



**State of Tennessee
Health Facilities Commission**

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

www.tn.gov/hsda

Phone: 615-741-2364

hsda.staff@tn.gov

CERTIFICATE OF NEED APPLICATION

1A. Name of Facility, Agency, or Institution

TriStar Horizon Medical Center

Name

2273 Fairview Boulevard

Williamson County

Street or Route

County

Fairview

Tennessee

37062

City

State

Zip

<https://www.tristarhealth.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

Wyatt Chocklett

Chief Executive Officer

Name

Title

TriStar Horizon Medical Center

Samuel.Chocklett@hcahealthcare.com

Company Name

Email Address

111 US-70E

Street or Route

Dickson

Tennessee

37055

City

State

Zip

Executive

615-446-0446

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: 02/27/26

Date LOI was Published: 02/27/26

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

Central Tennessee Hospital Corporation

Name

One Park Plaza		615-886-4900
Street or Route		Phone Number
Nashville	Tennessee	37203
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: TriStar Horizon Medical Center (“TriStar Horizon”) is owned by Central Tennessee Hospital Corporation. Applicant is ultimately owned by HCA Healthcare, Inc. through several wholly owned subsidiary corporations. Please see Attachments 7A-1 and 7A-2 for TriStar Horizon’s Charter and Assumed Name from the Tennessee Division of Business Services Department of State, respectively. Attachment 7A-3 contains a copy of TriStar Horizon’s Certificate of Existence. Attachment 7A-4 contains TriStar Horizon’s organizational chart. Attachment 7A-5 contains a listing of Central Tennessee Hospital Corporation’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
-

RESPONSE: Please see Attachment 9A.

10A. Floor Plan

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

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

RESPONSE: See Attachment 10A for a copy of the floor plan 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 located on Fairview Boulevard (State Route 100) and is an approximate 7 minute drive (4.5 miles) from Interstate 840, 3 minute drive (1.4 miles) from Highway 96, and a 10 minute drive (6.3 miles) from Interstate 40. The site is easily accessible by car, ambulance, and other ground transportation. The TriStar Fairview FSED will work with patients to ensure that safe transportation is available to and from its ED. There is no public bus system in Fairview.

12A. Plot Plan

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

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

(Attachment 12A)

RESPONSE: The size of the site is approximately 5.77 acres. Please see the plot plan included in Attachment 12A for the site relative to the entire parcel, location of the structure on the site, the location of the proposed construction, 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:

TriStar Horizon seeks to establish a FSED (“TriStar Fairview FSED”) in Fairview, TN, to be operated as a satellite location of its main campus emergency department (“ED”) in Dickson, Tennessee. It will be a full-service hospital ED able to care for all acuity levels of emergency patients. The ED will include 11 treatment rooms, including 1 trauma room, a lab, an imaging department, a nursing station, and support space. It will have isolation and behavioral health/holding capabilities. TriStar Health has long served the Fairview community. The proposed FSED will be located at 2273 Fairview Blvd., Fairview, Williamson County, Tennessee 37062 near the existing TriStar Medical Plaza located at 2340 Fairview Blvd., which houses primary care physicians, including Covenant Primary Care. The proposed FSED will serve the service area defined by the zip codes of 37062 (Fairview), 37025 (Bon Aqua), 37029 (Burns), and 38476 (Primm Springs). There are no EDs in the service area. Two-thirds (67%) of service area patient emergency visits are to a TriStar Health ED. TriStar Horizon and its TriStar Natchez FSED in Dickson together care for over 60% of service area ED patient visits. Accordingly, TriStar Health wants to improve the ability of its patients to have more timely access to high quality emergency care by establishing a FSED in Fairview. The FSED is needed to address:

- **Geographic Isolation:** The absence of any ED in the 217+ square mile service area demonstrates its geographic isolation from emergency services. This area is suburban in nature and includes a significant and growing base of ED patients. The service area has geographical barriers that affect travel dynamics. A rugged rural area bounded by forests and the Harpeth River separates the service area from Nashville to the east/northeast and Franklin to the east/southeast. Today, most patients from Fairview (36.5%) drive approximately 20 minutes north/northwest to Dickson to TriStar Horizon and the TriStar Natchez FSED. The next closest EDs are TriStar Bellevue FSED in Nashville and other EDs in Nashville or Franklin, including Williamson Medical Center (“WMC”) in Franklin (40 minutes) and St. Thomas West Hospital in Nashville (40 minutes). The TriStar Fairview FSED will be closer and more accessible than Dickson, Franklin or Nashville.
- **Population Growth:** The proposed service area is growing and includes an aging population, with its greatest population growth in the Fairview zip code area (37062), which has more than doubled in size since 2000. Fairview and the service area as a whole are projected to grow by another almost 6 percent in the next five (5) years.
- **Access/Availability:** There is no ED in the service area today. Therefore, TriStar Horizon wants to make emergency care more accessible by establishing a FSED in Fairview, which is the largest city in the service area and is central to an area where patients have to travel far for emergency services today.

-
- Ownership structure

RESPONSE: The TriStar Fairview FSED will be a satellite of TriStar Horizon, which is owned by Central Tennessee Hospital Corporation and whose ultimate parent company is HCA Healthcare, Inc. (“HCA Healthcare”). TriStar Horizon is part of the TriStar Health network, which operates 6 FSEDs in Middle Tennessee. Moreover, HCA Healthcare operates 189 FSEDs in the United States.

- Service Area

RESPONSE: The service area is defined by the zip codes of 37062 (Fairview), 37025 (Bon Aqua), 37029 (Burns), and 38476 (Primm Springs). 37062 (Fairview) and 38476 (Primm Springs) are in Williamson County. 37025 (Bon Aqua) is in Hickman County, and 37029 (Burns) is in Dickson County.

- Existing similar service providers

RESPONSE: There is no emergency care provider in the service area. TriStar Horizon's main campus ED is 19.2 driving miles from the proposed TriStar Fairview FSED. The TriStar Natchez FSED is 16.3 driving miles (using the shortest distance) from the proposed FSED. Using the shortest, but not fastest routes, the TriStar Bellevue FSED is 15.5 driving miles from the proposed FSED. The St. Thomas West ED is 21.1 miles from the proposed FSED, and the WMC ED is 24.2 miles from the proposed FSED.

- Project Cost

RESPONSE: The estimated capital cost of the project is \$21,018,000.

- Staffing

RESPONSE: The TriStar Fairview FSED will be staffed by approximately 30.1 FTEs, consisting of physicians, RNs, radiology, and lab tech, and nonclinical support staff to meet all acuity levels of ED services.

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 TriStar Fairview FSED is needed because it will be in the center of a geographically isolated 217+ square mile area from which access to emergency care is difficult. There is no emergency care provider in the service area. Residents must travel outside the service area for emergency care. No emergency department is closer than 20 minutes from the location of the proposed FSED. The nearest facilities to the proposed site (time and distance) are TriStar Horizon’s main campus emergency department (27 minutes; 19.2 miles), the TriStar Natchez FSED (21 minutes; 16.3 miles), and the TriStar Bellevue FSED (25 minutes; 15.5 miles) (shortest distance)). Under normal conditions, the realistic travel times of 20 to 40 minutes of travel time depend on the time of day or night of travel.

- Quality Standards

RESPONSE: The TriStar Fairview FSED will serve all ED acuity levels and operate under the same high-quality standards as the TriStar Horizon main campus ED. The TriStar Fairview FSED will provide high quality care that is accessible for all patients in the service area. As part of TriStar Horizon, the FSED will be accredited by the Joint Commission. In addition, the FSED will be part of TriStar Horizon’s robust Quality Assurance and Performance Improvement (“QAPI”) and Utilization Review Programs to maintain and ensure quality of care and patient safety. TriStar Horizon is an outstanding hospital with a Leapfrog hospital safety grade A rating for the last six (6) quarters, 4-Star CMS score and many other recognitions for its high quality. It is in the top quartile for median time to be seen for all hospitals in Tennessee and in the top quartile for all hospitals for the lowest left without being seen category.

- Consumer Advantage

- Choice

RESPONSE: The proposed FSED will introduce an additional emergency care option for service area residents. Patients will have the ability to obtain hospital-based emergency services within their own community rather than traveling to Dickson, Franklin, or Nashville. Expanding consumer choice in a currently unserved area supports competition and responsiveness to community need.

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

RESPONSE: The TriStar Fairview FSED provides clear consumer advantage by: (1) Establishing emergency services in a service area that currently has none; (2) Reducing travel times for residents who must now travel 20 to 40 minutes for emergency care; and (3) Improving timely access for residents who already use TriStar Health facilities for emergency care (67 percent currently choose a TriStar Health ED).

- Affordability

RESPONSE: The TriStar Fairview FSED will ensure financial access to emergency services for all patients. As part of TriStar Health, the facility will participate in TennCare, Medicare, and commercial insurance programs. HCA Healthcare through its TriStar Division is the largest TennCare provider in Tennessee and maintains one of the most comprehensive charity care policies in the region. Consistent with EMTALA requirements and system policy, All HCA Healthcare TriStar Division’s emergency departments treat all patients regardless of ability to pay or network status. The proposed FSED will therefore provide both geographic and financial access to emergency care for all residents of the service area, including vulnerable and underserved populations.

3E. Consent Calendar Justification

- Letter to Executive Director Requesting Consent Calendar (Attach Rationale that includes addressing the 3 criteria)
- Consent Calendar 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	\$519,000
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	\$150,000
3. Acquisition of Site	\$2,650,000
4. Preparation of Site	\$2,400,000
5. Total Construction Costs	\$9,359,000
6. Contingency Fund	\$1,097,000
7. Fixed Equipment (Not included in Construction Contract)	\$1,650,000
8. Moveable Equipment (List all equipment over \$50,000 as separate attachments)	\$1,900,000
9. Other (Specify): <u>Escalation, Testing, Other, Building Fees, Pre-Planning</u>	\$1,248,000

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) \$20,973,000

E. CON Filing Fee \$45,000

F. Total Estimated Project Cost (D+E) **TOTAL** \$21,018,000

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 proposed TriStar Fairview 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:

The proposed FSED is located on Fairview Boulevard (Highway 100), the major east-west thoroughfare in Fairview, the most populace community in the service area, and between Interstate 840 and Highway 96, two major north-south highways. This location enhances access to the defined four zip code service area of 37062 (Fairview), 37025 (Bon Aqua), 37029 (Burns), and 38476 (Primm Springs). The residents of the service area are geographically isolated from emergency care. They are distant from the existing EDs outside of the service area and road congestion and geographic qualities of the area enhance the isolated nature of the area.

Service Area Definition

See **Attachment 2N** for the required map showing all counties in which the service area zip codes are located. The proposed Service Area contains zip codes: 37062 (Fairview), 37025 (Bon Aqua), 37029 (Burns), and 38476 (Primm Springs). TriStar Horizon seeks to develop a FSED to eliminate the geographic isolation and enhance access for residents of the service area. The proposed FSED is centrally located within the defined four zip code service area and is located in the most populace community in the service area, the City of Fairview.

To define the proposed service area for the TriStar Fairview FSED, the evaluation considered the relationship of Fairview to its surrounding communities, the location of the EDs in Dickson, Nashville, and

Franklin, the geographic distribution of zip codes in the vicinity, roadway systems, travel distances and patient migration patterns.

In addition to these factors considered to identify the location of the proposed Fairview FSED, TriStar Horizon also considered the following factors in its determination of the proposed service area:

- Geographic proximity of zip codes to the proposed FSED;
- The 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 the TriStar Division and its affiliates' experience.

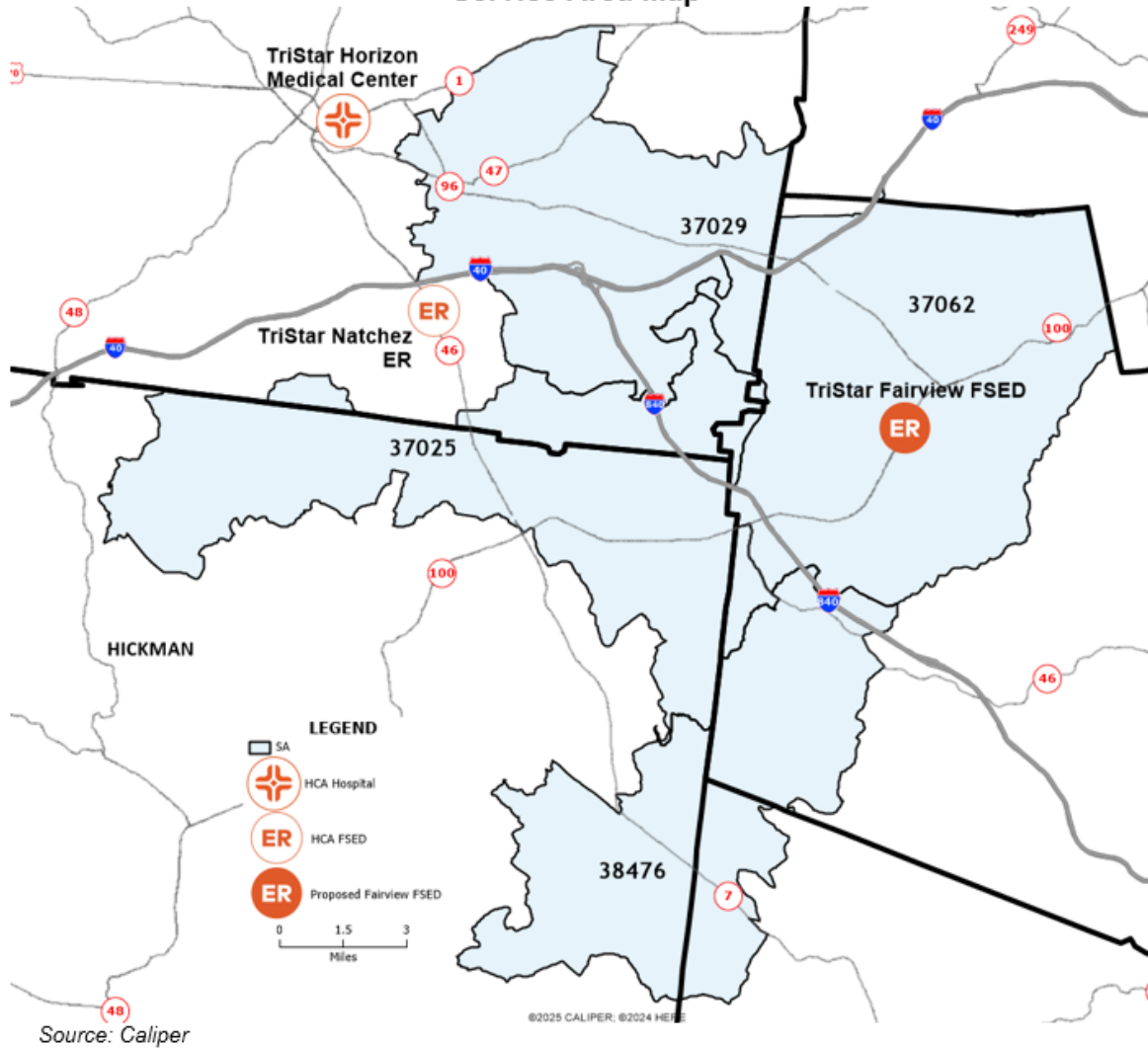
There are no existing emergency rooms in the Service Area, which includes portions of Dickson County, Hickman County, and Williamson County. Outside the defined Service Area, but within those counties, are:

- TriStar Horizon in Dickson County – 19.2 miles northwest of the proposed FSED;
- TriStar Natchez FSED in Dickson County – 16.3 miles west of the proposed FSED;
- WMC in Williamson County – 24.2 miles southeast of the proposed FSED;
- Ascension St. Thomas Hickman ("St. Thomas Hickman") in Hickman County – 28.4 miles to the southwest of the proposed FSED; and
- TriStar Nolensville FSED in eastern Williamson County – 32.9 miles to the east of the proposed FSED.

TriStar Fairview 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 the facilities but also the time required to access all other hospitals these patients are regularly utilizing for emergency services.

Given the population growth of the service area, and anticipated growth, it is important to implement an emergency care access point in the service area to enhance access for the residents of these four (4) zip codes through reduced travel times to reach an emergency room. In emergency care where time is muscle or time is brain, the proposed FSED not only saves time to treatment but also eliminates the need for patients to go into the more congested areas of Dickson, Franklin, or Nashville for emergency care.

Exhibit 2N-1 Service Area Map



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

Emergency Providers near the Service Area Exceed ACEP Guidelines for Optimal Capacity

As is described in **Attachment 1N**, proximate EDs to the service area are experiencing significant capacity challenges with the exception of the critical access hospital 40+ minutes from Fairview. **Exhibit 2N-2** below shows each ED's 2024 visits per treatment room along with ACEP optimal capacity:

**Exhibit 2N-2
Visits per Treatment Room in Existing ED Facilities in Service Area Counties
Including Host Hospital**

Emergency Department	Total Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP Mid Range	ACEP High Range
	2024	2024				
Exceeded ACEP Range						
TriStar Horizon Medical Center	37,325	22	1,697	1,522	1,386	1,250
TriStar Natchez FSED	17,749	9	1,972	1,429	1,340	1,250
WMC	54,504	36	1,514	1,667	1,459	1,250
Within ACEP Range						
Below ACEP Range						
St. Thomas Hickman	4,039	5	808	1,250	1,080	909

Source: Hospital Joint Annual Report, Search site <https://apps.health.tn.gov/PublicJARS/Default.aspx> American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 116-117

Service Area Historical Utilization

The TriStar Horizon main campus ED and TriStar Natchez FSED, combined, cared for 55,074 patient visits in 2024. Emergency visits from patients in the service area in 2025 encompassed 9 percent of the total patient visits at the TriStar Horizon main campus ED and 25 percent at TriStar Natchez FSED for an overall 14.3 percent rate. Applicant projects that approximately 1,900 of those patients will shift to the TriStar Fairview FSED in Year One, which should help relieve some of the burden on both TriStar Horizon and TriStar Natchez FSED.

Exhibit 2N-3 below provides the historical service area utilization at the existing TriStar Horizon main campus ED and TriStar Natchez FSED:

**Exhibit 2N-3
TriStar Horizon and TriStar Natchez FSED Historical ED Visits from Service Area**

Year	Service Area ED Visits		
	TriStar Horizon	TriStar Natchez FSED	Total Service Area Visits
2021	2,885	3,864	6,749
2022	3,154	4,313	7,467
2023	3,339	4,356	7,695
2024	3,395	4,410	7,805
Percent Change	17.7%	14.1%	15.6%

Source: THA Data

There is no ED in the service area. All EDs used by service area patients are located outside of the service area in Dickson, Nashville, or Franklin.

Residents of the service area will greatly benefit from the TriStar Fairview FSED because it is centrally located in the defined four zip code, 217 square mile service area and is easily accessible by residents from Highway 100 as well as Highway 96 and Interstate 840. Due, in part, to this location, the proposed FSED will enhance access for this fast-growing area. The service area is expected to grow at a 6 percent rate over the next five (5) years.

The TriStar Natchez FSED has very high patient satisfaction scores as evidenced by its Press Ganey Patient Satisfaction scores. Press Ganey is a 3rd party vendor used by thousands of hospitals to collect feedback from patients about their overall experience. TriStar Natchez FSED's 2025 rating is an excellent 80.1 percent. The TriStar Natchez FSED has an average ranking in the 82nd percentile, over the last four years (2022-2025).

TriStar Horizon wants to extend the availability of high-quality, easily accessible emergency care closer to service area residents who live closer to Fairview and who are already choosing one of the TriStar Horizon EDs for their emergency care. In 2024, over 60 percent of service area patient visits were to TriStar Horizon EDs. The proposed TriStar Fairview FSED is 19.2 miles (per Google maps) by road from TriStar Horizon and is 16.3 miles from the TriStar Natchez FSED (per Google maps).

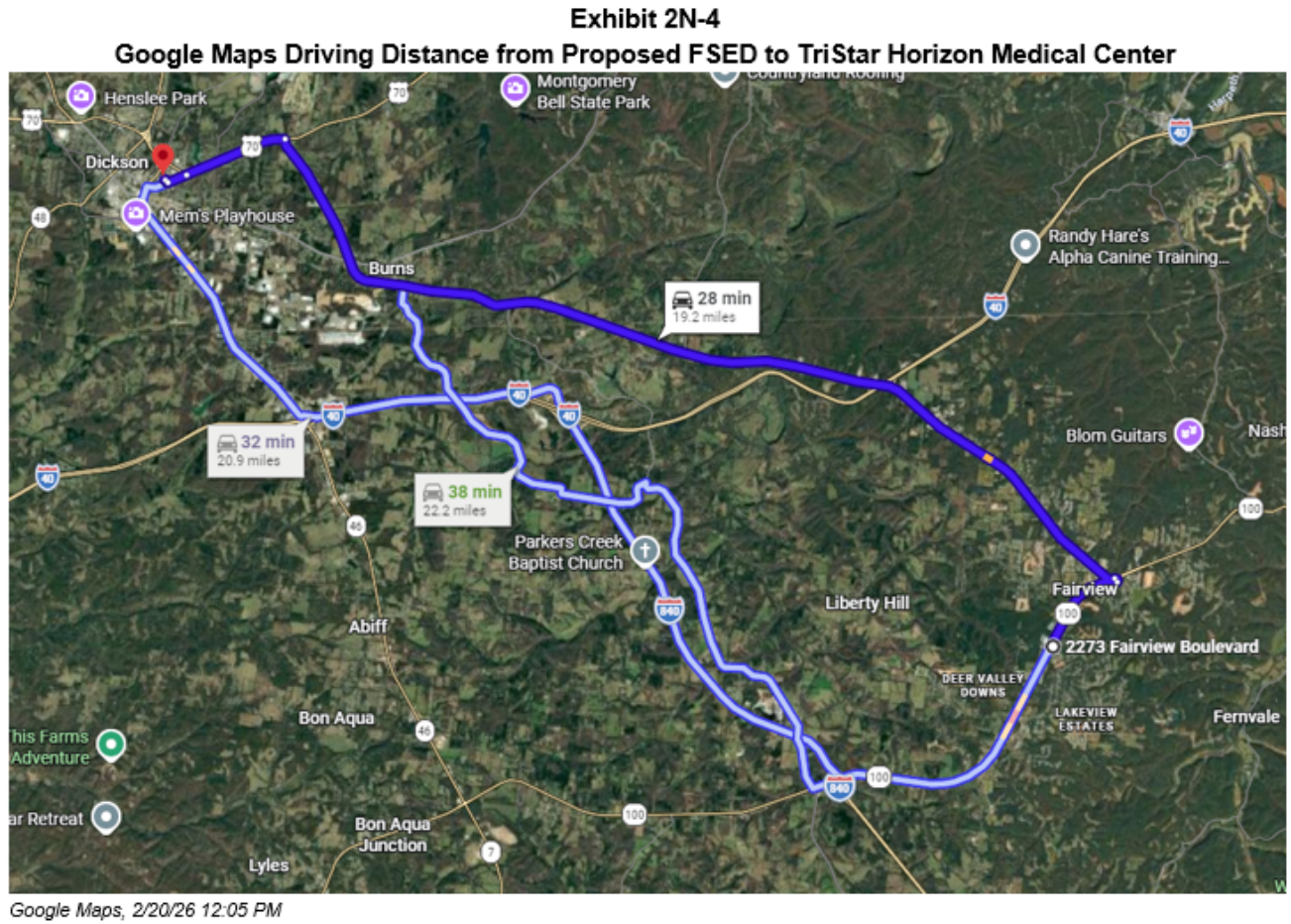
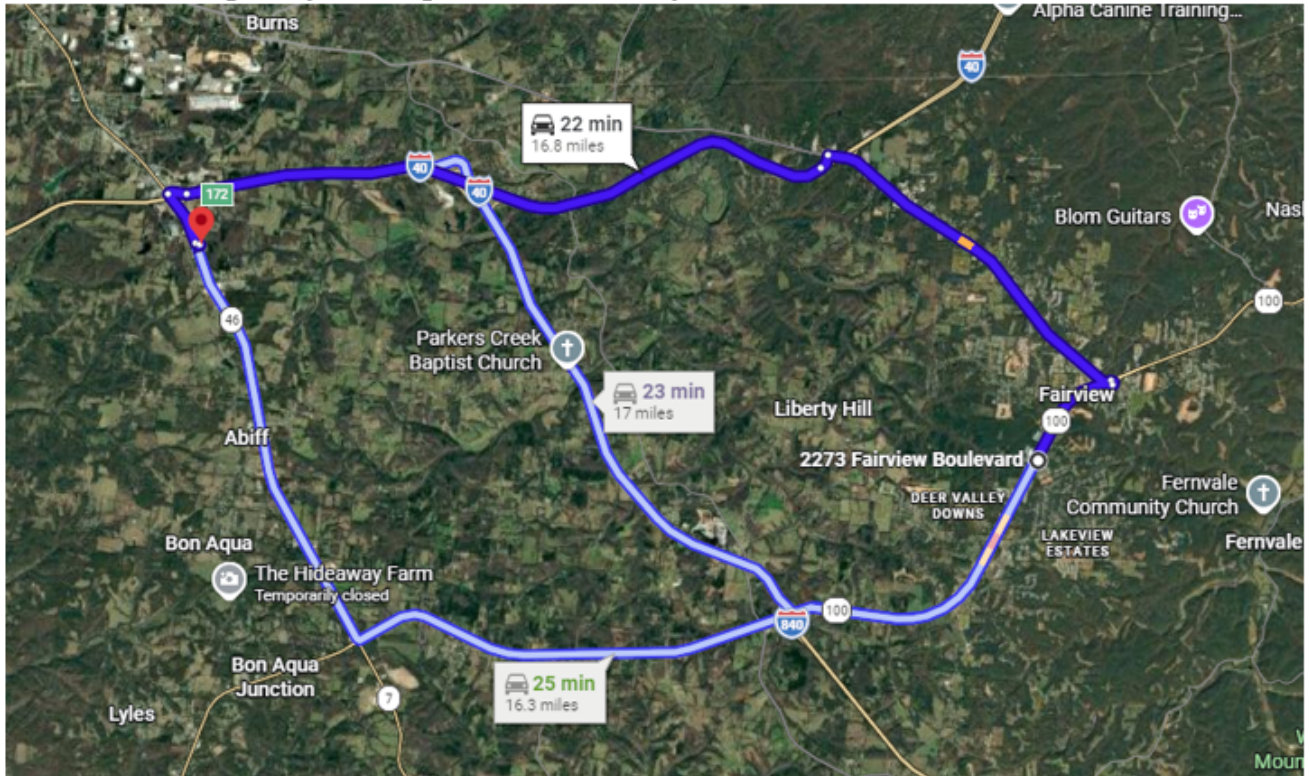


Exhibit 2N-5
Google Maps Driving Distance from Proposed FSED to TriStar Natchez FSED



Google Maps, 2/20/26 12:08 PM

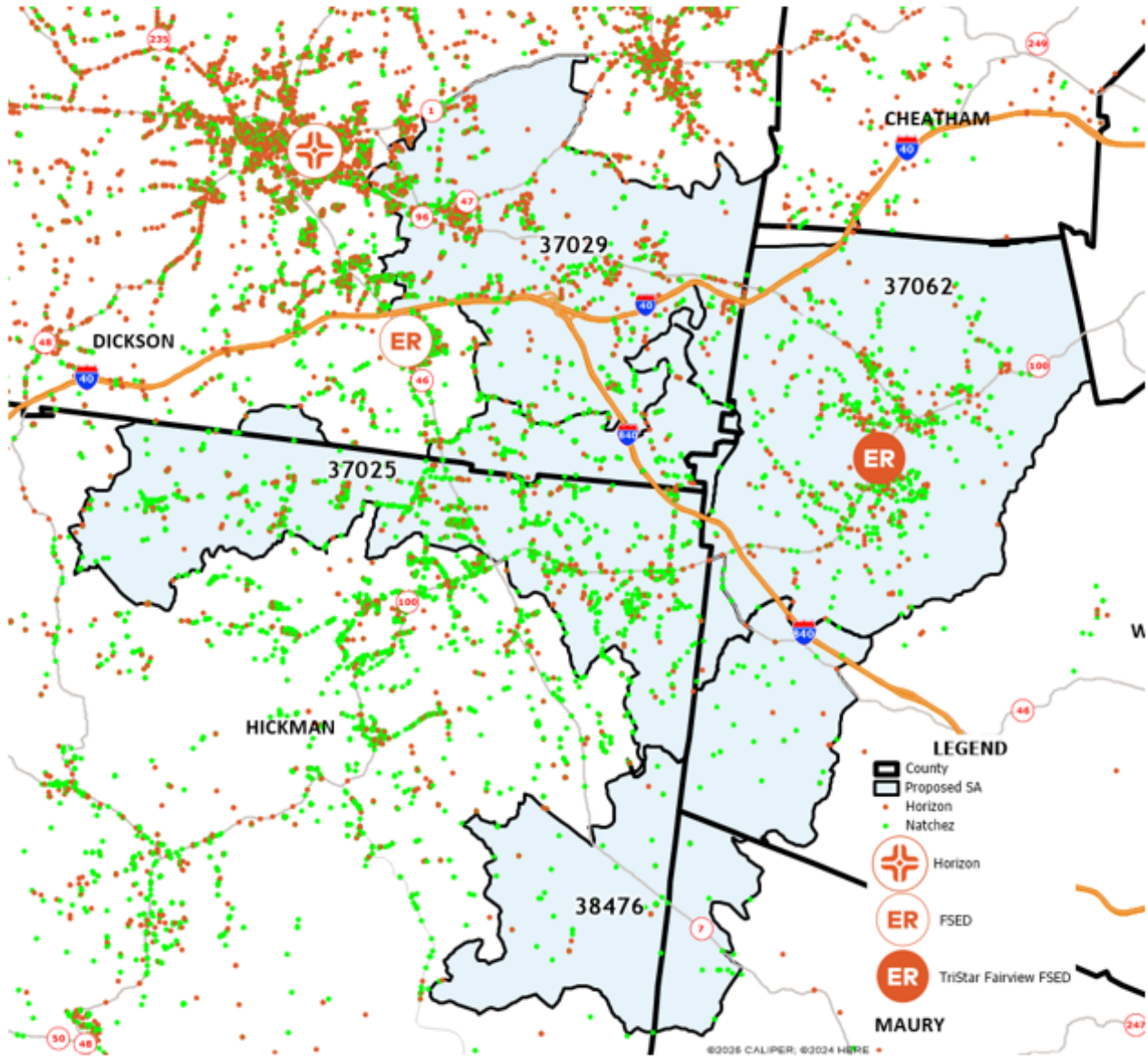
As shown by Exhibits 2N-6 and 2N-7 below, approximately 30 percent of TriStar Horizon’s service area patient visits are from patients who live closer to the proposed TriStar Fairview FSED than to a TriStar Horizon ED.

Exhibit 2N-6
2025 Service Area Visits From Patients Living Closer to the TriStar Fairview FSED than to TriStar Horizon or the TriStar Natchez FSED

2025 TriStar Unique Patients	Total	% of Total
TriStar Fairview FSED (proposed)	2,271	29.48%
TriStar Horizon ED	1,325	17.20%
TriStar Natchez FSED	4,108	53.32%
Unique Visits	7,704	100.0%

Source: Internal Data

Exhibit 2N-7
TriStar Horizon ED and TriStar Natchez FSED
Patient Visits from Service Area for
Calendar Year 2025



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

PROJECTED UTILIZATION

Unit Type:

- Procedures
- Cases
- Patients
- Other

ED Visits

Service Area Counties	Projected Utilization Recent Year 1 (Year =)	% of Total
Hickman	966	19.94%
Williamson	55	1.14%
Dickson	634	13.09%
Williamson	1,576	32.54%
Other not primary/secondary county	1,613	33.30%
Total	4,844	100%

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

RESPONSE:

Population

The service area has grown significantly since 2020. **Exhibit 3N-1** below shows the growth of the population in the service area since 2020:

**Exhibit 3N-1
Service Area Population**

Service Area	Population			Percent Change	
	2020	2026	2031	2020-2026	2026-2031
37062 (Fairview)	12,655	13,832	14,672	9.3%	6.1%
37025 (Bon Aqua)	6,910	7,426	7,761	7.5%	4.5%
37029 (Burns)	6,364	7,106	7,624	11.7%	7.3%
38476 (Primm Springs)	1,190	1,261	1,313	6.0%	4.1%
Service Area	27,119	29,625	31,370	9.2%	5.9%

Source: Claritas Spotlight, 2026

Since 2020, the population has increased by 9.2% and is expected to increase by another 6 percent in the next five (5) years.

The current population of the service area is 29,625. As shown in **Exhibit 3N-2** below, the TriStar Fairview FSED’s service area is projected to increase to 31,370 residents by 2031, representing a nearly 6 percent projected population growth in five (5) years.

Importantly, the population of the service area that will be served by the TriStar Fairview FSED is aging, which increases utilization and need for accessible and available healthcare, including emergency services. The proportion of over 65 in the service area is expected to increase from 18.4 percent to 20.9 percent in the next five years. This is shown below in **Exhibit 3N-3**.

**Exhibit 3N-2
Population of Service Area, 2020 through 2031**

Population	0-17	18-44	45-64	65+	Total
2020	6,497	8,574	7,698	4,350	27,119
2026	6,501	9,676	8,000	5,448	29,625
2031	6,475	10,024	8,299	6,572	31,370

Source: Claritas Spotlight, 2026

Service Area – Special Needs Populations – 65+

The 65+ population in the service area is material and is projected to increase significantly. By 2031, the 65+ age group will be 20.9 percent of the service area population. See **Exhibit 3N-3** below. In terms of growth rate, from 2026 to 2031, the 65 and older population is projected to grow by 20.6 percent compared to the overall population growth expected of nearly 6 percent. Because the 65 and over age cohort typically accesses emergency room care more often than other patient groups, the dramatic growth in that age group in the

service area further demonstrates the need for the TriStar Fairview FSED. 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. (See Ukkonen, M., Jämsen, E., Zeitlin, R., & Pauniahho, S. L. 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> (2019)).

Exhibit 3N-3 shows the service area 65+ age group and projected to 2030.

Exhibit 3N-3
Service Area Population by Age Cohort and Percent 65+ Age Group

Service Area	2020					
	0-17	18-44	45-64	65+	Total	%65+
37062 (Fairview)	3,292	4,094	3,401	1,868	12,655	14.8%
37025 (Bon Aqua)	1,586	2,204	2,042	1,078	6,910	15.6%
37029 (Burns)	1,380	1,961	1,871	1,152	6,364	18.1%
38476 (Primm Springs)	239	315	384	252	1,190	21.2%
Service Area Total	6,497	8,574	7,698	4,350	27,119	16.0%
	2026					
Service Area	0-17	18-44	45-64	65+	Total	%65+
37062 (Fairview)	3,075	4,613	3,690	2,454	13,832	17.7%
37025 (Bon Aqua)	1,641	2,463	1,976	1,346	7,426	18.1%
37029 (Burns)	1,553	2,248	1,965	1,340	7,106	18.9%
38476 (Primm Springs)	232	352	369	308	1,261	24.4%
Service Area Total	6,501	9,676	8,000	5,448	29,625	18.4%
	2031					
Service Area	0-17	18-44	45-64	65+	Total	%65+
37062 (Fairview)	2,929	4,808	3,995	2,940	14,672	20.0%
37025 (Bon Aqua)	1,673	2,522	1,949	1,617	7,761	20.8%
37029 (Burns)	1,645	2,330	2,001	1,648	7,624	21.6%
38476 (Primm Springs)	228	364	354	367	1,313	28.0%
Service Area Total	6,475	10,024	8,299	6,572	31,370	20.9%

Source: Claritas Spotlight, 2026

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 3N - 4**, the percent of service area residents are below the poverty level – by zip code – is shown below:

Exhibit 3N-4
Service Area Residents Living Below Poverty Level

Service Area	% of Residents Below Poverty Level
37062 (Fairview)	9.3%
37025 (Bon Aqua)	10.6%
37029 (Burns)	5.0%
38476 (Primm Springs)	3.1%

Source: Census Bureau

The percentage of residents of the service area without health insurance is significant as shown next.

Exhibit 3N-5
Service Area Residents Without Health Insurance

Service Area	% of Residents Without Insurance
37062 (Fairview)	6.4%
37025 (Bon Aqua)	7.4%
37029 (Burns)	6.2%
38476 (Primm Springs)	3.1%

Source: Counties and State, census.gov quick facts, accessed 2-16-26; ZCTA site for zip code information

The zip code with the greatest proportion of residents without insurance is 37025 (Bon Aqua) at 7.4 percent.

As a hospital emergency room operating under the TriStar Horizon license, the TriStar Fairview FSED will care for all who need emergency care. As previously established, the proposed TriStar Fairview FSED will be part of the larger TriStar Health network, which requires all facilities within its system to adhere to all financial

assistance and charity/indigent care policies. Financial relief is available to those patients who have received non-elective care and do not qualify for state or federal assistance and are unable to establish partial payments or pay their balance. Moreover, all self-pay patients will receive a discount similar to managed care, referred to as an “uninsured discount.” The Uninsured Discount is available to patients who have no third-party payer source of payment or do not qualify for Medicaid, Charity, or any other discount program the facility offers. Moreover, TriStar Health’s charity discount provides assistance for patients up to 400% of the poverty level. See **Attachment 4N-1** for the Charity Financial Assistance Policy for Uninsured and Underinsured Patients and

Discount Policy for Patients. Further, TriStar Horizon 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>).

RESPONSE:

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Census Bureau				TennCare	
	Total Population-Current Year 2026	Total Population-Projected Year 2030	Total Population Change		Target Population on-		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
			2026-2030	*Target Population on-	Target Population on-	Target Population on-							
			All Ages	All Ages	% Change 2026-2030	Current Year 2025							
37062 (Fairview)	13,832	14,504	4.9%	13,832	14,504	4.9%	100%	38.7	\$91,750	1,286	9.3%		
37025 (Bon Aqua)	7,426	7,894	3.6%	7,426	7,894	3.6%	100%	41.7	\$77,846	787	10.6%		
37029 (Burns)	7,106	7,520	5.8%	7,106	7,520	5.8%	100%	41.7	\$97,222	355	5.0%		
38476 (Primm Springs)	1,261	1,303	3.3%	1,261	1,303	3.3%	100%	29.8	\$83,654	39	3.1%		
Service Area Subtotal	29,625	31,021	4.7%	29,625	31,021	4.7%	100%			2,468	8.3%		
Dickson County	58,312	60,389	3.6%	58,312	60,389	3.6%	100%	39.1	\$75,003	5,890	10.1%	10,852	18.6%
Hickman County	25,727	25,788	0.2%	25,727	25,788	0.2%	100%	42.3	\$68,247	3,396	13.2%	5,339	20.8%
Williamson County	282,593	304,573	7.8%	282,593	304,573	7.8%	100%	41.1	\$135,594	12,717	4.5%	13,570	4.8%
State of TN Total	7,300,003	7,513,757	2.9%	7,300,003	7,513,757	2.9%	100%	39.1	\$69,595	985,500	13.5%	1,391,250	19.1%

Source: Tennessee Department of Health; Census.gov ACTS 1 year and 5 year, February 2026; Claritas, Inc. for zip code service area population; census.gov for zip code service area median age, median household income and poverty level; and Division TennCare, Enrollment as of December 2025 (latest available in February 2026).

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:

The TriStar Fairview FSED will ensure financial access for all patients. HCA Healthcare's TriStar Division is the largest TennCare provider in Tennessee. Thus, the TriStar Fairview FSED will be part of a network with vast experience caring for TennCare patients. TriStar Horizon projects that approximately 26 percent of the TriStar Fairview FSED patient visits will be TennCare or Medicaid recipients. This exceeds the service area percent Medicaid of 24 percent confirming TriStar Fairview FSED commitment to the medically indigent. TriStar Health's experience taking care of TennCare patients will be a benefit to this segment of the patients expected to come to the TriStar Fairview FSED for care.

In addition, the TriStar Health facilities have one of the most generous charity care policies in the region. All TriStar Health emergency departments care for all patients regardless of their ability to pay and regardless of whether they are in-network for all insurance products. Moreover, the proposed TriStar Fairview FSED will address the emergency care needs of the service area population. The service area is rapidly growing and aging. As the senior population has a higher incidence of emergent conditions, access to ED services is becoming increasingly critical to this community.

In accordance with TriStar Horizon's practice, and applicable Federal and State law, all patients presenting at the proposed TriStar Fairview FSED with emergency care needs will be served without regard to age, gender, race, ethnicity, income, or ability to pay. As previously discussed, the TriStar Fairview FSED will be part of TriStar Health, which requires all facilities within it to adhere to all financial assistance and charity/indigent care policies. Financial relief is available to those patients who have received non-elective care and do not qualify for state or federal assistance and are unable to establish partial payments or pay their balance. Moreover, all self-pay patients will receive a discount similar to managed care, referred to as an "uninsured discount." The Uninsured Discount is available to patients who have no third-party payer source of payment or do not qualify for Medicaid, Charity, or any other discount program the facility offers. <https://tristarhealth.com/patient-financial/charity-policy>. See also **Attachment 4N-1** for the Charity Financial Assistance Policy for Uninsured and Underinsured Patients and Discount Policy for Patients. TriStar Health's policy provides discounts for all persons who have income at less than 400% of the poverty level. And for those who are below 200% of the poverty level, personal responsibilities are written off in their entirety.

The proposed TriStar Fairview FSED will not discriminate in its service to any patient and will serve all patients regardless of race and ethnicity consistent with TriStar Horizon's policies and experience. Please see **Attachment 4N-2** for the Non-Discrimination Policy that will apply to the TriStar Fairview FSED.

TriStar Health has vast experience serving the service area patient population. As the provider of emergency care of approximately 67 percent of the emergency patient visits in 2024, TriStar Health is active in the Fairview area, with the TriStar Horizon main campus ED in Dickson and the TriStar Natchez Trace FSED accounting for 60.2 percent of the total ED visits by patients from the service area. TriStar Horizon has great relationships with the providers in and around the service area. See **Attachment 1N Question 18** for a list of TriStar Horizon's community linkages.

