LETTER OF INTENT

State of Tennessee
Health Facilities Commission

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

www.tn.gov/hsda Phone: 615-741-2364 hsda.staff@tn.gov

LETTER OF INTENT

The Publication of Intent is to be published in The Leaf Chronicle which is a newspaper of general circulation in Montgomery County, Tennessee, on or before 05/30/2025 for one day.

This is to provide official notice to the Health Facilities Commission and all interested parties, in accordance with T.C.A. §68-11-1601 et seq., and the Rules of the Health Facilities Commission, that TriStar Clarksville Hospital, a/an Hospital owned by Clarksville Health Services, LLC with an ownership type of Limited Liability Company and to be managed by itself intends to file an application for a Certificate of Need for the establishment of a full service acute care hospital with 68 licensed beds. The project also seeks to initiate diagnostic and therapeutic cardiac catheterization services, magnetic resonance imaging services (MRI), and will include a Level II neonatal intensive care unit (NICU). The address of the project will be located at an unaddressed site on Tiny Town Road, approximately 1,000 feet to the west of the intersection of Tiny Town Rd and Sandpiper Dr., Clarksville, Montgomery County, Tennessee, 37042. The estimated project cost will be $286,048,000.

The anticipated date of filing the application is 06/02/2025

The contact person for this project is Senior Vice President David Whelan who may be reached at TriStar Health - 1000 Healthpark Drive, Brentwood, TN 37027 – Contact No. 615-886-4900.

David Whelan	05/30/2025	david.whelan@hcahealthcare.com
Signature of Contact	**Date**	**Contact's Email Address**

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

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

wishing to oppose the application may file a written objection with the Health Facilities Commission at or prior to the consideration of the application by the Commission, or may appear in person to express opposition. Written notice of opposition may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov .

State of Tennessee
Health Facilities Commission

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

www.tn.gov/hsda Phone: 615-741-2364 hsda.staff@tn.gov

PUBLICATION OF INTENT

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

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Facilities Commission and all interested parties, in accordance with T.C.A. §68-11-1601 et seq., and the Rules of the Health Facilities Commission, that TriStar Clarksville Hospital, a/an Hospital owned by Clarksville Health Services, LLC with an ownership type of Limited Liability Company and to be managed by itself intends to file an application for a Certificate of Need for the establishment of a full service acute care hospital with 68 licensed beds. The project also seeks to initiate diagnostic and therapeutic cardiac catheterization services, magnetic resonance imaging services (MRI), and will include a Level II neonatal intensive care unit (NICU). The address of the project will be located at an unaddressed site on Tiny Town Road, approximately 1,000 feet to the west of the intersection of Tiny Town Rd and Sandpiper Dr., Clarksville, Montgomery County, Tennessee, 37042. The estimated project cost will be $286,048,000.

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CRITERIA AND STANDARDS

Attachment 1N-1, NICU

Transport Arrangements, Neonatal

Status Active PolicyStat ID 12087345

Origination	05/1988
Last Approved	10/2022
Last Revised	07/2013
Next Review	10/2025

Owner	Stella Edens: Dir Neonatal Svcs
Policy Area	Women's Services
Applicability	TriStar Centennial and Ashland City Policy Library
Locations	TriStar Centennial Medical Center

Transport Arrangements, Neonatal

PURPOSE:

1. **To provide guidelines for preparation of equipment and personnel for an infant transport from a referring hospital to TriStar Centennial Medical Center.**
2. **To provide guidelines for preparation of equipment and personnel for back transport of an infant transport from TriStar Centennial Medical Center to another hospital.**

POLICY:

1. The Neonatologist makes the decision regarding the team configuration, appropriateness of the transport, the time, location, and mode of transport.
2. The transport team that accompanies an infant from a referring hospital includes a Neonatologist or Neonatal Nurse Practitioner (NNP), with assistance from a registered nurse and/or respiratory therapist.
3. The transport team that accompanies infants on back transport includes a registered nurse with assistance by a respiratory therapist, or another registered nurse, if needed.
4. Infants must be placed in a transport isolette with heat, lighting, and cardio-respiratory monitoring.

PROCEDURE:

1. Calls regarding infant transports to Tristar Centennial Children's Hospital Medical Center NICU are transferred to the NICU Charge Nurse.
2. The Charge Nurse documents information regarding the transport including the patient's name, patient's condition, referring physician, referring hospital, and phone number. The Charge Nurse notes the time the call was received.
3. The call is directed to the Neonatologist. If the physician is not immediately available, then the call is directed to the Neonatal Nurse Practitioner.
4. The Neonatologist notifies the Charge Nurse to arrange the transport. The Neonatologist or designee notifies the Neonatal Nurse Practitioner of the transport.
5. The Neonatal Nurse Practitioner should communicate to the Charge Nurse the necessary team members needed for the transport.
6. The Charge nurse calls the ambulance service to meet the transport team at Tristar Centennial Children's Hospital Medical Center, and notes the time the call is made to the ambulance service.
7. The Charge Nurse and/or Neonatal Nurse Practitioner notifies the Neonatal Respiratory Therapist on duty.
8. The Charge Nurse notifies the Nursing Supervisor of the transport. The Nursing Supervisor assists in arranging staffing for the NICU and/or transport, as needed.
9. The personnel identified to complete the transport are responsible for checking all equipment and supplies prior to departure from the NICU. A notation is made of the time of departure.
10. The Neonatologist or NNP calls the referring/receiving hospital with the estimated time of arrival, as well as answers any further questions regarding stabilization or transport preparation.

References:

Manual of Neonatal Care, Cloherty, Eichenwald, & Stark. 6th Edition. Lippincott, Williams & Wilkins, 2008.

Pre-PolicyStat Number: WH-NEO-139

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Lisa Moore: VP Quality/Risk Mgmt	10/2022
Policy Review Committee	BRITTANY OWEN: Mgr Quality	09/2022

NICU Steering Committee	Jodie Heimbach: Dir Neonatal ICU	08/2022

Attachment 1N-2, NICU

Provision of Care Policy: Neonatal Intensive Care Unit

TriStar Centennial MEDICAL CENTER | TriStar Ashland City MEDICAL CENTER

Origination:	*05/2016*
Last Approved:	*12/2023*
Last Revised:	*12/2023*
Next Review:	*12/2024*
Owner:	*Stella Edens: Dir Neonatal Svcs*
Policy Area:	*Hospital Plans*
Locations:	*TriStar Centennial Medical Center*
Applicability:	*TriStar Centennial and Ashland City Policy Library*

Provision of Care: Neonatal Intensive Care Unit

Goal:

Women's and Children's Hospital Neonatal Intensive Care Unit (NICU) is a state-of-the-art 60- bed, Level 3 NICU. It consists of a multidisciplinary team that is comprised of neonatologists, neonatal nurse practitioners, specialty trained nurses and respiratory therapists, nurse educator, speech therapist, occupational therapists, lactation consultants, pediatric PharmD, social worker and case management staff to care for high-risk and premature infants. We have a specialized in-house Neonatal Transport Team that offers the unique service of going to outreach hospitals to be present prior to high-risk deliveries if requested. Our service is dedicated to providing exceptional care preparing the critically ill infant to be discharged to their home environment.

Scope of Service:

Any neonate may be admitted that requires specialized care above that required of healthy infants. This includes, but is not limited to, infants requiring intravenous therapy, cardiopulmonary therapy or support, continuous cardiorespiratory monitoring, or support of other vital functions. The most common diagnoses are mild to severe respiratory distress, prematurity, hypoglycemia, apnea, bradycardia, sepsis, temperature instability, and hyperbilirubinemia.

Department Description:

The 60-bed Neonatal Intensive Care Unit is located on the 7th and 8th Floor of the TriStar Centennial Women's and Children's Hospital. The unit is open 24-hours a day, seven days per week. The unit is comprised of 24 intensive care beds, which include 2 isolation beds, and 36 intermediate care beds which includes one isolation bed.

Identification of Needs:

A. Patient needs are evaluated on an on-going basis as assessed by staff, outcome measurements, parent/ family feedback, and physician assessment.

B. Staff education needs are determined at least annually as part of a departmental needs assessment. Special programs are also initiated in response to staff requests, new equipment or technology acquisitions, change in the requirements of accrediting and regulatory agencies, results from patient/ family satisfaction surveys, and management and physician observation. Individualized and group educational opportunities are also provided at the request of staff members and/or their immediate supervisor.

Performance Improvement:

The Neonatal Intensive Care Unit participates in unit-specific, departmental and hospital-wide performance improvement activities. Performance Improvement activities are designed to provide a planned, systematic approach to process design, performance measurement, assessment, and improvement. Performance improvement activities are reported through the designated facility committees. Patient safety initiatives including infant security, staffing effectiveness, and code review are reported to the hospital's Department of Quality and Risk on a specific schedule for assimilation with findings from other areas of the facility.

Admission Criteria:

The Neonatal Intensive Care Unit accepts any neonate designated by the neonatologist as meeting criteria for admission. Outborn neonates may be transferred to the TriStar Women's and Children's Hospital from outlying hospitals. Newborns previously discharged home will not be routinely admitted and will be evaluated for admission to the appropriate unit by a neonatal provider.

Exclusionary Criteria:

Well newborns are cared for on the Mother/Baby Unit. Inborn infants requiring cardiac surgery, ECMO therapy, pediatric surgery as determined by the neonatologists and pediatric surgeon, and infants requiring Level IV NICU care will be transferred.

Transfer Criteria:

Transfers between intensive care to intermediate care are based on the patient's need for change in level of care. Infants that require medical care beyond the scope of the TriStar Women's and Children's NICU may be transferred to another NICU, at the discretion of the neonatologist. Neonates requiring a higher level of care may be transported to a facility providing that level of care when accepted by a physician and facility.

Discharge Criteria:

Discharge planning for high-risk neonates by an interdisciplinary team will begin soon after admission. Family, caregivers, nurse practitioners and neonatologists are part of the team.

A. Before discharge the neonate will have a comprehensive physical examination to identify problems that may require ongoing close surveillance and to provide baseline data for future assessments; this includes physical and developmental milestones.

B. The neonate will be physiologically stable and able to maintain body temperature.

C. The neonate will be gaining weight appropriatly.

D. The neonate is able to breast feed and/or bottle-feed adequately. If the neonate's clinical condition precludes adequate nipple feeding that the caregiver is deemed competent in alternative feeding techniques.

E. The neonate is free of apnea/bradycardia for at least five days.

F. There is documentation that the family and/or caregiver has been assessed and is competent in infant care including any special needs their newborn may have.

G. immunizations have been administered or appropriate declinations in medical record.

H. A hearing screening has been accomplished or an appointment for hearing evaluation has been scheduled.

I. Ophthalmologic assessment of neonates born at less than 27 weeks or weighing less than 1,250 grams at birth has been performed, and/or a follow-up appointment has been scheduled.

J. Physician-directed source of continuing medical care, including periodic assessment of infant development has been identified.

K. Appropriate community resource referrals provided.

Governance:

A. The Nurse Manager assumes twenty-four hour accountability for the coordination and operation of the program including supervision of all program staff, including nursing personnel, unit secretaries, and Clinical Nurse Coordinators. Major responsibilities including personnel management (hiring, termination, counseling, evaluation, consultation, and staff development), quality management, problem solving, and communication with patients, visitors, physicians, staff, and other members of the health care team. In conjunction with the scheduling coordinator and/or supervisor, the Nurse Manager ensures adequate staffing coverage based on the patient needs. He/she works with other hospital departments to ensure that sufficient resources for patient care are available on a continual basis. The coordinator also develops and revises policies and procedures as appropriate, and participates in departmental and hospital-wide committees and teams as requested.

B. The Nurse Manager reports to the Administrative Director for Neonatal Services, who is accountable to the Chief Nursing Officer of TriStar Centennial Medical Center. A board-certified neonatologist provides clinical direction.

C. A Charge Nurse is scheduled on each shift, and reports to the Nurse Manager. They are responsible for staff assignments, problem solving, communication, and clinical management for the assigned shift.

D. After hours and on weekends, the Administrative Supervisor acts in lieu of the Nurse Manager and functions as the administrative representative of the TriStar Women's and Children's Hospital in consultation with the Administrator-On-Call.

Staffing:

A. The Neonatal Intensive Care Unit utilizes primary nursing care. Staffing assignments are based on patient acuity and skill level of the staff and follow AAP/ACOG Perinatal Staffing Guidelines. Ratios may be altered as patient census and acuity dictate. Minimum staffing should consist of 2 NICU RNs and 1 NICU respiratory therapist who will be immediately available. Increased staffing needs may be met through call, use of staff from other Women's and Children's Hospital nursing units, shared staffing, or contract labor. Neonatal Nurse Practitioners are available for education and practice support. The interdisciplinary team members include lactation, case management, pharmacy, chaplain, social workers, dietitians, respiratory therapists, physical therapists/ occupational therapists, speech therapists, infection control, neonatologist, and neonatal nurse practitioners.

B. All staff members who function under federal, state, and/or local requirements for licensing, registration, or certification are required to produce annual documentation of having met such requirements. All licensed personnel are required to complete CPR and NRP certification within the first 90 days of employment, STABLE certification with in 6 months of employment, and maintain certification status. All staff members complete department and unit-specific orientations at the time of their employment that

includes documentation and demonstration of core competencies. Annual reassessments of safety, infection control, hazardous materials, seclusion/restraint, patient rights, age appropriate care, and department-specific core competencies are conducted. Yearly competency is provided for all staff, and is a requirement of their employment.

Process Used for Positive and Negative Variance:

Staffing levels of nursing personnel are reviewed each shift by the Nurse Manager, Team Leader or charge nurse. Adjustments are made to meet the needs of the unit as dictated by patient census, acuity, care needs of the patients and unit activities. In cases of positive variances, adjustments are made utilizing one or more of the following strategies:

A. Flex staff are cancelled
B. Staff are assigned to other units which may have a negative variance
C. Leave time is offered to full-time and part-time staff
D. In the event of a negative variance, additional staff will be obtained by utilization of:
    1. Staff from units that have a positive variance
    2. Flex personnel
    3. Overtime

Support Systems:

A. Admitting
B. Biomedical Engineering
C. Case Management
D. CAPS
E. Central Sterile
F. Education Department
G. Environmental Services
H. Facilities engineering
I. Health Information Services
J. Infection Control
K. Information Systems
L. Laboratory
M. Marketing
N. Materials Management
O. Medical Imaging
P. Noninvasive Cardiology
Q. Nutritional Services

R. Pharmacy
S. Quality / Risk
T. Rehab Services
U. Respiratory Therapy
V. Social Work
W. Transport
X. Women's and Children's Services

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Lisa Moore: VP Quality/Risk Mgmt [BO]	12/2023
Policy Review Committee	Sonya Jackson: Coord Blood Utilz/Clin Review	11/2023
	Stella Edens: Dir Neonatal Svcs	10/2023

Applicability

TriStar Centennial and Ashland City Policy Library

Attachment 1N-3, NICU

Hadeer Karmo, MD, Director of Neonatology, Pediatrix

Letter of Support

pediatrix
MEDICAL GROUP

May 27, 2025

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

TriStar Clarksville Hospital CON Application

Executive Director Grant,

I am excited to write to you on behalf of Pediatrix Medical Group in support of TriStar Health's application to build a full-service hospital in Clarksville.

Pediatrix Medical Group takes pride in providing newborns and their families with intensive care. Our group currently staffs several level 2 and level 3 TriStar units in Tennessee with 24/7 in-house coverage by experienced neonatal nurse practitioners that are supervised by board certified neonatologists that are available 24/7. We provide daily rounds with the NNPs and talk to families daily and as needed.

We are fully supportive of TriStar Health's plan to bring hospital access to the community of Clarksville. Pedatrix Medical Group plans to staff TriStar Clarksville Hospital's NICU program. Our goal will be to support the community we are serving and try to keep many of the babies that require an NICU stay in Clarksville. Transferring babies to Nashville disrupts the mother/baby bond, interferes with breastfeeding, and increases drive time for parents and extended family.

For these reasons, and many more, we ask that you please approve TriStar Health's application for a Certificate of Need to bring additional hospital care to Clarksville.

Thank you,

Hadeer Karmo

Hadeer Karmo, MD
Director of Neonatology
Pediatrix Centennial Neonatology of Nashville
2300 Patterson Street
Nashville, TN 37203

1N

Cardiac Catheterization Standards and Criteria

Attachment 1N - 1, Cardiac

Physician Bios

Christopher N. Conley, MD

Phone

(615) 868-0352

Specialty

Clinical Cardiac Electrophysiology

Telemedicine Available

Gender

Male

Languages

English

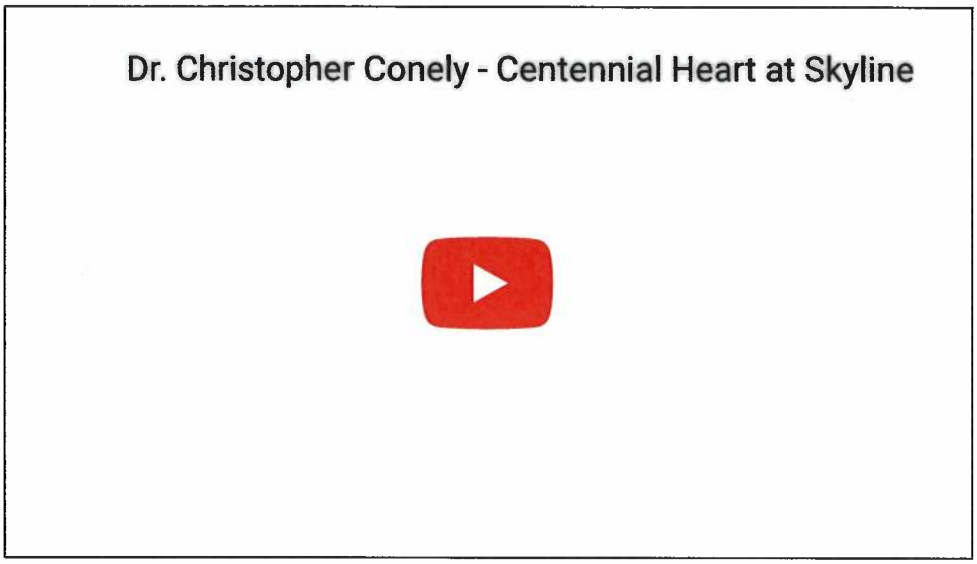
*Please call if you are a self-pay patient.

Address

Tennessee Heart and Vascular - Skyline
3443 Dickerson Pike Ste 430
Nashville, TN 37207

Choose Different Location (5)

About Christopher N. Conley, MD



Biography

Dr. Christopher Conley is a board-certified Cardiologist and Electrophysiologist practicing at Tennessee Heart and Vascular located in Nashville, TN.

Dr. Christopher Conley grew up in Gainesville, Georgia. He graduated with honors from North Georgia College with a Bachelor's of Science in Biology and Chemistry, in addition to participating in ROTC and varsity tennis. He then completed his medical training at the Medical College of Georgia, his residency in Internal Medicine and then fellowships in both General Cardiology and Cardiac Electrophysiology at Wake Forest University in Winston-Salem, North Carolina. Dr. Conley is board certified in both Cardiovascular Disease and Cardiac Electrophysiology and specializes in evaluation and medical management of arrhythmias, including the placement of pacemakers, implantable defibrillators, and implantable loop recorders for syncope and stroke evaluation, as well as EP study and ablation.

Close Bio

Procedures and Conditions Treated

- Cardiovascular Stress Test
- Electrocardiogram
- Electrophysiology Study
- Heart Failure
- Transradial Cardiac Catheterization - TCC

Specialties

- **Cardiovascular Disease** - Board Certified
- **Clinical Cardiac Electrophysiology** - Board Certified

Affiliations

- TriStar Skyline Medical Center

Clinic Website

- https://www.tristarmedgroup.com/locations/tennessee-heart-and-vascular/skyline

Credentials and Education

- **Wake Forest University Baptist Medical Center** Internship 1998
- **Wake Forest University Baptist Medical Center** Fellowship 2003

- **Wake Forest University Baptist Medical Center**
  Residency
  2000
- **Medical College of Georgia**
  Graduate Degree
  1997

Terry R. Ketch, MD

Phone

(615) 868-0352

Specialty

Interventional Cardiology

Telemedicine Available

Gender

Male

Languages

English

*Please call if you are a self-pay patient.

Address

Tennessee Heart and Vascular - Skyline
3443 Dickerson Pike Ste 430
Nashville, TN 37207

Choose Different Location (3)

(615) 868-0352

About Terry R. Ketch, MD

Biography

Dr. Terry Ketch is a board-certified Cardiologist practicing at Tennessee Heart and Vascular located in Nashville, TN.

Dr. Ketch, born and raised in Middle Tennessee, specializes in treating patients with coronary artery disease along with providing general cardiology care. He graduated Magna Cum Laude from Vanderbilt University in 1993. He then received his medical degree from Vanderbilt University School of Medicine in 1997. After serving in the United States Air Force, he returned to Vanderbilt to train as a research fellow in Clinical Pharmacology and complete a residency in Internal Medicine. He furthered his training at Wake Forest University Baptist Medical Center, completing both a Fellowship in Cardiology along with a Fellowship in Interventional Cardiology. He is Board Certified in Internal Medicine, Cardiovascular Disease, Interventional Cardiology, and Nuclear Cardiology. He has provided care to the Tristar Skyline surrounding community since 2010.

Close Bio

Procedures and Conditions Treated

- Acute Myocardial Infarction
- Angina Pectoris
- Atherosclerosis
- Cardiac Arrhythmia & Conduction Disorders
- Cardioversion
- Connective Tissue Disorders
- Electrocardiogram
- Electrophysiology Study
- Heart Disease
- Heart Failure
- Hypertension
- Myocarditis And Cardiomyopathy
- Pericarditis And Pericardial Disease
- Pulmonary Embolism

Specialties

- **Cardiovascular Disease** - Board Certified
- **Interventional Cardiology** - Board Certified

Affiliations

- TriStar Centennial Medical Center
- TriStar Skyline Medical Center

Clinic Website

- https://www.tristarmedgroup.com/locations/tennessee-heart-and-vascular/skyline

Credentials and Education

- **Vanderbilt University**
  Undergraduate Degree
- **Andrews Air Force Base, Malcolm Grow Medical Center**
  Internship
  1998
- **Vanderbilt University Medical Center**
  Fellowship
  2008
- **Vanderbilt University School of Medicine**
  Graduate Degree
  1997
- **Vanderbilt University Medical Center**
  Residency
  2005

Attachment 1N - 2, Cardiac

Cardiac Cath Lab to CMC Emergency Transfer

Status Active PolicyStat ID 10026041

TriStar Southern Hills MEDICAL CENTER

Effective	1/1/1996
Last Reviewed	9/11/2021
Last Revised	9/11/2021
Next Review	9/10/2024

Owner	Brandon Ward: Dir Cardiac Cath Lab
Policy Area	Cardiovascular Services
Applicability	TriStar Southern Hills Medical Center

Cardiac Cath Lab to CMC Emergency Transfer

PURPOSE:

To provide continuity of care and ensure patients are transferred safely and efficiently within an appropriate period of time as recommended by the American College of Cardiology.

POLICY:

Appropriate personnel should be notified for the emergent transport of a patient.

PROCEDURE:

Cath Lab Staff should:

1. Call Transfer Center @ (615) 342-1540 for contracted ambulance service for critical care transport. Info required: Patient Name, Weight, Referring Physician, Reason for Transfer
2. Notify the nursing supervisor.
3. Report will be given to the staff at the receiving facility. Report should include: patient name, reason for transfer, vital signs, meds administered, ETA, admitting MD and necessary equipment that should be available, including support devices ie IABP/ IMPELLA.
4. Prepare Cardiac Cath images and documentation to be transported with patient. Ensure the EMTALA transfer form is completed for all Observation and ER patients. A copy of the EMTALA sheet is to be retained at the facility and a copy sent to the receiving facility .

Cardiologist should:

1. Contact MD at receiving facility, and fill out the physician part of the EMTALA form.

Nursing Supervisor should:

1. Ensure the medical records are copied.
2. Notify ER to direct ambulance to CCL.
3. Explain the transfer process to the patient's family.
4. Ensure EMTALA form is completed.

Transporting the Patient:

The patient will be accompanied by an ACLS certified RN, or ALS crew if transport by private ambulance services, under the direction of the referring cardiologist. During transport, the patient should be reassessed continuously to ensure all equipment (i.e., IABP) is functioning properly. If necessary, the cardiologist should accompany the patient. Ensure the entire patient record accompanies the patient to the receiving facility.

All Revision Dates

9/11/2021, 7/31/2015, 8/1/2013, 12/1/2012, 9/1/2008, 3/1/2006, 10/1/2002, 5/1/2001, 1/1/1998

Attachments

EMTALA Memorandum of Transfer Form ENGLISH.pdf

EMTALA Memorandum of Transfer Form Spanish.pdf

Approval Signatures

Step Description	Approver	Date
Policy & Procedure	Laura Reed: CNO Southern Hills Med Ctr	9/11/2021
Cardiovascular Services	Brandon Ward: Dir Cardiac Cath Lab	8/16/2021

Applicability

TriStar Southern Hills Medical Center

Attachment 1N - 3, Cardiac

Cardiac Physician Letters of Support

May 23, 2025

Logan Grant
Executive Director
Tennessee Health Facilities Commission
502 Deaderick Street, Andrew Jackson Bldg., 9th Floor
Nashville, TN 36104

Re: TriStar Health's full-service hospital CON application

Mr. Grant,

I am a practicing cardiologist and also serve as the physician leader for the TriStar Cardiovascular Service Line. I am writing to extend my support for the addition of a full-service hospital in the city of Clarksville, Tennessee. Right now, Clarksville has only one hospital within the city and more than 50% of residents choose to travel long distances to neighboring cities to receive hospital services. With a rapidly growing population that is expected to exceed 200,000 people by 2028, there is a growing need for Clarksville residents to have increased access to hospital-based care.

TriStar has a team of experienced cardiologists, leaders in cardiac care and offer the latest advancements in cardiology and electrophysiology. If the TriStar Clarksville Hospital is approved, we look forward to helping staff the new hospital. TriStar Health facilities are known to be high quality and this brand-new facility will certainly provide the latest and most advanced cardiac services.

Please approve the application for TriStar Clarksville Hospital. Greater access and choice are always beneficial to patients and their families. I personally see a great need for this facility and look forward to seeing it built.

Sincerely,

TriStar Division Physician Director Cardiovascular Service Line
tom.mcrae@hcahealthcare.om

TRI STAR MEDICAL GROUP
Cardiovascular Surgery

May 23, 2025

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
502 Deaderick Street, Andrew Jackson Bldg., 9th Floor
Nashville, TN 36104
Re: TriStar Health's full-service hospital CON application

Dear Mr. Grant,

I have been a practicing cardiac surgeon in Nashville since 2011. Currently, I am director of cardiac surgery with TriStar Medical Group Cardiovascular Surgery. I am writing to extend my support for the addition of a full-service hospital in the city of Clarksville, Tennessee. At present, Clarksville has only one hospital within the city and more than 50% of residents choose to travel long distances to neighboring cities to receive hospital services. Clarksville has a rapidly growing population that is expected to exceed 200,000 people by 2028. Given this growth, there is a clear need for Clarksville residents to have increased access to advanced hospital-based care.

TriStar has a team of experienced cardiac surgeons and cardiologists who are leaders in cardiac care. TriStar Health facilities have documented high quality care and treatment, and this brand-new facility will certainly provide the latest and most advanced cardiac catheterization facilities among other services. If the TriStar Clarksville Hospital is approved, we look forward to replicating TriStar's seamless process for surgical patient transfers to Centennial Medical Center for advanced care while increasing access to a local facility for patients of the region.

Please rapidly approve the application for TriStar Clarksville Hospital. Greater access and choice are always beneficial to patients and their families. I see a great need for this facility and have many Clarksville friends and patients and look forward to seeing it built in the near future.

Sincerely,

V. Seenu Reddy MD, MBA, FACS, FACC
TriStar Medical Group Cardiovascular Surgery
2400 Patterson St Ste 307
Nashville, TN 37203

1. **Determination of Need: The need for neonatal nursery services is based upon data obtained from Tennessee Department of Health Office of Vital Records in order to determine the total number of live births which occurred within the designated service area. The need shall be based upon the current year's population projected for three years forward. The total number of neonatal intensive and intermediate care beds shall not exceed nine beds per 1,000 live births per year in a defined neonatal service area. These estimates represent gross bed need and shall be adjusted by subtracting the existing applicable staffed beds including certified beds in outstanding CONs operating in the area as counted by TDH in the Joint Annual Report (JAR).**

RESPONSE:

TCH proposes to establish an 8-bed Level II Neonatal Intensive Care Unit ("NICU") in the Service Area consisting of Montgomery County and Stewart County. The proposed hospital will be in Montgomery County, which has a net need of 27 beds. Additionally, there is a net need for 1 bed in Stewart County. Thus, there is a combined need in the two counties for 28 NICU beds.

As shown below in **Exhibit 1N, NICU – 1**, in 2022,[1] the number of live births in Montgomery County was 3,804 and 130 in Stewart County.

Exhibit 1N, NICU – 1

Live Birth Rate by County, 2022

County	Live Births	Population	Live Birth Rate
Montgomery	3,804	235,201	16.2
Stewart	130	14,035	9.3
Total	3,934	249,236	--

Source: Tennessee Department of Health: https://www.tn.gov/health/health-program-areas/statistics/health-data/birth-statistics.html, Boyd Series 2022 population

Exhibit 1N, NICU - 2 shows that the combined 2028 NICU bed need for Montgomery and Stewart County is 40 beds based on 9 NICU beds per 1,000 live births. At present, in the two counties, there are only 12 licensed NICU beds. Additionally, there are no approved but not yet licensed beds. Exhibit 1N, NICU – 2 also provides the live birth computation based on the 2022 live birth rate by county projected three years forward (2028) as set forth in the above-described formula.

Exhibit 1N, NICU – 2

Geographic Area	Current Year Population (2025)	Live Birth Rate per 1,000 Population (Service Area)	Projected Population 2028 (3 Years Forward)	Live Birth Rate per 1,000 Population Projected (Service Area 3 Years Forward)	Projected Bed Need (C x D)	Existing Service Area Staffed Beds	Outstanding CON Project Beds (Service Area)	Net Need
Montgomery County (*)	251,815	16.2	268,290	4,339	39	12	0	27
Stewart County (*)	14,231	9.3	14,369	133	1	0	0	1
Two Counties Combined	266,046	--	282,659	4,472	40	12	0	28

Source: Tennessee Department of Health: https://www.tn.gov/health/health-program-areas/health-data/birth-statistics.html

Population from Boyd Center, 2022 used for live birth rate, Beds from schedule D, Joint Annual Report

[1] Latest available data on TDOH website. https://www.tn.gov/health/health-program-areas/statistics/health-data/birth-statistics.html

With the approval of 8 Level II NICU beds, TCH expects to staff 4 to 5 of the beds during the first few years of operation and increase the number of beds as demand warrants.

2. **Minimum Bed Standard: A single Level II neonatal special care unit shall contain a minimum of 10 beds. A single Level III neonatal special care unit shall contain a minimum of 15 beds. These numbers are considered to be the minimum ones necessary to support economical operation of these services. An adjustment in the number of beds may be justified due to geographic remoteness.**

RESPONSE:

TCH is seeking approval for an 8-bed unit. The intent behind the minimum bed requirement was to ensure that the size of the NICU was sufficient to support a financially viable operation.[2] TriStar Health has considerable expertise in operating NICU's throughout the State, including Level II NICU's with less than 10 beds. In Middle Tennessee, it operates three such programs:

- TriStar Hendersonville Medical Center: 6 Level II NICU Beds
- TriStar StoneCrest Medical Center: 8 Level II NICU Beds
- TriStar Horizon Medical Center: 4 Level II NICU Beds

Each of these programs are staffed by qualified personnel and include 24-hour neonatology coverage. They are viable because the majority of hospital costs are in place, including management and support staff salaries, utilities, maintenance, support services, ancillary services, etc., and the need for additional resources is minimized. Therefore, costs associated with treating the Level II neonates are largely variable costs (staffing, supplies, ancillaries, and professional fees). Thus, the TCH NICU will be economically viable.

TriStar Health is committed to delivering quality care and needed services in the local community, close to where the consumer resides – a consumer advantage. The proposed Level II NICU at TCH is needed to provide the appropriate continuum of services in the hospital's maternity program. As described throughout this CON application, birthing mothers and their infants significantly out-migrate from this community for care. TCH's Level II NICU is needed to mitigate outmigration and give mothers the opportunity to deliver close to home. This will correspondingly allow the hospital to reduce unnecessary transfers and address any risk factors that may arise for infants who may need intermediate care after birth. Additionally, TCH recognizes the overall opportunity to improve the provider to patient ratio in both Montgomery and Stewart counties. Consequently, TCH aims to strengthen the existing Tristar Health relationships with obstetric providers in the community, who already provide exemplary care, by helping them grow their practices and ultimately reach more patients.

Importantly, TCH will assure the NICU provides quality care. Even with a unit size of less than 10 beds, TCH commits that its professional nursing staff will be properly trained, competencies well maintained and requisite certifications in place. The neonatologists who staff the unit will also be properly credentialed and experienced in caring for Level II neonates. Their support for the unit confirms that TCH's NICU will be a quality program that can successfully and viably operate at a lower census than suggested by this criterion.

[2] With the 2021 legislative change, economic feasibility is no longer a consideration in review of a CON application.

3. **Establishment of Service Area: The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant.**

RESPONSE:

The proposed Service Area for TCH, discussed at length in the CON Form, consists of Montgomery County and Stewart County. This Service Area is reasonable given the detailed analysis of population dynamics, population densities, county infrastructure, historical and anticipated healthcare purchase patterns, and availability of resources throughout each county. Based on the detailed analysis in this application, TCH expects 80 percent of its patients will reside within this two county area; the remaining 20 percent will reside outside these two counties.

TCH will be in 37042, which is one of three Clarksville, Montgomery County zip codes and its most populated. This Clarksville zip code is the 2nd most populous zip code in the state, with 93,580 population today and forecasted to be 101,989 in 2030.[3] This increase ranks it 2nd of any zip code in the state between 2020 and 2030. It also currently ranks as the 2nd most populous zip code in the State for females aged 18 to 44 in 2025 and will become the most populous by 2030.

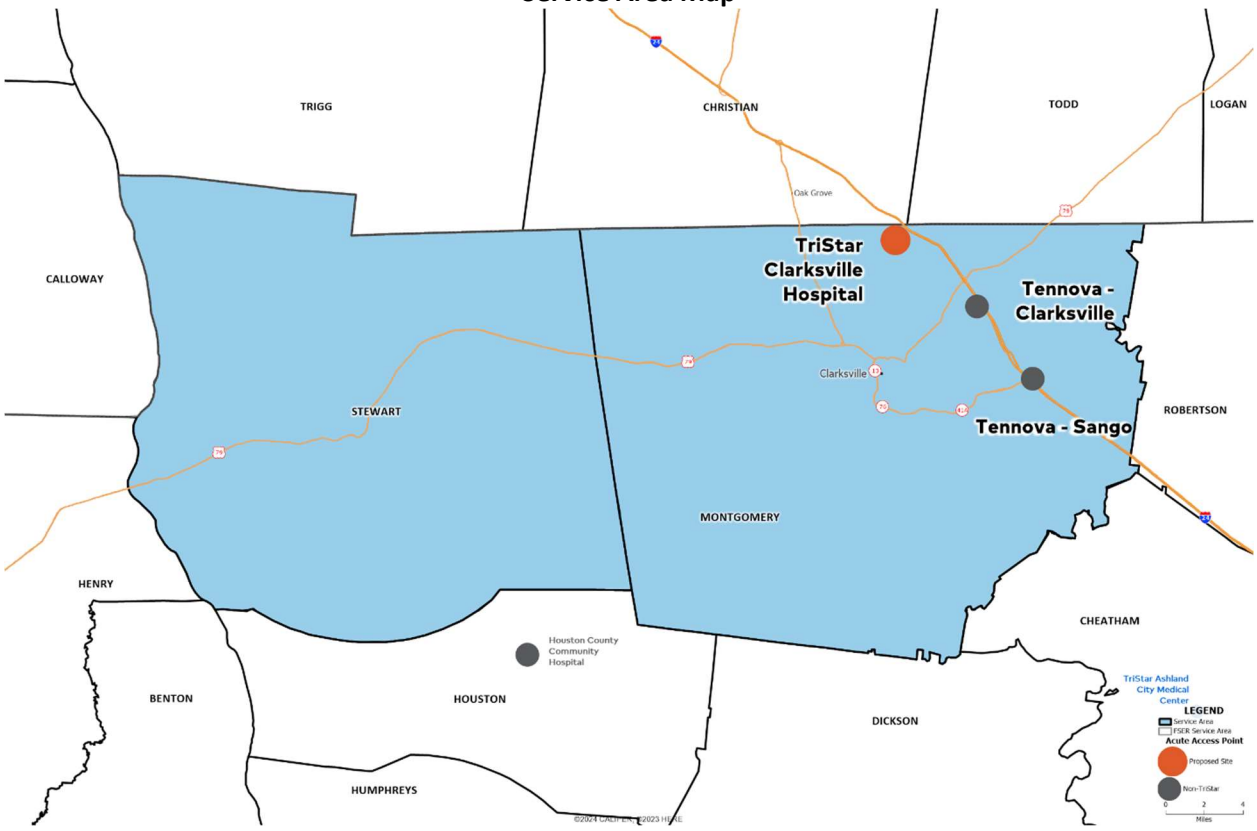
The centroid of zip code 37042 is 12.5 miles and between 20 and 45 minutes from Tennova Clarksville. Tennova Clarksville and Tennova Sango ER are each located in the other two Clarksville zip codes and in a separate part of Clarksville. The introduction of an additional hospital access point in Montgomery County, which is in an alternate location from the existing hospital and its FSED (Tennova Sango ER), will shorten travel times and distances for those residing in north Clarksville. This will be a favorable enhancement for the Service Area population.

Furthermore, having only one hospital provider in the county has resulted in significant outmigration for its residents to access alternative hospital services. Adding an additional hospital, with alternative practicing physicians, will be a consumer advantage.

The following map presents the Service Area relative to that region. The two counties are approximately 1,000 square miles and are situated in northwest Middle Tennessee, adjacent to the Kentucky border.

[3] Claritas, 2025.

Exhibit 1N, NICU - 3
Service Area Map



Also shown in Exhibit 1N, NICU 3, the proposed location of TCH is on Tiny Town Road as denoted by the red dot. This location is 7.5 miles from Tennova Clarksville and 11.7 miles from Tennova Sango ER, both also shown on the map with black dots south of the Applicant location.

The Applicant considered the proposed services, population dynamics, infrastructure and road systems, current migration patterns and the location of providers in the Service Area. The Service Area includes both Montgomery and Stewart Counties, which are each described in response to **Question 2N** in of the CON Form. Its demographic and economic characteristics are presented in response to **Question 3N** of the CON Form.

Service Area Discussion

The Service Area was defined through a series of analyses that included, but are not limited to, the following:

- Evaluation of the patient utilization patterns at Tennova Clarksville reported in its Joint Annual Reports from 2019 through 2023, including patient origin, patient transfers, emergency room utilization, among other schedules;
- Evaluation of patient utilization patterns at Tennova Clarksville and Tennova Sango ER utilizing THA data sets from 2019 through 2024 focusing on patient draw, service line utilization and utilization trends;

- Evaluation of patient utilization patterns of residents of Montgomery County, Stewart County and all bordering counties for the past several years using both THA data sets and KHA data sets, to determine patient flow patterns across counties, hospitals/locations of choice, service lines and related hospital access;
- Evaluation of EMS runs amongst the counties using the biospatial proprietary data set to account for trends in transports of residents of the area requiring emergency treatment;
- Patient transfer information from Montgomery, Stewart and bordering counties for the past several years using TriStar Health data from its transfer center;
- Evaluation of patient zip code utilization within Montgomery County, including consideration of the individual Clarksville zip codes in which the majority of Montgomery population resides;
- Population throughout the region including historical, current, projected and associated growth patterns;
- Location of and services provided by existing healthcare resources throughout the region and their patient draw by county;
- Timing to access the existing healthcare resources throughout the region; and
- Consideration of interstates, US routes, and State Routes traversing the counties and how access may be accomplished.

Based on these evaluations and assessments, it was concluded that the TCH Service Area will comprise Montgomery and Stewart Counties. An estimated 75 to 76 percent of patients are expected to reside in Montgomery County, 4 to 5 percent reside in Stewart County and the balance of 20 percent will reside outside the service area. This Service Area is reasonable and supportable based on the following facts:

- There is only one hospital in the service are – located in Montgomery County – providing services to more than a quarter of million people, the 2nd highest rate in the State, compared to an average of 65,000 people per hospital.
- Approximately 50 percent of Montgomery County residents are treated in Montgomery County. Conversely, about 50 percent leave .[4]
- Stewart County residents account for approximately 5 percent of Montgomery County admissions, with approximately one-third using that hospital and two-thirds leaving the area.
- Other counties' in-migration did not demonstrate meaningful patient draw from other surrounding counties; as a result they are not identified as Service Area but rather aggregated into 'out of area' admissions which will account for 20 percent of TCH patient utilization.
- Stewart County is due west of Montgomery County and has roadway access into Montgomery County via State Route 79.
- From a consumer perspective, consumers are not afforded any choice in hospital provider. Rather, there are two facilities operated by a single provider (one hospital and one ER).
- Beds per population indicate Montgomery County is one of the lowest of any high population county in the State.
  ER treatment rooms indicate Montgomery County is also one of the lowest of any high population county in the State.

[4] The reference to 'approximately 50 percent' is based on THA data with all service lines out-migrating at 53.8 percent and services lines excluding rehabilitation and behavioral health out-migrating at 48.9 percent.

Both the current and forecasted population support need for an additional hospital. The area has a significant population base and has experienced dramatic growth during the past 10 to 15 years. And, anticipated population increases are among the highest in the State.

In sum, establishment of TCH will enhance access for Service Area residents through the creation of a hospital and emergency room access point designed to reduce geographic and programmatic inaccessibility to serve the healthcare needs of this population.

Please see additional detailed discussion of hospital access problems and extent of TriStar Health affiliate access for residents of the Service Area provided in **Attachment 1N, Acute** and **Questions 2N, 4N and 5N** of the CON Form. The defined Service Area is reasonable for the proposed TCH including its NICU.

4. **Access: The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is a limited access in the proposed service area.**

RESPONSE:

TCH will serve equally all patients who present at its facility. TCH should be afforded special consideration under this provision as it is readily evident that there is limited access to inpatient community hospital services – including maternity and neonatal -- in the proposed Service Area. As noted, 37042 – the zip code in which TCH is located – is the 2nd most populated zip code for females aged 18 to 44, and will become the most populated for this age range by 2030.

Women in Montgomery and Stewart Counties face challenges accessing sufficient maternity care due to several interrelated factors. TCH's goal is to continue to support the great work that existing community obstetricians do every day, while helping them look to the future and aid in practice growth to reach even more patients. With respect to Montgomery County, the following interrelated factors play a significant role:

- Limited Obstetric Providers: With only one hospital program in Montgomery County and the need for more obstetricians including laborists, 40 percent of birthing mothers travel more than an hour to access services.
- Geographic and Transportation Barriers: While Montgomery County is not classified as a maternity care desert, a significant percentage of women live more than 30 minutes from the nearest birthing hospital. This distance can pose challenges for timely access to care, especially in emergencies.
- Socioeconomic Factors: Socioeconomic disparities, including lack of insurance and limited access to transportation, can hinder women's ability to obtain consistent prenatal care. These factors contribute to higher rates of inadequate prenatal care in the region.
- Mental Health Provider Shortages: There is a noted shortage of mental health providers in Montgomery County, with a high population-to-provider ratio. Mental health support is crucial during and after pregnancy, and this shortage can impact maternal well-being.

