revenge against another for opposing or reporting inappropriate actions.

e. **Intimidation**: the use of demeaning or undermining comments or actions with the intention to compel or deter another coworker from taking appropriate action or to cause distress to another by withholding support.

D. Reporting Obligations

1. HCA Healthcare and its Affiliated Employers encourage colleagues to report all incidents of harassment or other violations of this policy. If a colleague experiences any job-related harassment based on race, color, religion, sex, gender, national origin, age, pregnancy, disability, sexual orientation, gender identity or expression, genetic information or protected veteran status, or status in any group protected by federal, state or local law; believe that they have experienced job-related harassment or were treated in an unlawful, discriminatory manner; or experiences disrespectful behavior, the colleague should promptly report the incident to their supervisor and/or Human Resources, who will investigate the matter and take appropriate action. In addition, if a colleague believes that they have witnessed behavior that violates this policy, they are highly encouraged to report that conduct to their supervisor and/or Human Resources.

2. Colleagues should normally report these items to the colleague's supervisor, who must immediately notify Human Resources. However, if the colleague believes it would be inappropriate to discuss the matter with their supervisor, the colleague may bypass the immediate supervisor and report the incident directly to Human Resources. Additionally, colleagues may report issues at any time to the HCA Healthcare Ethics Line at (800) 455-1996 or online at http://hcahealthcareethicsline.ethix360.com.

3. Confidentiality safeguards will be applied in handling complaints of harassment, discrimination, retaliation, or other issues arising under this policy. To the extent possible, the privacy of the complainant, witnesses, and individual(s) accused are kept confidential, although absolute confidentiality cannot be promised.

4. If it is determined that a violation of this policy occurred, appropriate disciplinary action will be taken against the offending colleague, up to and including termination of employment. However, the level of discipline issued as a result of an investigation is typically a confidential matter between the employer and the colleague receiving discipline, and may not be shared with other individuals.

5. Any form of retaliation against any colleague for filing a good faith complaint under this policy or for assisting in a complaint investigation, even if the investigation produces insufficient corroboration to support the claim, is strictly prohibited.

E. Policy Violations and Other Policy Application Guidelines

1. Colleagues who knowingly make a false allegation, provide false or misleading information in the course of an investigation, or otherwise act in bad faith may be subject to appropriate discipline, up to and including termination; reference the Non-Retaliation Policy, EC.030, and Discipline, Counseling, and Corrective Action Policy, HR.ER.008.

2. Colleagues do not have the right to legal or any other representation during interviews conducted under this policy unless otherwise required by law.

3. Colleagues participating in an investigation are prohibited from recording any part of the investigatory process unless approved by all individuals involved in the recording. "Recording" includes all forms of recording including, but not limited to, audio, video, digital, etc., methods of recording.

4. When the alleged harasser is a member of the medical staff or another practitioner with clinical privileges, investigation and/or corrective action, as appropriate, will be handled in accordance with the applicable Medical Staff Policies and Bylaws.

DISCLOSURE:

If there is any conflict between the information in this policy and a Collective Bargaining Agreement (CBA), the CBA prevails for covered colleagues.

REFERENCES:

1. HCA Healthcare Code of Conduct
2. Appropriate Use of Communications Resources and Systems Policy, EC.026
3. Non-Retaliation Policy, EC.030
4. Communication Boards Policy, HR.ER.007
5. Discipline, Counseling, Corrective Action Policy, HR.ER.008
6. Employee Dispute Resolution Process Policy, HR.ER.011
7. Limitations on Employment Policy, HR.ER.019
8. Binding Arbitration Policy, HR.ER.054

Referenced Policies

Discipline, Counseling, Corrective Action Policy

Job Postings Policy

Solicitation Policy

Code of Conduct

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. In accordance with Parkridge Medical Center's 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, or ability to pay – just as they are being served at the Parkridge main hospital ED and each of its affiliates. As previously discussed, the proposed Cleveland FSED will be part of Parkridge Health System and the TriStar Division, 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.[9] See **Attachment 4N-1** for the Financial Assistance Policy for Uninsured Patients, Charity Financial Assistance Policy for Uninsured and Underinsured Patients and Discount Policy for Patients.[10]

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 Parkridge Medical Center's policies and experience. The proposed service area is approximately 20 percent minority population. Please see **Attachment 4N-2** for the Non-Discrimination Policy that will apply to the FSED.

Parkridge Medical Center has vast experience serving a diverse patient population. As reflected in **Exhibit 1N-49**, Parkridge Medical Center ED patients are approximately 22.2 percent TennCare/Medicaid and an additional 4.9 percent are uncompensated. Some of the ways in which Parkridge Medical Center addresses community need beyond just direct care to TennCare and low-income groups are reflected in its community participation. See **Attachment 1N Question 18** for a list of Parkridge Medical Center's community linkages including both healthcare facilities and social service organizations.

Parkridge Medical Center has a diverse employee and medical staff that mirrors the community it serves. The proposed FSED will serve all patients in the service area who present and will enhance access to care for the growing service area by adding a new access point for ED services, shortening travel time to reach an ED, shortening wait time, improving results reporting, minimizing LWOT rates, introducing a top quartile quality provider and increasing capacity to assure the service area is appropriately served.

Patient Types

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 proposed FSED to treat a variety of diagnoses for a myriad of reasons 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.

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

[10] TriStar Division makes allowances for all persons who have income at less than 400 percent of the poverty level. And for those who are below 200 percent of the poverty level, personal responsibilities are written off in their entirety.

Parkridge Medical Center expects that the types of patients who seek care at existing Parkridge-affiliated FSEDs will also seek care at the proposed FSED. A review of the principal diagnosis of the FSED patient visits seen by Parkridge satellite EDs in 2022 through June 2025 identify more than 5,400 different principal diagnoses.[11] 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 in descending order included:

- Acute upper respiratory infection, unspecified
- Viral infection, unspecified
- Urinary tract infection, site not specified
- Other chest pain
- Nausea with vomiting, unspecified

These top 5 diagnoses represent just 10.7 percent of all patients seen, emphasizing the diverse patient base treated at Parkridge affiliated 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 2024, Parkridge satellite based EDs provided more than 49,000 visits. Of those, the breadth of conditions treated is reflected in the following service line grouping:

- Cardiac medical 3,270 patient visits
- Orthopedics 6,459 patient visits
- Pulmonology 6,028 patient visits
- Gastroenterology 3,451 patient visits
- Medical psychiatry 2,038 patient visits
- Neurology 2,361 patient visits
- Spine (medical) 1,587 patient visits
- Urology 1,433 patient visits
- OB/GYN 1,304 patient visits

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

[11] Analysis of Parkridge satellite ED data includes Camp Jordan and Soddy Daisy FSED. Parkridge West and Parkridge North emergency room data is also included in this analysis as Parkridge West is not co-located with in-service acute care licensed beds, and Parkridge North, while located at a licensed acute care facility, operates as behavioral health. Therefore, they do not have acute medical/surgical inpatient availability on-site thereby requiring transfer for patients needing those inpatient services.

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.

Bradley County and Service Area Emergency Care Provider

There is one operational emergency care provider in Bradley County and in the service area: BMC on the northern edge of zip code 37311. There are no emergency room providers in Polk County. Trends in utilization for BMC are discussed in detail in **Attachment 1N**. **Exhibit 9** provides BMC emergency room visits by year since 2019. BMC has yet to rebound to pre-COVID levels currently operating at 10.6 percent less visits.

Exhibit 9
ED Visits by Bradley County Emergency Department, 2021 through 2024

County	Facility	2019 ED Visits	2020 ED Visits	2021 ED Visits	2022 ED Visits	2023 ED Visits	2024 ED Visits	% Change
Bradley	BMC	50,876	41,584	41,262	40,097	43,574	45,500	-10.6%

Source: Hospital Joint Annual Report for the respective year, page 41/42.

The emergency department in Bradley County provides less than two-thirds of ED services to service area residents. Using HDDS data provided in **Exhibit 10**, suggests that 61.7 percent out-migrate. However, this is distorted due to inclusion of the 373 truncated zip code. In 2023, the outmigration by residents of 37311 (Cleveland) and 37323 (SE Cleveland) ranged between 28 and 32 percent. And, when looking at THA data for the entire service area, overall, approximately 35 percent of the service area residents out-migrate. In terms of County population, overall 32.3 percent out-migrated in CY 2023 also shown in **Exhibit 10**. Analysis of data post 2023 confirms out-migration continues to increase. Given the truncated data distorts out-migration, it is reasonable to estimate that approximately 35 percent currently out-migrate from the service area.

Exhibit 10
Service Area ED Visits by Provider County, 2023

Zip Code	BMC	Out of County	Total	% Out-Migration
37311 Cleveland	12,133	4,699	16,832	27.9%
37323 SE Cleveland	9,716	4,606	14,322	32.2%
373 Truncated	4,148	32,631	36,779	88.7%
Total Service Area	25,997	41,936	67,933	61.7%
Distribution by % of Patients	38.3%	61.7%	100.0%	--
Bradley County	34,324	16,405	50,729	32.3%

Source: HDDS data request 35552215; Bradley County ED Visits from data request 35551101; total county from THA data.

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 federal

Emergency Medical Treatment and Labor Act ("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.

Research of service area zip codes to identify urgent care or walk in clinics confirms there are only two such locations: MinuteClinic at CVS (37311) and Bradley Polk Walk In Clinic (37361) with none being situated in 37323, 37353, 37362 or 37307. To the north of the service area in zip code 37312, approximately 10 such locations were identified. These include the following which notably are generally further from the proposed Cleveland FSED than the only other existing emergency room in the county.

- Fast Pace Health Urgent Care - Cleveland - TN (37312)
- Banyan Family Clinic and night clinic (37312)
- Erlanger Express Care – Cleveland (37312)
- CHI Memorial Convenient Care – Cleveland (37312)
- Fast Access Healthcare (37312)
- CHI Memorial Primary Care Associates – Cleveland (37312)
- Bradley Urgent Care (37312)
- AFC Urgent Care Cleveland TN (37312)
- Bradley Walk-In Clinic-North, Vitruvian Health (37312)
- Physician First Primary Care (37312)

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**	**Parkridge Campus ED**	**Proposed Cleveland FSED**
Stroke	X	✓	✓
Severe Chest Pain	X	✓	✓
Traumatic Injuries	X	✓	✓
EMS Offload	X	✓	✓
Advanced 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 a typical Parkridge Health System FSED treatment room and some of the typical equipment available 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**, Parkridge FSEDs serve all patients in all ED acuity levels.

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

Exhibit 11 provides the historical trend in ED visits from 2021 through 2024 for the service area. CY 2023 reflects a total of 37,577 ED visits in the service area; that is the latest year provided by HDDS including truncated zip codes. CY 2024 identifies 39,050 ED visits, a 3.9 percent increase from 2023.

Exhibit 11

ED Visits by Zip Code, Age Cohort and Year

	ER Visits by Year			
Zip Code	**2021**	**2022**	**2023**	**2024**
Cleveland - 37311				
<18	2,497	2,664	2,781	2,995
18-44	6,418	6,057	6,324	6,549
45-64	4,146	4,137	4,525	4,557
65-74	1,434	1,487	1,606	1,744
75-84	776	850	899	1,072
85+	321	343	382	377
Total	15,592	15,538	16,517	17,294
SE Cleveland - 37323				
<18	2,029	2,090	2,270	2,415
18-44	4,712	4,660	5,008	4,948
45-64	3,533	3,571	3,741	3,795
65-74	1,423	1,439	1,531	1,603
75-84	1,000	1,107	1,285	1,247
85+	351	357	444	466
Total	13,048	13,224	14,279	14,474
McDonald - 37353				
<18	234	244	282	319
18-44	638	586	596	604
45-64	485	466	496	589
65-74	223	247	237	257
75-84	212	204	222	219
85+	47	49	82	55
Total	1,839	1,796	1,915	2,043
Old Fort - 37362				
<18	234	292	290	343
18-44	665	617	650	653
45-64	405	366	438	458
65-74	192	175	207	212
75-84	103	135	136	125
85+	36	45	46	37
Total	1,635	1,630	1,767	1,828
Benton - 37307				
<18	369	361	382	429
18-44	867	845	792	855
45-64	593	649	678	697
65-74	297	249	251	329
75-84	209	217	244	246
85+	84	64	75	80
Total	2,419	2,385	2,422	2,636
Ocoee - 37361				
<18	103	113	104	94
18-44	227	201	217	240
45-64	169	185	176	213
65-74	79	92	87	97
75-84	49	69	69	112
85+	13	25	24	19
Total	640	685	677	775
Service Area Total				
<18	5,466	5,764	6,109	6,595
18-44	13,527	12,966	13,587	13,849
45-64	9,331	9,374	10,054	10,309
65-74	3,648	3,689	3,919	4,242
75-84	2,349	2,582	2,855	3,021
85+	852	883	1,053	1,034
Total	35,173	35,258	37,577	39,050

Source: THA Data

Distribution of the above ED visits by emergency room providing the care confirms that the patients residing in the service area who are treated outside this area have increased from 28.1 percent in 2019 to approximately 35.7 percent in Q1 2025.

HDDS data provides distribution of the 37311 and 37323 zip codes by hospital. Unfortunately, HDDS truncates zip code 37353 (McDonald), 37362 (Old Fort), 37307 (Benton) and 37361 (Ocoee) from its 2023 ED visit count of 1,915, 1,767, 2,422 and 677, respectively (THA data) to more than 36,000 visits. By aggregating all '373' zip codes with less than 20,000 persons, there is significant distortion in the result, which is not applicable to the proposed Cleveland FSED service area. Removing 37353 (McDonald), 37362 (Old Fort), 37307 (Benton) and 37361 (Ocoee) from the presentation due to data restriction policies, **Exhibit 12A** provides utilization by zip code and hospital for the most recent year (2023) for which HDDS data is provided. Out of county EDs are separated between Parkridge affiliates and all other. **Exhibit 12B** follows **Exhibit 12A** providing the two service area zip codes 37311 and 37323 which are not truncated enabling presentation of solely the hospitals with the most ED visits in those two zip codes.

Exhibit 12A
ED Visits by Hospital and Zip Code, 2023

	Service Area ED		Out of County EDs						
	Patient ED 1	Subtotal of	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital	
Service Area Zip Code	BMC	County EDs	Erlanger Baroness	Erlanger Bledsoe	Parkridge West	Erlanger East	Parkridge	ED Patients	Total
37311 Cleveland	12,133	12,133	1,848	*	9	931	569	1,351	16,832
37323 SE Cleveland	9,716	9,716	1,742	*	7	970	473	1,421	14,322
37353 McDonald					0		213	291	1,915
37362 Old Fort					0		51	399	1,767
37307 Benton					0		23	1,172	2,422
37361 Ocoee					0		12	210	677
Total Service Area	21,849	21,849	3,590	0	16	1,901	1,341	4,844	37,935
Distribution by % of Patients	57.6%	57.6%	9.5%	0.0%	0.0%	5.0%	3.5%	12.8%	100.0%

Source: HDDS data, except for 37353, 37362, 37307 and 37361 which is masked THA data

Exhibit 12B
ED Visits by Hospital for Zip Codes 37311 and 37323, 2023

	Service Area ED		Out of County EDs						
	Patient ED 1	Subtotal of	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital	
Service Area Zip Code	BMC	County EDs	Erlanger Baroness	Erlanger East	Parkridge	CHI Memorial	Parkridge East	ED Patients	Total
37311 Cleveland	12,133	12,133	1,848	931	569	377	257	717	16,832
37323 SE Cleveland	9,716	9,716	1,742	970	473	579	193	649	14,322
Total 37311 + 37323	21,849	21,849	3,590	1,901	1,042	956	450	1,366	31,154
Distribution by % of Patients	70.1%	70.1%	11.5%	6.1%	3.3%	3.1%	1.4%	4.4%	100.0%

ED visits by zip code have steadily increased during the past three years consistent with population growth and also a return to normalcy as a result of the COVID-19 pandemic's impact on ED usage between 2020 and 2022. As a result, ED visits are generally increasing at a faster rate than population resulting in recent higher use rates of ED visits per 1,000 population. **Exhibit 13** provides the annual ED visit per 1,000 population (use rates) for the past four years. Notably, while the ED use rates are increasing, those seeking care at BMC do not see a similar increase.

Exhibit 13
ED Use Rates by Zip Code, Age Cohort and Year

	ED Visits Per 1,000 Population by Year			
Zip Code	**2021**	**2022**	**2023**	**2024**
Cleveland - 37311				
<18	387.82	414.42	433.33	467.43
18-44	524.01	495.60	518.56	538.16
45-64	603.79	598.59	650.54	650.96
65-74	553.28	560.58	591.88	628.65
75-84	602.58	638.33	653.63	755.36
85+	719.73	762.22	841.41	823.14
Total	521.85	518.02	548.52	572.11
SE Cleveland - 37323				
<18	289.03	298.27	324.56	345.94
18-44	458.68	449.07	477.82	467.45
45-64	407.01	408.96	425.93	429.56
65-74	418.90	418.07	439.06	453.85
75-84	586.99	623.94	696.55	651.04
85+	806.16	795.45	960.62	979.81
Total	414.10	416.10	445.49	447.78
McDonald - 37353				
<18	229.46	243.37	286.18	329.48
18-44	429.51	388.13	388.48	387.53
45-64	315.96	302.20	320.21	378.53
65-74	357.72	387.27	363.39	385.54
75-84	602.27	558.90	587.30	560.10
85+	575.98	575.12	923.42	595.24
Total	360.79	349.25	369.15	390.42
Old Fort - 37362				
<18	298.55	371.69	368.30	434.62
18-44	570.72	524.04	546.40	543.35
45-64	347.28	313.25	374.17	390.52
65-74	445.48	402.30	471.53	478.56
75-84	513.97	643.47	620.44	546.81
85+	833.33	969.83	927.42	700.76
Total	431.42	426.41	458.32	470.14
Benton - 37307				
<18	369.52	359.85	379.04	423.75
18-44	558.78	541.25	504.20	541.00
45-64	386.32	422.25	440.55	452.30
65-74	464.50	389.79	393.29	516.00
75-84	660.97	660.78	716.38	697.28
85+	1160.22	844.33	946.97	968.52
Total	473.09	463.61	467.97	506.26
Ocoee - 37361				
<18	309.68	336.11	306.06	273.73
18-44	427.33	370.58	391.98	424.93
45-64	358.51	388.82	366.51	439.54
65-74	350.80	408.16	385.64	429.58
75-84	501.02	666.02	630.71	972.22
85+	375.72	690.61	634.92	482.23
Total	378.07	398.35	387.65	437.06
Service Area Total				
<18	329.41	348.01	369.52	399.66
18-44	496.33	473.39	493.63	500.69
45-64	460.69	460.27	490.97	500.69
65-74	461.32	459.31	480.54	512.37
75-84	593.51	627.83	669.03	683.14
85+	765.36	772.93	898.77	861.09
Total	456.31	454.33	480.96	496.48

Source: THA data and Claritas

Projected Utilization

To project the utilization of the proposed FSED, the historical utilization by service area residents by zip code and age cohort for 2021 through 2024 was analyzed using THA data. **Exhibit 14** provides the resulting forecasted service area ED visits by year for 2028 through 2030.

Exhibit 14
Projected Service Area ED Visits by Zip Code and Year

Zip Code	2028	2029	2030
Cleveland - 37311	17,728	17,844	17,960
SE Cleveland - 37323	15,041	15,181	15,322
McDonald - 37353	2,125	2,145	2,165
Old Fort - 37362	1,897	1,915	1,932
Benton - 37307	2,729	2,754	2,778
Ocoee - 37361	836	852	868
Service Area Total	40,356	40,690	41,025

Given that 2023 is the latest HDDS data available by calendar year, it is contrasted with the 2030 increase based on forecasted ED visits in 2030. The 2024 use rate by age cohort is the proxy for the forecasted utilization. The differential between historical and forecast in the service area is a result of population increases and the aging of that population. The impact is 3,448 ED visit growth in the service area between 2023 and 2030 as reflected in **Exhibit 15.**

Exhibit 15
ED Visits, 2023 versus 2030

Zip Code	2023	2030	Growth
Cleveland - 37311	16,517	17,960	1,443
SE Cleveland - 37323	14,279	15,322	1,043
McDonald - 37353	1,915	2,165	250
Old Fort - 37362	1,767	1,932	165
Benton - 37307	2,422	2,778	356
Ocoee - 37361	677	868	191
Service Area Total	37,577	41,025	3,448

There are several advantages derived by service area population being treated at the proposed FSED. These include a more proximate “closer to home” ED both within and outside the county, faster time to access treatment, shorter wait times, shorter treatment times, improved time associated with available diagnostic results, a more favorable treatment environment and a top quartile quality provider. Given the expected reception of the proposed FSED in the service area, **Exhibit 16** provides the percentage of ED visits to be treated at the proposed Cleveland FSED. This level of patients by zip code is consistent with Parkridge affiliate experience at other FSEDs in terms of patient percentage, distances and access enhancement. Overall, the proposed FSED, being the ED furthest south in the county and more proximate to Polk County, is estimated to treat 21.2 percent of the population residing in the service area.

Exhibit 16
Percent of Service Area Visits to be Treated by the Proposed Cleveland FSED

Zip Code	2028	2029	2030
Cleveland - 37311	18.0%	22.0%	22.0%
SE Cleveland - 37323	18.0%	22.0%	22.0%
McDonald - 37353	15.0%	18.0%	18.0%
Old Fort - 37362	15.0%	18.0%	18.0%
Benton - 37307	14.0%	17.0%	17.0%
Ocoee - 37361	14.0%	17.0%	17.0%
Service Area Total	17.3%	21.2%	21.2%

Applying the percentage of patients to the forecasted ED visits in the service area results in the estimated number of ED visits by year to be treated by the proposed Cleveland FSED. Years 1 and 2 (2028 and 2029) percent distribution by zip code area are provided in **Exhibit 17.** Additionally, it is estimated that 20 percent of the proposed FSED patients will originate from outside the service area. This 20 percent factor is also included in **Exhibit 17.**

Exhibit 17
Projected ED Visits Years 1 and 2

Zip Code	Year 1	% of Total	Year 2	% of Total
Cleveland - 37311	3,191	36.5%	3,926	36.5%
SE Cleveland - 37323	2,707	30.9%	3,340	31.0%
McDonald - 37353	319	3.6%	386	3.6%
Old Fort - 37362	285	3.3%	345	3.2%
Benton - 37307	382	4.4%	468	4.3%
Ocoee - 37361	117	1.3%	145	1.3%
Service Area	7,001	80.0%	8,609	80.0%
Out of Area	1,750	20.0%	2,152	20.0%
Total	8,751	100.0%	10,762	100.0%

Totals may not add due to rounding.