Since TriStar Horizon is part of TriStar Health, which operates hospitals throughout Middle Tennessee, its commitment to TennCare/Medicaid and uninsured patients is not just specific to TriStar Horizon. As a Tennessee provider, HCA's TriStar Division is the largest provider statewide of services to TennCare/Medicaid patients. Per **Exhibit 4N-1**, in 2023, HCA's TriStar Division, admitted more than 15 percent TennCare/Medicaid patients, which is more than any other Tennessee health system. This information is presented in the following table:

Exhibit 4N-1

Percentage of TennCare/Medicaid by Health System in Tennessee 2023

System	Medicaid IP % of Admissions/Discharges	Medicaid IP % of Total Days/Discharges
HCA Healthcare's TriStar Division	15.17%	13.51%
VUMC	10.57%	11.84%
Ballad	7.46%	5.70%
Methodist	7.11%	9.64%
Covenant	6.91%	4.54%
Baptist	5.69%	4.40%
Erlanger	5.03%	5.32%
Ascension	4.80%	4.45%
CHS	3.97%	2.64%

Source: Hospital Joint Annual Reports, 2023.

TriStar Horizon will continue the TriStar Health mission and serve all patients. This will include providing services to underinsured, uninsured, and low-income populations, including TennCare.

These are just some of the ways in which TriStar Horizon addresses community need beyond just direct care to TennCare and low-income groups. The TriStar Fairview 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.

Patient Types

TriStar Horizon cannot control or predict the type of patients that will choose to present at the proposed FSED. The largest percentage of patients are expected to be walk-in patients who choose to visit the FSED to treat a variety of diagnoses for a variety of reasons whether it be proximity to home or the expectation of timely travel or timely access to care. It is expected that EMS patients will also utilize the facility, and the EMS provider will determine which patients are appropriate given the patient's condition, location, patient choice, and a variety of other factors.

TriStar Horizon expects that the types of patients that seek care at existing TriStar Health-affiliated FSEDs will also seek care at the TriStar Fairview FSED. A review of the principal diagnosis of the FSED patient visits seen by the TriStar Natchez FSED identifies over 3,900 different principal diagnoses. For this reason, it is very difficult to anticipate what types of patients will present to the proposed FSED. The top ten diagnoses in 2025 are shown in **Exhibit 4N-2** below:

Exhibit 4N-2
Top Ten Diagnoses TriStar Natchez FSED,
Calendar Year 2025

J069 - Acute upper respiratory infection, unspecified
B349 - Viral infection, unspecified
R0789 - Other chest pain
N390 - Urinary tract infection, site not specified
R112 - Nausea with vomiting, unspecified
S0990XA - Unspecified injury of head, initial encounter
K529 - Noninfective gastroenteritis and colitis, unspecified
R109 - Unspecified abdominal pain
J189 - Pneumonia, unspecified organism
R079 - Chest pain, unspecified

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

TriStar Horizon's experience at its main campus ED and the TriStar Natchez FSED inform the following projection of the likely acuity level of patient visits at the TriStar Fairview FSED. Based on TriStar Health's experience operating 6 FSEDs in Middle Tennessee, and specifically at TriStar Natchez FSED which treats a significant number of service area patients, TriStar Horizon projects the relative Acuity Levels shown in **Exhibit 4N-3** below for the TriStar Fairview FSED:

Exhibit 4N-3
Projected TriStar Fairview FSED Acuity Level

Acuity Level	Projected Fairview FSED
Level 1 – 99281	3.9%
Level 2 – 99282	8.9%
Level 3 – 99283	44.4%
Level 4 – 99284	33.4%
Level 5 – 99285	9.3%
Critical Care	0.1%
Total	100.0%

Source: Internal Records; Note: CPT Code and Level of Care – Level 5 and Critical Care are most acute and Level 1 is least.

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:

EDs in the Counties

There are no existing EDs in the service area. Outside of the service area, but within the counties encompassing the zip codes, the providers are as follows:

- TriStar Horizon – 22 treatment rooms – 37,325 patient visits in 2024;
- TriStar Natchez FSED – 9 treatment rooms – 17,749 patient visits in 2024;
- WMC – 38 treatment rooms – 54,504 patient visits in 2024;
- St. Thomas Hickman – 5 treatment rooms – 4,039 patient visits in 2024; and
- TriStar Nolensville FSED –9 treatment rooms – 0 patient visits in 2024.

Trends in utilization for the four providers that were open in 2024 are shown in detail in **Exhibit 5N-1** below.

**Exhibit 5N-1
Historical Utilization of the EDs In Counties That Include Service Area Zip Codes
Latest 3 Years**

Zip Code/ County	Facility	Most Recent Years Reported				% Change
		2021 ED Visits	2022 ED Visits	2023 ED Visits	2024 ED Visits	
EDs in the Service Area						
NONE						
EDs In Counties Which Include Service Area Zip Codes						
Dickson County	TriStar Horizon	32,181	33,332	34,929	37,325	16.0%
Dickson County	TriStar Natchez FSED	16,662	18,312	17,753	17,749	6.5%
Williamson County	WMC	43,457	49,760	52,187	54,504	25.4%
Hickman County	St. Thomas Hickman	3,618	4,690	4,843	4,039	11.6%

Source: Joint Annual Reports for Respective Years; Note: TriStar Nolensville FSED is also located in Williamson County, however, it did not open until October 2025.

There is no data showing historical service area utilization by service area ED because there is no ED in the Service Area.

Exhibit 5N-2 shows the 2024 utilization of the providers outside the Service Area but in other portions of the counties in which the service area zip codes are situated. Utilization is contrasted with the ACEP Guidelines:

**Exhibit 5N-2
Visits per Treatment Room in Existing ED Facilities Outside the Service Area**

Emergency Department	Total Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP <u>Mid</u> Range	ACEP High Range
	2024	2024				
Exceeded ACEP Range						
TriStar Horizon Medical Center	37,325	22	1,697	1,522	1,386	1,250
TriStar Natchez FSED	17,749	9	1,972	1,429	1,340	1,250
WMC	54,504	36	1,514	1,667	1,459	1,250
Within ACEP Range						
Below ACEP Range						
St. Thomas Hickman	4,039	5	808	1,250	1,080	909

Source: Hospital Joint Annual Report, Search site <https://apps.health.tn.gov/PublicJARS/Default.aspx> American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 116-117

The data above demonstrates that the existing EDs at the general hospitals outside of the service area are well over the ACEP Guidelines for optimal ED capacity, with the exception of the critical access hospital more than 40 minutes away and serving a very small proportion of service area patients. Therefore, having a FSED located in Fairview would greatly enhance the accessibility of emergency care in the service area.

Urgent Care Provider Is 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. The only urgent care facility in the service area is:

Fast Pace Health Urgent Care - Fairview - TN	2377 Fairview Blvd, Fairview, TN 37062
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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	TriStar Horizon Campus ED	Proposed TriStar Fairview 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	✓	✓

Moreover, it is TriStar Health's experience that UCCs regularly refer patients to emergency rooms when a patient presents at a UCC but is not suitable for UCC treatment. TriStar Health incorporates information in its presentations to the community and providers in an area which educates them as to the distinguishing characteristics between EDs and UCCs, when to use each provider type, and what is considered emergency care versus urgent care. These activities are aimed at assuring lower acuity patients do not overuse ED services. The Applicant will mitigate the risk of overuse through community and provider education platforms it will incorporate in its service delivery.

The following photograph shows a typical TriStar Health 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. 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.

**Exhibit 5N-3
TriStar 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.

RESPONSE:

See Attachment 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:

The Applicant 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:

- CN1707-023 – The StoneCrest Surgery Center CON has an extension through May 31, 2026, to evaluate the impact of the acquisition of an existing surgery center in Rutherford County and the impact of the pandemic.
- CN2302-006 – TriStar Skyline East Nashville FSED was approved on April 26, 2023. Relocation of the CON was approved by the HFC on March 25, 2025. Groundbreaking occurred in fall 2025. This facility is to open by late 2026. TriStar Skyline believed that the 3-year implementation date runs from the relocation date, not the original CON approval date, but recent correspondence from the HFC has kept the original 7/1/26 date. TriStar Skyline anticipates that the FSED will be open in July or August 2026 and has requested an extension of the CON.
- CN2304-010 – TriStar Southern Hills Nolensville FSED began caring for patients in October 2025. The Final Report was submitted February 23, 2026.
- CN2308-020 – Chattanooga East Surgicenter was approved on October 25, 2023. It is currently under development.
- CN2404-010 – TriStar Spring Hill Hospital was approved for a CON for a new hospital on June 26, 2024. The CON was issued on August 28, 2024. Vanderbilt University Medical Center and Williamson Medical Center commenced contested case proceedings on June 28, 2024, which were set for trial in November 2025; on May 14, 2025, the Administrative Procedures Divisions entered its Initial Order of Dismissal dismissing the challenge to the CON. By rule, the time for completion of the CON is postponed for the period during which the challenge was pending. TriStar Spring Hill Hospital is currently engaged in the planning and development of this hospital.
- CN2407-020 – TriStar Hendersonville White House FSED was approved on October 23, 2024. The CON was issued on December 1, 2024. The groundbreaking occurred on March 27, 2025, with an anticipated opening date in 2026.
- CN2504-013 – Lebanon Center for Outpatient Surgery CON Application to establish a multi-specialty ASTC in Lebanon was approved unanimously by the HFC on June 25, 2025. The official CON was issued on July 23, 2025. The building that will house the facility already exists at 125 Willard Hagan Drive in Lebanon.
- CN2505-018 – TriStar Clarksville Hospital was approved on July 23, 2025. It is currently in the design process.
- CN2505-016 – TriStar StoneCrest – Murfreesboro FSED was approved on September 24, 2025. It is currently in the design process.
- CN2508-031 – TriStar Centennial Rehabilitation Bed Project was approved on October 22, 2025. It is currently in the design process.
- CN2511-040 – Parkridge Cleveland FSED was approved on February 25, 2026, less than a week before this application is submitted.

CON Number	Project Name	Date Approved	Expiration Date
CN2308-020	Chattanooga East Surgicenter	10/25/2023	12/1/2026
CN2505-018	TriStar Clarksville Hospital	7/23/2025	9/1/2028
	Parkridge Cleveland		

CN2511-040	FSED	2/25/2026	4/1/2029
CN2508-031	TriStar Centennial Inpatient Rehabilitation Bed Project	10/22/2025	1/1/2029
CN2404-010	TriStar Spring Hill Hospital	6/24/2024	8/1/2027
CN2302-006	TriStar Skyline East Nashville FSED	4/26/2023	7/1/2026
CN1707-023	TriStar StoneCrest Surgery Center	10/25/2017	5/31/2026
CN2407-020	TriStar Hendersonville White House FSED	10/23/2024	12/1/2027
CN2504-013	Lebanon Outpatient Surgery Center	6/25/2025	8/1/2027
CN2505-016	TriStar StoneCrest Murfreesboro FSED	9/24/2025	11/1/2028

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, 1C-2, and 1C-3 for copies of TriStar Horizon’s transfer agreements, list of TriStar Horizon’s community linkages and Annual Community Report.

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

- Aetna Health Insurance Company
- Ambetter of Tennessee Ambetter
- Blue Cross Blue Shield of Tennessee
- Blue Cross Blue Shield of Tennessee Network S
- Blue Cross Blue Shiled of Tennessee Network P
- BlueAdvantage
- Bright HealthCare
- Cigna PPO
- Cigna Local Plus
- Cigna HMO - Nashville Network
- Cigna HMO - Tennessee Select
- Cigna HMO - Nashville HMO
- Cigna HMO - Tennessee POS
- Cigna HMO - Tennessee Network
- Golden Rule Insurance Company
- HealthSpring Life and Health Insurance Company, Inc.
- Humana Health Plan, Inc.

- Humana Insurance Company
- John Hancock Life & Health Insurance Company
- Omaha Health Insurance Company
- Omaha Supplemental Insurance Company
- State Farm Health Insurance Company
- United Healthcare UHC
- UnitedHealthcare Community Plan East Tennessee
- UnitedHealthcare Community Plan Middle Tennessee
- UnitedHealthcare Community Plan West Tennessee
- WellCare Health Insurance of Tennessee, Inc.
- Others

RESPONSE: Coventry Healthcare; First Health/Coventry National; HCA Employee Benefit Plan; Health Alliance; Magellan Health Services; Multiplan/PHCS; PPO Plus; Ambetter Exchange; Oscar; Amerigroup; and 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

The proposed FSED will have many positive effects including:

- Addressing the lack of access to ED services in geographically isolated Fairview and its neighboring communities;
- Increasing access for residents – including the rapidly growing aging population – of the service area by providing ED care closer to their homes;
- Improving emergency outcomes by reducing travel times to emergency care facilities dramatically;
- Bringing a full-service ED to an area where people have to drive anywhere from 20 to 50 minutes without traffic to access care;
- Providing consumers with enhanced safety and peace of mind due to 67 percent of service area patients already using TriStar Health for their emergency care; and
- Shortening EMS patient transport times and giving EMS quicker access to emergency facilities.

Negative Effects

There are no material negative impacts for consumers. Quality ED services provided by TriStar Health will be made more readily available to service area residents. This will reduce time for this population to access TriStar Horizon and its affiliates, as well as other providers, depending on zip code and emergency room. Furthermore, residents of the largest zip code in the service area –37062 (Fairview) – will now be able to access emergency care within 4 minutes versus driving 20 to 50 minutes to access emergency care.

Much of the TriStar Fairview FSED’s volume will consist of patient visits already going to TriStar Horizon’s ED, the TriStar Natchez FSED, and EDs run by its TriStar Health affiliates, who will likely choose to go to the TriStar Fairview FSED because of its proximity.

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:

As previously discussed, TriStar Horizon, the Applicant, is part of TriStar Health and an affiliate of HCA Healthcare, one of the largest providers of healthcare and hospital services in the U.S. and U.K. With TriStar Horizon's local, statewide, and national affiliations, TriStar Horizon expects to be able to recruit highly qualified individuals with the appropriate licensure to staff and support the FSED. TriStar Horizon also has the benefit of a Nurse Residency Program to garner future nurses to meet the growing need for personnel across its service area. TriStar Horizon has had strong success integrating nurse residents into its existing ED and will utilize this talent pool for recruitment at the future FSED. In 2025, TriStar Horizon had rotations from nursing programs at schools, including Austin Peay, Belmont University (BSN), Nashville State Community College (ASN), South College (ASN), Tennessee College of Applied Technology Dickson (LPN), Tennessee College of Applied Technology Hohenwald (LPN), and Western Kentucky University (ASN). Additionally, in 2025, TriStar Horizon partnered with Nashville State Community College's Dickson Campus for its Associate of Science Nursing program. The program's first cohort began in January 2026. TriStar Horizon 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 TriStar Horizon's clinical training affiliations.

HCA Healthcare continues to strengthen its nursing workforce through its partnership with Galen College of Nursing, now one of the largest nursing colleges in the United States with 25 campuses and more than 19,000 students enrolled nationwide. Galen has grown rapidly—expanding from 6,260 students in 2019 to over 19,000 in 2025—and now supports more than 49,000 alumni, significantly increasing the talent pipeline across the communities where HCA Healthcare has facilities. At the Nashville campus, Galen currently enrolls 952 undergraduate nursing students, and between 2023 and 2026 yeartodate, 477 ADN and BSN students have graduated. Systemwide, Galen is projected to graduate 6,311 students in 2025, growing to more than 10,051 by 2029, with HCA receiving the vast majority of these graduates each year. HCA's hiring success continues to improve: 52% of Galen graduates joined HCA Healthcare facilities in 2025, and the TriStar Division has already achieved 56% success yeartodate in 2026. Additionally, turnover among Galen graduates is consistently lower than nonGalen new nurses, reflecting better retention and longterm workforce stability. This partnership remains a critical strategy for supporting TriStar's ongoing staffing needs and expanding its nursing workforce pipeline. This relationship will assist with ongoing recruitment of staff within the TriStar Division, including recruitment for the proposed TriStar Fairview FSED.

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 opened in April 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. 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 Health is extensively engaged with other educational and training programs throughout Middle Tennessee. These relationships provide for internships and other training opportunities for students at TriStar Health facilities and also provide a pipeline for future qualified employees.

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; and
- 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.

TriStar Fairview FSED Staffing

The staffing for the TriStar Fairview FSED is provided in response to **Question 8Q**.

- 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

TriStar Horizon is licensed by the Tennessee Health Facilities Commission Division of Licensure and Regulation, and the license is in good standing. It is certified to participate in the Medicaid and Medicare programs and currently meets all requirements of certification. TriStar Horizon is accredited by The Joint Commission. See **Attachment 5C-1** and **Attachment 2Q** for TriStar Horizon License and The Joint Commission Accreditation.

Clinical Leadership

Medical direction at the proposed TriStar Fairview FSED will be provided by Dr. Priscilla Shogan, D.O. Currently, Dr. Shogan is the Medical Director for the TriStar Horizon ED. Dr. Shogan is board certified by the American Board of Emergency Medicine and has been providing emergency services for almost 20 years. See **Attachment 5C-2** for Dr. Shogan's CV and 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. Additionally, they 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 TriStar Horizon, the proposed FSED will be part of its existing methods to ensure and maintain quality of care. TriStar Horizon uses 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. TriStar Horizon 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. TriStar Horizon's goal is to provide services which are measurably more accessible, affordable, and are focused on continuous quality improvement. The continuum of services may begin prior to admission, such as in an ED 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 TriStar Fairview FSED will be an extension of the ED at TriStar Horizon and a licensed department of TriStar Horizon and will therefore adhere to TriStar Health's plan for improving organizational performance, including planned performance assessment and improvement activities, initiating activities designed to follow-up on unusual occurrences or specific concerns/ issues, which may include following policies and procedures for ensuring staff competency and follow-up as appropriate on patient/family complaints and patient questionnaire results. Input and feedback from patients, staff and physicians guide the improvement process. TriStar Horizon addresses methods to ensure and maintain patients' quality of care.

TriStar Horizon is dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. As a satellite ED to TriStar Horizon, the proposed TriStar Fairview FSED will maintain the highest standards and quality of care, consistent with the high standard that TriStar Horizon has sustained throughout its history of providing patient care. In this regard, TriStar Horizon 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, TriStar Horizon provides a robust Utilization Review ("UR") program that provides ongoing concurrent reviews of patient care to determine whether treatments are medically necessary and, if not, to assist in placing patients in more appropriate care settings. Internal case management serves an important advisory purpose in enhancing and maintaining the quality of care provided. To this extent, systems are in place to conduct prospective, concurrent, and retrospective utilization reviews to ensure quality of care and protect revenue integrity. For more details, see **Attachment 5C-3** for TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence.

Clinical Staff Training Requirements

The TriStar Fairview FSED will be operationally integrated with TriStar Horizon's main campus 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.

In its dedication to enhance quality assurance and performance improvement, TriStar Horizon's 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, TriStar Horizon will continue to require all clinical staff members to attend continuing education programs, and receive annual in-services on HIPAA, Medicare Compliance, and OSHA. TriStar Horizon 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**.

Proposed TriStar Fairview FSED

All equipment at the TriStar Fairview 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 listed provided in **Attachment 4E-1**.

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
	<u>2023</u>	<u>2024</u>	<u>2025</u>
A. Utilization Data			
Specify Unit of Measure <u>Other : Admissions</u>	<u>7146</u>	<u>8107</u>	<u>8173</u>
B. Revenue from Services to Patients			
1. Inpatient Services	<u>\$443,723,149.00</u>	<u>\$551,791,698.00</u>	<u>\$652,881,850.00</u>
2. Outpatient Services	<u>\$711,121,099.00</u>	<u>\$773,885,799.00</u>	<u>\$863,339,795.00</u>
3. Emergency Services	<u>\$0.00</u>	<u>\$0.00</u>	<u>\$0.00</u>
4. Other Operating Revenue (Specify) <u>Includes cafeteria and rental income</u>	<u>\$10,668,229.00</u>	<u>\$6,735,665.00</u>	<u>\$708,993.00</u>
Gross Operating Revenue	<u>\$1,165,512,477.00</u>	<u>\$1,332,413,162.00</u>	<u>\$1,516,930,638.00</u>
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	<u>\$933,583,182.00</u>	<u>\$1,065,794,935.00</u>	<u>\$1,222,743,543.00</u>
2. Provision for Charity Care	<u>\$84,546,178.00</u>	<u>\$101,802,775.00</u>	<u>\$105,208,288.00</u>
3. Provisions for Bad Debt	<u>\$5,509,395.00</u>	<u>\$8,683,213.00</u>	<u>\$15,965,736.00</u>
Total Deductions	<u>\$1,023,638,755.00</u>	<u>\$1,176,280,923.00</u>	<u>\$1,343,917,567.00</u>
NET OPERATING REVENUE	<u>\$141,873,722.00</u>	<u>\$156,132,239.00</u>	<u>\$173,013,071.00</u>

PROJECTED DATA CHART

- Project Only
 Total Facility

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

	Year 1	Year 2
	<u>2029</u>	<u>2030</u>
A. Utilization Data		
Specify Unit of Measure <u>Other : ED Visits</u>	<u>4845</u>	<u>7018</u>
B. Revenue from Services to Patients		
1. Inpatient Services	<u>\$0.00</u>	<u>\$0.00</u>
2. Outpatient Services	<u>\$0.00</u>	<u>\$0.00</u>
3. Emergency Services	<u>\$44,414,115.00</u>	<u>\$64,334,006.00</u>
4. Other Operating Revenue (Specify) _____	<u>\$0.00</u>	<u>\$0.00</u>
Gross Operating Revenue	<u>\$44,414,115.00</u>	<u>\$64,334,006.00</u>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	<u>\$34,936,253.00</u>	<u>\$50,605,288.00</u>
2. Provision for Charity Care	<u>\$5,397,203.00</u>	<u>\$7,817,869.00</u>
3. Provisions for Bad Debt	<u>\$488,555.00</u>	<u>\$707,674.00</u>

Total Deductions \$40,822,011.00 \$59,130,831.00

NET OPERATING REVENUE \$3,592,104.00 \$5,203,175.00

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 (<i>Gross Operating Revenue/Utilization Data</i>)	\$0.00	\$0.00	\$9,167.00	\$9,167.00	0.00
Deduction from Revenue (<i>Total Deductions/Utilization Data</i>)	\$0.00	\$0.00	\$8,425.60	\$8,425.60	0.00
Average Net Charge (<i>Net Operating Revenue/Utilization Data</i>)	\$0.00	\$0.00	\$741.40	\$741.40	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 Gross Charges per ED visit for the TriStar Fairview FSED are projected to be \$9,167 in the first and second year. 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 TriStar Natchez FSED. As also noted above, as the deductions from revenue occur as expected in normal operations, the Average Net Charge in Year One will be \$741 and the Average Net Charge in Year Two will also be \$741, reflecting the ordinary expected deduction from Gross Charges. The proposed FSED is not expected to have any impact on the charges for ED services at TriStar Horizon or any affiliate.

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 TriStar Horizon’s ED, which are comparable throughout TriStar Health. It is difficult to compare the charges for ED services given the multiple levels of care and associated ancillary charges that varying types of ED patients experience.

Exhibit 9C-1 provides a comparison of standard average gross charges by CPT Code for Codes 99281-99285 for the ED providers outside of the service area, but within the counties in which the zip codes are located.

**Exhibit 9C-1
Average of Standard Gross Charges by CPT Codes (Current)**

CPT Code:	99281	99282	99283	99284	99285
TriStar Horizon	\$817	\$1,233	\$2,753	\$3,602	\$5,400
TriStar Southern Hills (including TriStar Nolensville FSED)	\$1,218	\$1,423	\$2,162	\$3,703	\$4,813

Source: Hospital Chargemasters.

The CMS transparency files on the WMC and St. Thomas Hickman websites do not have the charges for the five CPT codes required for this question. Therefore, that information is not available to the Applicant.

Even if comparative data was available from WMC and St. Thomas Hickman, it is important to consider in evaluating allegedly comparative CPT charges for ED services because:

- Gross charges do not reflect what either patients or payors pay for ED services as payors have discounted rates and insured patients are only responsible for co-pays and deductibles. Self-pay patients and even those with insurance may also qualify for a self-pay discount. In addition, low-income individuals may qualify for charity care.
- Charges for a single visit CPT code do not include associated ancillary charges that vary based on patient experience and acuity.
- It is not possible to fully acuity-adjust ED patient charges for accurate comparison.

The amount that patients pay is largely determined by their health insurance coverage. If a patient does not have health insurance, their financial liability will be determined by the application of TriStar Horizon's uninsured discount to their bill for non-elective services.

Comparisons of charge rates between hospitals will not reflect distinctions in prices due to variations in pricing methodology. For example, if an item or service is priced as a case rate (a set rate for an episode of care) with a particular payor or for a particular hospital, but as a per day rate with a different payer or hospital, then these rates cannot be compared without first determining the patient's length of stay and then applying the applicable contractual enhancements (e.g., stoploss or trauma activation).

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

Finally, as an emergency department, the TriStar Fairview FSED will care for every presenting patient regardless of their commercial insurance or insured status as required by EMTALA. Like TriStar Horizon, the TriStar Fairview FSED will comply 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.

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-2029		Year-2030	
	Gross Operating Revenue	% of Total	Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	\$12,036,225.00	27.10	\$17,434,516.00	27.10
TennCare/Medicaid	\$11,902,983.00	26.80	\$17,241,514.00	26.80
Commercial/Other Managed Care	\$13,546,304.00	30.50	\$19,621,872.00	30.50
Self-Pay	\$5,507,350.00	12.40	\$7,977,417.00	12.40
Other(Specify)	\$1,421,253.00	3.20	\$2,058,687.00	3.20
Total	\$44,414,115.00	100%	\$64,334,006.00	100%
Charity Care	\$5,397,203.00		\$7,817,869.00	

**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 Attachment 10C for explanation.

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.

- 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?

- Yes
- No

- Does the applicant commit to obtaining and maintaining all applicable state licenses in good 3standing?

- 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?

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	<input checked="" type="checkbox"/> Health Facilities Commission/Licensure Division <input type="checkbox"/> Intellectual & Developmental Disabilities <input type="checkbox"/> Mental Health & Substance Abuse Services	Active	000000029
Certification	<input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> TennCare/Medicaid <input type="checkbox"/> Other _____	Active Active	440046 0440046
Accreditation(s)	TJC - The Joint Commission	Active	7826

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/RNs	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		04/22/26
2. Building Construction Commenced	370	04/26/27
3. Construction 100% Complete (Approval for Occupancy)	734	04/24/28
4. Issuance of License	824	07/23/28
5. Issuance of Service	884	09/21/28
6. Final Project Report Form Submitted (Form HR0055)	1004	01/19/29

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

PUBLIC NOTICES**Foreclosure / Sheriff Sales****SUBSTITUTE TRUSTEE'S SALE**

Default having been made in the terms, conditions, provisions and payments made and provided for in a Deed of Trust dated October 18, 2010, executed by Francis Lupai and wife, Metsehet Wold Sembat, to B. Anthony Saunders, as Trustee, and recorded at Instrument No. 20101020-0083972 of record in the Register's Office for Davidson County, Tennessee, to secure the indebtedness therein described, and the entire indebtedness having been called due and payable as provided in said deed of trust, and said payment not having been made, and the lawful owner and holder of said indebtedness having appointed the undersigned, David G. Mangum, as substitute trustee by written instrument dated June 1, 2018 and recorded at Instrument No. 20180612-0056251, in the above mentioned Register's Office, notice is hereby given that I, the undersigned substitute trustee, or my designated agent, under the power and authority vested in me by said deed of trust, and having been requested to do so by the lawful owner and holder of said debt, will on Friday, March 20, 2026 at 12:00 pm (Noon) at the Front Door of the Historic Nashville Metro Courthouse, 1 Public Square, Nashville, TN 37201, sell at public outcry to the highest and best bidder for cash, free from the equity of redemption, homestead and dower, and all other exemptions and rights of every kind, all of which are expressly waived in said deed of trust, the following described tract or parcel of land situated and lying in Davidson County, Tennessee, and more particular described as follows, to-wit:

Land in Davidson County, Tennessee being Lot No. 62 as shown on the map entitled Timberwood Cluster Lot Development of record as Instrument No. 20080211-0013669 through 20080211-0013671, Register's Office for Davidson County, Tennessee to which plan reference is hereby made for a more complete legal description.

DEED REFERENCE:

Being the same property conveyed to Francis Lupai and wife, Metsehet Wold Sembat from Nashville Area Habitat for Humanity, Inc. by Special Warranty Deed of record as Instrument No.: 20101020-0083968 said Register's Office. This description was taken from the deed of trust being foreclosed on of record at Instrument No. 20101020-0083972 said Register's Office.

This property is sold SUBJECT to a first mortgage securing 3036 Barbara Lynn Way, Nashville, TN 37207 in favor of Nashville Area Habitat for Humanity, Inc. in the original principal amount of \$94,774.00, of record at Instrument No. 20101020-0083969 and assigned to Tennessee Housing Development Agency of record at Instrument No. 20101020-0083970, said Register's Office; a second mortgage securing 3036 Barbara Lynn Way, Nashville, TN 37207 in favor of Nashville Area Habitat for Humanity, Inc. in the original amount of \$20,000.00, of record at Instrument No. 20101020-0083971 as well as any and all existing easements, setback lines and restrictive covenants of record in the said Register's Office, including but not limited to ROW and/or Easement of record at Instrument No. 20070501-0051523 as well as Restrictive Covenants of record at Instrument No. 20080211-0013672, 20100202-0008170, 20100316-0019843, 20100910-0072176, an affidavit of record at Instrument No.: 201009290077630 and a quitclaim deed for common area of record at Instrument No.: 20140000-0082470 said Register's Office.

PUBLIC NOTICES**Foreclosure / Sheriff Sales****Public Notices**

12068863

NOTICE OF ATTORNEY FOR POWER OF SALE

Default having been made by Sue Turner in the terms, conditions and payments secured by the Lien for same created by the Declaration of Covenants, Conditions and Restrictions of Tanasi Shore Homeowners Association of record in Book 483, Pages 203-227 in the Register's Office for Sumner County, Tennessee, and further secured by the Notice of Lien of record in Record Book 6325, Page 368-370, et seq., said Register's Office; and,

WHEREAS, at time of such default, the Declaration of Covenants, Conditions and Restrictions of Tanasi Shore Homeowners Association was of record in Record Book 483, Page 203, et seq. ("Declaration") at the Register's Office for Sumner County, Tennessee; and,

WHEREAS, by Appointment of Attorney for Power of Sale of record in Record Book 6736, Pages 383-386 et seq. in said Register's Office, Tanasi Shore Homeowners Association Inc. has appointed Julie G. Hamner, Attorney for Power of Sale, to succeed to all of the rights, title and powers conferred upon the Association by the president thereof pursuant to authority granted to him by the Board; and,

WHEREAS, the entire indebtedness secured by said Notice of Lien, and all maintenance fees, assessments and related expenses which remain unpaid to date, as provided therein, are due and payable; and,

WHEREAS, Tanasi Shore Homeowners Association, in accordance with the said Declaration, has directed Julie G. Hamner, as Attorney for Power of Sale, to advertise the subject property for sale for the satisfaction of said indebtedness, as provided within the said Declaration of Covenants, Conditions and Restrictions and By-Laws.

NOW THEREFORE, notice is hereby given that I, Julie G. Hamner, Attorney for Power of Sale, by virtue of the power and authority vested in me by said Declaration, will, on **Wednesday, April 1, 2026, at 10:00 A.M.** Central Standard Time, at the main entrance of the Sumner County Courthouse, located at 155 E Main St, Gallatin 37066, sell at public auction, to the highest and best bidder for cash, in bar of all rights and/or equities of redemption, statutory and otherwise, homestead and dower, all of which are expressly waived in said Declaration and all of the said modifications thereto, and said sale will be subject to all unpaid taxes, prior liens and encumbrances of record; Described property located in Rutherford County, Tennessee to wit:

Land in Sumner County, Tennessee, being all of Unit "A", Building 7 on the Revised Plat to Phase One Tanasi Shores, of record in Plat Book 11, Page 395, which revises Plat Book 11, Page 105

The following parties constitute "party interested" as defined in Tennessee Code Annotated §35-5-104: Warranty Deed to Sue Turner, of record in Record Book 5707, Pages 626-628, Register's Office for Sumner County, Tennessee. The street address of the described property is 101 Tanasi Shores, Gallatin, TN. 37066. Assignment of Deed of Trust to Lakeview Loan Servicing, LLC of record in Record Book 6524, Pages 363-365, Register's Office for Sumner County, Tennessee. The street address of the described property is 101 Tanasi Shores, Galaltin, TN. 37066

The right is reserved to adjourn the day of the sale to another day, time and place certain without further publication, upon announcement at the time and place for the sale

Public Notices**Public Notices****NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED**

This is to provide official notice to the Health Facilities Commission and all interested parties, in accordance with T.C.A. §68-11-1601 et seq., and the Rules of the Health Facilities Commission, that TriStar Horizon Medical Center, a/an Hospital owned by Central Tennessee Hospital Corporation 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 Fairview, Williamson County, Tennessee on 5.77 acres. 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 entry canopies (2,000 square feet), one designated for emergency vehicles and one designated for the general public. The ultimate owner of Central Tennessee Hospital Corporation is HCA Healthcare, Inc. The address of the project will be 2273 Fairview Boulevard, Fairview, Williamson County, Tennessee, 37062. The estimated project cost will be \$21,018,000.

The anticipated date of filing the application is 03/02/2026

The contact person for this project is Chief Executive Officer Wyatt Chocklett who may be reached at TriStar Horizon Medical Center - 111 US-70E, Dickson, TN 37055 - Contact No. 615-446-0446.

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. February 27 2026 LOKR0466616

**Looking to**

THE TENNESSEAN

Public Notices

Originally published at tennessean.com on 02/27/2026

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February 27 2026

LOKR0466616

Attachment 7A-1

Charter of Central Tennessee Hospital Corporation

RECEIVED
STATE OF TENNESSEE

95 MAY -5 AM 11: 44

RILEY DARNELL
SECRETARY OF STATE

CHARTER

OF

CENTRAL TENNESSEE HOSPITAL CORPORATION

FILED

RECEIVED
STATE OF TENNESSEE

95 MAY 10 PM 4: 07

RILEY DARNELL
SECRETARY OF STATE

The undersigned person, under the Tennessee Business Corporation Act, adopts the following Charter for the above listed corporation:

1. The name of the corporation is Central Tennessee Hospital Corporation
2. The number of shares of stock the corporation is authorized to issue is one thousand (1,000) shares of common stock, par value of \$1.00 per share.
3. (a) The complete address of the corporation's initial registered office in Tennessee is 500 Tallan Building, Two Union Square, Chattanooga, Hamilton County, Tennessee 37402.
(b) The name of the initial registered agent, to be located at the address listed in 3(a), is The Prentice Hall Corporation System, Inc.

4. The name and complete address of each incorporator is:

Douglas S. Jackson, Esq.
117 Highway 70 East
Dickson, Tennessee 37055


5. The complete address of the corporation's initial principal office is 111 Highway 70 East, Dickson, Dickson County, Tennessee 37055.

6. The corporation is for profit.

7. The persons serving on the initial Board of Directors for the corporation are:

James T. Jackson	111 Highway 70 East	Dickson, TN 37055
James W. Jackson	111 Highway 70 East	Dickson, TN 37055
Anne Deason	111 Highway 70 East	Dickson, TN 37055
Bob Spencer	111 Highway 70 East	Dickson, TN 37055
Bill Kruse	111 Highway 70 East	Dickson, TN 37055
Mike Legg	111 Highway 70 East	Dickson, TN 37055

Dated: May 2, 1995.


Doug Jackson

Attachment 7A-2

TriStar Horizon Medical Center
Assumed Name Renewal



Tre Hargett
Secretary of State

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

CENTRAL TENNESSEE HOSPITAL CORPORATION
ATTN LEGAL DEPT
PO BOX 750
NASHVILLE, TN 37202-0750

April 12, 2022

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

Control # : 294588 Status: Active
Filing Type: For-profit Corporation - Domestic

Document Receipt

Receipt # : 007159307	Filing Fee:	\$20.00
Payment-Credit Card - State Payment Center - CC #: 3827375477		\$20.00

Amendment Type: Assumed Name Renewal Image # : B1199-3673
Filed Date: 04/12/2022 7:55 AM

This will acknowledge the filing of the attached assumed name renewal. When corresponding with this office or submitting documents for filing, please refer to the control number given above. The name registration is effective for five years from the effective date indicated above. You may renew the right to use this name within two (2) months preceding the expiration of such right, for a period of five (5) years, by filing an application with the Secretary of State.

Tre Hargett
Secretary of State

Processed By: Corp Web User

Field Name	Changed From	Changed To
Assumed Name	TriStar Horizon Medical Center	TriStar Horizon Medical Center
Expiration Date	04/13/2022	04/12/2027



006293030

**APPLICATION FOR RENEWAL OF
REGISTRATION OF ASSUMED NAME**

SS-4488



Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: \$20.00

For Office Use Only

-FILED-

Amendment # 006293030

Assumed Name: TriStar Horizon Medical Center

Date of Expiration: 04/13/2022

Pursuant to the Tennessee Business Corporation Act, Tennessee Nonprofit Corporation Act, Tennessee Limited Liability Company Act, Tennessee Revised Limited Liability Company Act, or the Tennessee Revised Uniform Partnership Act, the undersigned submits this application.

Failure to file the required document within the two (2) months preceding the expiration of the registration of the assumed name will result in expiration of the assumed name.

1. The Secretary of State Control Number is: 000294588
and the true name of the business entity is:
CENTRAL TENNESSEE HOSPITAL CORPORATION

2. The state or country of organization is:
TENNESSEE

3. The business entity intends to transact business under an assumed name.

4. The assumed name the business entity proposes to use is:
TriStar Horizon Medical Center
The assumed name must satisfy the statutory requirements for that type of entity.

04/12/2022

Signature Date

Electronic

Signature

Vice President & Asst. Secretary

Signer's Capacity

John M. Franck II

Name (typed or printed)

Note: Pursuant to T.C.A. § 10-7-503 all information on this form is public record.

B1199-3673 04/12/2022 7:55 AM Received by Tennessee Secretary of State Tre Hargett

Attachment 7A-3

Certificate of 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

tncab.tnsos.gov/portal/

Tre Hargett

Secretary of State

KRISTINA BAGWELL
ONE PARK PLAZA
NASHVILLE, TN 37203, USA

02/16/2026

Request Type: Certificate of Existence/Authorization

Issuance Date: 02/16/2026

Request #: C2026015757

Document Receipt

Order Number: C2026015757

Verification #: BEA2B0EE

Receipt #: 2026-163014

Filing Fee: \$20.00

Payment: Credit Card - 3915674870

\$20.00

Entity Name:	CENTRAL TENNESSEE HOSPITAL CORPORATION	Initial Filing Date:	05/10/1995
SOS Control #:	000294588	Formation Locale:	TENNESSEE
Entity Type:	For-profit Corporation	Duration Term:	Perpetual
Status:	Active	Annual Report Due:	04/01/2026
Fiscal Year Close:	December		
Business County:	DAVIDSON		
Shares of Stock:	1000		
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

CENTRAL TENNESSEE HOSPITAL CORPORATION

- * 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

Verification #: BEA2B0EE

Attachment 7A-4
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 the interest of

**Healthserv Acquisition,
LLC**

owns 100% of common stock of

**HCA Health Services of
Tennessee, Inc.**

owns 100% of common stock of

**Central Tennessee
Hospital Corporation**

Attachment 7A-5

TriStar Horizon Medical Center
Officers and Directors

September 5, 2025

OFFICERS AND DIRECTORS
OF
CENTRAL TENNESSEE HOSPITAL CORPORATION

* 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
Wyatt Chocklett	Vice President	111 Highway 70 E Dickson, TN 37055
Natalie H. Cline	Vice President and Secretary	One Park Plaza Nashville, TN 37203
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.

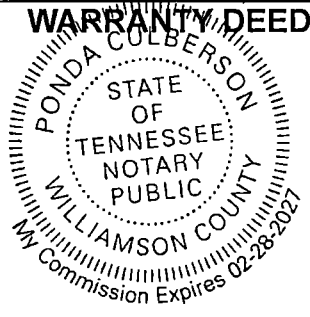
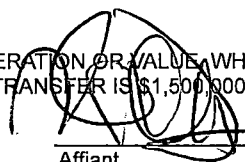
Attachment 8A

Not Applicable

Attachment 9A

Real Estate Purchase Agreement and Option Agreement for Site

①

 <p>WARRANTY DEED</p>	State of Tennessee County of Williamson THE ACTUAL CONSIDERATION OR VALUE, WHICHEVER IS GREATER, FOR THIS TRANSFER IS \$1,500,000.00 _____ Affiant SUBSCRIBED AND SWORN TO BEFORE ME, THIS 15th day of August, 2025  _____ Notary Public MY COMMISSION EXPIRES: <u>2-28-2027</u> (AFFIX SEAL)
---	--

Mis → **THIS INSTRUMENT WAS PREPARED BY**
 Bridgehouse Title, 342 Cool Springs Blvd., Suite 202, Franklin, TN 37067

ADDRESS NEW OWNER(S) AS FOLLOWS:	SEND TAX BILLS TO:	MAP PARCEL NUMBERS
Ken Karger	<i>New Owner</i>	042/166.00
1300 OLD HICKORY BLVD (NAME)	(NAME)	
BRENTWOOD 37027 (ADDRESS)	(ADDRESS)	
, TN (CITY) (STATE) (ZIP)	(CITY) (STATE) (ZIP)	

FOR AND CONSIDERATION OF THE SUM OF TEN DOLLARS, CASH IN HAND PAID BY THE HEREINAFTER NAMED GRANTEES, AND OTHER GOOD AND VALUABLE CONSIDERATIONS, THE RECEIPT OF WHICH IS HEREBY ACKNOWLEDGED, I, **Katherine R. Claiborne, a married woman**, HEREINAFTER CALLED THE GRANTORS, HAVE BARGAINED AND SOLD, AND BY THESE PRESENTS DO TRANSFER AND CONVEY UNTO **Ken Karger, unmarried**, HEREINAFTER CALLED THE GRANTEES, THEIR HEIRS AND ASSIGNS, A CERTAIN TRACT OR PARCEL OF LAND IN Williamson COUNTY, STATE OF TENNESSEE, DESCRIBED AS FOLLOWS, TO-WIT:

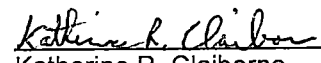
SEE EXHIBIT "A" ATTACHED HERETO

unimproved
 This is improved property, known as 2273 Fairview Blvd., Fairview, TN 37062
(House Number) (Street) (P.O. Address) (City or Town) (Postal Zip)

This conveyance is subject to the following: Taxes for the year 2025, which have been prorated, and payment thereof, by acceptance of this conveyance, is expressly assumed by Grantees; Twenty-foot ingress/egress easement per deed, right of way of record in Book 4835, page 525; Easement of record in Book 4296, page 644; all of record in the Register's Office for Williamson County, Tennessee.