All Stewart County residents leave the county for maternity services with only about one-third using Tennova Clarksville and the rest traveling even further distances. As a result, women in Stewart County

face even greater challenges accessing maternity care due to the county's classification as a maternity care desert. This designation indicates a complete absence of hospitals or birth centers offering obstetric services, as well as a lack of obstetric clinicians such as OB-GYNs, family physicians who deliver babies, and certified nurse midwives. Key factors contributing to insufficient maternity resources include:

- Absence of Local Obstetric Services: Stewart County lacks any hospitals or birth centers providing obstetric care, and there are no obstetric clinicians practicing within the county. This forces pregnant women to travel to neighboring counties for prenatal visits and delivery services, which can be particularly burdensome for those without reliable transportation or flexible work schedules.
- Financial and Insurance Barriers: A significant proportion of women in rural Tennessee, including those in Stewart County, rely on Medicaid for healthcare coverage. However, low Medicaid reimbursement rates make it financially challenging for hospitals to sustain obstetric services. Additionally, some women may lack any health insurance, further limiting their access to necessary prenatal and delivery care.
- Increased Travel Distances: With no local maternity care providers, women in Stewart County often travel long distances to receive care. This not only delays access to prenatal services but also increases the risk of complications during labor and delivery, especially in emergency situations.

Addressing these issues requires coordinated efforts to increase healthcare provider availability, expand hospital capacities, and improve access to comprehensive prenatal and mental health services. The addition of a new maternity program with Level II NICU capability will provide a much-needed resource for birthing mothers and neonates.

An excessive number of obstetric patients out-migrate from the Service Area to other areas. The migration patterns are shown in response to **Attachment 1N, Acute** and **Question 4N** in the CON Form.

Since the hospital and a maternity program are needed, it is critical to incorporate a Level II nursery into its obstetrics program. Birthing moms prefer hospitals with available neonatal services in the event of unforeseen circumstances. The comfort of knowing one can deliver in a holistic nurturing environment that can also respond to an emergency is foundational to TCH. Having such a resource closer to home is a consumer advantage. Level II nurseries provide care for stable or moderately ill infants born at >32 weeks gestation and weighing >1500 grams who have problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. These units also resuscitate and stabilize preterm and/or ill infants before transfer to a facility at which newborn intensive care is provided.

A Level II NICU at TCH will provide reasonable access to infants in addition to mothers and families. The mother's average length of stay ("ALOS") is expected to be 2.35 days. On average, the neonate stays at the hospital five days longer than the mother. In those instances where the mother is already discharged and the child has to stay an additional 5+ days in the NICU, it would be a significant hardship on the mother who chose TCH for delivery to have to travel daily to another facility away from home. Co-locating a Level II NICU with the TCH obstetrics program will improve access and enhance quality to the benefit of the community.

5. **Orderly Development of Applicant's Neonatal Nursery Services: The applicant shall document the number of Level II, Level III, and Level IV cases that have been referred out of the hospital during the most recent three year period of available data.**

RESPONSE:

This is not applicable as TCH is not an existing licensed hospital.

The need for the Level II NICU is demonstrated by the live birth rate and the NICU being an integral component of the full-service maternity program at TCH. The maternity program at TCH will have an open medical staff as there are several obstetrical practices in the community and this provides those physicians and their patients a choice of providers. TCH's program will be distinguishable as it will include laborists. A laborist program is a hospital-based model of care where a dedicated obstetrician (laborist) employed to provide in-hospital care exclusively for laboring patients. The laborist's primary responsibility is to manage labor and delivery for all patients in the hospital, regardless of whether they are privately insured or under the care of another provider. This program will also include midwifery as a laborist under the physician's supervision. This program ensures immediate response to obstetric emergencies or labor needs. Care is often more standardized and protocol-driven, with quicker interventions when necessary. This is also a benefit for community obstetricians who may rely on laborists to handle their patients' deliveries, particularly during off-hours or when unavailable.

Labor and Delivery at TCH will include the following:

- An early familiarity with the obstetrics unit, including tour and meeting the staff;
- A spacious, private room during labor and postpartum, with remote monitoring devices available if the mother wants to move around;
- A variety of birth choices and pain management options; and
- Access to a variety of items to assist during and after the birth, including immersion tubs, aromatherapy diffusers, luxurious blankets, swedish bars, rebozo technique, birth stools, birth balls, bassinets that snuggle up to the bed, and plush robes.

Establishment of the obstetrics and neonatal programs at TCH will decrease out-migration from the Service Area to birthing centers and other obstetrics programs in Middle Tennessee.

The Level II NICU is needed to create an appropriate continuum of care for women's services at TCH. Level II nurseries provide specialty neonatal services. The program will also include educational services for parents, including ongoing perinatal education programs. The nurse education program will conform to the latest edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, Level II, for neonatal nurses, published by the Tennessee Department of Health. These neonatal courses will be available periodically at the hospital or a TriStar Health affiliate by instructors on the staff of that institution and/or the staff from a Regional Perinatal Center. Courses may also be held at a Regional Perinatal Center or at another site remote from the Level II hospital. If courses are held remotely, TCH will provide its nurses with educational leave for attendance. TCH will be responsible for the necessary arrangements for nurse education.

A unique education program that will be incorporated into TCH's operations is Rachel's Gift. Rachel's Gift is a non-profit organization that is partnered with TriStar Health which provides the hospital staff with training on pregnancy and infant loss. The Rachel's Gift team helps TriStar Health provide resources to support grieving moms processing the loss of their baby, which is an amazing benefit to patients. Other TriStar Health affiliates in Middle Tennessee participate in this program and the plan is to incorporate this program at TCH.

Regarding physician education, such will be available upon request, provided by the instructional staff of the Regional Perinatal Center and by qualified individuals on the staff of the hospital or a TriStar Health affiliate.

In addition, TCH will maintain both current Neonatal Resuscitation Program ("NRP")[5] and S.T.A.B.L.E.[6] provider status. Required ancillary services will also be maintained, including routine laboratory services, 24/7 laboratory services and blood bank services. Consultation and transfer services will also be properly maintained.

TCH will maintain an active relationship with TriStar Centennial for consultation and transfer, including to TriStar Centennial's Level III NICU. This will provide continuity of care as the same neonatology team will oversee both NICUs. Protocols for transport will conform to the most recent edition of the Tennessee Perinatal Care System Guidelines on Transportation, published by the Tennessee Department of Health. When the severity of an illness requires a level of care that exceeds TCH's capacity, the infant will be transferred to either TriStar Centennial or other appropriate hospital capable of providing required care. Transfer of these infants will be provided after consultation with the parents and the receiving neonatal unit.

TCH anticipates that most infants requiring transfer will be transferred to TriStar Centennial utilizing TriStar Centennial's experienced transport team. TriStar Centennial has an active neonatal transport program dating back to 1988. It currently transports approximately 270 neonates each year, with 30-minute mobilizations. The TriStar Centennial NICU transport program staff includes 5 Clinical Nurse Coordinators (CNCs), 8 Neonatologists, 23 Neonatal Nurse Practitioners, 146 NICU RNs, and 3-4 dedicated respiratory therapists per shift. Approximately 86 percent of transports are via ground and 14 percent via air (SkyLife). Additionally, the transport team can now go to Kentucky by ground; this will be an advantage for those north of TCH in Kentucky to have access to a transport team. When a neonate is being transported by ground, a neonatal nurse practitioner, RN, and respiratory therapist travel in the ambulance with the EMTs. When being transported by air, in addition to these three personnel, a SkyLife native crew member (flight nurse or flight paramedic) accompanies the team with a pilot. All NICU transport personnel undergo initial training to familiarize themselves with equipment and procedures specific to the transport environment. Those involved in NICU transport via air also undergo initial and annual training specific to the aviation environment. TriStar Centennial has three isolettes dedicated to transport, two are configured for ground transport, and one is configured for air. The IV pumps are also specific to the transport environment. Soft supplies and smaller equipment are configured and standardized in EMS-style bags for use in air and ground transport environments. TriStar Centennial's policy for Neonatal Transport Arrangements is provided in **Attachment 1N-1, NICU.**

[5] NRP provides training for the most up-to-date evidence-based practices in neonatal resuscitation and incorporates innovative learning methodologies to better equip health care professionals to care for newborns at the time of birth. NRP is the first life support program that emphasized simulation, communication, and skills during a high-stakes resuscitation situation. NRP encourages healthcare professionals to practice neonatal resuscitation skills, teamwork and behavior skills, and ensure high competency and quality. NRP completion is the gold standard program in the U.S. and required of most healthcare providers present during childbirth.

[6] S.T.A.B.L.E. is the most widely distributed and implemented neonatal education program to focus exclusively on the post-resuscitation/pre-transport stabilization care of sick infants. Based on a mnemonic to optimize learning, retention and recall of information, S.T.A.B.L.E. stands for the six assessment and care modules in the program: Sugar, Temperature, Airway, Blood pressure, Lab work, and Emotional support. A seventh module, Quality Improvement stresses the professional responsibility of improving and evaluating care provided to sick infants.

6. **Occupancy Rate Consideration: The Agency may take into account the following suggested occupancy rates of existing facilities in the service area. The occupancy rates of an existing facility shall be 80 percent or greater in the preceding 12 months to justify expansion. The overall utilization of existing providers in the service area shall be 80 percent or greater for the approval of a new facility in a service area.**

RESPONSE:

Exhibit 1N, NICU – 4

Facility	County	2023 Licensed Neonatal Beds	Bed Days Available	Patient Days			Licensed Occupancy		
				2021	2022	2023	2021	2022	2023
Tennova Clarksville	Montgomery	12	4,380	1,216	1,206	1,126	28%	28%	26%

Noted above in the occupancy rate consideration is that 80 percent is a suggested rate. Given the variability of neonate utilization, and to assure beds are available when needed, the HFC bed formulas for small units typically convert to beds needed at a much lower rate than 80 percent. A Level II NICU is an important feature in the continuum of care for mothers and neonates. A Level II NICU is essentially the standard of care for residents of these counties, whether birthing locally or out-migrating. Achieving the NICU occupancy suggestion of 80 percent is not as critical in the development of a new access point in a large community. The standard of care at the existing obstetric programs in the Service Area includes the availability of a Level II NICU. This standard is expected by families in the community and should take priority over an occupancy metric.

7. **Assurance of Resources: The applicant shall document that it will provide the resources necessary to properly support the applicable level of neonatal nursery services. These resources shall align with those set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities. Included in such documentation shall be a letter of support from the applicant's governing board of directors documenting the full commitment of the applicant to develop and maintain the facility resources, equipment, and staffing to provide a full continuum of neonatal nursery services. The applicant shall also document the financial costs of maintaining these resources and its ability to sustain them to ensure quality treatment of patients in the neonatal nursery services continuum of care.**

RESPONSE:

TriStar Health and all its resources stand behind the implementation and licensure of TCH. The letter of support is no longer required as it is a relic of a previous statutory framework which included consideration of Economic Feasibility.

The Level II NICU at TCH will comply with the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities. The proposed hospital will provide care for stable or moderately ill infants born at >32 weeks gestation and weighing >1500 grams who have problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. Its unit will resuscitate and stabilize preterm and/or ill infants before transfer to a facility at which

newborn intensive care is provided. It will also provide mechanical ventilation for brief (<24 hrs) duration or continuous positive airway pressure, or both, until the infant's condition improves, or the infant can be transferred to a higher-level facility.[7] In addition, the unit is available to provide care for infants who are convalescing after intensive care.

Adequate Staffing

Requirements for adequate staffing will be based upon the assumption that patients will be transferred to a Level III or Level IV facility when their illnesses necessitate a level of care that exceeds the hospital's capabilities. TCH will have personnel (physicians, specialized nurses, respiratory therapists, radiology technicians, laboratory technicians) and equipment (i.e., portable chest radiograph, blood gas laboratory) continuously available to provide ongoing care as well as to address emergencies. If the hospital has an infant on a ventilator, specialized personnel will be available on site to manage respiratory emergencies.

Physicians

- A board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine will be chief of the neonatal care service. TCH will contract with Pediatrix Medical Group of Tennessee, ("Pediatrix") its neonatology partner at its other Middle Tennessee NICUs, to serve as medical director and also staff the Level II NICU.
- Medical Directors: The medical directors of obstetrics and neonatology are responsible for setting the hospital's standard of perinatal care by working together to incorporate evidence-based practice patterns and nationally recognized care standards. These co-directors will coordinate the hospital's perinatal care services and, in conjunction with other medical, anesthesia, nursing, respiratory therapy, and hospital administration staff, develop policies concerning staffing, procedures, equipment, and supplies.
- Every delivery will be attended by at least one person whose primary responsibility is for the newborn and who is capable of initiating neonatal resuscitation according to the American Heart Association and American Academy of Pediatrics Neonatal Resuscitation Program guidelines. Either that person or someone else who is immediately available should have the skills required to perform a complete resuscitation, including endotracheal intubation and administration of medications.
- Deliveries of high-risk fetuses should be attended by an obstetrician and at least two other persons qualified in neonatal resuscitation whose only responsibility is the neonate. With multiple gestations, each newborn should have his or her own dedicated team of care providers who are capable of performing neonatal resuscitation.

Pediatrix's commitment to staff the NICU and support the neonatal program at TCH is expressed in its letter of support from Hadeer Karmo, MD included in **Attachment 1N - 3, NICU**:

> *I am excited to write to you on behalf of Pediatrix Medical Group in support of TriStar Health's application to build a full-service hospital in Clarksville. Pediatrix Medical Group takes pride in providing newborns and their families with intensive care. Our group currently staffs several level 2 and level 3 TriStar units in Tennessee with 24/7 in-house coverage by experienced neonatal nurse practitioners that are supervised by board certified neonatologists that are available 24/7. We provide daily rounds with the NNPs and talk to families daily and as needed. We are fully supportive of TriStar Health's plan*

[7] American Academy of Pediatrics Levels of Neonatal Care, 2012.

to bring hospital access to the community of Clarksville. Pedatrix Medical Group plans to staff TriStar Clarksville Hospital's NICU program. Our goal will be to support the community we are serving and try to keep many of the babies that require an NICU stay in Clarksville. Transferring babies to Nashville disrupts the mother/baby bond, interferes with breastfeeding, and increases drive time for parents and extended family. For these reasons, and many more, we ask that you please approve TriStar Health's application for a Certificate of Need to bring additional hospital care to Clarksville.

Hadeer Karmo, MD
Director of Neonatology
Pediatrix Medical Group of Tennessee

Nurses:

- Nurse Manager: The nurse manager (RN) will be responsible for all nursing activities in the nurseries. The nurse manager will have completed the Level II neonatal courses prescribed for staff nurses in the most recent edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, Level II, published by the Tennessee Department of Health.
- All staff nurses (RN) will be skilled in the observation and treatment of sick infants. They will have completed the Level II neonatal course for nurses outlined in the most recent edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, published by the Tennessee Department of Health. Nurses will maintain unit-specific competencies. In addition, all nurses will be current NRP and S.T.A.B.L.E. providers.
- Recommended nurse ratios will be maintained.

Respiratory Therapists: Respiratory therapists who provide supplemental oxygen, assisted ventilation, and continuous positive pressure ventilation (including high flow nasal cannula) of neonates with cardiopulmonary disease will be continuously available on site to provide ongoing care as well as to address emergencies.

Social Services / Case Management: Personnel experienced in dealing with perinatal issues, discharge planning and education, follow-up and referral, home care planning, and bereavement support will be available to intermediate and intensive care unit staff members and families.

Dietitian / Lactation Consultant: The staff will include at least one dietitian who has special training in perinatal nutrition and can plan diets that meet the special needs of high risk neonates. Lactation consultants will be available 7 days a week to assist with complex breastfeeding issues.

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

<u>Adequate Facilities</u>

Physical facilities and equipment will meet criteria published in the latest edition of the Guidelines for Perinatal Care, jointly published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, and state requirements. Equipment for care of the normal infant includes:

- A platform scale, preferably with metric indicators.
- A controlled source of continuous and/or intermittent suction.

- Incubators and/or radiant warmers for adequate thermal support.
- Equipment for determination of blood glucose at the bedside.
- Ability to provide intensive phototherapy.
- A device for the external measurement of blood pressure from the infant's arm or thigh.
- Oxygen flow meters, tubing, binasal cannulas for short-term administration of oxygen.
- A headbox assembly (oxygen hood), an oxygen blending device, and warming nebulizer for short-term administration of oxygen.
- An oxygen analyzer that displays the ambient concentration of oxygen.
- A newborn pulse oximeter for non-invasive blood oxygen monitoring.
- An infusion pump that can deliver appropriate volumes of continuous fluids and/or medications for newborns.
- A fully equipped neonatal resuscitation cart.
- Positive pressure ventilation equipment and masks; endotracheal tubes in all the appropriate sizes for neonates.
- A laryngoscope with premature and infant size blades.
- A CO2 detector.
- Laryngeal mask airway (LMA, size 1)

The additional equipment required for the Level II neonates and their nursery that will be available include the following:

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

TCH is fully committed to developing and maintaining the facility resources, equipment, and staffing to provide a continuum of neonatal nursery services.

8. **Perinatal Advisory Committee. The Department of Health will consult with the Perinatal Advisory Committee regarding applications.**

RESPONSE:

The Applicant's proposal satisfies the Level II NICU Bed Need Formula warranting its approval to be implemented at TCH.

Incorporating the Level II program within the obstetrics continuum of care will enable expectant mothers to deliver locally without concern for risk factors associated with birthing an infant who may require intermediate care. The Pediatrix neonatology group will cover the Level II NICU 24/7. This is the same group that covers the NICUs at other TriStar Health hospitals throughout Middle Tennessee, including the TriStar Centennial Level III NICU that is comprised of 60 beds (intermediate and intensive care beds).

TriStar Centennial also has neonatal consulting subspecialists who will be available as a resource for the neonatologists practicing in the Service Area.

The Perinatal Advisory Committee's mission[8] is to assist the Department of Health in its oversight of perinatal and neonatal care, including regional development, expansion and maintenance of newborn centers, development of systems of rapid transportation and referral to obstetrics and newborn centers, development of educational programs, and assist in regional development, expansion, and maintenance of specialty level II birthing centers in every health region with certified obstetricians and pediatricians available who are trained in the prevention, early diagnoses, treatment, and stabilization of complications of pregnancy and childbirth.

Montgomery County is one of the fastest growing counties in the State with sufficient population and need to support an additional provider. The need for a full-service hospital including an active obstetrics program has been demonstrated. Since Level II programs operate in conjunction with obstetrics programs, the proposed Level II NICU should be approved. Establishing a TCH Level II NICU meets the mission of the Perinatal Advisory Committee as it will be an additional program and access point for obstetricians and pediatricians who are trained in prevention, early diagnoses, treatment, and stabilization of complications of pregnancy and childbirth. It will be engaged with TriStar Centennial which operates a Level III NICU and neonatal transport team.[9] TCH also plans to participate in the Tennessee Initiative for Perinatal Quality Care as do other TriStar Health affiliates in Middle Tennessee.

9. **An 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. The applicant shall comply with the staffing guidelines and qualifications set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities.**

RESPONSE:

TriStar Health affiliated facilities are located throughout Middle Tennessee including Montgomery County and counties contiguous to it (Robertson, Cheatham, and Dickson Counties). Today, there are 523 TriStar Health employees residing in Montgomery County. Of these, 483 provide direct patient care. Accordingly, TCH has a significant foundation of staff upon which it may build its employee and physician base to appropriately staff the proposed hospital.

Based on forecasted utilization, TCH estimates a need for 210 FTEs in its initial year of operation. Due to the significant number of TriStar Health employees residing in Montgomery County and its widespread recruitment and retention experience, TCH is confident that it will successfully recruit the necessary staff to safely and successfully operate.

Additionally, approximately 55 TriStar Health providers, such as doctors and advanced practice providers, reside in Montgomery County. TCH will capitalize on the presence of these providers as it develops its medical staff plan for its future operations.

[8] Chapter 1 - Department of Health, Part 8 - Perinatal and Neonatal Care, § 68-1-804. Items to Be Considered for Inclusion in Program

[9] TriStar Centennial's neonatal transport team is described above in response to criterion #5.

Moreover, TriStar Health and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. In 2021, HCA Healthcare opened the Galen College of Nursing in Nashville, which now has campuses and programs in Tennessee, Kentucky, Ohio, Virginia, South Carolina, Florida and Texas. The Nashville campus offers a 3-year Bachelor of Science in Nursing, an Associate Degree in Nursing (ADN) and an LPN to ADN Bridge program. It graduated 45 nurses in its first year (2023) and is currently enrolling 700 new students each year. It expects estimated enrollment to increase 5 to 10 percent each year. This year, Galen College of Nursing expects to graduate approximately 250 graduates. It is HCA's experience that 55 percent of the graduates join an HCA hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Health including recruitment for the proposed TCH.

The Thomas F. Frist, Jr. College of Medicine at Belmont University in Nashville, is a new medical school founded in alliance with HCA Healthcare to focus on training diverse physician leaders who embrace and value a whole-person approach to healing. The Thomas F. Frist, Jr. College of Medicine at Belmont University is housed in a new building that had its ribbon cutting on April 29, 2024. The nearly 200,000-square-foot building is located within a block of Belmont's Gordon E. Inman Center and McWhorter Hall, which house the University's well-known nursing, physical therapy, occupational therapy, social work and pharmacy programs. The College of Medicine has recruited a leadership team consisting of experts from across the country and is currently recruiting additional clinical faculty. Its first class commenced this past fall. TriStar Health and HCA Healthcare are working collaboratively with Belmont to support the supply of healthcare professionals entering and staying in the profession.

In Middle Tennessee, TriStar Health is integrally involved in graduate medical education (GME). It currently has 133 residents, with 72 at TriStar Centennial Medical Center (internal medicine, psychiatry, and transitional year), 37 at TriStar Skyline Medical Center (emergency medicine, neurology, surgical critical care and physical medicine and rehabilitation) and 24 family medicine residents at TriStar Southern Hills Medical Center. In July 2024, total resident count in these three hospitals will increase to 158, with 77 at TriStar Centennial, 56 at TriStar Skyline Medical Center and 25 at TriStar Southern Hills Medical Center. HCA Healthcare has more than 5,600 residents at its hospitals, making it one of the largest GME providers in the country. TriStar Health and HCA Healthcare look forward to working collaboratively with Belmont to support the supply of healthcare professionals entering and staying in the profession and to ensure that they have access to training.

In addition to these programs for nurses and physicians, TriStar 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 facilities and also provide a pipeline for future qualified employees. **Exhibit 47** in the CON Form provides a summary of programs that currently work with TriStar and the profession for which the students are matriculating and training.

Like TCH, its NICU will be adequately staffed with qualified personnel with the necessary competencies to meet the needs of the patients. TCH will have personnel (physicians, specialized nurses, respiratory therapists, radiology technicians, laboratory technicians) continuously available to provide ongoing care as well as to address emergencies. If the hospital has an infant on a ventilator, specialized personnel will be available on site to manage respiratory emergencies. As stated in the Applicant's commitment letter in the Attachments, it will comply with the staffing guidelines and qualifications set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities. It will retain qualified NICU personnel to include the following:

- Physicians: A board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine will be chief of the neonatal care service.
- Medical Directors: The medical directors of obstetrics and neonatology are responsible for setting the hospital's standard of perinatal care by working together to incorporate evidence-based practice patterns and nationally recognized care standards. These co-directors will coordinate the hospital's perinatal care services and, in conjunction with other medical, anesthesia, nursing, respiratory therapy, and hospital administration staff, develop policies concerning staffing, procedures, equipment, and supplies.
- Nurse Manager: The nurse manager (RN) will be responsible for all nursing activities in the nurseries. The nurse manager will have completed the Level II neonatal courses prescribed for staff nurses in the most recent edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, Level II, published by the Tennessee Department of Health.
- Nurses: All staff nurses (RN) will be skilled in the observation and treatment of sick infants. They will have completed the Level II neonatal course for nurses outlined in the most recent edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, published by the Tennessee Department of Health. Nurses will maintain unit-specific competencies. In addition, all nurses will be current NRP and S.T.A.B.L.E. providers.
- Respiratory Therapists: Respiratory therapists who provide supplemental oxygen, assisted ventilation and continuous positive pressure ventilation (including high flow nasal cannula) of neonates with cardiopulmonary disease will be continuously available on site to provide ongoing care as well as to address emergencies.
- Social Services/Case Management: Personnel experienced in dealing with perinatal issues, discharge planning and education, follow-up and referral, home care planning, and bereavement support will be available to intermediate and intensive care unit staff members and families.
- Dietitian / Lactation Consultant: The staff will include at least one dietitian who has special training in perinatal nutrition and can plan diets that meet the special needs of high risk neonates. Lactation consultants will be available 7 days a week to assist with complex breastfeeding issues.
- Pharmacist: A registered pharmacist with expertise in compounding and dispensing medications, including total parenteral nutrition (TPN) for neonates will be available 24 hours per day.

Given TriStar Health's footprint in Middle Tennessee, and its other operating NICUs throughout the region, TCH is confident it will be able to recruit, hire, train, employ, supervise and retain the necessary staff to successfully operate the Level II NICU.

10. **Staff and Service Availability for Emergent Cases: The applicant shall document the capability to access the neonatologist rapidly for emergency cases 24 hours per day, seven days per week, 365 days per year.**

RESPONSE:

The director of the NICU will be a full-time, board-certified pediatrician with subspecialty certification in neonatal-perinatal medicine. The director will be responsible for: (1) maintaining practice guidelines and, in cooperation with nursing and hospital administration, (2) developing the operating budget; evaluating and purchasing equipment; (3) planning, developing, and coordinating in-hospital and outreach educational programs; and (4) participating in the evaluation of perinatal care.

In-house physician consultation and coverage will be provided 24 hours per day by a board-certified neonatologist or a board-certified neonatal nurse practitioner. When a board-certified neonatologist is not in-house, one will be on-call and available to be on-site within 30 minutes of request of the board-certified neonatal nurse practitioner.

TCH will ensure coverage for emergency cases 24 hours per day throughout the year based on its policies and procedures which will be implemented.

11. **Education: The applicant shall provide details of its plan to educate physicians, other professional and technical staff, and parents. This plan shall be performed in accordance with the education guidelines set forth by Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities.**

RESPONSE:

TCH's obstetrics program will have the capability to provide a broad range of maternal-fetal services for normal patients and for those with mild or moderate obstetric illnesses or complications. The level of obstetric care provided by a hospital is determined, in large part, by the level of neonatal care available at that facility. TCH's Level II nursery will provide planned delivery services for women whose infants are expected to require newborn intermediate (but not intensive care). The proposed program will have the capabilities to provide:

- Planned delivery services for women whose infants are expected to be >32 completed weeks of gestation and have a birthweight of at least 1500 grams. Additionally, a need for immediate pediatric subspecialty care for these newborns should not be anticipated.
- Emergency care for unplanned births of younger, smaller, or sicker babies before transfer to a facility at which newborn intensive care is provided.

As part of its program, TCH will have a comprehensive education program in conformance with the guidelines set forth by the Tennessee Perinatal Care System. The program will include educational services for parents, including ongoing perinatal education programs.

The nurse education program will conform to the latest edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, Level II, for neonatal nurses, published by the Tennessee Department of Health. These neonatal courses will be available periodically at the hospital or a TriStar Health affiliate by instructors on the staff of that institution and/or the staff from a Regional Perinatal Center. Courses may also be held at a Regional Perinatal Center or at another site remote from the Level II hospital. If so, TCH will provide its nurses with educational leave for attendance. TCH will be responsible for the necessary arrangements for nurse education.

Regarding physician education, such will be available upon request, provided by the instructional staff of the Regional Perinatal Center and by qualified individuals on the staff of the hospital or a TriStar Health affiliate.

In addition, TCH will maintain both current NRP and S.T.A.B.L.E. provider status. Its nurses will each have NRP certification and S.T.A.B.L.E training. The neonatology group will supplement the staff training by providing additional education as identified.

Although services should be available as close to home as possible, transfer of patients from one hospital to another is inevitable if all levels of care are to be provided. TCH will also incorporate into its education system appropriate training relative to the level of service required by the neonate. Staff will be capable of identifying and stabilizing maternal-fetal complications that require intervention before transfer to another facility. There will be an ongoing relationship for consultative services in accordance with EMTALA guidelines.

Care of complicated patients will entail direct consultation with the referral facility. The availability of anesthesia, radiologic services, and laboratory/blood bank services will be appropriate for effective support of these emergencies. The staff will be educated on the protocols for maternal-fetal transport which will conform with the most recent edition of the Tennessee Perinatal Care System Guidelines for Transportation, published by the Tennessee Department of Health.

12. **Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/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 NICU usage.**

RESPONSE:

The Applicant intends on establishing many community linkages for its proposed NICU program. This will include but not be limited to the following:

- **Escalation for Transfers of Higher-Acuity Patients**
  - Transfer agreement with Centennial Medical Center (Level III NICU, High Risk OB)
- **Educational Classes**
  - Educate moms and family members on appropriately preparing and caring for their new baby. Many classes have virtual options for moms that can't make it to a facility. Moms also have access to any of our hospital's classes/events, not just those where they're delivering. The intent is that the better prepared a mom/family is, the less likely the baby will be admitted to the NICU.
    - Infant CPR and Safety Classes *(new or expectant parents or grandparents, family members or babysitters interested in learning about infant safety)*
    - Newborn Care Classes *(new parents, adoptive parents, grandparents and other caregivers)*
    - C-Section Class *(helps parents prepare for cesarean birth and recovery)*
    - Labor of Love *(instruction in pregnancy, labor and birth, comfort measures, medical procedures, cesarean section birth, and postpartum)*
    - Understanding Breastfeeding Class
- **Lactation Consultants**
  - Available to provide breastfeeding support during and after mom's hospital stay.
- **Nurses for Newborns**
  - Nurses for Newborns is an organization that helps provide critical healthcare services through their "Nurse Home Visiting Program" to infants and prenatal mothers who experience a wide range of medical, economic, environmental, and social risks. Most of their support is post-discharge, after the hospital stay. They target families that are most

at-risk in an effort to prevent infant mortality, child abuse and neglect by providing in-home nursing visits which promote healthcare, education, and positive parenting skills.

- **March of Dimes**
    - March of Dimes works to improve the health of all moms and babies. One of their goals is to end pre-term labor, which helps decrease NICU admissions.
    - HCA and TriStar provide monetary donations and participate in community events (i.e. March for Babies) to help fund research and provide patient support.
- **Rachel's Gift**
    - Infant loss and bereavement support *(see attached PowerPoint).*
    - Through educational courses and resources provided by Rachel's Gift, our partner hospitals are equipped to provide appropriate and compassionate care for moms who experience miscarriage, still-born birth and infant loss while in our care. The Rachel's Gift team also provides patients access to contiguous support beyond their hospital stay.
- **Dolly Parton's Imagination Library**
    - Offer sign-up sheets for Dolly's Imagination Library to parents. Once registered, the baby receives a book from Dolly every month until they are 5 years old.

13. **Data Requirements: Applicants shall agree to provide the Department of Health and/or the Health Services and Development Agency 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.**

RESPONSE:

TCH 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.

14. **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.**

RESPONSE:

TCH is a new hospital and therefore has no operational history.

TCH will participate in data reporting, quality improvement and outcome and process monitoring consistent with all TriStar Health facilities. As a future hospital in the TriStar Health organization, TCH will adopt TriStar Health methods to ensure and maintain quality of care. This includes a collaborative multidisciplinary team approach, which considers the unique knowledge, judgment, and skills of a variety of disciplines in achieving desired patient outcomes, serving as a foundation for quality.

TCH will be committed to providing a seamless continuum of health care both for individuals including neonates and for the community, linking together a full range of health care providers and services. TCH's goal will be to provide services which are measurably more accessible, affordable, and which are improving in quality on a continuous basis. The continuum of services may begin prior to admission, such as in an

ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

TCH will 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 will guide the improvement process. TCH will address methods to ensure and maintain patients' quality of care.

The NICU will also participate in unit-specific, departmental and hospital-wide performance improvement activities. Its performance Improvement activities are designed to provide a planned, systematic approach to process design, performance measurement, assessment, and improvement. Performance improvement activities are reported through the designated facility committees. Patient safety initiatives including infant security, staffing effectiveness, and code review are reported to the hospital's Department of Quality and Risk on a specific schedule for assimilation with findings from other areas of the facility. For more details, see **Attachment 1N -2**, **NICU** for TriStar Health's policy related to the Provision of Care for its NICU.

TCH will be dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. It will maintain the highest standards and quality of care. It will provide a robust Quality Assurance and Performance Improvement ("QAPI") Plan 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, TCH will provide 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 will play an important advisory purpose in enhancing and maintaining the quality of care provided. Systems will be 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** for TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence.

Lastly, TCH will comply with the quality recommendations of the Neonatal Intensive Care Technical Advisory Group including but not limited to demonstrating a commitment to evidence-based practices through the documentation of a Quality Improvement Plan each time they are verified or re-verified, continuous participation in an annual quality improvement initiative with a performance improvement program, such as Tennessee Initiative for Perinatal Quality Care (TIPQC), and proof of participation to the Health Facilities Commission annually of 1) enrollment in an approved QI collaborative, and 2) productive engagement in the QI collaborative over the period prior to re-verification.

15. **Tennessee Initiative for Perinatal Quality Care (TIPQC): The applicant is encouraged to include a description of its plan to participate in the TIPQC.**

RESPONSE:

The Tennessee Initiative for Perinatal Quality Care (TIPQC) seeks to promote meaningful change, advance health equity, and improve the quality of care through pregnancy, delivery, and beyond for all Tennessee families. TIPQC is the state's perinatal quality improvement collaborative, founded in 2008 through a grant from the Governor's Office to engage hospitals, practitioners, payers, families, and communities in its mission. Throughout Middle Tennessee, TriStar Health hospitals partnered with TIPQC include the following:

- TriStar Centennial Medical Center
- TriStar Horizon Medical Center
- TriStar NorthCrest Medical Center
- TriStar StoneCrest Medical Center
- TriStar Hendersonville Medical Center
- TriStar Summit Medical Center

A newer program at TIPQC is TeamBirth. It is a joint project with TIPQC and Ariadne Labs supporting open communication among patients, their support people, and clinicians during birth. Through structured huddles and a shared planning board, the goal of TeamBirth is to empower everyone to reach decisions together. The result is more dignified, respectful care that gives patients the role that they want. TriStar Centennial Medical Center is actively participating in TeamBirth; TriStar StoneCrest Medical Center plans to participate in the future. University of Tennessee Medical Center, Knoxville (previously implemented) has also joined as a mentor. TCH plans to participate in TIPQC as do other TriStar Health affiliates in Middle Tennessee which will also comply with the Neonatal Intensive Care Technical Advisory Group Quality recommendations.

1. **Compliance with Standards: The Division of Health Planning is working with stakeholders to develop a framework for greater accountability to these Standards and Criteria. Applicants should indicate whether they intend to collaborate with the Division and other stakeholders on this matter.**

RESPONSE:

TriStar Clarksville Hospital ("TCH") will collaborate with the Division of Health Planning and other appropriate stakeholders regarding a framework for greater accountability to the Standards and Criteria for cardiac catheterization services.

2. **Facility Accreditation: If the applicant is not required by law to be licensed by the Department of Health, the applicant should provide documentation that the facility is fully accredited or will pursue accreditation by the Joint Commission or another appropriate accrediting authority recognized by the Centers for Medicare and Medicaid Services (CMS).**

RESPONSE:

TCH is a new hospital and therefore has no operational history. TCH will be licensed by the Department of Health and seek accreditation by The Joint Commission.

In addition, TCH will seek certification or accreditation to be a STEMI receiving facility. TCH will also pursue Chest Pain Certification from The Joint Commission. In addition, TCH will seek accreditation as an Advanced Primary Stroke Center and designation as a Level III Trauma Center.

3. **Emergency Transfer Plan: Applicants for cardiac catheterization services located in a facility without open heart surgery capability should provide a formalized written protocol for immediate and efficient transfer of patients to a nearby open heart surgical facility (within 60 minutes) that is reviewed/tested on a regular (quarterly) basis.**

RESPONSE:

TCH will have a formalized written emergency transfer protocol with TriStar Centennial to ensure patients can be transported within 60 minutes. It will also use Vital Engine, a communication tool used between its cardiologists and cardiac surgeons, which is an enhanced means to share patient information including images among physicians. The hospital will also adopt a "Cardiac Cath Lab Emergency Transfer Policy" to assure an organized process to transfer in accordance with American College of Cardiology ("ACC") guidelines. Specifically, its policy will include the following elements:

- Purpose: To provide continuity of care and ensure patients are transferred safely and efficiently within an appropriate period of time as recommended by the ACC.
- Policy: Appropriate personnel should be notified for the emergent transport of a patient.
- Procedure for Cath Lab staff: The staff should:
    - Call the Transfer Center for ambulance service for critical care transport, providing the Patient Name, Weight, Referring Physician, and Reason for Transfer;
    - Notify the nursing supervisor;

    - Report to the staff at the receiving facility, which should include: patient name, reason for transfer, vital signs, meds administered, ETA, admitting physician and necessary equipment that should be available, including support devices i.e. IABP/ IMPELLA;
    - Prepare Cardiac Cath images and documentation to be transported with patient;
    - Ensure the EMTALA transfer form is completed for all Observation and ER patients; and
    - Ensure a copy of the EMTALA sheet is retained at the facility and a copy sent to the receiving facility.
- Procedure for cardiologist: The cardiologist should contact physician at the receiving facility, and fill out the physician part of the EMTALA form.
- Procedure for nursing supervisor: The nursing supervisor should:
    - Ensure the medical records are copied.
    - Notify ER to direct ambulance to CCL.
    - Explain the transfer process to the patient's family.
    - Ensure EMTALA form is completed.
- Transporting the Patient: The patient will be accompanied by an Advanced Cardiovascular Life Support ("ACLS") certified RN, or ALS crew if transport by private ambulance services, under the direction of the referring cardiologist. During transport, the patient will be reassessed continuously to ensure all equipment (i.e., IABP) is functioning properly. If necessary, the cardiologist will accompany the patient. In addition, the accompanying individual will be responsible for ensuring the entire patient record accompanies the patient to the receiving facility.

A sample copy of the above described policy is included in **Attachment 1N-2, Cardiac**.

4. Quality Control and Monitoring: Applicants should document a plan to monitor the quality of its cardiac catheterization program, including, but not limited to, program outcomes and efficiency. In addition, the applicant should agree to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, which may be developed per Policy Recommendation 2.

RESPONSE:

TCH, including its cardiac catheterization program, will participate in data reporting, quality improvement and outcome and process monitoring as is consistent with all Tristar Health facilities. As a future hospital within the TriStar Health network, TCH will adopt the TriStar Health methods to ensure and maintain quality of care. This includes a collaborative multidisciplinary team approach, which considers the unique knowledge, judgment, and skills of a variety of disciplines in achieving desired patient outcomes, serving as a foundation for quality.

TCH will be 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. TCH's goal will be to provide services which are measurably more accessible, affordable, and focused on continuous quality improvement. The continuum of services may begin prior to admission, such as in an ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

Within this context, TCH will 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 will guide the improvement process. TCH will address methods to ensure and maintain patients' quality of care. The proposed cardiac catheterization program will be incorporated into the overall quality plan summarized above and discussed in Question 5C of the CON Form.

In addition, TCH will participate in the American College of Cardiology Foundation's National Cardiovascular Data Registry ("NCDR"). The NCDR measurement processes include evaluation and reporting on patients treated, procedures performed, PCI performance measures, quality metrics, outcome measures, diagnostic metrics, efficiency metrics, safety metrics and appropriate use criteria (AUC) metrics. Specific PCI metrics incorporated into TriStar Health's quality monitoring and tracked on a monthly basis include mortality, complications such as bleeding, stroke, etc., outcomes, processes such as recorded times to procedure, creatinine levels, cardiac rehab referrals, and discharge medications.

In addition, TCH agrees to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee.

5. **Data Requirements: Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency 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 of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.**

RESPONSE:

TCH 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.

6. **Clinical and Physical Environment Guidelines: Applicants should agree to document ongoing compliance with the latest clinical guidelines of the American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards (ACC Guidelines). As of the adoption of these Standards and Criteria, the latest version (2001) may be found online at:**

   http://www.acc.org/qualityandscience/clinical/consensus/angiography/dirIndex.html

   Where providers are not in compliance, they should maintain appropriate documentation stating the reasons for noncompliance and the steps the provider is taking to ensure quality. These guidelines include, but are not limited to, physical facility requirements, staffing, training, quality assurance, patient safety, screening patients for appropriate settings, and linkages with supporting emergency services.

RESPONSE:

TCH agrees to document ongoing compliance with the latest clinical guidelines of the American College of Cardiology / Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document of Cardiac Catheterization Laboratory Standards (ACC Guidelines). These include, but are not limited to, the following AHA/ACC Clinical Practice Guidelines and Performance Measures:

- 2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain;
- 2017 AHA/ACC Clinical Performance and Quality Measures for Adults With ST-Elevation and Non–ST-Elevation Myocardial Infarction;
- 2014 AHA/ACC Guideline for the Management of Patients With Non–ST-Elevation Acute Coronary Syndromes; and
- 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction.

TCH will also comply with guidelines that address physical facility requirements, staffing, training, quality assurance, patient safety, screening patients for appropriate settings, and linkages with supporting emergency services.

7. Staffing Recruitment and Retention: The applicant should generally describe how it intends to maintain an adequate staff to operate the proposed service, including, but not limited to, any plans to partner with an existing provider for training and staff sharing.

RESPONSE:

Currently practicing within the TriStar Health affiliated hospitals throughout Middle Tennessee are cardiology providers who are affiliated with Tennessee Heart & Vascular Institute ("THV"). THV is one of the leading cardiac practices in Northern Middle Tennessee. In 1984, THV began with Dr. Tracy Callister and Dr. Donald Russo in Hendersonville, Tennessee. Since that time, THV's practice has grown to include 14 providers serving patients in 12 locations, which includes a satellite clinic in Montgomery County. THV providers have been treating patients at its clinic off Center Pointe Drive in Clarksville since December 2010. The two physicians currently practicing at this clinic are Christopher Conley, MD and Terry Ketch, MD. THV providers include non-invasive cardiologists, invasive cardiologists, and interventional cardiologists, all of whom practice exclusively in Middle Tennessee. THV providers currently operate at the cardiac catheterization labs at TriStar Skyline Medical Center, TriStar NorthCrest Medical Center and TriStar Hendersonville Medical Center.

Additionally, Centennial Heart Cardiovascular Consultants ("Centennial Heart") practices at other TriStar Health affiliated hospitals in Middle Tennessee. This physician group includes 45 non-invasive cardiologists, invasive cardiologists, and interventional cardiologists, most of whom are located in Middle Tennessee. Bryan Doherty, MD with Centennial Heart also has been treating patients at his clinic in Clarksville. Tom McRae, MD, another of its physicians, serves as TriStar's Physician Director Cardiovascular Service Line. Dr. McRae offers his support and insights regarding TCH:

> *I am writing to extend my support for the addition of a full-service hospital in the city of Clarksville, Tennessee. Right now, Clarksville has only one hospital within the city and more than 50% of residents choose to travel long distances to neighboring cities to receive hospital services. With a rapidly growing population that is expected to exceed 200,000 people by 2028, there is a growing need for Clarksville residents to have increased access to hospital-based care. TriStar has a team of experienced cardiologists, leaders in cardiac care and offer the latest advancements in cardiology and electrophysiology. If the TriStar Clarksville Hospital is approved, we look forward to helping staff the new hospital. TriStar Health facilities are known to be high quality and this brand-new facility will certainly provide the latest and most advanced cardiac services. … Greater access and choice are always beneficial to patients and their families. I personally see a great need for this facility and look forward to seeing it built.*

Tom McRae, MD
Physician Director Cardiovascular Service Line

TriStar Cardiology Partners (THV and Centennial Heart) are engaged in the planning for TCH's proposed cardiac catheterization program. The plan for TCH includes non-invasive cardiologists, invasive cardiologists, interventional cardiologists including EP physicians, and heart failure physician specialists supported by their extenders. Interventional cardiologists will staff the cardiac catheterization lab, while being supported by advance practice providers. In addition, TCH and TriStar Cardiology Partners will coordinate with TriStar Health affiliates for staffing and recruitment of additional providers as needed.