Next, the base of patients that would shift from existing service area Parkridge 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:

- Parkridge Medical Center's patients who live in the service area;
- Parkridge affiliates patient volume from the service area;
- 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 proportionate shift to the new FSED;
- The patient shifts were assumed to increase slightly from Year 1 to Year 2 based on a ramp-up period for the first years; and
- It was assumed that 20 percent of patients at the FSED would come from outside of the service area zip codes.

Based on these assumptions, **Exhibit 18** summarizes the growth in service area ED visits between 2023 and Year 3 and the number of visits expected to be shifted from Parkridge Medical Center and its affiliates.

Exhibit 18
Service Area ED Visit Growth and Patient Shift

CY 2023 Service Area Visits	37,577
Projected Year 3 Service Area Visits	41,025
Incremental Visits from Service Area Population Growth/Aging	3,448
Projected Shift from Parkridge Medical Center and Parkridge North	1,139
Combined Total of Growth and Shift	4,586
Projected FSED Service Area Visits Year 3	8,679

The proposed FSED service area ED visits in Year 3 are approximately 1.9 times the overall market increase and the patient shift from Parkridge affiliates as these components comprise 53 percent of the forecasted service area visits. The balance of the utilization is expected to be derived from reduced out-migration and provision of a community choice to select a top quartile quality provider.

Regarding level of care or acuity of the ED patient who will present at the proposed FSED, the Applicant anticipates its experience will be similar to the average across the Parkridge satellite EDs. Based on that assessment, **Exhibit 19** provides the expected patient acuity mix at the proposed FSED.

Exhibit 19
Expected Acuity by ER Level of Care at Parkridge Cleveland FSED

Acuity Level	Parkridge Cleveland FSED
ER Level 1	2.6%
ER Level 2	6.6%
ER Level 3	52.6%
ER Level 4	28.9%
ER Level 5	9.1%
ER Critical Level	0.1%
Grand Total	100.0%

Summary

The proposed Cleveland FSED will introduce an additional choice of provider in Cleveland. Allowing Parkridge Medical Center to alleviate geographic isolation for the proposed service area residents will provide consumers with a choice of providers locally to experience shorter wait times, access alternate medical staff, and reduce travel.

The proposed FSED is within 9 to 12 minutes of the centroid of three of the Bradley County zip codes in the service area. While the 4th Bradley County zip code will be 17 minutes from the proposed FSED, it is a five-minute improvement over BMC. While the two Polk County zip codes are further than 15 minutes, these residents' access will be improved as they will have shorter travel time to the proposed Cleveland FSED. Additionally with 35 percent of the service area's ED patients leaving for treatment, the Bradley travel times will reduce from 20+ to 50+ minutes to 9 to 17 minutes as noted in the travel time analysis presented in **Question 1N.** In addition to improvement in time to access an ED, it will also improve time to be cared for in the ED through shorter wait time, shorter median times for treatment by 93 minutes, reduced LWOT rates from 4 percent down to 1 percent and accelerating CT results reporting by more than double. Improved ED operational efficiencies and access to timely emergency care are positively associated with enhanced quality of care, patient safety, and patient satisfaction, leading to potential reduction of healthcare costs.

Attachment 1C-1

Transfer Agreements

FACILITY TRANSFER AGREEMENT

THIS TRANSFER AGREEMENT (the "Agreement") by and between **Parkridge Medical Center, Inc. d/b/a Parkridge East Hospital, Parkridge West Hospital, Parkridge Valley Hospital and Parkridge North**, and **Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System**, 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 the Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into the Agreement governing the transfer of patients between their facilities; and,

WHEREAS, the parties hereto desire to enter into the 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, the Transferring Facility will contact the appropriate admitting or transfer office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein; provided, however, non-emergent requests for transfer may be screened prior to transfer for appropriateness. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") or 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. When the transfer of a patient is deemed medically appropriate, the facilities agree to transfer and admit the patient as promptly as possible, provided all conditions of eligibility are met. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility unless transfer is made by the facility's owned air ambulance, ambulance, or other vehicle.

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 and while in transit;

   (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 for the purpose of coordinating 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, without limitation, 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, and financial and insurance information. 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 risks 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) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(M) Recognize the right of a patient to refuse consent to treatment or transfer;

(N) Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred;

(O) 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;

(P) Meet on an "as needed" basis with representatives of the Receiving Facility for the purposes of quality and process improvement; 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) Receive patients from the Transferring Facility when the following conditions are satisfied (i) an emergency condition exists or is likely to occur if transfer is not effected or specialized care is needed based upon information provided by or on behalf of the Transferring Facility, which the Transferring Facility certifies will be true and correct; (ii) the Transferring Facility is not capable of providing the nature of the emergency services or specialized medical care that the patient requires; (iii) the Receiving Facility is capable of providing the nature of emergency or specialized medical care that the patient requires, and the care of the patient is accepted by a receiving physician; (iv) the Receiving Facility has adequate facilities and staff available to receive and care of the patient; and (v) the patient is capable of being transferred, as determined by the Transferring Facility;

(B) 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 as promptly as possible after receipt of the request to

transfer a patient with an emergency medical condition or in active labor;

(C) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at the Receiving Facility and provide, on request, the names of on-call physicians to the Transferring Facility;

(D) 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;

(E) Designate a person who has authority to represent the Receiving Facility for the purpose of coordinating the transfer and receipt of patients into the facility;

(F) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

(G) Provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department or financial and insurance information;

(H) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

(I) 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;

(J) Meet on an "as needed" basis with representatives of the Transferring Facility for the purposes of quality and process improvement;

(K) 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 the Agreement;

(L) 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;

(M) Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

(N) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(O) Recognize the right of a patient to refuse consent to treatment or transfer;

(P) Complete, execute, and return the memorandum of transfer form to the Transferring 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.

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 the 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 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. Neither facility has any responsibility for the collection of any accounts receivable of the other facility arising as a result of the treatment or rendition of services by the other facility. Neither facility shall be liable for any debts, obligations, or claims of a financial or legal nature incurred by the other facility; each facility assumes full responsibility for its own maintenance and operation. Neither facility will be responsible for any expenses incurred in the transfer of any patients under this Agreement or otherwise. Any expenses incurred in the transfer of a patient shall be the responsibility of the patient or applicable 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, is placed in the care of the Transferring Facility's owned air ambulance, ambulance, or other vehicle, or is placed in the care of a contracted or other air ambulance, ambulance, or other vehicle.

6. **COMPLIANCE WITH LAW.** Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd et seq., and any amendments thereto, and 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. Both facilities warrant that all services to be provided under this Agreement shall fully comply with all applicable federal, state, and local statutes, rules, and regulations. It is the intent of the parties that this Agreement shall satisfy applicable exceptions set forth in the Ethics in Patient Referrals Act (commonly known as the "Stark Law" or "Stark"), 42 U.S.C. § 1395nn, and its accompanying regulations set forth in 42 C.F.R. Part 411, and, to the extent possible, safe harbor provisions set forth in the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), and its accompanying regulations set forth in 42 C.F.R. § 1001.952.

7. **INDEMNIFICATION.** 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, and its respective directors, officers, employees, and agents, 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 or otherwise arising as a result of or liability due to the transfer of a patient under this Agreement.

8. **TERM; TERMINATION.** The term of this Agreement shall be for one (1) year, commencing on the date of the latest signature to this Agreement (initial term). At the end of the initial term, the Agreement shall automatically renew for successive one (1) year terms, unless sooner terminated as provided herein. Either party may terminate the Agreement without cause for any reason upon thirty (30) days advance written notice to the other party, provided the facilities ensure the continuity of care of patients who are already involved in the transfer or treatment process contemplated herein. Either party may terminate the Agreement upon breach by the other party of any material provision of the 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. If either party gives such notice of breach and this Agreement is terminated, the parties will have no further obligation of any sort (legal, moral, or ethical) to receive any future transfers from the other. The 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, accreditation, or Medicare certification.

9. **RELATIONSHIP OF THE PARTIES.** The relationship of the parties one to another shall be that of independent

contractors. Nothing in this Agreement shall in any way affect the autonomy of either facility. The governing body of each facility shall have exclusive control of the management, assets, and affairs of the respective facility. Neither facility, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other party to this Agreement. Nothing in this Agreement shall be construed as limiting the rights of either party to affiliate or contract with any other health care institution while this Agreement is in effect.

10. **ADVERTISING AND PUBLIC RELATIONS.** Neither party shall use the name of the other in any promotional or advertising material unless the same is first reviewed and prior approval of its intended use is obtained from the party whose name is to be used in the material. Both parties shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each party shall maintain good public relations and efficiently handle any complaints or inquiries relating to the transfer of patients under this Agreement.

11. **COOPERATION REGARDING CLAIMS; ALTERNATIVE DISPUTE RESOLUTION.** The parties agree to promptly notify each other in writing of any incident, occurrence, transaction, or claim arising out of or in connection with the transfer or treatment of a patient under this Agreement and to cooperate with each other in the investigation of any such incident, occurrence, transaction, or claim. If a dispute arises out of or relates to this Agreement, or the breach thereof, the parties agree to meet and attempt to resolve the issue by negotiation. If the dispute cannot be settled through direct negotiation, the parties agree to try in good faith to settle the dispute by mediation. The mediation will be held in Chattanooga, Tennessee and shall be before a mediator chosen by the agreement of the parties. If the parties are unable to agree to a mediator within ten (10) business days of one party notifying the other that mediation is requested, the mediation shall be administered by the American Arbitration Association under its Mediation Procedures. Mediation shall be held before either party may resort to litigation.

12. **ENTIRE AGREEMENT; MODIFICATION.** The 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. The Agreement may not be amended or modified except by mutual written agreement.

13. **GOVERNING LAW; VENUE.** This Agreement is made and entered into in the State of Tennessee and shall be governed and construed in accordance with the laws of the State of Tennessee. Hamilton County, Tennessee shall be the sole and exclusive venue for any litigation, special proceedings, or other proceedings between the parties that may be brought or arise out of or in connection with or by reason by this Agreement. The parties irrevocably submit themselves to the jurisdiction of the courts of Hamilton County, Tennessee, and waive any right that they may have to any other jurisdiction.

14. **PARTIAL INVALIDITY.** If any provision of the Agreement is prohibited or rendered void or invalid by law or decree of any court of competent jurisdiction, such determination shall not invalidate or affect the remaining provisions of the Agreement.

15. **NOTICES.** All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, by overnight courier, or by facsimile or electronic mail transmission and shall be deemed to have been duly given when delivered personally, when deposited in the United States mail, postage prepaid, or when date and time stamped, addressed as follows:

If to: Parkridge Medical Center, Inc.
2333 McCallie Avenue
Chattanooga, TN 37404
Attention: Chief Executive Officer
Facsimile: 423-493-1208
Email: tom.ozburn@hcahealthcare.com

Copy to: Legal Department, Building I-2E
One Park Plaza, P.O. Box 550
Nashville, Tennessee 37202-0550
Attention: Senior Operations Counsel

Facsimile: 615-344-2598
Email: john.bradford@hcahealthcare.com

If to: Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System
975 East Third Street
Chattanooga, Tennessee 37403
Attention: Chief Executive Officer
Facsimile: (423) 778-7196
Email: ChiefOfficers@erlanger.org

Copy to: Legal Department
Chattanooga-Hamilton County Hospital Authority
975 East Third Street
Chattanooga, TN 37403
Attention: Chief Legal Officer
Facsimile: (423) 778-7525
Email: LegalTeam@erlanger.org

or to such other persons or places as either party may from time to time designate by written notice to the other.

16. **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.

17. **ASSIGNMENT; BINDING EFFECT.** The facilities shall not assign or transfer, in whole or in part, this Agreement or any of the facilities' 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 written 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.

18. **CHANGE IN LAW.** Notwithstanding any other provision of the 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 the Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend the Agreement to the satisfaction of both parties to compensate for such prohibition, restriction, limitation, or change.

19. **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 the 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 the Agreement immediately for cause.

20. **HIPAA COMPLIANCE REQUIREMENTS.** Each party agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA") and any current and future regulations promulgated thereunder, 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. Part 142 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements," to the extent applicable. Each party agrees not to use or further disclose any Protected Health

Information (as defined in 45 C.F.R. § 164.501) or Individually Identifiable Health Information (as defined in 42 U.S.C. § 1320d), other than as permitted by HIPAA Requirements and the terms of the Agreement. To the extent applicable under HIPAA, each party shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations.

21. **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 the Agreement.

22. **EXECUTION OF AGREEMENT.** The Agreement shall not become effective or in force until all of the below named parties have fully executed the Agreement.

[Remainder of Page Intentionally Left Blank. Signature Page to Follow.]

IN WITNESS WHEREOF, the parties hereto have executed the Agreement as of the date of the latest signature below.

Parkridge Medical Center, Inc.

By: _____

Name: Thomas H. Osburn

Title: President & CEO

Date: 5/25/21

Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System

By: _____

Name: Robert J. Maloney Jr.

Title: SVP & COO

Date: 5/26/21

PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT ("Agreement") is made by and between **Memorial Health Care System, Inc. d/b/a CHI Memorial,** a Kentucky nonprofit corporation ("Hospital"), and **Parkridge Medical Center, Inc. d/b/a/ Parkridge Medical Center, Parkridge East Hospital, Parkridge Valley Hospital, Parkridge West Hospital and Parkridge North,** a Tennessee corporation ("Parkridge"), to be effective as of March 1, 2021 (the "Effective Date"). References to "Transferring Facility" and "Receiving Facility" in this Agreement are used interchangeably for Hospital and Parkridge, as the case may be.

RECITALS

A. The parties, by way of a written agreement, desire to assist physicians and the parties hereto in the treatment of patients by facilitating the timely and medically appropriate transfer of patients, available medical records, and other information necessary for the care and treatment of patients being transferred; and

B. Each party agrees to accept the medically appropriate transfer of the other party's patients under the terms and conditions of this Agreement.

C. Hospital owns and operates; acute care facilities known as CHI Memorial, CHI Memorial-Hixson and CHI Memorial Hospital – Georgia (collectively referred to herein as "Hospital(s)"), within the States of Tennessee and Georgia (the "State(s)").

D. Hospital and Parkridge were parties to that certain Transfer Agreement dated September 8, 2020 ("Prior Agreement"). The Prior Agreement continued in full force and effect until the date of this Agreement. The parties intend to replace the Prior Agreement with this Agreement as of the Effective Date.

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, the parties agree as follows:

1. Term. This Agreement shall be effective as of the date listed in the first paragraph of this Agreement for an initial period of three (3) years. Thereafter, this Agreement shall be automatically renewed for successive three (3) year periods, unless sooner terminated as herein provided.

2. Termination.

2.1. Voluntary Termination. Either party for any reason may terminate this Agreement, by giving thirty (30) days written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients. To this end, the terminating party will be required to meet its commitments under the Agreement to all patients for whom the other party has begun the transfer process in good faith, and provided further that any obligations which arose prior to the termination shall continue and shall be governed by the terms set forth herein until satisfied.

2.2 Involuntary Termination. This Agreement shall be terminated immediately upon the occurrence of any of the following:

2.2.1 The physical premises of either party is destroyed to such an extent that the patient care provided by such party cannot be carried out adequately;

2.2.2 Either party loses its license or accreditation, or becomes an Excluded Provider under Section 14 or 15 of this Agreement;

2.2.3 Either party no longer is able to provide the clinical services for which this Agreement was sought; or

2.2.4 Either party is in default under any of the terms of this Agreement.

3. ***Patient Transfer.*** The parties agree that in the event: 1) the Transferring Facility does not have the specialized capabilities or facilities required by a patient; 2) the patient's condition is deteriorating so rapidly that failure to transfer the patient would significantly jeopardize the life or health of the patient; or 3) or the patient is in need of other medically appropriate services offered by Receiving Facility, the Receiving Facility will agree to accept the appropriate transfer of such individual(s) in order to render stabilizing or other appropriate treatment. The parties further agree the Transferring Facility will accept a patient back if higher level of care is no longer needed or if all needed medical care has been provided and the only remaining issue is placement or for social reasons.

4. ***Prior Acceptance of Transfer.*** Prior to moving the patient, Transferring Facility must receive confirmation from the Receiving Facility that it can accept the patient.

5. ***Provision of Information.*** The parties mutually agree:

5.1 That each party shall provide the other party with the names or classifications of persons authorized to initiate, confirm, and accept the transfer of patients on behalf of each party; and

5.2 That any transfer procedures shall be made available to the personnel at each party's facility who are involved in patient transfers.

6. ***Information and Confidentiality.*** Transferring Facility agrees to transmit with each patient at the time of transfer all available medical and financial information necessary to provide continuity of care for the patient. Transferring Facility agrees to supplement the information as necessary for the maintenance of the patient during transport and treatment by the Receiving Facility. Each party agrees to maintain the confidentiality of the medical information so as to comply with all state and federal laws, rules and regulations regarding the confidentiality of patient records.

7. ***Patient Authorization; EMTALA Compliance.*** Except in situations where a transfer to Receiving Facility is to be made because of a medical emergency and the patient is unconscious or otherwise unable to give consent, the patient's attending physician will inform the patient of the need for the transfer, the risks and benefits to transfer, if any, and that the transfer is acceptable to the Receiving Facility. If the patient is able to make an informed decision and then consent to the transfer after receiving the foregoing information, the patient may either accept or reject the proposed transfer.

Transferring Facility shall have responsibility for obtaining the patient's consent to the transfer to the other party prior to the transfer, if the patient is competent. If the patient is not competent, Transferring Facility shall attempt to obtain consent from any reasonably available legally responsible person acting on the behalf of the patient.

It shall be the responsibility of both the Transferring Facility and the Receiving Facility to comply with EMTALA, 42 USC §1395dd, regarding the "Emergency Medical Treatment and Active Labor Act" whenever applicable, and to obtain such additional consents or provide such additional documentation of

the patient's medical condition, risks and benefits of transfer and physician certification as may be required by such statute and regulations issued thereunder.

8. ***Transportation of Patient.*** Transferring Facility shall have the responsibility for arranging transportation of the patient to the Receiving Facility, including selection of the mode of transportation. The Receiving Facility's responsibility for the patient's care shall begin when the patient arrives at the Receiving Facility. In the event Receiving Facility utilizes its own transportation service or otherwise arranges to transport the patient, the Receiving Facility assumes responsibility for the patient's care upon acceptance of the patient prior to transport.

9. ***Payment for Services.*** Neither Transferring Facility nor Receiving Facility shall assume the responsibility for the collection of any accounts receivable other than its own incurred as a result of its rendering services directly to the patient. All other bills incurred with respect to services performed by either Transferring Facility or Receiving Facility for patients received pursuant to this Agreement, shall be collected by the party rendering such services directly from the patient, third-party insurance carriers, or other sources normally billed by the party rendering the services, and neither Transferring Facility nor Receiving Facility shall have any liability to the other for such charges, unless specifically agreed to by both parties and stated in writing.

10. ***No Payment/Requirement for Referrals.*** Nothing in this Agreement shall be construed to require either party to make referrals of patients to the other party. No payment shall be made under this Agreement in return for the referral of patients or in return for ordering, purchasing or leasing of products or services.

11. ***Insurance.*** Each Party shall, at its own cost and expense, procure, keep and maintain throughout the term of this Agreement, insurance coverage in the minimum amounts of: One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate for commercial general liability; One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate for professional liability; One Million Dollars ($1,000,000) each and every occurrence for automobile liability; and applicable state statutory limits for workers compensation. In addition to the coverage's specifically listed herein, each party shall maintain any other usual and customary policies of insurance applicable to the work being performed pursuant to this Agreement. Said policy(ies) shall cover all of the services hereunder. By requiring insurance herein, neither party represents that coverage and limits will necessarily be adequate to protect the parties, and such coverage and limits shall not be deemed as a limitation on either party's liability under the indemnities granted in this Agreement. In the event either party procures a "claims-made" policy to meet the insurance requirements herein, such party agrees to purchase "tail" coverage upon the termination of any such policy or upon termination of this agreement. Said "tail" coverage shall provide for an indefinite reporting period. Each party will obtain all insurance coverage's specified herein thorough either a program of self-insurance or through insurers with a current A. M. Best financial rating of B++ or better. Said policies shall be primary with respect to any insurance maintained by the parties. Each party shall provide copies of any and all insurance policies within ten (10) days of a party's request for said policies. Failure to maintain the required insurance, as set forth in this Agreement, may result in immediate termination of this Agreement by either party.

12. ***Indemnification.*** Receiving Facility agrees to indemnify and hold harmless Transferring Facility, its directors, officers, employees, agents, representatives, successors, assigns, and subcontractors from and against any and all claims, demands, actions, settlements or judgments, including reasonable attorneys' fees and litigation expenses, based upon or arising out of the activities described in this Agreement, where such claims, demands, actions, settlements or judgments relate to the negligence, actions or omissions of Receiving Facility.

Transferring Facility agrees to indemnify and hold harmless Receiving Facility, its directors, officers, employees, agents, representatives, successors, assigns, and subcontractors from and against any and all claims, demands, actions, settlements or judgments, including reasonable attorneys' fees and litigation expenses, based upon or arising out of the activities described in this Agreement, where such claims, demands, actions, settlements or judgments relate to the negligence, actions or omissions of Transferring Facility.

The duties to indemnify and hold harmless shall survive the termination and expiration of this Agreement.