TO HAVE AND TO HOLD the said tract or parcel of land, with the appurtenances, estate, title and interest thereto belonging to the said GRANTEES, their heirs and assigns forever; and we do covenant with the said GRANTEES that we are lawfully seized and possessed of said land in fee simple, have a good right to convey it and the same is unencumbered, unless otherwise herein set out; and we do further covenant and bind ourselves, our heirs and representatives, to warrant and forever defend the title to the said land to the said GRANTEES, their heirs and assigns, against the lawful claims of all persons whomsoever. Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

Witness my hand this 15th day of August, 2025.


 Katherine R. Claiborne

BK: 9807 PG: 521-522
25026884


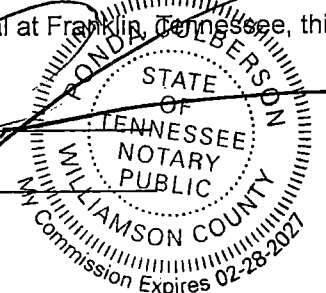
2 PGS:AL-DEED	
1058278	
08/20/2025 - 08:01 AM	
BATCH	1058278
MORTGAGE TAX	0.00
TRANSFER TAX	5550.00
RECORDING FEE	10.00
DP FEE	2.00
REGISTER'S FEE	1.00
TOTAL AMOUNT	5563.00

STATE OF TENNESSEE, WILLIAMSON COUNTY
SHERRY ANDERSON
 REGISTER OF DEEDS

State of Tennessee
 County of Williamson

Personally appeared before me, the undersigned authority, in and for said County and State, appeared Katherine R. Claiborne, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who acknowledged that she executed the foregoing instrument for purposes therein contained.

WITNESS my hand and official seal at Franklin, Tennessee, this 15th day of August, 2025.


 Notary Public
 My Commission Expires: _____


File No.: 39060

EXHIBIT "A"
LEGAL DESCRIPTION

Tract One: Beginning at a concrete stake in the right of way line of Highway 100; thence with said right of way line N 24-1/2 degrees E 12.08 poles to a concrete stake; thence S 65 degrees E 27 poles to a stake; thence S 24-1/2 degrees W 30.08 poles to a concrete stake; thence N 65-1/2 degrees W 18-3/4 poles to a concrete stake in Claiborne Sullivan's line; thence running with Claiborne Sullivan's line N 3 degrees E 19-3/4 poles to a concrete stake; thence N 81 degrees W 9 feet to the beginning, containing 4.55 acres, more or less.

Tract Two: Beginning at a concrete stake in Carroll Sullivan's NE corner; thence S 65-1/2 degrees E 12-2/3 poles; thence S 24-1/2 degrees W 25-1/8 poles to a concrete stake, Claiborne Sullivan's north boundary line; thence said Sullivan's line N 78 degrees W 13 poles to a stake in Carroll Sullivan's E boundary line, two poles N of Carroll Sullivan's SE corner; thence with said Carroll Sullivan's E line N 24-1/2 degrees E 28 poles to the beginning, containing 2.11 acres, more or less.

Tract Three: Beginning at a concrete block corner in Mrs. Lissie Sullivan's W boundary line also Claiborne Sullivan's E boundary line; thence with said line N 3-1/2 degrees E 128 feet to a concrete stake; thence N 87 degrees W 9-1/2 feet to a stake in the right of way line of No. 100 Highway; thence with said line S 24 degrees W 118 feet to a stake; thence S 66 degrees E 58-1/2 feet to the beginning, containing 11/100 of an acre, more or less.

Being the same property conveyed to Betty C. Hughes, George Marlin Hughes and Katherine Renee Claiborne by Warranty Deed from George W. Hughes and wife, Betty C. Hughes, dated July 31, 1992, of record in Book 998, page 538, Register's Office for Williamson County, Tennessee.

INCLUDED IN THE ABOVE DESCRIPTION BUT EXPRESSLY EXCLUDED FROM THIS CONVEYANCE is the tract or parcel of land that was conveyed to George Marlin Hughes (single), by Quitclaim Deed from Betty C. Hughes (single) and Katherine Renee Claiborne, dated May 26, 1993, of record in Book 1078, page 826, Register's Office for Williamson County, Tennessee, described as follows:

Being a tract of land shown on property map 43, Assessor's Office, and lying wholly within the 1st Civil District of Williamson County, Fairview, Tennessee, bounded in general by Fairview Boulevard West (State Highway 100) on the northwest, John Nutt on the north and the Betty Hughes remainder on the east and south, more particularly described as follows:

Beginning at an iron pin near a wood corner post on the southeast margin of Fairview Boulevard West, said pin being the common corner between John Nutt (Ref. Deed Book 154, page 100, ROWC, TN) and Betty Hughes (Ref. Book 998, page 538, ROWC, TN), and said pin being located S 21° 23' 56" West 295.13 ft. from a reference PK nail at the centerline intersection between Fairview Boulevard West and Meadow Wood Drive; thence leaving the Highway and with Nutt's southwest line running generally with the fence, S 61° 57' 26" E 332.44 ft. to an iron pin; thence leaving Nutt and the fence, and with new lines, S 27° 55' 47" W 112.09 ft. to an iron pin; thence N 67° 18' 43" W 155.27 ft. to an iron pin at a fence post; thence with the fence for the following 4 calls: N 79° 27' 24" W 48.05 ft. to an iron pin at a post; S 80° 26' 23" W 29.94 ft. to an iron pin at a post; N 44° 07' 30" W 72.26 ft. to an iron pin at a post; and N 47° 36' 15" W, crossing a joint 20 ft. ingress-egress easement, 40.75 ft. to an iron pin on the southeast margin of Fairview Boulevard West; thence with said margin N 27° 55' 47" E 127.07 ft. to the point of beginning, containing 1.00 acres, more or less.

The above described tract is served by a joint 20 ft. ingress-egress easement running from Fairview Boulevard West to the southwest corner of the property.

Being the same property conveyed to Katherine R. Claiborne by Quitclaim Deed from George M. Hughes (single) and Betty C. Hughes (single), dated May 26, 1993, of record in Book 1078, page 829, Register's Office for Williamson County, Tennessee.

REAL ESTATE PURCHASE CONTRACT

THIS REAL ESTATE PURCHASE CONTRACT (the "Agreement") is made and entered into as of the date of full execution of this Agreement (the "Effective Date") by and between KEN KARGER ("Seller") and FRANKLIN LAND ASSOCIATES, L.L.C., a Tennessee limited liability company ("Buyer").

WITNESSETH

For and in consideration of One Hundred Dollars (\$100.00), the agreements made herein, and other good and valuable considerations, the receipt and legal sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

1. Property. Seller hereby agrees to sell and Buyer hereby agrees to purchase, upon and subject to the terms and conditions herein set forth, that certain tract or parcel of land described as 5.77 +/- acres (APN# 042 16600 000) located at 2273 Fairview Blvd, Fairview, Williamson County, TN depicted on Exhibit A attached hereto.

2. Earnest Money. \$25,000.00, to be deposited with First American Title Company (hereinafter "Escrow Agent") within five (5) business days after the Effective Date, paid in accordance with the terms and provisions of this Agreement. All interest earned on the Earnest Money shall be the property of Buyer. Buyer and Seller shall indemnify and hold the Escrow Agent harmless from all damage, costs, claims and expenses arising from performance of its duties as Escrow Agent including reasonable attorneys' fees, except for those damages, costs, claims and expenses resulting from the gross negligence or willful misconduct of the Escrow Agent.

3. Purchase Price. \$2,650,000.00

4. Closing. Thirty (30) days after the end of the Inspection Period as extended (the "Closing Date"); provided however, Buyer at Buyer's sole discretion, may close sooner.

5. Obligations at Closing. At Closing, Seller shall deliver to Buyer, or Buyer's designee, a general warranty deed conveying to Buyer or its designee good and marketable title in fee simple to the Property, subject only to exceptions acceptable pursuant to Paragraph 6 below, and all other documents required by the Escrow Agent for closing, pay for Seller's attorney's fees, ½ the transfer taxes and all other cost incurred by Seller or required to be paid by Seller pursuant to any other provision of this Agreement, and surrender the Property to Buyer. At Closing, Buyer shall pay the Purchase Price, as adjusted, pay for Buyer's attorney's fees, costs of recording the deed, ½ the transfer tax, title, survey, and any costs associated with financing the purchase of the Property, and all other cost incurred by Buyer or required to be paid by Buyer pursuant to any other provision of this Agreement. Real property taxes will be prorated as of the Closing Date.

6. Inspection Period. Buyer shall be given one hundred twenty (120) calendar days following contract execution for the completion of due diligence actions, environmental and geotechnical testing, the obtaining of all necessary permits and licenses, platting, and title investigation. In the event Buyer, at its sole discretion, determines after making such inspections that the Property or the transaction is undesirable, Buyer, at its sole option, upon written notice prior to the expiration of the Inspection Period or any extensions thereof, may declare the Contract terminated. In the event that Buyer does elect to terminate the Contract, neither Buyer nor Seller shall have any responsibilities to each other with regard to the Contract, and the Earnest Money shall be returned to the Buyer. Seller shall provide Buyer copies of all available materials pertaining to the Property to Buyer within ten (10) days after the Effective Date.

If Buyer terminates this Agreement before the end of the Inspection Period, all Earnest Money, except for \$100.00, which is paid as independent consideration to Seller, shall be returned to Buyer. If Buyer terminates this Agreement after the end of the Inspection Period, all Earnest Money shall be sent to Seller, unless Seller defaults under this Agreement, in which case the Earnest Money shall be returned to Buyer. Upon the termination of this Agreement pursuant to this subparagraph, the parties shall be relieved of any further obligations hereunder.

If Buyer intends to proceed with the Closing of its purchase of the Property, then Buyer shall, on or before the expiration of the Inspection Period, notify the Seller and/or Escrow Agent in writing as provided in this Agreement of Buyer's intent to proceed with the Closing of its purchase of the Property, subject to all of the other terms and conditions hereof.

Buyer may extend the Inspection Period for one (1) sixty (60) day period upon the payment to the Escrow Agent on or before the date of the expiration of the original time period of the Inspection Period, or extension thereof, of an amount of \$25,000.00 per extension period required, held in escrow per the terms and conditions described herein and shall be non-refundable, but applicable to the Purchase Price at Closing.

6. Survey and Title. Buyer shall be responsible for obtaining an updated survey of the Property and a title policy commitment. Upon receipt of notice of any objections to title or survey, Seller shall have fifteen (15) days after receipt of such notice to satisfy or cure such objections to Buyer's satisfaction. If Seller fails or declines to satisfy the same within such period, the Buyer, at Buyer's option, may terminate the Agreement and all Earnest Money shall be returned to Buyer. Seller acknowledges that Seller is responsible for the removal of any tenant of the Property, and that any tenant must have vacated the property with sufficient notice under any applicable lease prior to the end of the Inspection Period, and Seller must provide Buyer with copies of all leases and all notices sent to tenants.

7. Commissions. Seller and Buyer warrant and represent to each other that they have not employed or dealt with any other real estate agent or broker relative to the sale and purchase of the Property except for Cushman Wakefield and Weichert Big Dog Group whose 6% commission will be split equally between the parties and paid by Seller at Closing. Each party hereby agrees to indemnify and hold harmless the other from and against any liability (including costs and reasonable attorney's fees) incurred in the defense thereof to any other agents or brokers with whom such party may have dealt.

8. Representations and Warranties and Covenants of Seller. Seller warrants and represents and covenants to Buyer that there are no actions, suits or proceedings pending or threatened against, by or affecting Seller or the Property; Seller has the authority to convey the Property to Buyer without the joinder of any other person or entity; other than as disclosed to Buyer, there are no environmental hazards on the Property; on the Closing Date, Seller will not be indebted to any contractor, laborer, mechanic, materialmen, architect or engineer for work, labor or services performed or rendered, or for materials supplied or furnished, in connection with the Property for which any person could claim a lien against the Property; and the Property will be delivered to Buyer at Closing free and clear from any leases, contracts and tenants in possession. Each representation and warranty of Seller contained in this Agreement shall be true and accurate as of the date hereof and shall be deemed to have been made again at and as of Closing and shall be then true and accurate in all material respects.

9. Damage and Condemnation. Seller shall notify Buyer promptly upon the occurrence of any damage, destruction, taking or threat of taking affecting the Property.

10. Default. If Buyer defaults, Seller may terminate this Agreement by written notice to Buyer, whereupon the Earnest Money, and any other deposits, if any, hereunder shall be paid to Seller as full and complete liquidated damages for the default of Buyer as Seller's sole and exclusive remedy, in which event neither party shall have any further rights, obligations, or liabilities under this Agreement. If Seller defaults, Buyer may avail itself of the remedy of specific performance or terminate this Agreement by written notice to Seller, whereupon the Earnest Money shall be refunded to Buyer as full and complete liquidated damages for such default and Seller shall reimburse Buyer for all out-of-pocket expenses.

11. Assignment. Buyer may at any time assign or transfer its interest in this Agreement, with notice to Seller. This Agreement shall be binding upon and enforceable against, and shall inure to the benefit of, the parties and their respective legal representatives, successors and assigns.

12. Applicable Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the state in which the Property is located.

13. Miscellaneous. Time shall be of essence in the performance of the terms and conditions of this Agreement. In the event any time period specified in this Agreement expires on a Saturday, Sunday or bank holiday on which national banks are closed for business, then the time period shall be extended so as to expire on the next business day immediately succeeding such Saturday, Sunday or bank holiday. For purposes of this Agreement, business days shall be Monday through Friday, excluding any Federal holidays. All captions, headings, paragraph and subparagraph numbers and letters and other reference numbers or letters are solely for the purpose of facilitating reference to this Agreement and shall not supplement, limit or otherwise vary in any respect the text of this Agreement. All references to particular paragraphs and subparagraphs by number refer to the paragraph or subparagraph so numbered in this Agreement. This Agreement supersedes all prior discussions and agreements between Seller and Buyer with respect to the purchase and sale of the Property. This Agreement contains the sole and entire understanding between Seller and Buyer with respect to the transactions contemplated by this Agreement, and all promise, inducements, offers, solicitations, agreements, representations and warranties heretofore made between the parties are merged into this Agreement. This Agreement shall not be modified or amended in any respect unless by a written Agreement executed by or on behalf of the parties to this Agreement in the same manner as this Agreement is executed. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which, collectively, shall be one and the same instrument. In addition, this Agreement may be transmitted between the parties via facsimile, and signatures transmitted by electronic mail shall be deemed originals and shall be binding upon the parties. Seller agrees that the terms of this Agreement shall be deemed confidential in nature and shall not be disclosed to any third parties by Seller without the prior written consent of Buyer. In the event of any litigation arising out of this Agreement, the party prevailing in obtaining the relief sought, in addition to all other sums that it may be entitled to recover, shall be entitled to recover from the other party its reasonable attorneys' fees and expenses incurred as a result of a litigation.

14. Notice. All notices shall be in writing and shall be deemed to have been duly given at the time and on the date when personally delivered, or upon being deposited with a nationally recognized commercial courier for next day delivery, to the addresses below, or upon delivery via pdf format sent by electronic mail. Rejection or other refusal to accept or inability to deliver because of changed address of which no notice was given shall be deemed to be in receipt of such communication. By giving prior notice to all other parties, any party may designate a different address for receiving notices.

Buyer: Franklin Land Associates, L.L.C.
c/o GBT Realty Corporation
9010 Overlook Boulevard
Brentwood, TN 37027
Attn: Legal Dept.


Seller: Ken Karger
President and CEO
342 Cool Springs Blvd, Ste 202
Franklin, TN 37067
Phone: 615-786-0008

***SIGNATURES ON THE FOLLOWING PAGE**

IN WITNESS WHEREOF, the parties have executed and sealed this Real Estate Purchase Contract, as of the day and year first above written.

BUYER:

FRANKLIN LAND ASSOCIATES, L.L.C.

By: 
Its: Authorized Agent
Date: 2/16/2026

SELLER:

KEN KARGER


By: 
Ken Karger
Date: 02/16/26

EXHIBIT A

To be replaced by Legal Description or Survey before Closing

5.77 +/- acres (APN# 042 16600 000) located at 2273 Fairview Blvd, Fairview, Williamson County, TN

[SELLER AUTHORIZATION LETTER]

Franklin Land Associates, L.L.C.
c/o GBT Realty Corporation
9010 Overlook Boulevard
Brentwood, Tennessee 37027

Re: Authorization for Submittals for 5.77 +/- acres (APN# 042 16600 000) located at 2273 Fairview Blvd,
Fairview, Williamson County, TN

To whom it may concern:

As the current owner of real property described above, Owner hereby authorizes Franklin Land Associates, L.L.C., and its successors and assigns, to act on Owner's behalf to request and apply for all city, county, and state approvals necessary for the intended development of the Property, including, without limitation, submissions for rezoning, platting, and site, building, and utility permit applications.

Owner:

Ken Karger

By:  *Ken Karger*
Date: 02/16/26

OPTION AGREEMENT

THIS OPTION 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 **FRANKLIN LAND ASSOCIATES, L.L.C.**, a Tennessee limited liability company (**“Seller”**), and **CENTRAL TENNESSEE HOSPITAL CORPORATION**, a Tennessee corporation, its successors and assigns (**“Purchaser”**). Seller and Purchaser are sometimes referred to in this Agreement individually as a **“Party”** and collectively as the **“Parties.”**

A. Seller has, or intends to have, a contract by and between Ken Karger, and Seller (as the same may be amended, collectively, the **“Purchase Agreement”**), to purchase approximately 5.77 acres, more or less, of real property situated in Williamson County, Tennessee, located 2273 Fairview Blvd., Fairview, Tennessee, having Parcel ID/Tax ID Number 042 166.00 000, and being more particularly described in the Purchase Agreement (the **“Property”**). Seller desires to sell to Purchaser, and Purchaser desires to purchase from Seller, an option to assume the Purchase Agreement and acquire the Property pursuant to the Purchase Agreement (**“Option”**).

IN CONSIDERATION of the Purchase Price, 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. **GRANT OF OPTION.** Seller grants to Purchaser the Option for the Option Term (defined below) pursuant to the terms and conditions of this Agreement.

2. **PURCHASE PRICE.** The purchase price for the Option is \$25,000 (**“Purchase Price”**). Such Purchase Price will be deemed earned by Seller on the Effective Date and Purchaser shall deliver such \$25,000 to Seller by check or federal wire transfer within five business days after the later of the Effective Date, or the date on which Seller provides Seller’s wire instructions to Purchaser. If and only if Purchaser delivers the Exercise Notice and takes an assignment of the Purchase Agreement by the Assignment Instrument as provided in this Agreement, then the Purchase Price will be increased to by \$75,000 to a total of \$100,000, in which event the additional \$75,000 will be paid by Purchaser to Seller in the manner provided above contemporaneously with Purchaser’s delivery of its executed counterpart to the Assignment Instrument as provided below.

3. **OPTION TERM.** The term of the option is the period commencing on the Effective Date and expiring on 11:59 PM local time where the Property is situated on the date that is five business days prior to the expiration of Seller’s contingencies under the Purchase Agreement (**“Option Term”**).

4. **EXERCISE OF OPTION.** To effectively exercise the Option, Purchaser must deliver written notice to Seller, on or before the expiration of the Option Term, of Purchaser’s election to exercise the Option (**“Exercise Notice”**). If Purchaser does not deliver the Exercise Notice to Seller, on or before the expiration of the Option Term, then Purchaser will be deemed to have elected to not exercise the Option and the Option and this Agreement will terminate upon the expiration of the Option Term. If Purchaser delivers the Exercise Notice to Seller, on or before the expiration of the Option Term, then Seller will execute the assignment instrument attached to this Agreement as Exhibit A (**“Assignment Instrument”**), and deliver the executed Assignment Instrument to Purchaser within two business days after Purchaser’s delivery of the Exercise Notice to Seller. Purchaser will then deliver its executed counterpart to the Assignment Instrument within two business days after receipt of the executed Assignment Instrument from Seller.

5. **PRE-ASSUMPTION MATTERS.** Throughout the Option Term, Seller: (i) shall not amend or modify or terminate the Purchase Agreement without the prior written consent of Purchaser, (ii) shall not enter into any agreement or grant any option or right to any person other than Purchaser with respect to the Purchase Agreement or the sale, transfer, conveyance, possession, use or occupancy of all or any portion of

the Property without the prior consent of Purchaser. Seller acknowledges that no other contracts, agreements or other documents signed or delivered or other acts or things done by Seller shall be binding upon Purchaser unless expressly approved or assumed in writing by Purchaser.

6. REPRESENTATIONS AND WARRANTIES – NON-REFERRAL SOURCE. Seller represents and warrants to Purchaser the following statements (A) and (B):

- (A) Seller is not a “Referral Source” (as hereinafter defined) and that no ownership or beneficial interest in Seller is owned or held by any Referral Source. For the purpose of this certification, “*Referral Source*” shall mean 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 hereinafter defined) 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 government 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” (as hereinafter defined) 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.

- (B) The following is the sole member of Seller: George Tomlin.

7. 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 the representations and warranties made in Section 6 above are untrue when made or become untrue during the Option Term due to the act or omission of Seller, then Purchaser, at its option and in addition to all other remedies available at law or in equity, may: (i) specifically enforce the provisions of this Agreement, and (ii) cancel and terminate this Agreement and receive a refund of the Purchase Price from Seller and retain all rights against Seller for damages arising out of such failure or untruthfulness, and (iii) without waiving Purchaser’s other remedies in this Section, forbear the exercise of such remedies as Purchaser deems reasonably necessary so as to allow an opportunity to cure such failure or untruthfulness in a manner satisfactory to Purchaser in Purchaser’s sole and absolute discretion.

(b) Default by Purchaser. If Purchaser fails to timely perform any of its obligations, covenants or agreements contained in this Agreement, then Seller, as its sole and exclusive remedy, may terminate this Agreement and retain the Purchase Price and Seller waives all rights or claims of Seller against Purchaser by reason of such failure, 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.

(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.

8. 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.

9. 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 Agreement. 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 Agreement. 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.

10. NOTICES. Any notice, request, approval, demand, instruction or other communication to be given to either Party under this Agreement must be in writing, and all deliverables from one Party to the other will be conclusively deemed to be delivered when personally delivered or when (a) hand-delivered, or (b) deposited for prepaid overnight delivery with an overnight courier such as UPS or other national overnight courier service, and such notices are addressed to the addresses provided on the signature pages of this Agreement or to such other addresses as either Party may have furnished to the other from time to time, in writing, as a place for the service of notice. All notices will be effective upon being sent in the manner described in this Section 10. 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.

11. 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.

[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:

FRANKLIN LAND ASSOCIATES, L.L.C.,
a Tennessee limited liability company

By: 

George Tomlin, Sole Member

Date: February 26th, 2026

Seller's Notice Address:

Franklin Land Associates, L.L.C.
Attn: George Tomlin
9010 Overlook Blvd.
Brentwood, TN 37027

PURCHASER SIGNATURE PAGE TO REAL ESTATE PURCHASE AND SALE AGREEMENT

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

PURCHASER:

CENTRAL TENNESSEE HOSPITAL CORPORATION,
a Tennessee corporation

By: 

Todd Maxwell, Vice President

Date: 2/26, 2026

Purchaser's Notice Address:

Central Tennessee Hospital Corporation
Attn: Clay Lehning, Real Estate Manager
2545 Park Plaza, 2nd Floor W.
Nashville, TN 37203

With a copy to:

Central Tennessee Hospital Corporation
Attn: Andrew P. Gulotta, Esq.
2545 Park Plaza, 2nd Floor W.
Nashville, TN 37203

EXHIBIT A TO OPTION AGREEMENT

ASSIGNMENT AND ASSUMPTION OF PURCHASE AND SALE AGREEMENT

THIS ASSIGNMENT AND ASSUMPTION OF PURCHASE AND SALE AGREEMENT ("*Assignment*"), is made and entered into effective as of the Closing Date ("*Effective Date*"), by and between FRANKLIN LAND ASSOCIATES, L.L.C., a Tennessee limited liability company ("*Assignor*"), and CENTRAL TENNESSEE HOSPITAL CORPORATION, a Tennessee corporation ("*Assignee*"). Assignor and Assignee are sometimes referred to in this Assignment collectively as the "*Parties*."

A. The Parties desire to assign and assume all of Assignor's right, title, interest and obligations in, to and under that certain contract by and between Ken Karger and Assignor (as the same may be amended, collectively, the "*Purchase Agreement*"), to purchase approximately 5.77 acres, more or less, of vacant real property situated in Williamson County, Tennessee, located 2273 Fairview Blvd., Fairview, Tennessee, having Parcel ID/Tax ID Number 042 166.00 000, and being more particularly described in the Purchase Agreement, as provided in this Assignment.

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

1. Assignment and Assumption. Assignor assigns, conveys, transfers, and sets over to Assignee, and Assignee accepts and assumes from Assignor, all of Assignor's right, title, interest and obligations in, to, and under the Purchase Agreement.

2. Indemnity. Assignor agrees to indemnify, defend and hold harmless Assignee from and against any and all claims and demands under the Purchase Agreement, based upon the acts or omissions of Assignor which first arise on or prior to the Effective Date. Assignee agrees to indemnify, defend and hold harmless Assignor from and against any and all claims and demands under the Purchase Agreement, based upon the acts or omissions of Assignee which first arise after the Effective Date.

3. Miscellaneous. All of the recitals above are incorporated into this Assignment by this reference. The section headings of this Assignment are for convenience only and must not be considered in the interpretation of the terms and provisions of this Assignment. This Assignment is binding upon and inures to the benefit of the Parties and their respective successors and assigns. If any provision of this Assignment is unenforceable or inapplicable, the other provisions of this Assignment will remain in full force and effect as if the unenforceable or inapplicable provision had never been contained in this Assignment. This Assignment 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.

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

ASSIGNOR:

FRANKLIN LAND ASSOCIATES, L.L.C.,
a Tennessee limited liability company

By: [EXHIBIT ONLY – DO NOT SIGN]
George Tomlin, Sole Member

ASSIGNEE:

CENTRAL TENNESSEE HOSPITAL CORPORATION,
a Tennessee corporation

By: [EXHIBIT ONLY – DO NOT SIGN]
Monica Cintado, Senior Vice President

Attachment 10A

Floor Plan



HEREFORD · DOOLEY
ARCHITECTS

11 LEA AVENUE · SUITE 601
NASHVILLE · TENNESSEE · 37210
P · 615 · 244 · 7399
F · 615 · 244 · 6697
WWW.HDARCHITECTS.COM

PROJECT #

FREESTANDING EMERGENCY
DEPARTMENT

STATUS

William E. Hereford, III

DATES OF ISSUANCE

TITLE

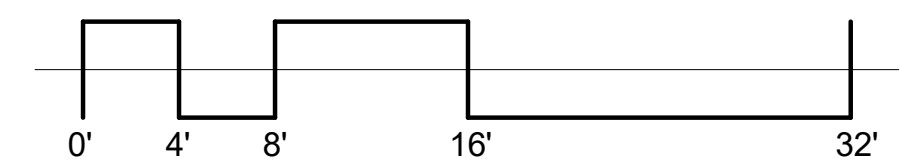
FLOOR PLAN -
NOTED

SHEET

A110



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



2/17/2026 15:11:10 PM
THIS DRAWING IS THE PROPERTY OF HEREFORD DOOLEY ARCHITECTS. IT IS NOT TO BE REPRODUCED IN WHOLE OR IN PART. IT IS NOT TO BE USED ON ANY OTHER PROJECT. IT SHALL BE RETURNED UPON REQUEST. COPYRIGHT AS DATED HEREFORD DOOLEY ARCHITECTS. NOT VALID UNLESS SIGNED AND SEALED.

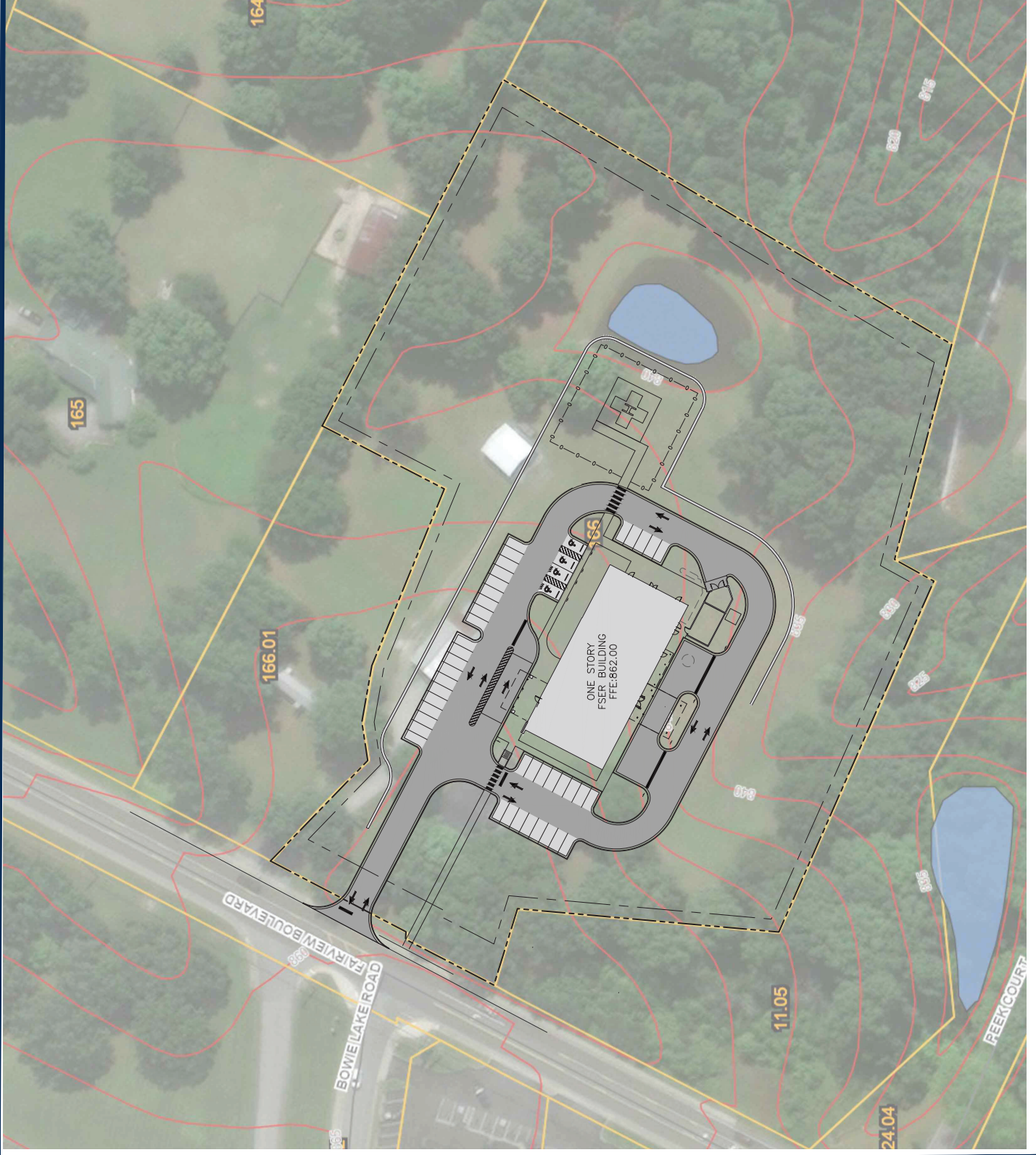
Attachment 12A

Site Plan

SITE SUMMARY

- Address** - The site is located at 2493 Fairview Boulevard (Parcel ID: 165-16607)
- Average** - The approximate site average is 5.77 acres according to the City of Fairfax GIS.
- Fairview GIS** - The proposed building is a single story FSER of approximately 11,000 square feet.
- Land Use** - The City of Fairfax Land Use Map designates the parcel as part of the Commercial Corridor. The parcel's existing land use is residential. The proposed building is a single story FSER of approximately 11,000 square feet according to the following definition in the City of Fairfax Zoning Ordinance:
 - Hospital** - An institution that offers services more intensive than those provided by a physician's office and that is licensed by the State Board of Health for treatment or care; makes available clinical laboratory services, diagnostic services and treatment facilities for surgery or obstetrical care or other dental personnel, central service facilities such as pharmacies, medical laboratories, and other related uses.
 - Zoning** - The City of Fairfax Zoning Ordinance allows for the following uses: Districts C1 - C7. C1 allows Same Day Medical Care Facilities and C2 allows Healthcare Facilities. Hospitals fall under the Healthcare Facility Use. The maximum building height is 35 feet. The maximum lot coverage is 50% whichever is greater. The city zoning ordinance noted that due to variability in lot sizes, the maximum building height is 35 feet. The maximum building height will be finalized as part of the Planning Commission review by the City Planner.
- Building Dimensions** - The maximum building height is 35 feet.
- Lot Requirements** - The lot must have a 80% maximum lot coverage and a minimum lot width of 80%. The following yard (including setbacks) dimensions are required:
 - Front Yard - 30 feet
 - Side Yard - 20 feet
 - Rear Yard - 20 feet
- Topography** - Due to existing grade changes across the site, the test fit shown requires a retaining wall. The retaining wall will be approximately 10 to 12 feet at its highest point.
- Floodplain** - The site is in the FEMA Flood Zone X - Area of Minimal Flood Hazard.
- State** - This is in the Waters of the State on Site. However, there is an existing wet pond in the rear of the site.

Requirement	Variable No.	No. of Spaces
15. Spaces per bed	11	17
Total Spaces Required	0	0
Existing Spaces	17	17
Additional Spaces	0	0
Total Proposed Spaces	17	17



Fairveiv FSER

PROJECT NAME

133826

PROJECT NUMBER

2-19-2026

DATE

T100

SHEET NUMBER

TEST FIT

SHEET NAME



INGRAM CIVIL ENGINEERING GROUP
 10000 WOODLAND DRIVE, SUITE 100
 FARMERSVILLE, TEXAS 77834
 409.335.1271 (TX)



GRAPHIC SCALE

Attachment 1N

Freestanding Emergency Department (FSED) Standards and Criteria Application Guide

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

As required, TriStar Horizon Medical Center (the “Applicant or “TriStar Horizon) 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 area.* 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 FSED known as TriStar Fairview FSED, which will be located in Fairview, Williamson County, Tennessee. The proposed FSED is approximately 10,860 square feet, with 11 treatment rooms.

The Applicant

The Applicant is TriStar Horizon, a 158-bed acute care hospital located at 111 Highway 70 East, Dickson, Dickson County, Tennessee. TriStar Horizon has been serving Dickson, Hickman, and west Williamson County, along with the adjacent rural counties, since 1958 and has continued to evolve to meet the needs of its community.

In addition to the main campus, TriStar Horizon operates the TriStar Natchez FSED, which is located in south Dickson, off exit 172 on Interstate 40, at 107 Natchez Park Drive, Dickson, Tennessee 37055.

The hospital’s numerous accreditations and distinctions include: accreditation by The Joint Commission;

accreditation as a Chest Pain Center and Primary Stroke Center; Leapfrog “A” Award for seven of the last eight periods; Healthgrades Patient Safety Excellence Award in 2025; and Chartis’ Top 100 Rural and Community Hospitals in the country for 2024, 2025, and 2026. Its key services include: cardiology, diagnostic imaging, inpatient rehabilitation, oncology, orthopedics, women’s services, and a Level II NICU. Its cancer treatment services are affiliated with the nationally recognized Sarah Cannon Cancer Institute.

Caring for the health of Fairview and the surrounding communities is not a new concept for TriStar Horizon. Notably, TriStar Horizon was one of the first medical entities to come to Fairview and HCA Healthcare’s TriStar Division was the first hospital system to do so when it leased space to Covenant Medical Group – the first primary care practice in Fairview – which opened in 2015 and is still in the community. The presence grew when TriStar Health completed and opened the TriStar Medical Plaza, located at 2340 Fairview Blvd, Fairview in 2017. Several Covenant Medical primary care physicians are on staff at TriStar Horizon.

Many service area residents use TriStar Horizon for their hospital services. In 2024, TriStar Horizon and its TriStar Natchez FSED cared for 60 percent of the service area residents’ emergency visits. Many service area patients have established relationships with providers at TriStar Horizon.

The proposed TriStar Fairview FSED will be a much-needed addition and a healthcare safety net in this community. For Fairview area residents, it offers significant relief – the ability to receive emergency care closer to home, eliminating the need for long drives to Dickson, Franklin, or Nashville. The FSED will provide essential life-saving care in a community that currently lacks ready access to emergency care. The closest ED is located over 20 minutes away from the Fairview location of the proposed FSED. With the continued growth and aging of the population, residents need an emergency care provider in the service area.

The Service Area

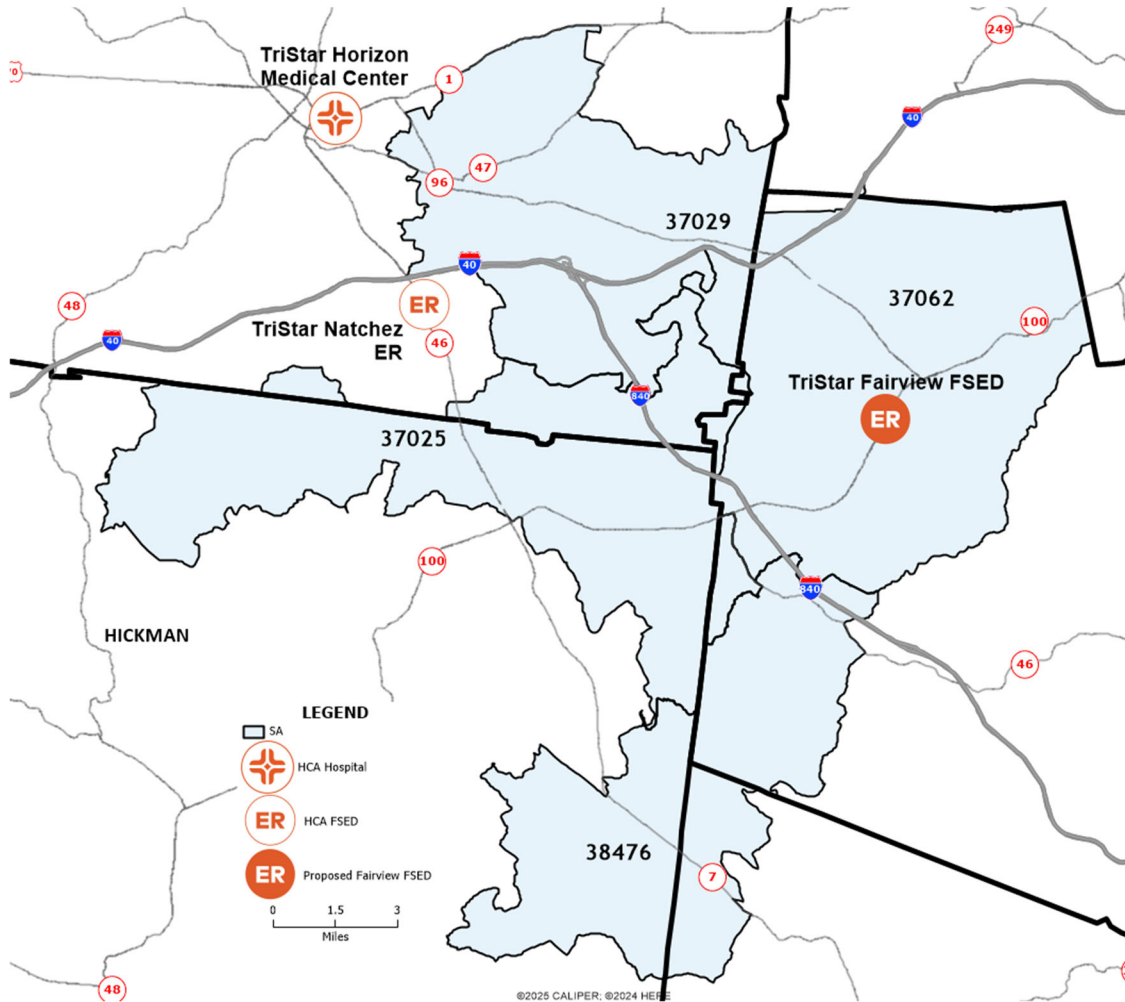
The proposed TriStar Fairview FSED service area comprises:

- 37062 (Fairview), the home zip code for the Fairview FSED, covering the northwest corner of Williamson County;
- 37025 (Bon Aqua), the zip code to the southwest of home zip code, covering the northern portion of Hickman County;
- 37029 (Burns), the zip code immediately to the northwest of the home zip code, covering the southeast corner of Dickson County; and
- 38476 (Primm Springs), located to the south of the home zip code and straddling the Williamson-Hickman County line.

This area includes the cities of Fairview and Burns and the unincorporated communities of Bon Aqua and Primm Springs. There are no emergency departments (“EDs”) in this service area.

Exhibit 1N-1 provides a map of the service area.

**Exhibit 1N-1
Site Location**



Interstate 40 and Fairview Boulevard (Highway 100) run east to west and Interstate 840 and Highway 96 run north to south through the service area and largely contribute to where emergency patients from the service area go. In 2024, 60.2 percent of emergency department visits from patients in the service area went to TriStar Horizon or TriStar Natchez FSED. During times of light to moderate traffic, the majority of service area residents are driving anywhere from 14 to 20 minutes from the centroid of their respective zip codes to the TriStar Natchez FSED or 15 to 32 minutes to access the TriStar Horizon main campus ED depending on the starting point in the service area. Travel from the service area to Dickson can be time consuming and often requires navigating two lane secondary roads through neighborhoods, commercial areas, and school zones. From Fairview (37062), residents must travel north to TriStar Horizon’s main campus via Highway 100/Fairview Boulevard, which is two lanes in many places and Highway 96, Spencer Mill Road, or Interstate 840. This drive can easily take 30 minutes without traffic jams. Travel from 37025 (Bon Aqua), 37029 (Burns), and 38476 (Primm Springs) to Dickson is also difficult.