Current THV physicians named at this early stage to be practicing at TCH include Chris Conley, MD and Terry Ketch, MD. An advanced practice provider will be selected to work with these physicians. In addition to those at TCH, other TriStar Cardiology Partner providers may be rotated among other TriStar Health hospitals and TCH to provide for continuity and collaboration of cardiac catheterization services amongst the practitioners and hospitals. TriStar Cardiology Partners are committed to staff the TCH cardiology program and its cardiac catheterization laboratory.

The Medical Director of the TCH Cardiac Catheterization program will oversee its clinical services and quality and assure appropriate physician coverage 24/7 at this location. The cardiac services planned for TCH and its heart program include the following:

Exhibit 1N, Cardiac Cath – 1
Cardiac Diagnostic, Testing & Procedures Proposed for TriStar Clarksville Hospital

Diagnostic & Procedures	**Status**
Angiography	Upon Licensure
Cardiac catheterization	Upon Licensure
Cardiac CT	Upon Licensure
Doppler Ultrasound	Upon Licensure
Electrocardiogram (ECG or EKG)	Upon Licensure
Electrocardiography	Upon Licensure
Pacemakers	Upon Licensure
Holter Monitoring	Upon Licensure
Intravascular Ultrasound	Upon Licensure
Nuclear Stress Test	Upon Licensure
Stress Echocardiography	Upon Licensure
Tilt Tables	Upon Licensure
Heart Failure Program	Upon Licensure

Additionally, TriStar Cardiology Partner providers are expected to initiate EP procedures during its second year of operation; currently EP procedures are not available within Montgomery County.

Today, TriStar Health has 523 employees residing in Montgomery County given its affiliates' services both in and in counties surrounding Montgomery County. Of these, 483 provide direct patient care including many who work in the various cardiac services at TriStar Health affiliates. The cardiac catheterization lab non-physician staff will be recruited through the TriStar Health network based on its current recruitment

methods. Given its ability to staff its quality cardiac programs throughout Middle Tennessee, it is confident it will successfully recruit qualified personnel to staff the TCH cardiac catheterization program.

8. Definition of Need for New Services: A need likely exists for new or additional cardiac catheterization services in a proposed service area if the average current utilization for all existing and approved providers is equal to or greater than 70% of capacity (i.e., 70% of 2000 cases) for the proposed service area.

RESPONSE:

TCH's Service Area is Montgomery County and Stewart County. Montgomery County has one hospital; Stewart County has no hospital. Within Montgomery County, the one hospital – Tennova Clarksville Hospital – operates two cardiac catheterization laboratories. Tennova Clarksville operates at 70 percent capacity as reflected in **Exhibit 1N, Cardiac Cath-2.**

Exhibit 1N, Cardiac Cath – 2
Tennova Clarksville Hospital Utilization, 2023

Procedure Type	Setting	Procedure Weight	# Labs	# Cases	Weighted Cases (Adult)	Pediatric	Weighted Cases (Pediatric)	Total Cases	Total Weighted Cases	Weighted Cases Per Lab	Utilization per 2,000 Cases (Full Capacity)	Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity)
Diagnostic Cardiac Catheterization	Inpatient	1.0	2	430	430	0	0	430	430	215		
	Outpatient	1.0	2	767	767	0	0	767	767	383.5		
Therapeutic Cardiac Catheterization	Inpatient	2.0	2	310	620	0	0	310	620	310		
	Outpatient	2.0	2	484	968	0	0	484	968	484		
Diagnotic EP	Inpatient	2.0	2	0	0	0	0	0	0	0		
	Outpatient	2.0	2	0	0	0	0	0	0	0		
Therapeutic EP	Inpatient	4.0	2	0	0	0	0	0	0	0		
	Outpatient	4.0	2	0	0	0	0	0	0	0		
Diagnostic Peripheral Vascular	Inpatient	1.5	2	0	0	0	0	0	0	0		
	Outpatient	1.5	2	0	0	0	0	0	0	0		
Therapeutic Peripheral Vascular	Inpatient	3.0	2	0	0	0	0	0	0	0		
	Outpatient	3.0	2	0	0	0	0	0	0	0		
Thrombolytic Therapy	Inpatient	3.0	2	0	0	0	0	0	0	0		
	Outpatient	3.0	2	0	0	0	0	0	0	0		
Total			2	1,991	2,785	0	0	1,991	2,785	1,393	70%	99%

Source: Tennova Clarksville JARs, 2023 and Cardiac Catheterization Standards and Criteria Weighting Table

In addition to a single year period, the Tennova Clarksville cardiac catheterization utilization is provided below for the most recent three Joint Annual Report ("JAR") years, years 2021 through 2023, as reported in its Joint Annual Reports. The following table provides a summary from the above chart with the first line providing the 2023 information, and the second line providing the average of the most recent three-year period. As shown below, Tennova Clarksville utilization has increased from the three year period to the most recent period, now reaching the 70 percent threshold indicated by this criterion.

Exhibit 1N, Cardiac Cath – 3
Tennova Clarksville Hospital Utilization, 2023 and 3-Year Average (2021 – 2023)

Time Period	# Cath Labs	Avg. Weighted Diagnostic Catheterizations	Diagnostic Catheterizations per Lab	Avg. Weighted Therapeutic Catheterizations	Therapeutic Catheterizations per Lab	Avg. Weighted Diagnostic and Therapeutic Catheterizations	Utilization per 2,000 Cases (Full Capacity)	Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity)
2023 Year	2	1,197	599	1,588	794	2,785	70%	99%
2021 - 2023 3-Year Average	2	1,124	562	1,037	519	2,161	54%	77%

Source: Tennova Clarksville JARs, 2023 and Cardiac Catheterization Standards and Criteria Weighting Table

Based on the stated 2023 capacity as presented above, there is need for additional cardiac catheterization services as proposed by TCH. Locating the additional capacity at TCH will provide consumers with a choice of providers, different cardiac physicians and access to TriStar Health facilities locally. Access enhancement and mitigation of out-migration will be benefits for Service Area residents as demonstrated throughout this CON Application.

The degree of heart muscle damage from a heart attack is associated with how long it takes from when heart attack symptoms start to when patients receive an artery-clearing procedure called percutaneous coronary intervention ("PCI"). The longer the time before PCI, called "symptom-to-balloon time", the more significant and damaging the heart attack. Symptom-to-balloon time directly correlates with the amount of time the myocardium/heart muscle undergoes inadequate blood supply. Shorter symptom-to-balloon times for individual patients is also associated with lower mortality at 30-days and at 1 year. Accordingly, reducing such time should reduce the degree of damage and ultimately improve patient outcomes.

For patients experiencing myocardial infarction ("MI")/heart attack, ACC, the American Heart Association (AHA), and the European Society of Cardiology have all concluded that the earlier therapy is initiated, the better the outcome.

Per the travel times presented in response to **Question 4N** in the CON Form, time to reach hospitals outside of Clarksville requires an hour or more of additional travel time than accessing TCH. The availability of TCH and its proposed catheterization laboratories in Clarksville would save these patients 60+ minutes in the symptom-to-balloon time. Time is muscle, and these minutes could be critical in patient outcomes.

TDOH provided the average number of diagnostic and therapeutic caths by resident county for 2021 to 2023. The average represents the total for the three years divided by three. As a result, use trends are not available. By county, the following was reported in the provided data set.

Exhibit 1N, Cardiac – 4

County	3 Year Average Diagnostic Caths	3 Year Average Therapeutic Caths	3 Year Total Caths
Montgomery	1,586.7	1,418.7	3,005.3
Stewart	180.3	181.3	361.7

Source: TDOH Data Request 35551128; data provided by resident county not hospital or hospital county.

The rates above do not indicate where the procedures were performed, so they include both in county service and out-migration for Montgomery County. Since Stewart County has no cardiac cath labs, there is 100 percent out-migration from Stewart County. However, given the defined service area, it would be

expected some patients would be treated in Montgomery County. Using THA data by Service Area county, we can identify where cases by county of residence were performed. CY 2023 is masked due to THA policy. **Exhibit 1N, Cardiac Cath – 5** provides this information.

Exhibit 1N, Cardiac Cath – 5
Cardiac Catheterizations by Service Area County and Related Out-Migration

	CY 2021	CY 2022	CY 2023
Montgomery County Residents			
Tennova Clarksville	1,516	1,403	Masked
Other Hospitals (Out-Migration)	1,002	999	
Total Montgomery County	2,518	2,402	2,729
Out-Migration	39.8%	41.6%	Masked
Stewart County Residents			
Tennova Clarksville	127	125	Masked
Other Hospitals (Other Out-Migration)	154	170	
Total Stewart County	281	295	293
Out-Migration from Service Area	54.8%	57.6%	Masked
Service Area			
Tennova Clarksville	1,643	1,528	Masked
Other Hospitals (Other Out-Migration)	1,156	1,169	
Total Service Area	2,799	2,697	3,022
Out-Migration from Service Area	41.3%	43.3%	Masked

Source: THA data.

Out-migration from Montgomery County approximates 40 percent while Stewart County is 56 percent from the Service Area. Combined the total is between 41 and 43 percent. Reaching a cardiac cath program outside the counties takes between 1 and 2 hours depending on the county origin and the destination. When time is muscle, this is critical and valuable time for survival and recovery.

The next table provides more detailed information on the outmigration identified above.

Exhibit 1N, Cardiac Cath – 6
Out-Migration by Destination Hospitals

Inpatient and Outpatient Cardiac Catheterization						
	CY 2021	**CY 2022**	**CY 2023**	**CY 2021**	**CY 2022**	**CY 2023**
Montgomery County Residents						
Number of Patients Who Out-Migrated	1,002	999	Masked	39.8%	41.6%	Masked
Number of Patients to TriStar Centennial	200	177	176	7.9%	7.4%	Masked
Number of Patients to Tristar Other	58	70	78	2.3%	2.9%	Masked
Out-Migration to Other Providers	744	752	Masked	29.5%	31.3%	Masked
Total and Percent of Out-Migration to TriStar	258	247	254	25.7%	24.7%	Masked
Stewart County Residents						
Number of Patients Who Out-Migrated	154	170	Masked	54.8%	57.6%	Masked
Number of Patients to TriStar Centennial	21	20	17	7.5%	6.8%	Masked
Number of Patients to Tristar Other	19	13	17	6.8%	4.4%	Masked
Out-Migration to Other Providers	114	137	Masked	40.6%	46.4%	Masked
Total and Percent of Out-Migration to TriStar	40	33	34	*26.0%*	*19.4%*	*Masked*

An average of 1,000 Montgomery County residents each year out-migrate from Montgomery County. Additionally, approximately 170 Stewart County residents bypass Montgomery County. This confirms the lack of access or consumers desiring a choice of providers. Of those out-migrating, approximately 25 percent have their catheterizations at TriStar Health hospitals.

This criterion indicates applying the State Utilization rates to the Service Area if there are no existing cardiac catheterization programs in the Service Area. While there is an existing program in Montgomery County, but none in Stewart County which is also in the Service Area. The State Utilization Rates provided by TDOH are provided in the following table.

Exhibit 1N, Cardiac Cath -7

Cardiac Cath - State Utilization Rates

Three-Year Average - Highest Weighted Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2021-2023

Diagnostic Cardiac Caths			
Age Grp	Diagnostic Cardiac Caths	TN Resident Population	Utilization Rate
Total	70,478	7,051,009	0.009995478
0 - 17	1,301	1,539,414	0.000845322
18 - 29	536	1,124,549	0.000476902
30 - 39	1,539	945,967	0.001626907
40 - 44	2,141	443,376	0.004828859
45 - 49	3,507	420,871	0.008332713
50 - 54	5,767	452,880	0.012734711
55 - 59	7,912	455,129	0.017382996
60 - 64	9,981	452,734	0.022046737
65 - 69	11,254	403,334	0.027902410
70 - 74	10,624	330,076	0.032186527
75 - 79	8,510	230,266	0.036955955
80 - 84	4,943	137,914	0.035841091
85 +	2,463	114,498	0.021508611

Therapeutic Cardiac Caths			
Age Grp	Therapeutic Cardiac Caths	TN Resident Population	Utilization Rate
Total	65,157	7,051,009	0.009240763
0 - 17	2,996	1,539,414	0.001946196
18 - 29	879	1,124,549	0.000781380
30 - 39	1,634	945,967	0.001727651
40 - 44	1,558	443,376	0.003513948
45 - 49	2,495	420,871	0.005928890
50 - 54	4,036	452,880	0.008912509
55 - 59	5,903	455,129	0.012969299
60 - 64	8,455	452,734	0.018676102
65 - 69	10,301	403,334	0.025539606
70 - 74	10,373	330,076	0.031427005
75 - 79	8,784	230,266	0.038148489
80 - 84	5,036	137,914	0.036515422
85 +	2,705	114,498	0.023627419

Cardiac Cath ICD-9, ICD-10, CPT codes and service categories provided by the Bureau of TennCare and the Tennessee Hospital Association.

Source: Tennessee Department of Health, Division of Population Health Assessment.

Hospital Discharge Data System, 2021-2023. Nashville, TN.

Health Statistics Population Series, 2021-2023. Nashville, TN.

Source: TDOH Data Request 35551128.

Given there is an existing program in the Service Area at Tennova Clarksville, and it operates at capacity, there is defined need for a program in the Service Area. It should be noted that applying the above rates to the Service Area population of Montgomery and Stewart Counties indicates a Service Area demand of 7,078 catheterizations in 2029 increasing to 7,443 in 2031.

Given historical Service Area resident utilization patterns, forecasted cardiac catheterizations were computed applying Service Area actual utilization rates to the forecasted population. The resulting Service Area forecasted utilization is presented in the following exhibit.

Exhibit 1N, Cardiac – 8

Total Cardiac Catheterization (Inpatient and Outpatient)			
	Year 1	**Year 2**	**Year 3**
Service Area			
Montgomery County	3,230	3,312	3,394
Stewart County	305	306	307
Service Area Total	**3,535**	**3,618**	**3,701**

With more than half of Service Area residents currently leaving the area, TCH's cardiac catheterization laboratories will significantly improve access and mitigate out-migration. Based on evaluation of migration patterns and associated anticipated percent of patients who will seek services at the proposed hospital,

the following percent of patients are estimated to utilize the proposed cardiac catheterization laboratories at TCH.

Exhibit 1N, Cardiac Cath – 9

Estimated Percent of TriStar Clarksville Hospital Patients			
	Year 1	**Year 2**	**Year 3**
Cardiac Catheterizations			
Montgomery County	9.0%	14.0%	16.0%
Stewart County	7.0%	10.0%	12.0%
Service Area Total	8.8%	13.7%	15.7%

Applying the above rates to the forecasts accounts for 80 percent of the forecasted patient population. As discussed in the CON Form, the Service Area is defined as 80 percent of the hospital's utilization with the remaining 20 percent emanating from outside the Service Area. Accordingly, the next table provides forecasted utilization at TCH.

Exhibit 1N, Cardiac Cath – 10

Forecasted Cardiac Catheterizations at TriStar Clarksville Hospital			
	Year 1	**Year 2**	**Year 3**
Service Area			
Montgomery County	291	464	543
Stewart County	21	31	37
Service Area Total	**312**	**494**	**580**
Out of Area (20%)	78	124	145
Total Utilization	**390**	**618**	**725**

The above forecasted utilization includes both diagnostic and therapeutic catheterizations. Based on experience, it is estimated that diagnostic catheterizations will represent 75 percent of cases and therapeutic catheterizations will represent 25 percent of cases. This results in the following catheterization counts by year.

Exhibit 1N, Cardiac Cath – 11

Diagnostic and Therapeutic Catheterization Distribution			
	Year 1	**Year 2**	**Year 3**
Diagnostic Catheterizations	293	463	544
Therapeutic Catheterizations	98	154	181
Total Catheterizations	390	618	725

Forecasted utilization confirms greater than 400 total cases per year by year two. In addition, therapeutic cases exceed 75 per year.

9. **Proposed Service Areas with No Existing Service: In proposed service areas where no existing cardiac catheterization service exists, the applicant must show the data and methodology used to estimate the need and demand for the service. Projected need and demand will be measured for applicants proposing to provide services to residents of those areas as follows:**

Need. The projected need for a service will be demonstrated through need-based epidemiological evidence of the incidence and prevalence of conditions for which diagnostic and/or therapeutic catheterization is appropriate within the proposed service area.

Demand. The projected demand for the service shall be determined by the following formula:

A. Multiply the age group-specific historical state utilization rate by the number of residents in each age category for each county included in the proposed service area to produce the projected demand for each age category;

B. Add each age group's projected demand to determine the total projected demand for cardiac catheterization procedures for the entire proposed service area.

RESPONSE:

Not applicable.

10. Access: In light of Rule 0720-4-.01 (1), which lists the factors concerning need on which an application may be evaluated, the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

b. Who documents that the service area population experiences a prevalence, incidence and/or mortality from heart and cardiovascular diseases or other clinical conditions applicable to cardiac catheterization services that is substantially higher than the State of Tennessee average;

c. Who is a "safety net hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program; or

d. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program.

RESPONSE:

TriStar Health is currently contracted with three TennCare MCOs in all its Middle Tennessee facilities, including with its facilities in contiguous counties of Robertson (TriStar NorthCrest) and Dickson (TriStar Horizon). TCH herein provides its written commitment to contract with these TennCare MCOs and is therefore entitled to special consideration under this criterion. In addition, TCH will seek Medicare certification upon licensure and will participate in the Medicare program.

Criterion 11 through 13 are Not Applicable as the Applicant is proposing to provide both diagnostic and therapeutic catheterizations.

14. Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 400 diagnostic and/or therapeutic cardiac catheterization cases per year by its third year of operation. At least 75 of these cases per year should include a therapeutic cardiac catheterization procedure. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. Only cases including diagnostic and therapeutic cardiac catheterization procedures as defined by these Standards and Criteria shall count towards meeting this minimum volume standard.

RESPONSE:

As detailed in response to #9 above, TCH forecasts performing 725 total cardiac catheterizations in its third year of operation, 181 of which will be therapeutic cardiac catheterizations. The following exhibit summarizes the forecasted TCH annual activity and provides the averages of year two and year three as requested.

Exhibit 1N, Cardiac Cath – 12
Annual TCH Cardiac Catheterization Forecast and Year Two/Three Average

Procedure	Year 1	Year 2	Year 3	Total	Year 2/3 Average
Diagnostic Catheterizations	293	463	544	1,300	504
Therapeutic Catheterizations	98	154	181	433	168
Total Catheterizations	390	618	725	1,733	671

15. **Open Heart Surgery Availability: Acute care facilities proposing to offer adult therapeutic cardiac catheterization services shall not be required to maintain an on-site open heart surgery program. Applicants without on-site open heart surgery should follow the most recent American College of Cardiology/American Heart Association/Society for Cardiac Angiography and Interventions Practice Guideline Update for Percutaneous Coronary Intervention (ACC/AHA/SCAI Guidelines). As of the adoption of these Standards and Criteria, the latest version of this document (2007) may be found online at**: http://circ.ahajournals.org/cgi/reprint/CIRCULATIONAHA.107.185159

RESPONSE:

THV and Centennial Heart interventionalists currently triage and transfer high risk or unstable patients from other hospitals without open heart surgery availability to TriStar Centennial based on ACC guidelines. The TCH interventionalists will similarly triage and transfer high risk or unstable patients from TCH per the ACC guidelines. Furthermore, TCH will maintain an emergency transfer protocol with TriStar Centennial to provide tertiary level care if an appropriate patient experiences an adverse event during a catheterization. Cardiac surgery is supported by TriStar Medical Group Cardiovascular Surgery, which also provides support for TCH and will work with the TCH TriStar Cardiology Partners to provide the quality care for which it is known.

> *I am writing to extend my support for the addition of a full-service hospital in the city of Clarksville, Tennessee. … TriStar has a team of experienced cardiac surgeons and cardiologists who are leaders in cardiac care. TriStar Health facilities have documented high quality care and treatment, and this brand-new facility will certainly provide the latest and most advanced cardiac catheterization facilities among other services. If the TriStar Clarksville Hospital is approved, we look forward to replicating TriStar's seamless process for surgical patient transfers to Centennial Medical Center for advanced care while increasing access to a local facility for patients of the region.*
>
> *V. Seenu Reddy, MD, MBA, FACS, FACC*
> *Tristar Medical Group Cardiovascular Surgery*

16. **Minimum Physician Requirements to Initiate a New Service: The initiation of a new therapeutic cardiac catheterization program should require at least two cardiologists with at least one cardiologist having performed an average of 75 therapeutic procedures over the most recent five year period. All participating cardiologists in the proposed program should be board certified or board eligible in cardiology and any relevant cardiac subspecialties.**

RESPONSE:

TCH will operate its cardiac catheterization laboratory in conjunction with Centennial Heart and THV. The initial physicians identified for the proposed hospital are Chris Conley, MD and Terry Ketch, MD.[1] These two cardiologists currently perform procedures at TriStar Skyline Medical Center. They also both have clinics in Clarksville, having such for many years, at the THV clinic identified above. Their current CVs are included in Attachment 1N, Cardiac. Additionally, several other THV and Centennial Heart physicians may also provide services at TCH. **Exhibit 1N, Cardiac - 14** includes Dr. Conley and Dr. Ketch's historic procedure volume during the past five years. **Exhibit 1N, Cardiac – 15** includes 24 other physicians in the two groups who have significant therapeutic catheterization procedure volume.

Exhibit 1N, Cardiac – 14

Christopher Conley, MD	**Yr. 1 (2020)**	**Yr. 2 (2021)**	**Yr. 3 (2022)**	**Yr. 4 (2023)**	**Yr. 5 (2024)**	**Total**	**5 Year Average**
Diagnostic Cardiac Catheterizations	629	838	696	728	619	3,510	702.0
Therapeutic Cardiac Catheterizations	73	79	97	107	87	442	88.4
TOTAL	702	916	793	835	706	3,952	790.3
Terry Ketch, MD	**Yr. 1 (2020)**	**Yr. 2 (2021)**	**Yr. 3 (2022)**	**Yr. 4 (2023)**	**Yr. 5 (2024)**	**Total**	**5 Year Average**
Diagnostic Cardiac Catheterizations	870	1,029	1,107	1,256	1,040	5,302	1060.4
Therapeutic Cardiac Catheterizations	27	29	35	44	26	160	32.0
TOTAL	897	1058	1142	1299	1066	5,462	1092.4

Source: Internal records.

Dr. Conley has performed more than 75 therapeutic procedures annually. Dr. Ketch currently does not meet this requirement. However, it is expected during 2025 through 2028, Dr. Ketch's therapeutic volume will increase to meet this minimum criterion. Four other THV interventionalists meet this requirement and THV's new physicians added to its practice also anticipate meeting this requirement by the time TCH is licensed and operational.

Further, in addition to THV, many Centennial Heart physicians will meet the minimum and are also available. Those THV and Centennial Heart physicians with a current three year average greater than 70 therapeutic catheterizations are shown in **Exhibit 1N, Cardiac – 15**. In addition to those physicians, there are others in these two TriStar Cardiology Partner practices with a smaller but increasing volume who anticipate achieving the 75 therapeutic procedure per year by TCH's opening.

[1] These two physicians are those who are initially identified for TCH. With TCH opening in 2029, it is likely other THV and Centennial Heart physicians who meet the required qualifications will be recruited and perform procedures at TCH.

Exhibit 1N, Cardiac – 15
Annual and Average Therapeutic Catheterizations by Year
TriStar Cardiology Partners with Greater Than 70 per Year on Average

	CY 2022	CY 2023	CY 2024	Average/Year
THV Physicians				
Butera, Brian	17	90	109	72
Callister, Tracy	73	82	71	75
Kudelko, Paul	98	84	91	91
Tonavin, Toug	112	82	116	103
Centennial Heart Physicians				
Allan, Michael	99	133	101	111
Jefferson, Brian	431	457	408	432
Wiisanen, Matthew	199	232	131	187
Basshian, Greg	107	129	150	129
Webber, Jeffrey	209	207	175	197
Goodman, Andrew	199	241	219	220
Jones Robert	124	124	137	128
Borek, Peter	128	146	127	134
Horr, Samuel	182	179	128	163
Haitas, Byron	162	126	121	136
Patel, Parag	75	88	70	78
Honeycutt, David	73	87	90	83
Johnston, Thomas	72	66	71	70
Hoda, Johnathon	131	167	134	144
Dorfman, Todd	265	236	196	232
Ali, Fathi	76	88	123	96
Gage, Anne	124	164	168	152
Mandsager, Kyle	73	96	119	96
Aziz, Hammad	17	82	110	70
Biersmith, Michael	38	116	132	95

Source: Internal records

Each of the identified physicians is board certified and all additional physicians who will join the program will be either board certified or board eligible.

17. **Staff and Service Availability: Ideally, therapeutic services should be available on an emergency basis 24 hours per day, 7 days per week through a staff call schedule (24/7 emergency coverage). In addition, all laboratory staff should be available within 30 minutes of the activation of the laboratory. If the applicant will not be able to immediately provide 24/7 emergency coverage, the applicant should present a plan for reaching 24/7 emergency coverage within three years of initiating the service or present a signed transfer agreement with another facility capable of treating transferred patients in a cardiac catheterization laboratory on a 24/7 basis within 90 minutes of the patient's arrival at the originating emergency department.**

RESPONSE:

Cardiac catheterization services, including therapeutic services, will be available on an emergency basis 24 hours per day, 7 days per week through a staff call schedule (24/7 emergency coverage). In addition, all laboratory staff will be available within 30 minutes of the activation of the laboratory. In addition to assure emergency coverage, TCH will also have a transfer agreement in place with TriStar Centennial and others, as appropriate, as an alternate resource for patients who are unstable or high risk to enable treatment within 90 minutes of the patient's arrival at TCH.

18. **Expansion of Services to Include Therapeutic Cardiac Catheterization: An applicant proposing the establishment of therapeutic cardiac catheterization services, who is already an existing provider of diagnostic catheterization services, should demonstrate that its diagnostic cardiac catheterization unit has been utilized for an average minimum of 300 cases per year for the two most recent years as reflected in the data supplied to and/or verified by the Department of Health.**

RESPONSE:

Not applicable. TCH and its catheterization labs are proposed facilities to be implemented upon licensure of the hospital.

Criterion 19 through 24 are Not Applicable.

1. Determination of Need: The following methodology should be used and the need for hospital beds should be projected four years into the future from the current year.

RESPONSE:

The Tennessee Department of Health provides the information and formula to enable forecasting the need for hospital beds by county four years into the future using both licensed and staffed beds. As identified in Question 2N in the CON Form, the defined Service Area for the proposed TCH is Montgomery County and Stewart County.

Per the Department of Health's ("TDOH") most updated CON Acute Bed Need 2025-2029, Base 2023, the following exhibit provides the inpatient days stated by TDOH. The Stewart County line item had no entries as it has no hospitals and therefore zero inpatient days so that line item is not included in this exhibit.

Exhibit TDOH CON Acute Bed Need, Montgomery County

	2023		CURRENT*	SERVICE AREA POPULATION			PROJECTED 2025		PROJECTED 2029		2023 ACTUAL BEDS		SHORTAGE/SURPLUS	
COUNTY	INPATIENT DAYS	AVERAGE DAILY CENSUS	NEED	2023	2025	2029	ADC-2025	NEED 2025	ADC-2029	NEED 2029	LICENSED	STAFFED	LICENSED	STAFFED
Montgomery	48,628	133	167	129,141	133,683	142,706	138	172	147	184	270	237	-98	-53

Source: Tennessee Department of Health, CON Acute Bed Need 2025 2029 base 2023.

The source of the above patient days is not readily discerned from the Tennova Clarksville 2023 JARS. Its total patient days for Tennessee residents was 44,651, Kentucky residents from adjoining counties is 3,825 and total 49,206. The Tennessee and Kentucky patient days total 48,476, somewhat lower than the above. It is the Applicant's position that total patient days should be utilized. Additionally, the population in the above **Exhibit TDOH** for Montgomery County is incorrect. The next series of exhibits also correct the population with the actual population per the Boyd State Data Center projections used throughout this CON Application.

Exhibit 1N, Acute – 1 provides the bed need computation using total patient days obtained from the 2023 JARS reports, the acute care bed need formula published by the HFC and most recent population published by the Boyd Center.

Exhibit 1N, Acute – 1[1]

	2023		CURRENT*	SERVICE AREA POPULATION			PROJECTED 2025		PROJECTED 2029		2023 ACTUAL BEDS		SHORTAGE/SURPLUS	
COUNTY	INPATIENT DAYS	AVERAGE DAILY CENSUS	NEED	2023	2025	2029	ADC-2025	NEED 2025	ADC-2029	NEED 2029	LICENSED	STAFFED	LICENSED	STAFFED
Montgomery	49,206	135	162	240,745	251,815	273,822	141	169	153	182	270	237	-101	-55
Stewart	0	0	0	14,088	14,231	14,397	0	0	0	0	0	0	0	0
TOTAL	49,206	135	162	254,833	266,046	288,219	141	169	153	182	270	237	-101	-55

Source: Tennessee Department of Health, JARS in the respective counties, JARS Summary Table for 2023, and Population from Boyd Center file, TN_CoPopProj_2022. Table 1N-1 includes total inpatient days for acute hospitals in each county; it is not limited to Tennessee residents, Schedule G, #3, page 30.

[1] In evaluating the Bed Need Formula, TCH assumes that all of Tennova Clarksville's rooms are single occupancy. However, it is important to note that, as of the Tennova Clarksville Satellite Application (CN2109-027), Tennova Clarksville noted that its acute care beds were largely in double occupancy rooms. (CN2109-027, CON Application, 6N). Indeed, the maximum acute care beds reported by Tennova Clarksville was 141, but if treated as single occupancy, the number reduces to 84. (Id).

Although the Tennessee State Health Plan's bed need formula ("Bed Need Formula") shows that Montgomery County has a surplus of inpatient beds, and Stewart County needs no beds, there are some limitations to the Bed Need Formula.

- First, the Bed Need Formula does not consider use of staffed beds to care for observation patients. The hospital in Montgomery County reports using inpatient beds to treat observation patients.[2] Observation bed utilization at Tennova Clarksville has been increasing with an average daily census ("ADC") as of FY 2023 of 13 patients. **Exhibit 1N, Acute-2** provides the Tennova Clarksville observation days for the past three years, identifying their impact on average daily census and occupancy rates:

Exhibit 1N, Acute – 2

Observation Beds	Tennova Healthcare - Clarksville		
	CY 2021	CY 2022	CY 2023
Observation Patients	2,974	3,284	3,689
Observation Patient Days	2,832	3,611	4,660
Average Daily Census Observation Patients	8	10	13
Occupancy Rate Based on IP Beds for Use	5.0%	6.3%	8.2%
Effect on Staffed Bed Occupancy Rate	5.0%	6.3%	8.2%

Source: JARs, Schedule F observation days.

- Including observations days from the most recent year in the bed need formula by County reduces the surplus by 16 beds:

Exhibit 1N, Acute – 3

	2023		CURRENT*	SERVICE AREA POPULATION			PROJECTED 2025		PROJECTED 2029		2023 ACTUAL BEDS		SHORTAGE/SURPLUS	
COUNTY	INPATIENT DAYS PLUS OBSERVATION DAYS IN INPATIENT	AVERAGE DAILY CENSUS (ADC)	NEED	2023	2025	2029	ADC-2025	NEED 2025	ADC-2029	NEED 2029	LICENSED	STAFFED	LICENSED	STAFFED
Montgomery	53,866	147.6	175.9	240,745	251,815	273,822	154	183.3	168	198.0	270	237	-87	-39
Stewart	0	0.0	0.0	14,088	14,231	14,397	0	0.0	0	0.0	0	0	0	0
TOTAL	53,866	148	176	254,833	266,046	288,219	154	183	168	198	270	237	-87	-39

Source: Tennessee Department of Health, Population from Boyd Center file, TN_CoPopProj_2022. Patient Days from JARs, page 30 and Schedule F observation days.

- Next, the Bed Need Formula fails to account for out-migration from the Service Area. Rather, the Bed Need Formula only considers patients who are treated at the hospitals located within each county. In 2023, approximately 48 percent of patients in Montgomery County out-migrated to short term hospitals.[3] Out-migration of this magnitude indicates inadequate access, including problematic geographic and programmatic access to hospital facilities and services. The following table shows that nearly half of the resident discharges seek services outside their home county.

[2] Tennova Clarksville JARs Schedule F.

[3] Out-migration to short term hospitals per the JARS is 48 percent (2023) as shown in Exhibit 1N, Acute – 4. When adjusting for behavioral health hospitals, the 2023 cases reduce to 8,454 and the rate is 47 percent.

Exhibit 1N, Acute – 4

Montgomery County Resident Migration Patterns			
Montgomery County Resident Discharges to Short Term Hospitals	**2021**	**2022**	**2023**
To Montgomery County Hospitals	9,148	8,823	9,698
Outmigration from Montgomery County	8,067	8,438	8,798
Total Montgomery County Admissions	17,215	17,261	18,496
Percent Outmigration from Montgomery County	46.9%	48.9%	47.6%

Source: Joint Annual Report Summary to Short Term Hospitals.

- As there are no hospitals in Stewart County, 100 percent of its residents out-migrate. However, given that it is part of the service area for Montgomery County hospitals, the following Exhibit identifies how many patients left Stewart County and did not utilize Montgomery County for its services. Indeed, nearly two-thirds of Stewart County residents did not utilize Clarksville Tennova despite its proximity.

Exhibit 1N, Acute – 5

Stewart County Resident Migration Patterns			
Stewart County Resident Discharges to Short Term Hospitals	**2021**	**2022**	**2023**
To Montgomery County Hospitals	514	458	534
Outmigration Other than Montgomery County	877	971	976
Total Stewart County Admissions	1,391	1,429	1,510
Percent Outmigration Other than Montgomery County	63.0%	67.9%	64.6%

Source: Joint Annual Report Summary to Short Term Hospitals.

- Had out-migration of approximately 8,800 discharges and the 976 from Stewart County been considered in the analysis, there would have been more than 37,000 additional Montgomery County resident patient days and 8,000 Stewart County patient days, ADCs of 102 and 22, respectively. Thus, if these out-migrating patients were considered in the bed need formula, enabling these residents to be treated in their home county, there would be a dramatic change to the bed need formula from a surplus of beds to a need for beds based on licensed capacity and 105 beds based on staffed beds as shown in **Exhibit 1N, Acute – 6.**[4]

[4] Myriad CON approvals by the HFC and its predecessor during the past ten years have not met this occupancy criteria; rather each of the applicants presented geographic and programmatic access challenges in the service areas sufficient to warrant each applications' approval. This includes the Tennova Satellite CON approval (CN2109-027), Vanderbilt Rutherford Hospital (CN2109-026), and, most recently, TriStar Spring Hill Hospital (CN2404-010).

Exhibit 1N – Acute, 6

COUNTY	2023		CURRENT*	SERVICE AREA POPULATION			PROJECTED 2025		PROJECTED 2029		2023 ACTUAL BEDS		SHORTAGE/SURPLUS	
Montgomery County	INPATIENT DAYS	ADC	NEED	2023	2025	2029	ADC-2025	NEED 2025	ADC-2029	NEED 2029	LICENSED	STAFFED	LICENSED	STAFFED
Montgomery Patient Days	49,206	135												
Montgomery Observation Days	4,660	13												
Montgomery Outmigration	37,370	102												
TOTAL	91,236	237	273	240,745	251,815	273,822	248	285	270	308	270	237	15	71
Stewart County	INPATIENT DAYS	ADC	NEED	2023	2025	2029	ADC-2025	NEED 2025	ADC-2029	NEED 2029	LICENSED	STAFFED	LICENSED	STAFFED
Stewart Patient Days	0	0												
Stewart Observation Days	0	0												
Stewart Outmigration	8,060	22												
TOTAL	8,060	22	33	14,088	14,231	14,397	22	33	23	34	0	0	33	34

a. New hospital beds can be approved in excess of the "need standard for a county" if the following criteria are met:

i. All existing hospitals in the proposed service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of staffed beds for two consecutive years.

RESPONSE:

TCH's Service Area includes Montgomery County and Stewart County. Based on the detailed analysis in this application, TCH expects 75 to 76 percent of its patients will reside in Montgomery County, 4 to 5 percent in Stewart County, and the remainder from outside the Service Area. There is only one existing acute care hospital in the Service Area: Tennova Clarksville.[5]

Exhibit 1N, Acute-7 includes patient days for the three most recent years for Tennova-Clarksville. Occupancy rates for inpatients have increased 2 percent in the past two years. When incorporating observation patients, patient days increased 6 percent from 2021 to 2023 reaching 62 percent occupancy. While Tennova Clarksville does not reach the 80 percent threshold, the fact that consumers have no choice in hospital providers contributes to its nearly 50 percent out-migration. Accordingly, the occupancy threshold of 80 percent should be given little weight in determining the need for an additional hospital in Montgomery County.

[5] As explained in the CON form, Blanchfield Army Community Hospital ("Blanchfield") is located on the base at U.S. Army Fort Campbell, spanning the Tennessee/Kentucky line including portions of Montgomery County (TN) and Christian County (KY). While Blanchfield has medical surgical capabilities, the facility provides no joint annual reports, does not report to states, is only accessible by entering the base, and is only available to civilians under extremely limited situations. Moreover, research shows that it is considered Kentucky. As such, the Applicant does not consider Blanchfield in the analysis.

Exhibit 1N, Acute – 7

Facility	County	2023 Licensed Beds	Bed Days Available	Patient Days			Licensed Occupancy			% Change in Patient Days 2021-2023
				2021	2022	2023	2021	2022	2023	
Tennova Clarksville	Montgomery	270	98,550	48,063	45,716	49,206	49%	46%	50%	2%

Facility	County	2023 Staffed Beds	Bed Days Available	Patient Days			Staffed Occupancy			% Change in Patient Days 2021-2023
				2021	2022	2023	2021	2022	2023	
Tennova Clarksville	Montgomery	237	86,505	48,063	45,716	49,206	56%	57%	57%	2%

Patient Days Including Observation Days in Staffed Beds				Patient + Observation Days			Staffed Occupancy			
Tennova Clarksville	Montgomery	237	86,505	50,895	49,327	53,866	59%	61%	62%	6%

Source: JARs for respective years; patient days from Schedule 5, #3, Payor, page 30 and Schedule F, page 28.

ii. **All outstanding CON projects for new acute care beds in the proposed service area are licensed.**

RESPONSE:

Tennova Clarksville has an outstanding CON to establish a micro-hospital through the relocation of 12 beds from its existing facility. This CON was issued four years ago. To date, its proposed site has had no construction related activities. Regardless, that location will not add any beds to the Service Area as it is strictly a relocation of already licensed beds. Therefore, there are no CON approved but not yet licensed beds in the Service Area.

iii. **The Health Services and Development Agency may give special consideration to applications for additional acute care beds by an existing hospital that demonstrates (1) annual inpatient occupancy for the twelve (12) months preceding the application of 80 percent or greater of licensed beds and (2) that the addition of beds without a certificate of need as authorized by statute will be inadequate to reduce the projected occupancy of the hospital's acute care beds to less than 80 percent of licensed bed capacity.**

RESPONSE:

Not applicable. The Applicant is not an existing hospital.

2. Quality Considerations: Applicants should utilize Centers for Disease Control & Prevention's (CDC) National Healthcare Safety Network (NHSN) measures. Applicants must provide data from the most recent four quarters utilizing the baseline established by the NHSN within the dataset.

RESPONSE:

TCH is a new hospital and does not have any operating history. However, TCH is part of TriStar Health operating throughout Middle Tennessee. The TriStar Health hospitals have attained notable accreditations and certifications as will be the case with TCH. As part of its commitment to the Service Area residents, and its plans for delivery of quality, TCH will be Joint Commission accredited, seek Advanced Primary Stroke Center status, certification as a Chest Pain Center, and designation as a Level III Trauma Center. It will also include 24/7 laborists in its obstetrics program to provide an additional community advantage for

OB/GYNs and the community, and highly credentialed neonatologists. Please refer to the travel time analyses associated with patients leaving the Service Area to access care. The availability of TCH will enhance access for the Service Area.

As requested in the supplemental rounds, since the Applicant has no quality data to report, it is to identify an affiliate and populate the NHSN measures with that hospital's data. A comparable existing facility owned by the Applicant's ultimate parent is TriStar Horizon Medical Center ("TriStar Horizon"). TriStar Horizon is in a contiguous county to the south of Montgomery, Dickson County, approximately 46 miles south of TCH. Below is a table which provides TriStar Horizon's quality measures.

Centers for Disease Control & Prevention's (CDC) National Healthcare Safety Network (NHSN) Measures				
Measure	**Source**	**National Benchmark**	**Hospital Standardize dInfection Ratio (SIR)**	**Hospital Evaluation (above, at,or below national benchmark)**
Catheter associated urinary tract infection (CAUTI)	Hospital Compare: Complications& Deaths – Healthcare-associated infections	Standardized infection ratio (SIR) national benchmark = 1.	0.0	Below = Better than national benchmark
Central line associated blood stream infection (CLABSI)	Hospital Compare: Complications& Deaths – Healthcare-associated infections	Standardized infection ratio (SIR) national benchmark = 1.	0.0	Below = Better than national benchmark
Methicillin resistant staphylococcus aureus (MRSA)	Hospital Compare: Complications& Deaths – Healthcare-associated infections	Standardized infection ratio (SIR) national benchmark = 1.	0.714	Below = Better than national benchmark
Clostridium difficile (C.diff.)	Hospital Compare: Complications& Deaths – Healthcare-associated infections	Standardized infection ratio (SIR) national benchmark = 1.	0.0	Below = Better than national benchmark
Surgical Site Infections (SSI)				
SSI: Colon	Hospital Compare: Complications & Deaths – Healthcare-associated infections	Standardized infection ratio(SIR) national benchmark = 1.	0.0	Below = Better than national benchmark
SSI: Hysterectomy	Hospital Compare: Complications& Deaths – Healthcare-associated infections	Standardized infection ratio (SIR) national benchmark = 1.	0.0	Below = better than national benchmark

		National Average	Tennessee Average	Hospital Percentage
Healthcare work influenza vaccinations	Hospital Compare: Timely & Effective Care – Preventive Care	81%	80%	50%

Source: CMS Medicare Compare and internal data.

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

RESPONSE:

The proposed Service Area for TCH, discussed at length in the CON Form, consists of Montgomery County and Stewart County. This Service Area is reasonable given the detailed analysis of population dynamics, population densities, county infrastructure, historical and anticipated healthcare purchase patterns, and availability of resources throughout each county. Based on the detailed analysis in this application, TCH expects 80 percent of its patients will reside within this two county area; the remaining 20 percent will reside outside these two counties.

