KIRKLAND & ELLIS LLP

September 8, 2026

VIA EMAIL

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

RE: TN Heart Cardiovascular Surgery Center, CN2607-017

Dear Mr. Grant:

This letter is submitted on behalf of Cookeville Regional Medical Center ("CRMC") in opposition to the proposal by Tennessee Heart, PLLC ("TN Heart") to establish a new cardiovascular ambulatory surgical treatment center ("ASTC") in Cookeville, Tennessee. Although TN Heart frames this application as addressing an urgent need for cardiovascular services in the Upper Cumberland region, the reality is that the proposed ASTC is unnecessary, would fragment care, and would harm the community CRMC has served for decades. There is simply no appropriate health planning justification for the project, and the project will not benefit consumers.

CRMC is an independent, city-owned, not-for-profit, 309-bed regional referral medical center located in Cookeville. As the largest hospital between Nashville and Knoxville, CRMC serves more than 350,000 residents across 14 counties and offers 40 medical specialties, including a robust cardiac and vascular team which includes the region's only cardiac imaging program. CRMC is also supported by more than 285 physicians with a total workforce of more than 2,600 employees, making it the largest employer in the Upper Cumberland region. Over the past five years, CRMC has reinvested millions of dollars back into the hospital to meet the healthcare needs of the region, including recently investing millions into renovations of its cardiac catheterization labs and further subsidizing outpatient cardiac rehabilitation programs.

The ASTC proposed by TN Heart will be less than three miles from CRMC and would impact the quality of the cardiac program at CRMC by unnecessarily diluting volumes and fragmenting care in a manner which could potentially harm patients. For the reasons stated below,

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the ASTC proposed by TN Heart is not needed, would not improve the quality of healthcare provided to the community, and would not be positive for consumers.

There Is No Need for Additional Cardiac Catheterization Labs in Putnam County

TN Heart's argument that there is a need for additional cardiac catheterization services in the community relies heavily on the assertion that CRMC's catheterization labs are "overwhelmed" and operating at "252% of capacity". This is simply not true. There is, in fact, ample capacity for catheterization services at the hospital.

CRMC operates four cardiovascular labs, including two catheterization labs, a dedicated EP lab, and a dedicated vascular lab. Based on a 40-hour week, CRMC's two catheterization labs operated at 63% and 37% capacity, respectively, in 2025, and at 74% and 25% capacity, respectively, year-to-date in 2026. In total, CRMC's combined cardiac catheterization lab utilization stands at approximately 49.5% in both 2025 and 2026 year-to-date, with all labs combined at just 62.7% year-to-date in 2026. Elective catheterizations are routinely scheduled within 24–48 hours – not the two-to-three-week or eight-month delays claimed by TN Heart.

Here, the utilization numbers do not evidence a need for additional cardiac catheterization services. Utilization data demonstrates that neither of CRMC's two catheterization labs is consistently operating at or above 70% of capacity.[1] And the current combined average utilization across both labs remains well below the 70% threshold.

Finally, CRMC's five-year procedure-volume data further undercuts the demand narrative. Total cardiovascular procedures at CRMC have remained essentially flat, ranging from approximately 2,778 to 3,028 annually between 2021 and 2025, with diagnostic catheterizations declining 8.1% over that period. This data directly contradicts TN Heart's claim that cardiovascular procedure volumes are "increasing more than four times faster than the population." In short, the existing infrastructure has ample capacity, is actively being upgraded, and is not experiencing the surging demand described in the application.

Any Minimal Cost Saving Does Not Outweigh the Risks to Patient Safety

TN Heart's application emphasizes that procedures performed in an ASTC will cost less than hospital-based procedures. While lower costs may exist on a per-procedure basis, this

[1] CRMC acknowledges that one of its catheterization labs has been operating above 70% in 2026. This higher volume is due to a recent renovation project completed at the catheterization lab which resulted in upgraded equipment and capabilities. As described in more detail below, CRMC has secured investments to similarly renovate its second catheterization lab in FY2027. Following completion of this second renovation, CRMC expects the utilization volumes between the two catheterization labs to stabilize, thereby maintaining below 70% capacity at both individual laboratories.

minimal cost saving must still be weighed against the clinical risks and potential additional costs created by fragmenting care between two facilities.

The proposed facility will perform therapeutic PCI and complex EP procedures, including ablations, without on-site open-heart surgery capability and without 24/7 emergent therapeutic coverage. Instead, TN Heart relies on emergency transfer to CRMC, estimated at approximately 10 minutes by ground transport. Yet, no executed transfer agreement is in place – only draft policies and a stated intention to maintain one. Regardless, this transfer scenario fragments care at precisely the moment when continuity matters most: a patient may receive initial treatment at the ASTC, experience a complication, and then have to wait for ambulance transport to CRMC for emergency treatment. While a 10-minute transfer estimate may seem negligible, this estimate does not account for EMS dispatch, patient stabilization, or adverse conditions. Any delay in these circumstances could prove fatal.

Moreover, the physicians of TN Heart have no experience operating a standalone cardiac catheterization facility. Formed less than one month before the application was filed, TN Heart has zero operating history. Indeed, each quality policy submitted in the application is marked "DRAFT." There are no facility-specific outcomes data, complication rates, transfer rates, patient satisfaction scores, or accreditation history. Despite Tennessee's CON criteria requiring that a project "meet appropriate quality standards," TN Heart requests the approval of a complex cardiovascular program, which would undoubtedly fragment the demonstrated care in the community, based entirely on aspirational policies. These limitations are directly relevant to whether the proposed setting can provide care that meets appropriate quality and patient-safety standards.