The remaining patient visits occur at a variety of facilities in Davidson County and Williamson Medical Center (“WMC”). Travel to WMC in Franklin for residents of the service area is time consuming, often taking 30 to 50 minutes. This travel requires navigating Highway 96, which contains a number of traffic lights and commuter

traffic. Travel to facilities in Nashville is even more difficult, especially in traffic. Indeed, travel requires navigating a mixture of Highway 100, Highway 96, and Interstate 96, and can take anywhere from 30 minutes to over an hour depending on traffic and starting point in the service area. The distances to existing EDs can be highly problematic when a patient is in need of emergency care for a life-threatening illness or injury.

TriStar Horizon’s objective in this project is to shorten service area residents’ travel time to emergency care, thereby reducing the isolation experienced by patients during a critical time when every minute is important for an emergency intervention. The proposed FSED will enhance geographic access to emergency services for patients in the service area and thus improve outcomes for patients with life threatening conditions.

Overview of the Service Area

The service area population of nearly 30,000 grew by over 9 percent from 2020 to 2026 and is projected to continue growing nearly another approximately 6 percent from now until 2031. **Exhibit 1N-2** below summarizes the population and growth rates for the service area zip codes.

**Exhibit 1N-2
Population of the Service Area**

Population	Population			Percent Change	
	2020	2026	2031	2020-2026	2026-2031
37062 (Fairview)	12,655	13,832	14,672	9.3%	6.1%
37025 (Bon Aqua)	6,910	7,426	7,761	7.5%	4.5%
37029 (Burns)	6,364	7,106	7,624	11.7%	7.3%
38476 (Primm Springs)	1,190	1,261	1,313	6.0%	4.1%
Service Area	27,119	29,625	31,370	9.2%	5.9%

Source: Claritas

Notably, the service area’s population age 65+ increased more than 25 percent from 2020 to 2026. Indeed, 37062 (Fairview)’s age 65+ population increased over 30 percent in that time period. In the next five years, the age 65+ population in the service area is expected to continue the extraordinary growth – growing another 20 percent. See **Exhibit 1N-3** below.

**Exhibit 1N-3
Service Area Population Growth Rate by Age Cohort**

Service Area	Percent Growth: 2020 to 2026				
	0-17	18-44	45-64	65+	Total
37062 (Fairview)	-6.6%	12.7%	8.5%	31.4%	9.3%
37025 (Bon Aqua)	3.5%	11.8%	-3.2%	24.9%	7.5%
37029 (Burns)	12.5%	14.6%	5.0%	16.3%	11.7%
38476 (Primm Springs)	-2.9%	11.7%	-3.9%	22.2%	6.0%
Service Area Total	0.1%	12.9%	3.9%	25.2%	9.2%

Service Area	Percent Growth: 2026 to 2031				
	0-17	18-44	45-64	65+	Total
37062 (Fairview)	-4.7%	4.2%	8.3%	19.8%	6.1%
37025 (Bon Aqua)	2.0%	2.4%	-1.4%	20.1%	4.5%
37029 (Burns)	5.9%	3.6%	1.8%	23.0%	7.3%
38476 (Primm Springs)	-1.7%	3.4%	-4.1%	19.2%	4.1%
Service Area Total	-0.4%	3.6%	3.7%	20.6%	5.9%

Source: Claritas

The City of Fairview has been experiencing growth in residential and commercial development. From 2020 through October 1, 2025, the City of Fairview alone approved 1,377 housing units (single family homes, townhouses, and apartments). In 2021, the city approved The Fairview City Center, a walkable, multiuse development, which is in development. Once complete, it will include 51 apartments, 235 townhomes, 42 single family homes, retail, and recreational facilities.

The proposed FSED will be located on Fairview Boulevard (Highway 100) in Fairview, Tennessee, in Williamson County, and is an approximate 7 minute drive (4.5 miles) from Interstate 840, 3 minute drive (1.4 miles) from Highway 96, and a 10 minute drive (6.3 miles) from Interstate 40. Highway 100 is the major east-west local thoroughfare and is a primary travel route for local residents not using the Interstate highways. The residents of the service area, which include 37062 (Fairview), 37025 (Bon Aqua), 37029 (Burns), and 38476 (Primm Springs), currently have no access to emergency care in their home zip codes. Rather, the residents are faced with lengthy drive times to any ED outside of the service area, having to drive anywhere from 20 to 50 minutes – without traffic – to access care.

TriStar Horizon is located in 37055 (Dickson) north of Interstate 40 and to the east of the center of Dickson. TriStar Natchez FSED is also located in Dickson, but it is located directly off Interstate 40. The TriStar Bellevue FSED is located in Nashville, Davidson County, northeast of the service area. WMC is located in the center of Williamson County in 37067 (Franklin) to the east of Interstate 65. TriStar Nolensville FSED is located on the eastern edge of Williamson County in Nolensville, approximately 13 miles and 20 minutes further east than WMC. Finally, Ascension St. Thomas Hickman (“St. Thomas Hickman”) is a Critical Access Hospital with 5 ED treatment rooms and is located in 37033 (Centerville), which is to the southwest of the service area.

Williamson County – the location of the Proposed TriStar Fairview FSED – has 2 EDs and 121 ED treatment rooms. With respect to the 2 EDs, this equates to 0.71 ED access points per 100,000 population. This is materially lower than every county in the state having a population of more than 150,000. **Exhibit 1N-4** presents this data.

**Exhibit 1N-4
Emergency Departments per 100,000 Population**

County/State	Access Points	2026 Population	Access Points/100,000 Population
Williamson	2	282,593	0.71

Rutherford (*)	5	397,974	1.26
Shelby	12	908,920	1.32
Knox	7	513,098	1.36
Davidson (*)	11	734,808	1.50
Montgomery (*)	4	257,280	1.55
Wilson (*)	3	175,794	1.71
Sullivan	3	164,794	1.82
Sumner	4	219,021	1.83
Hamilton	10	389,159	2.57
Tennessee (*)	134	7,300,003	1.84

(*) Added 7 additional EDs which are CON approved and under development: 2 in Rutherford County, 2 in Montgomery County, 1 in Wilson County, 1 in Bradley County and 1 in Davidson County.

The TriStar Fairview FSED will be in Williamson County, which has the far fewest EDs per population in Tennessee, with less than 1 ED per 100,000 population at 0.71. Montgomery County, which is most similar in size, currently has the same number of EDs. However, Montgomery County has two approved CONS for additional access points, which puts Montgomery County at 1.55 – more than double the number of ED access points per 100,000. This demonstrates a shortage of EDs in Williamson County.

Adding the proposed FSED to the above data increases the Williamson County rate to 1.06 EDs per 100,000. This is still less than all other high population counties and less than their average. And, this is still less than the Tennessee state average of 1.84. See **Exhibit 1N-5** below.

**Exhibit 1N-5
Emergency Departments per 100,000 Population**

County/State	EDs	2026 Population	EDs/100,000 Population
Williamson	2	282,593	0.71
Tennessee	134	7,300,003	1.84
<i>Williamson With TriStar Fairview FSED</i>	3	282,593	1.06

Similar disparities as shown in the EDs per population above are evident in identifying ED treatment rooms within these same high population counties. With respect to Williamson County’s 49 treatment rooms, this equates to 0.17 treatment rooms per 1,000 population throughout the county. This reflects an underservice of treatment rooms per population as it is 55 percent below the statewide average of 0.39 treatment rooms per 1,000 county residents and the lowest rate of any county in the state with more than 150,000 population. **Exhibit 1N-6** presents this information.

**Exhibit 1N-6
ED Treatment Rooms per 1,000 Population**

County	ED Rooms	2026 Population	ED Rooms / 1,000 Population
Williamson	49	282,593	0.17
Wilson (*)	38	175,794	0.22
Montgomery (*)	79	257,280	0.31
Sumner	68	219,021	0.31
Rutherford (*)	146	397,974	0.37
Shelby	402	908,920	0.44
Knox	257	513,098	0.50
Davidson (*)	408	734,808	0.56
Hamilton	234	389,159	0.60
Sullivan	123	164,794	0.75
Tennessee (*)	2,822	7,300,003	0.39

() Added 7 additional EDs with 83 additional treatment rooms, which are CON approved and under development: 25 treatment rooms in Rutherford County, 28 treatment rooms in Montgomery County, 8 treatment rooms in Wilson County, 11 treatment rooms in Bradley County and 11 treatment rooms in Davidson County.*

With respect to the ED treatment rooms per 1,000 population, Williamson County is the lowest at 0.17. This is less than half the state average. Moreover, Montgomery County, which has around 25,000 less people than Williamson County, is higher than Williamson by 3 points without including the CON approved emergency department treatment rooms. With those additional approved CONs, Montgomery County rate is 0.31, 77 percent higher than Williamson County. See **Exhibit 1N-6** above.

Williamson County is a large county with only 2 EDs, both of which are located east of the service area, 40 to 60+ minutes away. This is further highlighted by the distances and travel time from these zip codes to the EDs in the counties included in the service area. As required by the FSED Guide, **Exhibit 1N-7** below reflects the travel distance (miles) from the center of each zip code in the service area to the nearest ED outside of the service area. Travel time (minutes) is also presented because travel time is the most important consideration in considering geographic isolation.

**Exhibit 1N-7
Distance to Existing Emergency Departments Using Zip Code Centroids**

Emergency Department	Distance in Miles from the Center of the Following to each ED:	37062 (Fairview)	37025 (Bon Aqua)	37029 (Burns)	38476 (Primm Springs)	Distance in Miles from the Proposed FSED Site to:
TriStar Fairview FSED	Service Area	1.8	9.2	9.6	18.4	--
TriStar Horizon	Outside Service Area	16.9	15.5	9.3	21.6	19.2
TriStar Natchez FSED	Outside Service Area	14.5	10.0	6.6	16.1	16.3
WMC	Outside Service Area	23.4	35.8	31.2	32.5	24.2
St. Thomas Hickman	Outside Service Area	30.2	22.0	30.7	23.7	28.4
TriStar Nolensville FSED	Outside Service Area	32.1	49.5	50.4	42.2	32.9

Source: Google Maps

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. TriStar Horizon asserts that service area residents are geographically isolated due to the fact that there is a significant population base of nearly 30,000 residents in this area, which is growing and aging, without access to emergency services within a 15-minute drive. The closest provider is located more than 20 minutes away from most service area residents, and with the continued growth and aging of the population, as well as consistently increasing traffic congestion, residents need access to an emergency care provider in the service area.

Exhibit 1N-8 shows the travel time estimates from the zip code centroids to the existing EDs outside of the service area and to the proposed TriStar Fairview FSED. The times that exceed 15 minutes are shown in bold.

**Exhibit 1N-8
Drive Time to Existing Emergency Departments**

Emergency Department	Distance in TIME from the Center of the Following to each ED:	37062 (Fairview)	37025 (Bon Aqua)	37029 (Burns)	38476 (Primm Springs)	Distance in Time from the Proposed FSED Site to:
TriStar Fairview FSED	Service Area	4	15	15	27	--
TriStar Horizon	Outside Service Area	24	25	15	32	28
TriStar Natchez FSED	Outside Service Area	18	14	14	20	21
WMC	Outside Service Area	38	39	50	44	40

Attachment 1N – FSED Criteria and Standards

St. Thomas Hickman	Outside Service Area	44	31	45	33	41
TriStar Nolensville FSED	Outside Service Area	52	68	59	67	55

Source: Google Maps

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 patients get 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.

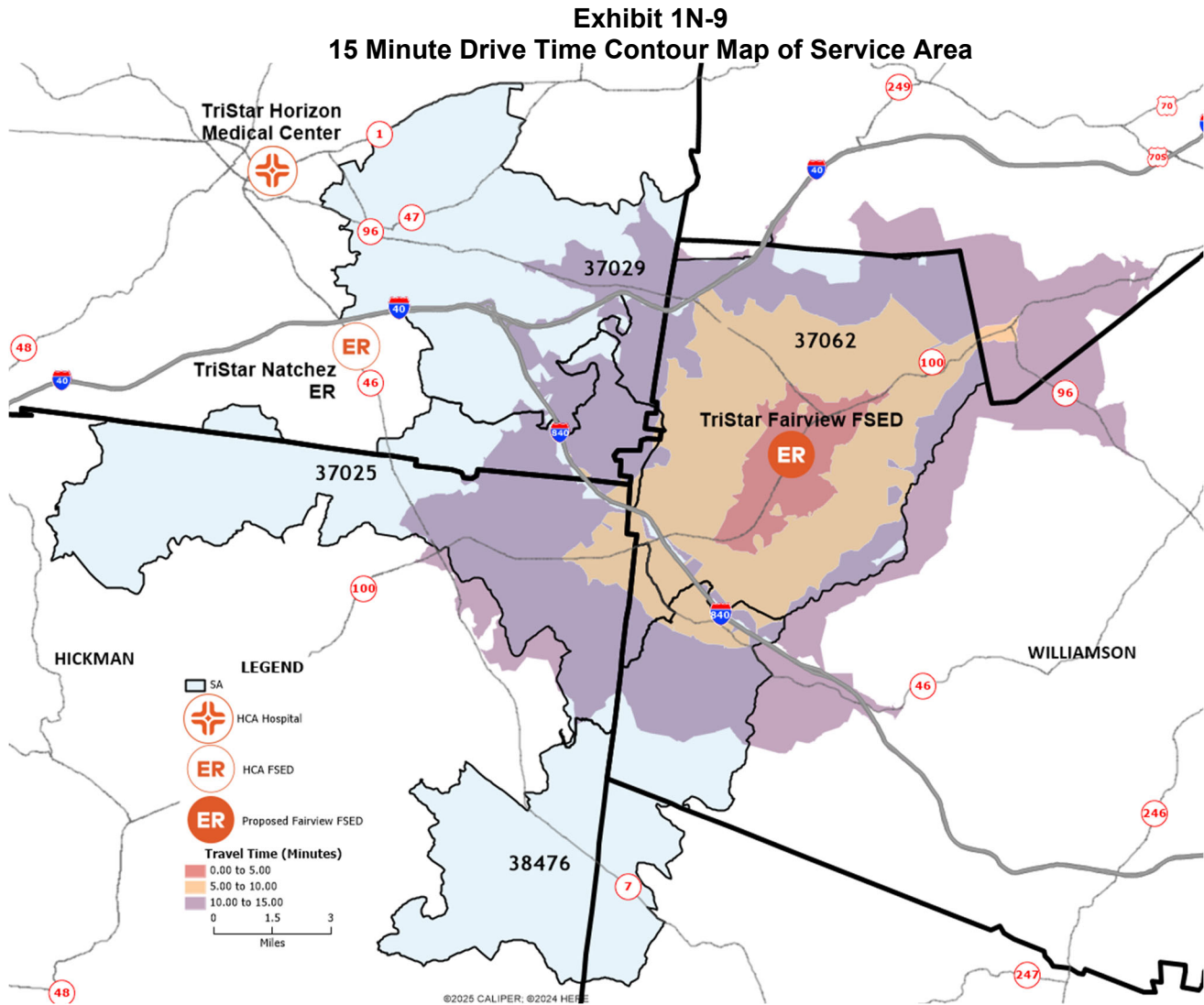
Reduced travel and transport times to ED services are directly linked to improved outcomes including lives saved. For example, in 2024, TriStar Horizon and its TriStar Health FSEDs cared for the following patients with common time-sensitive conditions:

Condition	Clinical Outcomes	# of Patients in TriStar FSEDs 2024
Cardiac Arrest	Survival Rates: 22% at 0 minutes 8% at 10 minutes 3% at 20 minutes	67
Stroke	1.9 million neurons die every minute a stroke goes untreated	76
Sepsis	1-year mortality risk increases 10% every hour delay in antibiotic administration	732

As confirmed in the above chart¹, the sooner patients get 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.

¹ 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

To address this geographic isolation, TriStar Horizon proposes to develop a FSED in Fairview. **Exhibit 1N-9** shows the service area within the 15 minute drive time for the proposed TriStar Fairview FSED location, and drive time contours around the proposed facility.



While the FSED Criteria and Standards do not provide a recommended drive time, TriStar Horizon believes a 15 minute drive time is relevant given studies that show that patients drive an average of 8 miles and 17.3 minutes to access ED services. As such, drive times that exceed these distances and times to access an ED indicate that patients experience less access and barriers to accessing care that exceed the average. While not every town, zip code or service area can support a FSED, TriStar Horizon believes that the data and analysis included in this application present compelling evidence that the TriStar Fairview FSED service area has reached a critical mass of patients needing emergency services that can support a FSED—based solely on shifting patients from its main campus ED and TriStar Natchez FSED that are the overwhelming choice of healthcare consumers in the service area today—while simultaneously decompressing TriStar’s existing EDs that are above or at ACEP capacity standards.

Need for the Proposed TriStar Fairview FSED

In sum, as will be demonstrated throughout this CON Application, the need for the proposed TriStar Fairview FSED is demonstrated by a series of planning metrics. These include:

- Relieving geographic isolation for the nearly 30,000 service area residents who must drive anywhere from 14 to 50 minutes without traffic to access emergency care;
- Providing care closer to where people live;
- 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 2031;
- Delivering quality ED services to its patients, with short wait times and low rates of left without treated (“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.

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-quality of 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.

Not Applicable. There are no existing emergency departments in the service area.

Quality of Care Provided at Existing ED Facilities in the Proposed Service Area: Tables 1C (1-8)

Measure: OP-1 Median Time to Fibrinolysis						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-2 Fibrinolytic Therapy Received Within 30 Minutes						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-4 Aspirin at Arrival						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-5 Median Time to ECG						
Emergency	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			

Attachment 1N – FSED Criteria and Standards

Department			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
Measure: OP-20: Door to Diagnostic Evaluation by a Qualified Medical Personnel						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-21 ED-Median Time to Pain Management for Long Bone Fracture						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						

D. Other Applicable Data Related to Need and Capacity

Check the Box that Applies:



The applicant is providing additional data related to need and capacity. If this box is checked the applicant must provide the information below.



The applicant is not providing additional data related to need and capacity.

Data:

The applicant may provide data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules at existing EDs in the proposed service area to demonstrate capacity challenges. If the applicant is providing additional data, at a minimum, complete the following table for all ED facilities in the proposed service area. Other relevant categories may be added to the table by the applicant.

Utilization Factors Impacting Capacity Constraints

The table below provides the percentage of behavioral health, low acuity, and 65+ ED patients treated by TriStar Horizon and TriStar Natchez FSED during the most recent year.

**Exhibit 1N-10
TriStar Horizon and TriStar Natchez FSED Behavioral Health, Level I or II, Level IV or V, and 65+, Calendar Year 2025**

Emergency Services Provider	% of Behavioral Health	% of Patients Level I or II	% of Patients Level IV or V	% of Patients Ages 65+
TriStar Horizon	2.00%	8.80%	59.6%	15.50%
TriStar Natchez FSED	3.90%	12.80%	42.7%	25.50%

Source: Internal Data

When contrasting TriStar Horizon and TriStar Natchez FSED with the service area experience in these categories, it is evident that the proposed TriStar Fairview FSED will be well equipped to accommodate the service area patients and clinical needs. **Exhibit 1N-11** contrasts the above with service area 2023, the three counties and the State using HDDS data. Notably, service area zip codes (37062, 37025, 37029) are grouped into '370 truncated'.

**Exhibit 1N-11
Service Area, Counties and the State,
Calendar Year 2023**

	% of Behavioral Health	Statewide Average	% of Patients Level I or II	Statewide Average	% of Patients Level IV or V	Statewide Average	% of Patients Ages 65+	Statewide Average
Truncated 370	1.5%	1.6%	38.0%	41.4%	10.5%	11.43%	23.6%	22.5%
Dickson County	1.8%		37.4%		6.65%		20.6%	
Hickman County	1.5%		43.9%		6.77%		21.2%	
Williamson County	1.6%		64.8%		11.19%		29.8%	

TriStar Horizon and TriStar Natchez FSED both treated a higher percentage of behavioral health patients than any of the counties or the state average. Moreover, TriStar Horizon and TriStar Natchez FSED have experience treating much higher acuity patients (Level IV-V) than the ED visits by residents in the counties containing the service area.

A high percentage of medically complex patients and behavioral health patients can contribute to capacity constraints for EDs. The TriStar Fairview FSED will have a behavioral health room to help address demand. TriStar Horizon’s main campus with high percentages of elderly and high acuity patient visits display 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.

Capacity Challenges at Host Hospital and Hospital Closest to Service Area

TriStar Horizon has continuously operated above the ACEP Guidelines. It exceeded the range by almost 17 percent in 2021, increasing to 34.5 percent in 2025.

Likewise, TriStar Natchez FSED exceeded ACEP guidelines by 36 percent in 2021 and 30 percent in 2025. These capacity measurements are presented in **Exhibits 1N-12** and **1N-13**.

Exhibit 1N-12
Visits Per Treatment Room at TriStar Horizon’s Main Campus ED
Calendar Years 2021 through 2025

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP Mid Range	ACEP High Range
2021	32,181	23	1,399	1,429	1,315	1,200
2022	33,332	23	1,449	1,522	1,386	1,250
2023	34,929	22	1,588	1,522	1,386	1,250
2024	37,325	22	1,697	1,522	1,386	1,250
2025	36,975	22	1,681	1,522	1,386	1,250

Source: Joint Annual Reports (“JARs”) for respective years; 2025 Internal Data.

Exhibit 1N-13
Visits Per Treatment Room at TriStar Natchez FSED
Calendar Years 2021 through 2025

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP Mid Range	ACEP High Range
2021	16,662	9	1,851	1,364	1,259	1,154
2022	18,312	9	2,035	1,429	1,340	1,250
2023	17,753	9	1,973	1,429	1,340	1,250
2024	17,749	9	1,972	1,429	1,340	1,250
2025	16,761	9	1,862	1,429	1,340	1,250

Source: JARs for respective years; 2025 Internal Data.

An additional advantage of the implementation of the proposed TriStar Fairview FSED is that some of the capacity overages identified above will be relieved through a re-direction of a portion of the ED visits at each of the above emergency rooms. Specifically, it is expected that in Year One approximately 1,900 patients currently being treated at TriStar Horizon’s main campus ED and TriStar Natchez FSED will re-direct to the proposed TriStar Fairview FSED.

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.

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 TriStar Fairview 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.

TriStar Horizon has been determined to be a High Range emergency room using the ACEP guidelines whereas TriStar Natchez FSED has been determined to be a Low Range emergency room per the guidelines. **Exhibit 1N-14** provides the ACEP criteria and ranking for each of these two emergency rooms.

**Exhibit 1N-14
ACEP Guidelines Designation for TriStar Horizon and TriStar Natchez FSED**

Factor	Result/Range		Metric
	TriStar Horizon	TriStar Natchez FSED	
% Emergency Department Patients Admitted as Inpatients	Mid-Range	Low Range	Less than 8% is low range. Greater than 20% high range. Horizon 18.1%; Natchez 6%

Attachment 1N – FSED Criteria and Standards

Length of Stay (Hours) in ED	Mid Range	Low Range	High-Range is > 3.75. Low range is <2. Horizon is 3.13; Natchez is 1.97.
% of ED Patients seen in Private Rooms	High Range	High Range	Most patients at Horizon seen in private rooms with exception of overflow; goal is 100%. Natchez all private.
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	High Range	High Range	Patients remain in private room for stay; patients are not moved (0% at both locations).
% of observation and extended stay patient remaining in ED	Low Range	Low Range	No patients remain in ER for this level of services (0% at both locations).
# Average Minutes an ED patient admitted as an inpatient remains in ED	High Range	High Range	ED patients who are admitted will remain in the department for over 150 minutes after order to admit; Horizon 333 minutes; Natchez 373 minutes.
Average turnaround time (minutes) for results for lab and imaging studies	Low Range	Low Range	Low range is <45 minutes; Mid-Range is 60 minutes; Horizon lab 33 and imaging 34; Natchez lab 31 and imaging 28 minutes.
% of behavioral health ED patients	High Range	Low Range	Mid is 4-6%; Horizon 6.3%, Natchez 3.6%
% of ED patients either ESI 4 or 5 (Percent of Non-Urgent Patients)	High Range	High Range	High is < 25%, Mid-Range 25-45%; Horizon 8.8%, Natchez is 12.8% for two levels least acute.
% of ED patients Age 65+	High Range	Mid-Range	Mid is 10-20% elderly; high is >20%. Horizon 26.3%, Natchez 15.6%
% 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	Mid-Range	Low Range	Four specific rooms used in ED; no specialty area at Natchez.
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; use behavioral health ED room.
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	High Range	Low Range	Highest count is High for Horizon; Highest count is Low for Natchez.

Both TriStar Horizon and TriStar Natchez FSED exceed the relevant ACEP guidelines for their utilization. Specifically, TriStar Horizon has continuously operated over the ACEP Guidelines. It exceeded the range

by 16.6 percent in 2021, increasing to 34.5 percent in 2025. TriStar Natchez FSED has continuously operated above ACEP guidelines no matter if it is classified as low, mid, or high. In 2021, TriStar Natchez FSED exceeded ACEP guidelines for Low Range by 36 percent. In 2025, it exceeded the ACEP guidelines by 30 percent. These capacity measurements are presented in **Exhibit 1N-15** and **1N-16**.

Exhibit 1N-15
Visits Per Treatment Room at TriStar Horizon’s Main Campus ED
Calendar Years 2021 through 2025

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP Mid Range	ACEP High Range
2021	32,181	23	1,399	1,429	1,315	1,200
2022	33,332	23	1,449	1,522	1,386	1,250
2023	34,929	22	1,588	1,522	1,386	1,250
2024	37,325	22	1,697	1,522	1,386	1,250
2025	36,975	22	1,681	1,522	1,386	1,250

Source: JARs for respective years; 2025 Internal Data.

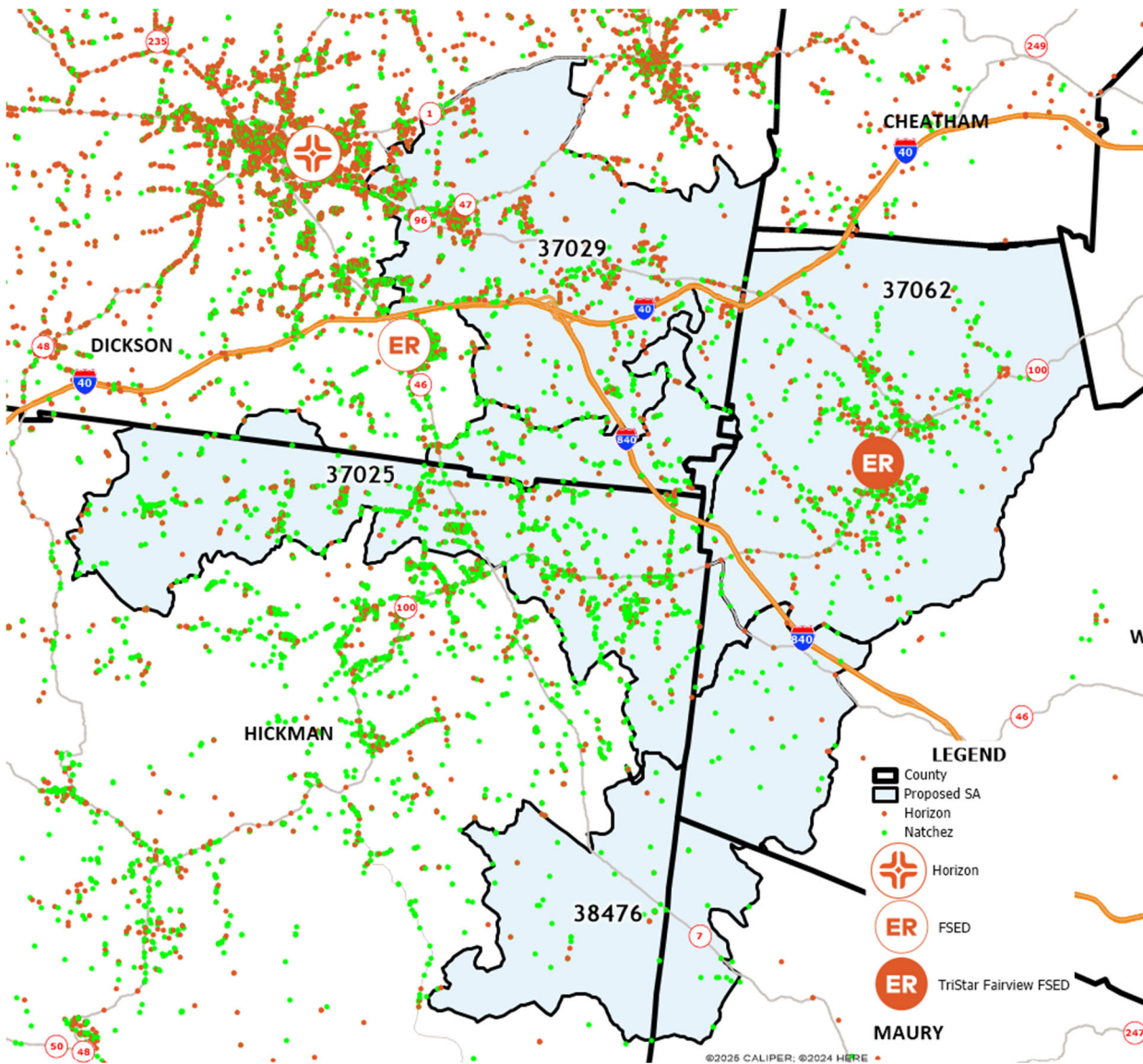
Exhibit 1N-16
Visits Per Treatment Room at TriStar Natchez FSED
Calendar Years 2021 through 2025

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP Mid Range	ACEP High Range
2021	16,662	9	1,851	1,364	1,259	1,154
2022	18,312	9	2,035	1,429	1,340	1,250
2023	17,753	9	1,973	1,429	1,340	1,250
2024	17,749	9	1,972	1,429	1,340	1,250
2025	16,761	9	1,862	1,429	1,340	1,250

Source: JARs for respective years; 2025 Internal Data.

An additional advantage of the implementation of the proposed TriStar Fairview 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, in 2025, nearly 30 percent of service area patients treated at TriStar Horizon’s main ED and TriStar Natchez FSED live closer to the TriStar Fairview FSED. Based on this estimate, the above visits per room will decrease at TriStar Natchez FSED, reducing the capacity overage. **Exhibit 1N-17** contains a map showing the four (4) zip code service area and the areas from which TriStar’s ED patient visits originated in 2025.

Exhibit 1N-17 TriStar Horizon ED and TriStar Natchez Patient Visits from Service Area for Calendar Year 2025



B. Additional Data

Check the Box that Applies:



The applicant is providing additional data related to capacity, efficiencies, and demographics. If this box is checked the applicant must provide the information below.



The applicant is not providing additional data related to capacity, efficiencies, and demographics.

Data:

The applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing host hospital ED facility in order to better demonstrate the need for expansion. The applicant may provide data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules. If the applicant is providing additional data, at a minimum, complete the following table for the host hospital ED. Other relevant categories may be added to the table by the applicant.

This CON Application is being submitted for the HFC Criteria related geographic isolation. An additional benefit to be derived is from the fact that TriStar Horizon’s main campus ED and TriStar Natchez FSED are over capacity relative to the ACEP guidelines. These hospitals are outside the service area; the proposed TriStar Fairview FSED will reduce patients having to leave the service area and simultaneously address TriStar Horizon’s capacity constraints.

Exhibit 1N-18 provides the number of visits at TriStar Horizon’s main campus ED and the TriStar Natchez FSED

**Exhibit 1N-18
ED Visit Trend at Host Hospital and TriStar Natchez FSED**

	TriStar Horizon	TriStar Natchez	Total
CY 2021	32,181	16,662	48,843
CY 2022	33,332	18,312	51,644
CY 2023	34,929	17,753	52,682
CY 2024	37,325	17,749	55,074
CY 2025	36,975	16,761	53,736
Percent Change	14.9%	0.6%	10.0%

Source: JARs for respective years; Internal Data

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 TriStar Horizon, host hospital, reflect a blend of each range under the ACEP criteria. The largest group is High Range with 6 of the 16 characteristics; the balance are Low Range and Mid-Range. Those factors resulting in High Range include private rooms, behavioral health patients, 65+ patients, and non-urgent patients. This scoring is reflected in **Exhibit 1N-19** presented next.

Exhibit 1N-19
ACEP Criteria with TriStar Horizon Metrics and Result

Factor	TriStar Horizon	Metric
% Emergency Department Patients Admitted as Inpatients	Mid-Range	Less than 8% is low range. Greater than 20% high range. Horizon 18.1%.
Length of Stay (Hours) in ED	Mid-Range	High-Range is > 3.75. Low range is <2. Horizon is 3.13.
% of ED Patients seen in Private Rooms	High Range	Most patients at Horizon seen in private rooms with exception of overflow; goal is 100%.
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	High Range	Patients remain in private room for stay; patients are not moved.
% of observation and extended stay patient remaining in ED	Low Range	No patients remain in ER for these level of services.
# Average Minutes an ED patient admitted as an inpatient remains in ED	High Range	ED patients who are admitted will remain in the department for over 150 minutes after order to admit; Horizon 333 minutes.
Average turnaround time (minutes) for results for lab and imaging studies	Low Range	Low range is <45 minutes; Mid-Range is 60 minutes; Horizon lab 33 and imaging 34 minutes.
% of behavioral health ED patients	High Range	Mid is 4-6%; Horizon 6.3%.
% of ED patients either ESI 4 or 5 (Percent of Non-Urgent Patients)	High Range	High is < 25%, mid-range 25-45%; Horizon 8.8% for two levels least acute.
% of ED patients Age 65+	High Range	Mid is 10-20% elderly; high is >20%. Horizon 26.3%.
% 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	Mid-Range	Four specific rooms used in ED.
Availability of pediatric specialty area	Low Range	No specialty area.
Availability of prisoner/detention patient specialty area	Low Range	No special provisions; use behavioral health ED room.
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	High Range	Highest count is High for Horizon.

TriStar Horizon is the host hospital and therefore relevant to this assessment. It is located 19 miles and approximately 28 minutes from the proposed TriStar Fairview FSED. As noted previously, also operating under TriStar Horizon's license is its TriStar Natchez FSED, which is the emergency room, located in south Dickson, off exit 172 on Interstate 40, at 107 Natchez Park Dr, Dickson, Tennessee 37055. It is located 21 minutes from the proposed TriStar Fairview FSED using the shortest route by mileage. The ACEP criteria for TriStar Natchez FSED are presented next in **Exhibit 1N-20**. These characteristics present a diverse range depending on the criteria with the largest group of factors classified as Low Range (9 of 16).

**Exhibit 1N-20
ACEP Criteria with TriStar Natchez FSED Metrics and Result**

Factor	TriStar Natchez	Metric
% Emergency Department Patients Admitted as Inpatients	Low Range	Less than 8% is low range. Greater than 20% high range. Natchez 6%.
Length of Stay (Hours) in ED	Low Range	High-Range is > 3.75. Low range is <2. Natchez is 1.97.
% of ED Patients seen in Private Rooms	High Range	Natchez all private.
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	High Range	Patients remain in private room for stay; patients are not moved.
% of observation and extended stay patient remaining in ED	Low Range	No patients remain in ER for these level of services.
# Average Minutes an ED patient admitted as an inpatient remains in ED	High Range	ED patients who are admitted will remain in the department for over 150 minutes after order to admit; Natchez 373 minutes.
Average turnaround time (minutes) for results for lab and imaging studies	Low Range	Low range is <45 minutes; Mid-Range is 60 minutes; Natchez lab 31 and imaging 28 minutes.
% of behavioral health ED patients	Low Range	Mid is 4-6%; Natchez 3.6%
% of ED patients either ESI 4 or 5 (Percent of Non-Urgent Patients)	High Range	High is < 25%, mid-range 25-45%; Natchez is 12.8% for two levels least acute.
% of ED patients Age 65+	Mid-Range	Mid is 10-20% elderly; Natchez 15.6%
% 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; use behavioral health ED room.
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	Highest count is Low for Natchez.

Exhibits 1N-21 and 1N-22 provide TriStar Horizon and TriStar Natchez FSED visit volume versus ACEP Ranges.

**Exhibit 1N-21
Visits Per Treatment Room at TriStar Horizon’s Main Campus ED
Calendar Years 2021 through 2025**

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP Mid-Range	ACEP High Range
2021	32,181	23	1,399	1,429	1,315	1,200
2022	33,332	23	1,449	1,522	1,386	1,250
2023	34,929	22	1,588	1,522	1,386	1,250
2024	37,325	22	1,697	1,522	1,386	1,250

2025	36,975	22	1,681	1,522	1,386	1,250
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Source: JARs for respective years; 2025 Internal Data.

**Exhibit 1N-22
Visits Per Treatment Room at TriStar Natchez FSED
Calendar Years 2021 through 2025**

Year	# of Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP Mid-Range	ACEP High Range
2021	16,662	9	1,851	1,364	1,259	1,154
2022	18,312	9	2,035	1,429	1,340	1,250
2023	17,753	9	1,973	1,429	1,340	1,250
2024	17,749	9	1,972	1,429	1,340	1,250
2025	16,761	9	1,862	1,429	1,340	1,250

Source: JARs for respective years; 2025 Internal Data.

Based on the proximity of both emergency rooms and the number of patients each treat at their respective ERs, TriStar Horizon expects some redirection of its main campus and TriStar Natchez patients to the TriStar Fairview FSED. As a result, implementation of the TriStar Fairview 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.

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

Currently, there is no emergency care provider in the service area. Historical utilization of existing providers serving the service area is presented below. **Exhibit 1N-23** provides relative percentages of emergency care services provided in the service area in Calendar Year 2023 using the required HDDS data. **Exhibit 1N-24** provides the relative percentages of emergency care services using Calendar Year 2024 THA data. None of these EDs are located in the proposed service area. In total, zip code service area ED visits are understated due to the suppression of data points within the HDDS data, which may impact each provider’s respective utilization percentages overall and in each zip code.

In 2024, the TriStar Horizon’s main campus ED and TriStar Natchez FSED provided approximately 60 percent of the service area ED visits. Combined, in 2024, TriStar EDs provide approximately 67 percent of total ED visits.

The FSED Guide requires that the Applicant use HDDS data. The HDDS data provided is not limited to the

service area for this project, as it 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 three of the four service area zip codes (37062, 37025, 37029) are combined into “370 zip codes”, which means it encompasses all 370 zip codes with less than 20,000 people, including visits for 37073 (Greenbrier), 37049 (Cross Plains), 37010 (Adams), and 37032 (Cedar Hill) among many others.

Nevertheless, because it is required to be used **Exhibit 1N-23** below shows the utilization as required by the FSED Guide:

Exhibit 1N-23
Historical Utilization of Existing Providers by Service Area Patient Visits

Hospital ED	County	PSA Resident ED Visits at Hospital ED (A)	Total Service Area Resident ED Visits (B)	Market Share in Service Area ((A)/(B) X 100 = Market Share %
TriStar Horizon	Dickson	18,914	130,371	14.51%
TriStar Ashland City	Cheatham	8,845	130,371	6.78%
VUMC	Davidson	8,120	130,371	6.23%
Vanderbilt Wilson County Hospital	Wilson	6,676	130,371	5.12%
Macon Community Hospital	Macon	6,399	130,371	4.91%
TriStar NorthCrest	Robertson	6,360	130,371	4.88%
SRMC	Sumner	6,102	130,371	4.68%
Tennova Clarksville	Montgomery	5,616	130,371	4.31%
St. Thomas Rutherford	Rutherford	5,462	130,371	4.19%
TriStar Centennial	Davidson	5,148	130,371	3.95%
WMC	Williamson	4,653	130,371	3.57%
St. Thomas West	Davidson	4,249	130,371	3.26%
TriStar Summit	Davidson	4,173	130,371	3.20%
Highpoint Health - Riverview	Smith	3,850	130,371	2.95%
TriStar Skyline	Davidson	3,703	130,371	2.84%
TriStar Hendersonville	Sumner	3,234	130,371	2.48%
Highpoint Health - Trousdale	Trousdale	3,131	130,371	2.40%
Houston County Community Hospital	Houston	2,947	130,371	2.26%
St. Thomas Hickman	Hickman	2,851	130,371	2.19%
St. Thomas Midtown	Davidson	2,469	130,371	1.89%
Maury Regional Medical Center	Maury	2,178	130,371	1.67%
Vanderbilt Bedford	Bedford	1,687	130,371	1.29%

Henry County Medical Center	Henry	1,676	130,371	1.29%
St. Thomas DeKalb	DeKalb	1,566	130,371	1.20%
TriStar Portland	Sumner	1,504	130,371	1.15%
Marshall Medical Center	Marshall	1,405	130,371	1.08%
Other TN Hospitals	All Other TN Counties	7,453	130,371	5.72%
Total		130,371		

Source: DR 35551569. 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 370 zip codes, which is a combined number of all 370.

Using THA data for 2024, a more accurate picture of historical ED utilization is shown in **Exhibit 1N-24** because that data reports all zip codes and does not suppress smaller hospital reported data.

Exhibit 1N-24
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 %)
TriStar Horizon	Dickson	7,805	12,958	60.2%
St. Thomas Hickman	Hickman	Masked	12,958	Masked
WMC	Williamson	Masked	12,958	Masked
VUMC	Davidson	Masked	12,958	Masked
TriStar Centennial	Davidson	632	12,958	4.9%
St. Thomas West	Davidson	Masked	12,958	Masked
Other TN Hospitals	All Other TN Counties	4,521		
Total		12,958		
Satellite ED Visits YR 1		4,681		

Source: THA Data, 2024. Masking required by THA Data Use Policy. Satellite ED Visits Year 1 are total volume.