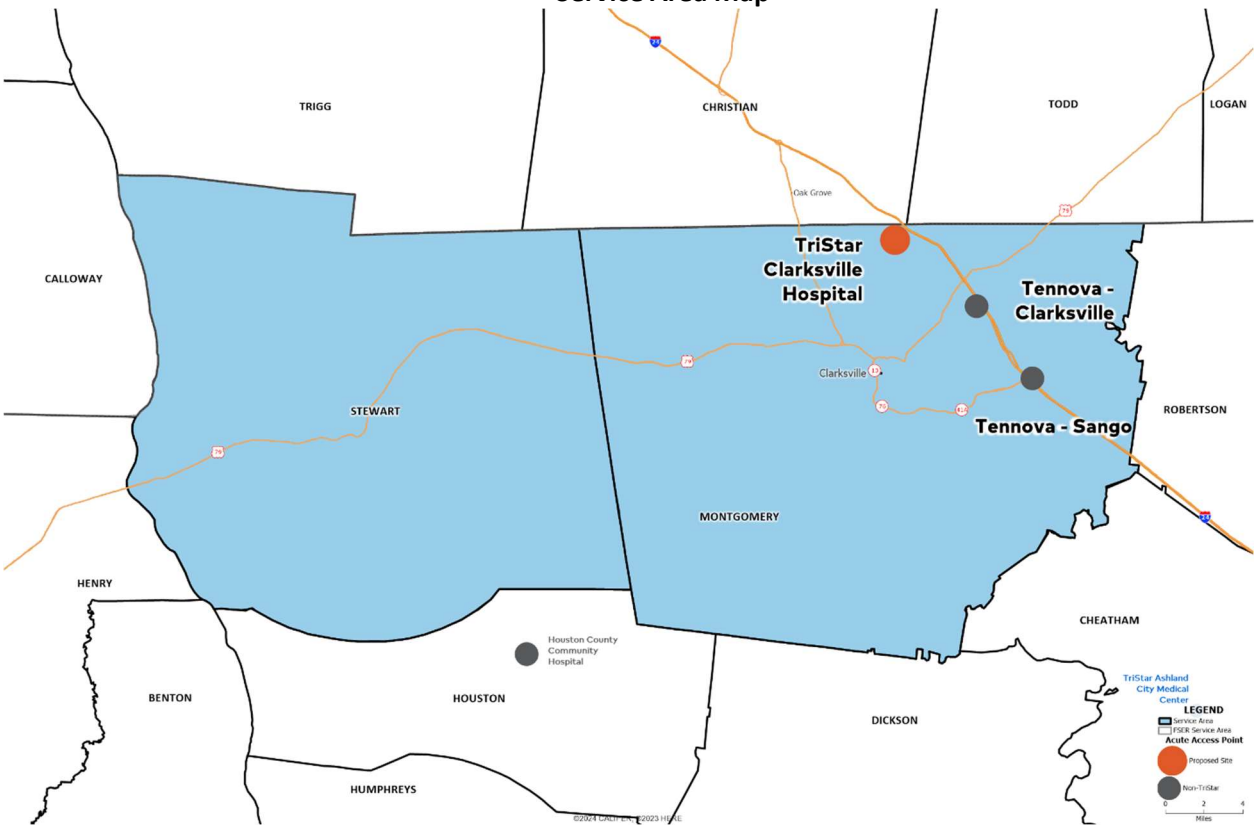
TCH will be located in 37042, which is one of three Clarksville, Montgomery County zip codes, and its most populated. Indeed, 37042 is the 2nd most populous zip code in the State, with 93,580 population today and forecasted to be 101,989 in 2030. This increase ranks it 2nd of any zip code in the State between 2020 and 2030. It also currently ranks as the 2nd most populous zip code in the State for females aged 18 to 44 in 2025 and will become the 1st most populous by 2030.

The centroid of zip code 37042 is 12.5 miles and between 20 and 45 minutes from Tennova Clarksville. Tennova Clarksville and Tennova Sango ER are each located in the other two Clarksville zip codes. The introduction of an additional hospital access point in Montgomery County in an alternate location than the existing hospital will shorten travel times and distances for those residing in north Clarksville. This will be a favorable enhancement for the Service Area population.

Furthermore, having only one hospital provider in the county has resulted in significant outmigration for its residents to access alternative hospital services. Adding an additional hospital, with alternative practicing physicians, will be a consumer advantage.

The following map presents the Service Area relative to that region. The two counties are approximately 1,000 square miles and are situated in the northwest Middle Tennessee, adjacent to the Kentucky border.

Exhibit 1N, Acute -8
Service Area Map



Also shown in the Exhibit is the proposed location of TCH on Tiny Town Road as denoted by the red dot. This location is 7.4 miles from Tennova Clarksville and approximately 12 miles from Tennova Sango ER, both also shown on the map with gray dots south of the Applicant's location.

The Applicant considered the proposed services, population dynamics, infrastructure and road systems, current migration patterns and the location of providers in the Service Area. The Service Area includes both Montgomery and Stewart Counties, which are each described in response to **Question 2N** in of the CON Form. Its demographic and economic characteristics are presented in response to **Question 3N** of the CON Form.

The Service Area was defined through a series of analyses that included, but are not limited to, the following:

- Evaluation of patient utilization patterns of residents of Montgomery County, Stewart County and all bordering counties for the past several years using both THA data sets and KHA data sets, to determine patient flow patterns across counties, hospitals/locations of choice, service lines and related hospital access.
- Evaluation of EMS runs amongst the counties using the biospatial proprietary data set to account for trends in transports of residents of the area requiring emergency treatment.
- Patient transfer information from Montgomery, Stewart and bordering counties for the past several years using TriStar Health data from its transfer center.
- Evaluation of patient zip code utilization within Montgomery County, including consideration of the individual Clarksville zip codes in which the majority of Montgomery population resides.

- Evaluation of the patient utilization patterns at Tennova Clarksville Hospital reported in its Joint Annual Reports from 2019 through 2023, including patient origin, patient transfers, emergency room utilization, among other schedules.
- Evaluation of patient utilization patterns at Tennova Clarksville Hospital and Tennova Sango ER utilizing THA data sets from 2019 through 2024 focusing on patient draw, service line utilization and utilization trends.
- Population throughout the region including historical, current, projected and associated growth patterns.
- Location of and services provided by existing healthcare resources throughout the region and their patient draw by county.
- Timing to access the existing healthcare resources throughout the region.
- Consideration of interstates, US routes, and State Routes traversing the counties and how access may be accomplished.

Based on these evaluations and assessments, it was concluded that the TCH Service Area will comprise Montgomery and Stewart Counties. An estimated 75 to 76 percent of patients are expected to reside in Montgomery County, 4 to 5 percent reside in Stewart County and the balance of 20 percent will reside outside the service area. This Service Area is reasonable and supportable based on the following facts:

- There is only one acute care hospital to provide services to more than one quarter million people, the 2nd highest population per hospital count which equates to the 2nd lowest rate of hospital access in the State; this compares to an average of 65,000 people per hospital.
- From a consumer perspective, they are not afforded any choice in hospital system including inpatient, outpatient or emergency room services.
- There are just two access points with a single provider (one hospital and one ER) which also makes it the 2nd lowest rate per population in the State.
- Beds per population indicate Montgomery County is the lowest of any high population county in the State.
- ER treatment rooms indicate Montgomery County is one of the lowest of any high population county in the State.
- 47 percent of Montgomery residents leave Montgomery County for short term hospital services; this totals more than 8,400 out-migrating discharges each year in addition to the unknown quantity out-migrating for outpatient services
- The only hospital in the Service Area admits approximately 85 percent of its patients from these two Counties.
- Roadways and infrastructure provide ready access to north Clarksville including from Montgomery County neighborhoods and adjacent Stewart County.
- TCH is accessible to Interstate 24 to its each, US 79 to its south and east and US 41A to its west. These major roadways provide expedited access to the Tiny Town area and TCH.
- Stewart County is due west of Montgomery County and has roadway access into Montgomery County via SR 79.
- Currently only one-third of Stewart County patients access the existing Montgomery County hospital, with the majority traveling further to access other hospitals including TriStar Health affiliates. Choice of providers will mitigate this greater travel time outside of the area.
- Both the current and forecasted population support need for an additional hospital. The area has a significant population base and has experienced dramatic growth during the past 10 to 15 years The anticipated population increase in Montgomery County is near the highest in the State. Given that growth, Montgomery County population will exceed 300,000 by 2034.

- Other county's in-migration did not demonstrate meaningful patient draw from other surrounding counties; as a result they are not identified as Service Area but rather aggregated into 'out of area' admissions which will account for 20 percent of TCH patient utilization.

In sum, establishment of TCH will enhance access for Service Area residents through the creation of a hospital and emergency room access point designed to reduce geographic and programmatic inaccessibility to serve the healthcare needs of this population.

Please see additional detailed discussion of hospital access problems and extent of TriStar Health affiliate access for residents of the Service Area provided in **Question 7 below** and **Questions 2N, 4N and 5N** of the CON Form.

4. **Relationship to Existing Similar Services in the Area: 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 increase in acute care beds on existing providers in the proposed service area and shall include how the applicant's services may differ from these existing services. The agency should consider if the approval of additional beds in the service area will result in unnecessary, costly duplication of services. This is applicable to all service areas, rural and others.**

RESPONSE:

Tennova Clarksville is the only acute care hospital located in the Service Area.[6] Occupancy and utilization are presented in the following table, with the first table identifying licensed beds and related occupancy and the second table addressing staffed beds and including observation patient days.

Exhibit 1N, Acute – 9

Facility	County	2023 Licensed Beds	Bed Days Available	Patient Days			Licensed Occupancy			% Change in Patient Days 2021-2023
				2021	2022	2023	2021	2022	2023	
Tennova Clarksville	Montgomery	270	98,550	48,063	45,716	49,206	49%	46%	50%	2%

Exhibit 1N, Acute – 10

Facility	County	2023 Staffed Beds	Bed Days Available	Patient Days			Staffed Occupancy			% Change in Patient Days 2021-2023
				2021	2022	2023	2021	2022	2023	
Tennova Clarksville	Montgomery	237	86,505	48,063	45,716	49,206	56%	57%	57%	2%
Patient Days Including Observation Days in Staffed Beds				**Patient + Observation Days**			**Staffed Occupancy**			
Tennova Clarksville	Montgomery	237	86,505	50,895	49,327	53,866	59%	61%	62%	6%

TriStar Clarksville Hospital

TCH's first phase is proposed to be a 68-bed hospital consisting of 42 medical-surgical beds, 8 intensive care ("ICU") beds, 10 obstetrics beds and 8 Level II neonatal intensive care unit ("NICU") beds. Its

[6] While Tennova Clarksville has an approved CON to relocate 12 beds from its hospital. This will have no impact on the licensed beds in the County. Furthermore, this CON was issued approximately four years ago, and to date, there has been no activity on the land identified for this hospital.

infrastructure is planned to accommodate up to 224 beds via future vertical expansions. Horizontal expansions are also planned to accommodate future growth in ancillary departments including but not limited to emergency, surgery, and radiology. TCH is planned with the community in mind. Its services are designed as comprehensive for a community hospital to enable treatment of most patients without having the need to leave the community, requiring travel up to 90 minutes to reach some hospitals in Davidson County.

TCH will achieve multiple goals, including:

- Improve access to care for Service Area residents;
- Offer residents an alternative in hospital and physician providers;
- Provide services locally to curtail patient need to seek services elsewhere;
- Decrease overall out-migration from the Service Area;
- Reduce travel times to access services;
- Establish an alternative accessible women's health program to enable birthing mothers to deliver close to home;
- Provide 24/7 OB laborists on site to be available for deliveries of private practice and community physician patients;
- Establish a locally accessible cardiac program in conjunction with Tennessee Heart & Vascular and Centennial Heart which have meaningful patient draw from the Service Area with two of its physicians currently operating a local clinic;
- Enable more immediate access to a Trauma Center; and
- Address the community's concerns about geographic isolation, and prolonged access to reach needed healthcare services.

Improve Access to Care for Residents

The first goal of TCH is to improve access to care for residents through, among other things, reducing out-migration from the Service Area to acute care hospitals outside of it. Additionally, it will largely eliminate the need for TriStar Health patients to seek care outside the service area. This will permit patients to receive care close to home, reduce direct and indirect costs to consumers, and reduce the time it takes for a resident to receive care.

Reduce the Number of Patients Seeking Treatment Away From Home

Implementing the TriStar Clarksville Hospital, a full-service community hospital, will improve access for patients who leave the Service Area to access care at hospitals away from the areas where they live.

To TriStar Health Facilities

TCH will improve geographic and programmatic access for patients who are already receiving care at TriStar Health facilities.

As shown in **Exhibit 1N, Acute – 11**[7] below, TriStar Health facilities are a significant source of care in the Service Area. More specifically, of the Montgomery County residents requiring acute care hospitalization, an average of 15 percent sought services at TriStar Health hospitals during the past three years. This represents nearly 35 percent of all patients out-migrating from that County. With respect to Stewart County, between 14 and 22 percent sought services at TriStar Health hospitals. This represents 22 to 26 percent of total out-migrating. Combined, approximately 31 percent of those out-migrating from the Service Area were admitted to TriStar Health hospitals. In total, there were approximately 2,600 annual Service Area discharges from TriStar.

Exhibit 1N, Acute – 11
Outmigration of Total Med-Surg, Obstetrics and NICU Discharges to TriStar Hospitals

County and Hospital Destination	CY 2021	CY 2022	CY 2023
Montgomery County			
TriStar Centennial	1,193	1,204	1,107
TriStar Skyline	580	535	519
TriStar Northcrest	238	223	235
TriStar Horizon	117	145	197
All Other TriStar	202	305	277
All Other Hospitals	4,968	5,243	Masked
Total Outmigration	7,298	7,655	Masked
Percent Outmigration to TriStar	15.2%	15.4%	14.4%
Percent to TriStar of Those Who Outmigrated	34.6%	34.8%	Masked
Stewart County			
TriStar Centennial	81	100	118
TriStar Skyline	47	42	61
TriStar Northcrest	6	10	10
TriStar Horizon	46	60	87
All Other TriStar	14	37	27
All Other Hospitals	685	695	Masked
Total Outmigration	879	944	Masked
Percent Outmigration to TriStar	14.4%	18.1%	21.5%
Percent to TriStar of Those Who Outmigrated	22.1%	26.4%	Masked
Total Service Area			
TriStar Centennial	1,274	1,304	1,225
TriStar Skyline	627	577	580
TriStar Northcrest	244	233	245
TriStar Horizon	163	205	284
All Other TriStar	216	342	304
All Other Hospitals	5,653	5,938	Masked
Total Outmigration	8,177	8,599	Masked
Total To TriStar Health Hospitals	2,524	2,661	2,638
Percent Outmigration to TriStar	15.1%	15.6%	14.9%
Percent to TriStar of Those Who Outmigrated	30.9%	30.9%	Masked

Source: THA data.

[7] This three-year trend represents discharges at acute care hospitals and includes medical/surgical, obstetrics and neonatology cases. Specialty hospitals such as behavioral health, rehabilitation and long-term acute care are excluded from this analysis as are behavioral health and rehab discharges from acute care hospitals.

This redirection of patients from TriStar Health hospitals to TCH will not impact existing providers as these patients are already bypassing other facilities in favor of TriStar Health facilities.

County Out-Migration

TCH will improve access to care for Montgomery and Stewart County residents who are already seeking care outside of where they reside. In 2023, approximately 47 percent of patients in Montgomery County out-migrated to short term hospitals. Out-migration of this magnitude indicates inadequate access, including problematic geographic and programmatic access to hospital facilities and services. **Exhibit 1N-12** provides med/surg hospital discharges for counties with a population exceeding 175,000 throughout the State.

Exhibit 1N, Acute – 12
Med-Surg Outmigration from Higher Population Counties

County	% Med Surg Who Admitted in Home County	% Med Surg Who Outmigrated	2025 Population	Med-Surg Admits, Total	Med-Surg Outmigrating Admits
Williamson County	38.9%	61.1%	271,521	14,025	8,571
Montgomery County	53.4%	46.6%	248,933	18,152	8,454
Sumner County	56.6%	43.4%	214,222	19,768	8,575
Rutherford County	66.0%	34.0%	378,969	26,283	8,931
Knox County	91.4%	8.6%	511,340	42,560	3,645
Davidson County	93.2%	6.8%	718,553	67,920	4,626
Hamilton County	95.6%	4.4%	388,064	33,421	1,481
Shelby County	98.9%	1.1%	902,243	92,705	1,021
Weighted Average	85.6%	14.4%	3,633,845	314,834	45,304

Source: Joint Annual Report Summary file. Excludes behavioral health, LTAC and rehab hospitals.

Montgomery County has the 2nd highest out-migration of any of these higher population counties. Furthermore, it is more than 3 times the average of these counties. Of the 8,454 med-surg patients leaving Montgomery County, 2,477 or 29 percent, were treated at TriStar Health facilities. Seventy percent of these were admitted to TriStar Centennial and TriStar Skyline, an additional 7 percent to other TriStar hospitals in Davidson County, 11 percent to TriStar Northcrest, 8 percent to TriStar Horizon and the balance to other TriStar Health hospitals.

When considering those with the most out-migration, three of the four counties are contiguous to Davidson County where most out-migrating patients are admitted. In contrast, Montgomery County residents have to cross Robertson, Cheatham or Dickson Counties to reach Davidson County.

Contrasting Rutherford County with Montgomery County, Montgomery County is 58 miles to Davidson County, while Rutherford is 40 miles. Travel time from Montgomery to Davidson County is 80 to 90+ minutes; Rutherford is 45 to 90+ minutes. Despite the similarities, an additional 12.6 percent of inpatient admissions occur in Rutherford County's **two** hospitals[8] than Montgomery County's **one** hospital (Tennova

[8] St. Thomas Westlawn opened in 2023, but it only was responsible for 4 admissions per the JARS summary file. A fourth hospital (VRH) has also been approved to, among other reasons, reduce out-migration to Davidson County.

Clarksville). Contrasting Sumner County to Montgomery County, Sumner County is 30 to 50+ minutes closer being contiguous to Davidson County where most out-migrating patients are admitted.

Service Area Out-Migration, Total Patients

Evaluating Service Area hospital utilization patterns is informative given the fact that Montgomery County is the 3rd fastest growing county in the State. In approximately 2020, the existing provider affiliated with Vanderbilt University Medical Center ("VUMC") becoming a 20 percent owner of Tennova Clarksville. Expectations that such an investment in the community would increase services 'at home' were not fulfilled. In fact, evaluation of migration trends from 2019 (prior to the partnership) to 2023 tells a unique story. Overall, outmigration did not reduce; the primary difference was VUMC increased its share of the outmigration by just 1 to 2 points. **Exhibit 1N, Acute – 13** provides total discharges including all service lines for the Service Area counties and the outmigration percentage.

Exhibit 1N, Acute – 13
Total Discharges by County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Total Discharges						
Montgomery County	17,585	16,721	17,416	17,883	18,508	923
Stewart County	1,610	1,494	1,476	1,503	1,571	-39
Out-Migration						
Montgomery County	53.6%	52.4%	52.7%	53.8%	Masked	0.2%
Stewart County	66.2%	67.3%	67.5%	70.7%	Masked	4.5%

Source: THA data for the respective years. Includes all services lines.

Removing behavioral health and rehabilitation service lines from the total discharges shown above, out-migration approximates 49 percent reflecting an 0.9 percent increase since 2019. **Exhibit 1N, Acute 14** provides this information.

Exhibit 1N, Acute -14
Discharges Excluding Behavioral Health and Rehabilitation by County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Discharges without Behavioral Health and Rehabilitation						
Montgomery County	15,684	14,945	15,577	15,929	16,531	847
Stewart County	1,484	1,368	1,361	1,383	1,419	-65
Out-Migration						
Montgomery County	48.0%	47.1%	47.7%	48.9%	Masked	0.9%
Stewart County	63.3%	64.3%	65.5%	69.0%	Masked	5.6%

Source: THA data for the respective years. Includes all services lines except behavioral health and rehab.

However, when considering some of the community services that are important to keep close to home, there has been a notable increase in outmigration. This is particularly evident when evaluating cardiac procedures, obstetrics and neonatology, three signature programs that will be offered at TCH. With respect to inpatient cardiac procedures, **Exhibit 1N, Acute – 15** provides the discharges and migration patterns for cardiac procedure discharges. Outmigration increased during the past years by 5 to 6 points.

Exhibit 1N, Acute – 15
Total Cardiac Procedure Discharges by County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Cardiac Procedure Discharges						
Montgomery County	1,243	1,085	1,066	1,179	1,250	7
Stewart County	75	53	66	68	71	-4
Out-Migration Cardiac Procedures						
Montgomery County	48.1%	52.5%	51.8%	54.3%	Masked	6.2%
Stewart County	62.7%	71.7%	65.2%	67.6%	Masked	5.0%

Source: THA data for the respective years.

With respect to obstetrics and neonatology services, similar trends are observed from before to after the Tennova Clarksville – VUMC partnership. **Exhibit 1N, Acute – 16** provides the similar discharge pattern for the obstetrics and neonatology service lines for Montgomery County; **Exhibit 1N, Acute -17** provides it for Stewart County. 2023 demonstrates further increases in out-migration; however that data is masked due to THA policy. As with the above analysis, while 100 percent must out-migrate from Stewart County, this information identifies outmigration from the Service Area.

Exhibit 1N, Acute – 16
Total Obstetrics and Neonatology Discharges for Montgomery County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Montgomery County Total Discharges						
Obstetrics	2,568	2,603	2,721	2,977	2,848	280
Neonatalogy	538	506	551	504	618	80
Montgomery County Out-Migration						
Obstetrics	31.8%	35.7%	38.0%	38.1%	Masked	6.3%
Neonatalogy	57.6%	56.9%	65.3%	66.7%	Masked	9.0%

Source: THA data for the respective years.

Exhibit 1N, Acute – 17
Total Obstetrics and Neonatology Discharges for Stewart County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Stewart County Total Discharges						
Obstetrics	156	141	138	129	139	-17
Neonatalogy	36	37	21	23	31	-5
Stewart County Out-Migration						
Obstetrics	26.9%	34.0%	40.6%	40.3%	Masked	13.4%
Neonatalogy	58.3%	59.5%	52.4%	65.2%	Masked	6.9%

Source: THA data for the respective years.

Establishment of TCH as a community provider will reverse these outmigration trends enhancing access for Service Area residents while providing necessary services close to home.

Service Area Out-Migration, Medical-Surgical Patients

Approximately half of patients leaving the Service Area to access hospital services – despite the underutilization of Tennova Clarksville and the time and distance required – confirms the existence of geographic and programmatic challenges experienced by Service Area residents. TCH will be a full-service community hospital primarily serving the inpatient acute care needs of non-tertiary medical surgical and obstetrics patients. Therefore, the migration analysis presented herein is separated into non-tertiary medical surgical and obstetrics migration patterns.[9] The next exhibit presents this information: the non-tertiary medical surgical patients of the Service Area and their respective migration patterns.

Exhibit 1N, Acute -18
Non-Tertiary Med-Surg Hospital Discharges by County – Migration Patterns

		CY 2021	CY 2022	CY 2023
Montgomery County				
	To Montgomery County Hospitals	6,069	5,940	Masked
	Outmigration from Montgomery County	5,200	5,481	Masked
	Total Montgomery Discharges	11,269	11,421	11,922
	Percent Outmigration from Montgomery County	46.1%	48.0%	Masked
Stewart County				
	To Montgomery County Hospitals	365	339	Masked
	Outmigration from Service Area	725	788	Masked
	Total Stewart Discharges	1,090	1,127	1,143
	Percent Outmigration from Montgomery County	66.5%	69.9%	Masked

Source: THA data for the respective years.

The outmigration analysis for Stewart County identifies the Montgomery County discharges as not out-migrating as both counties are in the defined TCH Service Area. This information confirms that the out-migration from the TCH Service Area is not only excessive but also results in non-tertiary patients traveling lengthy distances to access available community hospital services elsewhere. TCH will mitigate out-migration, improve access and provide available community hospital services in the Service Area.

Service Area Out-Migration, Obstetrics Patients

Obstetrics patients are defined as those being categorized within major diagnostic category (MDC) 14,[10] Pregnancy, Childbirth & the Puerperium. Most obstetrics cases are deliveries of infants. In addition, there are admissions for false labor, antepartum complications and other conditions associated with a pregnancy. Like total acute hospital patients and those with non-tertiary diagnoses, obstetrics patients experience significant out-migration from their home area for services. As shown in **Exhibits, 1N, Acute**

[9] Tertiary medical surgical cases are defined as transplants, trauma care, cardiac surgery, thoracic surgery, neurosurgery, burns, radiotherapy, neonatology and other complex interventions. Non-tertiary medical-surgical are the remaining inpatient services, excluding specialty services (behavioral health and medical rehabilitation). Obstetrics is also considered non-tertiary but is separately analyzed throughout this CON Application.
[10] DRGs in MDC 14 include 768, 769, 770, 783-788, 796-798, and 817-819.

16 and 17, obstetric patients from Montgomery County out-migrate at a 38 percent rate while Stewart County out-migrates at a 67 percent rate.

As with med/surg cases, a primary reason for obstetrics patients leaving the area for care is the lack of availability of services. TCH will not only provide OB services that are currently unavailable to the residents of the Service Area, TCH will be distinguishable from existing services in the Service Area as it will incorporate 24/7 laborist services with may include midwifery, doula, water immersion and other specialty programming to reduce out of area travel to access specialized obstetrics services.

TCH Will Reduce Clarksville EMS Transports Out of the Area

As part of its analysis of the TCH Service Area, TCH acquired the biospatial EMS dataset described in **Question 4N** of the CON Form. This EMS dataset includes EMS agency, county and hospital destination information to identify the level of transport from Montgomery and Stewart Counties. The following exhibit provides the EMS transports counts from each of the Service Area counties.

Exhibit 1N, Acute –19

Destination Hospital	Hospital County	EMS Scene Transports from		
		Montgomery County	Stewart County	Total
TriStar Horizon Medical Center	Dickson	100	35	135
TriStar Skyline Medical Center	Davidson	44	8	52
TriStar Centennial Medical Center	Davidson	3	1	4
Houston County Community Hospital	Houston	0	144	144
Vanderbilt University Medical Center	Davidson	131	26	157
Murray Calloway County Hospital	Calloway, KY	0	13	13
Blanchfield Army Community Hospital	Christian, KY	433	0	433
Count Outside Service Area		711	227	938

Source: biospatial proprietary database, May 2025.

Biospatial confirms that its data is not 100 percent reported. It therefore estimates by county the percentage of transports in its database that it represents of the total using its proprietary algorithm. For Montgomery and Stewart Counties, its algorithms suggest the above transports represent between 78 and 82 percent of total transports. As a result, the Service Area transports above (and in its database) are the minimum occurring and could conceivably be 18 to 22 percent greater.

The following exhibit provides more detail on the transports including hospitals which accepted the patient, travel time to each hospital and resulting out of Service Area time.

Exhibit 1N, Acute –20

Destination Hospital	Hospital County	EMS Scene Transports from: Montgomery County	Stewart County	Total
TriStar Horizon Medical Center	Dickson	100	35	135
TriStar Skyline Medical Center	Davidson	44	8	52
TriStar Centennial Medical Center	Davidson	3	1	4
Houston County Community Hospital	Houston	0	144	144
Vanderbilt University Medical Center	Davidson	131	26	157
Murray Calloway County Hospital	Calloway, KY	0	13	13
Blanchfield Army Community Hospital	Christian, KY	433	0	433
Count Outside Service Area		711	227	938
Average per Week Transports		14	4	18

Travel Times to Out of Area	Hospital County	Montgomery County to:	Stewart County to:
TriStar Horizon Medical Center	Dickson	63	73
TriStar Skyline Medical Center	Davidson	70	101
TriStar Centennial Medical Center	Davidson	80	107
Houston County Community Hospital	Houston	49	34
Vanderbilt University Medical Center	Davidson	78	109
Murray Calloway County Hospital	Calloway, KY	78	57
Blanchfield Army Community Hospital	Christian, KY	26	48

Potential Saved EMS Time Out of Service Area (Each Way)	Hospital County	Montgomery Origination	Stewart Origination	Total
TriStar Horizon Medical Center	Dickson	12,600	5,110	17,710
TriStar Skyline Medical Center	Davidson	6,160	1,616	7,776
TriStar Centennial Medical Center	Davidson	480	214	694
Houston County Community Hospital	Houston	0	9,792	9,792
Vanderbilt University Medical Center	Davidson	20,436	5,668	26,104
Murray Calloway County Hospital	Calloway, KY	0	1,482	1,482
Blanchfield Army Community Hospital	Christian, KY	22,516	0	22,516
Total		62,192	23,882	86,074

Source: biospatial proprietary database, May 2025

The total travel time of 86,000 minutes equates to more than 1,400 hours. With the establishment of TCH, Service Area residents who are being transported out of the area will be afforded the opportunity to receive services at their local community hospital resulting in reduced out-migration and geographic access improvement for patients and families.[11] These residents will be provided with a hospital where they live, work and play. The community will also benefit as EMS will be able to remain in the community, thus, reducing costs for transport out of the area and enabling EMS to be available locally for the next call.

[11] Transports to the military hospital may not be largely affected by TCH.

Avoidance of Transfers from Tennova Clarksville to Hospitals Outside the Service Area

Tennova Clarksville in the most recent JAR reported 1,720 acute care transfers from its hospital; this is in addition to 1,241 specialty transfers. The 1,720 acute transfers from its emergency room, excluding the Tennova Sango ER, ranks as the highest number of acute transfers from any hospital in the State. This equates to more than 3 percent of visits being transferred to another provider and impacts the out-migration rates previously discussed. Transfers are precipitated because of many factors including service availability, patient/family preference, and continuity of care, among others. These 1,700+ annual transfers all leave the Service Area, accessing hospitals in other counties and depending on time of day and destination up to 1 to 1.5 hours away.

Data to which hospital each of these transfers were taken is not available. However, of these 1,720 in 2023, 641 were transferred to TriStar Health facilities.[12] Data for this subset is discussed next. Establishing a full service community hospital in the Service Area will enhance access for its residents, both through elimination of transfers out of Clarksville and potentially avoiding two hospital encounters for one episode.

Redirection of Transfers Admitted to Other TriStar Facilities

As noted above, there were a total of 1,720 acute transfers from Tennova Clarksville in 2023 and an additional 1,241 specialty transfers. TriStar Health operates a transfer center which is engaged in managing transfers from non-HCA facilities to TriStar Health facilities, intra-facility transports between TriStar Health facilities, and transfers from TriStar Health to non-HCA facilities. Information on each transfer is detailed with the exception of those patients transferred to non-HCA facilities, as their information post transfer is not shared with the transfer center. The data set can be queried by referring facility, i.e. Tennova Clarksville, by accepting hospital, service line, payor, reason and other pertinent patient information.

Evaluation of transfers from Montgomery County to TriStar Health reflects a significant number of transfers annually to its hospitals in Davidson, Robertson, Dickson, and Sumner Counties. In aggregate, transfers have averaged nearly 700 per year in each of the last three years. This 700 is a subset of the 2,961 total transfers. Of the 700, on average there are 600 acute (or not behavioral health) in each of the last three years. **Exhibit 1N, Acute -21** provides annual transfers from Tennova Clarksville to TriStar Health hospitals.

[12] Transfers to TriStar Health are discussed in the next section. Of the 754 CY 2023 transfers, 113 were specialty (behavioral), 641 were acute.

Exhibit 1N, Acute -21
Tennova Clarksville Total Transfers to TriStar Health Hospitals
(Acute and Behavioral Health)

Accepting Facility	2022	2023	2024
HCA - Centennial Medical Center	212	283	328
HCA - Hendersonville Medical Center	47	40	11
HCA - Horizon Medical Center	22	4	12
HCA - NorthCrest Medical Center	79	36	13
HCA - Parthenon Pavilion	9	9	14
HCA - Pinewood Springs	11	33	42
HCA - Skyline Madison Campus	26	65	34
HCA - Skyline Medical Center	106	209	191
HCA - Southern Hills Medical Center	30	17	7
HCA - Summit Medical Center	32	45	29
HCA - Other	42	13	13
Total	**616**	**754**	**694**
Acute Only	**564**	**641**	**596**

Internal data. Other includes TriStar StoneCrest, TriStar Greenview (KY) and other hospitals

The transfers are currently 82 percent from Tennova Clarksville and 18 percent from Tennova Sango FSED. In the most recent year, 72 percent were due to service availability and 19 percent due to patient/family preference and continuity of care; the balance were a variety of other reasons. With respect to service lines, some, like tertiary service lines, will not be able to stay at home. Approximately 60 percent of the nearly 700 transfers (or 70 percent of the acute) are not tertiary/specialty patients and could be potentially re-directed – or admitted from the outset -- to TCH based on the service line into which the patient was admitted.

In addition to Tennova Clarksville transfers, Blanchfield, located on the base at Fort Campbell, spans the Tennessee/Kentucky line including portions of Montgomery County (TN) and Christian County (KY). This army hospital collaborates with TriStar Health in many of its programs. For example, for three years, Blanchfield soldier surgeons have worked side-by-side with TriStar Skyline's trauma surgeons to provide expert care to the most critically injured patients in the region. This program allows soldier medical providers to take the first-hand experience they learn alongside TriStar Health physicians and clinical staff with them as they provide life-saving care in the field. This relationship extends to Blanchfield's advance practice providers who also rotate with the trauma team at TriStar Skyline.

Establishment of TCH less than 10 miles away from Fort Campbell will be an exceptional advantage for the military enabling its enlisted, officers and their families' ready access to a Tristar Health hospital for services not provided at Blanchfield. As with Tennova Clarksville transfers, the transfer center also tracks transfer from Blanchfield to TriStar Health. **Exhibit 1N, Acute-22** provides those transfers for the past three years by destination hospital.

Exhibit 1N, Acute -22
Blanchfield Army Community Hospital Transfers to Tristar Health Hospitals

Accepting Facility	CY 2022	CY 2023	CY 2024
HCA - Centennial Medical Center	160	127	91
HCA - Greenview Regional Hospital	6	7	5
HCA - Hendersonville Medical Center	8	19	9
HCA - Horizon Medical Center	8	7	7
HCA - NorthCrest Medical Center	14	11	13
HCA - Parthenon Pavilion	0	1	0
HCA - Pinewood Springs	0	3	0
HCA - Skyline Madison Campus	1	0	2
HCA - Skyline Medical Center	47	65	52
HCA - Southern Hills Medical Center	7	8	5
HCA - StoneCrest Medical Center	3	3	1
HCA - Summit Medical Center	10	21	13
Total	264	272	198
Acute Only	263	268	196

Internal data.

The above reflects an additional 200+ patients per year from whom redirection is likely. Of note, military hospitals do not report to the State's database or to the HFC with a filing of a Joint Annual Report. Therefore, the above patient discharges are incremental to all out-migration, use rates and other analyses presented in this CON application.

In addition to the Montgomery County transfers to TriStar Health hospitals noted above, there are other hospitals transfers from counties surrounding Montgomery County, including Christian (KY), Trigg (KY) and Houston (TN). Jennie Stuart Medical Center in Christian County, KY, transfers an average of 180+ acute patients per year to TriStar Health hospitals. Houston Community Hospital in Houston County (TN) transfers an average of 160+ acute patients per year to TriStar Health hospitals. Lastly, Trigg County Hospital in Trigg County, KY, transfers an average of 34 acute patients per year to TriStar Health hospitals. Redirection of these patients is captured in the 'out of area' patients discussed in **Question 6N** in the CON form. TCH will be a more accessible TriStar Health hospital for these referring hospitals; accordingly, its implementation could similarly benefit hospitals, EMS and residents of these other counties outside the Service Area with shorter transport times, easier access by family and friends, less costly EMS trips, and a more accessible hospital option.

Collectively this data demonstrates there is a substantial time and economic burden on transport of thousands of patients annually out of the Service Area. Enabling a measurable portion of these residents to be diagnosed and treated where they reside is a distinct consumer advantage. It will also result in reduced out-migration and geographic access improvement for patients and families. Establishing TCH within the Clarksville community will provide an option for these patients to remain in the Service Area and be treated accordingly.

Accessible Women's Health Program

37042, the zip code where TCH will be located is currently the 2nd most populated zip code for females 18 to 44 in the State, at 20,896. It will increase to 21,751 by 2030 at which time its females of birthing years

will be the largest count of this cohort compared to any other zip code in the State. The Service Area overall has more than 54,000 females 18 to 44, of which 52,000+ reside in Montgomery County, the 3rd most populated county in the State.

Women in Montgomery and Stewart Counties face challenges accessing sufficient maternity care due to several interrelated factors. TCH's goal is to continue to support the great work that existing community obstetricians do every day, while helping them look to the future and aid in practice growth to reach even more patients. With respect to Montgomery County, the following interrelated factors play a significant role:

- Limited Obstetric Providers: With only one hospital program in Montgomery County and the need for more obstetricians including laborists, 40 percent of birthing mothers travel more than an hour to access services.
- Hospital Capacity Constraints: There is not sufficient hospital capacity with only one hospital, and therefore, one option to deliver locally.
- Geographic and Transportation Barriers: While Montgomery County is not classified as a maternity care desert, a significant percentage of women live more than 30 minutes from the nearest birthing hospital. This distance can pose challenges for timely access to care, especially in emergencies.
- Socioeconomic Factors: Socioeconomic disparities, including lack of insurance and limited access to transportation, can hinder women's ability to obtain consistent prenatal care. These factors contribute to higher rates of inadequate prenatal care in the region.
- Mental Health Provider Shortages: There is a noted shortage of mental health providers in Montgomery County, with a high population-to-provider ratio. Mental health support is crucial during and after pregnancy, and this shortage can impact maternal well-being.

All Stewart County residents leave the county for maternity services with only about one-third using Tennova Clarksville and the rest traveling even further distances. As a result, women in Stewart County face even greater challenges accessing maternity care due to the county's classification as a maternity care desert. This designation indicates a complete absence of hospitals or birth centers offering obstetric services, as well as a lack of obstetric clinicians such as OB-GYNs, family physicians who deliver babies, and certified nurse midwives. Key factors contributing to insufficient maternity resources include:

- Absence of Local Obstetric Services: Stewart County lacks any hospitals or birth centers providing obstetric care, and there are no obstetric clinicians practicing within the county. This forces pregnant women to travel to neighboring counties for prenatal visits and delivery services, which can be particularly burdensome for those without reliable transportation or flexible work schedules.
- Financial and Insurance Barriers: A significant proportion of women in rural Tennessee, including those in Stewart County, rely on Medicaid for healthcare coverage. However, low Medicaid reimbursement rates make it financially challenging for hospitals to sustain obstetric services. Additionally, some women may lack any health insurance, further limiting their access to necessary prenatal and delivery care.
- Increased Travel Distances: With no local maternity care providers, women in Stewart County often travel long distances to receive care. This not only delays access to prenatal services but also increases the risk of complications during labor and delivery, especially in emergency situations.

When considering the size of the birthing population and the level of out-migration for what is truly a community service, the need for an additional obstetrics program in Montgomery County is evident. With the establishment of a locally accessible women's health program, birthing mothers will be able to deliver close to home and avoid unnecessary travel and associated costs. A second program in the Service Area will be a distinct community advantage as women will have a choice in hospitals, providers and programs.

As presented in **Exhibit 13** in the CON Form, total travel time from Montgomery County to the hospital of admission for obstetrics patients now exceeds 93,000 minutes (CY 2023), increasing 17 percent from two years ago. Stewart County resident minutes totaled more than 5,700 (**Exhibit 14** in the CON Form). With population increases resulting in more deliveries, more out-migration, and more congested roadways, these times will only increase without the establishment of TCH's maternity program.

The maternity program at TCH will have an open medical staff as there are several obstetrical practices in the community and this provides those physicians and their patients a choice in providers. TCH's program will be distinguishable as it will include laborists. A laborist program is a hospital-based model of care where a dedicated obstetrician (laborist) employed to provide in-hospital care exclusively for laboring patients. The laborist's primary responsibility is to manage labor and delivery for all patients in the hospital, regardless of whether they are privately insured or under the care of another provider. This program will also include midwifery as a laborist under the physician's supervision. This program ensures immediate response to obstetric emergencies or labor needs. Care is often more standardized and protocol-driven, with quicker interventions when necessary. This is also a benefit for community obstetricians who may rely on laborists to handle their patients' deliveries, particularly during off-hours or when unavailable.

Labor and Delivery at TCH will include the following:

- An early familiarity with the obstetrics unit, including tour and meeting the staff.
- Each patient will be in a spacious, private room during labor and postpartum, with remote monitoring devices available if you want to move around.
- The program will support a variety of birth choices and pain management options.
- Patient can access immersion tubs, aromatherapy diffusers, luxurious blankets, swedish bars, rebozo technique, birth stool, birth balls, bassinets that snuggle up to the bed, and plush robes.

Establishment of the obstetrics and neonatal programs at TCH will decrease out-migration from the Service Area to birthing centers and other obstetrics programs in Middle Tennessee.

The Level II NICU is needed to create an appropriate continuum of care for women's services at TCH. Level II nurseries provide specialty neonatal services. The program will also include educational services for parents, including ongoing perinatal education programs. The nurse education program will conform to the latest edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, Level II, for neonatal nurses, published by the Tennessee Department of Health.

Another advantage for the TCH obstetrics patients who will utilize the new hospital is its affiliation with TriStar Centennial. This will be a destination hospital for tertiary patients including higher level obstetric and neonatal patients. TriStar Centennial has several attributes that are not available in Montgomery County. These include the following:

- OB Medical Director is board certified in maternal-fetal management of patients.
- Subspecialty Consultants at more than 2/3 full time at the hospital:
    - Obstetrics: Perinatal Sonologist, Hematologist and Cardiologist
    - Neonatal: Pediatric Radiologist, Pediatric Cardiologist, Pediatric Neurologist, Pathologist and Pediatric Surgeon

TCH medical staff, clinical professionals and patients will have ready access to these professionals to the benefit of its obstetrics and neonatal patients and their families.

Accessible Cardiac Program

As presented in **Attachment 1N, Cardiac Catheterization Services**, the existing Tennova-Clarksville cardiac catheterization program in Montgomery County operates at 99 percent of optimal capacity based on 2023 utilization. Given the population increased 4.6 percent between 2023 and 2025 and Tennova-Clarksville's cardiac catheterization utilization increased 35 percent in the two prior years (2021-2023), it is highly likely that today it exceeds 100 percent optimal capacity. Additionally, TCH will not open for 3 or so years, and anticipated population growth between 2025 and 2030 is 27,545, or 10.9 percent growth - the 3rd largest by county in the State.

Additionally, out-migration is considered in this analysis, with 40 percent leaving the Service Area to access catheterization labs in other Middle Tennessee counties, including Robertson, Dickson and Davidson. Given travel times and normal migration patterns, the availability of TCH's cardiac catheterization program will enhance access for Service Area residents, providing a community based choice in cardiac programs and cardiologists, reducing out-migration and more timely access to intervention.

For patients experiencing myocardial infarction ("MI")/heart attack, the American College of Cardiology ("ACC"), the American Heart Association ("AHA"), and the European Society of Cardiology have all concluded that the earlier therapy is initiated, the better the outcome. Reducing such time should reduce the degree of damage and ultimately improve patient outcomes. Shorter symptom-to-balloon times for individual patients is also associated with lower mortality at 30-days and at 1 year. Time is muscle, and these minutes are critical in patient outcomes.

As shown in **Exhibit 15** of the CON Form, total travel time from Montgomery County is approximately 415,000 minutes (6,900 hours) having increased 3 percent in the past two years. Notably, this is only inpatient care; outpatient travel to Davidson County is not available and therefore not quantifiable. Of the 415,000 minutes, more than 129,000 minutes are to TriStar Health hospitals, representing 31 percent of the out-migration. Availability of TCH's accessible cardiac program will inevitably reduce this outmigration to TriStar Health hospitals.