13. Agreement Not Exclusive. No part of this Agreement shall be interpreted as limiting the right of either party to make an agreement with any Parkridge.

14. Excluded Provider Representations By Receiving Facility.

14.1 Receiving Facility hereby represents and warrants that Receiving Facility is not and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid. Receiving Facility hereby agrees to immediately notify Transferring Facility of any threatened, proposed, or actual exclusion from any federally funded health care program, including Medicare and Medicaid. In the event that Receiving Facility is excluded from participation in any federally funded health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that Receiving Facility is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate.

14.2 Receiving Facility shall indemnify and hold harmless Transferring Facility against all actions, claims, demands and liabilities, and against all loss, damage, costs and expenses, including reasonable attorneys' fees, arising directly or indirectly, out of any violation of this Section of this Agreement by Receiving Facility, or due to the exclusion of Receiving Facility from any federally funded health care program, including Medicare or Medicaid, or out of an actual or alleged injury to a person or to property as a result of the negligent or intentional act or omission of Receiving Facility or any of Receiving Facility's employees, subcontractors or agents providing the services hereunder, in connection with Receiving Facility's obligations under this Agreement, except to the extent any such loss, damage, costs and expenses were caused by the negligent or intentional act or omission of Transferring Facility, its officers, employees or agents.

15. Excluded Provider Representations By Transferring Facility.

15.1 Transferring Facility hereby represents and warrants that Transferring Facility is not and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid. Transferring Facility hereby agrees to immediately notify Receiving Facility of any threatened, proposed, or actual exclusion from any federally funded health care program, including Medicare and Medicaid. In the event that Transferring Facility is excluded from participation in any federally funded health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that Transferring Facility is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate.

15.2 Transferring Facility shall indemnify and hold harmless Receiving Facility against all actions, claims, demands and liabilities, and against all loss, damage, costs and expenses, including reasonable attorneys' fees, arising directly or indirectly, out of any violation of this Section of this Agreement by Transferring Facility, or due to the exclusion of Transferring Facility from any federally funded health care program, including Medicare or Medicaid, or out of an actual or alleged injury to a person or to property as a result of the negligent or intentional act or omission of Transferring Facility or

any of Transferring Facility s employees, subcontractors or agents providing the services hereunder, in connection with Transferring Facility's obligations under this Agreement, except to the extent any such loss, damage, costs and expenses were caused by the negligent or intentional act or omission of Receiving Facility, its officers, employees or agents.

16. Compliance with All Laws, Regulations, and Standards. The parties intend and in good faith believe that this Agreement complies with the provisions of the Stark Law and all other federal and state laws (collectively "laws"). Should either party hold a reasonable belief that this Agreement is contrary to any provision of said laws or the regulations promulgated thereunder, or any memorandum, case law or other authority, then the parties agree to attempt in good faith to renegotiate the provisions to the mutual satisfaction of all parties. If an agreement cannot be reached within thirty (30) days, this Agreement may be immediately terminated by either party.

17. Jeopardy. Notwithstanding anything to the contrary herein contained, in the event the performance by either party hereto of any term, covenant, condition or provision of this Agreement jeopardizes the licensure of either party, its participation in or the payment or reimbursement from, the Medicare, state sponsored Medicaid program, Blue Cross or other reimbursement or payment programs, or its full accreditation by the Joint Commission or any other state or nationally recognized accreditation organization, or the tax-exempt status of a party, any of its property or financing (or the interest income thereon, as applicable), or will prevent or prohibit any physician, or any other health care professionals or their patients from utilizing a party or any of its services, or if for any other reason said performance should be in violation of any statute, ordinance, or be otherwise deemed illegal, or be deemed unethical by any recognized body, agency, or association in the medical or hospital fields, the party in jeopardy may at its option (i) terminate this Agreement immediately; or (ii) initiate negotiations to resolve the matter through amendments to this Agreement and if the parties are unable to resolve the matter within thirty (30) days thereafter, such party may, at its option, terminate this Agreement immediately.

18. Compliance with CHI Standards of Conduct. Parkridge recognizes that it is essential to the core values of Hospital that all persons and entities employed by or otherwise contracting with Hospital at all times conduct themselves in compliance with the highest standards of business ethics and integrity and applicable legal requirements, as reflected in the *CommonSpirit Health (CSH) Standards of Conduct*, as may from time to time be amended by CommonSpirit Health. As of the date of this Agreement, the CSH Standards of Conduct are set forth in *Our Values in Action* (E@W Guide) which is available at the following website: https://commonspirit.org/corporate-responsibility/.

19. Compliance with Ethical and Religious Directives. Parkridge recognizes that Hospital is subject to the United States Conference of Catholic Bishops' Ethical and Religious Directives for Catholic Health Care Services, available at http://www.usccb.org/ ("ERDs"). Nothing in this Agreement shall cause Hospital to violate the ERDs.

20. Confidential Information

20.1 Non-Public Information. Hospital and Parkridge shall treat all non-public information obtained as part of this Agreement as confidential and shall not, without written authorization from the other party, release or share such information with any third party, except as may be required by law. Hospital and Parkridge agree that prior to reporting any actual or perceived violation of law to any governmental entity, even if required by law to do so, it will first discuss any potential legal or compliance matter with the other party's Corporate Responsibility or Ethic and Compliance Officer and Legal Counsel and, unless otherwise required by law, provide the other party with an opportunity to investigate and appropriately report any compliance matter brought to its attention. Further, both parties agree that it will cause any financial benefit received as a result of reporting any violation or perceived violation of law based

on any such non-public information so obtained to be donated to an organization determined by the Internal Revenue Service to be qualified under section 501(c)(3).

20.2 Disclosure. The parties hereto shall hold in confidence the information contained in this Agreement and each of them hereby acknowledges and agrees that all information related to this Agreement, not otherwise known to the public, is confidential and proprietary and is not to be disclosed to third persons without the prior written consent of each of the parties except: To the extent necessary to comply with any law, rule or regulation including, without limitation, any rule or regulation promulgated by the SEC, or the valid order of any governmental agency or any court of competent jurisdiction; as part of its normal reporting or review procedure, to its auditors and its attorneys; to the extent necessary to obtain appropriate insurance, to its insurance agent; or as necessary to enforce its rights and perform its agreements and obligations under this Agreement.

21. Use of Protected Health Information. Both parties are covered entities as defined by, and are subject to, the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, including the final Standards for Privacy of Individually Identifiable Health Information at 45 CFR parts 160 and 164 (collectively "HIPAA" or "Privacy and Security Regulations"), as may be amended from time to time. Each party agrees to comply with all HIPAA requirements concerning such patients.

22. Advertising; Public and Patient Relations. Neither party shall use the name of the other party in any marketing, promotional or advertising material, television commercials, internet advertising, technical journal, and other trade publications and special interest articles that may appear in formats such as magazines and newspapers or any other medium, unless such party has received the prior written consent of the party whose name is to be used. Both parties shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each party shall maintain good public and private relations and efficiently handle complaints and inquiries with respect to transferred or transferring patients.

23. Independent Contractor Status. The parties to this Agreement are independent contractors. Neither party is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by either party, nor shall it in any way alter the control of the management, assets, and affairs of the respective parties. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other party to this Agreement.

24. Waiver. No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

25. Invalid Provision. In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties hereto in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

26. Governing Law. This Agreement is made and entered into in the State of Tennessee, and shall be governed and construed in accordance with the laws of Tennessee.

27. Assignment. Except as otherwise expressly provided in this Agreement, neither party may assign any of its rights or obligations under this Agreement without the prior written consent of the other party. Except as specifically provided in this Agreement, any attempted assignment or delegation of a party's rights, claims, privileges, duties or obligations hereunder shall be null and void.

28. ***Binding Agreement.*** Except as otherwise expressly provided in this Agreement, all covenants, agreements, representations and warranties, express and implied, shall survive the termination of this Agreement, and shall remain in effect and binding upon the parties until they have fulfilled all of their obligations hereunder and the statute of limitations shall not commence to run until the time such obligations have been fulfilled.

29. ***Notice.*** Whenever under the terms of this Agreement written notice is required or permitted to be given by any party to any other party, such notice shall be in writing and shall be deemed to have been sufficiently given if personally delivered, delivered by a national overnight courier service (such as Federal Express), transmitted by electronic facsimile or deposited in the United States Mail, in a properly stamped envelope, certified or registered mail, return-receipt-requested, addressed to the party to whom it is to be given, at the address hereinafter set forth. Any party hereto may change its address by written notice in accordance with this Section:

If to Hospital:

CHI Memorial
Attn: CEO
2525 DeSales Avenue
Chattanooga, TN 37404

If to Parkridge:

Parkridge Medical Center, Inc.
Attention: CEO
2333 McCallie Avenue
Chattanooga, TN 37404

30. ***Recordkeeping.*** If and to the extent required by 42 U.S.C. § 1395x(v)(1)(I), until the expiration of four (4) years after the termination of this Agreement, each party shall make available, upon written request by the Secretary of the Department of Health and Human Services ("DHHS"), or upon request by the Comptroller General of the United States General Accounting Office ("GAO"), or any of their duly authorized representatives, a copy of this Agreement and such books, documents, and records as are necessary to certify the nature and extent of the costs of the services provided by such party under this Agreement. Each party further agrees that in the event it carries out any of its duties under this Agreement through a subcontract with a related organization, and such subcontract has a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, the subcontract shall contain a provision requiring the related organization to make available until the expiration of four (4) years after the furnishing of services pursuant to the subcontract, upon written request of the Secretary of the DHHS, or upon request of the Comptroller General of the GAO, or any of their duly authorized representatives, a copy of the subcontract and such books, documents, and records of the related organization as are necessary to verify the nature and extent of such costs. The provisions of this Section shall survive the expiration or termination of this Agreement for any reason.

31. ***Access to Books.*** The parties agree that if this Agreement is determined to be a contract within the purview of §1861(b)(1)(I) of the Social Security Act and the regulations promulgated in implementation thereof at 42 CFR Part 420, Parkridge, its agents, employees, officers and directors agree to make available to the Comptroller General of the United States, the Department of Health and Human Services ("HHS") and their duly authorized representatives, access to the books, documents and records of the respective party and such other information as may be required by the Comptroller General or Secretary at HHS to verify the nature and extent of the cost of service provided by Parkridge. If Parkridge, its agents, employees, officers or directors refuse to make the books, documents and records available for said inspection, and if, as a result, Hospital is denied reimbursement for said services, then Parkridge agrees to indemnify Hospital for Hospital's loss or reduction in reimbursement. The obligation of Parkridge to make records available shall extend for four (4) years after the furnishing of the latest service under this Agreement or renewal thereof.

32. ***Reorganization or Discontinuation of Services.*** In the event that Hospital, alone or as a member of a health care system, elects to merge, discontinue, downsize, integrate, restructure or otherwise materially alter the services for which Hospital is engaged hereunder, Hospital may first request mutual discussions with Parkridge in this regard, which discussions shall continue for a thirty (30) day period subsequent to Hospital's request (hereafter "discussion period"). After the expiration of the thirty (30) day discussion period, Hospital may elect to terminate this Agreement by providing Parkridge with at least thirty (30) days advance written notice prior to the effective date of the termination.

33. ***Amendment.*** This Agreement may be amended only by written agreement signed by the Parties hereto.

34. ***Entire Agreement.*** This Agreement constitutes the entire understanding between the parties and may only be modified or amended by mutual agreement of both parties in writing. Any such modification or amendment shall be attached hereto and become a part of this Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed effective as of the Effective Date.

HOSPITAL:

Memorial Health Care System, Inc. d/b/a CHI Memorial

By: _____

Janelle Reilly, CEO

PARKRIDGE:

Parkridge Medical Center, Inc.

By: _____

Name: Tom Ozbun

Title: Chief Executive Officer

CHI Memorial Hospital - Georgia

By: _____

Janelle Reilly, CEO

AGREEMENT FOR HOSPITAL SERVICES

This Agreement for Hospital Services (Services) is entered into by and between Parkridge Medical Center, Inc. d/b/a Parkridge East Hospital, Parkridge West Hospital, Parkridge Valley Hospital and Parkridge North and Memorial Health Care System, Inc. d/b/a CHI Memorial, Memorial Hospital and Memorial Hospital - Hixson, either may individually be referred to as the "Party" or collectively as the "Parties".

I. RECITALS

1.01 The Parties each own and operate a general acute care hospital licensed by the State of Tennessee.

1.02 Each Party wishes to arrange for the provision of necessary diagnostic, therapeutic and/or laboratory services ("Services") to be available as necessary to inpatients of each hospital when such Services are not available at the requesting hospital.

1.03 Each Party is equipped and has the professional expertise to provide the Services.

In consideration of the foregoing premises and pursuant to the terms and conditions described below, the Parties agree as follows:

II. SERVICES

2.01 Services. Each Party agrees to provide Services to inpatients (the "Providing Party") of the other Party (the "Requesting Party") as necessary in accordance with appropriate referrals by the attending physicians of such inpatients. Services shall be of high professional quality and provided in a timely fashion consistent with the needs of patients of the requesting Party. For each patient who receives Services, Providing Party shall provide Requesting Party with progress notes and any other pertinent information to allow Requesting Party to maintain a complete and timely medical record of all services provided to the patient.

2.02 Qualifications. Each Party represents that all physicians or staff providing services on its behalf will obtain and maintain all required licenses, permits, and/or certificates necessary to provide the Services.

III. TRANSPORT

3.01 Transportation. Any inpatient requiring transport between the hospitals to receive Services from the Providing Party shall be transported to the premises of the Providing Party by the personnel and using the equipment of the Requesting Party. Upon completion of Services to any inpatient, the Providing Party shall notify the Requesting Party's personnel. At all times while the patient is on the premises of the Providing Party, the Providing Party is responsible for the care, security and professional treatment of the inpatient.

IV. PATIENT RESPONSIBILITY

4.01 Requesting Party's Responsibilities. The Requesting Party shall retain professional control and responsibility for the overall diagnostic and medical care of patients receiving Services from the Providing Party. All patients treated by the Providing Party shall remain the Requesting Party's inpatients. The Requesting Party shall maintain clinical records relating to Services provided by Providing Party and the attending physician of patient shall consult with Providing Party's staff.

V. Compensation and Billing

5.01 Technical Component. The Parties recognize that the Providing Party assumes all operating and overhead costs with respect to Services provided under this Agreement and that the Providing Party cannot receive reimbursement for such costs for Services to the Requesting Party's inpatient beneficiaries of the Medicare, Medicaid, and all other Federally Funded Programs because such reimbursement is a component of inpatient prospective payments under the Medicare, Medicaid, and all other Federally Funded Programs to the Requesting Party. Accordingly, the Requesting Party agrees to pay the Providing Party in accordance with the formula set forth at Exhibit A, attached hereto and incorporated herein by this reference.

5.02 Payment of Technical Component. Payments under Section 5.01 shall be made monthly in arrears within thirty (30) calendar days of receipt by the Requesting Party of documentation acceptable to the Requesting Party to establish the provision of Services.

5.03 Providing Party's Commitment. The Providing Party agrees that the payments under Section 5.02 constitute its total compensation for the Technical Component of Services under this Agreement. The Providing Party shall not bill the patients, the Medicare Program or any other payer for such Technical Component.

VI. Term and Termination

6.01 Term. This Agreement shall commence as of September 3, 2020 and shall expire on September 2, 2021 ("Initial Period"). At the end of this Initial Period, this Agreement will automatically renew for successive one (1) year periods (the "Renewal Periods"), unless either Party notifies the other of its intention not to renew at least thirty (30) days prior to the end of the then current term (the "Initial Period" and subsequent "Renewal Period(s)" are collectively defined herein as the "Term").

6.02 Termination. Notwithstanding the provisions in Section 6.01, this Agreement may be terminated:

(a) By either party upon written notice to the other party in the event that any federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation at any time while this Agreement is in effect that prohibits, restricts, limits or in any way substantially changes the arrangement contemplated herein or which otherwise significantly affects either the rights or obligations of the parties under this Agreement. If this Agreement can be amended to the satisfaction of both parties to compensate for any such prohibition, restriction, limitation or change, this clause shall not be interpreted to prevent such amendment; or

(b) By either party in the event of a material breach by the other party. In the event of a material breach, the non-breaching party shall have the right to terminate this Agreement after providing thirty (30) days written notice to the breaching party, unless such breach is cured to the satisfaction of the non-breaching party within the thirty (30) day period.

(c) Either Party may terminate this Agreement without cause at any time upon thirty (30) days prior written notice to the other Party.

VII. Under Arrangement

7.01 Medicare Compliance. It is the intent of both Parties that this Agreement be deemed an

under arrangement for Medicare payment and reimbursement purposes. Accordingly, both parties shall cooperate fully to ensure that the arrangement contemplated hereby is consistent with all applicable requirements of the Medicare laws and regulations to comply with any applicable requirements of the Medicare Program.

VIII. INDEPENDENT CONTRACTOR

No relationship of employer and employee is created by this Agreement. In performing duties pursuant to this Agreement, both Parties shall at all times act and perform as independent contractors.

IX. INSURANCE AND INDEMNIFICATION

9.01 Insurance. Each party shall at all times during the course of this Agreement maintain appropriate professional liability insurance and general liability insurance for no less than **Three Million ($3,000,000.00)** Dollars per occurrence coverage and **Five Million ($5,000,000.00)** Dollars aggregate coverage covering activities, errors and omissions of itself and its officers, agents and employees commitment pursuant to and in furtherance of this Agreement.

9.02 Indemnification. To the extent not covered by insurance, each Party shall indemnify, defend and hold the other Party harmless from all actions, claims or demands and against all liabilities, losses, costs or attorneys' fees through litigation and any appellate review thereof, or other damages arising out of any occurrence arising directly or indirectly out of an actual or alleged injury to a person or to property as an actual or alleged result of an act or omission by the other Party, its officers, directors, agents, employees, representatives, or contractors.

X. ACCESS TO RECORDS

As an independent contractor, each Party shall, in accordance with 42 U.S.C. section 1395x(V)(1)(I), until the expiration of four (4) years after the termination of this Agreement, make available upon written request to the Secretary of the United States Department of Health and Human Services, or upon written request to the Comptroller General of the United States, General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided under this Agreement. Each Party further agrees that, in the event the Party carries out any duties under this Agreement through a subcontract, with a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve-month period, with a related organization, such agreement shall contain a clause to the effect that until expiration of four (4) years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request, to the Secretary of the United States Department of Health and Human Services, or, upon request, to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents and records of such organizations as are necessary to verify the nature and extent of such costs.

XI. GENERAL PROVISIONS

11.01 Counterparts. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

11.02 Entire Agreement. This Agreement constitutes the entire agreement between the parties. Any oral representations or modifications concerning this Agreement shall be of no force and effect.

11.03 Governing Law. This Agreement shall be governed by and interpreted, enforced and construed in accordance with the law of Tennessee.

11.04 Notices. All notices or other communications under this Agreement shall be sent to the parties by certified mail, return receipt requested, or by personal delivery at the address below:

To Parkridge Medical Center, Inc.:
Attn: Chief Executive Officer
2333 McCallie Avenue
Chattanooga, Tennessee 37044

With Copy to: HCA - The Healthcare Company
One Park Plaza Building I-2E
P.O. Box 550
Nashville, Tennessee 37203-0550
Attention: Operations Counsel

To Memorial Health Care System, Inc.:
Attn: Chief Executive Officer
2525 de Sales Avenue
Chattanooga, Tennessee 37404

11.05 Referrals. This Agreement does not create any obligation, expectation or requirement that one Party shall make any patient referrals to the other Party. The Parties acknowledge that nothing contained herein shall be interpreted to require or obligate either party to admit or cause the admittance of a patient or to utilize its services. The parties further acknowledge that none of the benefits granted the parties under this Agreement is conditioned on any requirement or expected that the parties make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the other party. The parties further acknowledge that neither party is restricted from referring any service to, or otherwise generating any business for any other entity from their choosing.

11.06 Severability. If any term, provision, covenant or condition of this agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall continue in full force and effect and shall in no way be affected, impaired or invalidated.

11.07 Attorney Fees. In any lawsuit, action, proceeding, or arbitration arising out of or related to this Agreement each party shall be responsible for their own costs, attorneys' fees and expenses through litigation or any appellate review therefrom.

11.08 Waiver. Any failure of a party to insist upon strict compliance with any term undertaking or condition of this Agreement shall not be deemed to be a waiver of such term, undertaking or condition. To be effective, a waiver must be in writing and signed by both parties.

11.09 Prohibition against Excluded Parties. Each Party represents and warrants it has not been excluded, debarred, or otherwise made ineligible to participate in any Federal Healthcare program as defined in 42 USC § 1320a-7b(f). Each Party represents and warrants that it (i) is not currently excluded, debarred, or otherwise ineligible to participate in the Federal health care programs as defined in 42 USC § 1320a-7b(f) (the "Federal healthcare programs"); (ii) is not convicted of a criminal offense related to the

provision of healthcare items or services, but has not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal healthcare programs, and (iii) is not under investigation or otherwise aware of any circumstances which may result in being excluded from participation in the Federal healthcare programs. This shall be an ongoing representation and warranty during the terms of this Agreement and each Party shall immediately notify the other Party of any change in the status of the representation and warranty set forth in this section. If either Party becomes excluded from Federal program participation, this Agreement may be terminated immediately by the other Party for cause.

11.10 Confidential Information. Both parties recognize and acknowledge that, by virtue of entering into this Agreement and providing services hereunder, both parties may have access to certain information that is confidential and constitutes valuable, special and unique property of the other party. Both parties warrant and covenant to each other that neither party will at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without the other party's express prior written consent, except pursuant to the duties outlined in the Agreement, any confidential or proprietary information of the other party, including, but not limited to, information that concerns patients, costs, prices and treatment methods at any time used, developed or made, and which is not otherwise available to the public.