Similarly, the FSED Application Guide requires **Exhibit 1N-25** to report the HDDS data for the service area. But, as noted, due to truncation of zip code data and suppression of lesser used ED data, the Applicant acknowledges that the HDDS data does not present an accurate picture in **Exhibit 1N-26**.

**Exhibit 1N-25
Ranking of ED Providers Using HDDS Data
Calendar Year 2023**

Zip Code	% Highest ED Visits	% 2nd Highest ED Visits	% 3rd Highest ED Visits	Top 3 Facilities Total
370 Zip Codes	TriStar Horizon 14.51%	TriStar Ashland City 6.78%	VUMC 6.23%	27.52%

Source: DR 35551569; Note: Where the zip codes are smaller than 20,000 people, HDDS does not report the numbers separately. Accordingly, the zip code estimates are for 370 zip codes, which is a combined number of all 370 with less than 20,000 people.

A more accurate version of the requested data for the service area in this matter is shown in **Exhibit 1N-26** below. That data is reported by zip code without truncation and does not suppress visits to lesser used EDs.

**Exhibit 1N-26
Ranking of ED Providers Using THA Data,
Calendar Year 2024**

Zip Code	% Highest ED Visits	% 2nd Highest ED Visits	% 3rd Highest ED Visits	% ED Visits Top 3 EDs
37062 (Fairview)	TriStar Horizon 36.7%	WMC Masked	St. Thomas West Masked	74.8%
37025 (Bon Aqua)	TriStar Horizon 78.6%	VUMC Masked	St. Thomas West Masked	86.7%
37029 (Burns)	TriStar Horizon 75.5%	VUMC Masked	TriStar Centennial 5.4%	86.9%
38476 (Primm Springs)	TriStar Horizon 33.3%	WMC Masked	Maury Regional Medical Center Masked	73.6%

Source: THA Data, includes ED Visits admitted to Inpatient. 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 5N** in the main application, which requests historical utilization data (see **Exhibit 1N-27** below). From 2021 through 2024, the total ED visits at providers in Williamson, Dickson, and Hickman County increased.

**Exhibit 1N-27
Historical Utilization of the EDs In Counties That Include Service Area Zip Codes
Latest 4 Years**

Zip Code/County	Facility	Most Recent Years Reported				% Change
		2021 ED Visits	2022 ED Visits	2023 ED Visits	2024 ED Visits	
EDs in the Service Area						
NONE						
EDs In Counties Which Include Service Area Zip Codes						
Dickson County	TriStar Horizon	32,181	33,332	34,929	37,325	16.0%

Dickson County	TriStar Natchez FSED	16,662	18,312	17,753	17,749	6.5%
Williamson County	WMC	43,457	49,760	52,187	54,504	25.4%
Hickman County	St. Thomas Hickman	3,618	4,690	4,843	4,039	11.6%

Source: Joint Annual Reports for Respective Years; Note: TriStar Nolensville FSED is also located in Williamson County, however, it did not open until October 2025.

As the provider of over 60 percent of ED services for the service area, TriStar Horizon proposes the TriStar Fairview FSED to enhance geographic access by bringing emergency services closer to the Fairview community while simultaneously shifting volume from its highly utilized EDs, TriStar Horizon and TriStar Natchez FSED, which are well over capacity according to ACEP guidelines.

TriStar Horizon and TriStar Natchez FSED Increase in ED Demand

During the three years from 2021 to 2024, TriStar Horizon experienced a 16 percent increase in emergency room visits. TriStar Natchez FSED experienced a 6.5 percent increase during this same time period. Likewise, its visits per ED bed increased at the same rate. Accordingly, both EDs continue to exceed their respective high and low range capacity per ACEP guidelines. **Exhibit 1N-28** provides the ED visits including 2025 since that is available for the Applicant.

**Exhibit 1N-28
TriStar Horizon and TriStar Natchez Visits
CY 2021-2025 and ACEP Range**

Visits		
Year	TriStar Horizon	TriStar Natchez FSED
2021	32,181	16,662
2022	33,332	18,312
2023	34,929	17,753
2024	37,325	17,749
2025	36,975	16,761
ED Treatment Rooms		
2021	23	9
2022	23	9
2023	22	9
2024	22	9
2025	22	9
Visits Per ED Treatment Rooms		
2021	1,399	1,851
2022	1,449	2,035
2023	1,588	1,973

2024	1,697	1,972
2025	1,681	1,862
	High Range	Low Range
ACEP Range 2025	1,250	1,429
Over ACEP Range	34.5 %	30.3%

Source: Hospital Joint Annual Report for the respective year, Internal Data for 2025 and ACEP Tables 5.1 and 5.2

An added advantage of this CON Application is that some decompression of this overage will occur.

Impact on Existing Providers

The projected utilization for the proposed FSED is based on a combination of re-direction of patients accessing other TriStar Health emergency rooms, enhancing access to service area residents, and addressing the impending future growth. The basis for the projection is discussed in detail in **Question 6N**. It is not anticipated that the TriStar Fairview FSED will have a meaningful impact on existing providers. Rather, TriStar Horizon expects redirection of more than 2,800 patients from TriStar Horizon and its TriStar Health affiliates EDs, which in turn reduces out-migration to Dickson and other areas. The balance of the TriStar Fairview FSED visits will be from service area growth and service area residents seeking enhanced access to emergency services which will result in further reduction in out-migration. Consistent with the Consumer Advantage criteria, the proposed project will better serve the growing and aging service area population with an emergency access point closer to the homes of many patients in the service area.

Differentiation of the Proposed Service from Existing Services

There is no ED in the service area and thus no existing service to be differentiated from in the service area.

As previously established, TriStar Horizon’s main campus ED and the TriStar Natchez FSED care for 60 percent of the emergency patient visits from the service area. The TriStar Horizon ED is very highly utilized and experiencing material capacity challenges at nearly 1,700 visits per ED room. TriStar Natchez is also highly utilized and experiencing material capacity challenges at nearly 1,900 visits per ED room. TriStar FSEDs serve patients in all acuity levels. The TriStar Fairview FSED will enable service area residents who need emergency care for high-risk conditions – requiring prompt and often specialized medical intervention – improved access to such services through the expansion of ED capacity. It will also enable TriStar Horizon, which has top quality practices in and around the service area, to introduce those metrics at the new FSED site. These include operating with reduced waiting times for all patients and reduced rates of leaving without treatment at the main campus ED.

**Exhibit 1N-29
Projected TriStar Fairview FSED Acuity Level**

Acuity Level	Projected Fairview FSED
Level 1 – 99281	3.9%
Level 2 – 99282	8.9%

Level 3 – 99283	44.4%
Level 4 – 99284	33.4%
Level 5 – 99285	9.3%
Critical Care	0.1%
Total	100.0%

Source: Internal Records; Note: CPT Code and Level of Care – Level 5 and Critical Care are most acute and Level 1 is least.

The TriStar Fairview FSED will provide high-quality emergency care to the patients in the service area where there is no existing ED. While there is one urgent care and some primary care providers in 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 TriStar Fairview FSED in the community closer to where service area patients live. This location will save travel time while simultaneously alleviating the demonstrated capacity challenges.

B. Rural Service Area Applicants

The proposed service area is rural If this box is checked the applicant must provide their 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 western Williamson, Dickson, and Hickman County. Williamson County, the site of the FSED, is not rural, while the portion of the service area in Hickman County is rural. Accordingly, this criterion does not apply. However, the same information requested below is provided in **Exhibit _** 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; and
- 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.
-

**Exhibit 1N-30
TriStar Horizon: 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
TriStar Horizon	4/1/2024-3/31/2025	128				X

Measure: OP-22 LWOT						
Emergency Department	Timeframe	ED Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
TriStar Horizon	CY 2024	0				X

Measure: OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival						
Emergency Department	Timeframe	ED Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
TriStar Horizon	4/1/2024-3/31/2025	67%	Not applicable as not statistically significant Only 33 of 97 Tennessee hospitals reported data for this measure			

Source: CMS Time and Effective Care-Hospital, February 25, 2026 release.

When comparing TriStar Horizon (which includes TriStar Natchez FSED)² to all 90 EDs in the state, it is in the Top Quartile. In addition, TriStar Horizon is in the “High Volume” category of emergency departments as assigned by CMS based on total visit volume. As a result, TriStar Horizon’s peers also include other High Volume Hospitals within Tennessee. High Volume Hospitals have longer wait times as they typically serve more high acuity patients. Among the 18 High Volume emergency departments in the state, TriStar Horizon has the second lowest wait time. Notably, the lowest for high volume EDs is a TriStar Health affiliate – TriStar Southern Hills Medical Center. **Exhibit 1N-31** presents the minutes by hospital for the High Volume Hospitals.

² CMS data reports the main campus and TriStar Natchez FSED under TriStar Horizon. Accordingly, where referenced in relation to CMS data, the data includes both facilities.

Exhibit 1N-31**Median Time Spent in the Emergency Department (CMS OP 18B): High Volume Hospitals**

Facility Name	Time /ED Score	Rank	Quartile
TRISTAR SOUTHERN HILLS MEDICAL CENTER	122	1	Top Quartile
TRISTAR HORIZON MEDICAL CENTER	128	2	Top Quartile
HIGHPOINT HEALTH-SUMNER WITH ASCENSION SAINT THOMA	148	3	Top Quartile
TRISTAR HENDERSONVILLE MEDICAL CENTER	154	4	Top Quartile
ST FRANCIS HOSPITAL	159	5	Top/2nd
TRISTAR STONECREST MEDICAL CENTER	173	6	2nd Quartile
TRISTAR SKYLINE MEDICAL CENTER	180	7	2nd Quartile
WILLIAMSON MEDICAL CENTER	184	8	2nd Quartile
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	186	9	2nd Quartile
LECONTE MEDICAL CENTER	198	10	3rd Quartile
MORRISTOWN HAMBLEN HOSPITAL ASSOCIATION	200	11	3rd Quartile
BLOUNT MEMORIAL HOSPITAL	203	12	3rd Quartile
MAURY REGIONAL HOSPITAL	211	13	3rd Quartile
AFFILIATE OF VITRUVIAN HEALTH	213	14	3rd / Bottom
WELLMONT HOLSTON VALLEY MEDICAL CENTER	216	15	Bottom Quartile
FORT SANDERS REGIONAL MEDICAL CENTER	246	16	Bottom Quartile
PARKWEST MEDICAL CENTER	256	17	Bottom Quartile
REGIONAL ONE HEALTH	294	18	Bottom Quartile

Source: CMS Time and Effective Care-Hospital, February 25, 2025, release.

TriStar Horizon is also lower than the National and Tennessee average for its peer group hospitals by significant margins. TriStar Horizon's median time is below the State and National average by 66 and 75 minutes, respectively. This is shown below in **Exhibit 1N-32**.

Exhibit 1N-32**Median Time Spent in the ED: TriStar Horizon, Tennessee and U.S.**

Factor	TriStar Horizon	Tennessee	National
High Volume Hospitals	128	194	203
Benefit of TriStar Horizon	--	66	75

Source: CMS Time and Effective Care-Hospital, February 25, 2026 release.

Further proof of TriStar Horizon's excellent quality is its LWOT score, which is 0. When comparing TriStar Horizon to all 83 EDs in the state reporting the data, it is in the Top Quartile. Indeed, 7 of the 21 hospitals in the top quartile of hospitals for Left Without Treatment are TriStar Health affiliates. Among the 18 High Volume emergency departments in the state, TriStar Horizon is in the Top Quartile for Left Without Treatment.

TriStar Horizon is Recognized as a High Quality Hospital

In addition to its favorable ED time and 0 LWOT score, TriStar Horizon has a number of other quality recognitions. These include, but are not limited to, the following:

Attachment 1N – FSED Criteria and Standards

- Joint Commission Accreditation
- Primary Stroke Center (TJC)
- Chest Pain Center (TJC)
- Leapfrog “A” Award for seven of the last eight periods
- Healthgrades Patient Safety Excellence Award in 2025
- Chartis’ Top 100 Rural and Community Hospitals in the country for 2024-2026
- Healthgrades, Five-Star Recipient for Pacemaker Procedures, 2025-2026
- Healthgrades, Five-Star Recipient for Hip Fracture Treatment, 2022-2026
- Healthgrades, Five-Star Recipient for Treatment of Respiratory Failure in 2026
- Healthgrades, Five-Star Recipient for Treatment of Diabetic Hospitalizations, 2023-2026
- As part of the HCA Healthcare Sarah Cannon Network, it is part of the Commission on Cancer

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.³

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 189 FSEDs nationally, 70 to 80 percent of FSED patients reside within 15 minutes of the FSEDs. This is informative and relevant to the proposed TriStar Fairview FSED. As shown in the 15-minute drive time map above (**Exhibit 1N-9**), given the proposed FSED location in Fairview, access for service area residents will be enhanced. Indeed, from the location of the proposed FSED, there are no facilities within 15 minutes.

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 TriStar Natchez FSED and other TriStar Health affiliates.

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-33** summarizes the CY 2025 transfers from TriStar Health's Middle Tennessee FSEDs to a higher level of care. While 63.4 percent of patients were transferred to the host hospitals, which is often the closest facility, 9.9 percent were transferred to a trauma center and 26.6 percent were transferred to another hospital based on patient choice and care need.

Patients will be transferred based on choice and clinical needs. Based on TriStar Horizon's experience, it anticipates a similar transfer pattern at the proposed Fairview FSED.

³ <https://www.jucm.com/understanding-the-freestanding-emergency-department-phenomenon/>

**Exhibit 1N-33
Summary of FSED Transfers to Hospital Locations
Calendar Year 2025**

FSED	Transfers to Accepting Location				Discharges	Total ER Visits
	Host Hospital	Trauma Hospital	Other Hospital	Total Transfers		
TriStar Mt Juliet	5.7%	0.5%	1.8%	8.0%	92.0%	100.0%
TriStar Century Farms	1.9%	0.6%	1.6%	4.1%	95.9%	100.0%
TriStar Natchez	4.8%	0.7%	2.5%	7.9%	92.1%	100.0%
TriStar Spring Hill	4.0%	0.6%	1.5%	6.1%	93.9%	100.0%
TriStar Portland	5.0%	1.0%	2.2%	8.2%	91.8%	100.0%
TriStar Bellevue	5.2%	0.9%	0.8%	6.8%	93.2%	100.0%
Total	4.3%	0.7%	1.8%	6.7%	93.3%	100.0%
% of Transfers	63.4%	9.9%	26.6%	100.0%		

Source: Internal TriStar data, CY 2025. Trauma Centers include VUMC and TriStar Skyline.

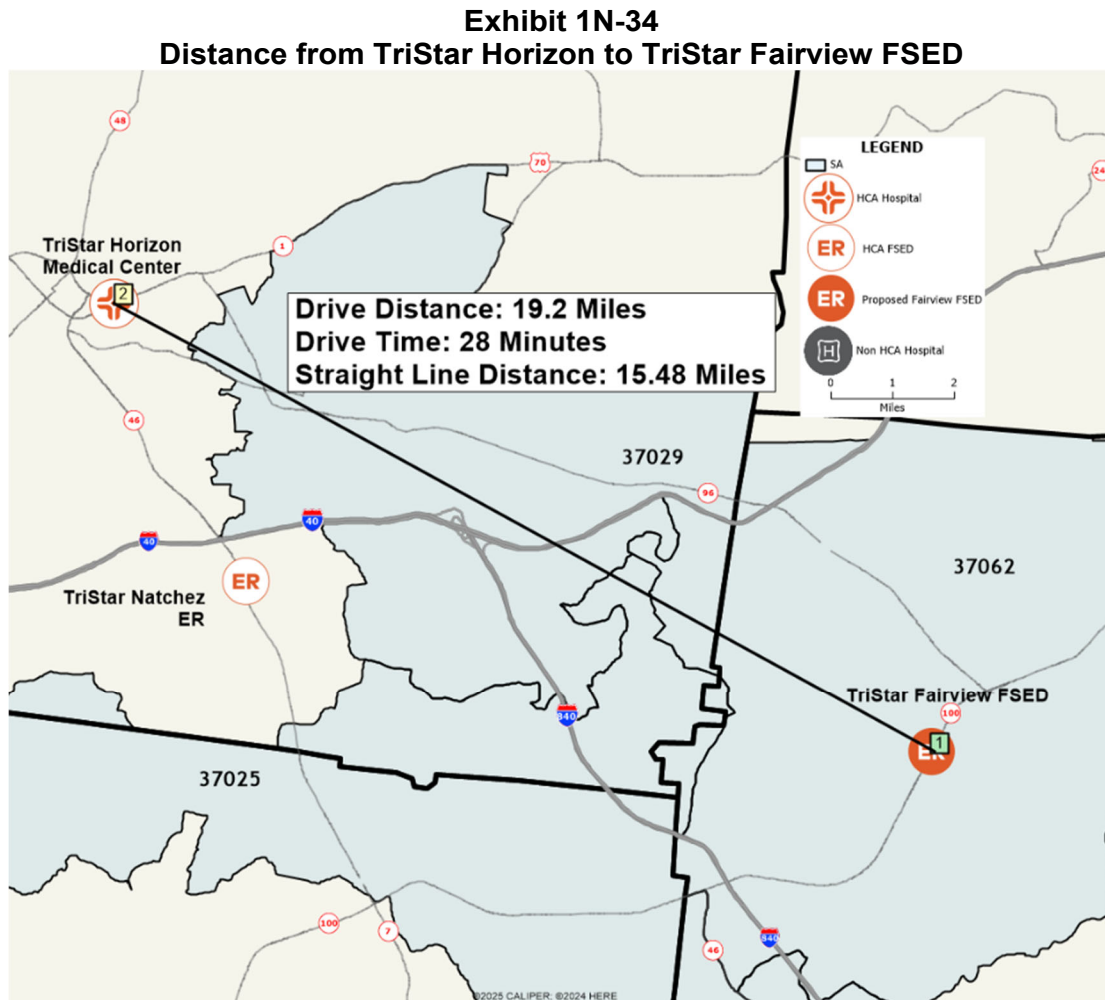
The proposed TriStar Fairview FSED will play a significant role in providing increased access to patients needing to be served at a higher level of care or to be admitted to a hospital setting by increasing the availability of emergency medical care for the increasing service area population.

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 19.2 driving miles (or 15.48 miles as the crow flies) southeast of the host hospital, TriStar Horizon. The below map, **Exhibit 1N-34**, demonstrates that the proposed FSED is located within a 35-mile radius of the hospital, TriStar Horizon.



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. TriStar Horizon 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 TriStar

Horizon (see the Applicant’s response to **Criterion 8** below). Further, in CY 2024, TriStar Horizon wrote off approximately \$101,000,000 in charity care dollars.⁴

TriStar Horizon 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 TriStar Horizon 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, TriStar Horizon 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 TriStar Horizon and its TriStar Natchez FSED serve – 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 2025, 40.9 percent of TriStar Horizon ED patients were uninsured and/or low-income patients, with 28.2 percent being designated as TennCare/Medicaid patients.⁵ This rate exceeds 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, **Exhibits 1N-35** and **1N-36**. 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.

⁴ Charity care and uninsured discounts for TriStar Horizon are from the 2024 Joint Annual Report, Schedule E, page 22.

⁵ Including TennCare/Medicaid and medically indigent/charity care patients.

Exhibit 1N-35
Service Area and TriStar Horizon ED Services to High Need Populations by Payor
Calendar Year 2023 – HDDS Data for the Counties; Calendar Year 2025 for the Host Hospital

Payor	Dickson County		Hickman County		Williamson County		Host Hospital	
	ED Patients	% Total	ED Patients	% Total	ED Patients	% Total	Total ED Patients	% Total
Medicare/Medicare Advantage	8,817	24.8%	4,010	25.3%	16,582	29.7%	14,598	27.2%
TennCare/Medicaid	12,334	34.6%	5,786	36.5%	5,592	10.0%	15,153	28.2%
Commercial/Commercial Other	10,425	29.3%	4,044	25.5%	29,500	52.9%	17,159	31.9%
Self-Pay	2,853	8.0%	1,564	9.9%	3,367	6.0%	5,686	10.6%
Medically Indigent / Free	1,162	3.3%	450	2.8%	311	0.6%	1,140	2.1%
Other	21	0.1%	15	0.1%	416	0.7%	0	0.0%
Total	35,612	100.0%	15,869	100.0%	55,768	100.0%	53,736	100.0%

Source: Hospital Discharge Data System (HDDS) DR# 35551101, 2023 ED Visits by Payor for Williamson, Dickson and Hickman Counties. Internal Data 2025 for host hospital, includes both TriStar Horizon and TriStar Natchez FSED

Exhibit 1N-36
Service Area and TriStar Horizon ED Services to High Need Populations by Payor
Calendar Year 2024 for the Service Area; Calendar Year 2025 for the Host Hospital

Payor	37062 (Fairview)		37025 (Bon Aqua)		37029 (Burns)		38476 (Primm Springs)		Service Area Total		Host Hospital	
	ED Patients	% Total	ED Patients	% Total	ED Patients	% Total	ED Patients	% Total	ED Patients	% Total	Host Hospital	% Total
Medicare/Medicare Advantage	1,370	28.0%	1,012	22.0%	762	26.0%	155	29.7%	3,299	25.5%	14,598	27.2%
TennCare/Medicaid	955	19.5%	1,541	33.5%	575	19.6%	89	17.0%	3,160	24.4%	15,153	28.2%
Commercial/Commercial Other	2,107	43.1%	1,436	31.2%	1,344	45.8%	223	42.7%	5,110	39.4%	17,159	31.9%
Self-Pay	371	7.6%	446	9.7%	184	6.3%	43	8.2%	1,044	8.1%	5,686	10.6%
Medically Indigent / Free	91	1.9%	168	3.6%	71	2.4%	12	2.3%	342	2.6%	1,140	2.1%
Other	0	0.0%	3	0.1%	0	0.0%	0	0.0%	3	0.0%	0	0.0%
Total	4,894	100.0%	4,606	100.0%	2,936	100.0%	522	100.0%	12,958	100.0%	53,736	100.0%

Source: THA Data for the individual zip codes; internal data 2025 for host hospital (includes TriStar Horizon and TriStar Natchez FSED).

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 their information below.

The proposed service area is rural.

The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant.

Data:

Socio-demographics of the service area

Projected populations to receive services

Complete the following tables to demonstrate:

- a. **Patient origin by ZIP Code for the hospital's existing ED in relation to the proposed service area for the FSED.**
- b. **Patient Origin by ZIP Code of the service area residents (i.e., market share).**

The applicant may add or remove as many ZIP Code and Hospital ED lines as is necessary.

The proposed TriStar Fairview FSED is located in Williamson County, which is not in a rural county. However, one service area zip code –37025 (Bon Aqua) – and part of 38476 (Primm Springs), are located in Hickman County, which as a whole, is considered rural.

To define the proposed service area for the TriStar Fairview FSED, the evaluation considered (i) geographic distribution of zip codes within and outside west Williamson County, Hickman County, and south Dickson County, (ii) lack of emergency department in the service area and location of the emergency departments outside of the service area, (iii) roadway systems, (iv) travel distances and (v) patient migration patterns. Based on this detailed analysis discussed throughout this CON Application, a reasonable service area was determined to include the following zip codes:

- 37062 (Fairview), the home zip code for the Fairview FSED, covering the northwest corner of Williamson County;
- 37025 (Bon Aqua), the zip code to the southwest of home zip code, covering the northern portion of Hickman County;
- 37029 (Burns), the zip code immediately to the northwest of the home zip code, covering the southeast corner of Dickson County; and
- 38476 (Primm Springs), located to the south of the home zip code and straddling the Williamson-Hickman County line.

Exhibit 1N-37 below provides patient origin by zip code for the TriStar Horizon's main campus emergency department and the TriStar Natchez FSED. As noted on the Exhibit, TriStar Horizon, including its TriStar Natchez FSED, treated more than 7,700 service area visits annually. **Exhibits 1N-38, 1N-39, and 1N-40** follow presenting the patient origin by zip code per THA data and the HDDS data set.

Exhibit 1N-37
TriStar Horizon ED and TriStar Natchez FSED Visits
by Zip Code, Calendar Year 2025

Zip Code	ED Visits	% of Total
37055 - Dickson	18,424	34.3%
37025 - Bon Aqua	3,544	6.6%
37187 - White Bluff	3,298	6.1%
37098 - Lyles	3,045	5.7%
37101 - McEwen	2,739	5.1%
37036 - Charlotte	2,472	4.6%
37029 - Burns	2,256	4.2%
37185 - Waverly	1,844	3.4%
37062 - Fairview	1,750	3.3%
37137 - Nunnelly	1,568	2.9%
37051 - Cumberland Furnace	1,248	2.3%
37033 - Centerville	1,095	2.0%
37061 - Erin	999	1.9%
37181 - Vanleer	781	1.5%
All Other (1,100+)	8,673	16.1%
Total	53,736	100.0%

Source: Internal Records, CY 2025

**Exhibit 1N-38
ED Patient Destination by Hospital ED, 2023**

Service Area Zip Code	Service Area ED	Out of Service Area EDs							Total
	NONE	Patient ED 1	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital	
		TriStar Horizon	St. Thomas West	WMC	VUMC	TriStar Centennial	St. Thomas Hickman	ED Patients	
37062 (Fairview)	0	1,778	971	872	475	279	16	452	4,843
37025 (Bon Aqua)	0	3,510	182	162	165	124	91	245	4,479
37029 (Burns)	0	2,218	149	43	218	168	6	204	3,006
38476 (Primm Springs)	0	189	38	118	46	19	16	139	565
Total Service Area	0	7,695	1,340	1,195	904	590	129	1,040	12,893
Distribution by % of Patients	0.0%	59.7%	10.4%	9.3%	7.0%	4.6%	1.0%	8.1%	100.0%

Source: CY 2023 THA Data

**Exhibit 1N-39
ED Patient Destination by Hospital ED, 2024**

Service Area Zip Code	Service Area ED	Out of Service Area EDs							Total ED Patients
	NONE	Patient ED 1	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital	
		TriStar Horizon	WMC	St. Thomas Hickman	St. Thomas West	VUMC	TriStar Centennial	ED Patients	
37062 (Fairview)	0	1,794	Masked	Masked	Masked	Masked	333	371	4,894
37025 (Bon Aqua)	0	3,620	Masked	Masked	Masked	Masked	121	265	4,606
37029 (Burns)	0	2,217	Masked	Masked	Masked	Masked	158	182	2,936
38476 (Primm Springs)	0	174	Masked	Masked	Masked	Masked	20	107	522
Total Service Area	0	7,805	Masked	Masked	Masked	Masked	632	925	12,958
Distribution by % of Patients	0.0%	60.2%	Masked	Masked	Masked	Masked	4.9%	7.1%	100.0%

Source: CY 2024 THA Data

**Exhibit 1N-40
ED Patient Destination by Hospital ED, HDDS Data, 2023**

Service Area Zip Code	Service Area ED	Out of Service Area EDs							Total
	NONE	Patient ED 1	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital ED Patients	
		TriStar Horizon	VUMC	TriStar Centennial	WMC	St. Thomas Hickman	St. Thomas West		
Truncated 370	0	18,914	8,120	5,148	4,653	2,851	4,249	86,436	130,371
Truncated 384	0	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Total Service Area	0	18,914	8,120	5,148	4,653	2,851	4,249	86,436	130,371
Distribution by % of Patients	0.0%	14.5%	6.2%	3.9%	3.6%	2.2%	3.3%	66.3%	100.0%

() Truncated 370 includes service area zip codes 37062, 37025 and 37029; these zip codes represent a majority of the service area. Truncated 370 geography is vast and includes zip codes throughout Middle Tennessee including counties of Dickson, Williamson, Wilson, Rutherford, Robertson, Stewart, Montgomery, Bedford and others. It reports more than 130,000 ED visits in CY 2023. DR 35551569.*

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 TriStar Fairview FSED will be in zip code 37062. At this location, it will improve access to underserved populations, including low-income and Medicaid-eligible residents. Williamson County on the whole is not medically underserved or a health professional shortage area. Hickman County, which contains 37025 (Bon Aqua) and part of 38476 (Primm Springs), is identified as having: (i) a medically underserved area, (ii) a medically underserved population, (iii) a professional shortage for primary care for the whole county, and (iv) a professional shortage for mental health for the whole county low-income population. Moreover, Dickson County, which contains 37029 (Burns), is currently⁶ identified as having (i) a professional shortage for primary care for the low-income population, and (ii) a professional shortage for mental health for the whole county. This is shown in **Exhibit 1N-41** below.

Exhibit 1N-41

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
Dickson County			Low Income*	X*
Hickman County	X	X	X	Low Income
Williamson County				

**Currently, Dickson County’s designations as a Primary Care HPSA, Mental Health HPSA, and Dental Health HPSA are proposed for withdrawal. However, it still remains in status. <https://data.hrsa.gov/topics/health-workforce/shortage-areas/hpsa-find>.*

⁶ Currently, the HRSA Data Warehouse identifies Dickson County as having these designations. However, the designations are listed as proposed for withdrawal. That being said, it currently remains in status. <https://data.hrsa.gov/topics/health-workforce/shortage-areas/hpsa-find>. <https://data.hrsa.gov/topics/health-workforce/shortage-areas/by-address>.

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 TriStar Fairview FSED will have all required medical services in-house. See **Exhibit 1N-42** below.

**Exhibit 1N-42
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

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 emergency care 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.⁷ Its medical staff and department staff are therefore trained and qualified to serve pediatric patients and do so daily. **Exhibit 1N-43** provides pediatric ED visits as a percentage of total visits at TriStar Horizon since 2021.

Exhibit 1N-43
TriStar Horizon: Pediatric ED Visits as a Percent of Total

Age Group	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
<18	16.7%	18.5%	18.3%	17.4%	15.5%

Source: Internal TriStar Horizon records.

Exhibit 1N-44 provides pediatric ED visits as a percentage of service area visits also since CY 2021, which have stayed flat in some parts of the service area, but grown in Fairview.

Exhibit 1N-44
Pediatric ED Visits by Zip as a Percent of Total Proposed Service Area

Zip Code	CY 2021	CY 2022	CY 2023	CY 2024
37062 (Fairview)	16.7%	16.9%	16.7%	17.4%
37025 (Bon Aqua)	20.3%	23.1%	21.8%	21.0%
37029 (Burns)	17.2%	17.8%	18.3%	19.1%
38476 (Primm Springs)	13.2%	13.4%	17.5%	15.1%
Service Area	18.0%	19.2%	18.8%	19.0%

Source: THA Data

The proposed TriStar Fairview FSED will be staffed by the same Emergency Physician group that covers TriStar Horizon’s main campus ED. All ER physicians are required to have PALS (Pediatric Advanced Life Support) certification.

Pediatric patients requiring admission at these EDs are generally transferred to Nashville area hospitals with specialized pediatric capabilities. The Children’s Hospital at TriStar Centennial has an ED serving emergent pediatric patients 24/7; this ED is fully staffed with pediatric emergency fellowship trained physicians. The facility operates with a pediatric unit and ICU, offering a wide variety of sub-specialties. When needed, transfer to higher levels of pediatric care at The Children’s Hospital at TriStar Centennial will be provided. Transfer to TriStar Health affiliates is regularly accomplished through direct communication between transferee and transferor facilities. Given common EMR, common emergency room physician group and common operational practices, TriStar Health is effective in timely securing transfers. In addition, TriStar Horizon has a transfer agreement in place with VUMC, which operates Middle Tennessee’s Comprehensive Regional Pediatric Center, to accommodate transfers to that specialty pediatric hospital in the appropriate case. See **Attachment 1C-1**.

⁷ 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. TriStar Horizon physicians and nurses are suitably trained to care for pediatric patients and to maintain the “Basic” Pediatric Emergency Facility qualification.

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.

TriStar Horizon 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 TriStar Fairview FSED is summarized in **Exhibit 1N-45** below.

**Exhibit 1N-45
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. TriStar Horizon contracts with Valesco for Emergency Medicine physician services.

The emergency room physician group for TriStar Horizon, including TriStar Natchez FSED, is HCA-EmCare Holdings, LLC d/b/a Valesco Ventures. This same group will staff the proposed TriStar Fairview FSED as it will be a department of TriStar Horizon.

TriStar Horizon is confident it will be able to fill each of the positions identified to staff the proposed TriStar Fairview FSED. Last year, TriStar Horizon’s nurse turnover ratio was 0 percent at the main campus ED and it

was 14.37 percent for the TriStar Natchez FSED. Currently, the year to date turnover rate at both locations is 0 percent.

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 Medical Director of the TriStar Horizon Emergency Department is Priscilla Shogan, DO, FACEP. A copy of Dr. Shogan’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. TriStar Horizon 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 the nature 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 applicant is 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 a very experienced 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, TriStar Horizon, and the TriStar Natchez FSED each have a helipad. As a department of the hospital, the TriStar Fairview FSED will have the capability to provide helicopter transport in addition to ambulance transport. As shown in the site plan (Attachment 12A), a location where a helicopter can access the FSED is included within the project scope. TriStar Horizon intends to work with the city of Fairview and its residents on the location of the helicopter access spot on the property.

The TriStar Fairview FSED will serve as an extension of TriStar Horizon and will use the experience of the host hospital's ED to provide emergency services to the service area. The FSED will stabilize and transfer patients as appropriate in accordance with the Emergency Medical Treatment and Labor Act (EMTALA).

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 should also 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, and other 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 of emergency services contrasted with appropriate use of urgent or primary care.

TriStar Horizon will educate the community regarding the availability of emergency care at the TriStar Fairview 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. TriStar Horizon 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.

TriStar Horizon works with other area providers and community access points to ensure that all patients have adequate access to care. With respect to behavioral health providers, TriStar Horizon has affiliate relationships with such programs in Middle Tennessee including but not limited to TriStar Centennial and Pinewood Springs. It also has relationships with non-affiliate behavioral health providers. In addition to behavioral programs, below is a list of healthcare entities with which TriStar Horizon has ongoing referral relationships:

Home Health:

- Amedisys Home Health
- Home Care Solutions
- Accent Care Home Health
- NHC Home Care
- TN Quality Home Care

Rehabilitation Hospitals:

- TriStar Horizon Medical Center
- Encompass Rehab - Franklin

Skilled Nursing Facilities:

- NHC Dickson
- Dickson Health & Rehab
- Waverly Hills Post-Acute
- Humphreys County Care & Rehab
- Life Care of Centerville
- Signature of Erin
- NHC Trace
- NHC Meadows
- West Meade Place

Long Term Acute Care Hospitals:

- Select Specialty

Hospice:

- Alive Hospice
- Gentiva Hospice
- TN Quality Hospice
- Caris Hospice

Assisted Living:

- Olive Branch Assisted Living
- Magnolia Place Assisted Living
- The Pearl

In addition to healthcare entity relationships, TriStar Horizon works closely with social services agencies and other similar organizations in the County. These organizations include but are not limited to:

- Dickson County Chamber of Commerce
- Dickson YMCA
- Dickson Help Center
- CASA of the Highland Rim
- Child Advocacy Center of the 23rd Judicial District
- Dickson Community Clinic
- Habitat for Humanity of Greater Nashville
- Dickson County Schools
- Humphreys County Schools
- Hickman County Schools
- City of Dickson, TN
- City of Dickson Police Department
- Dickson County Sheriff's Office
- Drug Free Dickson
- Dickson County Health Department
- UT Extension - Dickson County
- United Way of Greater Nashville - Dickson County
- Dickson Senior Center
- American Heart Association

TriStar Horizon also works with a network of physician practices to ensure continuity of care for patients.

Moreover, TriStar Horizon provides a number of community programs, including;

- EMS Outreach and Education
- Stop the Bleed
- Stroke Education
- CPR
- Lunch and Learn Events
- Drug Take Back
- Community Health Fairs
- Community Baby Shower Participant

TriStar Horizon 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 to report that data in the time and format requested. As a standard practice, existing data reporting streams 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, quality improvement, and outcome and process monitoring system. The FSED shall be integrated into the host hospital's quality assessment and process improvement processes.

The proposed TriStar Fairview FSED will be included in TriStar Horizon'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.

TriStar Horizon 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.

TriStar Horizon 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 (128 minutes), and 0 percent LWOT score, TriStar Horizon has other quality recognitions. These include, but are not limited to, the following:

- Joint Commission Accreditation

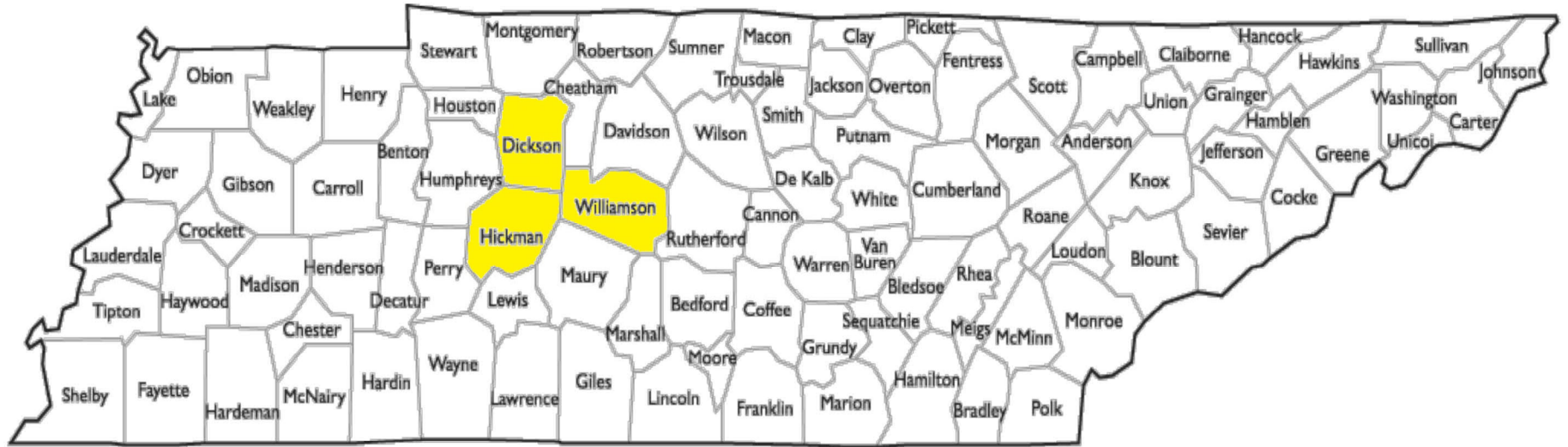
- Primary Stroke Center (TJC)
- Chest Pain Center (TJC)
- Leapfrog “A” Award for seven of the last eight periods
- Healthgrades Patient Safety Excellence Award in 2025
- Chartis’ Top 100 Rural and Community Hospitals in the country for 2024-2026
- Healthgrades, Five-Star Recipient for Pacemaker Procedures, 2025-2026
- Healthgrades, Five-Star Recipient for Hip Fracture Treatment, 2022-2026
- Healthgrades, Five-Star Recipient for Treatment of Respiratory Failure in 2026
- Healthgrades, Five-Star Recipient for Treatment of Diabetic Hospitalizations, 2023-2026
- As part of the HCA Healthcare Sarah Cannon Network, it is part of the Commission on Cancer

Please refer to **Attachment 1C-2** for a summary of TriStar Horizon community impact.

Attachment 2N

County Level Service Area Map

TENNESSEE COUNTY MAP



Attachment 3N.B

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Census Bureau				TennCare	
	Total Population-Current Year 2026	Total Population-Projected Year 2030	Total Population- % Change	*Target Population-	Target Population-	Target Population-	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
			2026-2030	All Ages	All Ages	% Change, 2026-2030							
				Current Year 2025	Project Year 2029								
37062 (Fairview)	13,832	14,504	4.9%	13,832	14,504	4.9%	100%	38.7	\$91,750	1,286	9.3%		
37025 (Bon Aqua)	7,426	7,694	3.6%	7,426	7,694	3.6%	100%	41.7	\$77,846	787	10.6%		
37029 (Burns)	7,106	7,520	5.8%	7,106	7,520	5.8%	100%	41.7	\$97,222	355	5.0%		
38476 (Primm Springs)	1,261	1,303	3.3%	1,261	1,303	3.3%	100%	29.8	\$83,654	39	3.1%		
Service Area Subtotal	29,625	31,021	4.7%	29,625	31,021	4.7%	100%			2,468	8.3%		
Dickson County	58,312	60,389	3.6%	58,312	60,389	3.6%	100%	39.1	\$75,003	5,890	10.1%	10,852	18.6%
Hickman County	25,727	25,788	0.2%	25,727	25,788	0.2%	100%	42.3	\$68,247	3,396	13.2%	5,339	20.8%
Williamson County	282,593	304,573	7.8%	282,593	304,573	7.8%	100%	41.1	\$135,594	12,717	4.5%	13,570	4.8%
State of TN Total	7,300,003	7,513,757	2.9%	7,300,003	7,513,757	2.9%	100%	39.1	\$69,595	985,500	13.5%	1,391,250	19.1%

Source: Tennessee Department of Health; Census.gov ACTS 1 year and 5 year, February 2026; Claritas, Inc. for zip code service area population; census.gov for zip code service area median age, median household income and poverty level; and Division TennCare, Enrollment as of December 2025 (latest available in February 2026).

CON Main Application Form

Section 6N

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 6N-1 provides the historical trend in ED visits from 2021 through 2024 for the service area. Calendar Year 2024 reflects a total of 12,958 ED visits in the service area.

**Exhibit 6N-1
ED Visits by Zip Code, Age Cohort and Year**

Zip Code	ED Visits by Year			
	2021	2022	2023	2024
37062 (Fairview)				
<18	721	758	807	853
18-44	1,633	1,684	1,775	1,698
45-64	1,058	1,070	1,146	1,188
65-74	489	493	567	543
75-84	303	345	383	433
85+	105	144	165	179
Total	4,309	4,494	4,843	4,894
37025 (Bon Aqua)				
<18	823	999	975	966
18-44	1,517	1,633	1,656	1,777
45-64	964	936	1,089	1,072
65-74	384	373	420	415
75-84	276	301	254	278
85+	93	78	85	98
Total	4,057	4,320	4,479	4,606
37029 (Burns)				
<18	431	503	549	562
18-44	912	946	1,032	1,011
45-64	565	654	639	605
65-74	285	355	345	331
75-84	217	266	330	299
85+	92	103	111	128
Total	2,502	2,827	3,006	2,936

38476 (Primm Springs)				
<18	56	62	99	79
18-44	134	134	162	153
45-64	121	136	156	151
65-74	71	49	77	67
75-84	28	68	55	57
85+	13	14	16	15
Total	423	463	565	522
Service Area Total				
<18	2,031	2,322	2,430	2,460
18-44	4,196	4,397	4,625	4,639
45-64	2,708	2,796	3,030	3,016
65-74	1,229	1,270	1,409	1,356
75-84	824	980	1,022	1,067
85+	303	339	377	420
Total	11,291	12,104	12,893	12,958

Source: THA Data

The above reflects an increase in ED visits of nearly 1,700 between 2021 and 2024, greater than population growth indicating an increasing use rate across all ages.