Establishing a locally accessible cardiac program in conjunction with TriStar Centennial's and TriStar Skyline's programs, which has significant presence in the Service Area, will improve access for Service Area residents. Currently practicing in the Service Area are cardiology providers who are affiliated with Tennessee Heart and Vascular ("THV") and Centennial Heart Cardiovascular Consultants ("Centennial Heart"). THV includes 14 non-invasive cardiologists, invasive cardiologists and interventional cardiologists, all of whom are in Middle Tennessee including Montgomery County. In addition to THV physicians, Centennial Heart has 45 providers including non-invasive cardiologists, invasive cardiologists, and interventional cardiologists. THV and Centennial Heart ("TriStar Cardiology Partners") will be partnered with TCH to oversee and provide cardiologists to staff the proposed catheterization laboratory at TCH. The

expertise of THV and Centennial Heart is widely recognized as they currently work throughout Middle Tennessee including in Davidson, Robertson and Dickson Counties to where Service Area residents out-migrate.

TriStar Cardiology Partners are engaged in the planning for TCH's proposed cardiac catheterization program. The plan for TCH includes non-invasive cardiologists, invasive cardiologists, interventional cardiologists including EP physicians, and heart failure physician specialists supported by their extenders. Interventional cardiologists will staff the cardiac catheterization lab, while being supported by advanced practice providers. In addition, TCH and TriStar's Cardiology Partners will coordinate with TriStar Skyline and TriStar Centennial for staffing and recruitment of additional providers as needed.

Current physicians named at this early stage to be practicing at TCH include Chris Conley, MD and Terry Ketch, MD. An advanced practice provider will be selected to work with these physicians. In addition to those at TCH, other providers from TriStar Cardiology Partners may be rotated among other TriStar hospitals and TCH to provide for continuity and collaboration of cardiac catheterization services amongst the practitioners and hospitals. The cardiac services planned for the TCH and its heart program include the following:

Exhibit 1N, Acute – 23
Cardiac Diagnostic, Testing & Procedures Proposed for TriStar Clarksville Hospital

Diagnostic & Procedures	Status
Angiography	Upon Licensure
Cardiac catheterization	Upon Licensure
Cardiac CT	Upon Licensure
Doppler Ultrasound	Upon Licensure
Electrocardiogram (ECG or EKG)	Upon Licensure
Electrocardiography	Upon Licensure
Pacemakers	Upon Licensure
Holter Monitoring	Upon Licensure
Intravascular Ultrasound	Upon Licensure
Nuclear Stress Test	Upon Licensure
Stress Echocardiography	Upon Licensure
Tilt Tables	Upon Licensure
Heart Failure Program	Upon Licensure

Additionally, TriStar Cardiology Partner providers are expected to initiate EP procedures during its second year of operation; currently EP procedures are not available within Montgomery County.

The proposed cardiac catheterization program will include both diagnostic and therapeutic catheterizations. By providing therapeutic catheterizations, an additional access point in the county will provide local EMS and its patients being transported with a choice for a locally accessible hospital and cardiac providers for probable AMIs within minutes, as opposed to traveling out of the area. This considerable time savings likely results in saving lives.

Respond to Calls from the Community

Please refer to the CON Form for community engagement and support and letters of support which accompany the CON Application.

5. Services to High-Need and Underserved Populations: Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including uninsured, low-income, and underserved geographic regions, as well as other underserved population groups.

RESPONSE:

TCH will provide care to all patients regardless of race, ethnicity, income or other factors. This will include providing services to underinsured, uninsured and low-income populations, including TennCare. While the Applicant is not yet licensed, TCH is part of TriStar Health which operates hospitals throughout Middle Tennessee. Its commitment to TennCare/Medicaid and uninsured patients is evident by the data. As a Tennessee provider, HCA Healthcare is the largest provider statewide of services to TennCare/Medicaid patients. This includes admissions and inpatient days. It is also one of the largest in treating the uninsured patients. Per **Exhibit 1N, Acute – 24**, HCA Healthcare admitted more than 15 percent of TennCare/Medicaid patients, or 1 of 6.5 patients statewide. This information is presented in the following table:

Exhibit 1N, Acute – 24

System	Medicaid IP % of Admissions/Discharges	Medicaid IP % of Total Days/Discharges
HCA	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%
West Tennessee	0.68%	0.34%

Source: JARs 2023

TCH will continue the TriStar Health mission and serve all patients as indicated above.

6. Relationship to Existing Applicable Plans; Underserved Area and Population: The proposal's relationship to underserved geographic areas and underserved population groups shall be a significant consideration.

RESPONSE:

TCH will address the inpatient acute care needs of the service area population. The fact that almost 50 percent of patients leave the Service Area to receive appropriate acute services confirms that its

population is underserved. Montgomery County has the second lowest statewide rate of hospitals per 100,000 population. Similarly, considering these factors, one can compute population per hospital. Here, too, Montgomery is 2nd lowest at 251,815 people per hospital compared to statewide average of 64,667. This geography is underserved as evidenced in **Exhibit 1N, Acute-25** below.

Exhibit 1N, Acute-25
Hospitals per 100,000 Population and Population per Hospital
in Counties with 175,000 or Greater Population

County	Hospitals	2025 Population	Hospitals / 100,000 Population	Population per Hospital
Williamson	1	277,193	0.36	277,193
Montgomery	1	251,815	0.40	251,815
Rutherford	3	388,909	0.77	129,636
Knox	6	508,654	1.18	84,776
Shelby	11	911,049	1.21	82,823
Davidson	9	728,443	1.24	80,938
Sumner	3	215,234	1.39	71,745
Hamilton	7	385,843	1.81	55,120
Statewide Average	112	7,242,733	1.55	64,667

Source: JARS

With the addition of TCH in Montgomery County, its rate increases to 0.79, still approximately one-half the statewide average. Population per hospital decreases to 125,908, still almost double the State's average. This is shown in the next exhibit.

Exhibit 1N, Acute-26
Hospitals per 100,000 Population and Population per Hospital
in Counties with 175,000 or Greater Population
With the Addition of TCH in Montgomery County

County	Hospitals	2025 Population	Hospitals / 100,000 Population	Population per Hospital
Williamson	1	277,193	0.36	277,193
Rutherford	3	388,909	0.77	129,636
Montgomery	2	251,815	0.79	125,908
Knox	6	508,654	1.18	84,776
Shelby	11	911,049	1.21	82,823
Davidson	9	728,443	1.24	80,938
Sumner	3	215,234	1.39	71,745
Hamilton	7	385,843	1.81	55,120
Statewide Average	113	7,242,733	1.56	64,095

Source: JARS. Note: In the above computation, Montgomery moves into 3rd lowest position by a slight margin; however the Rutherford County rate of 0.77 increases to 1.03 with the implementation of VRH-2 and the population per hospital decreases to 97,000.

Not only is Montgomery County the 2nd lowest rate in higher population counties, it is also the 2nd lowest rate of any county with a hospital statewide. Montgomery County being the 3rd fastest growing county statewide, Clarksville being the 5th largest city,[13] and TCH's zip code (37042) being the 2nd most populated zip code in the State, but having just one acute care hospital (0.4 hospitals per 100,000 population) demonstrates underservice.

The geographic area is also underserved when one factors in the beds at each of the hospitals per 1,000 population. **Exhibit 1N, Acute -27** provides this information. Here, Montgomery is the lowest rate for higher population counties.

[13] Notably, with respect to the largest cities in Tennessee, Clarksville (population 189,500) has only one (1) acute care med-surg community hospital, one (1) behavioral health hospital, and one (1) military hospital. Similarly sized Chattanooga (population 190,671) has eleven (11) hospitals, including six (6) acute care medical-surgical hospitals, two (2) rehabilitation hospitals, two (2) behavioral health hospitals, and one (1) long-term care hospital.

Exhibit 1N, Acute-27
Beds per 1,000 Population in Counties with 175,000 or Greater Population

County	2025 Population	Beds		Beds/1,000 Population	
		Licensed	Staffed	Licensed	Staffed
Montgomery	251,815	270	237	1.07	0.94
Williamson	277,193	337	337	1.22	1.22
Rutherford	388,909	513	487	1.32	1.25
Sumner	215,234	350	306	1.63	1.42
Knox	508,654	1,870	1,690	3.68	3.32
Shelby	911,049	4,132	3,039	4.54	3.34
Hamilton	385,843	1,674	1,381	4.34	3.58
Davidson	728,443	3,936	3,399	5.40	4.67
Statewide	7,242,733	21,470	16,175	2.96	2.23

Source: JARS adjusted to 337 beds for Williamson County and 24 additional beds being implemented at TriStar Hendersonville, Sumner County. Exhibit excludes behavioral health hospitals, long term acute care hospitals and rehabilitation hospitals.

Again, with the addition of TCH's 68 beds, the Montgomery County rate increases but is still far below comparable counties and the statewide average. **Exhibit 1N, Acute -28** presents this information with the TCH beds added to the county.

Exhibit 1N, Acute-28
Beds per 1,000 Population in Counties with 175,000 or Greater Population
With the Addition of TCH's 68 Beds in Montgomery County

Montgomery	251,815	338	305	1.34	1.21
Williamson	277,193	337	337	1.22	1.22
Rutherford	388,909	513	487	1.32	1.25
Sumner	215,234	350	306	1.63	1.42
Knox	508,654	1,870	1,690	3.68	3.32
Shelby	911,049	4,132	3,039	4.54	3.34
Hamilton	385,843	1,674	1,381	4.34	3.58
Davidson	728,443	3,936	3,399	5.40	4.67
Statewide	7,242,733	21,538	16,243	2.97	2.24

Source: JARS adjusted to 337 beds for Williamson County and 24 additional beds being implemented at TriStar Hendersonville, Sumner County. Exhibit excludes behavioral health hospitals, long term acute care hospitals and rehabilitation hospitals.

In addition to hospitals and beds, emergency rooms provide a community with an additional access point. When evaluating emergency rooms per population, Montgomery County is again determined to be underserved. It is 3rd lowest of these higher population counties and only 46 percent of the statewide average as shown in **Exhibit 1N, Acute – 29.**

Exhibit 1N, Acute-29
Emergency Rooms per 100,000 Population in Counties with 175,000 or Greater Population

County	Emergency Rooms	2025 Population	ERs / 100,000 Population
Williamson	1	277,193	0.36
Rutherford	3	388,909	0.77
Montgomery	2	251,815	0.79
Shelby	12	911,049	1.32
Knox	7	508,654	1.38
Davidson	11	728,443	1.51
Sumner	4	215,234	1.86
Hamilton	9	385,843	2.33
Statewide	124	7,242,733	1.71

Source: JARS. Note: Rutherford County has up to three additional emergency rooms, one CON approved and two pending CON approval. The effect of the three is to increase the 0.77 to 1.54 still below the statewide average.

The inclusion of TCH's emergency rooms increases the above ER access points in Montgomery County to 3 with a rate of 1.19, still well below the statewide average.

Exhibit 1N, Acute-30
Emergency Rooms per 100,000 Population in Counties with 175,000 or Greater Population
With the Addition of TCH's Emergency Room in Montgomery County

County	Emergency Rooms	2025 Population	ERs / 100,000 Population
Williamson	1	277,193	0.36
Rutherford	3	388,909	0.77
Montgomery	3	251,815	1.19
Shelby	12	911,049	1.32
Knox	7	508,654	1.38
Davidson	11	728,443	1.51
Sumner	4	215,234	1.86
Hamilton	9	385,843	2.33
Statewide	125	7,242,733	1.73

Source: JARS.

Lastly, the number of ER treatment rooms per 1,000 population is another metric where Montgomery County exhibits underservice as shown next.

Exhibit 1N, Acute-31
ER Treatment Rooms per 1,000 Population in Counties with 175,000 or Greater Population

County	ER Rooms by County			2025 Population	ER Rooms/ 1,000 Population
	Hospital Based	FSED	Total		
Williamson	36	0	36	277,193	0.13
Montgomery	43	9	52	251,815	0.21
Sumner	54	9	63	215,234	0.29
Rutherford	121	0	121	388,909	0.31
Shelby	394	8	402	911,049	0.44
Knox	233	8	241	508,654	0.47
Hamilton	205	22	227	385,843	0.59
Davidson	398	38	436	728,443	0.60
Total	**1,484**	**94**	**1,578**	**3,667,140**	**0.43**

Source: JARS. Note: Above are based on the most recent JARS; they do not include announced expansions, CON approved ER treatment rooms, or pending CON applications.

The inclusion of TCH's 12 ER treatment rooms increases the above 0.21 rate in Montgomery County to a rate of 0.25, still well below the statewide average.

Exhibit 1N, Acute-32
ER Treatment Rooms per 1,000 Population in Counties with 175,000 or Greater Population
With the Addition of TCH's 12 ER Treatment Room in Montgomery County

	ER Rooms by County				ER Rooms/ 1,000 Population
	Hospital Based	FSED	Total	2025 Population	
Williamson	36	0	36	277,193	0.13
Montgomery	55	9	64	251,815	0.25
Sumner	54	9	63	215,234	0.29
Rutherford	121	0	121	388,909	0.31
Shelby	394	8	402	911,049	0.44
Knox	233	8	241	508,654	0.47
Hamilton	205	22	227	385,843	0.59
Davidson	398	38	436	728,443	0.60
Total	**1,496**	**94**	**1,590**	**3,667,140**	**0.43**

Source: JARS.

Out-migration analyses previously presented in conjunction with the availability of services confirm that Montgomery County is an underserved geographic area otherwise referred to as a geographically isolated area for inpatient acute care services. There is one acute care hospital in the County, serving more than one-quarter million people. On its face, that is an astounding statistic. Even factoring in the freestanding emergency room as an additional access point supports that Montgomery County is underserved.

Both the current and forecasted population support the need for a hospital. The establishment of TCH will enhance access for Service Area residents through the creation of a hospital access point designed to reduce geographic and programmatic inaccessibility to serve the healthcare needs of this population.

7. **Access: The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-**

11-.01(1) (listing factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is a limited access in the proposed service area.

RESPONSE:

TCH will serve equally all patients who present at its facility, as it does at each of its hospitals. The Applicant should be afforded special consideration under this provision as it is readily evident that there is limited access to inpatient acute care hospital services in the proposed Service Area. The driving factors that support the need for the proposed hospital and are presented in detail in the CON Form include the following:

Service Area is Underserved
TCH will improve access by (1) establishing a hospital in a part of the service area where none exists; (2) bringing inpatient, emergency and specialized services to a community with needs for such services; (3) reducing travel time to hospital services, including emergency services; (4) reducing out-migration to hospitals in other cities; and (5) reducing EMS transports out of the area. More specifically,

- Clarksville, a city with 189,500 people, is the 5th largest city in Tennessee and has only one (1) underutilized hospital. Of the six (6) largest cities in the State (all over 100,000 people), Clarksville is the only city with only 1 acute care hospital. Clarksville is almost the size of Chattanooga (population 190,671), but Chattanooga has six (6) acute care hospitals,[14] while Clarksville has only one (1).
- Its population has grown dramatically from 104,045 in 2000 to 189,500 in 2025. Clarksville has grown at a rapid pace of 2.38 percent per year. And, Clarksville is on track to reach a milestone population of 200,000 by 2028, nearly double what it was in 2000.
- TCH will bring a second acute care hospital to Clarksville, the fifth (5th) most populated city in the State and to an area that is geographically isolated from other hospitals in the region, the Tiny Town community in northern Montgomery County.
- Montgomery County with more than 250,000 people is the 7th largest county in the State. Yet, it has only one (1) acute care hospital to serve nearly 1,000 square miles (Montgomery and Stewart County combined).
- On average, hospitals in the State serve smaller populations with the average population per hospital at approximately 65,000. In the case of Montgomery County, it has 251,000 population per hospital.
- In Tennessee, there is an average of 296 licensed beds per 100,000 population. Montgomery County's rate is 107 beds, just 36 percent of the statewide average.

[14] Hamilton County has twelve (12) hospitals, eleven (11) of which have Chattanooga addresses. Of the eleven (11) hospitals in Chattanooga, six (6) are acute care med-surg hospitals, Erlanger, Erlanger East, and Erlanger North (848 beds), Memorial (431 beds (bed total for Memorial includes its Hixson hospital), Parkridge (621 beds), Parkridge East (beds included in Parkridge); two (2) are rehab hospitals, Encompass (69 beds) and Siskin (96 beds); two (2) are behavioral health, Parkridge Valley Adult and Parkridge Valley Children (beds included in Parkridge's license); and one (1) is a long-term acute care hospital, Kindred (49 beds). The twelfth hospital is the acute care med-surg hospital CHI Memorial Hixson, next door to Chattanooga.

- Given that approximately half of the Service Area residents seek hospital services outside the Service Area, with at least 1 in 4 admitted to a TriStar Health hospital, material access improvements will be realized with the licensure of TCH.
- TCH is needed to improve access to emergency care. This part of Clarksville, zip code 37042, is the second most populated zip code in Tennessee and has no readily accessible emergency care. Indeed, the nearest ER is at Tennova Clarksville, 12.5 miles and between 20 and 45 minutes from the centroid of the zip code. Having another access point closer to where a multitude of people live will greatly enhance the effectiveness of the emergency care that these receive.
- The live birth rate in the community confirms Level II NICU beds are needed in Clarksville and the Criteria and Standards are met for additional cardiac catheterization and MRI services.
- TCH will bring needed hospital services into the community where patients live. With only one hospital in Clarksville, community residents confront geographic and programmatic access challenges and lengthy times to reach existing similar services. The proposed hospital will provide inpatient, emergency, ICU, cardiac cath, and NICU services, all of which are only available services at the lone hospital in Clarksville.
- It will bring a choice of providers and convenience to the community. The added choice is highlighted by the fact that approximately 47 percent of Montgomery County residents (8,400+ annually to short term hospitals) leave Montgomery County for inpatient hospital care.
- Currently, local EMS units transport emergencies from Clarksville to hospitals in other cities a total of 930+ times per year. Redirection of some of these EMS transports to a TCH will improve access for the patients and their families, reduce out-migration, reduce EMS transport costs, and provide local EMS with increased presence and availability in Clarksville to respond to the next incident.

Community Size and Population Dynamics (3N)

- Clarksville has three zip codes, the most populated of which is 37042, where TCH is located. This zip code – the 2nd largest in the State – contains nearly 94,000 people and is expected to increase to almost 102,000 by 2030. All jurisdictions (counties and cities) of this size have their own hospitals; and all rural communities with hospitals have population much less than 94,000.
- The 3 Clarksville zip codes, combined, currently, contain a population of 224,000 population, which is anticipated to increase to 245,000 in 2030. Clarksville comprises approximately 89 percent of the Montgomery County population.
- Montgomery County population exceeds 251,000 and is the 3rd fastest growing county in the State, expected to reach 279,340 population in 2030.
- Stewart County adjoining to the west of Montgomery County has a population of 14,231, increasing to 14,418 in 2030.

Access Challenges and Excessive Travel Times

- With only one hospital in the Service Area, there is significant outmigration which could be based on a series of factors, including but not limited to hospital preference, physician provider preference, patient/family preference, availability of services, continuity of care, among others. With such a large population (more than 250,000 in Montgomery County), out-migration of inpatients exceeded 8,400+ in 2023. This number will only increase as there is significant population growth expected to continue into the future.
- Outmigration from Montgomery County of non-tertiary med surg patients totaled approximately 415,000 minutes or 6,900 hours in CY 2023.
- Outmigration from Montgomery County of obstetrics patients totaled approximately 93,000 minutes of 1,550 hours in CY 2023.

- Outmigration from Stewart County (excluding those who were admitted in Montgomery County) total 71,000 minutes for non-tertiary patients and 5,700 for obstetrics patients, or 1,183 and 96 hours, respectively.
- Given the distance from Montgomery and Stewart Counties to out-of-Service Area hospitals and the number of hospital discharges, its residents collectively travel excessive miles to reach services resulting in some of the significant aggregate travel miles to reach a hospital in the region.
- Residents of Montgomery and Stewart Counties travel significant distances to access inpatient care, with such travel times being exacerbated each year by the continued population increases.

Out-Migration is Indicative of Access and Availability Challenges

- A very large percentage (almost 50 percent) of Montgomery County patients eschew their local hospital and seek their inpatient care in Nashville and elsewhere. Conversely, Hamilton County has 12 licensed hospitals, of which 7 are acute care med-surg hospitals, and it has less than 5 percent outmigration.
- Likewise, when considering counties with population greater than 175,000, Montgomery County has the 2nd highest out-migration of any of these counties. Furthermore, it is more than 3 times the average of these counties. [15]
- Of the 8,454 med-surg patients leaving Montgomery County, 2,477 or 29 percent, were treated at TriStar Health facilities. Seventy percent of these were admitted to TriStar Centennial and TriStar Skyline, an additional 7 percent to other TriStar hospitals in Davidson County, 11 percent to TriStar Northcrest, 8 percent to TriStar Horizon and the balance to other TriStar hospitals.
- Outmigration from the Service Area for cardiac procedures is 54 percent from Montgomery County and 68 percent from Stewart County.
- Outmigration from the Service Area for non-tertiary discharges [16] is 48 percent from Montgomery County and 70 percent from Stewart County.
- Outmigration from the Service Area for obstetrics discharges is approximately 40 percent from Montgomery and Stewart County.
- The out-migration percentages and, more importantly the number of patients (8400+ and counting) who out-migrate, confirm that effective healthcare planning is needed to mitigate these dramatic patient flows and improve access for Service Area patients.

Travel Times Necessitate Access Improvement

- Travel miles (product of distance and frequency) to access both inpatient med/surg care and obstetrics services for Service Area residents is excessive; more importantly is the time it takes to travel those miles.
- Non-tertiary medical surgical and obstetrics outmigration from Montgomery County totaled approximately 6,900 and 1,550 hours, respectively, in CY 2023.
- Stewart County out-migration, excluding those who went to Montgomery County, totaled 1,183 and 96 hours, respectively for non-tertiary med-surg and obstetrics hospitalizations.
- These counts exclude those who traveled to access outpatient services at counties throughout Middle Tennessee.

[15] County migration patterns from THA data are based on 2022 data since 2023 is masked due to THA policy; county data from the JARs are based on 2023 data.

[16] See footnote 6 for definition of tertiary and non-tertiary.

Hospital Transfers Verify Need

- Tennova Clarksville transfers more acute patients from its emergency room than any other hospital in the State, transferring 1,720 in CY 2023.
- Of those, 641 were transferred outside the Service Area to TriStar Health hospitals, the balance to other hospitals also outside the Service Area.
- Blanchfield also transfers a significant number of patients to TriStar Health hospitals, averaging 200 per year.
- If 70 percent of these transfers out of the area could be avoided that would meaningfully enhance access and create savings in terms of transport costs, and other hardships on patients and families leaving the Service Area.
- In addition to these Montgomery transfers out of the Service Area, hospitals outside the Service Area transfer hundreds of patients each year to TriStar Health hospitals. TCH will be a closer TriStar hospital for Jennie Stuart Medical Center (Christian County, KY), Trigg County Hospital (Trigg County, KY) and Houston County Hospital (TN) thereby enhancing access for these transferred patients and their families. Patients from these communities comprise part of the out of service area factor in the utilization analysis.

EMS Transports Support Need

- EMS transports from scenes to a hospital in Montgomery County were approximately 13,200 in the most recent 12-month period; combined with Stewart County, there were nearly 14,000 EMS scene transports to a hospital. Of the transports, the majority were taken to Tennova Clarksville.
- 938 were transported out of the Service Area including to TriStar Horizon, TriStar Skyline, TriStar Centennial, Houston County Community, VUMC, Murray Calloway, and Blanchfield.
- Based on travel time to the out of area facilities, an estimate of EMS out of the Service Area totals 68,000 minutes travel time. Travel each way is included; offload time is not included.
- When TCH is an alternative hospital provider available, local EMS providers will be able to reduce time spent out of the Service Area. TCH will positively impact the EMS services by being accessible and available more rapidly to meet local needs.
- Access for families will be enhanced. When some of these patients are no longer diverted out of the area, families will have improved access and relative short travel times to be with their family and participate in any recovery.

State Health Plan Criteria Are Met

- The State Health Plan Standards and Criteria includes a Bed-Need Formula, however, the HFC "has the discretion to approve new hospital beds even when not warranted under the State Health Plan criteria when there is a compelling reason to do so, and the Commission has done so when there was demonstrated need for additional health services in a particular community."[17] The situation in the Service Area detailed throughout this CON application demonstrates compelling reasons for TCH's approval.
- The bed need formula for Level II NICU beds confirms the need for additional Level II NICU beds in the Service Area.
- The cardiac catheterization services utilization formula confirms the need for additional cardiac catheterization laboratories in Montgomery County.

[17] VRH-2 Final Order, February 29, 2024; Spring Hill (CN2404-010).

- TCH will cure geographic isolation and inaccessibility through providing Service Area residents with an accessible and available inpatient hospital thereby enhancing access as demonstrated through health planning metrics and community support.
- Establishment of TCH will foster quality of care and cost effectiveness through more rapid treatment of the thousands of patients leaving the Service Area each year (and expected to increase), being transported from scenes each year to out of area facilities, minimizing impact on EMS to transport these patients out of the area, reducing the cost to the EMS system, and decreasing the costs to the Service Area residents. More rapid treatment leads to lives being saved.
- The economic impact to the Service Area with bringing a $286 million hospital to the community is meaningful and demonstrates a Consumer Advantage based on its construction and the ongoing impact of its operations.
- Community leaders and residents alike (the "Community") state there is an overwhelming need for another hospital in Clarksville. Their impetus is based on the tremendous population growth, traffic patterns extending travel time to service and the need for improved access to inpatient hospital services including obstetrics services.

> *I strongly support HCA TriStar Health's plan to build a comprehensive, high-quality hospital in Montgomery County … As one of the fastest-growing areas in the country, our families need greater access to the essential care the TriStar Clarksville Hospital would provide.*
>
> *Mayor Wes Golden*
> *Montgomery County Mayor*

> *TriStar Health's effort to expand access to quality healthcare in our region is a welcome development for our growing community … I support the TriStar Clarksville Hospital as an important investment in the health and well-being of local families.*
>
> *Senator Bill Powers*
> *Tennessee State Senator*

- Consumer Advantage is meaningfully demonstrated by the community support for TCH as expressed by city leaders, large community employers, business leaders, physicians, referral sources, elected officials, prior patients and others with personal knowledge and experiences in the Service Area.

> *I am pleased to hear that TriStar Health is interested in bringing a multimillion-dollar healthcare facility to our community… Their investment will result in expanded healthcare options for our citizens and Fort Campbell families.*
>
> *Mayor Joe Pitts*
> *Clarksville Mayor*

Each of the above underlying reasons to approve the proposed TriStar Clarksville Hospital are discussed in response to **Questions 2N, 3N and 4N** in the CON Form.

8. Adequate Staffing: An 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.

RESPONSE:

TriStar Health with its hospitals and other healthcare sites throughout Middle Tennessee has identified that 523 of its employees reside in Montgomery County. Of these, 483 are in direct patient care roles. Accordingly, TCH has a significant foundation of staff upon which it will build its employee and physician base to appropriately staff the proposed hospital.

TriStar Health also has a significant representation of its providers (physicians and extenders) who reside in Montgomery County, totaling 55 based on current counts. TCH will capitalize on the presence of these providers as it develops its medical staff plan for its future operations.

Based on forecasted utilization, TCH estimates a need for 210 FTEs in its initial year of operations. With this level of employees residing in the County, of which approximately 483 are in direct patient care roles, the Applicant is confident it will successfully recruit the needed complement to staff the hospital.

TriStar Health and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. In 2021, HCA Healthcare opened the Galen College of Nursing in Nashville, which now has campuses and programs in Tennessee, Kentucky, Ohio, Virginia, South Carolina, Florida and Texas. The Nashville campus offers a 3-year Bachelor of Science in Nursing, an Associate Degree in Nursing (ADN) and an LPN to ADN Bridge program. It graduated 45 nurses in its first year (2023) and is currently enrolling 700 new students each year. It expects estimated enrollment to increase 5 to 10 percent each year. This year, Galen College of Nursing expects approximately 250 graduates to graduate. It is HCA Healthcare's experience that 55 percent of graduates join an HCA Healthcare hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Health including recruitment for the proposed TCH.

The Thomas F. Frist, Jr. College of Medicine at Belmont University in Nashville, is a new medical school founded in alliance with HCA Healthcare to focus on training diverse physician leaders who embrace and value a whole-person approach to healing. The Thomas F. Frist, Jr. College of Medicine at Belmont University is housed in a new building that had its ribbon cutting on April 29, 2024. The nearly 200,000-square-foot building is located within a block of Belmont's Gordon E. Inman Center and McWhorter Hall, which house the University's well-known nursing, physical therapy, occupational therapy, social work and pharmacy programs. The College of Medicine has recruited a leadership team consisting of experts from across the country and is currently recruiting additional clinical faculty. Its first class commenced this past fall. TriStar Health 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 Middle Tennessee, TriStar Health is integrally involved in graduate medical education (GME). It currently has 133 residents, with 72 at TriStar Centennial (internal medicine, psychiatry, and transitional year), 37 at TriStar Skyline (emergency medicine, neurology, surgical critical care and physical medicine and rehabilitation) and 24 family medicine residents at TriStar Southern Hills. In July 2024, total resident count in these three hospitals will increase to 158, with 77 at TriStar Centennial, 56 at TriStar Skyline and 25 at TriStar Southern Hills. HCA Healthcare has more than 5,600 residents at its hospitals, making it one of the largest GME providers in the country. TriStar Health and HCA Healthcare look forward to working collaboratively with Belmont to support the supply of healthcare professionals entering and staying in the profession and to ensure that they have access to training.

In 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 internships and other training opportunities for students at TriStar Health facilities and also provide a pipeline for future qualified employees. **Exhibit 1N, Acute – 33** below provides a summary of programs that currently work with TriStar Health and the profession for which the students are matriculating and training.

Exhibit 1N, Acute – 33

Academic Partners	Degree/ Program
Nursing - Nashville Market	
Belmont	BSN
Galen - Nashville	ADN/BSN
South College (Knoxville & Nashville campus)	BSN
Austin Peay State University (APSU)	BSN
Middle Tennessee State University (MTSU)	BSN
Cumberland *DEU	BSN
Lipscomb	BSN
Tennessee Tech	BSN
Vol State *DEU	ADN
Nashville State	ADN
Columbia State	ADN
Herzing *New program	ADN/BSN
Fortis	ADN
Surgical Technology - Nashville Market	
South College	Surgical Tech
Fortis Institute	Surgical Tech
South Kentucky Community & Technical College	Surgical Tech
Nashville State	Surgical Tech
Diagnostic Imaging - Nashville Market	
South College	Rad Tech (AAS)
Austin Peay	Rad Tech (AAS)
Fortis Institute	Rad Tech (AAS)
Vol State	Rad Tech (AAS)
Columbia State	Rad Tech (AAS)
Nashville State	Rad Tech (AAS)
South Kentucky Community & Technical College	Rad Tech (AAS)
Casa Loma	Rad Tech (AAS)

9. **Assurance of Resources: The applicant shall document that it will provide the resources necessary to properly support the applicable level of services. Included in such documentation shall be a letter of support from the applicant's governing board of directors, Chief Executive Officer, or Chief Financial Officer documenting the full commitment of the applicant to develop and maintain the facility resources, equipment, and staffing to provide the appropriate services. The applicant shall also document the financial costs of maintaining these resources and its ability to sustain them.**

RESPONSE:

Per the HFC, the letter of support is no longer required as it is a relic of a previous statutory framework which included consideration of Economic Feasibility.

10. **Data Requirements: Applicants shall agree to provide the Department of Health and/or the Health Services and Development Agency 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.**

RESPONSE:

TCH 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.

11. **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.**

RESPONSE:

TCH will participate in data reporting, quality improvement and outcome and process monitoring, as is consistent with all TriStar Health facilities. As a future hospital within the TriStar Health organization, TCH will adopt TriStar Health's methods to ensure and maintain quality of care. This includes a collaborative multidisciplinary team approach, which considers the unique knowledge, judgment, and skills of a variety of disciplines in achieving desired patient outcomes, serving as a foundation for quality.

TCH will be 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. TCH's goal will be to provide services which are measurably more accessible, affordable, and which are improving in quality on a continuous basis. The continuum of services may begin prior to admission, such as in an ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

Within this context, TCH will 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 will guide the improvement process. TCH will address methods to ensure and maintain patients' quality of care.

TCH will be dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. It will maintain the highest standards and quality of care. It will provide a robust Quality Assurance and Performance Improvement ("QAPI") Plan 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, TCH will provide 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 will play an important advisory purpose in enhancing and maintaining the quality of care provided. Systems will be 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 TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence.

12. **Licensure and Quality Considerations: Any existing applicant for this CON service category shall be in compliance with the appropriate rules of the TDH. The applicant shall also demonstrate its accreditation status with the Joint Commission or other applicable accrediting agency.**

RESPONSE:

The Applicant is a new hospital and, therefore, has no operational history.

13. **Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care.**

RESPONSE:

TCH will build upon existing post-acute and provider partnerships expanding access to specialty care throughout Montgomery County. Clarksville is already home to several affiliated specialists including three cardiologists, a neurosurgeon, and four general surgeons, an ENT, a Urologist and collaboration with a large group of orthopedic specialists. We have well documented plans of, and begun development, establishing a medical park off exit 11 to support additional placement of sub-specialist clinics and ambulatory surgery capabilities (through partnership with independent group). We are also continuing to advance relationships with multiple large independent provider groups to support sub-specialist timeshares, elevate cancer care screenings, and expand access to research protocols for Montgomery County residents.

TriStar hospitals support Blanchfield through continuing education opportunities, best practice sharing opportunities to observe/shadow, Mom/Baby support (NICU), and Emergency Preparedness. As an example, TriStar Skyline provide Blanchfield general surgeons the opportunity to shadow and care for trauma patients alongside Skyline's trauma surgeons. This partnership allows soldier medical providers to take the first-hand experience they learn alongside our physicians and clinical staff with them as they provide life-saving care in the field. Recently, we executed an Executing External Resource Sharing Agreement that allows Blanchfield physicians to perform surgical procedures at TriStar Health hospitals, including Skyline, Centennial, Summit and NorthCrest and also a Care Collaboration Agreement, that includes TriStar Mobile Care and a broader availability of service offerings and technical assistance.

In summary, TriStar Health's collaboration with Blanchfield continues to deepen through clinical education, shadowing opportunities, and shared protocols in areas such as surgery, emergency preparedness, and

maternal care. Through formal resource-sharing and care collaboration agreements, Blanchfield physicians now provide surgical services at multiple TriStar facilities and work closely with our clinical teams—enhancing both military and civilian care delivery across the region. These arrangements will be extended to TCH which will become the closest TriStar hospital to Blanchfield.

In the event that patients seeking care at TCH require tertiary or quaternary care, the patients will be directly transferred to TriStar Skyline, TriStar Centennial, or another facility that can provide such levels of care.

Moreover, if a patient needs behavioral health treatment, TCH will refer to the most appropriate facility whether it be Unity Psychiatric Care in Clarksville with which TriStar Health has a relationship, or a TriStar Health affiliate. TriStar Health operates behavioral health programs throughout Middle Tennessee, including TriStar Centennial Medical Center and Pinewood Springs Behavior Health Hospital. Between these programs, TriStar Health provides a broad range of inpatient and outpatient behavioral health services within a supportive and therapeutic environment

ORIGINAL APPLICATION

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

CERTIFICATE OF NEED APPLICATION

1A. Name of Facility, Agency, or Institution

TriStar Clarksville Hospital

Name

located at an unaddressed site on Tiny Town Road, approximately 1,000 feet to the west of the intersection of Tiny Town Rd and Sandpiper Dr.

Street or Route

Montgomery County

County

Clarksville	Tennessee	37042
City	**State**	**Zip**

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

David Whelan	Senior Vice President
Name	**Title**
TriStar Health	david.whelan@hcahealthcare.ocm
Company Name	**Email Address**

1000 Health Park Drive

Street or Route

Brentwood	Tennessee	37027
City	**State**	**Zip**
Executive		615-886-4900
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: 05/30/25

Date LOI was Published: 05/30/25

RESPONSE: Please refer to attached proof of publication.

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

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

Initiation of HealthCare services

- [ ] Burn Unit
- [x] Neonatal Intensive Care Unit
- [ ] Open Heart Surgery
- [ ] Organ Transplantation
- [x] Cardiac Catheterization
- [ ] Linear Accelerator
- [ ] Home Health
- [ ] Hospice
- [ ] Opiate Addiction Treatment Provided through a Non-Residential Substitution-Based Treatment Section for Opiate Addiction

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)*

- [x] 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

Clarksville Health Services, LLC

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: The proposed TriStar Clarksville Hospital ("TCH") is owned by Clarksville Health Services, LLC. The Applicant is ultimately owned by HCA Healthcare, Inc. ("HCA Healthcare") through several wholly-owned subsidiary corporations. Please see Attachments 7A-1, 7A-2 and 7A-3 for Clarksville Health Services, LLC's Articles of Organization, from the Tennessee Division of Business Services of the Department of State, Certificate of Existence, and Assumed Name Registration, respectively. Attachment 7A-4 contains Clarksville Health Services, LLC's organizational chart. Attachment 7A-5 contains a listing of Clarksville Health Services, LLC's directors and officers.

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

Name

Street or Route | **County**

City | **State** | **Zip**

Website Address

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

9A. Legal Interest in the Site

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

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

- ☐ Ownership (Applicant or applicant's parent company/owner) – Attach a copy of the title/deed.
- ☐ Lease (Applicant or applicant's parent company/owner) – Attach a fully executed lease that includes the terms of the lease and the actual lease expense.
- ☑ Option to Purchase - Attach a fully executed Option that includes the anticipated purchase price.
- ☐ Option to Lease - Attach a fully executed Option that includes the anticipated terms of the Option and anticipated lease expense.
- ☐ Letter of Intent, or other document showing a commitment to lease the property - attach reference document
- ☐ Other (Specify)

RESPONSE: Please see Attachment 9A for the fully executed Real Estate Purchase and Sale Agreement.

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: The proposed hospital is a three-story structure of approximately 213,500 square feet, with both vertical and horizontal expansion zones for future growth. See Attachment 10A for a copy of the floor plans of the three-story structure. There is one page for each level.

11A. Public Transportation Route

Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients. (Attachment 11A)

RESPONSE: See Attachment 11A. The proposed TCH is located on Tiny Town Road, Clarksville in zip code 37042. The site is also accessible by several roadways to both the east and west including Interstate 24, US 79, Needmore Road, Trenton Road, Peachers Mills Road and Fort Campbell Boulevard. In addition, the Clarksville Transit System ("CTS") is centralized at the Transit Center on 200 Legion Street. All buses leave the Transit Center at approximately the same time and travel to the outer reaches of the city. The buses then return to the Transit Center at approximately the same time, enabling passengers to transfer from one route to another route to reach their final destination. Route 2 travels north from the Transit Center and turns onto Tiny Town Road at the intersection of Fort Campbell Boulevard and Tiny Town Road. It then travels east, making stops along Tiny Town Road, passing in front of TCH.

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: See Attachment 12A. The TCH site is approximately 45 acres to be developed for the proposed hospital. TCH's first phase will be 213,500 square feet, which includes 42 med/surg beds, 8 intensive care unit ("ICU") beds, 10 labor/delivery/recovery/postpartum ("LDRP") beds, 8 Level II neonatal intensive care unit ("NICU") bassinets, and a 12 treatment room ER. It will have 4 surgery suites, 2 endoscopy suites, 2 cardiac catheterization labs, a pre and post-operative unit, imaging (including MRI), laboratory, pharmacy, respiratory therapy, and inpatient dialysis. The infrastructure is designed to expand to 224 beds with associated ancillary department expansions such as ER, OR, imaging; such expansions will be both vertical and horizontal. The site plan shows the proposed hospital location on the site. Please see the plot plan included in Attachment 12A for the site relative to the entire parcel, the location of the proposed construction, and the name of adjacent road (Tiny Town Road).

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:

  TCH will be a full-service community hospital located at an unaddressed site on Tiny Town Road in Clarksville, Montgon County, TN 37042, approximately 1,000 feet to the west of the intersection of Tiny Town Rd and Sandpiper Dr. The 68- hospital will include new construction of approximately 213,500 square feet and will have 42 med/surg beds, 8 ICU beds obstetrics beds, 8 Level II NICU bassinets, and a 12 treatment room ER. The hospital will have 4 surgery suites, 2 endosc suites, 2 cardiac catheterization labs, a pre and post-operative unit, imaging (including MRI), laboratory, pharmacy, respira therapy, and inpatient dialysis.

  Clarksville is the fifth (5th) largest city in Tennessee and has only one (1) underutilized community hospital.[1] Its population grown dramatically from 104,045 in 2000 to 189,500 in 2025. Clarksville has grown at a rapid pace of 2.38% per year. Clarks is on track to reach a milestone population of 200,000 by 2028, nearly double what it was in 2000. Clarksville is almost the siz Chattanooga (population 190,671), but Clarksville has only one (1) acute care med-surg community hospital, one (1) behavi health hospital, and one (1) military hospital at nearby Fort Campbell across the state line in Kentucky. Chattanooga has ele (11) hospitals, including six (6) acute care medical-surgical hospitals, two (2) rehabilitation hospitals, two (2) behavioral he hospitals, and one (1) long-term care hospital. Another acute care med-surg hospital is located in neighboring Hixson, in Hami County.[2]

  Ø **Need:** TCH is needed:

  · **To Provide Access/Availability:** With only 1 acute care hospital in Clarksville, residents of the Service Area conf geographic isolation, programmatic access challenges, and lengthy times to reach hospital inpatient services. TCH will pro more inpatient care, cardiac cath, emergency and NICU care in Clarksville. Patients will receive inpatient care in their commu where their families can more readily visit and participate in their recuperation. Having another access point for hospital emergency care in north Clarksville, will improve care. Proximity is especially critical for emergency services when obtai prompt quality care is essential.

  · **To Address Population Growth:** The Clarksville population has nearly doubled since 2000. Recently, Clarksville recognized as the 22nd fastest growing city in the United States[3] and is forecasted to increase to nearly 200,000 by 2 Continued growth highlights the need for a hospital.

  · **To Reduce Patient Out-Migration:** Approximately fifty percent (50%)[4] of Montgomery County residents leave Montgon County for inpatient hospital care. TCH will provide another and better access point for Clarksville and Montgomery Co residents living in the rapidly growing Tiny Town area of Clarksville as well as Stewart County and all of nortl Clarksville. Having TCH in the proposed location will significantly reduce the outflow of Clarksville and Montgomery Co residents needing inpatient care.

  · **To Eliminate Patient Transfers and EMS Bypass:** Many patients are transferred from the current hospital in Clarksvill other hospitals, mostly in Nashville. Adding TCH to the Clarksville community will reduce the need for transfers of patients can be cared for in a full-scale community hospital like TCH.

[1] Blanchfield Army Community Hospital ("Blanchfield") is part of the Fort Campbell, U.S. Army base, and is in Chris County, Kentucky. Its address is 650 Joel Drive, Fort Campbell KY, 42223. While Blanchfield has medical surg capabilities, the facility provides no joint annual reports, reports to states, is only accessible by entering the base, and is available to civilians under extremely limited situations. As such, the Applicant does not consider Blanchfield in analysis.