11.11 Patient Information. The parties acknowledge that many providers are "covered entities" as that term is defined at 45 C.F.R. §160.103. Each party 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 U.S.C.A. §1320d et seq. ("HIPAA") and any current and future regulations promulgated under 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 Transaction Regulations"), all as amended from time to time and collectively referred to herein as the "HIPAA Requirements". Each party agrees not to use or further disclose any "Protected Health Information," including "Electronic Protected Health Information," (as such terms are defined in the HIPAA Requirements) other than as permitted by the HIPAA Requirements and the terms of this Agreement. Contractor will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the HIPAA Requirements. In addition, each Party warrants and covenants to that, if necessary, it will resist in judicial proceedings any effort to obtain access to such records or information except such access as is expressly permitted by the aforementioned federal regulations and/or state law.

IN WITNESS WHEREOF, the parties, through their duly authorized representatives, have executed this Agreement as of the day and year first above written.

Parkridge Medical Center, Inc.:

By: Tom Ozburn
Chief Executive Officer
Date: 9/4/20

Memorial Health Care System Inc.:

By:
Title: CFO
Date: 9/8/20

EXHIBIT A

The Requesting Party agrees to pay the Providing Party for Services rendered pursuant to this Agreement at the prevailing Medicare rates in effect on the date of Service.

Attachment 1C-2

Annual Community Report

Market overview

PARKRIDGE
HEALTH SYSTEM

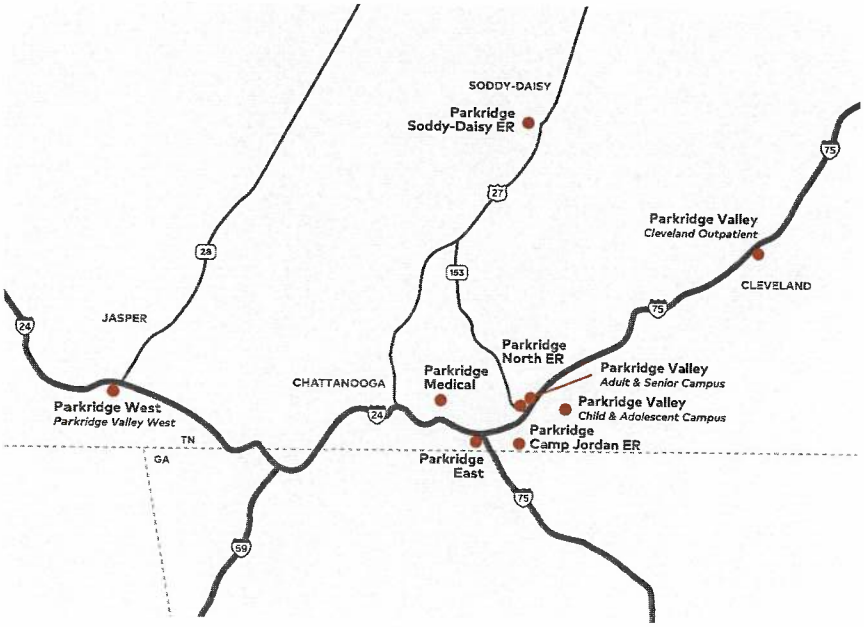
Above all else, we are committed to the care and improvement of human life.

Our patient promise:

We are committed to excellence – every patient, every action, every time.

Our vision:

Be the healthcare system of choice for our patients, providers and colleagues.



Access made easy

5
Hospitals

6
Emergency rooms

4
Imaging centers

10
Physician offices
Employed providers

120,824
Emergency room visits

21,475
Patient admissions

2,201
Babies delivered

2,321
Colleagues

Visit **ParkridgeHealth.com** for more information

Based on 2024 data.

Our facilities

Chattanooga

Parkridge Medical
Chattanooga, TN

Parkridge East
Chattanooga, TN

Parkridge North ER
Chattanooga, TN

Parkridge Camp Jordan ER
Chattanooga, TN

Parkridge Valley Adult & Senior Campus
Chattanooga, TN

Parkridge Valley Child & Adolescent Campus
Chattanooga, TN

Soddy-Daisy

Parkridge Soddy-Daisy ER
Soddy-Daisy, TN

Jasper

Parkridge West
Jasper, TN

Attachment 4C-1

Clinical Training Affiliations

School	Program Name
American National University	Nursing
Bluegrass Community & Technical College	LPN
Bluegrass Community & Technical College	Medical Assisting
Bluegrass Community & Technical College	Paramedic
Bluegrass Community & Technical College	Radiography
Bluegrass Community & Technical College	Respiratory Therapy
Bluegrass Community & Technical College	RN
Bluegrass Community & Technical College	Sonography
Bluegrass Community & Technical College	Surgical Technology
Marshall University	BSN
Marshall University	Communication Science and Disorders
Marshall University	Dietetics
Marshall University	Health Informatics
Marshall University	MSN
Marshall University	Pharmacy
Marshall University	Physical Therapy
Marshall University	Physician Assistant
Marshall University	Respiratory Therapy
New York University	Speech and Language and Communicative Scien
Spring Arbor University	BSN
Spring Arbor University	MSN
Concorde Career College	Occupational Therapy Assistant
Grand Valley State University	Medical Dosimetry
Yale University	Physician Assistant
Hanover College	Doctor of Physical Therapy
NHC/LP	Dietetic Internship
Northwestern University	Counseling
Northwestern University	Physical Therapy
Middle Tennessee Cardiovascular Institute	Echocardiography
Bellarmine University	Physical Therapy
Bellarmine University	Respiratory Therapy
Fortis Institute	Assoc Degree in Nursing
Fortis Institute	BSN
Fortis Institute	Cardiovascular Technology
Fortis Institute	Emergency Medical Services
Fortis Institute	EMT - Paramedic
Fortis Institute	Medical Assisting
Fortis Institute	Medical Laboratory Technology
Fortis Institute	Pharmacy Technician
Fortis Institute	Radiologic Technology
Fortis Institute	Surgical Technology
Georgetown University	Nursing and Health Studies
Vanderbilt University	Child Studies
Vanderbilt University	DNP
Vanderbilt University	MSN
Vanderbilt University	Ph.D. in Nursing

Vanderbilt University	Philosophy
Medical Institute of Kentucky	Surgical Technology
Spalding University	Occupational Therapy
Spalding University	Physical Therapy
Meharry Medical College	Physician Assistant
King University	DNP
King University	MSN AGACNP
King University	MSN FNP
King University	MSN NLA
King University	MSN PMHNP
King University	MSN PNP
University of South Alabama	APN
University of South Alabama	Audiology
University of South Alabama	BSN
University of South Alabama	DNP
University of South Alabama	MSN
University of South Alabama	Occupational Therapy
University of South Alabama	Physical Therapy
University of South Alabama	Speech Therapy
Madisonville Community College	Assoc Degree in Nursing
Madisonville Community College	EMS - Paramedic
Madisonville Community College	Medical Laboratory Technology
Madisonville Community College	Occupational Therapy Assistant
Madisonville Community College	Physical Therapy Assistant
Madisonville Community College	Radiography
Madisonville Community College	Respiratory Therapy
Madisonville Community College	Surgical First Assistant
Madisonville Community College	Surgical Technology
University of Tennessee Southern	Nursing
University of Tennessee Southern	Public Health Education
Saint Francis University	Exercise Physiology
Saint Francis University	Nursing
Saint Francis University	Occupational Therapy
Saint Francis University	Physical Therapy
Saint Francis University	Physician Assistant
Saint Francis University	Social Work
Concordia University	Diagnostic Medical Sonography
University of the Cumberlands	Nursing
Richmont Graduate University	Counseling
Milligan University	Master of Science on Occupational Therapy
Milligan University	Physician Assistant
Puckett EMS Training Academy	Emergency Medical Technician
Puckett EMS Training Academy	EMT - Paramedic
Lincoln Memorial University	Nursing
Lincoln Memorial University	Physician Assistant
University of Puget Sound	Occupational Therapy
University of Puget Sound	Physical Therapy

Institute of Ultrasound Diagnostics	General Sonography
University of Tennessee Health Science Center	BSN
University of Tennessee Health Science Center	College of Health Professions
University of Tennessee Health Science Center	DNP
University of Tennessee Health Science Center	MSN
University of Tennessee Health Science Center	Nurse Practitioner
University of Tennessee Health Science Center	Physician Assistant
University of Tennessee Health Science Center	Social Work
University of Tennessee Health Science Center	Speech Language Pathology
University of Kentucky	College of Fine Arts
University of Kentucky	Health Sciences
University of Kentucky	Nursing
University of Kentucky	Pharmacy
University of Kentucky	Social Work
Hopkinsville Community College	Nursing
Calvin University	Speech Language Pathology
University of Saint Mary	Occupational Therapy
City of Frankfort	Paramedic
Middle Tennessee State University	Health Care Informatics
Middle Tennessee State University	Professional Counseling
University of West Georgia	BSN
University of West Georgia	MSN
University of West Georgia	Speech Language Pathology
Nova Southeastern University	Speech Language Pathology
University of South Carolina Aiken	BSN
University of Tennessee Knoxville	BSN
University of Tennessee Knoxville	DNP
University of Tennessee Knoxville	Kinesiology
University of Tennessee Knoxville	Licensed Advanced Practitioner in Social Work (
University of Tennessee Knoxville	MSN
University of Tennessee Knoxville	Nurse Practitioner
University of Tennessee Knoxville	Recreation and Sports Studies
University of Tennessee Knoxville	Social Work (BSSW)
University of Tennessee Knoxville	Social Work (MSSW)
Crown College	Master of Arts in Counseling
Cardiac & Vascular Institute of Ultrasound	Cardiac and Vascular Ultrasound
Western Kentucky University	College of Health & Human Service
Western Kentucky University	Counseling
Cleveland State University	Nursing
Medical Career and Technical College	Practical Nursing
Ross Medical Education Center	Healthcare administration
Ross Medical Education Center	Medical Assisting
Ross Medical Education Center	Medical Insurance Billing and Office Admin
Ross Medical Education Center	Nursing
Ross Medical Education Center	Occupational Therapy Assistant
Ross Medical Education Center	Pharmacy Technician
Ross Medical Education Center	Surgical Technology

West Kentucky Community and Technical College	Medical Laboratory Technology
Belmont University	APN
Belmont University	BSN
Belmont University	DNP
Belmont University	Exercise Science
Belmont University	Mental Health Counseling
Belmont University	MSN
Belmont University	Music Therapy
Belmont University	Occupational Therapy
Belmont University	Pharmacy
Belmont University	Physical Therapy
Belmont University	Post-Doctoral Pharmacy Fellowship
Belmont University	Public Health
Belmont University	Social Work
Chamberlain University	APN
Chamberlain University	BSN
Chamberlain University	DNP
Chamberlain University	MSN
Tennessee State University	Assoc Degree in Nursing
Tennessee State University	BSN
Tennessee State University	Dental Hygiene
Tennessee State University	Health Information Management
Tennessee State University	Healthcare Administration
Tennessee State University	Human Performance
Tennessee State University	Medical Lab Science
Tennessee State University	MSN
Tennessee State University	Occupational Therapy
Tennessee State University	Phlebotomy Technician Program
Tennessee State University	Physical Therapy
Tennessee State University	Radiation Therapy
Tennessee State University	Radiography
Tennessee State University	Respiratory Bachelor of Science in Cardio-Respir
Tennessee State University	Social Work
Tennessee State University	Speech Language Pathology
Tennessee State University	Surgical Technology
Lipscomb University	APN
Lipscomb University	BSN
Lipscomb University	College of Pharmacy & Health Sciences
Lipscomb University	Dept. of Psychology, Counseling, & Family Scien
Lipscomb University	DNP
Lipscomb University	MSN
Lipscomb University	Pharmacy
Lipscomb University	Physician Assistant
University of Louisville	Audiology
University of Louisville	Nursing
University of Louisville	Speech Language Pathology

Marian University	BSN
Marian University	Doctor of Nurse Anesthesia Practice
Marian University	MSN
Maryville University	APN
Maryville University	BSN
Maryville University	DNP
Maryville University	MSN
University of North Alabama	BSN
University of North Alabama	MSN
Cumberland University	APN
Cumberland University	BSN
Cumberland University	DNP
Cumberland University	MSN
East Tennessee State University	Exercise Science
East Tennessee State University	Nursing
East Tennessee State University	Social Work
Grand Canyon University	Addiction Counseling
Grand Canyon University	Christian Counseling
Grand Canyon University	Clinical Mental Health Counseling
Grand Canyon University	Health Care Professions
Grand Canyon University	Health Information Management
Grand Canyon University	Master of Science in Health Admin
Grand Canyon University	Nursing
Grand Canyon University	Social Work
Herzing University	BSN
Herzing University	Health Information Management
Herzing University	Healthcare Management
Herzing University	MSN
Lee University	BSN
Lee University	DNP
MedCerts	Central Service Tech
MedCerts	Medical Lab Assistant
MedCerts	Phlebotomy
MedCerts	Surgical Technology
Middle Tennessee School of Anesthesia	Doctor of Nurse Anesthesia Practice
Middle Tennessee School of Anesthesia	MSN
Middle Tennessee School of Anesthesia	Nurse Practitioner
Tennessee Technological University	BSN
Tennessee Technological University	Child Life Sciences
Tennessee Technological University	DNP
Tennessee Technological University	Food & Nutrition Sciences
Tennessee Technological University	MSN
Tennessee Technological University	Nurse Practitioner
Tennessee Technological University	Pre-Athletic Training
Tennessee Technological University	Pre-Occupational Therapy
Tennessee Technological University	Pre-Physical Therapy

Tennessee Technological University	Pre-Physician Assistant
Washington State University	Speech and Hearing Sciences
Nashville General Hospital	Radiologic Technology
Bethel University	BSN
Bethel University	Physician Assistant
Lindsey Wilson University	Nursing
Lindsey Wilson University	School of Professional Counseling
Capella University	Clinical Mental Health Counseling
Capella University	DNP
Capella University	MSN
Capella University	Social Work
Miller Motte Technical College	Surgical Technology
University of Mississippi	Speech Therapy
Boise State University	Genetic Counseling
Boise State University	Medical Imaging
Boise State University	Nursing and Health Care
Boise State University	Respiratory Care
Boise State University	Social Work
University of Tennessee Martin	BSN
University of Tennessee Martin	Dietetics
Pulse Radiology	American Registry of Radiologic Technologists
Walden University	BSN
Walden University	DNP
Walden University	MSN
Walden University	Psychology
Walden University	Public Health
Walden University	School of Counselling
Walden University	Social Work
Georgia Northwestern Technical College	Adult Echocardiography
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	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	Paramedic Technology
Georgia Northwestern Technical College	Patient Care Assistant
Georgia Northwestern Technical College	Phlebotomy Technician Program
Georgia Northwestern Technical College	Practical Nursing
Georgia Northwestern Technical College	Radiologic Technology
Georgia Northwestern Technical College	Respiratory Care
Georgia Northwestern Technical College	Surgical Technology
Georgia Northwestern Technical College	Vascular Technology

University of Alabama at Birmingham	BSN
University of Alabama at Birmingham	DNP
University of Alabama at Birmingham	MSN
University of Alabama at Birmingham	Nurse Practitioner
University of Alabama at Birmingham	Nutrition Sciences
Galen College of Nursing	Assoc Degree in Nursing
Galen College of Nursing	BSN
Galen College of Nursing	DNP
Galen College of Nursing	MSN
South College	Doctor of Nurse Anesthesia Practice
South College	Health & Therapy Programs
South College	Imaging Science
South College	Nursing
South College	Pharmacy
South College	Physical Therapy
South College	Physician Assistant
South College	Surgical Technology
Shenandoah University	BSN
Shenandoah University	DNP
Shenandoah University	MSN
Shenandoah University	Nurse Midwifery
Shenandoah University	Nurse Practitioner
Shenandoah University	Nutrition/Dietetics
Shenandoah University	Occupational Therapy
Shenandoah University	Pharmacy
Shenandoah University	Physical Therapy
Shenandoah University	Physician Assistant
Shenandoah University	Speech Language Pathology
Samford University	Doctor of Pharmacy
Samford University	Nursing
Samford University	Physical Therapy
Emergency Medical Training Professionals LLC/Central KY Pa	Paramedic
Murray State University	BSN
Murray State University	DNP
Murray State University	Exercise Science
Murray State University	Nutrition and Dietetics
Murray State University	Occupational Therapy
Murray State University	Public and Community Health
Murray State University	Speech Language Pathology
Union University	APN
Union University	BSN
Union University	DNP
Union University	MSN
Antioch University	Counseling
Antioch University	Therapy
Sacred Heart University	Nursing

Northern Kentucky University	A/G Acute
Northern Kentucky University	A/G Primary
Northern Kentucky University	DNP
Northern Kentucky University	FNP
Northern Kentucky University	NED
Northern Kentucky University	NEL
Northern Kentucky University	P/M Health
Northern Kentucky University	Social Work
University of Kansas	Pharmacy
Barton Community College	Medical Laboratory Technology
Barton Community College	Phlebotomy
Auburn University	BSN
Auburn University	DNP
Auburn University	Medical Lab Science
Auburn University	MSN
Dalton State College	Assoc Degree in Nursing
Dalton State College	BSN
Dalton State College	Medical Laboratory Technology
Dalton State College	Phlebotomy
Dalton State College	Radiologic Technology
Dalton State College	Respiratory Therapy
Dalton State College	Social Work
Duke University	MSN
Trevecca Nazarene University	Master of Healthcare Administration
Trevecca Nazarene University	Physician Assistant
Trevecca Nazarene University	Social Work
University of Alabama at Huntsville	APN
University of Alabama at Huntsville	BSN
University of Alabama at Huntsville	DNP
University of Alabama at Huntsville	MSN
United States University	BSN
United States University	MSN
United States University	Nurse Practitioner
Western Governors University	BSN
Western Governors University	Health Information Management
Western Governors University	Healthcare Management
Western Governors University	Master of Business Healthcare Management
Western Governors University	MSN
University of Tennessee at Chattanooga	BSN
University of Tennessee at Chattanooga	Certified Nursing Assistant
University of Tennessee at Chattanooga	CRNA
University of Tennessee at Chattanooga	Mental Health Counseling
University of Tennessee at Chattanooga	Music Therapy
University of Tennessee at Chattanooga	Nurse Practitioner
University of Tennessee at Chattanooga	Occupational Therapy
University of Tennessee at Chattanooga	Occupational Therapy
University of Tennessee at Chattanooga	Pharmacy Technician

University of Tennessee at Chattanooga	Physical Therapy
University of Tennessee at Chattanooga	Physician Assistant
University of Tennessee at Chattanooga	Social Work
Harding University	Dietetics
Harding University	Physical Therapy
Harding University	Social Work
Harding University	Speech Language Pathology
Beckfield College	Nursing
Campbellsville University	Case Management
Campbellsville University	Nursing
Campbellsville University	Phlebotomy
Kentucky State University	Nursing
Maysville Community and Technical College	Health Sciences
Austin Peay State University	BSN
Austin Peay State University	Masters of Counseling
Austin Peay State University	Medical Lab Science
Austin Peay State University	MSN
Austin Peay State University	Phlebotomy Technician Program
Austin Peay State University	Radiation Therapy
Austin Peay State University	Social Work
MedQuest College	Diagnostic Medical Sonogrophy
MedQuest College	Practical Nursing
Midway University	Nursing
Morehead State University	Imaging Science
Mary Baldwin University	BSN
Mary Baldwin University	DNP
Mary Baldwin University	Doctor of Occupational Therapy
Mary Baldwin University	Doctor of Physical Therapy
Mary Baldwin University	MSN
Mary Baldwin University	Physician Assistant
Texas Tech University	Medical Laboratory Sciences
Texas Tech University	Molecular Pathology
Texas Tech University	Occupational Therapy
Texas Tech University	Physical Therapy
Texas Tech University	Speech Language Pathology
Saint Mary of the Woods College	Art Therapy
Saint Mary of the Woods College	Music Therapy
Saint Mary of the Woods College	Paramedic to BSN
Arizona State University	Behavioral Health
National Institute of First Assisting	First Assisting
Emory University School of Nursing	APN
Emory University School of Nursing	BSN
Emory University School of Nursing	DNP
Emory University School of Nursing	MSN
Emory University School of Nursing	Ph.D. in Nursing
Des Moines	Doctor of Occupational Therapy
Des Moines	Doctor of Osteopathic Medicine

Des Moines	Doctor of Physical Therapy
Des Moines	Master of Heatlh Care Administration
Des Moines	Master of Public Health
Des Moines	Master of Public Health
Des Moines	Podiatric Medicine and Surgery
Southcentral Kentucky Community and Technical College	Assoc Degree in Nursing
Southcentral Kentucky Community and Technical College	EMT - Paramedic
Southcentral Kentucky Community and Technical College	Medical Laboratory Technology
Southcentral Kentucky Community and Technical College	Radiography
Southcentral Kentucky Community and Technical College	Respiratory Therapy
Southcentral Kentucky Community and Technical College	Sonography
Southcentral Kentucky Community and Technical College	Surgical Technology
Azusa Pacific University	BSN
Azusa Pacific University	Child Life Sciences
Azusa Pacific University	DNP
Azusa Pacific University	MSN
Augustana University	Physical Therapy
John Patrick University of Health and Applied Sciences	Medical Dosimetry
John Patrick University of Health and Applied Sciences	Radiation Therapy
John Patrick University of Health and Applied Sciences	Radiological Science
Union University	Doctor of Nurse Anesthesia Practice
Georgia State University	Associate of Science in Nursing
Georgia State University	BSN
Georgia State University	Communication Science and Disorders
Georgia State University	DNP
Georgia State University	Exercise Science
Georgia State University	MSN
Georgia State University	Nutrition
Georgia State University	Occupational Therapy
Georgia State University	Physical Therapy
Georgia State University	Respiratory Therapy
Meridian Institute of Surgical Assisting	Surgical First Assistant
Gannon University	Physician Assistant
Faulkner University	Occupational Therapy
Faulkner University	Physical Therapy
Faulkner University	Physician Assistant
Faulkner University	Speech Language Pathology
Sullivan University	MSPA
Sullivan University	Pharmacy Technician
Sullivan University	PharmD
Casa Loma College	Diagnostic Medical Sonogrophy
Casa Loma College	Magnetic Resonance Imaging
Casa Loma College	Medical Radiography
Casa Loma College	Nursing
Hopkinsville-Christian County EMS Paramedic	Paramedic
Frontier Nursing University	Certified Nurse Midwife

Frontier Nursing University	DNP
Frontier Nursing University	MSN
Frontier Nursing University	Nurse Practitioner
Tennessee Board of Regents	Anesthesia Technology
Tennessee Board of Regents	Assoc Degree in Nursing
Tennessee Board of Regents	BSN
Tennessee Board of Regents	Certified Dietary Management
Tennessee Board of Regents	Computed Topography
Tennessee Board of Regents	Diagnostic Medical and Cardiovascular Sonogro
Tennessee Board of Regents	Emergency Medical Services
Tennessee Board of Regents	Health Information Management
Tennessee Board of Regents	Magnetic Resonance Imaging (MRI)
Tennessee Board of Regents	Mammography
Tennessee Board of Regents	Medical Lab Science
Tennessee Board of Regents	Mental Health Technician
Tennessee Board of Regents	MSN
Tennessee Board of Regents	Nuclear Medicine
Tennessee Board of Regents	Occupational Therapy
Tennessee Board of Regents	Occupational Therapy Assistant
Tennessee Board of Regents	Opthalmic Technology
Tennessee Board of Regents	Pharmacy Technician
Tennessee Board of Regents	Phlebotomy Technician Program
Tennessee Board of Regents	Physical Therapy
Tennessee Board of Regents	Physical Therapy Assistant
Tennessee Board of Regents	Radiation Therapy
Tennessee Board of Regents	Radiography
Tennessee Board of Regents	Respiratory Care Technology
Tennessee Board of Regents	Sleep Diagnostics
Tennessee Board of Regents	Speech Language Pathology
Tennessee Board of Regents	Surgical Technology
Freed-Hardeman University	APN
Freed-Hardeman University	BSN
Freed-Hardeman University	DNP
Freed-Hardeman University	MSN
Eastern Kentucky University	Communication Sciences and Disorders
Eastern Kentucky University	Nursing
Academy of Allied Health	Advanced EMT
Academy of Allied Health	Clinical Medical Assistant
Academy of Allied Health	Phlebotomy Technician Program
Academy of Allied Health	Practical Nursing
Middle Tennessee State University	BSN
Middle Tennessee State University	MSN
Middle Tennessee State University	Social Work
Southern Adventist University	APN
Southern Adventist University	Assoc Degree in Nursing
Southern Adventist University	BSN

Southern Adventist University	Clinical Mental Health Counseling
Southern Adventist University	DNP
Southern Adventist University	MSN
Southern Adventist University	Physical Therapy Assistant
Southern Adventist University	Social Work
Edgewood University	Dept. of Psychology, Counseling, & Family Scien
Georgetown Scott County Emergency Medical Service	EMT - Basic
University of Missouri	Speech and Hearing Sciences
Washburn University	Radiation Therapy

Attachment 4C-2

EMTALA Policy

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EMTALA – Tennessee Medical Screening Examination & Stabilization

SCOPE:

Organizational Wide

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.