There are no EDs in the service area confirming its geographic isolation. In terms of hospitals utilized by the service area residents, TriStar Horizon and its TriStar Natchez FSED are the dominant providers of emergency services for patients residing in these four zip codes. In fact, TriStar Horizon has the highest percentage of patient visits in each of these zip codes. Furthermore, it treats more than 60 percent of service area patients ranging from a low of 33.3 percent in 38476 (Primm Springs) to a high of 78.6 percent in 37025 (Bon Aqua). In addition, an additional 6.7 percent of patients travel to other TriStar Health EDs outside the service area. In aggregate, in the proposed home zip code (37062), TriStar Health treats more than 46 percent of patients while in the overall service area, it treats more than two-thirds of the patients. This is shown by zip code in **Exhibit 6N-2** for the most recent Calendar Year available (2024).

**Exhibit 6N-2
Percent of Service Area ED Visits Treated at TriStar
Hospitals, 2024**

Service Area Zip Code	% of ED Patients Treated	
	TriStar Horizon	Other TriStar
37062 (Fairview)	36.7%	8.9%
37025 (Bon Aqua)	78.6%	4.3%
37029 (Burns)	75.5%	7.0%
38476 (Primm Springs)	33.3%	5.4%
Service Area Total	60.2%	6.7%

Source: THA Data

In terms of other hospitals which treat service area ED patients residing in Fairview, all have rates below 20 percent. For both 37025 (Bon Aqua) and 37092 (Burns), none have rates exceeding 6 percent. In the aggregate, no single other provider has more than 10 percent of the-patient visits coming from the service area.

In looking at the data to identify what additional hospitals outside the service area treated service area patients, the HDDS data is not reliable. This is because each of the four zip codes have less than 20,000 population. As a result, their data is truncated into the first three digits. This means that zip codes 37062, 37025 and 37029 are truncated into “370” which has 130,000 ED visits per the HDDS data. In reality, these three zip codes only had 12,400+ ED visits in Calendar Year 2024. Less than 10 percent as suggested by the truncated data. Accordingly, that data is not relevant to a service area health planning analysis. Relying on THA data provides relevancy and can present the service area patient migration patterns. Due to THA policy, the Calendar Year 2024 data must be masked; yet Calendar Year 2023 data is available for unmasking.

Exhibit 6N-3 provides the migration data for Calendar Year 2024 with hospital data masked except for TriStar Health affiliates. First as noted in the Exhibit, there are no EDs in the service area. Next, TriStar Horizon and TriStar Centennial combined treated more than 65 percent of service area residents. Notably, while the percent patient distribution by hospital for non-affiliates is masked, none treated greater than 10 percent of the total service area ED visits.

Exhibit 6N-3
Service Area ED Visits by Hospital and Zip Code, 2024

Service Area Zip Code	Service Area ED	Out of Service Area EDs						Other Hospital	Total
	NONE	Patient ED 1	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6		
		TriStar Horizon	WMC	Asc Hickman	Asc West	VUMC	TriStar Centennial	ED Patients	
Fairview - 37062	0	1,794	Masked	Masked	Masked	Masked	333	371	4,894
Bon Aqua - 37025	0	3,620	Masked	Masked	Masked	Masked	121	265	4,606
Burns - 37029	0	2,217	Masked	Masked	Masked	Masked	158	182	2,936
Primm Springs - 38476	0	174	Masked	Masked	Masked	Masked	20	107	522
Total Service Area	0	7,805	Masked	Masked	Masked	Masked	632	925	12,958
Distribution by % of Patients	0.0%	60.2%	Masked	Masked	Masked	Masked	4.9%	7.1%	100.0%

Source: THA data

From an informative perspective, while the data is older, Calendar Year 2023 shows a similar pattern of service area destination, with TriStar Horizon and TriStar Centennial treating approximately 65 percent of service area ED visits. This is presented in **Exhibit 6N-4** below. WMC, approximately 40 minutes from the proposed FSED and 37062 (Fairview) treated just 9.3 percent of ED visits. The other two Davidson County providers treated between 7 and 10.4 percent of visits.

**Exhibit 6N-4
Service Area ED Visits by Hospital and Zip Code, 2023**

Service Area Zip Code	Service Area ED	Out of Service Area EDs							Total
	NONE	Patient ED 1	Patient ED 2	Patient ED 3	Patient ED 4	Patient ED 5	Patient ED 6	Other Hospital	
		TriStar Horizon	WMC	Asc Hickman	Asc West	VUMC	TriStar Centennial	ED Patients	
Fairview - 37062	0	1,778	872	16	971	475	279	452	4,843
Bon Aqua - 37025	0	3,510	162	91	182	165	124	245	4,479
Burns - 37029	0	2,218	43	6	149	218	168	204	3,006
Primm Springs - 38476	0	189	118	16	38	46	19	139	565
Total Service Area	0	7,695	1,195	129	1,340	904	590	1,040	12,893
Distribution by % of Patients	0.0%	59.7%	9.3%	1.0%	10.4%	7.0%	4.6%	8.1%	100.0%

Source: THA data

ED visits have steadily increased during the past four 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 higher use rates of ED visits per 1,000 population.

Exhibit 6N-5 provides the annual ED visit per 1,000 population (use rates) for the past four years, demonstrating the increasing use rate noted above.

**Exhibit 6N-5
Service Area ED Use Rates by Zip Code, Age Cohort and Year**

Zip Code	Use Rates by Year			
	2021	2022	2023	2024
37062 (Fairview)				
<18	221.45	235.43	253.49	271.02
18-44	390.62	394.66	407.72	382.43
45-64	306.74	305.95	323.23	330.58
65-74	387.17	376.34	417.83	386.75
75-84	549.91	581.79	603.15	639.59
85+	692.31	898.13	976.33	1007.50
Total	335.30	344.44	365.69	364.15
37025 (Bon Aqua)				
<18	515.93	622.69	604.28	595.32
18-44	675.07	713.00	709.66	747.69
45-64	474.64	463.37	542.06	536.54
65-74	535.19	504.05	550.82	528.66
75-84	820.61	853.50	688.35	721.45
85+	1351.09	1044.64	1055.90	1135.14
Total	579.90	610.00	624.86	634.96
37029 (Burns)				
<18	305.93	349.87	374.36	375.84
18-44	453.99	459.97	490.38	469.72
45-64	299.47	343.79	333.16	312.88
65-74	393.47	480.60	458.17	431.36

75-84	604.46	707.45	839.69	729.27
85+	920.00	1030.00	1110.00	1280.00
Total	385.65	427.60	446.33	428.07
38476 (Primm Springs)				
<18	235.46	261.97	420.38	337.13
18-44	417.23	409.37	485.76	450.44
45-64	317.17	358.84	414.34	403.74
65-74	399.62	270.22	416.22	355.12
75-84	428.57	962.26	723.68	700.82
85+	709.09	750.00	842.11	775.86
Total	351.96	381.49	461.04	421.88
Service Area Total				
<18	312.57	357.32	373.90	378.48
18-44	479.12	491.76	506.85	498.35
45-64	349.49	358.52	386.04	381.80
65-74	426.37	427.61	460.83	431.16
75-84	628.21	703.85	693.82	686.76
85+	894.24	958.53	1023.07	1095.65
Total	410.04	432.99	454.43	450.09

Source: THA data and Population by Zip Code, 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 were analyzed. It was determined the 2024 use rates by zip code and age cohort are a reliable forecast proxy. **Exhibit 6N-6** provides the resulting forecasted service area ED visits by year by zip code and age cohort for 2028 through 2030.

**Exhibit 6N-6
Projected Service Area ED Visits by Zip Code and Year**

Zip Code	2028	2029	2030
Fairview - 37062	5,255	5,342	5,430
Bon Aqua - 37025	4,828	4,877	4,926
Burns - 37029	3,172	3,233	3,294
Primm Springs - 38476	548	555	561
Service Area	13,803	14,007	14,212

Given that the use rate by age cohort for 2024 is the proxy for the forecasted utilization, the differential from 2024 driving the increased ED visits in the service area is solely the population and the aging of that population. The impact is 1,254 ED visit growth in the service area between 2024 and 2030 as reflected in **Exhibit 6N-7**.

**Exhibit 6N-7
ED Visits, 2024 versus 2030**

Zip Code	2024	2030	Change
Fairview - 37062	4,894	5,430	536
Bon Aqua - 37025	4,606	4,926	320
Burns - 37029	2,936	3,294	358
Primm Springs - 38476	522	561	39
Service Area	12,958	14,212	1,254

Source: 2024 is THA data.

There are several advantages derived by service area population being treated at the proposed FSED. These include a more proximate closer to home ED, faster time to access treatment, shorter wait times, shorter treatment times and a quality provider. Given the expected reception of the proposed FSED in the service area, the fact that nearly two-thirds already select a TriStar Health affiliate and the materially reduced travel times for the home zip code, **Exhibit 6N-8** provides the percent of ED patients to be treated at the proposed TriStar Fairview FSED. This level of patients by zip code is consistent with TriStar Health affiliate experience at other FSEDs in terms of patient percentage, distances and access enhancement. Overall, the proposed FSED is estimated to treat 33 to 34 percent of the ED patients residing in the service Area.

**Exhibit 6N-8
Percent of Service Area Patients Projected to be Treated by
the TriStar Fairview FSED**

Zip Code	2028	2029
Fairview - 37062	30.0%	40.0%
Bon Aqua - 37025	20.0%	30.0%
Burns - 37029	20.0%	30.0%
Primm Springs - 38476	10.0%	20.0%
Service Area (Weighted Avg)	23.4%	33.4%

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 Fairview FSED. Years One and Two percent distribution by zip code area are provided in **Exhibit 6N-9**. Additionally, it is estimated that one-third of the proposed FSED patients will originate from outside the service area. This 33.3 percent factor is also included in **Exhibit 6N-9**.

**Exhibit 6N-9
Projected ED Visits Years 1 and 2**

Zip Code	Year 1	% of Total	Year 2	% of Total
Fairview - 37062	1,576	32.5%	2,137	30.4%
Bon Aqua - 37025	966	19.9%	1,463	20.8%
Burns - 37029	634	13.1%	970	13.8%
Primm Springs - 38476	55	1.1%	111	1.6%
Service Area	3,231	66.7%	4,681	66.7%
Out of Area	1,613	33.3%	2,337	33.3%
Total	4,845	100.0%	7,018	100.0%

Next, the base of patients that would shift from existing service area TriStar Health affiliates and unaffiliated providers to the proposed FSED was calculated based on the assumption that some patients closer to the proposed FSED would shift their use to the new facility. This is highly likely given the fact that TriStar Horizon has the greatest number of patients in each zip code and in the entire service area. These shift percentages consider the following:

- TriStar Horizon patients who live in the service area;
- TriStar Horizon service area patients who live closer to the Fairview FSED than either TriStar Natchez FSED or TriStar Horizon main campus:
 - Specifically, more than 2,271 service area ED patients treated at TriStar Horizon and TriStar Natchez FSED during Calendar Year 2025 live closer to TriStar Fairview FSED than TriStar Horizon or TriStar Natchez FSED;
- TriStar Health affiliates patient volume from the service area;
- Shift percentages were adjusted based on the relative proximity of each existing hospital and the FSED to the service area population;
- Patients of the host hospital and affiliates are projected to experience the largest proportionate shift to the new FSED;
- A limited number of visits was projected to come from other ED providers outside the service area based on the increased access to care in the service area that will be created through the proposed 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 33.3 percent of patients at the FSED would come from outside of the service area zip codes.

Based on these assumptions, more than 2,800 visits are expected to shift from TriStar Health EDs with the remainder of patients resulting from population growth and other service area residents selecting a more accessible emergency care provider. Proposed FSED service area ED visits in year two address both population growth and the overall shift amongst providers confirming the proposed TriStar Fairview FSED will be a consumer advantage.

Regarding level of care or acuity of the ER patient who will present at the proposed FSED, the Applicant anticipates its experience will be similar to the acuity level of TriStar Natchez FSED. Based on that assessment, **Exhibit 6N-11** provides the expected patient acuity mix at the proposed FSED.

Exhibit 6N-11
Expected Acuity by ER Level of Care at TriStar Fairview FSED

Acuity Level	Projected Fairview FSED
ER Level 1	3.9%
ER Level 2	8.9%
ER Level 3	44.4%
ER Level 4	33.4%
ER Level 5	9.3%
ER Critical Level	0.1%
Total	100.0%

Summary

The proposed TriStar Fairview FSED will be the only provider in Fairview thereby eliminating geographic isolation, the current status quo. Additionally, it will aide in decompressing the extreme overcapacity of TriStar Horizon’s EDs. Approving TriStar Fairview FSED will provide consumers with a locally available ED which will reduce travel, offer shorter wait times, access proximate medical staff, and provide treatment closer to home.

Attachment 4E-1

Equipment List > \$50,000



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

Attachment 4N-1

Charity Financial Assistance Policy for Uninsured and Underinsured Patients and Discount Policy for Patients



Origination 11/2017
Last Approved 01/2026
Effective 03/2023
Last Revised 01/2026
Next Review 01/2027

Owner Ryan Thomas: Dir
Operations
Support
Area AR Core
Operations
Support
Tags PARA.PP.OPS.016

Charity Financial Assistance Policy for Uninsured and Underinsured Patients - PARA.PP.OPS.016

SCOPE:

All SSC and Facility areas responsible for requesting and evaluating Financial Assistance Applications ("FAA") for the purposes of processing a charity write-off for certain patients receiving services at HCA-affiliated, non-partnership, acute-care hospitals ("Hospitals").

PURPOSE:

To define the policy for providing partial or full financial relief to patients who (i) have received emergency services, (ii) meet certain income requirements, (iii) do not qualify for state or federal assistance for the date of service, (iv) are uninsured or underinsured, and (v) are unable to make partial or full payment on outstanding balances. In addition, with respect to the FAA and income validation, to establish protocols and supporting documentation requirements.

POLICY:

The following types of patients may qualify for a charity write-off based on the patient's total household income, supporting income verification documentation or processes, as required, and the amount of the patient liability:

1. To be eligible for a charity write-off review, a patient must have incurred emergent, non-elective services.
2. To be eligible for a charity write-off, a patient must be (a) uninsured or underinsured and (b) have an out-of-pocket patient responsibility of \$1,500 or more for an individual account. Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than \$1,500 may be reviewed and a charity write-off applied if

Federal Poverty Guidelines/Level ("FPL") thresholds are met as set forth in **Section 9**, below.

3. For purposes of this policy, an uninsured patient is one (i) with no third party payer coverage for emergent health care services, (ii) who provides documentation that the patient is unable to pay for some or all of the provided non-elective hospital services and (iii) who satisfies the financial eligibility criteria set forth herein.
4. For purposes of this policy, an underinsured patient is one with some form of third party payer coverage for health care services, but such coverage is insufficient to pay the current bill such that the patient retains a patient liability that they are unable to pay.
5. A validation will be completed, as required in this Policy, to ensure that if any portion of the patient's medical services can be paid by any federal or state governmental health care program (e.g., Medicare, Medicaid, Tricare, Medicare secondary payer), private insurance company, or other private, non-governmental third-party payer, that the payment has been received and posted to the account. No charity write-off can be applied to any account with any outstanding payer liability.

6. **Supporting Income Verification Documentation & Review:**

A. **Medicare Accounts**

- i. All Medicare patients (i.e., inpatients and/or outpatients) must submit supporting income verification documentation. Electronic validation of patient income, e.g., Experian, alone is not sufficient. Medicare requires independent income and resource verification for a charity care determination with respect to Medicare beneficiaries (PRM-I § 312).
- ii. In addition to the FAA, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement:
 - State Income Tax Return for the most current year
 - Supporting W-2
 - Supporting 1099's
 - Copies of all bank statements for last 3 months
 - Most recent bank and broker statements listed in the Federal Tax Return
 - Current credit report
- iii. Dual-Eligible Beneficiaries: A Medicare beneficiary who also qualifies for Medicaid (dual-eligible beneficiary) may be deemed indigent as long as the "Must Bill" requirements are met. That these requirements are met must be supported by a State Medicaid remittance advice. When claiming an amount as Medicare Bad Debt for a dual-eligible beneficiary, Medicaid must be billed. In addition, the remittance advice showing non-payment must be maintained as supporting documentation for the Medicare Bad Debt adjustment. Charity write-offs for Medicaid Exhausted beneficiaries may be less than \$1,500.

- iv. Patients who qualify for a Medicare Savings Program (Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), Qualified Disabled and Working Individuals (QDWI)) will be eligible for a full charity write-off. Charity write-offs for Medicare Savings Program qualified patients may be less than \$1,500.

B. Non-Medicare Accounts

- i. Generally, for all non-Medicare Accounts, the following will be acceptable supporting documentation: (i) the documentation listed in A. above, (ii) or any one of the following:
 - Most Recent Employer Pay Stubs
 - Written documentation from income sources
 - Proof of Medicaid Eligibility
 - Electronic validation of patient income and family size, such as Experian
- ii. Supporting income verification documentation through an electronic validation of patient information/income, such as Experian, shall be obtained where no other income verification is obtained.
- iii. To the extent required by state law, a complete FAA shall be obtained for any dollars reported as charity to the state.
- iv. Review of assets may take place during the application process where required by state law or regulation.

C. Patients/Responsible Party Deemed Eligible.

The patient/responsible party may be deemed to meet the charity guidelines if:

- the patient/responsible party is determined to be eligible by a local clinic under poverty and income guidelines similar to the ones in this policy; or
- the patient/responsible party presents with Medicaid, and Medicaid does not pay.

D. Charity Processing Based on Extenuating Circumstances, i.e., Potential Charity Write-off Absent Full Documentation.

There may be extenuating circumstances where resource testing cannot be completed because the patient/responsible party does not/cannot (i) complete the FAA, or (ii) provide supporting documentation listed in A or B, above. In those circumstances, a manager may waive the required documentation and extend a charity care write-off, consistent with this Policy. The following may be considered by the manager to be extenuating circumstances:

- i. *Patients identified as an undocumented residents or homeless through:*
 - Medicaid Eligibility screening
 - Registration process

- Discharge to a shelter
 - Clinical or Case Management documentation
 - Absence of a credit report
- ii. *Patients that expire* - if it is determined through family contact and/or courthouse records that an estate does not exist, it may be considered for a charity write-off (even if the patient had a spouse) upon documentation and with the manager's review and approval of a policy exception.
 - iii. *Medically Indigent* – In addition to the above, if a patient/responsible party meets the medically indigent status based upon state guidelines or requirements, a charity write-off may be applied after the manager completes a resource testing process for the patient/responsible party.

7. Pending Medicaid Effect on Charity Write-off:

The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Pending Charity.

8. Health Insurance Marketplace for Qualified Health Plans:

Pending qualification in the Health Insurance Marketplace may take place concurrently with the Pending Charity process. The QHP enrollment is not retroactive. Rather, the coverage becomes effective for future dates of service. Therefore, it is necessary to continue with the Pending Charity process for visits occurring prior to QHP effective dates.

9. Charity Processing based on Federal Poverty Guidelines:

A. Patients with individual or household incomes of between 0-200% of Federal Poverty Guidelines:

Patients with more than a \$1,500 patient liability that fall within 0-200% of the FPL will have the entire patient balance processed as charity write-off. Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than \$1,500 may be reviewed and a charity write-off applied.

B. Patients with individual or household incomes of between 201- 400% of Federal Poverty Guidelines:

Patients with incomes between 201% and 400% of FPL will have their balances capped at a percentage of their income according to the table below. This percentage will be determined using the patient's FPL.

- 201% - 300% - balances capped at 3% of annual household income
- 301% - 400% - balances capped at 4% of annual household income

Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than \$1,500

may be reviewed and a charity write-off applied.

- C. **Insured Accounts with emergency services only:** Additional financial relief will be available for insured patients with emergent services only. These patients will be identified by having one of the following emergency Evaluation and Management (E/M) codes on their account: 99281,99282,99283,99284,99285, or 99291, and NOT in inpatient status.

After all managed care payments, contractals and/or discounts have been applied, patients will have their balance capped to a fixed amount depending on their income and corresponding FPL. The patient balance caps are as follows:

E/M Levels 1-3

201% - 300% - balance capped at \$1500
301% - 400% - balanced capped at \$1750

E/M Levels 4 +

201% - 300% - balance capped at \$2500
301% - 400% - balanced capped at \$2750

In the event that **Section 9A** or B above provides more relief to the patient, then Section 9)A or B will be used to determine patient responsibility.

10. **Patients Who Are Uninsured:**

Notwithstanding 9)A. and B. above, patients who are uninsured and who provide the supporting income verification documentation and otherwise meet the requirements of this Policy, will have their patient balance capped at the lesser of the amount calculated under 9)A. or 9)B. above, or the amount calculated pursuant to the uninsured discount model.

Balances from multiple accounts for the same patient may be considered together to determine out-of-pocket responsibility minimums and for calculating the cap.

The write-off will be applied to the entire outstanding patient balance.

11. **Refunds on Charity Accounts:**

Please refer to the state specific policies regarding charity refunds. Some states have additional operational and legal requirements relating to patient refunds. 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 (Viewing Charity Review Appeal Process).

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.PP.OPS.019](#) Utilizing the Artiva Charity Process
- [PARA.PP.OPS.020](#) Charity Review Appeal Process

Approval Signatures		
Step Description	Approver	Date
VP AR Core Services	Taylor Randalls: VP AR Core Svcs	01/2026
Policy Owner	Ryan Thomas: Dir Operations Support	12/2025



Origination 01/2015
Last Approved 12/2025
Effective 12/2025
Last Revised 12/2025
Next Review 12/2026

Owner William Rowzee:
AVP Patient
Access Ops
Area PTAC
Tags PARA.PP.GEN.043

Discount Policy for Patients - PARA.PP.GEN.043

SCOPE:

All SSC (including Specialty Services) and Facility areas responsible for offering discounts at the time of service, or settlements after services are rendered, for the sole purpose of expediting collection efforts.

PURPOSE:

To define the policy for providing discounts and / or settlement offers to patients with outstanding patient liable amounts for the purposes of liquidating receivables. All discounts will be offered in an effort to liquidate receivables and not to induce incremental volume.

POLICY:

Discounts as defined below may be provided to uninsured and insured patients receiving non-elective and elective care based on the patient liable amount as courtesy type discounts. Discounts cannot be considered for Medicare Bad Debt and should not be included in the Medicare Bad Debt Log. Discounts cannot be advertised and are to be offered only in an effort to liquidate receivables. The following outlines the associated discount types:

Uninsured Patients

- **Prompt Pay** – Prompt pay discounts may be offered at the time of service. The discount should be offered contingent on payment of the remaining balance. The maximum prompt payment discount should be no more than 20%.
- **Settlement Offers** – Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the collection process to settle a delinquent account.

Insured Patients

- **Prompt Pay** – Prompt pay discounts may be offered at the time of service provided the patient liable portion has been determined and, provided that the prompt pay discount is in accordance with payer contract provisions and state law. The maximum prompt payment discount should be no more than 20%. A written notification that the provider may have offered a prompt payment discount to the patient liable portion will be included in the remarks section of the UB claim form in FL-80.
- **Out of Network Discounts** – Out of Network discounts may be applied provided the Payer has been notified in advance that the facility intends to waive the out-of-network penalty.
- **Out of Network Medicare and Medicaid PPO/HMO** - Waiving the difference between out-of-network charges and in-network charges for beneficiaries is prohibited. For example, a facility cannot tell a physician that the facility will accept the in-network charge of \$300 instead of the out-of-network charge of \$700, when the facility is an out-of-network provider. Refer to Compliance Alert #15 (attached) for information regarding permissible waivers.
- **Out of Network PPO/HMO with Medicare as Secondary/Tertiary Payer**- Discounts may not be offered to reduce or waive an Out Of Network penalty when Medicare is also listed as a payer on the account. For example, if the account lists an OON Payer as primary and Medicare as secondary, you may not offer a discount to offset the primary payer's penalty.
- **Settlement Offers** – Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the patient liability collection process to settle a delinquent account.

The Division and SSC management teams will work together to establish the allowable discount percent for their respective facilities. The maximum prompt payment discount should be no more than 20%.

PROCEDURE:

Responsible Party	Action
Registrar/Financial Counselor/ Collection and Support Services Staff	Identifies that the patient/responsible party collection efforts could be shortened if a discount would be provided.
Registrar/Financial Counselor/ Collection and Support Services Staff	Determines the appropriate type of discount to offer in accordance with the list of discounts previously approved by the facility, Division and SSC.
Registrar/Financial Counselor/ Collection and Support Services Staff	Offers discount to patient/responsible party. If patient/responsible party is contacted by phone, the Verification of Requestors policy should be followed. (SSD.PP.PRI.103)
Registrar/Financial Counselor/ Collection and Support Services Staff	Documents the account.

REFERENCE:

Compliance Alert #15: Beneficiary Inducement Prohibition (updated 06/01/2012)

<http://atlas2.medcity.net/portal/site/ethics>

Select Compliance Alerts and choose Alert #15

Please see the attached Q: Partial Payment/Settlement Guidelines

Attachments

[Q: Partial Payment/Settlement Guidelines](#)

Approval Signatures

Step Description	Approver	Date	
AVP Patient Access Ops	William Rowzee: AVP Patient Access Ops	12/2025	
Policy Owner	William Rowzee: AVP Patient Access Ops	12/2025	

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](#)

Attachment 4C-1

Clinical Training Affiliations

TriStar Horizon
Clinical Affiliations

1. South College (ASN)
2. Belmont University (BSN)
3. Austin Peay State University
4. Tennessee College of Applied Technology Dickson (LPN)
5. Tennessee College of Applied Technology Hohenwald (PN)
6. Western Kentucky University (ASN)
7. Galen College of Nursing
8. Herzing University
9. Columbia State Community College

Additionally, TriStar Horizon hosts students from:

1. Dickson County Schools HOSA-Future Health Professionals
2. Humphreys County Schools HOSA – Future Health Professionals

Attachment 4C-2

Tennessee EMTALA Transfer Facility
Policy,
Tennessee EMTALA Medical Screening
Examination and Stabilization,
EMTALA Provision On-Call Coverage,
EMTALA Central Log Policy, and
Tennessee EMTLA – Signage Policy

Status **Active** PolicyStat ID **17458980**



Origination 04/2010
Last Approved 01/2025
Last Revised 01/2025
Next Review 01/2028

Owner Gina Bullington:
CNO Horizon
Med Ctr
Policy Area Patient Care
Applicability TriStar Horizon
Medical Center

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 the 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 affected 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 EMC 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 affected.

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 PLC 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 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.
- 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 affect 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.

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.

- b.
 - 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 appropriate 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:

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.

- i. 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.
- ii. 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.
- iii. 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.

- a. Waiver of Sanctions. Sanctions under EMTALA for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site for the MSE during a national emergency do not apply to a hospital with a DED located in an emergency area if the following conditions are met:
 - i. the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period;
 - ii. the direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency ("PHE") that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan;

- iii. the hospital does not discriminate on the basis of an individual's source of payment or ability to pay;
- iv. the hospital is located in an emergency area during an emergency period; and
- v. there has been a determination that a waiver of sanctions is necessary.

b. Waiver Limitations.

- i. An EMTALA waiver can be issued for a hospital only if:
 - the President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act;
 - the Secretary of HHS has declared a PHE; and
 - the Secretary of HHS invokes his or her waiver authority including notifying Congress at least 48 hours in advance.
- ii. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.
- iii. 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.
- iv. 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.
- v. 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.
- vi. 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:

EMTALA Model Policy Effective 5/1/19

HCA Ethics and compliance policies

EMTALA Model Policy updated 9/2024 was approved by FECC on 10/3/2024

Attachments

[Emergency Medical Condition.docx](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sharon Anderson: Dir Med Staff Svcs	01/2025
Policy & Forms	Cynthia Self: Executive Admin Asst	01/2025
Policy Owner	Daria Yang: VP Quality/Risk Mgmt	01/2025
	Sharon Anderson: Dir Med Staff Svcs	01/2025

Applicability

TriStar Horizon Medical Center

Status **Active** PolicyStat ID **16770298**



Origination 04/2004
Last Approved 10/2024
Last Revised 10/2024
Next Review 10/2027

Owner Gina Bullington:
CNO Horizon
Med Ctr
Policy Area Patient Care
Applicability TriStar Horizon
Medical Center

EMTALA- Medical Screening Examination and Stabilization 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 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:

- owned and operated by the hospital*, even if the ambulance is not on hospital grounds, or
- 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 is licensed by the state as an Emergency Department 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 of 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 individual's 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 affected 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 affect a transfer, the medical judgment of the transferring physician takes precedence over that of the off-site physician.

Refer to the hospital’s Transfer Policy for additional directions regarding transfers of those individuals who are not medically stable. If a hospital has exhausted all its capabilities and is unable to stabilize an individual, an appropriate transfer should be implemented by the transferring physician.

- c. **Stabilizing Treatment and Individuals Whose EMCs Are Resolved.** An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his or her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions. The EMC that caused the individual to present to the DED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.

8. When EMTALA Obligations End

The hospital’s EMTALA obligation ends when a physician or QMP has made a decision:

- a. That no EMC exists (even though the underlying medical condition may persist);
- b. That an EMC exists and the individual is appropriately transferred to another facility; or
- c. That an EMC exists and the individual is admitted to the hospital for further stabilizing treatment; or
- d. That an EMC exists and the individual is stabilized and discharge

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.*

k. EMTALA Waivers and Requirements During Pandemics and Other Declared Emergencies.

- a. Alternative Screening Sites on Campus for Screening during a Pandemic (No Waiver Required.) For the screening of influenza like illnesses, the hospital may establish an alternative screening site(s) on campus. Individuals may be redirected to these sites AFTER being logged in. The redirection and logging can take place outside the entrance to the DED. However, the person doing the directing must be qualified (e.g., an RN or QMP) to recognize individuals who are obviously in need of immediate treatment in the DED. The MSEs must be conducted by qualified personnel.
- b. Alternative Screening Site Off-Campus (No Waiver Required.) The hospital may encourage the public to go to an off-campus hospital-controlled site for the screening of influenza like illness. However, the hospital may NOT tell an individual who has already come to the DED to go to the off-site location for the MSE. The off-campus site for influenza like illnesses should not be held out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis.
- c. EMTALA Waivers.
 - i. A hospital operating under an EMTALA waiver will not be sanctioned for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site, for the MSE if the following conditions are met:
 1. The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period (as those terms are defined in the hospital's EMTALA Transfer Policy);
 2. The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan;
 3. The hospital does not discriminate on the basis of an individual's source of payment or ability to pay;
 4. The hospital is located in an emergency area during an emergency period; and
 5. There has been a determination that a waiver of sanctions is necessary.
 - ii. An EMTALA waiver can be issued for a hospital only if:

1. The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act; and
2. The Secretary of HHS has declared a Public Health Emergency (PHE); and
3. The Secretary invokes his or her waiver authority including notifying Congress at least 48 hours in advance; and
4. The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.

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:

EMTALA Model Policy Effective 5/1/2017

Pre-PolicyStat Number: LL.EM.001 (Corporate Policy)

EMTALA Model Policy updated 9/2024 was approved by FECC on 10/3/2024

Attachments

[Informed Refusal for Partial Refusal of Care and AMA form-Combined English and Spanish.doc](#)



[Sign-in Sheet for Emergency Services and Waiver of Right to Medical Screening Examination form.doc](#)

[Sign-in Sheet for Emergency Services_ES-LA_11_2024.docx](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sharon Anderson: Dir Med Staff Svcs	10/2024
Policy & Forms Committee	Cynthia Self: Executive Admin Asst	10/2024
Policy Owner	Gina Bullington: CNO Horizon Med Ctr	09/2024

Applicability

TriStar Horizon Medical Center

COPY

Status **Active** PolicyStat ID **17458773**



Origination 08/2016
Last Approved 01/2025
Last Revised 01/2025
Next Review 01/2028

Owner Gina Bullington:
CNO Horizon
Med Ctr
Policy Area Patient Care
Applicability TriStar Horizon
Medical Center

EMTALA – Provision of On-Call Coverage 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 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 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:

EMTALA Model Policy Effective 8/1/2016

EMTALA Model Policy Adopted by FECC June 24, 2024

Approval Signatures

Step Description	Approver	Date
MEC	Sharon Anderson: Dir Med Staff Svcs	01/2025
Ethics & Compliance	Cynthia Self: Executive Admin Asst	01/2025
Policy & Forms	Cynthia Self: Executive Admin Asst	01/2025
Policy Owner	Daria Yang: VP Quality/Risk Mgmt	01/2025

Applicability

TriStar Horizon Medical Center

COPY

Status **Active** PolicyStat ID **16770296**



Origination 09/2012
Last Approved 10/2024
Last Revised 10/2024
Next Review 10/2027

Owner Gina Bullington:
CNO Horizon
Med Ctr
Policy Area Patient Care
Applicability TriStar Horizon
Medical Center

EMTALA – Tennessee Signage 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 providing all individuals with the opportunity to be aware of and view their right to medical screening examination (MSE) and stabilization for an emergency medical condition (EMC) as required of any hospital with an emergency department by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

Policy:

All emergency departments and any other place likely to be noticed by all individuals entering the emergency department and those individuals waiting for examination and treatment in areas of the hospital other than the traditional emergency department such as the entrance area, admitting areas, waiting rooms, and treatment areas located on hospital property must post conspicuously, appropriate signage notifying individuals of their right to an MSE and stabilization or treatment for an EMC and required services for women in labor as specified under EMTALA as well as information indicating whether or not the hospital participates in the Medicaid program. The entrance to the emergency department shall be clearly marked.

Procedure:

All hospitals must post signage that, at a minimum, meets the following requirements:

- signage must be conspicuously posted in any place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than the traditional emergency department (e.g., entrance, admitting area, waiting room, labor and delivery, and other treatment areas located on hospital property):
 - signage must be readable from anywhere in the area
 - wording on signage must be clear and in simple terms in a language(s) that is (are) understandable by the population the hospital serves

The contents of the signage must:

- indicate whether or not the hospital participates in a Medicaid program approved under a State plan under Title XIX;
- specify the rights of individuals with EMCs to receive an MSE and necessary stabilization and treatment for any EMC regardless of the ability to pay; and
- specify the rights of women in labor who come to the emergency department for health care services.

The signage content must include the following language:

IT'S THE LAW!

If you have a medical emergency or are in labor, even if you cannot pay or do not have medical insurance or you are not entitled to Medicare or Medicaid, you have the right to receive, within the capabilities of this hospital's staff and facilities:

- **An appropriate medical screening examination;**
- **Necessary stabilizing treatment (including treatment for an unborn child); and**
- **If necessary, an appropriate transfer to another facility.**

This hospital (does) participate in the Medicaid program.

References:

EMTALA Model Policy Effective 2/1/2016

Tenn. Comp. R. & Regs. 1200-8-1-07(5)(i)

EMTALA Model Policy Effective 9/2024 was adopted by FECC 10/3/2024

Approval Signatures

Step Description	Approver	Date
------------------	----------	------

Medical Executive Committee	Sharon Anderson: Dir Med Staff Svcs	10/2024
Policy & Forms	Cynthia Self: Executive Admin Asst	10/2024
Policy Owner	Gina Bullington: CNO Horizon Med Ctr	09/2024

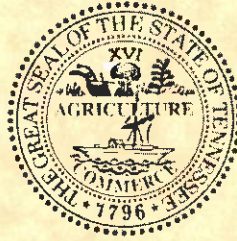
Applicability

TriStar Horizon Medical Center

COPY

Attachment 5C-1

License



State of Tennessee
Health Facilities Commission
Board for Licensing Health Care Facilities

License No. 29
No. Beds 158

This is to certify that a license is hereby granted by the Health Facilities Commission to
HCA HEALTHCARE to conduct and maintain an Hospital
TRISTAR HORIZON MEDICAL CENTER
Located at 111 HWY 70 EAST, DICKSON TN 37055
County of DICKSON, TENNESSEE.

The license shall expire April 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 26th day March, 2025.



GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL
TRAUMA CENTER LEVEL 3

By Caroline R. [Signature] Esq. C.H.S.
Director, Licensure & Regulation

By [Signature]
Executive Director

Attachment 5C-2

Medical Director Letter of Support
and CV

Priscilla Moutinho Shogan, DO

790 Saussy Place

Nashville, TN 37205

(215) 917-5011

priscillamoutinho@hotmail.com

Employment:

Horizon Medical Center Site Medical Director (2022-present) Assistant Medical Director (2012-2015) Dickson, TN	8/2011-present
TriStar Natchez FSED Site Medical Director (2018-present) Assistant Medical Director (2015-2018) Dickson, TN	6/2015-present
Sinai Hospital (EmCare) Baltimore, MD	8/2009-6/2011
Bowie Medical Center (EmCare) Bowie, MD	8/2010-6/2011

Education:

Emergency Medicine Residency: York Hospital York, Pennsylvania Vickrey Residency Award: For Excellence in ECG Interpretation (2007, 2008, 2009)	7/2006-6/2009
Medical Education: Philadelphia College of Osteopathic Medicine Philadelphia, Pennsylvania Sigma Sigma Phi Honor and Service Fraternity Doctor of Osteopathic Medicine (DO) 2006	6/2002-5/2006
Undergraduate Studies: Florida International University Miami, Florida BS, Chemistry 2000 Florida Academic Scholars Scholarship FIU Honors College Program	7/1995-5/2000

Awards and Recognition

Frist Humanitarian Award	2023
LEADs Challenge Award	2024
TriStar ED Medical Director of the Year	2024

Licensure and Certifications:

Board Certification ABEM #48559	2010
Basic Life Support (BLS)	2004
Advanced Cardiac Life Support (ACLS)	2004
Pediatric Advanced Life Support (PALS)	2006
Advanced Pediatric Life Support (APLS)	2006
Advanced Trauma Life Support (ATLS)	2006
Neonatal Resuscitation Program (NPR)	2006

Professional Affiliations:

American Osteopathic Association	2002
American College of Emergency Physicians	2005
American Academy of Emergency Medicine	2006

Research:

Research Assistant

1/1998-6/2000

Stanislaw F. Wnuk, PhD, Florida International University. Synthesized doubly homologated dihalovynil and acetylene analogues of adenosine, performed purifications and separations using silica gel column chromatography as well as thin layer chromatography and analyzed compounds using both ¹³C and ¹H NMR.

Publications, and Presentations:

1. S.F. Wnuk, C.A. Valdez, J. Khan, **P. Moutinho**, M.J. Robins, X. Yang, R.T. Borchardt, J. Balzarini, E. deClercq, "Doubly Homologated Dihalovynil and Acetylene Analogues of Adenosine Synthesis, Interaction with S-adenosyl-L-homocysteine Hydrolase and Antiviral and Cytostatic Effects". J. Med. Chem. **43**, 1180-1186 (2000).
2. Walker J, **Shogan P**, Pollack M, Benenson R. "Effect of Tamsulosin on Stone Expulsion and Pain Resolution in ED Patients with Ureterolithiasis".
 - Poster presentation, SAEM Annual Meeting 2009, New Orleans, LA
 - Outstanding Resident Research Manuscript Award, York Hospital, 2009
3. Walker J, **Shogan P**, Schradling W, Fortney S. Bougie-Assisted Intubation via King

LT® (King Systems Corporation) Outcomes Trial.

- Presented at Pennsylvania ACEP Annual Conference 2009, Pittsburg, PA
- Best Oral Presentation, Mid-Atlantic SAEM Annual Conference 2009, Newark, DE

Personal:

Born: Rio de Janeiro, Brazil

Fluent: Portuguese and Spanish

Interests: cooking, reading, fitness, travel, cats

References available upon request

February 24, 2026

Mr. Logan Grant
Executive Director
Health Facilities Commission
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Fairview CON Application

Dear Mr. Grant:

I have served as the Site Medical Director of Emergency Services at TriStar Horizon Medical Center since 2022 and as Site Medical Director of Emergency Services at TriStar Natchez Freestanding Emergency Department since 2018. Additionally, I have worked in the TriStar Horizon Emergency Department in various roles since 2011. Over the past 14 years, I have witnessed tremendous growth in Fairview and the surrounding communities.

I am writing to express my strong support for TriStar Horizon Medical Center's Certificate of Need (CON) application to develop a new freestanding emergency department (FSED) in Fairview, Tennessee. The community continues to experience steady residential growth, with more families relocating to Fairview and nearby areas each year. Traffic congestion to and from these communities continues to increase accordingly.

The population within the proposed service area has grown by more than 9% over the past five years and is projected to continue rising. Notably, the population age 65 and older has grown by more than 25% during that same period. This age group represents a significant portion of emergency department utilization, making timely access to emergency care even more critical.

Currently, residents in this area must travel approximately 14 to 50 minutes—without traffic—to reach the nearest emergency department, as none exists within the service area. As is common throughout Middle Tennessee, traffic congestion frequently extends travel times well beyond those estimates. Establishing a freestanding emergency department in Fairview would significantly reduce travel times for emergency care, particularly during peak traffic periods, when minutes can make a life-saving difference.

In addition, the proposed FSED would help alleviate congestion at surrounding emergency departments, including TriStar Horizon Medical Center's main campus and TriStar Natchez FSED, thereby improving access and patient flow across the region.

My foremost priority is always the well-being of our patients. Residents within the service area will greatly benefit from having high-quality emergency care closer to home while simultaneously easing

capacity constraints at neighboring facilities. This facility will fill a critical gap in access to care and will undoubtedly save lives.

For these reasons, I strongly urge the Commission to approve TriStar Horizon Medical Center's CON application for the proposed TriStar Fairview Freestanding Emergency Department.