Finally, for a patient who experiences a complication at the ASTC and requires transfer to CRMC, the combined cost of the ASTC procedure and the resulting hospital admission will far exceed the cost of performing the procedure in a hospital setting. In that circumstance, the apparent cost savings articulated in the application are illusory: the patient bears the cost of two episodes of care, as well as the clinical and logistical burdens of transfer. These additional costs are completely avoidable and unnecessary with no value to the patient or the payor. Minimal cost savings on a per-procedure basis do not justify placing patients in a setting that lacks the safety infrastructure of a full-service hospital – particularly when CRMC is less than three miles away and has ample capacity.

The Project Will Fragment Care to the Detriment of Patient Safety and Experience

Beyond the immediate clinical risks described above, the proposed ASTC threatens to fragment the delivery of cardiovascular care in the Upper Cumberland region in ways that extend well beyond individual patient encounters. The proposed ASTC will require the same highly specialized professionals who currently staff CRMC's four cardiovascular labs, including specialized nursing staff, catheterization-lab technologists, EP-trained nurses and technologists, scrub technicians, monitoring technicians, ACLS-certified recovery nurses, and anesthesia

providers. In a rural region with a limited healthcare workforce, the most likely source of qualified staff for the new ASTC is CRMC itself. Recruiting away CRMC's trained cardiovascular staff, who have developed institutional expertise over years, would not expand the regional workforce; it would merely redistribute it from a full-service hospital to a freestanding center, while degrading CRMC's ability to maintain safe staffing levels for its remaining cardiac operations, including emergent cases, inpatient procedures, and open-heart surgery.

Losing staff to the new ASTC would be especially damaging given CRMC's demonstrated commitment to cardiovascular care through substantial capital investments aimed at upgrading its equipment and capabilities. Indeed, before TN Heart filed its letter of intent and CON application, CRMC had already secured multimillion-dollar investments for its two catheterization labs. In 2025, CRMC invested $1.6 million to renovate one of its two cardiac catheterization labs, resulting in a new state-of-the-art facility that is fully operational. Similarly, CRMC is also currently in the process of investing more than $1 million to renovate its second cardiac catheterization lab. CRMC anticipates this second renovation to be completed in FY2027.

These renovation efforts reflect CRMC's ongoing commitment to ensuring that patients in the Upper Cumberland region have access to high-quality, state-of-the-art cardiovascular services within the hospital setting. Maintaining state-of-the-art medical technology remains vital to CRMC's ability to serve the patients of the Upper Cumberland region and provide the highest quality cardiac care to the community. Permitting a new freestanding ASTC to enter the market and divert patients away from CRMC after these substantial investments would undermine CRMC's ability to sustain these improvements and continue investing in cardiac care for the community.

Even if only outpatient-appropriate cases migrate to the ASTC, CRMC's own data shows that outpatient procedures account for more than half of its cardiovascular volume. Stripping away most commercially favorable outpatient cases would leave CRMC with a disproportionate share of emergent, inpatient, high-acuity, and uncompensated cases. The resulting loss of volume would threaten the financial viability of the cardiac program that allows CRMC to maintain the essential community services that a freestanding ASTC cannot and will not provide.

Today, a patient presenting to CRMC can receive diagnostic catheterization, therapeutic intervention, EP evaluation, device implantation, open-heart surgery if needed, ICU care, cardiac rehabilitation, and post-discharge follow-up within a single integrated system. The proposed ASTC would fracture this continuum by routing lower-acuity patients to a separate facility while still relying on CRMC as the emergency backstop for any complications. This creates a paradox: the ASTC will depend on CRMC's continued viability for emergency transfers, surgical backup, and the full spectrum of inpatient cardiac services, while simultaneously undermining the patient volumes, revenue, and staffing that sustain CRMC's ability to provide those very services. If CRMC's cardiac program diminishes to the point where it can no longer maintain 24/7 open-heart

surgery capability – or worse, it can no longer serve as the transfer hospital – the entire patient-safety premise of the proposed ASTC collapses.

A Freestanding ASTC Is Inconsistent with the Recently Enacted CON Legislation

Finally, the Tennessee General Assembly has recently spoken directly to this issue through recently enacted legislation eliminating CON requirements for cardiac catheterization labs attached to or associated with a hospital, effective July 2028. This legislative approach reflects a deliberate policy judgment that cardiac catheterization services should be provided in connection with a hospital setting where comprehensive backup services are available.

The timing of TN Heart's application is notable in this context. TN Heart filed its letter of intent and CON application in July 2026 – after the General Assembly enacted this legislation but before its effective date. Approving a freestanding ASTC would be inconsistent with the General Assembly's policy direction. If the Legislature intended to promote freestanding cardiac catheterization labs, it could have removed the CON requirement for those facilities as well. Instead, it chose to remove the CON requirement only for hospital-based expansions, indicating that the preference is to support the development of cardiac catheterization services in hospital-based settings.

Representatives of CRMC will attend the Commission's meeting on September 23, 2026 to speak in opposition to the TN Heart ASTC application. We appreciate the Commission's attention to this letter, and we respectfully request that the TN Heart ASTC application be denied.

Sincerely,

Kirkland & Ellis LLP

Travis Swearingen

cc: Jeffrey Stofko (via email)