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.

a. **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.**

b. **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:

a. a physician examines all individuals whose conditions or symptoms require physician examination;

b. an ED physician on duty is responsible for the general care of all individuals presenting themselves to the emergency department; and

c. 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 EMC's 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*.

i. ***EMTALA Waivers and Requirements During Pandemics and Other Declared Emergencies.***

i. 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.

ii. 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.

iii. EMTALA Waivers.

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

REFERENCES:

Pre-PolicyStat Number: RI-POL/PRO-2.008.005

Attachments

Informed Refusal for Partial Refusal of Care and AMA Form.doc

Sign-in Sheet for Emergency Services and Waiver of Right to Medical Screening Examination Form ENGLISH 11.2024.docx

Sign-in Sheet for Emergency Services and Waiver of Rights to Medical Screening Examination Form SPANISH 11.2024.docx

Approval Signatures

Step Description	Approver	Date
Board of Governors	Karen Beam: VP Quality	12/2024

Medical Executive Leadership	Misty Maddox: Dir Med Staff Svcs	11/2024
Senior Nursing Leadership	Lisa Roberson: Mgr Quality	10/2024
Senior Nursing Leadership	Karen Respess: Dir Regulatory Compliance	10/2024
Senior Nursing Leadership	Karen Beam: VP Quality	10/2024
Senior Nursing Leadership	Lori Feltner	09/2024
Senior Nursing Leadership	Amy Whipple: CNO Parkridge Valley Hosp	09/2024
Senior Nursing Leadership	Deborah Deal: CNO Parkridge Med Ctr	09/2024
Policy Owner	Kristi Delaney: ECO	09/2024

Applicability

TriStar Parkridge Medical Center

Status Active PolicyStat ID 16708890

Origination	08/2008	Owner	Kristi Delaney: ECO
Last Approved	12/2024	Policy Area	Ethics and Compliance
Last Revised	12/2024	Applicability	TriStar Parkridge Medical Center
Next Review	12/2027		

EMTALA – Transfer Policy

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.

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.

b. 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.

c. **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.

2. **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.

3. **Authority to Decline a Transfer Request**

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. A 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 PLC representative or the facility's CEO designee or ED physician. Individuals qualified to serve as an AOC include the CEO, CFO, CNO, COO, CMO, ECO, VP Quality and other senior leaders reporting directly to the CEO. Other individuals who may be qualified based on experience include an ACFO, ACNO, Associate Administrator or similarly titled individuals. In general, a department director is not qualified to serve as an AOC. Additionally, a Nursing Supervisor, House Supervisor or other similarly titled position is not considered to be an equivalent of the AOC.

4. **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.

5. **Patient Logistics Center (PLC) Use**

   Hospitals may utilize a PLC 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 PLC then facilitates the transfer from the transferring facility to the facility selected by the transferring physician and/or the patient. A PLC does 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.

The PLC may utilize algorithms developed with a facility to accept a transfer on behalf of a hospital or decline a transfer request when the hospital does not provide the services needed or lacks capacity. Otherwise, a PLC may make no independent decision to accept or refuse a transfer request on behalf of a facility.

At the ED Physician's request, the PLC 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 information about receiving facilities with capability and capacity for accepting the individual in need of transfer. The ED Physician and the individual to be transferred then make the decision on the receiving facility.

The PLC 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 transferring physician retains the responsibility to determine the method and mode of transportation and the personnel and equipment needed. Transfer acceptance cannot be predicated upon the transferring facility using a method of transportation chosen by the receiving facility or a PLC.

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 PLC 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 the PLC. 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.

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 PLC to assist in facilitating the transfer. But, the PLC generally may not provide any information to, or respond to questions from, to the receiving facility or physician at the receiving facility, 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 PLC. After the receiving hospital's designated transfer coordinator is contacted, this individual or PLC 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 PLC must have in place a procedure to review potential refusals and/or to monitor any refusals of transfer from other facilities. The PLC shall establish a process to notify a hospital of a potential EMTALA violation.

7. **Reporting Potential EMTALA Violations**

   Any employee working with the DED, including but not limited to, a 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.

   1. **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:

      a. the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period;

      b. 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;

c. the hospital does not discriminate on the basis of an individual's source of payment or ability to pay;

d. the hospital is located in an emergency area during an emergency period; and

e. there has been a determination that a waiver of sanctions is necessary.

2. **Waiver Limitations.**

a. 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. 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).

REFERENCES:

Pre-PolicyStat Number: RI-POL-2.007.004.

Attachments

1: EMTALA – Transfer Form

Approval Signatures

Step Description	Approver	Date
Board of Governors	Karen Beam: VP Quality	12/2024
Medical Executive Leadership	Misty Maddox: Dir Med Staff Svcs	11/2024
Senior Nursing Leadership	Lisa Roberson: Mgr Quality	10/2024
Senior Nursing Leadership	Karen Respess: Dir Regulatory Compliance	10/2024
Senior Nursing Leadership	Karen Beam: VP Quality	10/2024
Senior Nursing Leadership	Lori Feltner	09/2024
Senior Nursing Leadership	Amy Whipple: CNO Parkridge Valley Hosp	09/2024
Senior Nursing Leadership	Deborah Deal: CNO Parkridge Med Ctr	09/2024
Policy Owner	Kristi Delaney: ECO	09/2024

Applicability

TriStar Parkridge Medical Center

Status Active PolicyStat ID 16708813

Origination	08/2008	Owner	Kristi Delaney: ECO
Last Approved	12/2024	Policy Area	Ethics and Compliance
Last Revised	12/2024	Applicability	TriStar Parkridge Medical Center
Next Review	12/2027		

EMTALA - Provision of On-Call Coverage

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.

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 Patient Logistics Center (PLC) 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 PLC.

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:

1. 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.
2. If a PLC is being utilized to contact the on-call physician, the on-call physician must respond to the PLC within a reasonable timeframe (generally, within 30 minutes).
3. 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.
4. 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.
5. 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. A 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 PLC representative or the facility's CEO designee or ED physician. Individuals qualified to serve as an AOC include the CEO, CFO, CNO, COO, CMO, ECO, VP Quality and other senior leaders reporting directly to the CEO. Other individuals who may be qualified based on experience include an ACFO, ACNO, Associate Administrator or similarly titled individuals. In general, a department director is not qualified to serve as an AOC. Additionally, 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 PLC 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 PLC 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.

REFERENCES:

Pre-PolicyStat Number: RI-POL-2.011.00

Approval Signatures

Step Description	Approver	Date
Board of Governors	Karen Beam: VP Quality	12/2024
Medical Executive Leadership	Misty Maddox: Dir Med Staff Svcs	11/2024
Senior Nursing Leadership	Lisa Roberson: Mgr Quality	10/2024
Senior Nursing Leadership	Karen Respess: Dir Regulatory Compliance	10/2024

Senior Nursing Leadership	Karen Beam: VP Quality	10/2024
Senior Nursing Leadership	Lori Feltner	09/2024
Senior Nursing Leadership	Amy Whipple: CNO Parkridge Valley Hosp	09/2024
Senior Nursing Leadership	Deborah Deal: CNO Parkridge Med Ctr	09/2024
Policy Owner	Kristi Delaney: ECO	09/2024

Applicability

TriStar Parkridge Medical Center

Status Active PolicyStat ID 16708696

Origination	08/2008	Owner	Kristi Delaney: ECO
Last Approved	12/2024	Policy Area	Ethics and Compliance
Last Revised	12/2024	Applicability	TriStar Parkridge Medical Center
Next Review	12/2027		

EMTALA — Tennessee Central Log Policy

SCOPE:

Organizational Wide

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.

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.
4. 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.
5. 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.
6. 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.

REFERENCES:

Pre-PolicyStat Number: RI-POL/PRO-2.009.004

Approval Signatures

Step Description	Approver	Date
Board of Governors	Karen Beam: VP Quality	12/2024
Medical Executive Leadership	Misty Maddox: Dir Med Staff Svcs	11/2024
Senior Nursing Leadership	Lisa Roberson: Mgr Quality	10/2024
Senior Nursing Leadership	Karen Respess: Dir Regulatory Compliance	10/2024
Senior Nursing Leadership	Karen Beam: VP Quality	10/2024
Senior Nursing Leadership	Lori Feltner	09/2024
Senior Nursing Leadership	Amy Whipple: CNO Parkridge Valley Hosp	09/2024
Senior Nursing Leadership	Deborah Deal: CNO Parkridge Med Ctr	09/2024
Policy Owner	Kristi Delaney: ECO	09/2024

Applicability

TriStar Parkridge Medical Center

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, Parkridge Medical Center, the Applicant, is part of Parkridge Health System and an affiliate of HCA Healthcare, one of the largest providers of healthcare and hospital services in the U.S. and U.K. With its local, statewide, and national affiliations, Parkridge Medical Center expects to be able to recruit highly qualified individuals with the appropriate licensure to staff and support the proposed FSED. Its success in this is shown in its experience.

Parkridge Medical Center also has the benefit of a Nurse Residency Program to garner future nurses to meet the growing need for personnel across its service area. Parkridge has had strong success integrating nurse residents into its existing ED and will utilize this talent pool for recruitment at the proposed FSED. Parkridge Medical Center has in place the clinical and administrative leadership needed to develop and operate the proposed FSED. Please see **Attachment 4C-1** for a list of Parkridge's clinical training affiliations.

TriStar Division of which Parkridge Medical Center is a part, and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. In 2021, HCA Healthcare opened the Galen College of Nursing in Nashville, 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. It graduated 45 nurses in its first year (2023) and is currently enrolling 700 new students each year. It expects estimated enrollment to increase 5 to 10 percent each year. This year, Galen College of Nursing expects to graduate approximately 250 graduates. It is HCA Healthcare's experience that 55 percent of the graduates join an HCA hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Division including recruitment for the proposed Cleveland FSED. TriStar Division is also committed to increasing its nursing residency programs.

In addition to Galen College of Nursing, Parkridge Medical Center offers clinical training programs with other schools in Tennessee and out of State. The Parkridge Cleveland FSED will benefit from these extensive nurse training relationships. The entire list is included in **Attachment 4C-1**. Tennessee schools, in addition to Galen, with which it has nurse training programs include the following:

- University of Tennessee at Chattanooga
- University of Tennessee Health Science Center
- University of Tennessee Knoxville
- University of Tennessee Martin
- Austin Peay State University
- Belmont University
- Cumberland University
- Lipscomb University
- Maryville University
- Middle Tennessee State University
- Tennessee State University
- Tennessee Technological University

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 is housed in a new building that had its ribbon cutting on April 29, 2024. The nearly 200,000-square-foot building is 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 consisting of experts from across the country and is currently recruiting additional clinical faculty. Its first class commenced in fall 2024. TriStar Division and HCA Healthcare are 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.

In addition to these programs for nurses and physicians, TriStar Division is extensively engaged with other educational and training programs throughout Tennessee. These relationships provide for internships and other training opportunities for students at TriStar Division facilities and also provide a pipeline for future qualified employees. Please see **Attachment 4C-1** for a list of Parkridge's clinical training affiliations which in addition to nursing include paramedic, respiratory therapy, sonography, surgical technology, pharmacy, PT, OT, ST, PA, echocardiography, cardiovascular technology, laboratory technician, social work, cardiac and vascular ultrasound, counseling, radiography, phlebotomy, radiology technician and CRNA, among others.

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 189 FSEDs nationally. HCA Healthcare operates its FSEDs as a department of a hospital and each FSED has all 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 physicians 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 Division'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, provide rapid transfer to a hospital chosen by the patient or by the emergency department physician's assessment of the best location for treatment.

As such, the Applicant has all the appropriate resources and is familiar with, and meets, all human resource requirements of the Health Facilities Commission / Licensure Division and the Joint Commission. The Applicant is licensed and accredited by these bodies.

Cleveland FSED Staffing

The staffing for the proposed Cleveland FSED is provided in response to **Question 8Q**. Please see **Attachment 1N, Criterion 14** for additional information regarding Parkridge Medical Center's successful recruitment and retention experience.

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.

	Year 1			Year 2	
Payor Source	**Gross Operating Revenue**	**% of Total**		**Gross Operating Revenue**	**% of Total**
Medicare/Medicare Managed Care	$ 13,211,000	23.6%		$ 17,547,000	22.6%
TennCare/Medicaid	$ 14,200,000	25.4%		$ 18,860,000	25.5%
Commercial/Other Managed Care	$ 17,680,000	31.6%		$ 23,482,000	32.2%
Self-Pay	$ 7,592,000	13.6%		$ 10,084,000	11.8%
Other: VA, Worker Comp, Champus	$ 3,311,000	5.9%		$ 4,398,000	7.9%
Total*	$ 55,994,000	100.0%		$ 74,371,000	100.0%
Charity Care	$ 5,848,576			$ 7,772,480	

Parkridge Medical Center participates in both Medicare and TennCare/Medicaid. As a satellite ED to Parkridge Medical Center, the proposed Cleveland FSED will be included in all state and federal revenue programs for the host hospital, Parkridge Medical Center, including Medicare and TennCare. Moreover, the proposed Cleveland FSED will be part of Parkridge Health System, and part of TriStar Division. 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. Parkridge Medical Center makes allowances for all persons who have income at less than 400 percent of the poverty level. And for those who are below 200 percent of the poverty level, personal responsibilities are written off in their entirety. Furthermore, 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 2024, Parkridge Medical Center wrote off approximately $125 million in charity care dollars.[12] Parkridge also 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 is reflected in the contractual allowance line and not shown as charity or bad debt. Please see **Attachment 4N-1** for the Uninsured Discount, Charity Care Write Off Policies and Discount Policy for Patients.

[12] Charity care for Parkridge Medical Center from its 2024 Joint Annual Report, page 22, lines A5a and A5b. 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.

Attachment 5C-1

Parkridge Medical Center License

License No. 66
No. Beds 621

State of Tennessee

Health Facilities Commission

Board for Licensing Health Care Facilities

This is to certify that a license is hereby granted by the Health Facilities Commission to PARKRIDGE MEDICAL CENTER, INC. to conduct and maintain an Hospital
PARKRIDGE MEDICAL CENTER, INC.
Located at 2333 MCCALLIE AVENUE, CHATTANOOGA TN 37404
County of HAMILTON, TENNESSEE.

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The license shall expire February 20, 2026 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 Health Facilities Commission, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the Health Facilities Commission issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State
this 19th day February, 2025.

GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL
STEMI-RECEIVING CENTER

By Caroline R Ayers, Esq. CHC
Director, Licensure & Regulation

By
Executive Director

HFC

Attachment 5C-2

Daniel M. Poor, MD Letter of Support

PARKRIDGE
HEALTH SYSTEM

ParkridgeHealth.com
2333 McCallie Avenue
Chattanooga, TN 37404
(423) 698-6061

11/18/2025

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: Parkridge Health's Cleveland ER Application

Executive Director Grant,

It is my privilege to serve as the regional director of emergency medicine at Parkridge Health System. Parkridge puts patients first, and I believe that this application is representative of our efforts to ensure that patients in this region have adequate access and choices when it comes to emergency care. Emergency healthcare access in Cleveland has not kept up with the growth of the population or the needs of the community. The proposed freestanding ER will reduce wait times, provide better access for rural populations just outside the city limits, and give patients a choice in where they get their emergency care.

Cleveland and Bradley County are growing. The aging population and strong industrial base make emergency care access points a critical and necessary piece of infrastructure. These residents deserve to know that high-quality emergency care is nearby. The proposed ER will also serve parts of Polk County, where many residents face 45-minute travel times to get to the nearest ER. 25% of Polk County residents are 65 and older. It is critical that these residents get the emergency care access that they need.

Parkridge Health System owns and operates other freestanding ERs in the region that have been extremely beneficial to the communities they serve. The Camp Jordan, Soddy Daisy, and Parkridge North ERs all provide lifesaving care, improve access, and cut wait times. I have no doubt that the Cleveland ER would improve the healthcare landscape in Cleveland and provide world-class care for the area.

For these reasons, I urge this commission to approve the Parkridge Cleveland ER. This ER will serve as a critical access point for rural patients and provide a growing county with options for ER care.

Sincerely,

Daniel Poor, MD
Regional Director of Emergency Medicine | Parkridge Health System
2333 McCallie Ave,
Chattanooga, TN 37404

Attachment 5C-3

2023 QAPI Plan

Status: *Active* **PolicyStat ID:** *17324842*

Origination: *01/2016*
Last Approved: *02/2025*
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Owner: *Karen Beam: VP Quality*
Policy Area: *Leadership Plans - Annual*
References:
Applicability: *TriStar Parkridge Medical Center*

Plan for Improvement of Organizational Performance and Clinical Excellence 2025

MISSION AND VALUES

Mission:

Above all else, we are committed to the care and **improvement of human life**. In recognition of this commitment, we strive to deliver high quality, cost-effective healthcare in the communities we serve. In pursuit of our mission, we believe the following value statements are essential and timeless:

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect, and dignity.

Parkridge Medical Center, Inc. is committed to the comprehensive delivery of high quality and safe healthcare to the residents of the greater-Chattanooga area. Thus our employees, caregivers and leaders have defined the following as our mission.

PHILOSOPHY/OBJECTIVES/SCOPE OF SERVICES

PHILOSOPHY

The Performance Improvement Program's underlying philosophy:

- Utilizes principles of industrial quality measurement based on data collection, objective analysis, and results dissemination.
- Offers facility leaders, medical staff and facility staff objective information, which they can use for purposes of review, patient management, and quality measurement.
- Facilitates activities that are collaborative and interdisciplinary in order to respond to the needs of the patient, physician, staff and community.
- 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 achieve clinical excellence, preserve and/or 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, is delivered within the dimensions of performance (as follows), documented to facilitate evaluation and effective communication and is continuously evaluated and improved.

- Doing the Right Thing
- Efficacy – accomplish the desired outcome
- Appropriateness – relevant to the needs of the patient
- Doing the Right Thing Well
- Availability to meet the patients' needs
- Timeliness – in a safe and timely manner
- Effectiveness – consistent with achievable goals
- Continuity of Services – within the range of available resources
- Safety
- Efficiency - in a cost-efficient manner as possible
- Respect and Caring – patient/designee involved in care decisions

C. A system in which the same 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 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 and patient expericen. (patients/family/ community, physicians, employees).

LEADERSHIP'S ROLE AND RESPONSIBILITY FOR IMPROVEMENT OF ORGANIZATIONAL PERFORMANCE

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 also are 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 methods of Performance Improvement.

BOARD OF GOVERNORS

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:

- Receive, review and accept/reject, periodic reports on findings, conclusions, recommendations, actions and results of program activities.
- Assess the program's effectiveness and efficiency and require modification in organizational structure and systems where necessary to improve program performance.
- Provide for resources and support systems for Performance Improvement functions related to patient care.
- Verify that the overall goal of patient care enhancement is being achieved.
- Require a process designed to assure that all individuals responsible for the assessment, treatment or care of patients are competent.

MEDICAL EXECUTIVE COMMITTEE

A. The Medical Executive Committee of the Medical Staff is accountable to the Board of Governors 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 Governors.