Sincerely,



[Priscilla M. Shogan, DO \(Feb 25, 2026 11:58:25 GMT-3\)](#)

Priscilla Shogan, DO

Site Medical Director, Emergency Services

TriStar Horizon Medical Center

TriStar Natchez Freestanding Emergency Department

Attachment 5C-3

Most Recent Quality/Patient Safety Plan



Origination 05/2010
Last Approved 06/2025
Last Revised 06/2025
Next Review 06/2026

Owner Ashley Reed: VP
Quality/Risk
Mgmt
Policy Area Plans
Applicability TriStar Horizon
Medical Center

Plan for Quality Improvement, Patient Safety, and Risk Management (QI/PS/RM)

INTRODUCTION

TriStar Horizon Medical Center is a 158-bed Hospital with a Natchez Free Standing Emergency Department, Women's Services and Sarah Cannon Cancer center with comprehensive Oncology services.

PURPOSE

The purpose of the Quality Assessment, Performance Improvement (QAPI) and Patient Safety Plan and Evaluation is to provide a formal mechanism by which THMC utilizes objective measures to monitor and evaluate the quality of services provided to patients. Quality and Patient Safety are defined broadly to include care that strives to be safe, effective, patient-centered, timely, efficient, and equitable. The plan and evaluation facilitates a multidisciplinary, systematic performance improvement approach to identify and pursue opportunities to improve patient outcomes and reduce the risks associated with patient safety in a manner that embraces the mission, vision, and standards in pursuit of service excellence.

VISION, MISSION, AND STANDARDS IN PURSUIT OF SERVICE EXCELLENCE

TriStar Horizon Medical Center's Mission is "Above all else, we are committed to the care and improvement of human life" and is committed to offering advanced healthcare services to patients in the Dickson community with a compassionate, patient-focused approach. Our vision is to keep care local.

OBJECTIVE

Objectives of the CY 2025 QAPI and Patient Safety Plan and Evaluation are:

- To integrate Just Culture methodology into the existing working framework that supports safety, encourages non-punitive reporting, addresses maintenance and improvement in patient safety issues in every department throughout the facility, and establishes mechanisms for the disclosure of information related to errors.
- Continue and grow the integrating quality, safety, and service into performance improvement opportunities, implementing actions, and evaluating results based on the aspirational goals of always providing care that is safe, effective, patient-centered, timely, efficient, and equitable.

- To focus and coordinate the organization-wide performance improvement, patient safety, and patient experience initiatives based on sound metrics, state of the art analysis, and contemporary improvement methods.
- To facilitate communication, reporting, and documentation of all quality, patient safety, and patient experience activities to professional staff, administration, and appropriate governing members.
- To enhance the integration of medical staff physicians into meaningful patient safety, patient experience, and quality improvement initiatives.
- To maximize effective organizational and clinical decision making.
- Promote teamwork and group responsibility in identifying and implementing opportunities for improvement.
- To utilize tools and approaches that capitalize on knowledge regarding holistic approaches to improving quality and safety systems, including those developed outside of health care.

STRUCTURE AND LEADERSHIP

Key employees responsible for the development and implementation of the QAPI and Patient Safety Plan. These individuals, the THMC Chief Executive Officer,

Chief Medical Officer, Chief Nursing Officer, Chief Financial Officer, Vice President of Operations, Vice President of Quality, Chief of Staff, Patient Safety Director, and Vice President of Human Resources in partnership with the organized medical staff of THMC to fully represent the spectrum of hospital services. These leaders work directly and openly to improve quality by setting priorities, modeling core values, promoting a learning atmosphere that supports a Just Culture, acting on recommendations from hospital committees and leaders, and allocating necessary resources for improvement. This accomplished within a structure of formal and informal committees or work groups where the components of the program are defined, implemented, refined, and monitored. These groups are structured around the Institute of Medicine's (IOM) Six Key Dimensions of Care Delivery. See *Diagram - Appendix B*. These quality domains include effective, timely, appropriate, safe, efficient, and patient-centered care. These groups are comprised of attending physicians, staff, and management and are represented via a reporting process to the Patient Safety and Quality Committee, which acts as the "oversight committee" for QAPI and patient safety reporting. The Patient Safety and Quality Committee (comprised of attending physicians, administrators, and service line leaders) reports to and is supported by the Medical Executive Committee, which in turn reports to the Board of Trustees. Refer to THMC Quality and Patient Safety Committee Structure.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROCESS

PRIORITIZATION OF AREAS FOR MEASUREMENT

The process for identifying priorities for measurement requires input and discussion with senior leadership, departments, the medical staff, the nursing staff and services from all areas involved with quality performance measurement and improvement. Priorities are identified based on leadership objectives, regulatory requirements, opportunities identified from regulatory survey findings, opportunities identified through analysis of patient safety event reports and opportunities identified through serious risk events, high priority case reviews, morbidity and mortality reviews, sentinel events and any deviations from standard of care findings. These objectives or topics are then displayed in a matrix to prioritize opportunities that are pervasive and are of high risk of causing patient harm. See *Diagram - Appendix C*. where the priorities of the objectives are defined.

DEVELOPING MEASURE SPECIFICATIONS

The Patient Safety and Quality Committee (in partnership with key stakeholders) shall define the metrics

(indicators, goals, and benchmarks) for each topic. Representatives from all involved services collaboratively develop quality performance measure specifications based on the opportunities identified to be studied. Team members are identified with the help of clinical and administrative leadership. Work groups develop written measurement specifications, along with data abstraction tools when necessary. Medical staff leaders and nursing leaders will be integrally involved in defining and refining metrics.

Department-based Performance Improvement measures are submitted by individual departments based on incident reporting trends, FMEAs, or employee recommended for process and outcome improvement. Annual metrics are selected and championed by a department member of each department. The Quality team partners to provide guidance and training to adhere to the PDCA model. Metrics are evaluated annually and either continued or retired as needed by the department.

GATHERING DATA

Data is then gathered on a pre-determined time frame (weekly, monthly, and quarterly). Regular reporting of data requires continued attention from teams. A designated person will be assigned and held accountable for gathering data and having the information available when due. Sampling sizes are determined based on recognized, statistically significant sample sizes of at least 30 a month.

Real time data are collected as possible.

ANALYZING AND REPORTING DATA

The work groups discuss data analysis and determine what initiatives must be implemented to attain the desired outcome. Analysis usually involves multiple iterations and analysis to examine different aspects of the quality issue. Whenever possible and appropriate, statistical control methods, trending, and/or comparison with published benchmarks are used to analyze quality and safety measures.

IMPLEMENTATION OF ACTIONS AND DISSEMINATION OF INFORMATION

Implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Communication of quality and safety information is the responsibility of clinical and administrative leadership. This information is reported to the Quality

Management Department, and throughout the organization, using the Performance Improvement Quarterly report and other methods of disseminating critical information. Annually or more frequent as necessary, the performance is presented at the Quality and Patient Safety Committee of the Medical Staff with minutes and then presented to the Medical Executive Committee up to the Board of Trustees. *See Diagram - Appendix A.*

QAPI MODEL

THMC has adopted the Plan, Do, Check, and Act (PDCA) methodology for quality assessment and improvement. The PDCA model is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a process.



P = Plan: Identify a goal or purpose, formulate a theory, define success metrics and put a plan into action. D = Do: Implement the components of the plan

C = Check: Monitor outcomes to test the validity of the plan for signs of progress or success or problems and areas for improvement **A = Act:** Integrate the learning generated by the process, adjust the goal or change interventional methods if necessary.

CONTENT/SCOPE OF ACTIVITIES

The QAPI and Patient Safety Plan is the framework for integration of departmental activities within the organization. Each department links to one of the main areas of focus identified for improvement. All departments develop annual objectives to address and support improvement of the care, treatment, service, and safety outcomes that align with the TriStar Horizon mission and annual QAPI areas of focus. These objectives become the essence of the QAPI activities organization-wide. *See Appendix A, B, C, D, and E.*

THE 2025 QAPI AND PATIENT SAFETY AREAS OF FOCUS INCLUDE

Improve Patient Safety, Quality, & Service

- Maintain current trend of zero preventable hospital acquired infections
 - o Decrease number of blood stream infections
 - o Decrease number of surgical site infections
 - o Decrease number of urinary tract infections
 - o Decrease number of clostridium difficile infections
 - o Decrease number of MRSA infections
- Maintain excellent hand hygiene compliance across multiple departments and disciplines with at least 90%
- Integrate Pressure Injury Prevention goals to reduce preventable pressure injuries
- To achieve a goal of zero preventable falls with injuries to align with Falls Committee goals
- Reduce Hospital Acquired Conditions (including VAPS) to zero
- Reduction of medication errors to align with Medication Safety Committee goals
- Integration of the Patient Experience in Quality & Safety processes to align with Care Experience Committee Goal
- Improve our SEP-1 Compliance rate by 20%
- Improve our PC-06 Unexpected complications in newborn rate by 20%
- Maintain post-partum hemorrhage rate $\leq 3.0\%$

Improve Resource Utilization

- Improve patient flow and throughput by focusing on length of stay (goal 105% of GMLOS)
- Reduce AMI and HF readmissions rate by 20%
- Reduce Opioid reversal agent usage to a goal of $\leq 0.5\%$
- Maintain NTSV-C rate goal rate $\leq 23.60\%$
- Adhere to antimicrobial stewardship principles

CMS 5 Star + Social Determinants of Health

- Reduce AMI and HF readmissions by 20%
- Increase utilization of SDOH screening assessment by 35%
- Target social determinant risk with community resource based on community risk assessment – 2025 focus on Alcohol Anonymous, modifiable behaviors for AMI patients and Addiction Medicine service utilization

Monitor External Regulatory Compliance Indicators

- Improve Core Measures/eCQM Measures to meet national thresholds
- Improve Restraint safety
- Reduce Adverse Drug Reactions
- Reduce Blood Utilization (Transfusion Reactions)
- Pain Management and timely reassessment and documentation
- Radiology CT indicators with an aim to reduce patient exposure to ionizing radiation
- Resuscitation Program
- Organ conversion rates
- Operative/Invasive procedures (ensuring appropriate indications, complications, readmissions and return to the OR, as well as complete documentation) ?Occurrence/Sentinel/Never Event report trends
- Complications related to procedural sedation
- Patient Seclusion safety monitoring
- Complications and outcomes metrics
- Risk Management
- Monitor compliance with National Patient Safety Goals through the event reporting system Vigilanz
- Cardiovascular Initiatives:
 - NCDR Registry - Cath PCI
 - The Joint Commission Chest Pain Survey
- Radiation Safety Initiative
- Sepsis Program
 - Compliance with 1 hour antibiotic administration of 90%
 - Compliance with 3 hour and 6 hour severe sepsis bundle of 90%
- Stroke Program (increase utilization of stroke order sets with an aim of 100% utilization, achieve superior outcomes)
 - The Joint Commission Primary Stroke Certification

- Compliance of at least 80% meeting Door to Needle time of 45mins

Medical Executive Committee (MEC)

The Patient Safety and Quality Committee of the Medical Staff will report on quality activities to the Medical Executive Committee on a regular basis. Patterns and trends are identified and the Medical Executive Committee makes recommendations for improving performance to the Board of Trustees, and other committees and departments, as appropriate.

In addition, the Medical Executive Committee is responsible to:

- Receive and act upon recommendations from the clinical departments, Medical Staff Committees and officers of the Medical Staff concerning performance improvement review, evaluating and monitoring functions;
- Account to the Board of Trustees and to the Medical Staff for the overall quality and efficiency of patient care in the hospital; and
- Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Medical Staff members, maintaining the culture of safety, and initiating investigations and pursuing corrective action when warranted.

Patient Safety and Quality Committee

The Patient Safety and Quality Committee is a committee of the Medical Staff and organizational leaders that coordinates all organization wide improvement activities and makes recommendations, as appropriate. It is chaired the appointee of the Chief of Staff of the Medical Staff and accountable to the Medical Executive Committee.

Specific areas of responsibility include, but are not limited to:

- Recommending, for approval plans for maintaining quality patient care within the hospital;
- Setting priorities for action on problem correction;
QUALITY ASSESSMENT, PERFORMANCE IMPROVEMENT (QAPI), AND PATIENT SAFETY PLAN AND EVALUATION 2025
- Referring priority problems for assessment and corrective action to appropriate departments or committees;
 - Monitoring the results of quality assessment and improvement activities; and
 - Coordinating quality assessment and improvement activities

Medical Staff Interdisciplinary Committees

The Medical Staff Department Committees are interdisciplinary Medical Staff committees composed of physicians, other clinical staff, administrators, and other assigned members as may be appropriate. Interdisciplinary Committees may be formed for any Hospital clinical service, clinical location, or treatment program by recommendation of the MEC and approval of the Board. The Interdisciplinary Committees are tasked with setting departmental priorities for quality improvement and assuring that quality improvement initiatives are communicated to medical staff members and that the desired results are achieved and sustained.

PATIENT SAFETY ORGANIZATION

As a patient safety organization, TriStar Horizon Medical Center has been developed to promote and support

practices and policies for providing quality patient care and minimizing adverse incidents in patient care and safety. See *Appendix E*. This program will assist to reduce/prevent risk exposures to the patients, employees and visitors in our facility, maintain equipment, and conserve hospital property. The Patient Safety and performance improvement systems are mutually compatible and interdependent.

THMC ("Hospital") is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided to the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.

Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. (See 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.) There are additional protections offered by the State of Tennessee. All PSWP will be collected when distributed at any meeting and staff members and medical staff will be reminded not to discuss PSWP outside of the confines of the patient safety meetings.

The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as root cause analyses, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes. The organization is committed to prohibiting any retaliation (for employees and medical staff members) for reporting patient safety or quality concerns.

Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

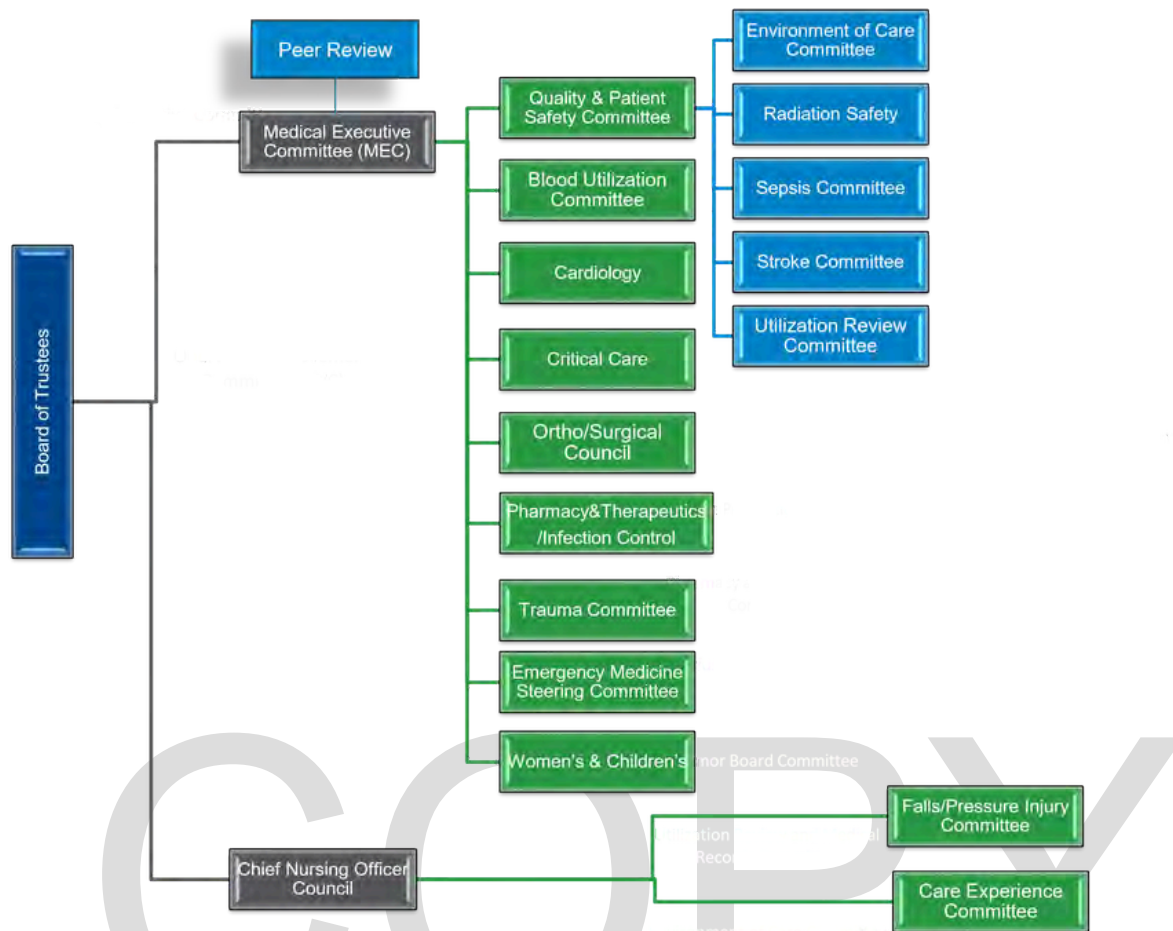
ANNUAL PLAN EVALUATION

THMC and Medical Staff leaders shall review the effectiveness of the Performance Improvement Plan at least annually in alignment with the calendar year of HCA. An annual evaluation is completed to identify components of the plan that require development, revision or deletion. THMC and Medical Staff Leaders also evaluate annually their contributions to the performance improvement and patient safety activities at THMC. An annual report is submitted to the Board of Trustees incorporated in the plan.

QUALITY ASSESSMENT, PERFORMANCE IMPROVEMENT (QAPI), AND PATIENT SAFETY PLAN AND EVALUATION

APPENDIX A

QUALITY AND PATIENT SAFETY COMMITTEE STRUCTURE



QUALITY ASSESSMENT, PERFORMANCE IMPROVEMENT (QAPI), AND PATIENT SAFETY PLAN AND EVALUATION

APPENDIX B

2025 MEDICAL STAFF PERFORMANCE IMPROVEMENT INDICATORS

2025 HCA TriStar Division– TriStar Horizon Medical Center Medical Staff Performance Improvement Indicators

The following departmental indicators are chosen, reviewed and approved by the medical staff committee chair and members. They are criteria designated for the Quality Management Department to use as a screening mechanism to identify cases that need to be further reviewed by the physician's peers. Any case that does not meet these criteria is sent for Peer Review for further review, discussions, and interventions as needed:

	Medical Staff Indicators and Measures have been selected to identify opportunities to improve patient care and safety at TriStar Horizon Medical Center.
	All identified Clinical Indicator fallout will be reviewed by a Quality Management ("QM") staff member, entered into the QM database, and tracked and trended.
	We ask our physicians, nurses and other clinical staff to immediately report events related to clinical indicators in Procedure Section 1 (a-l) and Section 2 (a-b) below.
	This immediate communication of important patient

	safety events to the QM Department is critical to our Culture of Safety program.
	Significant adverse events will be reported by QM staff to the Vice President of Quality and may generate an immediate interdisciplinary Root Cause Analysis (RCA)
CLINICAL INDICATORS <i>Cases and/or Trends Reviewed by the Professional Practice Evaluation Committee (PPEC)</i>	GLOBAL OPPE MEASURES <i>An undesirable significant variation related to an OPPE measure will be reviewed by the Department Chair and may be referred for additional Medical Staff committee review</i>
<ol style="list-style-type: none"> 1. Unexpected Mortality 2. Adverse medication event related to Practitioner prescribing error 3. Failure to follow Medical Staff approved treatment guidelines and/or protocols 4. Unplanned Readmission Within 30 Days and 7 day readmissions 5. CMS Hospital-Acquired Conditions (HACs) 6. Unplanned Transfer From General to Special Care Unit 7. Unplanned Return to the OR 8. Substantiated Patient/Family Complaints Regarding Physician Clinical Care 9. Use of Reversal Agents or Intubation with Procedural Sedation 10. Unexpected Occurrence Raising Concerns Regarding Patient Safety 11. Tissue Indicators – Single Case if significant variation identified by Pathology 	<ol style="list-style-type: none"> 1. Interpersonal and Communication Skills <ol style="list-style-type: none"> a. Compliments b. Substantiated Grievance/Complaint (#) 2. Practice-based Learning and Improvement <ol style="list-style-type: none"> a. Adverse/Sentinel Event b. Filed Claim (#) c. National Patient Safety Goal Compliance d. Peer Review (#) 3. Professionalism <ol style="list-style-type: none"> a. Non-compliance with Medical Staff Bylaws, Rules & Regs b. Unacceptable/Disruptive Behavior 4. Systems-based Practice <ol style="list-style-type: none"> a. Medical Record Delinquency (#) b. Resource Utilization Issue (Electronic Systems) (#) c. Unapproved Abbreviations
PROFESSIONALISM STANDARDS Review by the Professional Leadership Council (PLC) <ol style="list-style-type: none"> 1. Unprofessional or Disruptive Behavior 2. Patient/Family/Colleague Complaints Regarding Physician Professionalism 3. Referral from Risk Management or External Agency Regarding a Physician Professionalism Concern 	
4) Violation of Bylaws, R&Rs and/or Policy – Single Case or Aggregate Review	
QUALITY ASSESSMENT, PERFORMANCE IMPROVEMENT (QAPI), AND PATIENT SAFETY PLAN AND EVALUATION 2025	

2025 PATIENT SAFETY PLAN

GOALS

The goal of the Patient Safety Plan is to reduce patient harm and improve patient outcomes by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety. This approach centers on the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive reductions in medical/health care errors; and integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions and services.

- A proactive ongoing systematic approach for the detection and resolution of events which may or do impact patient safety will be supported through:
- Recognition and acknowledgement of the potential for medical/health errors and/or injuries and risks to patient safety; Initiation of actions to reduce these risks;
- Internal reporting of what has been found and the actions taken
- Process and system focused corrections to reduce related failures including thorough and credible Serious Event Analysis and routine Failure Mode and Effects Analysis
- Minimization of individual blame or retribution for involvement in a medical/health care error utilizing "Just Culture";
- Organizational learning about medical/health care error; and,
- The support of sharing of lessons learned to effect behavioral changes organizational wide and across other health care organizations.

SCOPE

GENERAL

This plan pertains to all staff and all patients receiving care at this facility. To be effective, the plan requires the active involvement of all members of the healthcare team, as well as patients and families, to:

- Encourage recognition and acknowledgement of risks to patient safety
- Initiate actions to reduce identified risks
- Internally report what has been identified and the actions taken

LEADERSHIP AND RESPONSIBILITY

PRESIDENT AND CHIEF EXECUTIVE OFFICER

- Provides qualified personnel and resources to support the operation of the patient safety program;
- Reviews patient safety reports and participates in the assignment of priorities for the investigation of problems as appropriate;
- Acts upon identified problems recognized through patient safety activities.

CEO, CNO, VPO, CMO, VPQ (Executive Leaders)

- Fosters an environment which encourages recognition and acknowledgement of risks to patient safety;
- Focuses on processes and systems and a minimization of individual blame;
- Facilitates effective response to events and close calls;
- Ensures there is a process for identification and management of adverse events;

- Participates in the assignment of priorities for the investigation of problems;
- Studies and acts upon risks identified through patient safety activities, as appropriate; and,
- Supports a system that builds and reinforces a just and fair culture for reporting and reducing patient safety risks.
- Hospital leaders provide the foundation for an effective patient safety program by:
 - Promoting learning and becoming a learning organization
 - Motivating staff to uphold a just and fair safety culture
 - Providing a transparent environment in which quality measures and patient harms are freely shared with staff ?Modeling professional behavior
 - Removing intimidating behavior that might prevent safe behaviors and jeopardize psychologically safe culture
 - Providing the resources and training necessary to take on improvement initiatives

VICE PRESIDENT OF QUALITY (Senior Leader)

- Oversight to the design and implementation of the Quality, Infection Prevention, and Regulatory Compliance programs;
- Provide guidance on Performance Improvement initiatives hospital-wide;
- Advises and serves as an educational resource to facility leaders on Hospital Quality, regulatory agencies, patient safety, and risk management;
- Promotes and exemplifies Just Culture and transparency;

PATIENT SAFETY AND RISK DIRECTOR

- Advances patient safety through systems thinking and design
- Identifies and mitigates patient safety risk
- Encourages and supports a safety culture that balances systems and individual accountability
- Increases patient safety awareness and practice among clinicians and staff
- Engages with executive and clinical leaders in patient safety activities and promoting a culture of safety
- Identifies opportunities for patient and family engagement in patient safety
- Measures performance and clinical outcomes. Reports measures to appropriate committees.
- Collaborates with HCA PSO, LLC to engage in efforts to improve patient safety and quality of healthcare delivery.
- Ensures completion of patient event notifications within 60 calendar days from date entered into event reporting system.
- Facilitates event management training for department directors and managers.
- Conducts overall facility patient safety/risk assessment on an annual basis.
- Facilitates thorough and credible serious event analysis that result in strong sustainable improvement strategies.
- Conducts trend analysis of occurrences
- Assists in resolution of treatment issues, such as patient refusal of treatment, consent issues and AMA discharges.

DEPARTMENT DIRECTORS

- Responsible for patient safety, loss control and general safety activities within their area.
- Participates in patient safety risk identification and evaluation activities and communicates findings to the Patient Safety Director/Risk Manager so that activities are coordinated and will be used as

appropriate in departmental education programs, policy and procedure development, and performance improvement.

- Completes incident report investigations and documentation within 15 business days.
- Works collaboratively with patient safety/risk management staff to analyze incidents, develop and monitor compliance with associated action plans developed to mitigate patient safety risk.
- Encourages collective mindfulness where staff realize that systems have the potential to fail and effective communication, to include a shared mental model, can prevent errors.

MEDICAL STAFF AND ALLIED HEALTH PROFESSIONALS

- Reviews and evaluates patient care related concerns
- Is committed to a robust, multi-disciplinary peer review process which includes the consideration of actions on supporting the Culture of Safety
- Participates in review of patient safety activities which includes Serious Event Analysis (SEA), identification and resolution of problems affecting delivery of safe patient care.
- Promotes trust and a collaborative, cooperative working environment which supports a culture of safety.
- Engages in patient safety improvement activities.

QUALITY ASSESSMENT, PERFORMANCE IMPROVEMENT (QAPI), AND PATIENT SAFETY PLAN AND EVALUATION

2025

OVERSIGHT

QUALITY AND PATIENT SAFETY COMMITTEE

- Performs on going assessment, using internal and external sources to prevent error occurrence, and improve patient safety.
- Reviews patient safety information from aggregated data reports and individual incident occurrence reports to prioritize organizational patient safety activity efforts.
- Selects one high-risk safety process for proactive risk assessment at least every 18 months.
- Establishes patient safety activities based on high risk, high volume and problem prone processes within the organization;
- Analyzes and reviews organizational patient safety activities data and identify opportunities for improvement and risk reduction;
- Collaborates in development of policies and procedures regarding patient safety and medical/health care error reduction;
- Compares patient safety measures regarding processes and outcomes internally and externally.

ENVIRONMENT OF CARE COMMITTEE

- Manages safety, security, hazardous materials, fire, medical equipment and utilities across the facility to ensure minimal impact upon patient safety.
- Performs ongoing assessment, using internal and external sources to improve safety and manage the facilities environment of care.
- Reviews safety and environment of care program from aggregated data reports and incident occurrence reports to prioritize organizational safety activity efforts.
- Facilitates development of policies and procedures regarding safety and environment of care.
- Compares safety measures regarding processes and outcomes internally and externally.

MEDICAL EXECUTIVE COMMITTEE

- Ensures quality care and services are provided to patients;
- Evaluates the clinical performance of all providers with delineated privileges;
- Supports and participates in patient safety initiatives.

BOARD OF TRUSTEES

- Retains overall responsibility and authority for the Patient Safety Program and reviews the Program on an annual basis;
- Is advised of the occurrence of any sentinel events or "never" events in a timely fashion
- Provides oversight for all patient safety activities within the organization;
- Receives and evaluates the patient safety summary reports at least quarterly indicating the status of hospital wide patient safety activities
- Assesses the effectiveness of the patient safety activities in eliminating avoidable harm

PATIENT SAFETY ORGANIZATION (PSO) MEMBERSHIP

MEMBERSHIP AGREEMENT

- This organization is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided at the Hospital. To further this objective, the Hospital contracted with HCA Patient Safety Organization, LLC ("HCA PSO, LLC"), a federally certified Patient Safety Organization ("PSO"), to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.
- The Hospital will be receiving and exchanging patient safety information with the PSO, including event or incident reports and investigations, analytic tools such as serious event analysis, patient safety communications, quality reviews, and other documents aimed at improving patient safety. Documents will be submitted in a standardized format to allow for comparison with like providers. As part of this effort, the Hospital will operate a Patient Safety Evaluation System ("PSES") designed to encourage internal reporting of adverse events, close calls, and unsafe conditions for purposes of reporting to HCA PSO, LLC. The PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes.
- Designated Hospital personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

CONFIDENTIALITY

Confidentiality attaches to patient safety information when it is collected or developed by the Hospital for reporting to the PSO or to conduct patient safety activities; this includes the internal process for developing the information, as well as deliberations or analysis conducted by the Hospital or HCA PSO, LLC for patient safety purposes.

PRIVILEGE

Generally speaking, patient safety work product ("PSWP") is not subject to subpoena or discovery in state or federal court, in administrative proceedings, or pursuant to the Freedom of Information Act ("FOIA"), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act ("PSQIA") and its associated regulations. (See 42 CFR § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206,

Confidentiality of patient safety work product.)

CSIP

- The Clinical Safety Improvement Program (CSIP) offers hospitals an opportunity to voluntarily develop

and implement specific patient safety initiatives focused on issues identified by the evaluation of close calls, adverse events, and current hospital clinical performance metrics.

- This program aims to:
 - Reduce the incidence of adverse events.
 - Reduce patient harm.
 - Promote the development and competency of patient safety leadership.
- HCA PSO will guide participating hospitals in the submission of required program deliverables and will communicate completion of results to facilities.

SAFETY CULTURE AND LEARNING ORGANIZATION

DEFINE

The safety culture of a hospital is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety.

INDIVIDUAL ACCOUNTABILITY

The aim of a safety culture is not a "blame-free" culture but one that balances learning with accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a manner that is applied consistently, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the hospital a clear, equitable, and transparent process for recognizing and separating the blameless errors that fallible humans make daily from the unsafe or reckless acts that are blameworthy.

NATIONAL PATIENT SAFETY GOALS (NPSG)

A culture of safety ensures compliance with the National Patient Safety Goals, The Joint Commission's yearly patient safety requirements based on data obtained from the Joint Commission's Sentinel Event Database and recommended by a panel of patient safety experts. (For a list of the current National Patient Safety Goals, go to http://www.jointcommission.org/standards_information/npsgs).

HIGH RELIABILITY

An environment of "collective mindfulness" in which all workers look for, and report, small problems or unsafe conditions before they pose a substantial risk to the organization and when they are easy to fix. To achieve this, a leadership commitment exists for achieving zero patient harm, a fully functional culture of safety throughout the organization, and the widespread deployment of highly effective process improvement tools.

MEASUREMENT

- An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve.
- Data and information will be used to guide decisions and to understand variation in the performance of processes supporting safety and quality.

HARM IDENTIFICATION AND REPORTING

DUTY TO REPORT

All health care providers, agents and employees of the facility have an affirmative duty to report events and close calls to the Patient Safety Director, Risk Manager or to his or her designee.

INTERNAL REPORTING

- The leaders will provide and encourage the use of systems for blame-free internal reporting of a system

or process failure, or the results of a proactive risk assessment.

- The hospital will provide staff with information regarding improvements based on reported concerns to help foster trust that encourages further reporting.
- Leaders will support and encourage event/error reporting throughout the organization through use of the Incident Reporting System to include standardized dictionaries and taxonomy.

EXTERNAL REPORTING

External reporting will be completed in accordance with state, federal, and regulatory body rules, regulations, and requirements.

SYSTEM ANALYSIS AND RISK ASSESSMENT

SYSTEMS THINKING AND RELIABLE DESIGN

- Patient Safety Science Principles will be utilized to build safer processes and systems (e.g. forcing functions, checklists, error causation thinking, human factors, applied informatics, culture).
- Patient safety activities will focus on reliability and application of the principles of reliable design to improve the consistent delivery of evidence-based care and reduction in preventable harm.

FMEA (Failure Modes, Effects Analysis)

- An FMEA will be used to prospectively examine how failures could occur during high-risk processes and, ultimately, how to prevent them.
- This proactive risk assessment will allow the hospital to evaluate a process to see how it could potentially fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement.
- The proactive risk assessment increases understanding within the organization about the complexities of process design and management—and what could happen if the process fails.

SEA (Serious Event Analysis)

- The standardized HCA Serious Event Analysis (SEA) framework, under the auspices of HCA PSO, will be utilized to conduct a thorough and credible analysis of serious events.
- Use of the SEA framework will reduce variation in the serious event analysis process throughout the organization and provide the opportunity for organizational learning.

DATA MANAGEMENT

COLLECTION

The hospital collects data on the performance of its processes and systems to include events, close calls and outcomes.

AGGREGATION

- Data is compiled in useable formats.
- Statistical tools and techniques are used to display aggregated data.
- Aggregated data is compared to internal data over time to identify levels of performance, patterns, trends, and variations.
- Aggregated data is compared to external sources, when available.

ANALYSIS

- The hospital compares data over time to identify risk points, levels of performance, patterns, trends, and variations.

- Based on analysis of its data, as well as review of the literature for new technologies and best practices, the hospital identifies opportunities for improvement.

UTILIZATION

- The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.
- The hospital uses data and information to identify and respond to internal and external changes in the environment.

PATIENT SAFETY EDUCATION

NEW HIRE AND ONGOING EDUCATION

- Staff education includes information about the need to report close calls and unanticipated adverse events as well as how to report these events.
- Staff and Clinicians will be educated in patient safety initiatives.
- Staff participation is documented.

PATIENT AND FAMILY ENGAGEMENT

SATISFACTION/PERCEPTION SURVEYS

- Hospital participates in satisfaction/perception surveys (e.g. Hospital Consumer Assessment of Healthcare Providers and Systems) to measure patients' perspectives of hospital care.
- Leaders assess results of the satisfaction survey for trends that may indicate potential patient safety issues

EDUCATION

- Hospital acknowledges patients and families are partners at every level of care.
- The patient is informed about his or her responsibilities related to his or her care, treatment, and services.
- All staff respect the patient's right to participate in decisions about his or her care, treatment, and services.

DISCLOSURE AND EVENT ANALYSIS

The hospital performs and documents disclosure of serious events to patients and/or families.

ANNUAL PROGRAM EVALUATION

REVIEW AND REVISION

- The effectiveness of the Patient Safety Program will be evaluated on an annual basis.
- The evaluation will include a review of the organization, scope and objectives of the program.
- Based on the findings of this review, modifications will be made to maximize its effectiveness with regard to improving the quality of patient care outcomes.

AREAS OF FOCUS

In conjunction with the HCA PSO, we will be participating in the Clinical Safety Improvement Program. The areas for focus include the following:

- **Identification and Mitigation of Patient Safety Risk**
 - **Serious Event Analysis (SEA)** – this deliverable requires us to complete and submit timely, thorough and credible Root Cause Analysis reports within 60 days of any sentinel event. We are also expected to submit a tracking tool to show our progress with all action plan items. It is

also required that we participate in monthly support calls.

- **Patient Event and Close Call Reporting** - This element looks at timely 'patient event management', where all leaders are to complete their incident investigations and reviews within 15 business days. The Patient Safety Director then validates the accuracy of severity, primary cause and specific cause, and makes final PSWP (patient safety work product) determination.
- **PSO Safe Table** - The goal is to operate Safety Zone PSO Safe Tables for organizational learning and systematic process improvement in response to harm events, unsafe conditions, and close calls. Safe Tables will provide a confidential and privileged environment for organizational learning and systematic process improvement related to: associated root causes, defect learnings and improvement actions. This work will generate innovation and care improvement that can be spread throughout the enterprise. The first improvement project will relate to the prevention of retained sponges.
- **Safety Culture Advancement**
 - **Culture of Safety Survey** – this aspect of the program requires us to continue to implement our action plan based on the results of the survey. We are also expected to submit quarterly action plan updates to demonstrate our progress. New hire employees will watch the video "the Dream" and all employees will watch a video called, "Hindsight".

KEY TERMS

- **Adverse Event:** Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Events include errors, preventable adverse events, and hazards. An incident in which a patient is harmed (WHO). An injury or the risk thereof caused by medical management rather than the underlying disease. An untoward, undesirable, and usually unanticipated occurrence. An act of commission or omission arising during clinical care which causes physical or psychological injury to a patient regardless of severity (VA NCPS, NQF & NPSF). Any injury caused by medical care. An adverse event does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process (AHRQ). Adverse events may be preventable or non-preventable (WHO).
- **Close Call:** Events or situations that could have resulted in an adverse event (accident, injury, or illness), but did not, whether by chance or through timely intervention. Such events have also been referred to as "near miss" incidents. An example of a close call would be a surgery or other procedure almost performed on the wrong patient due to lapses in verification of patient identification, but caught prior to the procedure (Source: VA Patient Safety Program).
- **National Patient Safety Goals:** The Joint Commission's yearly patient safety requirements based on data obtained from the Joint Commission's Sentinel Event Database and recommended by a panel of patient safety experts. (For a list of the current National Patient Safety Goals, go to http://www.jointcommission.org/standards_information/npsgs.)
- **The Patient Safety and Quality Improvement Act (PSQIA)** of 2005, Pub. L. 109-41, 42 U.S.C. 299b-21-b-26 (for which the final rule implementing the regulations became effective on January 19, 2009), was enacted in response to growing concern about patient safety in the United States and the Institute of Medicine's 1999 report, To Err is Human: Building a Safer Health System. The goal of the Act is to improve patient safety by encouraging voluntary and confidential reporting of events that adversely affect patients.
- **Patient Safety Activities** means the following activities carried out by or on behalf of a PSO or a provider: (1) Efforts to improve patient safety and the quality of health care delivery; (2) The collection and analysis of patient safety work product; (3) The development and dissemination of information with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices; (4) The utilization of patient safety work product for the purposes of encouraging a culture of safety and of providing feedback and assistance to effectively minimize patient risk; (5) The maintenance of procedures to preserve confidentiality with respect to patient safety work product; (6)

The provision of appropriate security measures with respect to patient safety work product; (7) The utilization of qualified staff; and (8) Activities related to the operation of a patient safety evaluation system and to the provision of feedback to participants in a patient safety evaluation system.

- **Patient Safety Organization (PSO)** means a private or public entity or component thereof that is listed as a PSO by the Secretary of Health and Human Services. A health insurance issuer or a component organization of a health insurance issuer may not be a PSO. The PSO enters into bona fide contracts, each of a reasonable period of time, each with a different provider for the purpose of receiving and reviewing patient safety work product.
- **Patient Safety Work Product (PSWP)** (1) Except as provided in (2) below, patient safety work product means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material) (i) Which could improve patient safety, health care quality, or health care outcomes; and (A) Which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or (B) Are developed by a PSO for the conduct of patient safety activities; or (ii) Which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system. (2)(i) Patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider information; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered patient safety work product. (ii) Patient safety work product assembled or developed by a provider for reporting to a PSO may be removed from a patient safety evaluation system and no longer considered patient safety work product if: (A) The information has not yet been reported to a PSO; and (B) The provider documents the act and date of removal of such information from the patient safety evaluation system. (iii) Nothing in this part shall be construed to limit information that is not patient safety work product from being: (A) Discovered or admitted in a criminal, civil or administrative proceeding; (B) Reported to a Federal, State, local or Tribal governmental agency for public health or health oversight purposes; or (C) Maintained as part of a provider's recordkeeping obligation under Federal, State, local or Tribal law. o **PSWP is NOT:**
 - A patient's medical record, billing and discharge information, or any other original patient or provider information.
 - Information that is collected, maintained, or developed separately, or exists separately, from a PSES. Such separate information or a copy thereof reported to a PSO shall not by reason of its reporting be considered PSWP.
 - PSWP assembled or developed by a provider for reporting to a PSO but removed from a PSES and no longer considered PSWP if: Information has not yet been reported to a PSO; and
 - Provider documents the act and date of removal of such information from the PSE

REFERENCES

- HCA PSO Event and Close Call Reporting Policy
- Facility PSO Operating Policy and Procedure
- The Patient Safety and Quality Improvement Act of 2005. Overview, June 2008. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/psoact.htm>
- PatientSafetyOrganizations:Legislation,Regulations,andGuidance.AgencyforHealthcareResearchandQuality,Rockville,MD. <http://www.pso.ahrq.gov/regulations/regulations.htm>
- The Joint Commission Patient Safety Systems Chapter

Attachments

[THMC 2024 QAPI.pdf](#)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sharon Anderson: Dir Med Staff Svcs	06/2025
Policy & Forms Committee	Cynthia Self: Executive Admin Asst	05/2025
Policy Owner	Ashley Reed: VP Quality/Risk Mgmt	05/2025

Applicability

TriStar Horizon Medical Center

History

Edited by Yang, Daria: VP Quality/Risk Mgmt on 2/18/2025, 4:17PM EST

Updated metrics

Last Approved by Yang, Daria: VP Quality/Risk Mgmt on 2/18/2025, 4:17PM EST

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correct grammar errors.

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corrected grammatical errors.

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Last Approved by Anderson, Sharon: Dir Med Staff Svcs on 6/20/2025, 12:12PM EDT

Approved by MEC 6/19/2025.