[2] Hamilton County has twelve (12) hospitals, eleven (11) of which have Chattanooga addresses. Of the eleven hospitals in Chattanooga, six (6) are acute care med-surg hospitals, Erlanger, Erlanger East, and Erlanger North (848 be Memorial (431 beds (bed total for Memorial includes its Hixson hospital), Parkridge (621 beds), Parkridge East (b included in Parkridge); two (2) are rehab hospitals, Encompass (69 beds) and Siskin (96 beds); two (2) are behavi health, Parkridge Valley Adult and Parkridge Valley Children (beds included in Parkridge's license); and one (1) long-term acute care hospital, Kindred (49 beds). The twelfth hospital is the acute care med-surg hospital CHI Memo Hixson, next door to Chattanooga.

[3]
https://www.wkrn.com/news/national/2-middle-tennessee-cities-among-the-25-fastest-growing-cities-in-the-us-study-sho

[4] The reference to 'approximately 50 percent' is based on THA data with all service lines out-migrating at 53.8 per and services lines excluding rehabilitation and behavioral health out-migrating at 48.9 percent.

- Ownership structure

  RESPONSE: TCH is owned and will be operated by Clarksville Health Services, LLC, whose ultimate parent compan HCA Healthcare, Inc. ("HCA Healthcare"). TCH is part of HCA Healthcare's TriStar Health network, which operates hospitals in Middle Tennessee. HCA Healthcare operates 186 hospitals in 20 states and the U.K.

- Service Area

  RESPONSE: The Service Area is defined as Montgomery and Stewart Counties in Tennessee.

- Existing similar service providers

  RESPONSE: There is one (1) acute care hospital in Clarksville, Tennova Healthcare – Clarksville ("Tennova Clarksvil located at 651 Dunlop Lane, which is 7.5 miles to the southwest of TCH. In addition, Tennova Clarksville operates a hig utilized freestanding emergency room in the Sango community ("Tennova Sango ER"), 11.7 miles from the proposed T Ascension St. Thomas also recognizes that Clarksville needs another hospital. On May 15, 2025, it filed a LOI proposi 44-bed hospital in the Sango area southeast of Clarksville.

- Project Cost

  RESPONSE: The estimated capital cost of the project is $286,048,000.

- Staffing

  RESPONSE: TCH will be staffed by 210 FTEs. With more than 500 TriStar Health employees who reside in Montgon County of which over 475 are TriStar Health direct care positions, TCH is confident it will successfully recruit the nee complement to staff the hospital.

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: • TCH is needed to provide inpatient hospital care to the Clarksville, Montgomery County, Stewart County and the surrounding communities. Clarksville is the 5th largest city in Tennessee, and it has only one (1) acute care hospital. Fifty percent (50%) of Montgomery County patients eschew their local hospital and seek their inpatient care in Nashville and elsewhere. Clarksville is one of the fastest growing cities in the nation, both historically and expected into the future. Clarksville's population is nearly the same as Chattanooga, but it only has 1 Tennessee licensed acute care med-surg community hospital (Tennova Clarksville), one (1) psychiatric care hospital (Unity), and one (1) military hospital located on the nearby Fort Campbell US Army Base in Kentucky, while Chattanooga/Hamilton County has 12 licensed hospitals, of which 7 are acute care med-surg hospitals.. Tennova Clarksville obtained a CON in 2021 for the establishment of a 12-bed satellite hospital approximately 4 miles west of its current facility. Per its CON application, the 12 beds were going to be taken from the bed complement at the host hospital. Tennova Clarksville has neither built nor started construction on the approved satellite hospital, estimated cost $58,000,000. • TCH is needed to improve access to emergency care. This part of Clarksville, zip code 37042, is the second most populated zip code in Tennessee and has no readily accessible emergency care. The nearest ER is at Tennova Clarksville, 12.5 miles and 20 to 45 minutes from the centroid of the zip code. Having another access point closer to where a multitude of people live will greatly enhance the effectiveness of the emergency care that these receive. • The live birth rate in the community confirms Level II NICU beds are needed in Clarksville and the Criteria and Standards are met for additional cardiac catheterization and MRI services. • TCH will bring needed hospital services into the community where patients live. With only one hospital in the Service Area, community residents confront geographic and programmatic access challenges and lengthy times to reach existing similar services. The proposed hospital will provide inpatient, emergency, ICU, cardiac cath, and NICU services. All of these services are currently only available at a Tennova facility: the Tennova Clarksville hospital and Tennova Sango ER, which provides emergency care. • Currently, local EMS units transport emergencies from Clarksville to hospitals in other cities a total of 930+ times per year. Redirection of these EMS transports to a Clarksville hospital will improve access for the patients and their families, reduce out-migration, reduce EMS transport costs, and provide local EMS with increased presence and availability in Clarksville to respond to the next incident.

- Quality Standards

  RESPONSE: As part of TriStar Health, TCH will operate under the same quality standards as the 11 hospitals TriStar Health operates in Middle Tennessee. TCH will provide high quality care that is accessible for all patients in the Service Area. The hospital will be appropriately licensed and accredited by the Joint Commission. It will seek accreditation as an Advanced Primary Stroke Center, certification as a Chest Pain Center, and designation as a Level III Trauma center. The ER will serve all acuity levels and operate under the same high quality standards as all TriStar Health hospitals. In addition, as part of HCA Healthcare, it will have a robust Quality Assurance and Performance Improvement (QAPI) and Utilization Review Program to maintain and ensure quality of care and patient safety.

- Consumer Advantage
  - Choice

    RESPONSE: TCH will bring another hospital to Clarksville, the fifth (5th) most populated city in the state, and to an area in northern Montgomery County which is geographically isolated from other hospitals in the region. It will

bring a choice of providers and convenience to the community. The added choice is highlighted by the fact that annually more than 8,400 Montgomery County residents leave Montgomery County for inpatient hospital care.

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

  RESPONSE: TCH will improve access by (1) establishing a hospital in a part of the Service Area where none exists; (2) bringing inpatient, emergency and specialized services to a community with needs for such services; (3) reducing travel time to hospital services, including emergency services; (4) reducing out-migration to hospitals in other cities; and (5) reducing EMS transports out of the area.

- ○ Affordability

  RESPONSE: TCH will ensure access for all patients. TriStar Division is the largest TennCare provider in Tennessee and has the most generous charity care policy in the region. As part of TriStar Health, it will adhere to Non-Discrimination and Charity/Indigent Care policies. These policies ensure access to healthcare by treating all patients regardless of race, ethnicity, or socioeconomic status. The hospital will accept all government payors, including Medicare and TennCare, and will treat all patients regardless of their ability to pay. TCH, like all facilities in the TriStar Health network, will adhere to HCA Healthcare's financial assistance policies, which aim to reduce cost of care or provide free care to eligible patients. TCH emergency services will also comply with the No Surprises Act, by holding the patients harmless from any differences between in-network or out-of-network insured status.

3E. Consent Calendar Justification

- ☐ Letter to Executive Director Requesting Consent Calendar (Attach Rationale that includes addressing the 3 criteria)
- ☑ Consent Calender NOT Requested

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

4E. PROJECT COST CHART

A. Construction and equipment acquired by purchase:	
1. Architectural and Engineering Fees	$10,881,000
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$150,000
3. Acquisition of Site	$13,500,000
4. Preparation of Site	$9,000,000
5. Total Construction Costs	$157,970,000
6. Contingency Fund	$16,698,000
7. Fixed Equipment (Not included in Construction Contract)	$19,790,000
8. Moveable Equipment (List all equipment over $50,000 as separate attachments)	$39,558,000
9. Other (Specify): Testing, Inspection, Escalation, Building Fees and Pre-Planning	$18,456,000
B. Acquisition by gift, donation, or lease:	
1. Facility (inclusive of building and land)	$0
2. Building only	$0
3. Land only	$0
4. Equipment (Specify):	$0
5. Other (Specify):	$0
C. Financing Costs and Fees:	
1. Interim Financing	$0
2. Underwriting Costs	$0
3. Reserve for One Year's Debt Service	$0
4. Other (Specify):	$0
D. Estimated Project Cost (A+B+C)	$286,003,000
E. CON Filing Fee	$45,000
F. Total Estimated Project Cost (D+E) **TOTAL**	$286,048,000

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:

The Health Facilities Commission ("HFC") has criteria and standards for various healthcare services. The HFC has the discretion to approve new hospital beds even when all criteria under the State Health Plan are not precisely met when there is a compelling reason to do so; and the HFC has done so when there was demonstrated need for additional health services in a particular community. As demonstrated throughout this CON Application, the evidence supporting a hospital the Clarksville community is compelling and overwhelmingly warrants its approval.

With respect to the proposed TCH, three criteria and standards are relevant and applicable, as follows:

Ø Acute Care Beds Criteria and Standards;

Ø Neonatal Intensive Care Unit (NICU) Criteria and Standards; and

Ø Cardiac Catheterization Criteria and Standards.

While Magnetic Resonance Imaging (MRI) services are also proposed, Montgomery County has a population exceeding 175,000. As a result, TCH does not require CON approval for MRI services. TCH's responses to the three criteria and standards applicable to the proposal in this CON Application are individually provided in Attachment 1N. As is shown in these three sections within Attachment 1N, the need for the proposed TCH is overwhelmingly demonstrated.

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:

Please see attached PDF of response to Question 2N.

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

PROJECTED UTILIZATION

Unit Type: ☐ Procedures ☐ Cases ☑ Patients ☐ Other _____

Service Area Counties	Projected Utilization Recent Year 1 (Year = 2029)	% of Total
Other not primary/secondary county	484	20.00%
Montgomery	1,822	75.29%
Stewart	114	4.71%
Total	2,420	100%

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

RESPONSE:

Please see attached PDF of response to Question 3N.

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

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

RESPONSE:

Please see attached PDF of response to Question 3N.

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

RESPONSE:

Please see attached PDF of response to Question 4N.

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

RESPONSE:

Please see attached PDF of response to Question 5N.

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

RESPONSE:

Please see attached PDF of response to Question 6N.

7N. Complete the chart below by entering information for each applicable outstanding CON by applicant or share common ownership; and describe the current progress and status of each applicable outstanding CON and how the project relates to the applicant, and the percentage of ownership that is shared with the applicant's owners.

RESPONSE:

The Applicant does not have any outstanding CON applications. The Applicant's TriStar 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.

· CN 2205-027 – TriStar Centennial – Bellevue FSED has been open and receiving patients since December 2024. A final report was submitted to the HFC staff on May 30, 2025.

· 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. Development of the recently approved location is underway.

· CN2304-010 – TriStar Southern Hills Nolensville FSED was approved on June 28, 2023. The groundbreaking occurred on January 16, 2025, with an anticipated opening in October 2025.

· 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 (VUMC) and Williamson Medical Center (WMC) commenced contested case proceedings challenging the CON on June 28, 2024, which were set for trial in November 2025. Both VUMC and WMC dismissed their challenges in May 2025, and on May 14, 2025, the Administrative Procedures Divisions entered its Initial Order of Dismissal dismissing the challenge to the CON. Accordingly, TriStar Spring Hill Hospital is proceeding with the planning and development of this hospital.

· 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.

CON Number	Project Name	Date Approved	Expiration Date
CN2205-027	TriStar Centennial Bellevue FSED	8/24/2022	10/1/2025
CN1707-023	TriStar StoneCrest Surgery Center	10/25/2017	5/31/2026
CN2302-006	TriStar Skyline East Nashville FSED	4/26/2023	6/1/2026
CN2204-010	TriStar Spring Hill Hospital	6/26/2024	8/1/2027
CN2304-010	TriStar Southern Hills Nolensville FSED	6/25/2023	8/1/2026
	Chattanooga East		

CN2308-020	Surgicenter	10/25/2023	12/1/2025
CN2407-020	TriStar Hendersonville White House FSED	10/23/2024	12/1/2027

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: TCH is a new hospital, so it does not have any existing transfer agreements. However, transfers among TriStar Health facilities are accomplished by its transfer center. With respect to unrelated parties, TCH will enter into transfer agreements with hospitals to transfer patients for services not available at TCH, such as tertiary services, or transfers based on patient requests. See Attachment 1C for a proposed TCH transfer agreement which is a standard template to use as appropriate.

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: Other plans: Coventry Healthcare; First Health/Coventry National; HCA Employee Benefit Plan; Health Alliance; Magellan Health Service; MultiPlan/PHCS; PPO Plus; Ambetter Exchange; Oscar; Amerigroup; WellPoint

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

RESPONSE:

Consumer advantage weighs heavily in support of TCH. Indeed, TCH will have an overwhelmingly positive effect on the healthcare landscape in the Service Area, including:

· Establishing a hospital in north Clarksville, where no such facility exists, which will provide an option close to where citizens live, work, and play;

· Providing an alternative hospital, physicians, and programming as only one such hospital and provider exists today so consumers have no choice but to utilize that provider or leave the Service Area;

· Reducing travel time for patients and families with approximately 50 percent leaving the Service Area for alternate providers, including a large percent coming to TriStar Health hospitals;

· Improving access for patient and families with shorter time to reach services and to visit with patients who are not diverted out of the area;

· Providing cardiac catheterization services by an alternate cardiac services team rather than leaving the Service Area to reach these providers. This, in turn, will save heart muscle by reducing the symptom to balloon time for patients needing intervention in a cath lab;

· Improving the time for birthing mothers to reach a hospital;

· Providing 24/7 OB coverage with laborists and a state-of-the-art LDRP facility with program enhancements such as immersion tubs, doulas and other desired features;

· Establishing a Level II NICU to support the maternity program;

· Reducing travel time for a discharged mother to be with her Level II NICU baby while s/he remains hospitalized;

· Decreasing out-migration to access hospital services.

· Reducing ER to hospital transports for the significant number of patients being transported from the one existing hospital in Montgomery County;

· Reducing transfers from Montgomery County providers to other TriStar Health hospitals in Middle Tennessee;

· Reducing transfers from Blanchfield Army Community Hospital to other TriStar Health hospitals in Middle Tennessee.

· Decreasing EMS transports from scenes to hospitals in other cities, which will reduce the time for EMS transports to reach a hospital and reduce the time that the EMS providers are out of service; and

· Providing an additional training site for Blanchfield providers who have a collaborative agreement with TriStar Health hospitals.

As a general principle, consumers benefit from having choices for their healthcare. This is especially true when it comes to hospital services. The HFC has recently recognized that patient choice is a valuable consumer benefit, especially when there is no such service available in a community. Here, there is only one hospital in Montgomery so consumers will benefit from the competition of alternate hospital provider in their community rather that – as required currently – having to leave the Service Area for an alternate provider.

Moreover, as discussed more fully in context with **Exhibit 48**, the charges at TCH are comparable to the charges at Tennova Clarksville. Accordingly, the cost and inconvenience of traveling to another city for inpatient hospital care will be greatly reduced by approving TCH.

TCH will bring needed services to the Service Area, including cardiac catheterization, an ICU, hospital operating rooms, and a maternity center including a Level II NICU. These program benefits flow to consumers with the approval of TCH. Respectfully, there are no negative impacts for consumers.

Favorable Impact of TriStar Clarksville Hospital on the Local Economy

In addition, TCH will benefit all residents of the Service Area, not only those who require inpatient and outpatient services via the direct, indirect and induced impact the hospital's implementation will have on the local economy, both short term and long term. This includes creating a significant long-term employment base, positive impact on local taxes to enable authorities to redeploy these revenues into its community commitments, indirect impact benefiting local businesses and induced impact resulting from employees spending their wages on consumer-related services such as retail, restaurants, and other activities.

During the multi-year construction process, it will also generate significant employment in the construction industry, taxes from material, equipment, systems and other related purchases, indirect impact relative to local businesses supporting the construction and equipping activities and induced impact with workers spending locally. TCH will have a significant economic impact on the Clarksville community which is a direct Consumer Advantage.

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, Clarksville Health Services, LLC., the Applicant, is part of TriStar Health, an affiliate of HCA Healthcare, one of the largest providers of healthcare and hospital services in the U.S. and U.K. HCA Healthcare operations include 186 hospitals and 2,400+ sites of care in 20 states and the United Kingdom. In addition to hospitals, sites of care include surgery centers, freestanding ERs, urgent care centers, diagnostic and imaging centers, walk-in clinics and physician clinics.

HCA Healthcare's facilities in Tennessee and Kentucky, are organized within its TriStar Division. Within the TriStar Division, TriStar Health manages 11 hospitals, 6 freestanding EDs, 8 surgery centers, 20 urgent care centers, and 116 physician practices, with a continuum of services for residents of Middle Tennessee and Southern Kentucky. With TriStar Health's local, statewide, and national affiliations, TCH expects to be able to recruit highly qualified individuals with the appropriate licensure to staff and support the hospital.

TriStar Health with its hospitals and other healthcare sites throughout Middle Tennessee has identified that 523 of its employees reside in Montgomery County. Of these, 483 are in direct patient care roles. Accordingly, TCH has a significant foundation of staff upon which it will build its employee and physician base to appropriately staff the proposed hospital. TriStar Health also has a significant representation of its providers (physicians and extenders) who reside in Montgomery County, totaling 55 based on current counts. TCH will capitalize on the presence of these providers as it develops its medical staff plan for its future operations.

Based on forecasted utilization, TCH estimates a need for 210 FTEs in its initial year of operations. With this level of employees residing in the County, of which approximately 483 are in direct patient care roles, the Applicant is confident it will successfully recruit the needed complement to staff the hospital.

TriStar Health and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. In 2021, HCA Healthcare opened the Galen College of Nursing in Nashville, which now has campuses and programs in Tennessee, Kentucky, Ohio, Virginia, South Carolina, Florida and Texas. The Nashville campus offers a 3-year Bachelor of Science in Nursing, an Associate Degree in Nursing (ADN) and an LPN to ADN Bridge program. It graduated 45 nurses in its first year (2023) and is currently enrolling 700 new students each

year. It expects estimated enrollment to increase 5 to 10 percent each year. This year, Galen College of Nursing expects to graduate approximately 250 graduates. It is HCA Healthcare's experience that 55 percent of the graduates join an HCA Healthcare hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Health including recruitment for the proposed Murfreesboro FSED. TriStar Health is also committed to increasing its nursing residency programs.

The Thomas F. Frist, Jr. College of Medicine at Belmont University in Nashville, is a new medical school founded in alliance with HCA Healthcare to focus on training diverse physician leaders who embrace and value a whole-person approach to healing. The Thomas F. Frist, Jr. College of Medicine at Belmont University is housed in a new building that had its ribbon cutting on April 29, 2024. The nearly 200,000-square-foot building is located within a block of Belmont's Gordon E. Inman Center and McWhorter Hall, which house the University's well-known nursing, physical therapy, occupational therapy, social work and pharmacy programs. The College of Medicine has recruited a leadership team consisting of experts from across the country and is currently recruiting additional clinical faculty. Its first class commenced this past fall. TriStar Health 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 Middle Tennessee, TriStar Health is integrally involved in graduate medical education (GME). It currently has 133 residents, with 72 at TriStar Centennial (internal medicine, psychiatry, and transitional year), 37 at TriStar Skyline (emergency medicine, neurology, surgical critical care and physical medicine and rehabilitation) and 24 family medicine residents at TriStar Southern Hills. In July 2024, total resident count in these three hospitals will increase to 158, with 77 at TriStar Centennial, 56 at TriStar Skyline and 25 at TriStar Southern Hills. HCA Healthcare has more than 5,600 residents at its hospitals, making it one of the largest GME providers in the country. TriStar Health and HCA Healthcare look forward to working collaboratively with Belmont to support the supply of healthcare professionals entering and staying in the profession and to ensure that they have access to training.

In 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 internships and other training opportunities for students at TriStar facilities and also provide a pipeline for future qualified employees. **Exhibit 47** below provides a summary of programs that currently work with TriStar Health and the profession for which the students are matriculating and training.

Exhibit 47

Academic Partners	Degree/ Program
Nursing - Nashville Market	
Belmont	BSN
Galen - Nashville	ADN/BSN
South College (Knoxville & Nashville campus)	BSN
Austin Peay State University (APSU)	BSN
Middle Tennessee State University (MTSU)	BSN
Cumberland *DEU	BSN
Lipscomb	BSN
Tennessee Tech	BSN
Vol State *DEU	ADN
Nashville State	ADN
Columbia State	ADN
Herzing *New program	ADN/BSN
Fortis	ADN
Surgical Technology - Nashville Market	
South College	Surgical Tech
Fortis Institute	Surgical Tech
South Kentucky Community & Technical College	Surgical Tech
Nashville State	Surgical Tech
Diagnostic Imaging - Nashville Market	
South College	Rad Tech (AAS)
Austin Peay	Rad Tech (AAS)
Fortis Institute	Rad Tech (AAS)
Vol State	Rad Tech (AAS)
Columbia State	Rad Tech (AAS)
Nashville State	Rad Tech (AAS)
South Kentucky Community & Technical College	Rad Tech (AAS)
Casa Loma	Rad Tech (AAS)

TCH will:

· Be licensed by all required state agencies;

· Be accredited by The Joint Commission;

· Seek Advanced Primary Stroke Center status;

· Become Chest Pain Center certified;

· Achieve Trauma Level III Designation;

· Provide on-site diagnostic imaging and clinical laboratory services meeting all required clinical certifications and accreditations;

· Be staffed by credentialed physicians; and

· Provide access to on-call specialty physicians for consultations.

The Applicant will have all appropriate resources and be familiar with and meet all human resource requirements of the Health Facilities Commission/Licensure Division and the Joint Commission. In addition, the Applicant will be licensed and accredited by these bodies.

TriStar Clarksville Hospital Staffing

More specific staffing estimates for TCH are 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 Certification

TCH will seek licensure by the Health Facilities Commission / Licensure Division. TCH will also apply to become certified to participate in the Medicaid and Medicare programs and meet all requirements of certification. TCH will also plan to be accredited by The Joint Commission as are all TriStar Health hospitals. In addition, TCH will seek to become an accredited Advanced Primary Stroke Center, certified Chest Pain Center and achieve Trauma Level III designation.

Plan for Improvement of Organization Performance and Clinical Excellence

As part of TriStar Health, TCH will be part of TriStar Health's methods to ensure and maintain quality of care. At TriStar Health, 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 Health 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. TCH's goal will be 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 ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

TCH, as part of TriStar Health, will 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. TCH will address methods to ensure and maintain patients' quality of care.

TCH will be dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. It will maintain the highest standards and quality of care, consistent with the high standard at

other TriStar Health affiliates in Middle Tennessee. In this regard, TCH will incorporate a robust Quality Assurance and Performance Improvement ("QAPI") Plan, which will be 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, TCH will provide 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 will serve an important advisory purpose in enhancing and maintaining the quality of care provided. To this extent, systems will be 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** for TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence.

The NICU will also participate in unit-specific, departmental and hospital-wide performance improvement activities. Its performance Improvement activities are designed to provide a planned, systematic approach to process design, performance measurement, assessment, and improvement. Performance improvement activities are reported through the designated facility committees. Patient safety initiatives including infant security, staffing effectiveness, and code review are reported to the hospital's Department of Quality and Risk on a specific schedule for assimilation with findings from other areas of the facility. For more details, see **Attachment 1N, NICU** for TriStar Health's Provision of Care for its NICU.

The Cardiac Cath lab will also participate in unit-specific, departmental and hospital-wide performance improvement activities. Its performance improvement will be in accordance with ACC Guidelines. TCH will document ongoing compliance with the latest clinical guidelines of the American College of Cardiology / Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document of Cardiac Catheterization Laboratory Standards (ACC Guidelines). These are identified in **Attachment 1N, Cardiac Catheterization Services**. TCH will comply with guidelines that address physical facility requirements, staffing, training, quality assurance, patient safety, screening patients for appropriate settings, and linkages with supporting emergency services. will also receive certification/accreditation to be a STEMI receiving facility. TCH will pursue a similar Chest Pain Center certification from The Joint Commission.

The proposed MRI will be certified by the FDA. TCH is constructing a new hospital that will be built to current codes, including applicable federal and state standards, manufacturer's specifications and TDOH requirements. TCH will have protocols in place that assure MRI procedures performed are medically necessary and will not unnecessarily duplicate other services. As part of its radiology department operations, TCH will meet the staffing recommendations and requirements set forth by the American College of Radiology, including staff education and training programs. Additionally, TCH commits to obtaining accreditation from the American College of Radiology within two years following operation of the proposed MRI Unit. Given the population in Montgomery County exceeds 175,000 people, TCH is not required to respond separately to the MRI Criteria and Standards.

Clinical Leadership

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

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

TCH will be actively engaged in developing its leadership, establishing a performance improvement culture and empowering staff in their delivery of quality care in the Service Area.

Clinical Staff Training and Requirements

In its dedication to enhance quality assurance and performance improvement, TCH employees will be 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, TCH will require all clinical staff members to attend continuing education programs, and receive annual in-services on HIPAA, Medicare compliance, and OSHA. TCH will offer 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.

PROJECTED DATA CHART

☑ Project Only
☐ Total Facility

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

	Year 1	Year 2
	2029	2030
A. Utilization Data		
Specify Unit of Measure Other : Adjusted Admissions	5358	8012
B. Revenue from Services to Patients		
1. Inpatient Services	$175,988,702.00	$288,387,125.00
2. Outpatient Services	$213,644,614.00	$349,863,032.00
3. Emergency Services	$0.00	$0.00
4. Other Operating Revenue (Specify) _____	$0.00	$0.00
Gross Operating Revenue	$389,633,316.00	$638,250,157.00
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$314,870,000.00	$520,301,000.00
2. Provision for Charity Care	$20,629,764.00	$34,116,087.00
3. Provisions for Bad Debt	$1,815,236.00	$3,001,913.00
Total Deductions	$337,315,000.00	$557,419,000.00
NET OPERATING REVENUE	$52,318,316.00	$80,831,157.00

PROJECTED DATA CHART

☑ Total Facility
☐ Project Only

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

	Year 1	Year 2
	2029	2029
A. Utilization Data		
Specify Unit of Measure Other : Adjusted Admissions	5358	8012
B. Revenue from Services to Patients		
1. Inpatient Services	$175,988,702.00	$288,387,125.00
2. Outpatient Services	$213,644,614.00	$349,863,032.00
3. Emergency Services	$0.00	$0.00
4. Other Operating Revenue (Specify) _____	$0.00	$0.00
Gross Operating Revenue	$389,633,316.00	$638,250,157.00
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$314,870,000.00	$520,301,000.00
2. Provision for Charity Care	$20,629,764.00	$34,116,087.00
3. Provisions for Bad Debt	$1,815,236.00	$3,001,913.00
Total Deductions	$337,315,000.00	$557,419,000.00

NET OPERATING REVENUE	$52,318,316.00	$80,831,157.00

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

Project Only Chart

	Previous Year to Most Recent Year	Most Recent Year	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	$0.00	$0.00	$72,719.92	$79,661.78	0.00
Deduction from Revenue *(Total Deductions/Utilization Data)*	$0.00	$0.00	$62,955.39	$69,573.02	0.00
Average Net Charge *(Net Operating Revenue/Utilization Data)*	$0.00	$0.00	$9,764.52	$10,088.76	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:

TCH is proposing to establish a new community hospital; it therefore does not have current hospital charges. Its proposed charge structure utilizes a composite of TriStar Health's four community hospitals in Middle Tennessee, outside Davidson County.[16] It is that composite that was utilized to forecast gross charges as presented in the projected chart on the previous page. Deductions from revenues are based on TriStar Health's reimbursement experience by payor for both inpatient and outpatient services. TCH also factors in anticipated bad debt and charity care based on that experience.

Gross charges do not reflect what either patients or payors pay as payors have discounted rates and insured patients are only responsible for co-pays and deductibles. In reality, the average net charge is what patients and/or payors pay in aggregate for the services received. As reflected in the above chart, the average net charge per adjusted admission at TCH is estimated to be $10,089 in year two.

[16] The four hospitals are TriStar Hendersonville Medical Center, TriStar StoneCrest Medical Center, TriStar NorthCrest Medical Center and TriStar Horizon Medical Center.

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 a composite of the existing charges at TriStar Health's four community hospitals in Middle Tennessee as mentioned above. It is important to consider several factors when reviewing charge data:

· Comparison of charges for services are not meaningful as gross charges do not reflect what either patients or payors pay for 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.

· 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 TCH'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 the Service Area. On the CMS Hospital Compare website there are four patient conditions for which Medicare publishes what it paid each hospital on average for these conditions. The four conditions and respective payments to Tennova Clarksville are presented below. Since TCH is not a hospital yet, it has no such reporting for comparison purposes. However, since the composite of four area hospitals were utilized to estimate charges for TCH, these four TriStar Health hospitals are included in the below exhibit. The conclusion that may be drawn from this comparative information is that on average across these four conditions, Medicare payments are comparable among the TriStar Health hospitals and Tennova Clarksville.

Exhibit 48

Condition	Medicare Payments by Condition				
	TriStar StoneCrest	TriStar NorthCrest	TriStar Horizon	TriStar Hendersonville	Tennova Clarksville
Heart Attack Patients	$28,328	$28,110	$29,715	$27,760	$26,783
Heart Failure Patients	$20,428	$18,164	$19,549	$20,790	$20,267
Hip/Knee Replacement Patients	n/a	$22,811	$21,416	$21,686	n/a
Pneumonia Patients	$21,174	$22,317	$21,274	$21,693	$21,943

Source: Centers for Medicare and Medicaid Services, Hospital Compare, February 19, 2025. n/a - not available on CMS website.

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	$122,012,242.00	31.31	$200,703,333.00	31.45
TennCare/Medicaid	$81,223,629.00	20.85	$132,345,527.00	20.74
Commercial/Other Managed Care	$101,254,066.00	25.99	$165,017,250.00	25.85
Self-Pay	$22,619,712.00	5.81	$37,383,256.00	5.86
Other(Specify)	$62,523,667.00	16.05	$102,800,791.00	16.11
Total	$389,633,316.00	100%	$638,250,157.00	100%
Charity Care	$20,629,764.00		$34,116,087.00	

**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: TCH will participate in both Medicare and TennCare/Medicaid. Consistent with TriStar Health policy, TCH will also offer a prompt pay discount of 20 percent for patients paying estimated deductible and co-pays at the time of service. TCH will be part of the 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. All self-pay patients will receive a discount similar to managed care, referred to as an "uninsured discount." The Uninsured Discount is available to patients who have no third-party payer source of payment or do not qualify for Medicaid, Charity, or any other discount program the facility offers. See Attachment 10C for these policies.

QUALITY STANDARDS

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

- [x] Yes
- [ ] No

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

- Does the applicant commit to maintaining the staffing comparable to the staffing chart presented in its CON application?

  - [x] Yes

☐ No

- Does the applicant commit to obtaining and maintaining all applicable state licenses in good 3tanding?
  - ☑ 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	☑ Health Facilities Commission/Licensure Division ☐ Intellectual & Developmental Disabilities ☐ Mental Health & Substance Abuse Services	Will Apply	
Certification	☑ Medicare ☑ TennCare/Medicaid ☐ Other _____	Will Apply Will Apply	
Accreditation(s)	TJC - The Joint Commission	Will Apply	

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		
Registered Nurses Direct Care	0.00	66.40
LPN/LVN Direct Care	0.00	7.10
Patient Care Support	0.00	26.10
Clinical Specialists/Prof	0.00	17.00
Clinical Technicians	0.00	23.10
Total Direct Patient Care Positions	N/A	139.7

B. Non-Patient Care Positions		
Clerical and Other Admin	0.00	4.50
Clinical Specialists/Prof	0.00	5.30
Environ/Food Services/Plant Ops	0.00	12.40
Management & Supervision	0.00	14.30
Non-clinical Specialists/Prof	0.00	5.30
Total Non-Patient Care Positions	N/A	41.8
Total Employees *(A+B)*	0	181.5

C. Contractual Staff		
Contractual Staff Position	0.00	28.20
Total Staff *(A+B+C)*	0	209.7

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		07/23/25
2. Building Construction Commenced	365	07/22/26
3. Construction 100% Complete (Approval for Occupancy)	1036	05/23/28
4. Issuance of License	1106	08/01/28
5. Issuance of Service	1198	11/01/28
6. Final Project Report Form Submitted (Form HR0055)	1318	03/01/29

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

Classifieds

To Advertise, visit our website: **Classifieds.theleafchronicle.com**
Public Notices/Legals email: **Publicnotice@tnmedia.com**
Business & Services email: **Servicedirectory@theleafchronicle.com**
To post job openings, visit: **Theleafchronicle.com/jobs**

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

PUBLIC NOTICES

Auto Auction

11354690
Notice is hereby given that Jones Bros Towing will sell at public auction to the highest bidder, the following described abandoned vehicles:
2007 MAZDA MAZDA3
JM1BK12F271439124
OWNER: NOLA MORRIS
2010 CHEVROLET IMPALA
2G1WC5EM4A1200095
OWNER: BOBBY SMITH
1994 CHEVROLET C/K 1500 SERIES
1GCEK14S7RE113459
OWNER: RYLEY COPPOCK
2008 HONDA ACCORD
1HGCP36808A013796
OWNER: AUSTIN HUTCHENS
2011 MAZDA MAZDA3
JM1BL1VF3B1901783
OWNER: MONTE FLUD
2007 FORD E-SERIES
1FTSE34L87DA57372
OWNER: LINDEKO LLC
2002 FORD EXPLORER
1FMZU73E82UC69074
OWNER: CHERYL WATKINS
LIENHOLDER: E AND S MOTORS
2003 GMC ENVOY XL
1GKES16S536184679
OWNER: DEMETRIUS RIVES
LIENHOLDER: TMX FINANCE OF TENNESSEE
2011 HYUNDAI SONATA
5NPEC4AC9BH138316
OWNER: DALLAS GRANT
The owner (s) and any lien holders has the right to reclaim this vehicle within 10 days after the date of this notice upon payment of all towing, preservation, and storage charges. The failure to exercise this right to reclaim the vehicle within the time provided shall be deemed a waiver of all right, title and interest in the vehicle and consent to sale of the vehicle at public auction on June 27, 2025

Public Notices

Notice of sale of abandoned vehicles
Bo's Shop and Towing
1223 Gupton CT
Clarksville Tn 37040
on 6/6/25 at 8am

555WF8DB0KU304547
2019 Mercedes-Benz C-Class
1N4AL3AP6DN500249
2013 Nissan Altima
1G1BE5SMXH7235802
2017 Chevrolet Cruze
2CTAL.MEC1B8259939
2011 GMC Terrain
2GNALDEK3G1148494
2016 Chevrolet Equinox
May 30, June 6 2025
LOKR0300919

Public Notices

11304624
NOTICE OF SUBSTITUTE TRUSTEE'S SALE

WHEREAS, default has occurred in the performance of the covenants, terms and conditions of a Deed of Trust dated September 20, 2017, executed by CHADDRICK E. DAVIS and JENNIFER REINBRECHT conveying certain real property therein described to JONATHAN R. VINSON, as Trustee, as same appears of record in the Register's Office of Montgomery County, Tennessee recorded September 22, 2017, in Deed Book 1767, Page 812; and

WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to Citizens Bank, N.A. who is now the owner of said debt; and

WHEREAS, the undersigned, Rubin Lublin TN, PLLC, having been appointed as Substitute Trustee by instrument to be filed for record in the Register's Office of Montgomery County, Tennessee.

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that the undersigned, Rubin Lublin TN, PLLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty and authority vested and imposed upon said Substitute Trustee will, on July 17, 2025 at 10:00 AM at the Front Steps of the Montgomery County Courthouse, Clarksville, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash or certified funds ONLY, the following described property situated in Montgomery County, Tennessee, to wit:

LAND SITUATED IN MONTGOMERY COUNTY, TENNESSEE, BEING LOT 461 ON THE PLAN OF ARBOUR GREEN SOUTH SUBDIVISION, AS SHOWN BY PLAT OF RECORD IN PLAT F, PAGE 291 AND REPLATTED IN PLAT F, PAGE 328, IN THE REGISTER'S OFFICE FOR MONTGOMERY COUNTY, TENNESSEE. TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE COMPLETE LEGAL DESCRIPTION. BEING THE SAME PROPERTY CONVEYED TO CHADDRICK E. DAVIS AND JENNIFER REINBRECHT FROM DUNCAN FAMILY PARNERSHIP BY: JARROD K DUNCAN ITS: PARTNER BY WARRANTY DEED DATED 9/20/17 AND RECORDED IN BOOK 1767, PAGE 809, IN THE REGISTER'S OFFICE OF MONTGOMERY COUNTY, TENNESSEE.

Parcel ID: 017D-H-023.00

PROPERTY ADDRESS: The street address of the property is believed to be 900 CINDY JO CT, CLARKSVILLE, TN 37040. In the event of any discrepancy between this street address and the legal description of the property, the legal description shall control.

CURRENT OWNER(S): CHADDRICK E. DAVIS, JENNIFER REINBRECHT OTHER INTERESTED PARTIES:

The sale of the above-described property shall be subject to all matters shown on any recorded plat; any unpaid taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; and to any matter that an accurate survey of the premises might disclose. This property is being sold with the express reservation that it is subject to confirmation by the lender or Substitute Trustee. This sale may be rescinded at any time. 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 set forth above. All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The Property is sold as is, where is, without representations or warranties of any kind, including fitness for a particular use or purpose.

THIS LAW FIRM IS ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

Rubin Lublin TN, PLLC, Substitute Trustee
3145 Avalon Ridge Place, Suite 100
Peachtree Corners, GA 30071
rlselaw.com/property-listing
Tel: (877) 813-0992
Fax: (470) 508-9401

Public Notices

11313358
SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on July 17, 2025 at 11:00AM local time, at the front door, Montgomery County Courthouse, 2 Millennium Plaza, Clarksville, Tennessee pursuant to Deed of Trust executed by Hisako Wright, to Legends Title Services LLC, Trustee, as trustee for Mortgage Electronic Registration Systems, Inc., as nominee for Reverse Mortgage Funding, LLC on April 30, 2018 at Volume 1809, Page 1662, Instrument No. 1163485; conducted by LLG Trustee TN LLC, having been appointed Substitute or Successor Trustee, all of record in the Montgomery County Register's Office. Default has occurred in the performance of the covenants, terms, and conditions of said Deed of Trust and the entire indebtedness has been declared due and payable.

Party Entitled to Enforce the Debt: Carrington Mortgage Services LLC, its successors and assigns.

The real estate located in Montgomery County, Tennessee, and described in the said Deed of Trust will be sold to the highest call bidder. The terms of the said Deed of Trust may be modified by other instruments appearing in the public record. Additional identifying information regarding the collateral property is below and is believed to be accurate, but no representation or warrant is intended.

Street Address: 221 Andrew Drive, Clarksville, Tennessee 37042
Parcel Number: 030P D 011.00
Current Owner(s) of Property: Hisako Wright

This sale is subject to, without limitation, all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory right of redemption of any governmental agency, state or federal; any prior liens or encumbrances including those created by a fixture filing or any applicable homeowners' association dues or assessments; all claims or other matters, whether of record or not, which may encumber the purchaser's title and any matter that an accurate survey of the premises might disclose.

The following parties may claim an interest in the above-referenced property to be affected by the foreclosure: any judgment creditor or lien holder with an interest subordinate to the said Deed of Trust or any party claiming by, though, or under any of the foregoing. Such parties known to the Substitute Trustee may include: Secretary of Housing and Urban Development.

Terms of Sale will be public auction, for cash, free and clear of rights of homestead, redemption and dower to the extent disclaimed or inapplicable, and the rights of Hisako Wright, and those claiming through him/her/it/them.

Any right of equity of redemption, statutory and otherwise, and homestead are waived in accord with the terms of said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

The right is reserved to 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 set forth above. If you purchase a property at the foreclosure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified/bank check made payable to or endorsed to LOGS Legal Group LLP. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the lender and any other bidders. Insufficient funds will not be accepted. Amounts received in excess of the winning bid will be refunded to the successful purchaser at the time the foreclosure deed is delivered.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded only by the Substitute Trustee at any time. If the Substitute Trustee rescinds the sale, the purchaser shall only be entitled to a return of any money paid towards the purchase price and shall have no other recourse. Once the purchaser tenders the purchase price, the Substitute Trustee may deem the sale final in which case the purchaser shall have no remedy. The real property will be sold AS IS, WHERE IS, with no warranties or representations of any kind, express or implied, including without limitation, warranties regarding condition of the property or marketability of title.

This office may be a debt collector. This may be an attempt to collect a debt and any information obtained may be used for that purpose.

LLG Trustee TN LLC
Substitute Trustee
10130 Perimeter Parkway, Suite 400
Charlotte, NC 28216
Phone (704) 333-8107
Fax (704) 333-8156

File No. 25-125726

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 Clarksville Hospital, d/an Hospital owned by Clarksville Health Services, LLC with an ownership type of Limited Liability Company and to be managed by itself intends to file an application for a Certificate of Need for the establishment of a full service acute care hospital with 68 licensed beds. The project also seeks to initiate diagnostic and therapeutic cardiac catheterization services, magnetic resonance imaging services (MRI), and will include a Level II neonatal intensive care unit (NICU). The address of the project will be located at an unaddressed site on Tiny Town Road, approximately 1,000 feet to the west of the intersection of Tiny Town Rd and Sandpiper Dr., Clarksville, Montgomery County, Tennessee, 37042. The estimated project cost will be $286,048,000.

The anticipated date of filing the application is 06/02/2025

The contact person for this project is Senior Vice President David Whelan who may be reached at TriStar Health – 1000 Healthpark Drive, Brentwood, TN 37027 – Contact No. 615-886-4900.

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 .
May 30 2025
LOKR0305631

Leaf Chronicle

Public Notices

Originally published at theleafchronicle.com on 05/30/2025

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The anticipated date of filing the application is 06/02/2025

The contact person for this project is Senior Vice President David Whelan who may be reached at TriStar Health - 1000 Healthpark Drive, Brentwood, TN 37027*Contact No. 615-886-4900.

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 .
May 30 2025
LOKR0305631

Attachment 7A-1

Charter / Articles

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

Clarksville Health Services, LLC
PO BOX 750
NASHVILLE, TN 37202

Karen Johnson Davidson County
Batch# 1049385 CHARTER
09/13/2023 12:16:30 PM 4 pgs
Fees: $7.00 Taxes: $0.00
20230913-0071824

September 13, 2023

Filing Acknowledgment

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

SOS Control # :	**001465815**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	09/12/2023
Filing Date:	09/12/2023 11:57 AM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2024
Duration Term:	Perpetual	Image # :	B1431-3650
Managed By:	Director Managed		
Business County:	DAVIDSON COUNTY		

Document Receipt

Receipt # : 008359712	Filing Fee:	$300.00
Payment-Check/MO - CFS-1, NASHVILLE, TN		$300.00

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

Principal Address:
ONE PARK PLAZA
NASHVILLE, TN 37203

Congratulations on the successful filing of your **Articles of Organization** for **Clarksville Health Services, LLC** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (www.tn.gov/revenue) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Nichole Hambrick

21

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

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

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: Clarksville Health Services, LLC

(NOTE: Pursuant to the provisions of T.C.A. § 48-249-106, each Limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. Name Consent: (Written Consent for Use of Indistinguishable Name)
☐ This entity name already exists in Tennessee and has received name consent from the existing entity.

3. This company has the additional designation of: _____

4. The name and complete address of ithe Limited Liability Company's initial registered agent and office located in the state of Tennessee is:
Name: C T Corporation System
Address: 300 Montvue Rd
City: Knoxville State: TN Zip Code: 37919-5546 County: Knox

5. Fiscal Year Close Month: December

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)
Effective Date: ____/____/____ (Month/Day/Year) Time: _____

7. The Limited Liability Company will be: ☐ Member Managed ☐ Manager Managed ☒ Director Managed

8. Number of Members at the date of filing: 1

9. Period of Duration: ☒ Perpetual ☐ Other ____/____/____ (Month/Day/Year)

10. The complete address of the Limited Liability Company's principal executive office is:
Address: One Park Plaza
City: Nashville State: TN Zip Code: 37203 County: Davidson
Business Email: shirley.scharf@hcahealthcare.com

202309130071824

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

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

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

The name of the Limited Liability Company is: Clarksville Health Services, LLC

11. The complete mailing address of the entity (If different from the principal office) is:
Address: PO Box 750
City: Nashville State: TN Zip Code: 37202

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)
☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. § 67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)
☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.
Licensed Profession: _____

14. Series LLC (required only if the Additional Designation of "Series LLC" is entered in section 3.)
☐ I certify that this entity meets the requirements of T.C.A. § 48-249-309(a) & (b)

15. Obligated Member Entity (list of obligated members and signatures must be attached)
☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: ____/____/____ (Month / Day / Year)
☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.