B. The Medical Executive Committee shares the responsibility for the operations of the monitoring and evaluation functions with the Medical Staff 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 appointment and reappointment to the Medical Staff.

SENIOR LEADERSHIP

Senior Leadership, through the Chief Executive Officer (CEO) and Medical Staff Committees is accountable to the Board of Governors for the quality and performance of care provided. The CEO will:

- Promote the participation of the appropriate members of professionals and technical staffs and departments in the program through interdisciplinary monitoring and evaluation of patient care activities through the Quality Department.
- Establish and maintain operational linkages between Risk Management, Patient Safety, and Performance Improvements functions.
- Assure that sufficient resources and personnel are provided to support Performance Improvement activities and that staff are provided adequate time to participate.

QUALITY MANAGEMENT DEPARTMENT

Senior Leadership will provide adequate resources to conduct Quality and Performance Improvement functions. These resources will be directed through the Quality 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.

B. Reports of changes in regulations, laws, and accreditation standards to Senior Leadership, Medical Staff

and hospital staff.

C. Conduct data retrieval functions and aggregate Performance Improvement findings for presentation to Board of Governors, Medical Staff, Senior Leadership and hospital staff.

D. The Market VP Quality will be responsible for ensuring that appropriate actions are implemented within established time frames.

E. The Market VP Quality or his/her designee will attend meetings including, but not limited to Board of Governors, Medical Executive Committee, Credentials Committee, Senior Leadership Committees, Medical Staff Committees, Peer Review Committee, Infection Prevention, Pharmacy and Therapeutics, Utilization Management, Environment of Care, and Patient Safety Committee.

PLAN

Parkridge Medical Center Inc. 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

Parkridge Medical Center Inc. will utilize proven Performance Improvement tools and methodologies in its improvement efforts. Our primary Improvement Model will be Focus PDCA.

Find a process to improve

Organize a team that knows the process

Clarify the current knowledge of the process

Understand the causes of process variation

Select the process improvement

Plan the improvement and continued data collections

Do the improvement, data collection and analysis

Check and study the results

Act to hold the gain and to continue to improve the process

Senior 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. Opportunities involving large scale and complex inter-departmental processes are reviewed, prioritized and resourced through the, the Quality Department with representatives from Clinical Departments, Ancillary Departments, Quality, Risk, Medical Staff and Senior Leadership. Additionally, the Corporate and Division Performance Improvement Team are facility partners utilizing an approach that is data-driven and organizationally structured to deliver solutions designed to assist in improving quality, increasing efficiency and reducing costs. Facility Teams and Performance Improvement Resources are aligned to support improvements in patient care, surgical services, general support and ancillary services. As a part of the Performance Improvement Team, Subject Matter Experts (SMEs) bring in-depth knowledge and best demonstrated practices to clinical and operational areas to drive change within the organization. Lean Specialists assist in building a performance improvement culture, while Performance Improvement Team

leaders facilitate the implementation of action plans and engagement with project management and financial tracking. This collaborative approach supports the commitment to deliver high-quality, cost-effective healthcare in the community in which we serve.

ORGANIZAIONAL WIDE PRIORITIES

Priorities for hospital-wide Clinical Excellence and Performance Improvement activities at Parkridge Medical Center Inc. will be designed to provide clinical excellence, improve processes and improve patient outcomes. These priorities will be developed by Senior Leadership and the Quality Department, with participation of all hospital disciplines, and approved by the Medical Executive Committee and Board of Governors. 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

2025 Clinical Excellence and Performance Improvement Priorities:

In addition to the ongoing improvement activities outlined by the clinical excellence and performance improvement indicators, the organization has identified strategic initiatives in Exceptional Clinical Quality and Unparalleled Patient Services. These strategic initiatives were developed from review of trends in quality improvement data, current industry literature and proactive initiatives derived from our mission and values statements.

A. Achieve and maintain metrics for Quality Construct at or better than goal.
B. Achieve and maintain full accreditation and certifications.
C. Hospital Acquired Infections: Aim for Zero – Reduction in rates r/t CLABSI, CAUTI, MRSA, SSI Colo / Hyst and CDiff.
D. Overall CHOIS Analytics mortality rate at or below goal of 0.72
E. Overall CHOIS Analytics complication rate at or below goal of 0.66
F. CMS Sep 1 Bundle Compliance at or above goal 73%
G. Cardiac Services Metrics of Isolated CABG Mortality, PCI Mortality and TAVR Mortality at or below goal. Obtain and maintain STS 3 star rating for CABG.
H. ED Services Metrics of SEP POA 1 Hr Antibiotics, SEP 3 hour bundle and Stroke D2N at or above goal
I. PEH OB Services Metrics of NTSV C-section rate, PPH rate and Unexpected complications at or better than goal.

Reprioritizing:

The priorities may be re prioritized periodically in response to unusual or urgent events such as those identified through PI 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 unusual 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, 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. Senior Leadership and Leaders 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.

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. Measures of both processes and outcomes

B. Measures of patient safety issues incorporated into the monitors

C. Measurement of high volume, high risk, and problem prone processes/outcomes

D. Identify areas for focused or targeted data collection

E. Establish a performance baseline

F. Comparison of outcomes to external databases, when available, as appropriate

G. Measures will focus on sustaining improvement

MEDICAL STAFF MONITORING, EVALUATION AND ACTION

A. The Medical Staff is responsible for participating in interdisciplinary ongoing physician practice evaluation and focused physician practice evaluation. Medical staff responsibilities include, but are not limited to:

   1. Participate in identification of interdisciplinary indicators, collect data for each indicator, reach conclusions, make recommendations and initiate actions.
   2. Communicate findings, conclusions, recommendations and actions to Peer Review Committee, Credentials Committee and Medical Executive Committee.
   3. Assess the effectiveness of actions and document improvement in patient care.
   4. Participate on Performance Improvement Teams.
   5. Work collaboratively to review and evaluate the Performance Improvement findings.

B. All Performance Improvement activities related to the Medical Staff will be reported to the appropriate Medical Staff Committee and the Medical Executive Committee. The Medical Executive Committee is responsible for participating in and evaluation of Medical Staff Performance Improvement activities and these are reported to the Board of Governors.

C. When findings are relevant to an individual Medical Staff Member's performance the peer review process will be utilized, whether it is trended analyzed data or case by case as defined in the peer review policy and medical staff rules and regulations.

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:

- Collected data are aggregated and analyzed
- Data are aggregated at the frequency appropriate to the activity or process being studied.
- Statistical tools and techniques are used to analyze and display data
- Data are analyzed and compared internally overtime and externally with other sources of information when available (benchmarking)
- Comparative data are used to determine if there is excessive variability or unacceptable levels of performance when available.

Intensive analysis is conducted when performance varies significantly or is undesirable from recognized standards, when unusual events occur or when trends vary significantly from expectations. This includes but is not limited to confirmed transfusion reactions, significant adverse drug events/reactions, medication errors, or adverse anesthesia events.

When findings are relevant to an individual hospital staff member's performance the Department Director/ Manager will review the information and develop an improvement strategy as defined in the Human Resources policies and procedures.

Reference Databases

The hospital utilizes 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.

Other comparative databases used by Parkridge Medical Center, Inc. include but are not limited to:

- NHSN national databank with the CDC
- American College of Cardiology – Cath/PCI and ICD
- Getting with the Guidelines
- HCAHPS – Patient Satisfaction
- ORYX
- COMET – outcomes measurement for core measures
- American College of Radiology
- American College of Pathology
- American Association of Blood Banks
- Leapfrog
- Vermont Oxford Network
- Society of Thoracic Surgeons
- Agency for Healthcare Research and Quality
- Centers for Medicare and Medicaid Service
- American College of Surgeons Commission on Cancer

- CHOIS Analytics
- HCA Corporate Dashboards for Clinical Excellence

ACTIONS FOR IMPROVEMENTS

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 based on the following factors:

A. Opportunities to improve processes within the important functions.

B. Results of Performance Improvement activities.

C. Resources needed to improve.

D. Organization's mission and priorities.

Opportunities to improve care may be referred to Quality from the following sources:

- Patients/ Families/Community Members
- Board of Governors
- Medical Staff/ Credentialed Practitioners
- Employees/Volunteers/Students/Vendors
- Senior Leadership
- Committees
- Corporate or Divisional Office
- Risk Management Activities

Once results have been evaluated and the decision is made that improvement is necessary, the Quality Department in conjunction with Senior Leadership, Department Directors, Medical Staff and staff will determine actions to be implemented for the improvement. These actions are:

A. Tested on a trial basis

B. Effectiveness is evaluated using the dimensions of performance

C. If not effective, a new action will be taken and may include the formation of PI Team

D. Full implementation

PERFORMANCE IMPROVEMENT TEAMS

The hospital may utilize Performance Improvement teams to study processes which occur in the hospital, design new processes, and to make improvements. The Performance Improvement Teams are interdisciplinary and include members from all involved departments and Medical Staff members, as necessary. The following factors assist in determining when to use a team:

TEAM DECISION	INDIVIDUAL MANAGER'S DECISION
• The need exists to combine old and new information - requires brainstorming, data-gathering, and innovation	• No need for extensive data-gathering

• The situation doesn't require an immediate solution • Consensus is needed to make the solution work • When the problem is a process problem • When the process crosses departmental boundaries • When the process seems to be very complex	• Quick decision is required • Consensus is not needed • When the problem is a people or performance problem

The Performance Improvement Teams are groups of people who work together for a common objective. The teams identify processes or problems needing improvement, study the processes methodically to improve them by eliminating root causes of problems. Team meetings will be conducted as often as determined necessary by the team to work on the process. Each team will have a team leader/facilitator. Department Directors and Managers will encourage employees to serve on Performance Improvement Teams as needed for Performance Improvement functions.

MANAGEMENT OF INFORMATION

A. INFORMATION SYSTEMS

The hospital utilizes a number of systems to assist in the management of information for the Performance Improvement 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 Department.

INTEGRATION OF RISK MANAGEMENT/PATIENT SAFETY

RISK MANAGEMENT

In order for this Plan to be effective, it is essential that Risk Management/Patient Safety functions be integrated with the Performance Improvement functions. Integration of Risk Management/Patient Safety functions will be accomplished through the following:

1. Risk Management and Patient Safety reports will be presented to the appropriate committees at a minimum of quarterly, including but not limited to occurrence data trends and grievance trends.
2. Life Safety, Security and Environment of Care trends will be presented to the EOC committee as appropriate.

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 Parkridge Medical Center Inc. or outside agencies that are involved in the review process will be made aware of the responsibility. All data shall be considered the property of Parkridge Medical Center Inc. and the hospital shall ensure the maximum protection of all confidential data, including any findings, and recommendations or actions.

The Plan for Improvement of Organizational Performance and Clinical Excellence of Parkridge Medical Center, Inc. is established based on the facilities professional review function and is designed to comply with TJC standards, applicable federal and state laws, including HIPPA 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 facilities, all information relative to the Plan for Improvement of Organizational Performance and Clinical Excellence 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 of 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 Clinical Excellence is evaluated annually to determine the effectiveness of the plan in meeting the objectives. A report of the evaluation is provided to the Medical Executive Committee and the Board of Governors. 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 a 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.

DEFINITIONS:

Action Plan – the product of analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, timelines, and strategies for measuring the effectiveness of the actions.

Peer Review – the concurrent or retrospective review of an individual's qualifications and competence, including thorough clinical professional review activities. Peer review activities are conducted to determine whether an individual may have Medical Staff membership or clinical privileges to determine the scope and conditions of membership. Peer review is more completely defined by the Tennessee Peer Review law of 1967 (TCA 63-6-219).

Provider – any person furnishing medical or healthcare services

Significant Medical Error – an unexpected occurrence, within the control of the provider that has an untoward effect/outcome.

Performance Improvement Tools and Techniques:

Problem Solving – structured processes for acquiring and analyzing data in a way that will identify the root cause of quality problems and remove or reduce those causes. Problem statements are a description in specific and measurable terms of how a particular deficiency affects the quality of an organization.

Brainstorming – is a group technique for generating new, useful ideasw; it uses a few simple rules for discussion that increase the changes for originality and innovation.

Multi – voting - a method by which a group or combination of groups determine the relative importance of a quality improvement need; focuses on proposed solutions.

Consensus – a technique by which quality improvement group members discuss proposed actions and agree upon a direction/solution to the area of identified concern.

Cause and Effect Diagrams – a way to organize theories about the causes of a problem.

Flow Diagrams – graphic representations of the sequence of steps needed to produce some output.

Control Charts - graphic representation of data which includes an expected standard of quality.

Histograms – graphic summary of the variation in a set of data.

Pareto Charts – graphic display in ranked comparison of factors related to a quality problem which separates the vital few from the useful many.

Scatter Diagrams – graphic representation of the observed relationship between two variables.

Trend Charts – graphic representation of quality over time.

Storyboarding – visual display of the activities and results achieved by a quality improvement team.

Attachments

PI Plan 2019.pdf

Approval Signatures

Approver	Date
Karen Beam: VP Quality	02/2025
Karen Beam: VP Quality	01/2025

Applicability

TriStar Parkridge Medical Center

Current Status: *Active* **PolicyStat ID:** *11680298*

Origination:	*08/2015*
Last Approved:	*08/2022*
Last Revised:	*08/2022*
Next Review:	*08/2025*
Owner:	*Deborah Hopcroft: Dir Patient Safety/Risk Mgmt*
Policy Area:	*Patient Safety - PSO*
References:	
Applicability:	*TriStar Parkridge Medical Center*

Patient Safety Serious Event Analysis

SCOPE:

This policy applies to HCA PSO member facilities (including, but not limited to, hospitals, ambulatory surgery centers, imaging centers, free-standing emergency centers, free-standing psychiatric facilities and physician practices) that have executed an HCA PSO Provider Agreement.

PURPOSE:

The policy provides direction to the facility on identification, notification and management of patient serious safety events. The policy will provide guidance to the facilities on :

- Identification
  - Identify patient events meeting the criteria to be considered a serious safety event
- Notification
  - Initiate internal and external communication of patient serious safety event occurrences in a timely and appropriate format
  - Manage the disclosure process
- Management
  - Perform a thorough and credible patient serious safety event analysis
  - Identify and understand the factors that contributed to the event (such as human factors, communication, technology, culture or underlying process failures)
  - Improve the facility's culture, systems, and processes with the intent to prevent recurrence and improve safety systems

POLICY:

Parkridge Medical Center, Inc. "facility" will utilize this policy following identification of a patient serious safety event. Once identified, the facility will utilize JIRA SSE to initiate notifications. The standardized HCA PSO event analysis framework will be utilized as the primary mechanism for patient serious event analysis. Patient-related serious event analyses are reported to HCA PSO as Patient Safety Work Product (PSWP).

Facility will first focus on care of the patient, the patient's representative/family and/or support person and then any impacted staff. Dr. Thomas Frist, Sr., HCA's founder, always demonstrated putting the patient first in his daily practice and was quote3d as saying, "Put the patient first and the rest will follow". Implement stabilization treatment, increase monitoring and notify the patient's physician for any change in treatment plan.

All staff involved in a Serious Safety Event should be treated as a potential Second Victim. Their care should be a priority after the patient's representative/family and or support person needs are met and stabilized. Support strategies for Second Victims should be implemented as soon as possible after the event. Second Victim strategies are not within the scope of this Policy. Facility-specific policies will address employee assistance and/or other crisis intervention resources. In addition, medical staff policies should be address health issues within the medical staff.

PROCEDURE:

Identification

- The Facility Chief Executive Officer (CEO) or Administrator, in consultation with the Chief of the Medical Staff or Chief Medical Officer, has the primary responsibility for determination if an event qualifies as a serious safety event and to ensure that discloser occurs with the patient/patient's representative/family and /or support person.
- A patient serious safety event is a safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm.
    - Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a light-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

Patient serious safety events are a subcategory of adverse events. An event can also be considered a patient serious safety event even if the outcome was not death, permanent harm, or severe temporary harm but, indicative of serious process gaps that suggest the facility is at risk for future harm events. In addition to the above definition, the list below contains some events that meet the criteria for patient serious safety events; however, this list is not all inclusive:

- Suicide of any patient receiving care, treatment, and services in a staffed around the clock care setting or within 72 hourse of discharge, including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infact
- Discharge of an infant to the wrong family
- Death or serious injury associated with medication error involving wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong round of administration
- Death or serious injury related to physical restraints or bedrails
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around the clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
- Death or serious injury of patient or staff associated with the introduction of a metallic object into the MRI area
- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilites,† hemolytic transfusion reactions, or transfusions resulting in severe temporary harm, permanent harm, or death
- Rape, assault (leading to death, permanent harm or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor whole on site at the hospital
- Death or serious injury resulting in delay of care
- Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient

- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology or radiology test results
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose > 1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the hospital. To be considered a serious safety event, equipment must be in use at the time of the event; staff do not need to be present
- Any intrapartum (related to the birth process) maternal death or severe maternal morbidity
- Fall resulting in any of the following: any fracture; surgery, casting, or traction; required consult/ management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liber laceration) injury; or a patient with coagulopathy who received blood products as a result of the fall; death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the

Notification

Internal

- Facility employees will:
  - notify their supervisor
  - enter event into the event reporting system
- If serious safety event:
  - Supervisor will immediately notify patient safety/risk management
- Patient Safety/Risk Management
  - will notify executive leaders
  - activate the serious event response team within sixty (60) minutes of discovery of the event when possible to:
    - ensure patient care and second victim needs are met
    - begin preliminary fact finding investigation
    - identify the appropriate next actions
    - coordinate all communications
    - assign responsibility for the initial communication with the patient and/or the patient's representative/family and/or support person

External

- Patient Safety/Risk Management will utilize the JIRA SSE notification link to provide initial relevant facts to the Division. This notification should not include any analysis or other information that might be Patient Safety Work Product (PSWP).
- Division will review the SSE notification and approve or decline the report.
  - If approved, notification automatically goes to appropriate parties vis JIRA
  - If declined, notification goes to facility Patient Safety/Risk Management
    - where it can be resubmitted for content revision, if appropriate, or
    - is determined not to be a serious safety event in consultation with Division and facility leaders
- Division and Corporate leaders who receive the SSE notification should understand this is an initial event notification only and should not contain any analysis. The facility will need time to conduct a thorough, credible event analysis.

- Following notification, if additional information is needed, analysis and PSWP may be shared via email with 'CONFIDENTIAL PSWP' in the subject line
- All reporting requirements for mandatory or voluntary notifications of state and federal law enforcement, and regulatory/accrediting agencies should be completed within the agencies' specified timeframes.

Manage the Disclosure process

A. When a SSE has occurred, the Facility CEO, or Administrator (or, in their absence, their designee, per Facility Policy) makes the initial decision to activate the disclosure process to inform the patient/patient's representative/family and/or support person about the event.
    1. If the Facility CEO or Administrator, after consultation with the Chief of the Medical Staff or Chief Medical Officer, questions applicability of this Policy as related to the event identification, the DCMO or DVPQ should be consulted.

B. Share event information with the patient and/or patient's representative/family and/or support person (individual identified as the legally responsible Patient Representative or decision maker):
    1. Convene a multidisciplinary meeting to:
        a. review the facts surrounding the SSE
        b. assign disclosure participants and responsibilities
            i. presenter (who may or may not be the patient's physician)
                a. should be able and fully prepared to answer or readily obtain an answer for any questions the patient and/or patient's representative/family and/or support person may have about the event
            ii. point of contact for ongoing patient communication and/or follow up given that causal information can become available over time
    2. At least one Facility representative should be present during disclosure.
    3. Conduct initial disclosre as soon as possible after the determination of the serious safety event occurrence.
        a. Do not delay for coroner's investigation or other information that may shed light on causality, but rather explain that more information may be forthcoming.
    4. Disclosure should:
        a. occur in a place appropriate for exchange of confidential clinical information
        b. include discussion of the unanticipated outcome of care, treatment and services
        c. include an apology
        d. allow adequate time for the disclosure to include questions and concerns by patient and/or patient's representative/family and/or support person
        e. provide communication and/or language assistance to patients and.or patient's representative/ family and.or support person who have limited English proficiency and.or other communication needs at no cost to them, and in their preferred language in a manner that they can understand
        f. be documented in the medical record and include:
            i. Names of those present during the disclosure, including language interpreter if needed
        g. occur not only at the time of the event but as a component in ongoing support, resolution, and

improvement processes

C. Large scale and or multi-patient disclosure should:
    1. Confer with Division and Corporate Leadership to develop a plan for disclosure as well as external notification in special circumstances that may have affected multiple patients, such as failures associated with sterilization, contamination of endoscopic devices, etc.
D. If a serious safety event is identified after the patient has been discharged, the same disclosure process should occur

Management

Perform a thorough and credible patient serious safety event analysis

A. A serious safety event analysis will be conducted on all serious safety events as defined above.
B. Facility may choose to also conduct a serious safety event analysis for near miss/close calls and other events/unsafe conditions
C. Facility will use the assigned HCA Healthcare framework for completing serious safety event analysis on events that meet the criteria for patient serious safety events
D. To have an efficient and effective event analysis, consider:
    1. Designating an executive team member to provide time, resources, and financial support
    2. Designating trained and competent facilitators
    3. Assigning and completing pre-work, e.g. timeline, securing/reviewing applicable documents, meeting logistics, best practice research
    4. Assigning appropriate people to the analysis team; enough, but not too many
    5. Establishing team rules as a team efficiency strategy
    6. Focusing non-confrontational interviews on the cognitive tasks and decisions of those involved. For example,
        a. What was the individual focusing on at the time of the incident occurred?
        b. What scenario did the person believe he or she was dealing with?
        c. How did the person's understanding change as the event progressed?
        d. Assessing whether or not a different person could have made the same error under similar circumstances
        e. The serious safety event analysis preliminary assessment, to include the nature of the event and initial contributing factors, will be completed within five (5) business days of the event occurrence or identification by the facility. While acknowledging that some information may still be required to fully understand and finalize the event analysis, by the end of five (5) business days, the facility should be prepared to discuss the current understanding of principal contributors with facility, division, and corporate leaders.
        f. For the event analysis process to be successful, it is critical that it is supported by all levels of the organization, including the Board.