Activated on 6/20/2025, 12:12PM EDT

COPY

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

EFFECTIVE DATE: May 1, 2015

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

Listing from The Joint Commission

ORGANIZATION

TriStar Horizon Medical Center

HCO ID: 7826


DBA: TriStar Horizon Medical Center


111 Highway 70 East


Dickson, Tennessee 37055


<http://www.horizonmedicalcenter.com>




 Accredited Programs	Decision	Effective Date
Hospital	Accredited	June 13, 2025

 Certifications	Decision	Effective Date
Chest Pain	Certification	February 21, 2024

 Advanced Certifications	Decision	Effective Date
Primary Stroke Center	Certification	December 10, 2025

 Deemed and CMS-Recognized Programs
Hospital

 Sites			
<table border="0"> <tr> <td style="vertical-align: top;"> <p>TriStar Horizon Medical Center DBA: TriStar Horizon Medical Center 111 Highway 70 East, Dickson, TN, 37055</p> </td> <td style="vertical-align: top;"> <p>Available Services</p> <ul style="list-style-type: none"> • Cardiac Catheterization Lab • CT Scanner • Ear/Nose/Throat Surgery • EEG/EKG/EMG Lab • Gastroenterology • GI or Endoscopy Lab • Gynecological Surgery </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> • Ophthalmology • Orthopedic Surgery • Orthopedic/Spine Unit • Outpatient Clinics • Post Anesthesia Care Unit (PACU) • Rehabilitation Unit • Sterile Medication Compounding • Stroke (Primary Stroke Center) </td> </tr> </table>	<p>TriStar Horizon Medical Center DBA: TriStar Horizon Medical Center 111 Highway 70 East, Dickson, TN, 37055</p>	<p>Available Services</p> <ul style="list-style-type: none"> • Cardiac Catheterization Lab • CT Scanner • Ear/Nose/Throat Surgery • EEG/EKG/EMG Lab • Gastroenterology • GI or Endoscopy Lab • Gynecological Surgery 	<ul style="list-style-type: none"> • Ophthalmology • Orthopedic Surgery • Orthopedic/Spine Unit • Outpatient Clinics • Post Anesthesia Care Unit (PACU) • Rehabilitation Unit • Sterile Medication Compounding • Stroke (Primary Stroke Center)
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- Inpatient Unit
- Interventional Radiology
- Labor & Delivery
- Magnetic Resonance Imaging
- Medical /Surgical Unit
- Medical ICU
- Nuclear Medicine
- Surgical Unit
- Teleradiology
- Thoracic Surgery
- Ultrasound
- Urology
- Vascular Surgery

Accredited Programs

- Hospital

Advanced Certifications

- Primary Stroke Center

Certifications

- Chest Pain

TriStar Horizon Medical Center

DBA: Natchez Imaging and Cancer Center
107 Natchez Park Drive,
Dickson, TN, 37055

Available Services

- Outpatient Clinics
- Perform Invasive Procedure

Accredited Programs

- Hospital

TriStar Horizon Medical Center

DBA: TriStar Natchez ER
107 Natchez Park Drive,
Dickson, TN, 37055

Available Services

- Administration of Blood Product
- Administration of High Risk Medications
- Anesthesia
- Perform Invasive Procedure

Accredited Programs

- Hospital

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* The use of Joint Commission Resources advisory services is not necessary to obtain a Joint Commission accreditation or certification award, nor does it influence the granting of such awards.

Attachment 2Q-2

Awards



Top 100 Rural & Community Hospitals 2024

Hospital Name	City	State
Mat-Su Regional Medical Center	Palmer	AK
Lawrence Medical Center	Moulton	AL
Russell Medical Center	Alexander City	AL
South Baldwin Regional Medical Center	Foley	AL
John Ed Chambers Memorial Hospital	Danville	AR
Johnson Regional Medical Center	Clarksville	AR
Ouachita County Medical Center	Camden	AR
Sutter Amador Hospital	Jackson	CA
Mercy Hospital	Durango	CO
UCHealth Yampa Valley Medical Center	Steamboat Springs	CO
Windham Hospital	Willimantic	CT
Doctors Memorial Hospital	Perry	FL
HCA Florida Lake City Hospital	Lake City	FL
Fairview Park Hospital	Dublin	GA
Union General Hospital	Blairsville	GA
Hilo Medical Center	Hilo	HI
Lakes Regional Healthcare	Spirit Lake	IA
Spencer Hospital	Spencer	IA
UnityPoint Health Grinnell Regional Medical Center	Grinnell	IA
HSHS St Joseph's Hospital - Breese	Breese	IL
Jersey Community Hospital	Jerseyville	IL
Memorial Hospital and Health Care Center	Jasper	IN
HaysMed	Hays	KS
Labette Health	Parsons	KS
Morton County Hospital	Elkhart	KS
Pratt Regional Medical Center	Pratt	KS
St Catherine Hospital	Garden City	KS
Bourbon Community Hospital	Paris	KY
Nantucket Cottage Hospital	Nantucket	MA
Garrett Regional Medical Center	Oakland	MD
UM Shore Medical Center at Easton	Easton	MD
Northern Maine Medical Center	Fort Kent	ME
Corewell Health Big Rapids Hospital	Big Rapids	MI
Corewell Health Ludington Hospital	Ludington	MI
Dickinson Hospital - Iron Mountain	Iron Mountain	MI
Munson Healthcare Cadillac Hospital	Cadillac	MI
Munson Healthcare Manistee Hospital	Manistee	MI
MyMichigan Medical Center Alpena	Alpena	MI
UP Health System - Portage Main Campus	Hancock	MI
Alomere Health	Alexandria	MN

Hospital Name	City	State
Hutchinson Health Hospital	Hutchinson	MN
Lake Region Healthcare Hospital	Fergus Falls	MN
Mayo Clinic Health System - Fairmont	Fairmont	MN
Mayo Clinic Health System - Red Wing	Red Wing	MN
Owatonna Hospital	Owatonna	MN
Bozeman Health Deaconess Regional Medical Center	Bozeman	MT
Logan Health Medical Center	Kalispell	MT
St Peters Health Regional Medical Center	Helena	MT
Columbus Community Hospital	Columbus	NE
Mercer County Community Hospital	Coldwater	OH
Mercy Health - Tiffin Hospital	Tiffin	OH
OhioHealth OBleness Hospital	Athens	OH
Parkview Bryan Hospital	Bryan	OH
ProMedica Memorial Hospital	Fremont	OH
University Hospitals Samaritan Medical Center	Ashland	OH
Elkview General Hospital	Hobart	OK
Saint Francis Hospital Vinita	Vinita	OK
SSM Health St Anthony Hospital - Shawnee	Shawnee	OK
CHI Mercy Health Mercy Medical Center	Roseburg	OR
Sky Lakes Medical Center	Klamath Falls	OR
Evangelical Community Hospital	Lewisburg	PA
Geisinger Lewistown Hospital	Lewistown	PA
Penn Highlands DuBois	Du Bois	PA
Penn Highlands Huntingdon	Huntingdon	PA
St Lukes Miners Campus	Coaldale	PA
UPMC Bedford	Everett	PA
UPMC Somerset	Somerset	PA
Avera Sacred Heart Hospital	Yankton	SD
Avera St Lukes Hospital	Aberdeen	SD
Avera St Mary's Hospital	Pierre	SD
Brookings Health System	Brookings	SD
Monument Health Spearfish Hospital	Spearfish	SD
Prairie Lakes Healthcare System	Watertown	SD
TriStar Horizon Medical Center	Dickson	TN
Childress Regional Medical Center	Childress	TX
CHRISTUS Mother Frances Hospital - Sulphur Springs	Sulphur Springs	TX
Eastland Memorial Hospital	Eastland	TX
Gonzales Healthcare Systems Memorial Hospital	Gonzales	TX
Methodist Hospital Hill Country	Fredericksburg	TX
Nocona General Hospital	Nocona	TX
Rolling Plains Memorial Hospital	Sweetwater	TX
Seymour Hospital	Seymour	TX
Wilbarger General Hospital	Vernon	TX

Hospital Name	City	State
Ashley Regional Medical Center	Vernal	UT
Bear River Valley Hospital	Tremonton	UT
Castleview Hospital	Price	UT
Cedar City Hospital	Cedar City	UT
Park City Hospital	Park City	UT
Sevier Valley Hospital	Richfield	UT
Lonesome Pine Hospital	Big Stone Gap	VA
Riverside Shore Memorial Hospital	Onancock	VA
Smyth County Community Hospital	Marion	VA
Warren Memorial Hospital	Front Royal	VA
Olympic Medical Center	Port Angeles	WA
Aurora Medical Center - Manitowoc County	Two Rivers	WI
SSM Health St Clare Hospital - Baraboo	Baraboo	WI
Watertown Regional Medical Center	Watertown	WI
Evanston Regional Hospital	Evanston	WY
Sheridan Memorial Hospital	Sheridan	WY
St Johns Health	Jackson	WY

Rural & Community Hospitals

Top 100 for 2025



Hospital	City	State
Mat-Su Regional Medical Center	Palmer	AK
Troy Regional Medical Center	Troy	AL
John Ed Chambers Memorial Hospital	Danville	AR
Sutter Amador Hospital	Jackson	CA
Mercy Hospital	Durango	CO
Montrose Regional Health	Montrose	CO
Sterling Regional MedCenter	Sterling	CO
UCHealth Yampa Valley Medical Center	Steamboat Springs	CO
Vail Health	Vail	CO
Valley View Hospital	Glenwood Springs	CO
Colquitt Regional Medical Center	Moultrie	GA
Fairview Park Hospital	Dublin	GA
Memorial Health Meadows Hospital	Vidalia	GA
Lakes Regional Healthcare	Spirit Lake	IA
Spencer Hospital	Spencer	IA
UnityPoint Health Grinnell Regional Medical Center	Grinnell	IA
HSHS St Joseph's Hospital	Breese	IL
Jersey Community Hospital	Jerseyville	IL
OSF Saint Elizabeth Medical Center	Ottawa	IL
Memorial Hospital and Health Care Center	Jasper	IN
Parkview Huntington Hospital	Huntington	IN
St Elizabeth Dearborn	Lawrenceburg	IN
Labette Health	Parsons	KS
Pratt Regional Medical Center	Pratt	KS
Bourbon Community Hospital	Paris	KY
Owensboro Health Twin Lakes Medical Center	Leitchfield	KY
Springhill Medical Center	Springhill	LA
Baystate Franklin Medical Center	Greenfield	MA
Garrett Regional Medical Center	Oakland	MD
UM Shore Medical Center at Easton	Easton	MD
Munson Healthcare Cadillac Hospital	Cadillac	MI
Munson Healthcare Manistee Hospital	Manistee	MI
MyMichigan Medical Center Alpena	Alpena	MI
MyMichigan Medical Center Sault	Sault Sainte Marie	MI
MyMichigan Medical Center Tawas	Tawas City	MI
Alomere Health	Alexandria	MN
Essentia Health - St Joseph's Medical Center	Brainerd	MN
Essentia Health St Mary's - Detroit Lakes	Detroit Lakes	MN
Hutchinson Health Hospital	Hutchinson	MN

Hospital	City	State
Mayo Clinic Health System - Fairmont	Fairmont	MN
Mayo Clinic Health System - Red Wing	Red Wing	MN
Neshoba County General Hospital	Philadelphia	MS
Bozeman Health Deaconess Regional Medical Center	Bozeman	MT
Logan Health Medical Center	Kalispell	MT
St Peters Health Regional Medical Center	Helena	MT
Northern Regional Hospital	Mount Airy	NC
Columbus Community Hospital	Columbus	NE
Faith Regional Health Services	Norfolk	NE
Kearney Regional Medical Center	Kearney	NE
Adirondack Medical Center - Saranac Lake	Saranac Lake	NY
UPMC Chautauqua	Jamestown	NY
Fisher Titus Medical Center	Norwalk	OH
Mercer County Community Hospital	Coldwater	OH
Mercy Health - Defiance Hospital	Defiance	OH
Mercy Health - Tiffin Hospital	Tiffin	OH
OhioHealth OBleness Hospital	Athens	OH
Parkview Bryan Hospital	Bryan	OH
Wood County Hospital	Bowling Green	OH
Duncan Regional Hospital	Duncan	OK
Jackson County Memorial Hospital	Altus	OK
Saint Francis Hospital Vinita	Vinita	OK
SSM Health St Anthony Hospital	Shawnee	OK
CHI Mercy Health Mercy Medical Center	Roseburg	OR
Sky Lakes Medical Center	Klamath Falls	OR
Geisinger Lewistown Hospital	Lewistown	PA
Punxsutawney Area Hospital	Punxsutawney	PA
UPMC Bedford	Everett	PA
UPMC Somerset	Somerset	PA
WellSpan Waynesboro Hospital	Waynesboro	PA
Newberry County Memorial Hospital	Newberry	SC
Avera Sacred Heart Hospital	Yankton	SD
Avera St Luke's Hospital	Aberdeen	SD
Avera St Mary's Hospital	Pierre	SD
Brookings Health System	Brookings	SD
Monument Health Spearfish Hospital	Spearfish	SD
Prairie Lakes Healthcare System	Watertown	SD
Baptist Memorial Hospital - Carroll County	Huntingdon	TN
TriStar Horizon Medical Center	Dickson	TN
Childress Regional Medical Center	Childress	TX
CHRISTUS Mother Frances Hospital	Sulphur Springs	TX
Methodist Hospital Hill Country	Fredericksburg	TX
Nocona General Hospital	Nocona	TX

Hospital	City	State
Peterson Health	Kerrville	TX
Rolling Plains Memorial Hospital	Sweetwater	TX
Ashley Regional Medical Center	Vernal	UT
Bear River Valley Hospital	Tremonton	UT
Castleview Hospital	Price	UT
Cedar City Hospital	Cedar City	UT
Park City Hospital	Park City	UT
Sevier Valley Hospital	Richfield	UT
Uintah Basin Medical Center	Roosevelt	UT
Riverside Shore Memorial Hospital	Onancock	VA
Warren Memorial Hospital	Front Royal	VA
Aspirus Stevens Point Hospital	Stevens Point	WI
Aurora Medical Center - Manitowoc County	Two Rivers	WI
Fort Memorial Hospital	Fort Atkinson	WI
SSM Health St Clare Hospital	Baraboo	WI
Evanston Regional Hospital	Evanston	WY
Ivinson Memorial Hospital	Laramie	WY
St Johns Health	Jackson	WY

Rural & Community Hospitals

Top 100 for 2026



Facility	City	State
Mat-Su Regional Medical Center	Palmer	AK
Troy Regional Medical Center	Troy	AL
John Ed Chambers Memorial Hospital	Danville	AR
Colusa Medical Center	Colusa	CA
Sutter Amador Hospital	Jackson	CA
St Elizabeth Community Hospital	Red Bluff	CA
Adventist Health Sonora	Sonora	CA
Mercy Hospital	Durango	CO
Valley View Hospital	Glenwood Springs	CO
Montrose Regional Health	Montrose	CO
UCHealth Yampa Valley Medical Center	Steamboat Springs	CO
Sterling Regional MedCenter	Sterling	CO
Vail Health	Vail	CO
Baptist Medical Center Nassau	Fernandina Beach	FL
Piedmont Mountainside Hospital	Jasper	GA
Colquitt Regional Medical Center	Moultrie	GA
Washington County Regional Medical Center	Sandersville	GA
Memorial Health Meadows Hospital	Vidalia	GA
Hilo Benioff Medical Center Main	Hilo	HI
Wilcox Medical Center	Lihue	HI
UnityPoint Health Grinnell Regional Medical Center	Grinnell	IA
Spencer Hospital	Spencer	IA
Lakes Regional Healthcare	Spirit Lake	IA
HSHS St Josephs Hospital - Breese	Breese	IL
SSM Health St Marys Hospital - Centralia	Centralia	IL
HSHS Holy Family Hospital	Greenville	IL
Jersey Community Hospital	Jerseyville	IL
OSF Saint Elizabeth Medical Center	Ottawa	IL
Deaconess Memorial Medical Center	Jasper	IN
Marion Health	Marion	IN
Major Health Partners Medical Center	Shelbyville	IN
NMC Health Medical Center	Newton	KS
Labette Health	Parsons	KS
Pratt Regional Medical Center	Pratt	KS
Owensboro Health Twin Lakes Medical Center	Leitchfield	KY
Baptist Health Richmond	Richmond	KY

Facility	City	State
Springhill Medical Center	Springhill	LA
Nantucket Cottage Hospital	Nantucket	MA
UM Shore Medical Center at Easton	Easton	MD
Garrett Regional Medical Center	Oakland	MD
CalvertHealth Medical Center	Prince Frederick	MD
MyMichigan Medical Center Alpena	Alpena	MI
Corewell Health Big Rapids Hospital	Big Rapids	MI
Munson Healthcare Cadillac Hospital	Cadillac	MI
UP Health System - Portage Main Campus	Hancock	MI
Corewell Health Ludington Hospital	Ludington	MI
Munson Healthcare Manistee Hospital	Manistee	MI
MyMichigan Medical Center Tawas	Tawas City	MI
Alomere Health	Alexandria	MN
Sanford Bemidji Medical Center	Bemidji	MN
Essentia Health - St Josephs Medical Center	Brainerd	MN
Mayo Clinic Health System - Fairmont	Fairmont	MN
Lake Region Healthcare Hospital	Fergus Falls	MN
Hutchinson Health Hospital	Hutchinson	MN
Mayo Clinic Health System - Red Wing	Red Wing	MN
Mercy Hospital Washington	Washington	MO
Bozeman Health Deaconess Regional Medical Center	Bozeman	MT
St Peters Health Regional Medical Center	Helena	MT
Logan Health Medical Center	Kalispell	MT
Columbus Community Hospital	Columbus	NE
Faith Regional Health Services	Norfolk	NE
Presbyterian Espanola Hospital	Espanola	NM
Jones Memorial Hospital	Wellsville	NY
Mercy Health - Tiffin Hospital	Tiffin	OH
OhioHealth Van Wert Hospital	Van Wert	OH
Jackson County Memorial Hospital	Altus	OK
Mercy Hospital Ardmore	Ardmore	OK
Duncan Regional Hospital	Duncan	OK
SSM Health St Anthony Hospital - Shawnee	Shawnee	OK
Sky Lakes Medical Center	Klamath Falls	OR
CHI Mercy Health Mercy Medical Center	Roseburg	OR
UPMC Bedford	Everett	PA
Geisinger Lewistown Hospital	Lewistown	PA
Geisinger St Lukes Hospital	Orwigsburg	PA
Warren General Hospital	Warren	PA
WellSpan Waynesboro Hospital	Waynesboro	PA

Facility	City	State
Avera St Lukes Hospital	Aberdeen	SD
Brookings Health System	Brookings	SD
Monument Health Spearfish Hospital	Spearfish	SD
Prairie Lakes Healthcare System	Watertown	SD
Avera Sacred Heart Hospital	Yankton	SD
TriStar Horizon Medical Center	Dickson	TN
Childress Regional Medical Center	Childress	TX
Gonzales Healthcare Systems Memorial Hospital	Gonzales	TX
Peterson Health	Kerrville	TX
Cedar City Hospital	Cedar City	UT
Park City Hospital	Park City	UT
Sevier Valley Hospital	Richfield	UT
Mountain West Medical Center	Tooele	UT
Bear River Valley Hospital	Tremonton	UT
Ashley Regional Medical Center	Vernal	UT
Riverside Walter Reed Hospital	Gloucester	VA
Riverside Shore Memorial Hospital	Onancock	VA
Northwestern Medical Center	Saint Albans	VT
SSM Health St Clare Hospital - Baraboo	Baraboo	WI
SSM Health Monroe Hospital	Monroe	WI
Aurora Medical Center - Manitowoc County	Two Rivers	WI
St Johns Health	Jackson	WY
Ivinson Memorial Hospital	Laramie	WY
Sheridan Memorial Hospital	Sheridan	WY

Attachment 1C-1

Transfer Agreement
Vanderbilt University Medical Center

**PATIENT TRANSFER AGREEMENT
BETWEEN
VANDERBILT UNIVERSITY MEDICAL CENTER
AND
TRISTAR HORIZON MEDICAL CENTER**

In consideration of the needs of the patients of the area served by both the institutions herein named, this Agreement is entered into by and between Vanderbilt University Medical Center, a Tennessee not-for-profit corporation (hereinafter referred to as "VUMC"), and TriStar Horizon Medical Center, (hereinafter referred to as "Facility") (both Vanderbilt and Facility will also be referred to collectively as "Institutions" or individually, an "Institution").

WITNESSETH:

WHEREAS, each Institution owns and operates an acute care hospital providing health care services for residents of the area served by such Institution; and,

WHEREAS, both Institutions desire to assure continuity of care and treatment appropriate to the needs of patients and to use the skills and resources of both institutions in a coordinated and cooperative fashion; and

WHEREAS, the parties share a common desire to benefit the communities they serve by assuring the provision of medical care within the communities for those needs that can be met locally and for facilitating access to specialized care when deemed necessary;

WHEREAS, the Institutions have previously executed an affiliation agreement that is of mutual interest and benefit to the communities served by the two Institutions and will further benefit the Institutions' patients; and

WHEREAS, VUMC desires to enter into a transfer agreement with Facility for the continuation of care of certain emergency patients during those times when VUMC does not have immediate capacity to serve such patients; and

WHEREAS, Facility desires to enter to a transfer agreement with VUMC for the continuation of care of certain patients in the event that it is deemed that those Facility patients are in need of the specialized capabilities provided at VUMC.

NOW, THEREFORE, in consideration of the promises herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

I. TERMS AND CONDITIONS:

A. Patient Transfer from Facility to VUMC.

1. VUMC will provide treatment and hospitalization, when and if VUMC has sufficient capacity and capabilities as required by law, for patients of Facility on an as-needed basis when requested by Facility. Facility will refer patients to VUMC only when the patients need treatment, care or tests that are not available at Facility and are available at VUMC.

2. For patients being transferred to VUMC for treatment associated with (burns, trauma) Facility will also adhere to the specific criteria listed in Appendix I, attached hereto and made a part hereof by this reference.
3. Whenever questions or disagreements arise related to the decision to transfer or mode of transfer, among other things, Facility shall have the right to escalate the discussion to the Chief of Staff/Administrative Physician on call, who provides general oversight and possesses senior authority over transfer decisions.

B. Patient Transfer from VUMC to Facility.

1. Facility will provide treatment and hospitalization, when and if Facility has sufficient capacity and capabilities, for patients of VUMC on an as-needed basis when requested by VUMC, in those instances when VUMC does not have immediate capacity to admit the patient and to provide inpatient services for such patient. Only patients who are appropriate for transfer and who consent after being informed of risks and benefits shall be transferred to Facility.
2. If Facility is an inpatient facility, then it is agreed by VUMC and Facility as follows: When a patient has been transferred to VUMC from Facility and it is determined by the VUMC attending physician that the patient has been stabilized and no longer has an emergency medical condition, requires emergency treatment, or needs additional specialty services provided at VUMC, but the patient does require further hospitalization, Facility agrees to readmit that patient for appropriate hospitalization within 24-48 hours of such determination. In the event Facility's referring physician does not accept the patient, Facility's Chief of Medical Staff or other authorized representative of Facility shall facilitate identification of an appropriate accepting physician and transfer of the patient back to Facility.

C. Mutual Obligations.

1. A patient may only be admitted at a receiving Institution after an attending physician at the receiving Institution accepts the patient's admission after speaking with a transferring Institution physician. If the receiving Institution's attending physician has approved and agreed to the admission of the transfer patient (i) after concluding that all conditions of eligibility are met; (ii) subject to availability of appropriate personnel, space and facilities at the receiving Institution; and (iii) to the extent permitted by law if financial arrangements have been made, then the receiving Institution agrees to facilitate prompt admission of the patient. The parties hereto agree to conduct any patient transfers in compliance with state and federal law, including 42 U.S.C. § 1395dd et seq. and any amendments thereto ("EMTALA regulations") and, as applicable, all requirements set forth in 42 C.F.R. § 483 regarding discharge, transfer, and re-admission of nursing home patients, and such other requirements as may be imposed by the Secretary of Health and Human Services and federal or state law.
2. The transferring Institution shall provide, or arrange for the provision of, transportation for a patient for the purpose of his or her transfer to and from the receiving Institution under this Agreement. The appropriate method of transportation is dependent upon patient's condition and such transportation (ground, fixed wing or

rotary wing) will be determined after consultation between the transferring and receiving physicians.

3. If the admitting physician or transferring physician should deem it medically necessary for the patient to be accompanied by personnel and/or equipment during the transfer, the transferring Institution shall provide or arrange for, at its cost and expense, the appropriate personnel and/or equipment for the transfer.
4. The transferring Institution agrees to send with each patient at the time of transfer, or, in case of emergency, as promptly as possible after the transfer, pertinent medical and other information necessary to continue the patient's treatment without interruption, together with essential identifying and administrative information.
5. The receiving Institution shall assume responsibility for patient care at the time it takes physical custody of the patient and shall remain responsible for patient care only during the time that the receiving Institution has such physical custody of the patient.

II. BILLING AND PAYMENT

- A. It is agreed that the services rendered by the receiving Institution or the receiving Institution's physicians shall be charged to the patient, the patient's Managed Care Organization ("MCO"), or other third party payor. The transferring Institution shall not be held responsible for payment of services rendered to a patient by the receiving Institution or the receiving Institution's physicians and the receiving Institution and the receiving Institution's physicians shall not be held responsible for payment of services rendered to a patient by the transferring Institution.
- B. The transferring Institution will provide the receiving Institution with all information necessary to enable the receiving Institution to bill the patient, his or her MCO, or other third party payor for all patient care services rendered by the receiving Institution prior to patient's transfer.

III. TERM AND TERMINATION

- A. This Agreement shall be effective from November 1, 2024 and continue until amended, modified, or terminated. This Agreement shall be reviewed on a periodic basis and at that time, both parties will evaluate the program and policies, discuss any related problems, and make necessary revisions. Neither party shall be bound by this Agreement until it is signed by the appropriate officials as indicated on the signature page of this Agreement.
- B. Notwithstanding any other terms and conditions hereunder, this Agreement may be terminated without cause by either party by written notification to the other party at least thirty (30) days prior to the desired effective date of termination.
- C. In the event that either party shall become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceedings under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of rights of creditors, then, at the option of either party, this Agreement may be terminated immediately by either party and be of no further force and effect.

- D. In the event that either party sells all or substantially all of its assets, there is a sale of a majority ownership of either party, or there occurs a material change in the management or ownership of either party, this Agreement may be terminated by either party and be of no further force and effect.
- E. Each party warrants that it is duly licensed under the laws of its state and agrees to abide by applicable state and/or federal laws and regulations governing the licensure and operation of its facility. Each party further agrees to give prompt notice in writing to the other party in the event of institution of proceedings for suspension or revocation of its license, and to notify the other party in the event of any suspension or revocation of its license within twenty-four (24) hours of its occurrence. This Agreement will immediately terminate upon the revocation or suspension of licensure of either party. Further, either party, at its sole discretion, may terminate this Agreement in the event the other party is given notice of the institution of proceedings to suspend or revoke its licensure.

IV. INDEMNIFICATION

Each party shall indemnify, defend, and hold harmless the other party, its trustees, officers, agents and employees, from any judgments, damages, costs and expenses, including reasonable attorney's fees, from any claim, action or proceeding to the extent arising out of its own negligent acts or omissions in the performance of this Agreement. Each party's agreement to indemnify and hold the other party harmless is conditioned on the party to be indemnified: (i) providing written notice to the indemnifying party of any claim, demand or action arising out of the indemnified activities within such a period of time as to not materially prejudice the rights of the indemnifying party after the indemnified party has knowledge of such claim, demand or action; (ii) assisting the indemnifying party, at the indemnifying party's reasonable expense, in the preparation for and defense of any such claim or demand; and (iii) not compromising or settling such claim or demand without the indemnifying party's written consent, which shall not be unreasonably withheld. Furthermore, the indemnifying party shall not compromise or settle any claim or demand without the indemnified party's written consent, which shall not be unreasonably withheld. Notwithstanding the foregoing, each party shall have the right to participate at its own expense in the defense of any claims through counsel of its own choosing.

V. INSURANCE

During the term of this Agreement, Facility shall maintain the following insurance coverage with limits not less than the amount specified with companies rated A or better by A.M. Best & Company and, if subcontracting is permitted, Facility shall require its subcontractor(s) to maintain similar insurance coverage:

- A. Commercial General Liability insurance including products and completed operations coverage with limits of \$2,000,000 per occurrence and \$4,000,000 in the aggregate. The required limits may be satisfied in combination of both Primary and Excess insurance.
- B. Cyber (Network and Security) insurance with a minimum aggregate limit of \$5,000,000 including coverage for Privacy Notification Cost and providing protection against liability for: (1) privacy breaches, including, but not limited to, liability arising from the loss or disclosure of confidential information, no matter how such loss or disclosure occurs; (2) system breach; (3) denial or loss of service; (4) introduction, implantation, or spread of malicious software code; and (5) unauthorized access to or use of computer systems.

- C. Professional Liability/Errors and Omissions insurance, with minimum limits of \$5,000,000 for each wrongful act and in the aggregate. Claims-made coverage is permitted, provided the policy retroactive date for coverage is no later than the commencement date of this Agreement and is continuously maintained during all periods in which the Facility is performing services under the Agreement. Coverage shall stay in force with the retroactive date maintained for an additional period of three years after such services have been rendered to VUMC.
- D. Any self-insurance arrangement must be through an actuarially sound program of self-insurance. Any limitation of liability or disclaimer of damages in this Agreement shall not apply to the extent that the applicable damages or liability is an insurable loss for which the Facility is required to maintain insurance and would otherwise be recoverable if not for the limitation of liability or disclaimer of damages.
- E. Facility shall endorse its Commercial General Liability (including products/completed operations coverage) to add VUMC as an additional insured with respect to liability arising out of the operations of Facility. All policies required shall be written as primary policies, and shall not be contributing to or in excess of any coverage VUMC may choose to maintain. Facility shall provide thirty (30) days' advance written notice to VUMC of any adverse material change to any insurance coverage required in this Agreement.
- F. Upon request, Facility shall furnish certificates of insurance that provide sufficient information to verify that Facility has complied with the insurance requirements of this Agreement. The following is the proper wording that will need to be used in the description section of the certificate: *VUMC, for the benefit of itself and its affiliated entities and their respective officers, directors, employees, representatives and agents, are named additional insureds. The liability coverages shown on this certificate are primary, non-contributing and contain waivers of subrogation against any coverage held by VUMC.*

VI. NOTIFICATION OF CLAIMS

The parties agree to notify each other as soon as possible in writing of any incident, occurrence, or claim arising out of or in connection with this Agreement which could result in a liability or claim of liability to the other party. Further, the notified party shall have the right to investigate said incident or occurrence and the notifying party will cooperate fully in this investigation.

VII. NOTICES

All notices or other communication provided for in this Agreement shall be given to the parties addressed as follows:

FACILITY:

VUMC:

Liza M Weavind, MBBCh., MMHC, FCCM
 Medical Director of the Operations Control Center
 Medical Arts Building, Suite 422
 Vanderbilt University Medical Center
 Nashville, TN 37232-2415

with a copy to: Office of Sponsored Programs - Contracts Management
Vanderbilt University Medical Center
3319 West End Avenue, Suite 100
Nashville, TN 37203-6869
Research.contracts@vumc.org

VIII. MEDIA

The parties agree they will not use each other party's name or programs in any advertising, promotional material, press release, publication, public announcement, or through other media, written or oral, whether to the press, to holders of publicly owned stock without the prior written consent of the party whose name is to be used.

IX. DISCRIMINATION

In compliance with federal law, including the provisions of Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967 and the Americans with Disabilities Act of 1990, each party hereto will not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service in its administration of its policies, including admissions policies, employment, programs or activities.

X. ASSIGNMENT AND BINDING EFFECT

Neither party shall assign, subcontract, or transfer any of its rights or obligations under this Agreement to a third party without the prior written consent of the other party. If an assignment, subcontract, or transfer of rights does occur in accordance with this Agreement, this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors or assigns.

XI. INDEPENDENT CONTRACTOR

Each party shall be considered to be an independent party and shall not be construed to be an agent or representative of the other party, and therefore, has no liability for the acts or omissions of the other party. In addition, neither party, nor any of its employees, agents, or subcontractors, shall be deemed to be employees or agents of the other party. Therefore, neither party nor any of its employees, agents or subcontractors, shall be entitled to compensation, workers compensation, or employee benefits of the other party by virtue of this Agreement.

XII. COUNTERPART SIGNATURE

This Agreement may be executed in one or more counterparts (facsimile transmission or otherwise), each counterpart shall be deemed an original and all of which shall constitute but one Agreement.

XIII. WRITTEN AMENDMENT/WAIVERS

This Agreement cannot be amended, modified, supplemented or rescinded except in writing signed by the parties hereto. No waiver of any provision of this Agreement shall be valid unless such waiver is in writing signed by the parties hereto.

XIV. GOVERNING LAW AND JURISDICTION

This Agreement shall be governed in all respects by, and be construed in accordance with, the laws of the State of Tennessee. Each party hereby consents to the jurisdiction of all state and federal courts sitting in Davidson County, Tennessee, agrees that venue for any such action shall lie exclusively in such courts, and agrees that such courts shall be the exclusive forum for any legal actions brought in connection with this Agreement or the relationships among the parties hereto.

XV. MEDICAL RECORDS

All medical records and case histories of patients treated by VUMC shall be kept at VUMC, and shall be the property of VUMC. Facility will be provided access to such medical records only with prior written consent of the patient and subject to VUMC policies. Likewise, VUMC will be provided access to such medical records only with prior written consent of the patient and subject to Facility policies.

XVI. ACCESS TO BOOKS AND RECORDS

Until the expiration of four years after the furnishing of services pursuant to this Agreement, the parties shall upon written request, make available to the Secretary of Health and Human Services or the Comptroller General or their duly authorized representative the contract, books, documents, and records necessary to verify the nature and extent of the cost of such services. If either party carries out any of its obligations under this Agreement by means of a subcontract with a value of \$10,000 or more, that party agrees to include this requirement in any such subcontract.

XVII. CONSTRUCTION OF AGREEMENT

The headings used in this Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement. This Agreement has been prepared on the basis of mutual understanding of the parties and shall not be construed against either party by reason of such party's being the drafter hereof.

XVIII. NON-EXCLUSIVITY

Each party shall have the right to enter into similar agreements with other parties.

XIX. CONFIDENTIALITY

The parties agree to maintain as private and confidential all information which relates to or identifies a particular patient, including but not limited to the name, address, medical treatment or condition, financial status, or any other personal information which is deemed to be confidential in accordance with applicable state and federal law and standards of professional ethics and shall train and require their employees, contractors, subcontractors, agents, and representatives to comply with such confidentiality requirements.

XX. HIPAA REQUIREMENTS

The parties acknowledge that each party is a "covered entity" as that term is defined at 45 C.F.R. Part 160.103. As such, the parties agree 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". The parties agree not to use or further disclose any Protected Health Information, other than as permitted by HIPAA Requirements and the terms of this Agreement. The parties will respectively make their 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.

XXI. COMPLIANCE WITH PATIENT TRANSFER REQUIREMENTS

All parties hereto agree that any patient transfers shall be in compliance with the EMTALA Regulations, and such other requirements as may be imposed by the Secretary of Health and Human Services, and any other applicable State patient transfer laws.

XXII. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter herein and supersedes any other agreements, restrictions, representations, or warranties, if any, between the parties hereto with regard to the subject matter herein.

Signature page follows.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives.

FOR VANDERBILT UNIVERSITY MEDICAL CENTER

Approved by:

C. Wright Pinson

10/29/2024

C. Wright Pinson, M.D., MBA
Deputy CEO and Chief Health System Officer
Vanderbilt University Medical Center

Date

FOR TRISTAR HORIZON MEDICAL CENTER

Bergmeier

9/30/24

Name
Title

Date

Name
Title

Date

Date

APPENDIX I

Transfers of burn patients will be evaluated upon the following medical criteria:

- A. Transfer of a burn patient may be requested by the FACILITY when the extent of the burn patient's injuries or the number of burn patients exceed FACILITY'S capabilities in accordance with the following:
 1. Any full thickness burns.
 2. Partial thickness burn $\geq 10\%$ TBSA.
 3. Any deep partial or full thickness burns of hands, face, feet, genitalia, perineum, or over any joints.
 4. Patients with concomitant traumatic injuries.
 5. Poorly controlled pain.
 6. All patients with suspected inhalation injury.
 7. High voltage electrical injuries.
 8. Chemical burns.
 9. Burns associated with extremes of age or serious pre-existing medical illnesses.
 10. All pediatric patients with a burn injury. If patient is intubated, patient will be transferred to Pediatric Intensive Care Unit after being accepted by Pediatric Intensive Care Unit attending service.

- B. FACILITY shall be responsible for preparation of patient for transfer including performing the following therapeutic interventions as ordered by the transferring physician prior to the transfer:
 1. Establishment and maintenance of a secure airway and satisfactory ventilation with continuous monitoring during transport.
 2. Resuscitation and Early Care may include:
 - a. Establishment of large bore intravenous catheters.
 - b. Fluid resuscitation with Lactated Ringer's to maintain a urine output greater than 2cc/Kg/hr for patient weighing less than 60 kilograms or 30cc's for an adult.
 - c. Calculation and estimation of fluid needs with the following formula: (2-4cc's) multiplied by %TBSA burn multiplied by patient weight in kilograms for the first 24 hours.
 - d. Half of the calculated fluid to be given with the first eight hours post burn, the second half to be given over the next 16 hours.
 - e. Insertion of a Foley catheter.
 - f. Insertion of a nasogastric tube.
 - g. Administration of small amounts of intravenous narcotics as needed for pain.
 - h. Adequate lavage and irrigation of chemical burns.
 - i. Ongoing examination of peripheral pulses in circumferentially burned extremities.
 - j. Escharotomy is to be considered in the presence of circumferential burns when vascular compromise is evident. In the absence of a trained surgeon, the referral facility should communicate with the burn fellow or attending physician prior to performing an escharotomy.
 - k. Burn wounds are to be managed by wrapping in clean, dry sheets.

- C. Patients will not routinely receive antibiotics prior to transfer, but tetanus immunization status will be ascertained by patient's attending physician, and prophylaxis administered and documented by transferring facility.

- D. Every effort will be made to transport burn patients as soon as possible. However, patients who are hemodynamically unstable may require a period of up to 48 hours of stabilization.





esr17265

Final Audit Report

2024-10-29

Created:	2024-10-29
By:	Amanda Lowe (amanda.j.lowe@vumc.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAA6YVetXI7CLaRmwMt-0BdqVH4LJB5LbkB

"esr17265" History

-  Document created by Amanda Lowe (amanda.j.lowe@vumc.org)
2024-10-29 - 1:53:47 PM GMT- IP address: 160.129.250.238
-  Document emailed to Wright Pinson (wright.pinson@vumc.org) for signature
2024-10-29 - 1:54:39 PM GMT
-  Email viewed by Wright Pinson (wright.pinson@vumc.org)
2024-10-29 - 2:54:48 PM GMT- IP address: 104.47.55.254
-  Document e-signed by Wright Pinson (wright.pinson@vumc.org)
Signature Date: 2024-10-29 - 2:54:58 PM GMT - Time Source: server- IP address: 160.129.250.163
-  Agreement completed.
2024-10-29 - 2:54:58 PM GMT

Attachment 1C-2

List of Non-HCA Affiliations

TriStar Horizon Medical Center Community Linkages and Affiliations

Home Health:

- Amedisys Home Health
- Home Care Solutions
- Accent Care Home Health
- NHC Home Care
- TN Quality Home Care

Rehabilitation Hospitals:

- TriStar Horizon Medical Center
- Encompass Rehab - Franklin

Skilled Nursing Facilities:

- NHC Dickson
- Dickson Health & Rehab
- Waverly Hills Post-Acute
- Humphreys County Care & Rehab
- Life Care of Centerville
- Signature of Erin
- NHC Trace
- NHC Meadows
- West Meade Place

Long Term Acute Care Hospitals:

- Select Specialty

Hospice:

- Alive Hospice
- Gentiva Hospice
- TN Quality Hospice
- Caris Hospice

Assisted Living:

- Olive Branch Assisted Living
- Magnolia Place Assisted Living
- The Pearl

Attachment 4N-3

Community Benefit Report



TriStar Horizon

Dickson, Tennessee

TriStar Horizon Medical Center proudly offers high-quality, individualized patient care and continues to invest in the community's increased healthcare needs with enhanced services and a commitment to provide excellent patient care.

TriStar Horizon recently opened a 14-bed, state-of-the-art ICU. The Birth Center features private suites and a four-bed Level II NICU. TriStar Natchez ER is a satellite campus, offering convenient outpatient imaging and cancer treatment in addition to 24/7 emergency care.



Wyatt Chocklett
Chief Executive Officer

Additional location:
TriStar Natchez ER

7,495

Patient admissions

55,519

Total annual ER visits

35,309

Outpatient visits

534

Colleagues

158

Licensed beds

Key services:

- Cardiology
- Emergency
- Inpatient rehabilitation
- Obstetrics
- Oncology
- Orthopedics
- Robotic-assisted surgery
- Surgical care
- Trauma (Level III)
- Women's health
- Wound care

Attachment - Bed Count

Not Applicable

CON Main Application Form

Section 10C

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.

TriStar Horizon participates in both Medicare and TennCare/Medicaid. As a satellite ED to TriStar Horizon, the proposed TriStar Fairview FSED will be included in all state and federal revenue programs for the host hospital, TriStar Horizon, including Medicare and TennCare. Moreover, the proposed TriStar Fairview FSED will be part of TriStar Health network which requires all facilities within it to adhere to all financial assistance and charity/indigent care policies.

As an emergency department, the TriStar Fairview FSED will care for every presenting patient regardless of their commercial insurance or insured status as required by EMTALA. Like TriStar Horizon, the TriStar Fairview FSED will comply 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.

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. TriStar Horizon provides discounts for all patients who have income at less than 400% of the poverty level. And for those who are below 200% 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 2024, TriStar Horizon and TriStar Natchez FSED provided \$101,802,775 in charity care. (TriStar Horizon 2024 JAR). See response to 6.C. above. See **Attachment 4N-1** for the Uninsured Discount and Charity Care Write Off Policies.

The Table in 10C provides the projected payor mix for Project Year 1 and 2.

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Addendum to Section 7Q

The below appends the 'check marks' in the HFC portal for responses to question 7Q.

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 TriStar Horizon nor any of its upstream entities are the subject of any pending healthcare regulatory or criminal action.

In addition, at any given time there are numerous routine audits, surveys, reviews and/or payment adjustments by the OIG, CMS, Medicare, Medicaid, RACs, UPICs, federal and state regulatory agencies, The Joint Commission, etc.