16. This entity is prohibited from doing business in Tennessee:
☐ This entity, while being formed under Tennessee law, is prohibited from engaging in business in Tennessee.

17. Other Provisions: _____

September 12, 2023
Signature Date

John M. Franck II
Signature

Director
Signer's Capacity (if other than individual capacity)

John M. Franck II
Name (printed or typed)

Rev. 12/19

RDA 2458

202309130071824

Tennessee Certification of Electronic Document

I, Jerry Lowe, do hereby make oath that I am a licensed attorney and/or the custodian of the original version of the electronic document tendered for registration herewith and that this electronic document is a true and exact copy of the original document executed and authenticated according to law on 09/12/2023 (date of document).

Affiant Signature

09/13/2023
Date

State of Tennessee

County of Davidson

Sworn to and subscribed before me this 13 day of September, 2023.

Aubrey D. Burns
Notary's Signature

MY COMMISSION EXPIRES: September 7, 2026

NOTARY'S SEAL

AUBREY D. BURNS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires 09-07-2026

202309130071824

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

Clarksville Health Services, LLC
PO BOX 750
NASHVILLE, TN 37202

September 13, 2023

Filing Acknowledgment

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

SOS Control # :	**001465815**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	09/12/2023
Filing Date:	09/12/2023 11:57 AM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2024
Duration Term:	Perpetual	Image # :	B1431-3650
Managed By:	Director Managed		
Business County:	DAVIDSON COUNTY		

Document Receipt

Receipt # : 008359712	Filing Fee:	$300.00
Payment-Check/MO - CFS-1, NASHVILLE, TN		$300.00

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

Principal Address:
ONE PARK PLAZA
NASHVILLE, TN 37203

Congratulations on the successful filing of your **Articles of Organization** for **Clarksville Health Services, LLC** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (www.tn.gov/revenue) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and receive it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Nichole Hambrick

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

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

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: Clarksville Health Services, LLC

(NOTE: Pursuant to the provisions of T.C.A. § 48-249-106, each Limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. Name Consent: (Written Consent for Use of Indistinguishable Name)
☐ This entity name already exists in Tennessee and has received name consent from the existing entity.

3. This company has the additional designation of: _____

4. The name and complete address of ithe Limited Liability Company's initial registered agent and office located in the state of Tennessee is:
Name: C T Corporation System
Address: 300 Montvue Rd
City: Knoxville State: TN Zip Code: 37919-5546 County: Knox

5. Fiscal Year Close Month: December

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)
Effective Date: ____/____/____ (Month / Day / Year) Time: _____

7. The Limited Liability Company will be: ☐ Member Managed ☐ Manager Managed ☒ Director Managed

8. Number of Members at the date of filing: 1

9. Period of Duration: ☒ Perpetual ☐ Other ____/____/____ (Month / Day / Year)

10. The complete address of the Limited Liability Company's principal executive office is:
Address: One Park Plaza
City: Nashville State: TN Zip Code: 37203 County: Davidson
Business Email: shirley.scharf@hcahealthcare.com

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

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

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

The name of the Limited Liability Company is: Clarksville Health Services, LLC

11. The complete mailing address of the entity (If different from the principal office) is:

Address: PO Box 750

City: Nashville State: TN Zip Code: 37202

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)

☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. § 67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)

☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.

Licensed Profession: _____

14. Series LLC (required only if the Additional Designation of "Series LLC" is entered in section 3.)

☐ I certify that this entity meets the requirements of T.C.A. § 48-249-309(a) & (b)

15. Obligated Member Entity (list of obligated members and signatures must be attached)

☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: ____/____/____ (Month / Day / Year)

☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.

16. This entity is prohibited from doing business in Tennessee:

☐ This entity, while being formed under Tennessee law, is prohibited from engaging in business in Tennessee.

17. Other Provisions: _____

September 12, 2023
Signature Date

John M. Franck II
Signature

Director
Signer's Capacity (if other than individual capacity)

John M. Franck II
Name (printed or typed)

Attachment 7A-2

Certificate of Good Standing

Division of Business and Charitable Organizations
Department of State
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
sos.tn.gov/

Tre Hargett
Secretary of State

KRISTINA BAGWELL
ONE PARK PLAZA
NASHVILLE, TN 37203, USA

05/21/2025

Request Type: Certificate of Existence/Authorization

Issuance Date: 05/21/2025

Request #: C2025035895

Document Receipt

Order Number: C2025035895
Receipt #: 2025-367912
Payment: Credit Card - 3898866790

Verification #: 8141BBD5
Filing Fee: $20.00
$20.00

Entity Name:	CLARKSVILLE HEALTH SERVICES, LLC		
SOS Control #:	001465815	Initial Filing Date:	09/12/2023
Entity Type:	Limited Liability Company (LLC)	Formation Locale:	TENNESSEE
Status:	Active	Duration Term:	Perpetual
Fiscal Year Close:	December	Annual Report Due:	04/01/2026
Business County:	DAVIDSON		
Managed By:	Director Managed		
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

CLARKSVILLE HEALTH SERVICES, LLC

* is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;
* has paid all fees, interest, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;
* has filed the most recent annual report required with this office;
* has appointed a registered agent and registered office in this State;
* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Attachment 7A-3

Clarksville Health Services, LLC d/b/a Documentation

Division of Business and Charitable Organizations
Department of State
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
sos.tn.gov/

Tre Hargett
Secretary of State

SHIRLEY SCHARF-CHEATHAM
ONE PARK PLAZA - LEGAL DEPT.
NASHVILLE, TN 37203, USA

05/22/2025

Filing Acknowledgment

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

Entity Name:	CLARKSVILLE HEALTH SERVICES, LLC		
SOS Control #:	001465815	Initial Filing Date:	09/12/2023
Entity Type:	Limited Liability Company (LLC)	Formation Locale:	TENNESSEE
Status:	Active	Duration Term:	Perpetual
Fiscal Year Close:	December	Annual Report Due:	04/01/2026
Business County:	DAVIDSON		
Managed By:	Director Managed		
Obligated Member Entity:	No		

Document Receipt

Receipt #: 2025-372306		Filing Fee:	$20.00
Payment: Credit Card - 3898968687			$20.00

Amendment Type:	Assumed Name Registration		
Filing Date:	05/22/2025 02:57 PM	Tracking Number:	B2025274361
Assumed Name:	TRISTAR CLARKSVILLE HOSPITAL		

This will acknowledge the filing of the attached Assumed Name Registration with an effective date as indicated above. 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 date the original registration was filed with the Secretary of State.

Tre Hargett
Secretary of State

Event History

New Assumed Name: TRISTAR CLARKSVILLE HOSPITAL

Tracking Number
B2025274361

Application for Registration of Assumed Name

Tre Hargett
Secretary of State

Division of Business and Charitable Organizations
Department of State
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
sos.tn.gov/businesses

Control #: 001465815
Filed: 05/22/2025 02:57 PM
Tre Hargett
Secretary of State

Assumed Name Details

Entity Name: CLARKSVILLE HEALTH SERVICES, LLC

Entity Type: Limited Liability Company

Managed By: Director Managed

Place of Formation: TENNESSEE

Control Number: 001465815

The entity intends to transact business in Tennessee under an assumed name.

The assumed name the entity proposes to use is:
TRISTAR CLARKSVILLE HOSPITAL

Signature

☑ By entering my name in the space provided below, I certify that I am authorized to file this document on behalf of this entity, have examined the document and, to the best of my knowledge and belief, it is true, correct and complete as of this day.

☑ Pursuant to the provisions of § 48-14-101(d) of the Tennessee Business Corporation Act or § 48-54-101(d) of the Tennessee Nonprofit Corporation Act, or Section 48-207-101(d) of the Tennessee Limited Liability Act, or Section 48-249-106(d) of the Tennessee Revised Limited Liability Act, or Section 61-1-1003 of the Tennessee Uniform Partnership Act, or Section 61-3-101 of the Limited Partnership Act of 2017, the entity hereby submits this application:

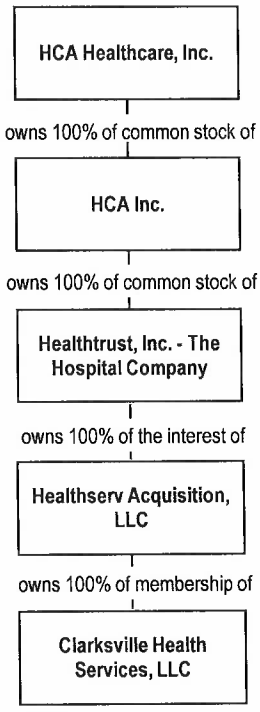
Signed Electronically: JOHN M. FRANCK II

Date: 05/22/2025

Title: DIRECTOR

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 membership of
Clarksville Health Services, LLC

Attachment 7A-5

Clarksville Health Services, LLC

Officers and Directors

May 1, 2024

OFFICERS AND DIRECTORS
OF
CLARKSVILLE HEALTH SERVICES, LLC

* **Samuel N. Hazen**	**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 R. McAlevey	Senior Vice President	One Park Plaza Nashville, TN 37203
Tim McManus	Senior Vice President	One Park Plaza Nashville, TN 37203
Joseph A. Sowell, III	Senior Vice President	One Park Plaza Nashville, TN 37203
* **Christopher F. Wyatt**	**Senior Vice President**	**One Park Plaza** **Nashville, TN 37203**
Kevin A. Ball	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Mike T. Bray	Vice President	One Park Plaza Nashville, TN 37203
Monica Cintado	Vice President	One Park Plaza Nashville, TN 37203
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
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
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 and Assistant Administrator of facilities owned and/or operated by this Company or by a partnership for which this Company acts as general partner or by a limited liability company for which this Company acts as managing member, are hereby authorized to, subject to the Company's policies and procedures, (a) manage the facilities and all day-to-day operations of, and the employees and agents of the Company at, such facilities, and take such other acts as are necessary or appropriate for the proper functioning of the facilities, and (b) negotiate and enter into contracts and agreements necessary to conduct the day-to-day business of such facilities, including, but not limited to, physician contracts, personal property leases, purchase agreements, cost reports, and similar documents (but specifically excluding any contracts or leases relating to real estate, except for leases to tenants in buildings owned by or leased to the Company entered into pursuant to the Company's policies and procedures) which with the advice of legal counsel shall be deemed appropriate and advisable, and to execute and deliver Certificates of Resolution required in connection with such contracts and agreements.

Attachment 8A

Management Agreement

NOT APPLICABLE

Attachment 9A-1

Real Estate Purchase and Sale Agreement

REAL ESTATE PURCHASE AND SALE AGREEMENT

THIS REAL ESTATE PURCHASE AND SALE AGREEMENT ("***Agreement***") is made and entered into effective as of the date the last of the Parties executes this Agreement ("***Effective Date***"), by and between **WILLIAM BELEW, JR.**, an individual ("***Seller***"), and **CLARKSVILLE HEALTH SERVICES, LLC**, a Tennessee limited liability company, its successors and assigns ("***Purchaser***"). Seller and Purchaser are sometimes referred to in this Agreement individually as a "***Party***" and collectively as the "***Parties.***"

A. Seller owns approximately 319.02 acres of land situated in Montgomery County, Tennessee, located on Tiny Town Road in Clarksville, Tennessee, and having parcel ID number: 018 01600 000 and generally depicted on Exhibit A attached to this Agreement (the "***Parent Tract***").

B. In accordance with the terms and provisions of this Agreement, Seller desires to sell to Purchaser and Purchaser desires to purchase from Seller that certain portion of the Parent Tract consisting of approximately 45 acres (the "***Land***"), together with any and all improvements on the Land and all appurtenances to the Land (collectively, the "***Property).*** The boundaries of the Land are to be finalized between Seller and Purchaser in connection with Purchaser obtaining the Survey (as defined in Section 7(c) herein). As of the Effective Date, Purchaser and Seller agree that the boundaries of the Land are expected to be as shown on the diagram attached hereto as Exhibit B.

C. As part of the sale contemplated herein and as part of further development of a portion the Parent Tract including the Land, Seller has had a site plan with placement of roads to be constructed (as to road placement only "***Site Plan***") approved by the Clarksville-Montgomery County Regional Planning Commission as shown on the attached Exhibit B-1.

D. For purposes of this Agreement, the portion of the Parent Tract which is outside of the final agreed on boundaries of the Land is hereinafter referred to as the "***Restricted Parcel***").

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

1. SALE OF PROPERTY. Seller and Purchaser agree to sell, purchase and transfer the Property according to the terms of this Agreement.

2. PURCHASE PRICE. The purchase price ("***Purchase Price***") for the Property is $13,500,000.00.

3. EARNEST MONEY. Purchaser shall deliver $75,000.00 ("***Earnest Money***") to First American Title Insurance Company – National Commercial Services having an address of 511 Union Street, Suite 1600, Nashville, Tennessee 37219, Attn.: Stacey Palmer ("***Title Company***") promptly after the Effective Date. The Earnest Money will be held and disbursed according to this Agreement and credited against the Purchase Price at Closing. Said Earnest Money shall become non-refundable after the Contingency Date, as defined in Section 7 of this Agreement.

4. PRORATIONS AND ADJUSTMENTS. The following prorations and adjustments will be made to the Purchase Price at Closing.

(a) Taxes. All taxes imposed on the Property ("***Taxes***") for the year in which Closing occurs which are not yet due and payable will be prorated to the Closing Date. This proration will be based on the latest information available regarding Taxes and on a 365-day calendar year and will be final on the Closing Date. Taxes allocable to the Closing Date will be charged to Purchaser. If Taxes for the year in

which Closing occurs have not been fixed by the Closing Date, then the proration will be based upon the Purchase Price and rate of levy for the previous calendar year. Seller will be responsible to pay for all special assessments by any governmental authority that are due, assessed, approved or contemplated by such authority on or before the Closing Date. All refunds of Taxes received by Seller or Purchaser after the Closing with respect to any property tax appeals (each a "***Tax Refund***") will be applied as follows. First, such Tax Refund will be applied to reimburse Seller or Purchaser, as the case may be, for third party expenses incurred in protesting and obtaining such Tax Refund. Second, such Tax Refunds will be paid (i) to Seller if such Tax Refund is for any period which ends before the Closing Date, (ii) to Purchaser if such Tax Refund is for any period which commences on or after the Closing Date, or (iii) to Seller and Purchaser prorated based on the Closing Date, if such Tax Refund is for a period which includes the Closing Date. If Seller or Purchaser receives any Tax Refund, then each shall retain or promptly pay such amounts (or portions of such amounts) in order that such payments are applied in the manner set forth in this Section 4(a). Purchaser and Seller agree to cooperate with respect to any pending Tax Refund request. The provisions of this Section 4(a) will survive Closing.

(b) Utilities. Inasmuch as the Land is unimproved, there will be no proration of public utility costs at the Closing.

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

(d) Expenses. Seller will be responsible to pay for: (i) all expenses in connection with the payment of any Seller Encumbrances (as defined in Section 8(b)) and recording costs to release any Seller Encumbrances, (ii) the costs of obtaining the Title Commitment and the premium for Purchaser's owner's policy of title insurance and endorsements to such policy satisfactory to Buyer, (iii) Seller's attorneys' fees, (iv) 1/2 of the customary escrow or closing fees charged by the Title Company, and (v) such other expenses provided to be paid by Seller in this Agreement. Purchaser will be responsible to pay for: (i) recording fees not related to the release of Seller Encumbrances, (ii) Purchaser's expenses for tests, inspections and surveys, (iii) all real estate transfer taxes, documentary stamp taxes or similar charges or taxes, if any (iv) Purchaser's attorneys' fees, (v) 1/2 of the customary escrow or closing fees charged by the Title Company, if applicable, and (vi) such other expenses provided to be paid by Purchaser in this Agreement.

(e) Miscellaneous. Other items of proration not enumerated in (a)–(d) above, will be prorated or allocated consistent with local custom where the Property is located.

5. ITEMS TO BE DELIVERED BY SELLER. Seller shall deliver to Purchaser or otherwise make available to Purchaser and its consultants for review and copying, within five (5) days following the Effective Date, all Property Information (defined below) that is in the possession or control of Seller. If Purchaser does not acquire the Property pursuant to this Agreement, then Purchaser shall return any Property Information received by Purchaser to Seller within ten business days after termination of this Agreement. "***Property Information***" means any of the following with respect to the Property: (i) a copy of Seller's existing title policy, if any; existing boundary survey in Seller's possession; any soil reports, environmental reports, compaction reports, or engineering reports in Seller's possession, (ii) copies of Seller's existing petitions, motions, and similar litigation documents in Seller's possession of which Seller

is aware, relating to the Property together with a status report of any pending or contemplated litigation, and (iii) copies of any restrictive covenants, or other agreements affecting the use of the subject property, common area charges, height and line of sight restrictions, use restrictions, any agreements with other owners or tenants which may restrict the proposed use of the property in Seller's possession.

6. INVESTIGATION OF THE PROPERTY BY PURCHASER. Seller grants to Purchaser and its agents and representatives the full right of access to the Property from and after the Effective Date, and Purchaser, its agents and representatives, may conduct a complete physical inspection of the Property including, without limitation, preparation of boundary line, spot and topographical surveys, soil sampling and boring tests, environmental and hazardous waste and substance investigations and such other engineering and mechanical inspections and investigations as Purchaser may reasonably require. Purchaser shall indemnify Seller against any mechanic's liens arising from Purchaser's inspections or other claims, costs, liabilities or expenses (including reasonable attorneys' fees) against the Property or Seller's ownership in the Property resulting from Purchaser's negligence or willful misconduct in the performance of its inspections. Purchaser shall restore any damage to the Property caused by such inspections to substantially the same condition as it existed prior to such investigations. The provisions of this Section 6 will survive the expiration or earlier termination of this Agreement.

7. CONTINGENCIES. Excluding matters shown the Site Plan, Purchaser may terminate this Agreement, for any reason or for no reason in Purchaser's sole and absolute discretion, on or before the date that is 120 days from the Effective Date ("***Contingency Date***"). Without limiting the generality of the previous sentence, Purchaser's obligation to proceed to Closing is subject to the fulfillment, by satisfaction or waiver, in Purchaser's sole and absolute discretion, of the following contingencies (a) through (d) of this Section 7 prior to the Contingency Date (the "***Contingencies***"). Purchaser has the right and option to postpone the Contingency Date for two (2) additional periods of 30 days each by providing written notice to Seller of such election prior to 5:00 p.m., CST, on the then-current Contingency Date. If Purchaser elects to terminate this Agreement as provided in this Section 7, then Purchaser will provide written notice to Seller of such termination on or before the Contingency Date (as may be extended). If Purchaser does not give written notice to Seller on or before the Contingency Date (as may be extended) that Purchaser has elected to either terminate this Agreement or otherwise proceed to Closing, then Purchaser will be deemed to have elected to terminate this Agreement and this Agreement will terminate upon the expiration of the Contingency Date. Upon termination of this Agreement pursuant to this Section 7, the Earnest Money will be returned to Purchaser (less $100.00 to be paid to Seller as independent consideration for the rights granted to Purchaser in this Agreement) and the Parties will have no further obligations under this Agreement except for those which expressly survive the termination of this Agreement. Seller agrees to fully cooperate with and assist Purchaser in Purchaser's attempt to satisfy the Contingencies set forth in this Agreement (and inspections of documents and materials furnished by Seller or made available for inspection in Seller's offices), and in connection with such cooperation, Seller agrees to execute such documents reasonably requested by Purchaser to make applications and obtain approvals or otherwise as is reasonably necessary for Purchaser to satisfy such Contingencies. Upon the Contingency Date (as may be extended), all Contingencies shall be deemed to have been satisfied or waived, excluding any false or incorrect statements or breach by Seller concerning the Contingencies that may occur or be discovered after the Contingency Date.

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

(b) Appraisal. Purchaser's satisfaction that the Purchase Price is within the range of fair market value as determined by an appraisal performed by Purchaser's appraiser, in a form approved by Purchaser in Purchaser's sole and absolute discretion.

(c) Title and Survey Matters. Purchaser's approval of (i) a commitment for an ALTA owner's policy of title insurance ("***Title Commitment***") from Title Company, in a form satisfactory to Purchaser, reflecting good and marketable fee simple title to the Property, to insure the Property and all easements and other rights benefiting the Property in a condition approved by Purchaser with such coverage and including such endorsements as Purchaser may require, and (ii) a survey of the Property ("***Survey***") as may be required by Purchaser. Within 10 days of receipt by Purchaser of both the Title Commitment and Survey, Purchaser shall notify Seller in writing if the Title Commitment or Survey discloses any defects which are unsatisfactory to Purchaser ("***Title & Survey Objections***"), Purchaser will notify Seller of such Title & Survey Objections ("***Objection Notice***"). Seller will have 10 days from receipt of the Objection Notice to cure or commit to cure the Title & Survey Objections. If Seller does not cure or commit to cure the Title & Survey Objections within said 10-day period or if Seller notifies Purchaser that it will not attempt to cure, Purchaser may elect to (i) terminate this Agreement up to the Closing Date, or (ii) accept title as it then is without any reduction in the Purchase Price. Notwithstanding anything in this Agreement to the contrary, with respect to title matters not disclosed on the initial Title Commitment or Survey and which are not caused by Purchaser, Purchaser may elect to terminate this Agreement up to the Closing Date and the Earnest Money will be returned to Purchaser.

(d) Subdivision of the Land out of the Parent Tract. Purchaser and Seller shall have agreed on the legal description of the Land as set forth in the final Survey referenced in Section 7(c) above and, if a formal subdivision of the Land out of the Parent Tract is required as a condition to a lawful transfer of the Land then all such governmental approvals for such subdivision shall have been received by Purchaser. If a formal subdivision of the Land is required, Purchaser shall be responsible to undertake all reasonable actions to seek a formal subdivision of the Land and Seller agrees to cooperate and support Purchaser's efforts to secure such subdivision approvals. If a formal subdivision is required, then the legal description to be used in Seller's general warranty deed shall be the legal description of the Land in the recorded subdivision plat (otherwise the legal description of the Land shall be the legal description of the Land as set forth in the final Survey).

(e) Site Plan. Notwithstanding the foregoing, Seller and Purchaser both acknowledge that all Contingencies and matters as contained in this Agreement are subject to the Site Plan and Purchaser does hereby adopt and approve said Site Plan. Purchaser accepts the Site Plan and may not terminate this Agreement prior to the Contingency Date as a result of any matter shown on the Site Plan.

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

(a) Operation of Property. Seller shall operate, maintain and manage the Property in the same manner as Seller has in the past, including maintenance of property and general liability insurance with respect to the Property. Seller shall make all payments of principal and interest as they come due under any note or other evidence of indebtedness secured by any encumbrance on the Property and otherwise perform the obligations of grantor under such notes and encumbrances. Seller shall not enter into any settlement or other agreement which results in an increase in Taxes. Seller shall not solicit, initiate or negotiate a sale of all or any portion of the Property with any person other than Purchaser. Seller shall not enter into any agreement or lease with or grant any option or right to any person other than Purchaser with respect to the sale, transfer, conveyance, possession, use or occupancy of all or any portion of the Property. Seller shall take such steps as are necessary to terminate all leases and all third party contracts as the same relate to the Property. Seller shall not take any other action which would cause any representation, warranty

or covenant set out in this Agreement to be untrue as of Closing without Purchaser's prior consent. Seller shall immediately notify Purchaser if any of the representations and warranties in this Agreement become untrue or inaccurate on or before the Closing Date.

(b) Release of Encumbrances. On or before Closing, Seller shall cause, at Seller's sole cost and expense, any and all assessments, liens (monetary and otherwise), security interests, mortgages or deeds of trust and other encumbrances affecting the Property which were not caused by Purchaser ("***Seller Encumbrances***"), to be satisfied and released. The proceeds due at Closing may be applied by Seller to satisfy and release any Seller Encumbrances.

(c) Delivery Conditions. Seller shall have caused the following utilities to be installed to the boundary line of the Land along Tiny Town Road: electric, gas, water (minimum 6-inch domestic water line; and minimum 10-inch fire water service line) and sanitary and storm sewer (minimum 10-inch line). If the Delivery Conditions set forth herein this Section 8(c) have not been met by the Closing Date, then Purchaser may postpone the Closing until all such Delivery Conditions are met or elect to close the transaction contemplated by this Agreement, and cause Two Million and No/100 Dollars ($2,000,000.00) of the Purchase Price to be withheld from Seller at Closing (the "***Withheld Funds***") and held in escrow by Title Company pursuant to a written escrow agreement (the "***Escrow Agreement***"). The form of the Escrow Agreement shall be subject to the mutual agreement of Seller, Purchaser and Title Company and shall provide, among other things, for (i) the release of the escrowed funds upon full completion of the Delivery Conditions and (ii) use of the escrowed funds by Purchaser to complete any unfinished Delivery Conditions as of an outside date to be set forth in the Escrow Agreement.

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

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

(b) Documents. All documents, instruments and assurances required to be delivered on or before the Closing to Purchaser or Title Company shall have been duly and timely delivered in form, substance and execution satisfactory to Purchaser and Title Company (including the Declaration of Restrictive Covenants (as defined in Section 23 herein).

(c) Covenants. All covenants and agreements of Seller in this Agreement must have been duly and timely performed and satisfied.

(d) No Change in Condition. There must not have been any change, in the time that has elapsed from the Contingency Date to the Closing Date, with respect to (i) the environmental condition of the Property, or (ii) other than ordinary wear and tear, the physical condition of Property excepting environmental conditions.

(e) Title Company Committed. Title Company must be irrevocably committed to issue, upon payment of the applicable premiums, Purchaser's owner's policy of title insurance, reflecting good and marketable fee simple title to the Property vested in Purchaser, insuring the Property and all

easements and other rights benefiting the Property in a condition approved by Purchaser with such coverage and including such endorsements as Purchaser may require ("***Owner's Policy***").

(f) Corporate Authority. Purchaser must have received or obtained all company approvals, authorizations, resolutions and consents required to authorize the transactions contemplated by this Agreement.

(g) Regulatory Compliance. Purchaser must be satisfied, in its sole and absolute discretion, that the transactions contemplated by this Agreement will not result in a violation of any applicable laws and regulations including, without limitation, federal and state health care laws and regulations such as, by way of example and not limitation, Medicare Anti-Kickback and Stark laws and regulations.

10. CLOSING.

(a) Place and Closing Date. The closing of the purchase and sale of the Property ("***Closing***") will take place on the date that is 30 days after the later to occur of the Contingency Date, as it may be extended pursuant to the terms and conditions contained herein this Agreement ("***Closing Date***"), or such other date as the Parties may mutually agree in writing signed by each of them. Closing will be conducted in escrow through Title Company. Notwithstanding anything contained herein to the contrary, Buyer shall have the right to extend the Closing Date in Buyer's sole discretion if any existing tenants have not vacated the Property as of the Closing Date.

(b) Possession. At Closing, Seller shall deliver possession of the Property to Purchaser free of all tenancies or other rights of occupancy and physically free of all tenants or other occupants and physically free of all personal property of Seller, tenants and other occupants.

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

(i) Deed. A special warranty deed, in a form acceptable to Purchaser, conveying to Purchaser or its designee fee simple title to the Property, subject only to real estate taxes for the current year, not yet due or payable.

(ii) Assignment of Intangibles. An assignment, in a form acceptable to Purchaser, assigning all of Seller's right, title and interest in and to all intangible rights and property used in connection with the Property, if any, including, without limitation, all development rights, guaranties, licenses, plans, drawings, permits, approvals, and warranties, applicable to the Property ("***Assignment of Contracts and Intangibles***").

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

(iv) Seller's Affidavit. A seller's affidavit as required by the Title Company in order for the Title Company to issue the Owner's Policy.

(v) FIRPTA Affidavit. An affidavit pursuant to Section 1445 of the Internal Revenue Code of 1986, as amended (the "***Code***"), certifying that Seller is not a foreign corporation, foreign partnership, foreign trust, foreign estate or foreign person (as those terms are defined in the Internal Revenue Code and regulations promulgated under the Code).

(vi) Bring-Down Certificate. A certificate, in a form approved by Purchaser,

certifying that the representations of Seller in this Agreement are true and correct as of the Closing Date.

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

(viii) Miscellaneous. Any other documents reasonably required by this Agreement or the Title Company to be executed or delivered by Seller or necessary to implement and effectuate the Closing hereunder and to cause Title Company to issue the Owner's Policy, including without limitation, a closing statement and documents, consents and approvals, marital waivers, trust documentation, and evidence of authority of Seller to sell the Property pursuant to this Agreement, as is reasonably satisfactory to Purchaser and Title Company.

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

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

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

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

(a) Title to Property. Seller is the sole owner of the Property and has good and marketable fee simple title to the Property. No other person has any basis to assert any interest in any portion of the Property or its proceeds.

(b) Authority of Signatories; No Breach of Other Agreements. Seller is in good standing under the laws of the state in which it is organized or incorporated. The execution, delivery of and performance under this Agreement is pursuant to authority validly and duly conferred upon Seller and the signatories of Seller to this Agreement. The consummation of the transaction contemplated by this Agreement and the compliance by Seller with the terms of this Agreement do not conflict with or result in breach of any of the terms or provisions of, or constitute default under any agreement, lease, arrangement, understanding, accord, document or instrument by which Seller or the Property is bound, and will not and does not constitute a violation of any applicable law, rule, regulation, judgment, order or decree of any governmental instrumentality or court, domestic or foreign, to which Seller or the Property is subject.

(c) Litigation and Condemnation. There are no pending or threatened matters of litigation, administrative action or examination, claim or demand whatsoever relating to the Property, and Seller has not received any notice of any pending and, to the best knowledge and belief of Seller, there is not contemplated any eminent domain, condemnation or other governmental taking of any part of the Property.

(d) Offsite Improvements. Seller has received no notice of any public improvements in the nature of offsite improvements or otherwise which have been ordered to be made or which have not been assessed including, but not limited to, any road impact fee obligation, and there are no special or general assessments (public or private) not of record pending or affecting the Property.

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

(f) Violations of Law. The condition of the Property does not and will not prior to Closing violate any zoning, building, health, fire or similar statute, ordinance, regulation or code and Seller has not received any notice, written or otherwise, from any governmental agency alleging any such violations. There are no unperformed obligations relative to the Property outstanding to any governmental or quasi-governmental body or authority.

(g) Private Restrictions. Seller is not in default under any Private Restrictions, and there exist no events or circumstances which, with the passage of time or the giving of notice, constitutes a default by Seller under any Private Restrictions.

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

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

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

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

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

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

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

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

12. BREACH OF REPRESENTATIONS, WARRANTIES OR COVENANTS. If Seller breaches any representation, warranty or covenant set forth in this Agreement, then Seller shall indemnify, protect, defend and hold Purchaser harmless from and against all claims, demands, causes of action, losses, damages, liabilities, costs, expenses (including reasonable attorneys' fees and litigation costs) and charges arising or resulting from, or in connection with, such breach. If any of the representations and warranties in this Agreement become untrue or inaccurate on or before the Closing Date, then Purchaser will have the right and option, at any time up to and including the Closing Date, to terminate this Agreement and receive the Earnest Money and Purchaser will not have any further obligations hereunder. The provisions of this Section 12 will survive the Closing, expiration or earlier termination of this Agreement.

13. DEFAULTS AND REMEDIES.

(a) Default by Seller. If Seller fails to timely perform any of its obligations, covenants or agreements contained in this Agreement or breaches any representation or warranty set forth in this Agreement, then Purchaser, at its option and in addition to all other remedies available at law or in equity, may: (i) close the purchase of the Property pursuant to the terms of this Agreement, (ii) specifically enforce the provisions of this Agreement, and (iii) cancel and terminate this Agreement and receive the Earnest Money. In any event, Purchaser will retain all rights against Seller for damages arising out of Seller's default for any reason other than a willful refusal to transfer the Property to Purchaser, but in no event shall Purchaser be entitled to more than $100,000.00 as damages. If, however, Seller willfully refuses to transfer the Property to Purchaser despite Purchaser having fulfilled its obligations under this Agreement, then in such event Purchaser shall be entitled to a full refund of the Earnest Money and may pursue a claim for damages against Seller, but in no event shall Purchaser be entitled to more than $500,000.00 as damages in such circumstances.

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

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

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

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

16. ASSIGNMENT. Purchaser may assign this Agreement and its rights under this Agreement to any person, entity or subsidiary associated with the Purchaser, without the necessity of obtaining the prior consent, written or otherwise, of Seller. Any other assignments of this Agreement by Purchaser must be approved in writing by Seller.

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

18. NOTICES. Any notice, request, approval, demand, instruction or other communication to be given to either Party under this Agreement must be in writing, and will be conclusively deemed to be delivered when personally delivered or when (a) hand-delivered; or (b) deposited for prepaid overnight delivery with an overnight courier such as UPS or other national overnight courier service; or (c) if the

receiving Party's address for notices is a P.O. Box, then when deposited with U.S. Mail; and such notices are addressed to the addresses provided on the signature page of this Agreement or to such other addresses as either Party may have furnished to the other from time to time, in writing, as a place for the service of notice. All notices will be effective upon being sent in the manner described in this Section 18. However, the time period in which a response to any such notice must be given will commence to run from the date of receipt by the addressee of such notice. Rejection or other refusal to accept or the inability to deliver because of changed address of which no notice was given, will be deemed to be receipt of the notice as of the date of such rejection, refusal, or inability to deliver.

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

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

21. MISCELLANEOUS. All of the recitals above and all exhibits attached to this Agreement are incorporated into this Agreement by this reference. The section headings of this Agreement are for convenience only and must not be considered in the interpretation of the terms and provisions of this Agreement. This Agreement is binding upon and inures to the benefit of the Parties and their respective successors and assigns. The word "person" as used in this Agreement, includes all individuals, partnerships, corporations, or any other entities whatsoever. If any provision of this Agreement is unenforceable or inapplicable, the other provisions of this Agreement will remain in full force and effect as if the unenforceable or inapplicable provision had never been contained in this Agreement. This Agreement may be executed in counterparts. Electronic signatures (including scanned signatures in .PDF format) sent via e-mail will have the same force and effect as executed originals. This Agreement must be governed by and construed in accordance with the laws of the state in which the Property is situated. This Agreement constitutes the entire agreement between the Parties. No subsequent alteration, amendment, change, deletion or addition to this Agreement will be binding upon the Parties unless in writing and signed by both Parties. Time is of the essence in the performance of the obligations of the Parties under this Agreement. If any date, time period or deadline under this Agreement falls on a weekend, a state or federal holiday, or any other day on which Title Company or the governmental office for the recordation of deeds is not open for business, then such date will be extended to the next occurring business day. As used in this Agreement, "business day" means any day other than a Saturday, Sunday or state or federal holiday.

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

23. RESTRICTED TRACT. As a condition to Purchaser's obligation to close on the purchase of Land, (a) Seller must execute and deliver to Purchaser a declaration of restriction covenants (the "***Declaration of Restrictive Covenants***") in the form attached hereto as Exhibit C and (b) any lender holding a lien on the Restricted Parcel shall subordinate its lien to the Declaration of Restrictive Covenants.

[*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:

William Belew, Jr.

Date: October 24, 2024

Seller's Notice Address:

William Belew, Jr.
1193 Cardinal Creek Drive
Clarksville, TN 37040

With a copy to:

Mitchell, Ross, Rocconi & McMillan, PLLC
308 South Second Street
Clarksville, TN 37040

Attn: R. Mitchell Ross and Britt Young

ross@mrrmlaw.com & britt@mrrmlaw.com
931-572-0700

PURCHASER SIGNATURE PAGE TO REAL ESTATE PURCHASE AND SALE AGREEMENT

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

PURCHASER:

CLARKSVILLE HEALTH SERVICES, LLC,
a Tennessee limited liability company

By: _____
Name: Joseph A. Sowell
Title : Senior Vice President
Date: 11/25, 2024

HTM

Purchaser's Notice Address:

Clarksville Health Services, LLC
HCA Healthcare
Legal / Real Estate Department
2545 Park Plaza, Bldg. 3, 2nd Floor West
Nashville, TN 37203
Attn : Vice President – Real Estate

With a copy to:

HCA Healthcare
Legal / Real Estate Department
2545 Park Plaza, Bldg. 3, 2nd Floor West
Nashville, TN 37203
One Park Plaza
Nashville, TN 37203
Attn: Clay Lehning

With a copy to:

Holland & Knight LLP
511 Union St., Ste. 2700
Nashville, TN 37219
Attn: Jeffrey A. Calk, Esq.

EXHIBIT A TO REAL ESTATE PURCHASE AND SALE AGREEMENT

The Parent Tract

[see attached diagram of 319.02 acre tract]

EXHIBIT B TO REAL ESTATE PURCHASE AND SALE AGREEMENT

The Land

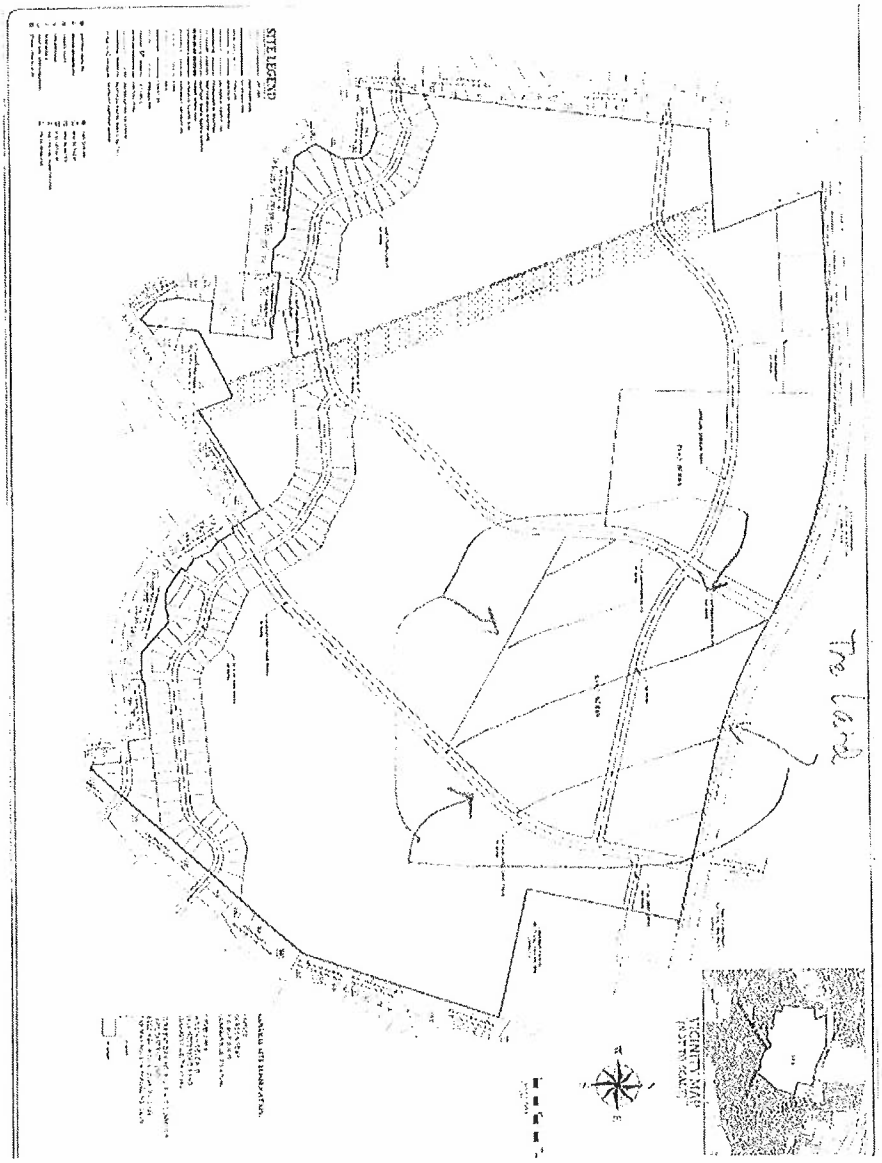
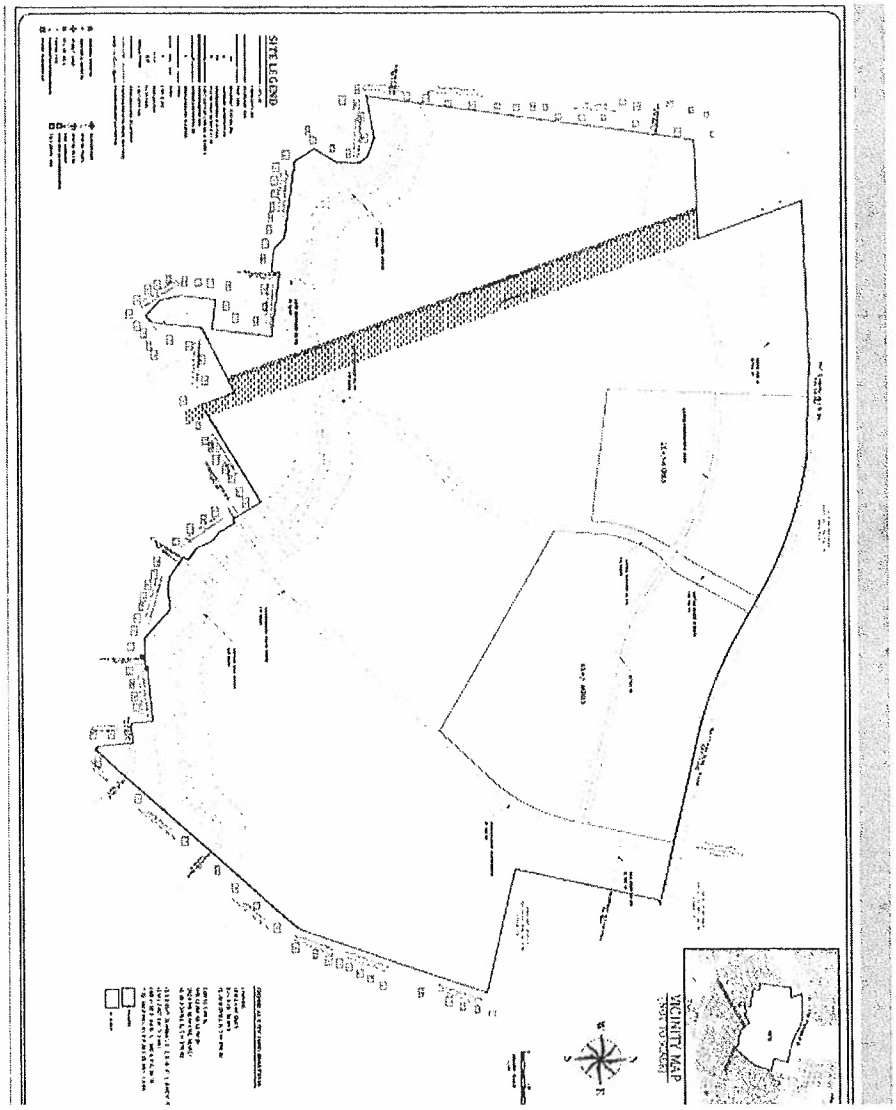


EXHIBIT B-1 TO REAL ESTATE PURCHASE AND SALE AGREEMENT

The Site Plan



Holland & Knight

Nashville City Center | 511 Union Street, Suite 2700 | Nashville, TN 37219 | T 615.244.6380 | F 615.244.6804
Holland & Knight LLP | www.hklaw.com

Jeffrey A. Calk
615.850.8129 direct
jeff.calk@hklaw.com

March 24, 2025

VIA UPS NEXT DAY AND EMAIL

William Belew, Jr.
1193 Cardinal Creek Drive
Clarksville, Tennessee 37040

With a copy to:

Mitchell, Ross, Rocconi & McMillan, PLLC
308 South Second Street
Clarksville, Tennessee 37040
Attention: Mitchell Ross and Britt Young

Re: *Real Estate Purchase and Sale Agreement, dated as of November 25, 2024 (the "Contract") by and between WILLIAM BELEW, JR., an individual ("Seller"), and CLARKSVILLE HEALTH SERVICES, LLC, a Tennessee limited liability company ("Purchaser"), relating to that certain 45-acre portion of parcel ID number 018 01600 000 located on Tiny Town Road in Clarksville, Tennessee (the "Property")*

Gentlemen:

I am legal counsel to Purchaser. By this letter, pursuant to Section 7 of the Contract, Purchaser exercises both of Purchaser's options to extend the Contingency Date through and including May 26, 2025.