Identify and understand the factors that contributed to the event (such as human factors, communication, technology, culture, or underlying process failures

A. Focus on work as staff actually perform it; encourages organization learning
B. Delve deeply into events; seek contributing factors that reflect deeper systems issues
C. Minimize hindsight bias by understanding the contest and seeing things from the perspectives of the people involved as they unfold.
D. Do not underestimate the impact of conflicting goals on the day-to-day work of staff
E. Use trigger questions and team generated open ended questions
F. Recognize human error is not an acceptable root cause; human error is inevitable
G. Consult with expertise outside of the analysis team when indicated

Improve the facility's culture, systems, and processes with the intent to prevent recurrence and improve safety systems

A. Develop actions to eliminate or control the system hazards or vulnerabilites identified as contributing factors
B. Consult outside resources when developing action plans
C. Establish stronger or intermediate strength actions; avoid stand alone weaker actions such as training or policy changes
D. Implement established actions
    1. Assign one individualresponsible for each action
    2. Set a date for when the action must be completed
E. Monitor implementation, effectiveness, and sustainability of actions
F. Act when monitoring indicates actions are not effective and/or sustained

It is essential that involved staff as well as involved patients/families are provided feedback of the findings and be given the opportunity to comment on whether the proposed actions make sense to them.

Feedback to the organization as a whole is also essential to create a culture of safety and shared learning

Report Management

A. Use the executive summary to communicate the team's final event analysis to senior leadership. The executive summary is considered PSWP.
B. A non-PSWP summary is also available for use.

Submission to HCA PSO and Storage of PSWP

A. Event analysis documents should be marked with statutory language and designated as PSWP
B. Any supporting documents declared as PSWP will be appropriately maintained in the facility PSES.
C. The HCA Healthcare framework for completing serious safety event analysis should be within thirty (30) business days and submitted to the HCA PSO PSES teamroom.

REFERENCES:

American College of Obstetricians and Gynecologists. (2019). ACOG618: Disclosure and Discussion of Adverse Events. Washington, DC: American College of Obstetrics and Gynecologists.

Conway J, Federico F, Steward K, Campbell MJ. Respectful managemtn of serious clinical adverse events, 2nd ed. IHI Innovation Series white paper [after login]. Cambridge (MA): Institute for Healthcare Improvement; 2011

Developing corrective action plans: the do's and don'ts [webinar]. 2014 May 19 [cited 2018 Jan 26]. https://www.ecri.org/components/PSOCore/Pages/Mtg051914.aspx

National Quality Forum. (2016). Topics: Serious Reportable Events. Retrieved from National Quality Forum: https://www.quality forum.org/topics/sres/serious_reportable_events.aspx

National Patient Safety Foundation. Lucian Leape Institute. Shining a light: safer health care through transparency. Boston (MA): NPSF; 2015. Retrieved from: https://www.ihi.org/resources/Pages/Publications/Shining-a-Light Safer-Health-Care-Through-Transparency.aspx

The core competencies of organization learning.[cited 2018 Jan 26]. https://www.solonline.org/organization-learning/

The Joint Commission (TJC). (2020). The Joint Commission Sentinel Event Policy

HCA PSO Event and Close Call Reporting Policy

Facility PSO Operating Policy and Procedure

Pre-PolicyStat Number: PS-POL/PRO-1.017.001

Attachments

No Attachments

Approval Signatures

Approver	Date
Karen Beam: VP of Quality	08/2022
Darla Pendergrass: Mgr Med Staff Svcs	07/2022
Karen Beam: VP of Quality	06/2022
Karen Respess: Dir Regulatory Compliance	05/2022
Nancy Toth: Asst CNO	05/2022
Amir Hamad: CNO Parkridge East Hosp	05/2022
Amy Whipple: CNO Parkridge Valley Hosp	05/2022
Lori Feltner: Asst CNO	05/2022
Deborah Deal: CNO	05/2022
Lisa Roberson: Risk/Safety Director	05/2022
Lisa Roberson: Risk/Safety Director	05/2022

Approver	Date
Deborah Hopcroft: Mgr Risk	05/2022

Applicability

TriStar Parkridge Medical Center

Attachment 5C-4

Staff Education Policies

Education and Training Policy

Index

Policy - Education and Training - HR.LD.003

ORGANIZATION UNIT (DEPARTMENT):

Human Resources

PAGE: 1 of 2

POLICY DESCRIPTION:

Education and Training

REPLACES POLICY DATED:

1/1/15

EFFECTIVE DATE: May 1, 2015

REFERENCE NUMBER:

HR.LD.003

DIVISION/LOB/ENTERPRISE: Enterprise-Wide

SCOPE:

Applies to volunteers, contract staff, and colleagues excluding employee groups listed as "At Will" in the Limitations on Employment policy **HR.ER.019** and colleagues with a written employment agreement.

PURPOSE:

To outline training opportunities for colleague development and provide guidelines for acquiring and maintaining required training as defined by his/her job description

DEFINITIONS:

1. **Training and Ongoing Education:** Training and ongoing education topics offered by the business entity are based on orientation and job training needs, safety concerns, quality improvement findings, new equipment or technology, new policies and procedures, and individual or group self-identified learning needs. Assessment of training designated as mandatory by the business entity, and the skills associated with the training, may be part of the competency assessment; reference Competency Assessment policy **HR.LD.001**.

2. **Regulatory Training:** The business entity provides specific training annually to meet regulatory requirements and the standards established by the business entity.

RESPONSIBILITIES:

1. Business entity:

a. The business entity identifies a role that has primary responsibility for the oversight and design of ongoing education and training programs to meet regulatory standards as well as the needs of the population served and services offered.

b. It is the business entity's responsibility to define and execute a strategy to continually monitor the education and training needs of staff to address competency gaps and job performance deficiencies.

Development may include clinical, patient care, managerial, leadership, technical, computer, and safety topics.

c. The business entity has the responsibility to ensure education and training requirements defined in job descriptions are in good standing.

2. Colleagues:

a. All colleagues are responsible for attending business entity, position-specific, or regulatory training deemed mandatory by their manager or administrative personnel.

b. For outside training or seminars, all colleagues are responsible for obtaining prior approval from their manager or designee and for recording attendance on an in-service record.

c. Colleagues who are interested in pursuing educational opportunities toward a degree should consult with their manager or HR Business Partner for information on programs available through the business entity; reference Educational Reimbursement policy **HR.TR.002**.

REQUIREMENTS:

Education and training documentation should be maintained as part of the "Approved List" in the colleague record; reference Employee Records policy **HR.WF.001**.

TIME REPORTING:

1. Time spent attending lectures, meetings, and training programs need not be counted as hours worked, provided the following conditions are met:

a. The meetings are held outside working hours.

b. Attendance by the colleague is voluntary. Attendance is not voluntary if the colleague is led to believe that non-attendance would adversely affect his employment.

c. The course, lecture, or meeting is not directly related to the colleague's job.

· Training is directly related to a colleague's job if it is designed to make them more effective in the present job, not if it teaches a different job.

d. If a colleague, on their own initiative, attends school, college, or trade school after hours, that time is not hours worked even if the courses are job-related.

DISCLOSURE:

If there is any conflict between the information in this policy and a Collective Bargaining Agreement (CBA), the CBA prevails for covered colleagues.

REFERENCED POLICIES:

1. Education Reimbursement, HR.TR.002

2. Job Descriptions, HR.LD.004

3. Licensure Verification, HR.ER.018

4. Certification, Verification, and Renewal, HR.ER.041

5. Competency Assessment, HR.LD.001

6. Limitations on Employment, HR.ER.019

7. Code of Conduct

8. TJC HR Standard, HR.01.05.03: Staff participate in ongoing education and training

WORK INSTRUCTIONS:

1. Documentation and roster maintenance

2. Ongoing educational needs assessment

PROCESS MAPS:

1. To be completed at a future date

Referenced Policies

Job Descriptions Policy

Licensure Verification Policy

Limitations on Employment Policy

Competency Assessment Policy

Attachment 2Q-1

The Joint Commission and Other Accreditations

Parkridge Medical Center, Inc.

Chattanooga, 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

September 30, 2023

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #7815
Print/Reprint Date: 01/05/2024

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

Parkridge Medical Center

Chattanooga, 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.

December 20, 2024

Certification is customarily valid for up to 24 months.

Michael Suk, MD, JD, MPH, MBA, FACS
Chair, Board of Commissioners

ID #7815

Print/Reprint Date: 02/24/2025

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

Parkridge Medical Center

Chattanooga, 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.

December 4, 2024

Certification is customarily valid for up to 24 months.

Carlos A. Pellegrini, MD, FACS
Chair, Board of Commissioners

ID #7815

Print/Reprint Date: 12/13/2024

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.

COLLEGE of AMERICAN PATHOLOGISTS

CERTIFICATE OF ACCREDITATION

Parkridge Medical Center
Respiratory Care Laboratory
Chattanooga, Tennessee
Eugene G. Fong, MD

CAP#: 1574302
CLIA#: 44D0705108

The organization named above meets all applicable standards for accreditation and is hereby accredited by the College of American Pathologists' Laboratory Accreditation Program. Reinspection should occur prior to **February 22, 2026** to maintain accreditation.

Accreditation does not automatically survive a change in director, ownership, or location and assumes that all interim requirements are met.

Kathleen G. Beavis, MD
Chair, Accreditation Committee

Donald S. Karcher, MD, FCAP
President, College of American Pathologists

CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

CERTIFICATE OF ACCREDITATION

LABORATORY NAME AND ADDRESS

PARKRIDGE MEDICAL CENTER
RESPIRATORY CARE LABORATORY
2333 MCCALLIE AVE
CHATTANOOGA, TN 37404-3258

CLIA ID NUMBER

44D0705108

EFFECTIVE DATE

08/06/2025

LABORATORY DIRECTOR

DR. EUGENE G. FONG

EXPIRATION DATE

08/05/2027

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

Gregg Brandush, Director
Division of Clinical Laboratory Improvement & Quality
Quality & Safety Oversight Group
Center for Clinical Standards and Quality

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	LAB CERTIFICATION (CODE)	EFFECTIVE DATE
CHEMISTRY - ROUTINE CHEMISTRY (310)	10/21/2011		
CHEMISTRY - TOXICOLOGY (340)	10/21/2011		

PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.
FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA.

7Q Text Attachment

The foregoing responses are made with respect to facilities within the TriStar Division, which includes the Applicant. The Applicant made a good faith effort to respond to these questions regarding the entities identified in the organizational chart for direct upstream ownership of the Applicant, to the best of its knowledge, information, and belief, as well as other TriStar Division facilities. Due to the breadth of the questions and lack of definition of key terms, the Applicant cannot represent these responses are totally comprehensive, but no responsive information is being intentionally withheld. The Applicant assumes for the purpose of the first question that “state licensure action” refers to facility licensure. The Applicant has not been the subject of a Final Order or Judgment in a state licensure action. The other entities in the chain of ownership do not hold a hospital license.

Because of the breadth of the term “regulatory action,” and the potential scope as including matters completely unrelated to healthcare, Applicant interprets the last question to be asking about “any healthcare regulatory or criminal action.” Using that definition, neither Parkridge Medical Center nor any of its upstream entities are the subject of any pending healthcare regulatory or criminal action.

Project Name : Parkridge Medical Center

Supplemental Round Name : 1 **Due Date :** 12/10/2025
Certificate No. : CN2511-040 **Submitted Date :** 12/3/2025

1. **1E. Overview**

What are wait time for emergency care at BMC currently?

What percentage of total out-migrating patients are travelling from the proposed service area to a Parkridge system facility for emergency services?

Where are the major population centers in the proposed service area located? Please identify specific towns, cities, or neighborhoods for reference.

Is any of the quality data reported throughout the application reflective of BMC operations since it changed ownership? If so, to what extent?

Does the applicant have any data on the acuity level of patients who are out-migrating from the proposed service area? Are higher acuity patients travelling to Hamilton County for care?

Response : According to the available data, the emergency room wait times at BMC have deteriorated since Vitruvian's acquisition of the hospital. The average ER wait time has increased to 203 minutes in CMS' latest release dated November 26, 2025. During this reported time frame, Vitruvian operated the hospital for 5 of the 12 reported months. From the prior release (August 6, 2025) used in the initial CON submittal, the wait time was 196 minutes; Vitruvian operated the hospital for 2 of the 12 months during that period.

Of the total out-migrating ED visits from the service area in 2024, 16.7 percent were cared for at a Parkridge Health System affiliated ED. This is presented by service area zip code in the chart below.

Service Area Zip Code	CY 2024
Cleveland – 37311	20.0%
SE Cleveland – 37323	16.2%
McDonald – 37353	24.4%
Old Fort – 37362	10.3%
Benton - 37307	5.6%
Ocoee - 37361	8.5%
Conasauga - 37316	28.0%
Total Service Area	16.7%

(*) Zip code 37316 (Conasauga) is a postal box within 37362 (Old Fort) and has no population; however, it has ED visits identified in this zip code. While incorporated into the service area analysis, references to the service area throughout focuses on the six populated service area zip codes. Where appropriate, information on this zip code is provided throughout the CON Application.

The service area is defined by the foregoing zip codes that are 2 of 3 of the Cleveland zip codes (Cleveland and Southeast Cleveland) and the communities of McDonald, Old Fort, Benton, Ocoee and Conasauga. These zip codes include but are not limited to portions of the following cities and neighborhoods in Bradley and Polk Counties: Cleveland, Tasso, South Mapleton Hills, Jason Gorbett Subdivision, Downtown Cleveland, Black Fox, Williamsburg Estates, Blue Springs, Ocoee Hills, Chestuee, McDonald, Mineral Park, Tucker Springs, Pine Hill, Old Fort, Conasauga, Sugar Grove, Benton, Benton Springs, Benton Station, Oak Grove, Ocoee and Ocoee Hills.

The quality data for wait time in the ED (18b) represents calendar year 2024 during which the new owner operated the hospital for 5 months, 42 percent of the year.

The acuity level of ED service area patients out-migrating is not materially different than the overall acuity of those patients seeking treatment in the Service Area. The following chart compares overall ED visits by level of care compared to those who left Bradley County.

ED Level of Care	Total Service Area ED Visits by Level of Care	Service Area Out-Migration ED Visits by Level of Care
CY 2024 ED Visits	*39,078*	*13,586*
Level 1 - Least Acute	1.1%	1.4%
Level 2	7.1%	7.9%
Level 3	39.0%	42.6%
Level 4	36.2%	35.1%
Level 5 - Most Acute	16.6%	13.0%
Total	100.0%	100.0%

Level 1 and 2, the least acute patients, combined out-migrate approximately 1.1 percent greater than overall. Level 3 and 4 combined out-migrate 2.5 percent greater than overall. The difference (3.6 percent) represents Level 5, the highest acuity difference.

2. **2E. Rationale for Approval**

Of the (35%) what is the split in the out-migration percentage between Bradley and Polk County service area ZIP Codes respectively?

Does this split differ significantly from the out-migration for inpatient care in Bradley and Polk Counties?

The number of ED sites per county population is noted. What are the number of ED treatment rooms compared to other counties with similar populations?

Response : Of the approximate 35 percent of service area ED patients out-migrating, the following breakdown between Bradley and Polk residents is noted:

· Residents of the service area zip codes assigned to Bradley County out-migrated 32.8 percent in 2024 and 34.1 percent in 2025.

· Residents of the service area zip codes assigned to Polk County out-migrated 46.2 percent in 2024 and 44.6 percent in 2025.

· Overall, service area residents out-migrated 34.8 percent in 2024 and 35.7 percent in 2025.

Inpatient out-migration during 2024 from the service area was greater than out-migration for ED visits. Service area zip codes out-migrated for inpatient services as follows: Bradley County zip codes, 50.6 percent and Polk County zip codes, 59.1 percent. Overall, service area resident patients out-migrated 51.4 percent for inpatient services in 2024.

The number of ED treatment rooms by County for similar sized counties is shown in the following table. A comparison to surrounding counties, the same counties as presented in Exhibit 1N-8, is also shown. Both indicate Bradley County is on the low end of ED rooms per 1,000 population.

County	ED Rooms	2025 Population	ED Rooms / 1,000 Population
~100,000 to ~140,000 Population			
Bradley	**41**	**113,913**	**0.36**
Madison	75	99,089	0.76
Sevier	38	101,026	0.38
Maury	50	116,119	0.43
Washington	61	140,553	0.43
Surrounding Counties			
Bradley	**41**	**113,913**	**0.36**
Hamilton	234	385,843	0.61
Rhea	14	33,948	0.41
Marion	10	29,265	0.34
McMinn	23	55,752	0.41
Bledsoe	11	15,248	0.72

While reporting 41 ER treatment rooms in its JARs, it is unknown if all rooms are operational given its ER visit volume and the level of out-migration from the county.

3. **3C. Effects of Competition and/or Duplication**

Please describe the applicant's system affiliations with non-emergency care providers in the proposed service area.

Are there any known differences between the applicant's in-network payors, charity care / financial assistance policies and those of BMC?

What percentage of ED patients are projected to require transfer to an acute care hospital? Of those, what percentage does the applicant expect to refer to the closest available facility vs transferring to Hamilton County?

Please discuss how those transfers will be handled, what percentage will be handled by county EMS vs. private EMS transport?

Will the applicant have any ambulances stationed at the proposed FSED?

How will patient charges be affected in the event that they are transferred for inpatient care to a Parkridge affiliate vs. a non-affiliate hospital?

What are the differences in acuity levels treated by the applicants FSEDs in the service area vs. its on-campus EDs?

Are there any known limitations in the service lines available at BMC driving out-migration to Hamilton County?

In what ways is the host-hospital's service capacity expected to represent improved access to care for the patients of this satellite ED?

Response : Parkridge Health System operates an outpatient behavioral health program in Bradley County; it has no current operations in Polk County.

Parkridge Medical Center is in-network with United Healthcare Medicare Advantage and commercial products; per BMC's website it is not in-network with this payor. In terms of differences in financial assistance, BMC's documentation on its website indicates it provides relief for patients up to 250 percent of poverty level. As noted in the CON application, Parkridge's financial assistance policy includes relief for patients up to 400 percent of poverty level.

The Parkridge Health System ED transfer rate as presented in **Exhibit 1N-48** reflects a current transfer rate of 3.8 percent. This is similar to what is expected at the Parkridge Cleveland FSED. The hospital to which patients are transferred from an ED is dependent on patient choice, provided the receiving hospital has the service line available and is willing to accept the patient.

For patients requiring transport, for every such patient, the Parkridge Cleveland FSED will first contact Bradley County EMS as they require right of first refusal to transport the patient. The percentage that will be transported by Bradley County EMS versus private transport will be determined by Bradley County EMS.

Parkridge Cleveland FSED welcomes the opportunity for Bradley County EMS to station an ambulance at its FSED. Given that Bradley County regulates EMS activity in the county, this will be a Bradley County decision.

A patient being treated at the Parkridge Cleveland FSED will incur an ED visit charge in accordance with their ED encounter. If that patient is then transferred to a Parkridge Health System affiliate, the patient is directly admitted into the hospital bypassing the ED and not incurring a second ED visit. When the patient is transferred to an unaffiliated hospital, it is that hospital's decision if the patient is directly admitted or requires an additional ED visit. However, patients admitted to a hospital covered by Medicare or other DRG related payors, including but not limited to Blue Cross, United Healthcare, Medicaid/TennCare, pay a single rate based on diagnosis; there are not two payments as the ED visit(s) is incorporated into the transfer DRG payment by Medicare or other DRG related payor.

The acuity level of Parkridge's hospital based EDs versus those on satellite campuses without inpatient medical surgical services indicates that those in the highest acuity (Level 5 and critical care) are proportionately greater at the hospital-based EDs by 12.5 percentage points. Notably, although middle acuity levels (III and IV) are greater at satellite EDs by 9.8 percentage points. The least acute only differs by 0.6 percentage points. This information is summarized in the chart below.

ED Level of Care	Campus	Satellite
Level I	2.2%	2.8%
Level II	4.5%	6.5%
Level III	38.4%	51.9%
Level IV	33.6%	30.0%
Level V/Critical Care	21.3%	8.8%

Service line availability when an ED visit is required does not generally affect migration as the majority of ED visits are outpatient. Parkridge Medical Center expects limitations of tertiary service available at BMC may affect outmigration for high acuity services requiring an admission but we expect this is less likely to impact most patients requiring immediate, ED care.

Patients from the proposed service area will benefit with the establishment of the Parkridge Cleveland FSED due to proximity to a Parkridge ED. Saved times for those traveling to Parkridge Medical Center who will seek care at Parkridge Cleveland FSED is between 20 and 36 minutes. When time is muscle or time is brain, these minutes count. Additionally, with a reduction in visits at Parkridge's Hamilton County EDs, other Parkridge Medical Center patients may benefit from further reduction in ED wait times.

4. **9C. Other Facilities Charges**

Please send the Chargemaster for the host hospital as an attachment CSV or excel file as the JSON is too large to download.

Response : The chargemaster was emailed to the HFC on December 10, 2025.

5. **2N. Service Area**

What ZIP Code is BMC located in?

Based on Exhibit 1N-10 it appears that the majority of Polk County is more than 15 minutes from the proposed FSED. What percentage of total Polk County ED patients is the proposed FSED projected to serve?

How far are the Polk County ZIP Code centroids from the host hospital?

Also - given that approximately 20% of total utilization is projected to come from non-service area ZIP Codes, please discuss where this 20% non-service area population is projected to reside.

Do the applicant or its affiliates currently operate any FSEDs at equal or greater distance away from the host hospital in Tennessee?

Response : BMC's ED is located at the northern edge of zip code 37311, near to zip code 37312. BMC has as West Campus located in zip code 37312.

The Polk zip codes within the service area are expected to utilize the Parkridge Cleveland FSED at a rate of 17 percent. Those in other parts of Polk County were incorporated into the out of area (20 percent) rate at the proposed FSED. Their expected volume per zip code is each less than those in the service area.

As identified on **Exhibit 1N-26**, Benton is 60 minutes and Ocoee is 65 minutes from the host hospital; these zip codes are 24 and 29 minutes to the Parkridge Cleveland FSED (**Exhibit 1N-9**), thus a savings of 36 minutes.

The expected out of area draw is estimated to generate 1,750 ED visits in year one. It is expected that there would be several hundred zip codes comprising this aggregate amount. Those in closest proximity which will comprise a measurable portion of the 20 percent likely include Reliance, Delano, northern Cleveland, Copperhill, Farner, Turtletown, Ducktown, Charleston, Georgetown, Athens, Etowah, Englewood, Ooltewah, Harrison, Hixson, Chattanooga, Ocoee vacationers from all over, and other surrounding communities. Hundreds more zip codes will comprise the balance representing visitors/travelers to or through the area.

Parkridge Cleveland FSED is 23 miles straight line from Parkridge Medical Center. The Applicant's ultimate parent company, HCA Healthcare, operates 189 FSEDs, nationally. Of those, as of 2024, the following is noted regarding 'crow flies' or straight line miles (not drive miles):

- 7 FSEDs are more 30 miles away from the host hospital;

- 14 FSEDs are 20 to 30 miles from the host hospital;
- 68 FSERs 10 to 20 miles from the host hospital;
- All other are less than 10 miles from the host hospital

Of the 7 FSED more than 30 miles from the host, the details and location are presented in the below exhibit. One of these is in Tennessee: TriStar Spring Hill FSED (Maury County) is a satellite of TriStar Centennial Medical Center (Davidson County).

State	Host Hospital	FSED	Date Opened	Distance from Host Hospital (as the crow flies)
Texas	Corpus Christi Medical Center	Rockport	1/5/2021	35
Florida	HCA Florida Brandon Hospital	Lakeland	5/22/2020	35
Florida	HCA Florida Brandon Hospital	Wesley Chapel	6/1/2020	34
Tennessee	TriStar Centennial	Spring Hill	2/18/2013	33
Texas	St. David's South Austin Medical Center	Bastrop	6/1/2012	32
Florida	HCA Florida North Florida Hospital	Starke	5/1/2020	31
Florida	HCA Florida Fawcett Hospital	Cape Coral	4/25/2022	30

6. **3N. Demographics**

What is the percentage of residents of each service area ZIP Code without health insurance, per Census data?

Please utilize the available ZIP Code level census data from the website linked above to complete Table 3NB. Median Household Income and Persons Below Poverty Level as a % of Total.

Response The percentage of residents of each service area zip code without health insurance is as follows:
:

Bradley Portion	
Cleveland - 37311	13.0%
SE Cleveland - 37323	11.0%
McDonald - 37353	9.5%
Old Fort - 37362	13.7%
Polk Portion	
Benton - 37307	16.8%
Ocoee - 37361	8.0%

https://data.census.gov/profile?q=health+insurance&g=860XX00US37307,37311,37316,37323,37353,3736

Table 3NB has been updated to include median household income and poverty level from the censu
Exhibit 8 which summarizes poverty level was replaced with census poverty level. These updates a
included in a revised **3N Response** uploaded into the portal.

7. **4N. Special Needs of Service Area**

Please list the FSEDs included in the 49,000 visits referenced on Page 24. Is this for calendar year 2024?

Response : As noted in footnote 11 on page 24, these visits include Camp Jordan and Soddy Daisy FSEDs, Parkridge West and Parkridge North satellite EDs. The data is for calendar year 2024.

8. **5N. Unimplemented services**

Exhibit 10 - Page 25: It appears that the total ED Visits for 2023 are 50,097 in the copy of HDDS DR 35552215. Is there a different version of the report, or is this an error in the table? If it is an error, please revise Exhibit 10.

Response : As footnoted on **Exhibit 10**, the total county ED visits are from THA data. The reason THA data is used is because there is no suppression in that total data, and therefore it represents an accurate presentation of out-migration. Below is that same line item with the TDOH total:

	BMC	Out of County	Total	% Out-Migration
Bradley County	34,324	15,773	50,097	31.5%

Source: HDDS DR 35551101.

9. **6N. Utilization and/or Occupancy Statistics**

Exhibit 12 - Page 30: Why is CHI Memorial Hospital Chattanooga not included in the utilization table when it has a higher number of reported visits than Erlanger Bledsoe and Parkridge West? Please include CHI utilization from ZIP Codes 37311 and 37323.

What percentage of total ED visits from each service area ZIP Code have been served at a Parkridge affiliated facility?

Exhibit 18 - Page 34: Please explain how the combined total of growth and shift (4,586) relates to the projected FSED service area visits in Year 3 (8,679). Are these all included in the projection of 8,679?

Exhibit 19 - Page 34: Please explain the basis for the acuity level projection as they appear to differ significantly from the HDDS reported acuity levels of patients in the two largest ZIP Codes for the project:

37311:

Level I - 6.0% vs 2.6% (projected)

Level II - 27.3% vs 6.6% (projected)

Level III - 50.6% vs 52.6% (projected)

Level IV - 11.1% vs 28.9% (projected)

Level V - 4.9% vs 9.1% (projected)

37323:

Level I - 5.3% vs 2.6% (projected)

Level II - 24.2% vs 6.6% (projected)

Level III - 52.0% vs 52.6% (projected)

Level IV - 12.6% vs 28.9% (projected)

Level V - 5.9% vs 9.1% (projected)

Response : When including the truncated 373 zip code, the CHI hospitals are not in the top grouping because of 373's distortion of 36,000+ ED visits. Exhibit 12, page 30 has been retitled Exhibit 12A. Exhibit 12B has been inserted and only includes zip codes 37311 and 37323 and its top hospitals with ED visits. An updated 6N Response has been uploaded into the portal.

The following chart provides the 2024 percent of ED visits at Parkridge affiliates by service area zip code:

Service Area Zip Code	CY 2024
Cleveland – 37311	5.7%
SE Cleveland – 37323	5.3%
McDonald – 37353	15.4%
Old Fort – 37362	4.2%
Benton – 37307	3.3%
Ocoee – 37361	3.7%
Conasauga – 37316	25.0%

Exhibit 18, page 34 shows the incremental growth in service area visits (3,448) and also the shift expected from Parkridge Medical Center and Parkridge North. This information is provided to place the forecasted Parkridge Cleveland FSED visits within the context of growth and shift. The remaining forecasted volume will result from a decrease in overall out-migration so service area residents may access an ED closer to home, and also a shift of those who do not out-migrate based on improved consumer access, choice and quality.

Regarding **Exhibit 19**, page 34, the forecasted acuity level is based on the Parkridge experience and evaluation of total ED visits in the service area. The TDOH data as previously observed is distorted when evaluating the level of care. Specifically, the above actual values are only derived from a small subset of the overall ED visits in those two zip codes, rather than the total ED visits. Per the CY 2023 TDOH data, there were 16,832 ED visits in 37311 and 14,322 ED visits in 37323. Yet, the level of care values in that file are derived from only 12.9 and 10.7 percent of ED visits, respectively. This is shown in the below table:

Total ED Visits	16,832	14,322
CPT Codes	**37311**	**37323**
99281	131	82
99282	592	371
99283	1,099	799
99284	241	194
99285	107	90
Total	2,170	1,536
99281	6.0%	5.3%
99282	27.3%	24.2%
99283	50.6%	52.0%
99284	11.1%	12.6%
99285	4.9%	5.9%
Total	100.0%	100.0%
% in Grouping	12.9%	10.7%

10. **1N. Criteria and Standards**

Attachment 1N, FSED Criteria and Standards, Criterion #1, Determination of Need

Are there any ZIP Codes outside of the defined service area that are within 15 minutes of the proposed facility?

What non-service area ZIP Codes are projected to represent up the 20% of the total FSED utilization? What is the basis for these projections if these ZIP Codes are more than 15 minutes from the proposed FSED site?

Are any population centers located closer to an existing ED outside of the defined service area?

The hospitals, emergency rooms, imaging centers, etc. included with Parkridge Health System are noted. Where are these facilities, practice offices based? How many are in the proposed service area?

Response : There are no zip code centroids outside the defined service area that are within 15 minutes of the proposed FSED.

Non-service area zip codes which comprise the remaining 20 percent of total FSED utilization will likely far exceed hundreds of different zip codes. As noted in **Table 9A1**, Parkridge ED patients represent more than 1,800 zip codes. BMC ED visits in 2024 included residents of more than 850 zip codes. Those in closest proximity which will comprise a measurable portion of the 20 percent likely include Reliance, Delano, northern Cleveland, Copperhill, Farner, Turtletown, Ducktown, Charleston, Georgetown, Athens, Etowah, Englewood, Ooltewah, Harrison, Hixson, Chattanooga, Ocoee vacationers from all over, and other surrounding communities. Hundreds more zip codes will comprise the balance representing visitors/travelers to or through the area.

None of the service area population centers are located closer to an existing ED outside the defined service area.

The Parkridge Health System facilities are dispersed in Hamilton and Marion Counties with one outpatient behavioral health facility located in Cleveland, Bradley County. Aside from providers in that practice, all other provider practice offices are in Hamilton or Marion Counties.

11. **1N. Criteria and Standards**

Attachment 1N, FSED Criteria and Standards, Criterion #1, Determination of Need

Exhibit 1N-8 - Page 1N 10: Does the number of Hamilton County emergency rooms (9) include the Soddy Daisy FSED?

Exhibit 1N-9 - Page 1N 11: "From ZIP Code Centroid to TriStar Cleveland FSED" - The shortest distance from 37323 appears to be less than the 6.7 miles listed (6.1 miles). Please verify and revise as necessary.

What population centers located within 15 minutes radius for the proposed FSED would be outside of the 15-minute radius for BMC if the same contour map were applied?

Response : **Exhibit 1N-8** and the related narrative have been updated to include Soddy Daisy.

The shortest distance from centroid 37323 to the Parkridge Cleveland FSED is 6.1 miles. However, this was not the shortest travel time. **Exhibit 1N-9** (Page 1N-11) identifies the mileage associated with the shortest travel time rather than identifying the shortest distance and the shortest travel time even if disassociated.

The population centers that are within 15 minutes of the proposed FSED but outside the 15 minutes for BMC include 37353 (McDonald), 37311 (Cleveland) and 37323 (SE Cleveland). See **Exhibit 1N-9** (page 1N-11) for the time measurements to both the Parkridge Cleveland FSED and BMC.

12. **1N. Criteria and Standards**

Attachment 1N, FSED Criteria and Standards, Criterion #1, Determination of Need

Does any of the CMS data provided for BMC reflect operations since the facility changed ownership?

Exhibit 1N-13, Page 1N-19: The data provided appears to be outdated. Please provide the most current CMS data for calculating these measures and submit a revised Attachment 1N (labeled as Attachment 1NR).

Please list the State and National Averages for OP18B Low, Moderate, High and Very High-volume emergency departments as a footnote to the table.

Exhibit 1N-14, Page 1N-20: Please update the data to reflect the most current available.

Exhibit 1N-15, Page 1N-20: Please update the data to reflect the most current available.

Exhibit 1N-16, Page 1N-20: Please update the data to reflect the most current available.

Exhibit 1N-17, Page 1N-21: Please update the data to reflect the most current available.

Exhibit 1N-21, Page 1N-24: Please update the data to reflect the most current available. Data appears to be missing got Wellmont Bristol, TriStar Stonecrest, Cookeville Regional, Cumberland Medical Center and TriStar Southern Hills.

Also, it appears that the data for the existing hospital - Affiliate of Vitruvian Health, Parkwest Medical Center, and Baptist Memorial Hospital are not available for the most recent reported data set.

Exhibit 1N-22, Page 1N-25: Please update the data to reflect the most current available.

Response : The OP 18b statistic is for calendar year 2024 which includes 5 of 12 months under new ownership. Similarly, the CT head results are for CY 2024; the last release was for the 12 months ending September 30, 2024 which include 2 of 12 months under new ownership.

Exhibits on pages 1N-19, 1N-20, 1N-21, 1N-24 and 1N-25 have been updated to include the November 26, 2025 release; previous data was the August 6, 2025 release. The Tennessee and National averages for OP18B Low, Medium, High and Very High volume emergency departments are appended to **Exhibit 1N-13**. The associated narrative has also been updated. To the extent data was not updated, such is noted where applicable. A revised **1NR Response** has been uploaded.

Exhibit 1N-21, Page 1N-24 has been updated and included in the revised **1NR Response**.

13. **1N. Criteria and Standards**

Attachment 1N, FSED Criteria and Standards, Criterion #1, Determination of Need

Exhibit 1N-24, Page 1N 27: The reported Statewide Rate of % of Behavioral Health Patients appears to be higher (1.7%) than listed (1.6%).

Polk County % of Patients Level I or III (Low Acuity) is lower (42.1%) than listed (41.3%).

Exhibit 1N-25, Page 1N 27: The number of ED rooms is reported as 23 instead of 19 for 2022 and 2023. Please address and revise as appropriate.

Response : **Exhibit 1N-24** has been revised to 1.7 percent for Statewide Rate of % of Behavioral Health Patients and 42.1% for Polk County % of Patients Level I or II (Low Acuity).

The ED rooms were not reduced at the host hospital. There are 19 ED rooms at the hospital and have been that same number for years. The 2020 through 2023 JARs incorrectly included four hallway beds that are not ED treatment rooms and incorrectly accounted for the Parkridge North ED beds in 2020. The Hospital is submitting revisions to the HFC to correct reporting.

14. **1N. Criteria and Standards**

Attachment 1N, FSED Criteria and Standards, Criterion #2, Expansion of Host Hospital

Exhibit 1N-33, Page 1N 37: Please update the exhibit and narrative on Page 1N-37 incorporate most current data.

Why were ED rooms reduced at the host hospital according to 2024 JAR reporting?

Response : The exhibit and narrative have been updated; see **1NR Response** uploaded in the portal.

The ED rooms were not reduced at the host hospital. There are 19 ED rooms at the hospital and have been that same number for years. The 2020 through 2023 JARs incorrectly included four hallway beds that are not ED treatment rooms. The Hospital is submitting revisions to the HFC to correct reporting.

15. **1N. Criteria and Standards**

Attachment 1N, FSED Criteria and Standards, Criterion #4, Host Hospital Emergency Department Quality of Care

Exhibit 1N-45, Page 1N 47: Please update to reflect current data.

Exhibit 1N-46, Page 1N 48: Please update to reflect current data.

Exhibit 1N-47, Page 1N 48: Please update to reflect current data.

Response : Each of the exhibits have been updated; see the revised **1NR Response** uploaded in the portal.

16. **1N. Criteria and Standards**

Attachment 1N, FSED Criteria and Standards, Criterion #9, Establishment of a Service Area

Please list the EDs represented in Table 9A1.

Does the applicant have HDDS data to demonstrate ZIP Code utilization of the host hospital? If so, please provide.

Table 9A2, Page 1N-57: Please list the EDs with the highest volume for the two largest ZIP Codes 37311 and 37323 as reported in HDDS. The second table appears to exclude CHI utilization and includes limited or no utilization from other facilities.

Response : The EDs represented in Table 9A1 include the entire Parkridge Health System: Parkridge Medical Center main campus, Soddy Daisy FSED, Parkridge North, Parkridge Medical Center East, Camp Jordan FSED and Parkridge West.

The Applicant does not have HDDS data for the entirety of Parkridge Medical Center; the HDDS data is limited to the service area zip codes and presented in the respective exhibits within the CON application.

When including the truncated 373 zip code, the CHI hospitals are not in the top grouping because of 373's distortion of 36,000+ ED visits. Following is an alternate 9A2 which only includes zip codes 37311 and 37323 and its top hospitals with ED visits.

	Service Area ED		Out of County EDs						
	Patient ED 1	Subtotal of	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital	
Service Area Zip Code	BMC	County EDs	Erlanger Baroness	Erlanger East	Parkridge	CHI Memorial	Parkridge East	ED Patients	Total
37311 Cleveland	12,133	12,133	1,848	931	569	377	257	717	16,832
37323 SE Cleveland	9,716	9,716	1,742	970	473	579	193	649	14,322
Total 37311 + 37323	21,849	21,849	3,590	1,901	1,042	956	450	1,366	31,154
Distribution by % of Patients	70.1%	70.1%	11.5%	6.1%	3.3%	3.1%	1.4%	4.4%	100.0%

Project Name : Parkridge Medical Center

Supplemental Round Name : 2 **Due Date :** 12/12/2025

Certificate No. : CN2511-040 **Submitted Date :** 12/11/2025

1. **1E. Overview**

Please identify the sources of data provided in response to Supplemental Round #1 Question #1.

Regarding the neighborhoods listed, how many are closer in proximity to the proposed FSED vs. BMC?

Response : The data presented in both charts in response to Supplemental Round #1 Question #1 is THA data.

Regarding the cities, towns, and neighborhoods listed, when measuring from the centroid of the area using Google maps, the following are closer to the FSED: Cleveland, Black Fox, Williamsburg Estates, Blue Springs, Ocoee Hills, Chestuee, McDonald, Mineral Park, Tucker Springs, Pine Hill, Old Fort, Conasauga, Sugar Grove, Benton, Benton Springs, Benton Station, Oak Grove, Ocoee and Ocoee Hills. Tasso and downtown Cleveland are each one minute further to the FSED. South Mapleton Hills in the northeast of Cleveland and Jacen Gorbett in the northwest are both closer to BMC.

2. **2E. Rationale for Approval**

Please identify the source of the data provided in response to Supplemental #1, Question #2 regarding the 35% breakdown.

Response : The data associated with the 35 percent breakdown in response to Supplemental Round #1 Question #2 is THA data.

3. **6N. Utilization and/or Occupancy Statistics**

How many of the 3,448 service area visits resulting from incremental growth are projected to be served at the proposed FSED?

Response : The forecasted utilization at the Parkridge Cleveland FSED is expected to be 80 percent service area ED visits and 20 percent out of area ED visits. Of the service area ED visits, the forecast estimates that that proposed Cleveland FSED will care for 21.2 percent of service area ED visits (Exhibit 16, Question 6N) including incremental growth. For that reason, this 21.2 percent can also be expected to apply to the forecasted incremental growth.

4. **1N. Criteria and Standards**

Attachment 1N, FSED Criteria and Standards, Criterion #1, Determination of Need

Exhibits 1N-15, 1N-19: Please list the CMS reported measures for all high-volume EDs corresponding with the listed quartile rankings of BMC.

Response : The chart below provides the CMS reported measures for each high volume ED by minutes and quartile; the source is the November 26, 2025 release by hospital.

Median Time Spent in the Emergency Department (CMS OP 18B): High Volume Hospitals

Hospital	ED Time	Rank	Quartile
TRISTAR SOUTHERN HILLS MEDICAL CENTER	129	1	Top Quartile
TRISTAR HORIZON MEDICAL CENTER	136	2	Top Quartile
HIGHPOINT HEALTH-SUMNER WITH ASCENSION SAINT THOMA	150	3	Top Quartile
ST FRANCIS HOSPITAL	154	4	Top Quartile
TRISTAR STONECREST MEDICAL CENTER	161	5	Top/2nd
TRISTAR HENDERSONVILLE MEDICAL CENTER	163	6	2nd Quartile
TRISTAR SKYLINE MEDICAL CENTER	175	7	2nd Quartile
WILLIAMSON MEDICAL CENTER	182	8	2nd Quartile
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	185	9	2nd Quartile
MORRISTOWN HAMBLEN HOSPITAL ASSOCIATION	200	10	2nd/3rd
AFFILIATE OF VITRUVIAN HEALTH	203	11	3rd Quartile
BLOUNT MEMORIAL HOSPITAL	203	12	3rd Quartile
LECONTE MEDICAL CENTER	204	13	3rd Quartile
MAURY REGIONAL HOSPITAL	206	14	3rd Quartile
WELLMONT HOLSTON VALLEY MEDICAL CENTER	224	15	3rd/Bottom
COOKEVILLE REGIONAL MEDICAL CENTER	233	16	Bottom Quartile
FORT SANDERS REGIONAL MEDICAL CENTER	250	17	Bottom Quartile
PARKWEST MEDICAL CENTER	256	18	Bottom Quartile
REGIONAL ONE HEALTH	290	19	Bottom Quartile

The next chart provides the CMS reported LWOT for each high volume ED by percentage and quartile; the source is the November 26, 2025 release by hospital.

LWOT (CMS OP 22): High Volume Hospitals

Hospital	LWOT Score	Rank	Quartile
ST FRANCIS HOSPITAL	0	1	Top Quartile
TRISTAR HORIZON MEDICAL CENTER	0	2	Top Quartile
TRISTAR SOUTHERN HILLS MEDICAL CENTER	0	3	Top Quartile
TRISTAR STONECREST MEDICAL CENTER	0	4	Top Quartile
WELLMONT HOLSTON VALLEY MEDICAL CENTER	0	5	Top/2nd
FORT SANDERS REGIONAL MEDICAL CENTER	1	6	2nd Quartile
HIGHPOINT HEALTH-SUMNER WITH ASCENSION SAINT THOMA	1	7	2nd Quartile
TRISTAR HENDERSONVILLE MEDICAL CENTER	1	8	2nd Quartile
TRISTAR SKYLINE MEDICAL CENTER	1	9	2nd Quartile
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	1	10	2nd/3rd
BLOUNT MEMORIAL HOSPITAL	2	11	3rd Quartile
MAURY REGIONAL HOSPITAL	2	12	3rd Quartile
REGIONAL ONE HEALTH	2	13	3rd Quartile
WILLIAMSON MEDICAL CENTER	2	14	3rd Quartile
COOKEVILLE REGIONAL MEDICAL CENTER	3	15	3rd/Bottom
MORRISTOWN HAMBLEN HOSPITAL ASSOCIATION	3	16	Bottom Quartile
AFFILIATE OF VITRUVIAN HEALTH	4	17	Bottom Quartile
LECONTE MEDICAL CENTER	4	18	Bottom Quartile
PARKWEST MEDICAL CENTER	4	19	Bottom Quartile