Pursuant to Section 7 of the Contract, Purchaser is not required to make an earnest money deposit in connection with its exercise of these options to extend the Contingency Date.

Very truly yours,

Jeffrey A. Calk

JAC:

cc: Mr. Clay Lehning - HCA Real Estate (via email)
Ms. Stacey Palmer - First American Title Insurance Company (via email)
Mr. Britt Young - Mitchell, Ross, Rocconi & McMillan, PLLC (via email)

#518563785_v2

Attachment 9A-2

First Amendment to Real Estate Purchase and Sale Agreement

FIRST AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT

THIS FIRST AMENDMENT TO REAL ESTATE PURCHASE AND SALE AGREEMENT (this "Amendment") is made and entered into effective as of the 25th day of May, 2025 (the "Amendment Effective Date"), by and between **WILLIAM BELEW, JR.**, an individual ("Seller"), and **CLARKSVILLE HEALTH SERVICES, LLC**, a Tennessee limited liability company, its successors and assigns ("Purchaser"). Seller and Purchaser are sometimes referred to in this Amendment individually as a "Party" and collectively as the "Parties."

RECITALS

A. Buyer and Seller entered into a certain Real Estate Purchase and Sale Agreement, dated November 25, 2024 (the "Contract") regarding the sale of that certain parcel of land consisting of approximately 45 acres (the "Land"), together with any and all improvements on the Land and all appurtenances to the Land (collectively, the "Property"). The Land is a portion of a larger tract of land located on Tiny Town Road in Clarksville, Tennessee, and having parcel ID number: 018 01600 000 and more particularly described in the Contract.

B. Buyer has previously exercised its two (2) options to extend the Contingency Date pursuant to Section 7 of the Contract and the Contingency Date is now scheduled to expire on May 26, 2025, and the Parties desire to amend the Contract to (i) extend the Contingency Date to and including June 20, 2025, (ii) grant to Purchaser the right to extend the Contingency Date through August 15, 2025 by giving written notice and depositing an additional $225,000 in escrow with Title Company which shall become a part of the Earnest Money.

AGREEMENT

NOW, THEREFORE, in consideration of the foregoing recitals, which are hereby incorporated into this Amendment, the premises and the mutual promises set forth in this Amendment and for other good and valuable consideration, the receipt, legal sufficiency, and adequacy of which are hereby acknowledged, the Parties agree as follows:

1. **Contingency Date**. Section 7 of the Contract is hereby amended by extending the Contingency Date to and including June 20, 2025. On or before June 20, 2025, Purchaser shall have the right to further extend the Contingency Date to and including August 15, 2025 by delivering written notice of such extension on or before June 20, 2025 and depositing $225,000 in escrow with Title Company on or before June 30, 2025, which sum shall be added to and included in the Earnest Money. If the extension option is exercised by Purchaser, following the deposit of the $225,000, the total amount of the Earnest Money will be $300,000. If Purchaser has not terminated the Contract pursuant to Section 7 on or before June 20, 2025, the Earnest Money shall be non-refundable to Purchaser if the transaction fails to close for any reason other than a breach of the Contract by Seller. If the transaction closes, the Earnest Money shall be applied as a credit against the Purchase Price. The Closing Date shall be the date that is 30 days after the Contingency Date (as may be extended).

2. **Definition of the Land.** The Contract is generally amended to modify the definition of the term of the "Land" and to replace Exhibit A to the Contract. Upon the Amendment Effective Date, the term "Land" shall mean that parcel of land, containing approximately 43.03 acres and more particularly described in Replacement Exhibit A attached hereto.

3. **Miscellaneous.**

(a) Except as amended by this Amendment, the Contract is not otherwise amended, and the Contract is hereby ratified and confirmed and remains in full force and effect, as amended hereby. In the

event of a conflict between the terms of this Amendment and the terms of the Contract, the terms of this Amendment shall control.

(b) This Amendment may be executed in any number of counterparts, each of which shall be an original, but all of which together shall constitute one and the same instrument.

(c) Capitalized terms used in this Amendment and not defined herein shall have the meaning given to such terms in the Contract.

[Signature pages follow]

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

Seller has executed this Agreement effective as of the date listed below Seller's signature.

SELLER:

William Belew, Jr.

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

Purchaser has executed this Agreement effective as of the date listed below Purchaser's signature.

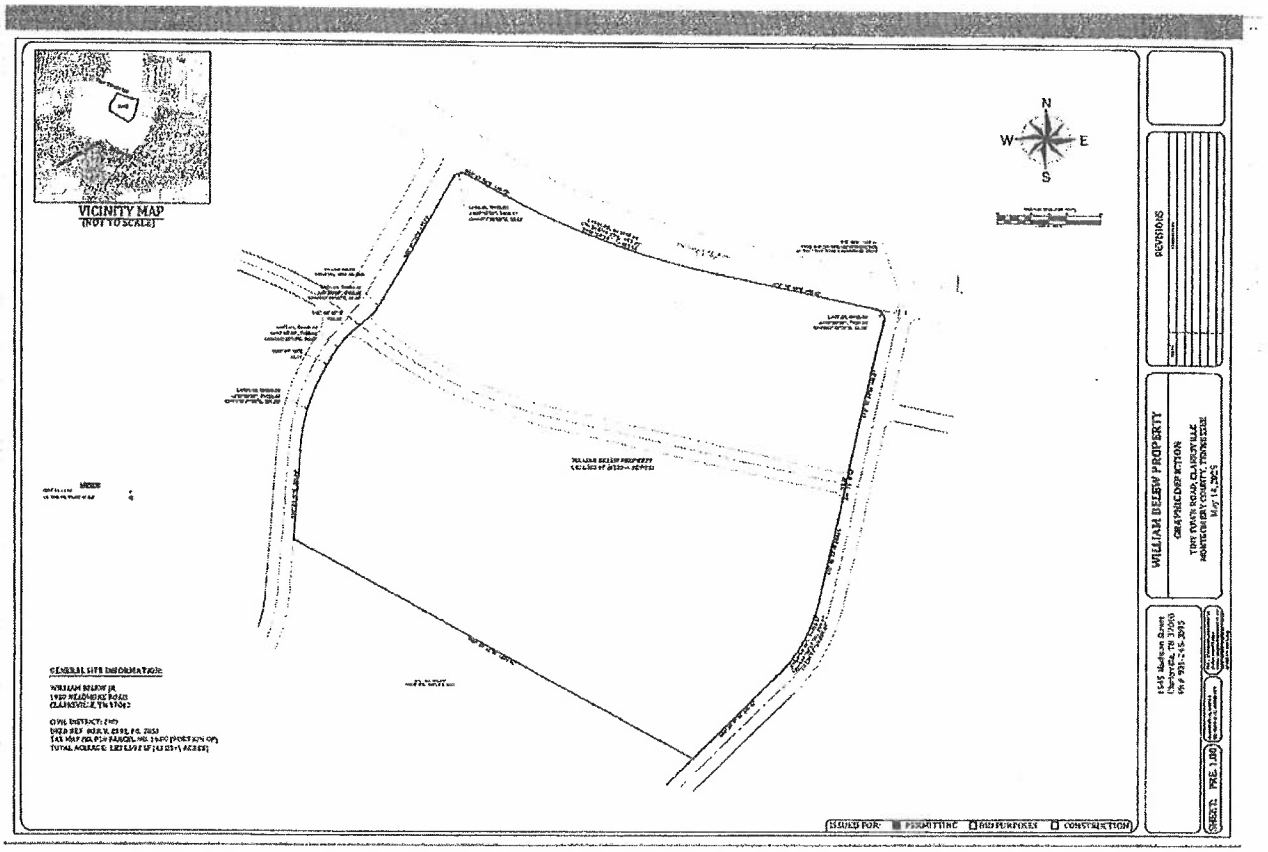
PURCHASER:

CLARKSVILLE HEALTH SERVICES, LLC,
a Tennessee limited liability company

By: _____
Name: Todd Maxwell
Title : Vice President

Replacement Exhibit A

Diagram Showing the Boundaries of the Land



Attachment 9A-3

Warranty Deed Evidencing Seller Owns Land

Julie C. Runyon, Register
Montgomery County Tennessee
Rec #: 621956 Instrument #: 1472080
Rec'd: 35.00 Recorded
State: 96200.00 8/27/2024 at 10:47 AM
Clerk: 1.00 in Volume
Other: 4.00 2391
Total: 96240.00 Pages 2853-2859

THIS SPACE FOR OFFICIAL USE ONLY

STATE OF TENNESSEE

COUNTY OF Montgomery

The actual consideration or value, whichever is greater, for this transfer is $ 26,000,000.00.

Affiant

Subscribed and sworn to before me, this the 27th day of August, 2024.

Notary Public

My commission expires: 8/15/26

STEVEN J HASTON
STATE OF TENNESSEE
NOTARY PUBLIC
MONTGOMERY COUNTY

This Instrument Prepared By:
TOWNSEND TITLE LLC
2684 TOWNSEND COURT SUITE A
CLARKSVILLE, TN 37043
File No. 2024-318

Address New Owner:
William L. Belew, Jr.
1920 Needmore Road
Clarksville, TN 37042

Send Tax Bills To:
New Owner

Map/Parcel No.
018-016.00

WARRANTY DEED

FOR AND IN CONSIDERATION of the sum of Ten Dollars and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, **R. Gordon Seay, Jr. and wife, Sandra A. Seay,** ("GRANTOR") has bargained and sold, and by these presents does transfer and convey unto **William L. Belew, Jr., a married man** ("GRANTEE"), his heirs, successors and assigns forever, certain land in **Clarksville, TN** being described more particularly in Exhibit A, attached hereto and incorporated herein by reference, together with all right, title, and interest of GRANTOR in and to any improvements, easements, alleyways, streets, and rights-of-way adjoining or abutting said land and any covenants and other rights appurtenant thereto (the "Property").

This conveyance of the Property, and all covenants and warranties contained herein, are made expressly subject to the exceptions, limitations, restrictions, encumbrances, and other matters set forth herein. Notwithstanding anything to the contrary contained herein or in any exhibit hereto, GRANTOR makes no warranty as to the amount of acreage contained in the Property.

TO HAVE AND TO HOLD the Property, together with all appurtenances, estate, title, and interest thereto belonging, to GRANTEE, his heirs, successors and assigns forever. GRANTOR covenants with the said GRANTEE that they are lawfully seized and possessed of said land in fee simple, has a good right to convey it, and the same is unencumbered, unless otherwise herein set out; and GRANTOR further covenants and binds them, their heirs, successors, representatives, and assigns to warrant and forever defend the title to the Property to GRANTEE, his heirs, successors and assigns forever, against the lawful claims of all persons whomsoever except for **2024** property taxes, restrictive covenants, easements and setback lines, as may be of record in the Register's Office for **Montgomery** County, Tennessee and any other matters as set forth in Exhibit A, attached hereto and incorporated herein by reference.

The words "Grantor" and "Grantee" shall include their respective heirs, successors and assigns where the context requires or permits. Whenever used, the singular shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

IN WITNESS WHEREOF, Grantor has signed this Instrument as of 27th day of August, 2024.

GRANTOR:

R. Gordon Seay, Jr.

Sandra A. Seay

STATE OF TENNESSEE
COUNTY OF MONTGOMERY

On this 27th day of August, 2024, before me personally appeared R. Gordon Seay, Jr. and Sandra A. Seay, to me known to be the person (or persons) described in and who executed the foregoing instrument, and acknowledged that such person (or persons) executed the same as such person's (or persons') free act and deed.

Witness my hand, at office, this 27th day of August, 2024.

Notary Signature
My commission expires: 8/15/26

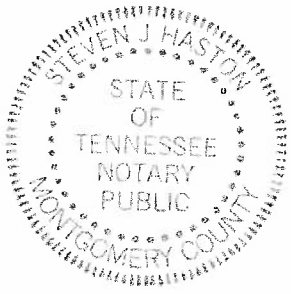


EXHIBIT "A"

PROPERTY DESCRIPTION

Being a parcel of land in the 2nd Civil District of the City of Clarksville, Montgomery County, Tennessee, said parcel being a portion of Tract I of the R. Gordon Seay, Jr. and wife, Sandra A. Seay Property as recorded in Volume (Vol) 715, page 341 Register's Office Montgomery County Tennessee (ROMCT), said parcel bearing a 2174 Tiny Town Road, Clarksville, Tennessee 37042 property address, said parcel also being generally described as south of and adjacent to Tiny Town Road/State Route 236, west of and adjacent to the western terminus of Scrub Oak Drive, a public 50' public right of way, west of and adjacent to the western terminus of Maliki Drive, a public 50' right of way, north of and adjacent to the northern terminus of Country Haven, a public 50' right of way, northeast of and adjacent to the northeastern terminus of Horseshoe Cave Drive, a public 50' right of way, north of and adjacent to the western terminus of Autumnwood Boulevard, a public 50' right of way, and east of and adjacent to the eastern terminus of Caroline Drive, a public 50' right of way, said parcel being more particularly described as follows:

Beginning at an iron pin new, (a ½" rebar capped Dhority), said pin bearing Tennessee State Plane Coordinates, with a northing of 838577.63 and an easting of 1572663.19 North American Datum/Grid North, said pin also being S 86°37'45" E for 546 feet, more or less, from the centerline intersection of Tiny Town Road/State Route 236 and Barkers Mill Road, said pin being the northeastern corner of the City of Clarksville Property as recorded in Vol 713, page 1000 ROMCT, said pin also being on the southern right of way of said Tiny Town Road/ State Route 236, a varying width public right of way, said pin also being the northwestern corner of the herein described parcel.

Thence with said southern right of way the following six (6) calls, N 87° 56' 24" E for a distance of 945.72 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence, S 87° 52' 59" E for a distance of 556.14 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence with a curve turning to the right through an angle of 20° 31' 56", having a radius of 2244.09 feet, and whose long chord bears S 70° 58' 07" E for a distance of 799.88 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence, S 60° 43' 36" E for a distance of 300.71 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence with a curve turning to the left through an angle of 16° 08' 36", having a radius of 2349.08 feet, and whose long chord bears S 69° 18' 23" E for a distance of 659.67 feet an iron pin new, (a ½" rebar capped Dhority).
Thence S 77° 15' 08" E a distance of 965.55 feet to an iron pin old, a ½" rebar, said pin being the northwestern corner of the Lifepoint Church property as recorded in Vol 2054, page 2038 ROMCT, said pin bearing Tennessee State Plane Coordinates, with a northing of 837737.04 and an easting of 1576741.40 North American Datum/Grid North, said pin being the northeastern corner of the herein described parcel.

Thence with said Lifepoint Church boundary lines, the following three (3) calls, on a curve turning to the left through an angle of 89° 45' 06", having a radius of 25.00 feet, and whose long chord bears S 57° 39' 09" W for a distance of 35.28 feet to an iron pin old, a ½" rebar.
Thence, S 12° 37' 59" W for a distance of 811.30 feet to an iron pin old, a ½" rebar.

Thence, S 77° 23' 40" E for a distance of 728.95 feet to an iron pin old, a ½" rebar, said pin being the northwestern corner of the Blue Grass Meadows Final Plat as recorded in Plat Book (Pb) 13, page 745 ROMCT, said pin bearing Tennessee State Plane Coordinates, with a northing of 836767.42 and an easting of 1577245.54.40 North American Datum/Grid North.

Thence with the western boundary line of said Blue Grass Meadows the following two (2) calls, S 19° 07' 25" W for a distance of 567.27 feet to an iron pin old, a ½" rebar.
Thence, S 19° 10' 21" W for a distance of 296.84 feet to an iron pin old, a ½" rebar, said pin being the northwestern corner of the Bluegrass Downs, Section 4, Final Plat as recorded in Plat Book (Pb) F, page 1136 ROMCT.

Thence with said Bluegrass Downs, Section 4, Final Plat the following two (2) calls, S 19° 10' 24" W for a distance of 249.23 feet to an iron pin old, a ½" rebar.
Thence, S 40° 47' 18" W for a distance of 27.17 feet to an iron pin new, (a ½" rebar capped Dhority), said pin being

the northern corner of the Hazelwood, 9 Final plat as recorded in Plat Book (Pb) F, page 1136 ROMCT.

Thence with the boundary lines of said Hazelwood, 9 Final plat the following three (3) calls, S 42° 07' 28" W for a distance of 617.62 feet to an iron pin old, a ½" rebar.
Thence, S 42° 07' 28" W for a distance of 707.16 feet to an iron pin old, a ½" rebar.
Thence, S 42° 09' 39" W for a distance of 198.83 feet to an iron pin new, (a ½" rebar capped Dhority), said pin being the northeastern corner of lot 486 of the Autumnwood Farms, 5A Final plat as recorded in Plat Book (Pb) K, page 170 ROMCT, said pin also being the southeastern corner of the herein described parcel.

Thence with the boundary line of said Autumnwood Farms, 5A Final plat the following seven (7) calls, N 72° 03' 51" W for a distance of 21.60 feet to an iron pin old, a ½" rebar.
Thence, N 05° 37' 01" W for a distance of 209.25 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence, S 84° 21' 34" W for a distance of 115.63 feet to an iron pin old, a ½" rebar.
Thence, N 05° 38' 26" W for a distance of 124.94 feet to an iron pin old, a ½" rebar.
Thence, S 84° 21' 01" W for a distance of 143.95 feet to an iron pin old, a ½" rebar.
Thence, S 84° 23' 08" W for a distance of 178.18 feet to an iron pin old, a ½" rebar.
Thence, S 02° 22' 38" E for a distance of 10.47 feet to an iron pin old, a ½" rebar, said pin being the northeastern corner of said Country Haven.

Thence with said Country Haven, S 89° 32' 02" W for a distance of 50.03 feet to an iron pin old, a ½" rebar, said pin being the northwestern corner of lot 211.

Thence, S 88° 21' 55" W for a distance of 108.49 feet to an iron pin new, (a ½" rebar capped Dhority), said pin being the northeastern corner of the Autumnwood Farms, 11C Final Plat as recorded in Pb J, page 302 ROMCT.
Thence with the boundary line of said Autumnwood Farms, 11C Final plat the following five (4) calls,
N 48° 27' 31" W for a distance of 224.56 feet to an iron pin old, a ½" rebar.
Thence, S 82° 21' 15" W for a distance of 122.52 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence, N 80° 18' 25" W for a distance of 66.67 feet to an iron pin new, (a ½" rebar capped Dhority).

Thence, N 55° 59' 40" W for a distance of 89.44 feet to an iron pin old, a ½" rebar, said pin being on the northeastern corner of Lake Meadow Court, a public 50' right of way.

Thence with said right of way, N 55° 59' 33" W for a distance of 50.00 feet to an iron pin old, a ½" rebar, said pin being a corner of the Autumnwood Farms, 11A Final Plat as recorded in PB J, page 302 ROMCT.

Thence with said Autumnwood Farms, 11A Final Plat the following seven (7) calls, N 34° 01' 20" E for a distance of 31.61 feet to an iron pin old, a ½" rebar.
Thence, N 56° 02' 36" W for a distance of 80.73 feet to an iron pin old, a ½" rebar.
Thence, N 24° 54' 33" W for a distance of 90.65 feet to an iron pin old, a ½" rebar.
Thence, N 25° 43' 41" W for a distance of 8.49 feet to an iron pin old, a ½" rebar.
Thence, N 52° 05' 46" W for a distance of 66.67 feet to an iron pin old, a ½" rebar.
Thence, N 31° 11' 04" W for a distance of 106.89 feet to an iron pin old, a ½" rebar.

Thence, S 58° 48' 12" W for a distance of 24.62 feet to an iron pin new, (a ½" rebar capped Dhority), said pin being on the terminus of Horseshoe Cave Drive, a public 50' R/w.
Thence with said right of way, N 31° 07' 38" W for a distance of 50.03 feet to an iron pin old, a ½" rebar.

Thence with said Autumnwood Farms, 11A Final Plat the following three (3) calls, N 31° 06' 11" W for a distance of 140.08 feet to an iron pin old, a ½" rebar.
Thence, S 58° 52' 27" W for a distance of 524.06 feet to an iron pin old, a ½" rebar.
Thence, S 58° 52' 59" W for a distance of 134.90 feet to an iron pin old, a ½" rebar, said pin being a corner of the Autumnwood Farms, 10 Final Plat as recorded in Pb H, page 12 ROMCT.

Thence with said Autumnwood Farms, 10A Final Plat the following five (5) calls, N 20° 17' 44" W for a distance of 203.55 feet to an iron pin old, a ½" rebar.
Thence, S 63° 53' 28" W for a distance of 86.36 feet to an iron pin old, a ½" rebar.

Thence, S 63° 53' 28" W for a distance of 332.08 feet to an iron pin old, a ½" rebar.
Thence, S 06° 54' 10" W for a distance of 286.05 feet to an iron pin old, a ½" rebar.
Thence, S 45° 40' 24" W for a distance of 49.17 feet to an iron pin old, a ½" rebar, said pin being a corner of the Autumnwood Farms, 10 Final Plat as recorded in Pb H, page 12 ROMCT.

Thence with said Autumnwood Farms, 10 Final Plat the following thirteen (13) calls, N 46° 37' 46" W for a distance of 127.42 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence, N 11° 30' 42" W for a distance of 61.18 feet to an iron pin old, a ½" rebar.
Thence, N 11° 31' 59" W for a distance of 57.29 feet to an iron pin old, a ½" rebar.
Thence, N 06° 55' 12" E for a distance of 57.21 feet to an iron pin old, a ½" rebar.
Thence, N 06° 59' 27" E for a distance of 66.23 feet to an iron pin old, a ½" rebar.
Thence, N 06° 38' 17" E for a distance of 71.43 feet to an iron pin old, a ½" rebar.
Thence, S 83° 14' 57" E for a distance of 171.53 feet to an iron pin old, a ½" rebar.
Thence, N 07° 03' 26" E for a distance of 186.73 feet to an iron pin old, a ½" rebar.
Thence, N 07° 01' 38" E for a distance of 159.29 feet to an iron pin old, a ½" rebar.
Thence, N 82° 44' 02" W for a distance of 61.52 to an iron pin old, a ½" rebar.
Thence, N 83° 02' 14" W for a distance of 313.37 feet to an iron pin old, a ½" rebar.
Thence, S 07° 09' 50" W for a distance of 45.24 feet to an iron pin old, a ½" rebar.

Thence, N 82° 58' 52" W for a distance of 129.56 feet to an iron pin old, a ½" rebar, said pin being a corner of the Autumnwood Farms, 7 Final Plat as recorded in Pb F, page 807 ROMCT.

Thence with said Autumnwood Farms, 7 Final Plat the following ten (10) calls, N 48° 45' 37" W for a distance of 87.15 feet to an iron pin old, a ½" rebar.
Thence, N 82° 59' 15" W for a distance of 431.92 feet to an iron pin old, a ½" rebar.
Thence, N 83° 03' 19" W for a distance of 15.90 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence, N 32° 25' 44" W for a distance of 131.02 feet to an iron pin old, a ½" rebar.
Thence, N 31° 36' 17" E for a distance of 153.85 feet to an iron pin old, a ½" rebar.
Thence, N 01° 01' 42" E for a distance of 125.12 feet to an iron pin old, a ½" rebar.
Thence, N 38° 44' 14" W for a distance of 56.26 feet to an iron pin old, a ½" rebar.
Thence, N 68° 51' 36" W for a distance of 116.05 feet to an iron pin old, a ½" rebar.
Thence, S 79° 48' 36" W for a distance of 249.64 feet to an iron pin new, (a ½" rebar capped Dhority), said pin being 3.3 feet east of an iron rod old capped Suiter, said pin bearing Tennessee State Plane Coordinates, with a northing of 836118.10 and an easting of 1572051.19 North American Datum/Grid North, said pin also being a corner of the Crestview, 1D Final Plat as recorded in Pb 13, page 323 ROMCT, said pin being the southwestern corner of the herein described parcel.

Thence with the boundary line of said Crestview, 1D Final Plat, N 07° 52' 48" E for a distance of 127.29 feet to an iron pin old, a ½" rebar, said pin being the southeastern corner of the eastern terminus of Meredith Way, a public 50' right of way.
Thence with said terminus and the eastern boundary of said Crestview, 1D Final Plat, N 07° 57' 44" E for a distance of 177.25 feet to an iron pin old, a ½" rebar, said pin being a corner of the Breckenridge 1C Final Plat as recorded in Pb 13, page 352 ROMCT.

Thence with said Breckenridge 1C Final Plat the following five (5) calls, N 07° 56' 20" E for a distance of 114.13 feet to an iron pin old, a ½" rebar.
Thence, N 08° 01' 03" E for a distance of 137.80 feet to an iron pin old, a ½" rebar.
Thence, N 08° 08' 57" E for a distance of 156.70 feet to an iron pin old, a ½" rebar.
Thence, N 07° 50' 02" E for a distance of 112.15 feet to an iron pin old, a ½" rebar.
Thence, N 07° 53' 31" E for a distance of 161.55 feet to an iron pin old, a ½" rebar, said pin being the southeastern corner of The Towers Final Plat as recorded in Pb 13, page 268 ROMCT.

Thence with said The Towers Final Plat the following three (3) calls, N 07° 58' 02" E for a distance of 213.12 feet to an iron pin old, a ½" rebar.
Thence, N 07° 56' 35" E for a distance of 455.06 feet to an iron pin old, a ½" rebar.
Thence, N 07° 59' 05" E for a distance of 206.98 feet to an iron pin new, (a ½" rebar capped Dhority), said pin being

the southwestern corner of said City of Clarksville property.

Thence with said City of Clarksville property the following two (2) calls, N 87° 50' 36" E for a distance of 573.03 feet to an iron pin new, (a ½" rebar capped Dhority).
Thence, N 20° 11' 49" W for a distance of 632.79 feet to the point of beginning, said parcel containing 13,896,705 Square Feet or 319.02 acres, more or less, according to survey of Matthew Dhority, RLS #2727, 2867 Brunswick Drive, Clarksville, TN 37043, dated 6-27-2024. Together with and subject to all right of ways, easements, restrictions, covenants, and conveyances of record and not of record.

BEING a part of the same property conveyed to R. Gordon Seay, Jr. and wife, Sandra A. Seay, by deed dated 08/16/1999 and recorded 08/16/1999, from First American National Bank, Executor of the Estate of John B. Ferguson, Jr., Trustee under the Will of John B. Ferguson, Jr., of record in Volume 715, Page 341, Register's Office for Montgomery County, Tennessee.

Property Address: 2174 Tiny Town Road, Clarksville, TN 37042

Certificate of Authenticity

I, Steve Haston, do hereby make oath that I am a licensed attorney and/or the custodian of the original version of the electronic document tendered for registration herewith and that this electronic document is a true and exact copy of the original document executed and authenticated according to law on 8/27/2024.

Affiant Signature

Date 8/27/2024

State of Tennessee

County of Montgomery

Sworn to and subscribed before me this 27th day of August, 2024.

Notary's Signature

DUSTIN LOBATO
TENNESSEE NOTARY PUBLIC
My Comm Exp January 21, 2025
COUNTY OF MONTGOMERY

My Commission Expires: 1/21/25

Notary's Seal (if on paper)

MONTGOMERY COUNTY
TENNESSEE
ASSESSOR OF PROPERTY

APPLICATION FOR GREENBELT ASSESSMENT

Agricultural Land

The Agricultural, Forest and Open Space Land Act of 1976 (commonly referred to as the "Greenbelt Law") permits qualifying land to be assessed for property taxes at its current use value rather than at its fair market value which might be based on a more intensive use. YOU MAY BE LIABLE FOR ROLLBACK TAXES later if the land, or any portion, approved for greenbelt is converted to other uses or disqualified due to a sale or otherwise. Rollback taxes are based upon the amount of taxes saved during the last three (3) years the land was classified as agricultural land.

For land to qualify for the agricultural land classification, it must be at least fifteen (15) acres, including woodlands and wastelands, and either:

(1) constitute a farm unit engaged in the production or growing of agricultural products; or

(2) have been farmed by the owner or the owner's parent or spouse for at least twenty-five (25) years and be used as the residence of the owner and not used for any purpose inconsistent with an agricultural use.

The assessor may presume that property is used as agricultural land if it produces gross agricultural income averaging at least $1,500 per year over any three (3) year period. However, the assessor will also consider other available evidence indicating how the property is actually used. The assessor may ask for information concerning property income, ownership, and other information needed to determine how the property is used and how it should be valued.

Applications must be filed by March 15 to be considered for the current tax year. Applications filed after March 15 will be processed for the following tax year.

Initials: W.B. _____

STATE OF TENNESSEE COUNTY OF: MONTGOMERY

Control Map	Group	Parcel	Special Interest	Acres
018		01600		319.02

1. **Name:** William Belew Jr.
2. **Mailing Address:** 1193 Cardinal Creek Dr. Clarksville TN 37040
3. **Address of Property:** 2174 tiny town Rd Clarksville TN 37042
4. **Total Acreage:** 319
5. **Approximate acreage in crop, pasture or other active farm use:** 318
6. **Current crop(s) or other agricultural product(s) and expected yield or volume which will be sold:**

Product	Expected Yield or Sales
Soybeans	$150,000
Corn	$150,000

7. **Do you own or have an ownership interest in other property in this county which has been approved for greenbelt? If so, please identify the parcel(s) using the assessor's description(s). Attach additional pages if necessary.**

Control Map	Group	Parcel	Special Interest	Acres
031		00800		134.58

8. **Source of Title:** ☐ Deed Book: 2391 Page: 2853 ☐ Other: _____

I certify that I am an owner of the property described above, that the information I have supplied is true and correct to the best of my knowledge and belief, and that I am presently using said property as agricultural land as described in the above instructions. I have read and understand the requirements for greenbelt eligibility and agree to notify the assessor of any change in the use of ownership of the property which might affect its continued eligibility.

Dated: 10/9/24 **Property Owner:** William Belew Jr

On this 9 day of October, 2024, before me personally appeared the above-named property owner, to me known to be the person described in and who executed the foregoing certification and acknowledged its execution as (his) (her) free act and deed.

KELLY SKINNER
STATE OF TENNESSEE
NOTARY PUBLIC
MONTGOMERY COUNTY

Kelly Skinner
Notary Public

My commission expires June 17, 2026

This instrument was prepared by: Name: William Belew Jr.
Address: 1193 Cardinal Creek Dr. Clarksville TN 37040

ASSESSOR'S USE

☑ Approved ☐ Denied

Assessor of Property GIS SUPERVISOR

10/25/2024
Date

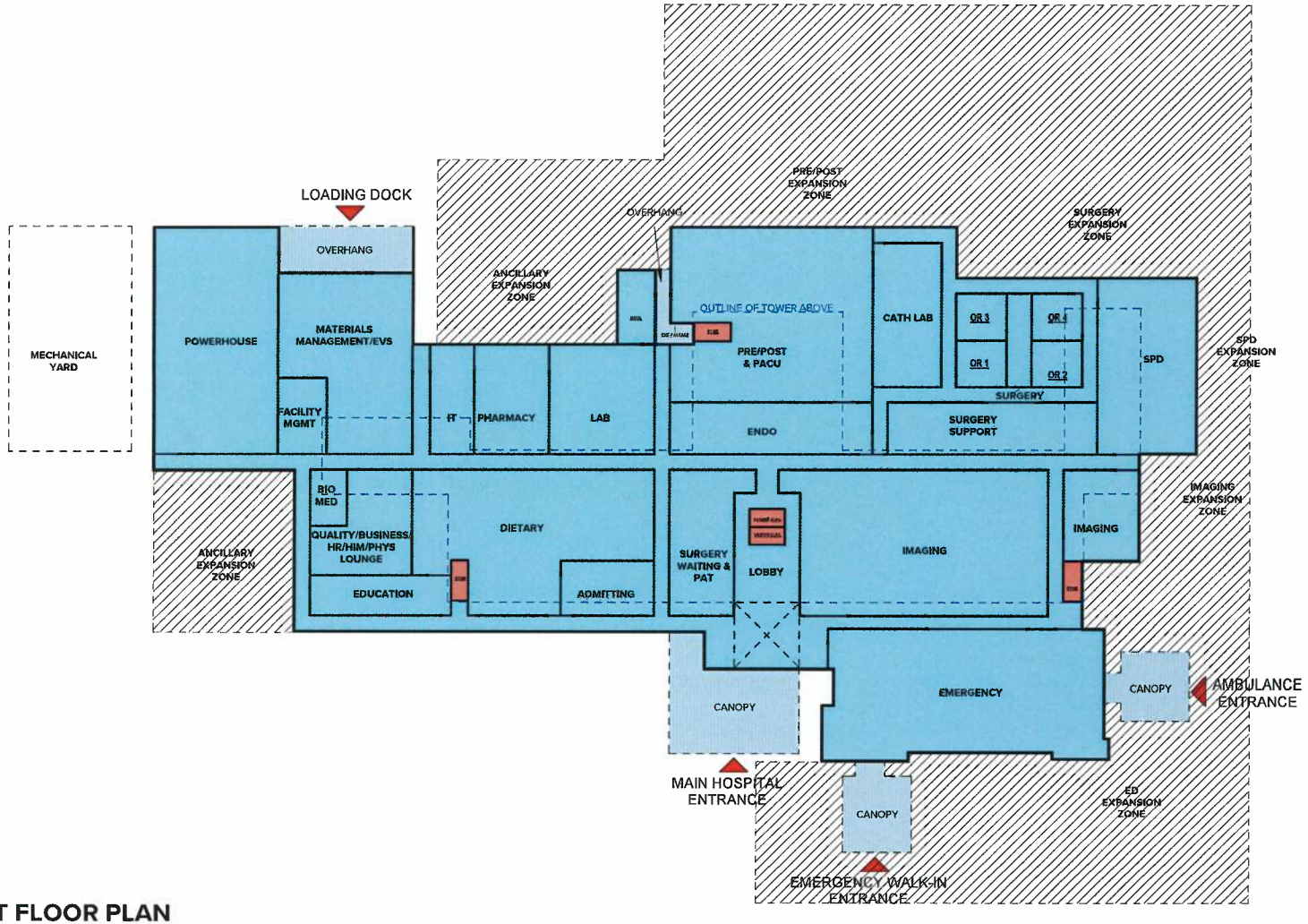
Form approved by the Tennessee State Board of Equalization: 01/2022

Julie C. Runyon, Register
Montgomery County Tennessee

Rec #:	627182	Instrument #:	1479036
Rec'd:	10.00	Recorded	
State:	0.00	10/30/2024 at	10:18 AM
Clerk:	0.00	in Volume	
Other:	2.00		2406
Total:	12.00		PGS 2971-2972

Attachment 10A

Proposed Floor Plans



FIRST FLOOR PLAN

0 30' 60' 120'

TRISTAR CLARKSVILLE HOSPITAL

NEW HOSPITAL
CLARKSVILLE, TN - 25135.00 - 2025-05-27

A1 OF 6
FIRST FLOOR PLAN

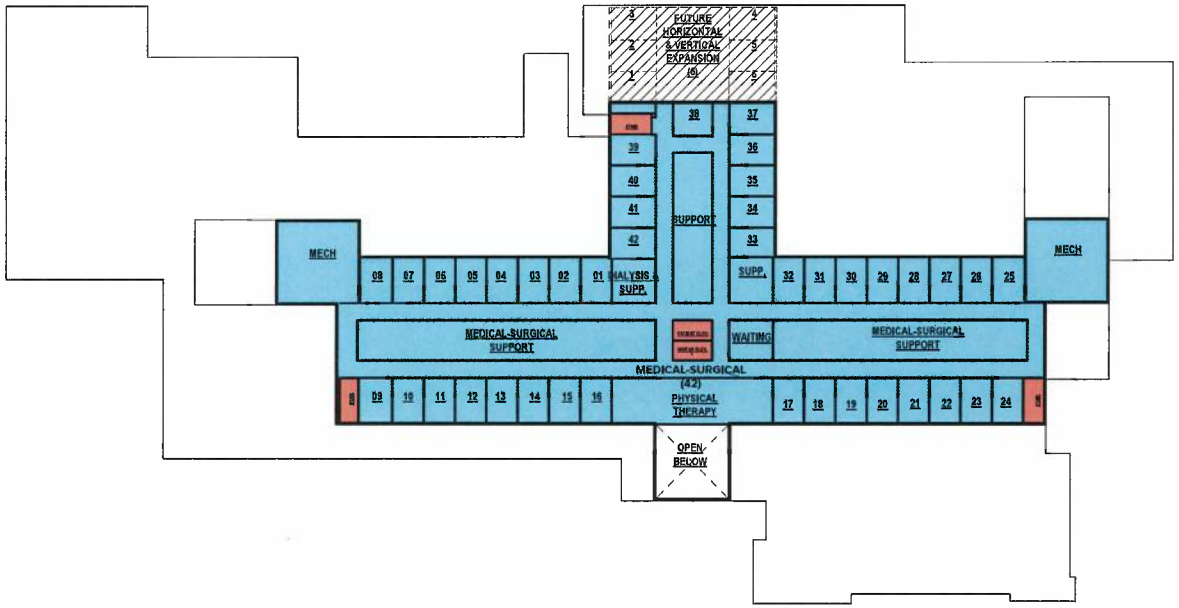
ESa

SECOND FLOOR PLAN

0 30' 60' 120'

TRISTAR CLARKSVILLE HOSPITAL

NEW HOSPITAL
CLARKSVILLE, TN - 25135.00 - 2025-05-27



THIRD FLOOR PLAN

0 30' 60' 120'

TRISTAR CLARKSVILLE HOSPITAL

NEW HOSPITAL
CLARKSVILLE, TN - 25135.00 - 2025-05-27

A3 OF 6
THIRD FLOOR PLAN

ESa

ROOF PLAN

0 30' 60' 120'

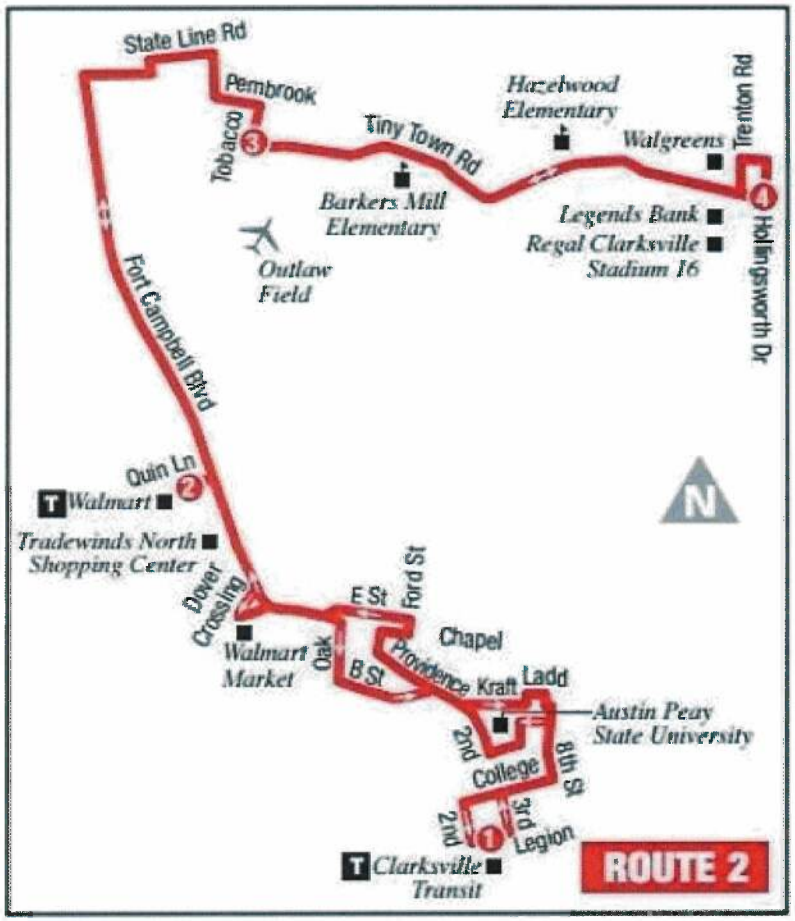
TRISTAR CLARKSVILLE HOSPITAL

NEW HOSPITAL
CLARKSVILLE, TN - 25135.00 - 2025-05-27

Attachment 11A

Public Transportation (Bus) Route

ROUTE 2 - TINY TOWN ROAD



//chatbotScript

ROUTE 2: Tiny Town Road • Monday – Saturday

	1 BUS LEAVES Transit Center	2 Bus Leaves Walmart North	3 Bus Leaves Tobacco & Tiny Town Rd.	4 Bus Leaves Hollingswood Dr.	3 Bus Leaves Tobacco & Tiny Town Rd.	2 Bus Leaves Walmart North	1 BUS ARRIVES Transit Center
A.M.	6:30	6:57	7:16	7:25	7:33	7:57	8:20
	7:30	7:57	8:16	8:25	8:33	8:57	9:20
	8:30	8:57	9:16	9:25	9:33	9:57	10:20
	9:30	9:57	10:16	10:25	10:33	10:57	11:20
	10:30	10:57	11:16	11:25	11:33	11:57	12:20
	11:30	11:57	12:16	12:25	12:33	12:57	1:20
P.M.	12:30	12:57	1:16	1:25	1:33	1:57	2:20
	1:30	1:57	2:16	2:25	2:33	2:57	3:20
	2:30	2:57	3:16	3:25	3:33	3:57	4:20
	3:30	3:57	4:16	4:25	4:33	4:57	5:20
	4:30	4:57	5:16	5:25	5:33	5:57	6:20
	5:30	5:57	6:16	6:25	6:33	6:57	7:20
	6:30	6:57	7:16	7:25	7:33	7:57	8:20

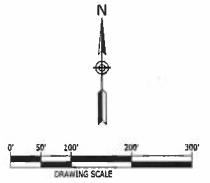
Shaded trips operate on Saturday

Translate

Hi 🍊, how can I help?

Attachment 12A

Plot Plan



SITE DATA TABLE

PARCEL ID: TAX MAP NO. 018, PORTION OF PARCEL 16.00; ±43.03 ACRES

PROPOSED USES: HOSPITAL, MEDICAL OFFICE BUILDING (MOB)

HOSPITAL BEDS: 68
FUTURE BEDS: 156
TOTAL BEDS: 224

MEDICAL OFFICE BUILDING: 60,000SF

PARKING SUMMARY

EXISTING PARKING:	0	SPACES
PROPOSED PARKING:	538	SPACES
FUTURE PARKING:	546	SPACES
TOTAL PARKING:	1,084	SPACES

Catalyst DESIGN GROUP
5100 TENNESSEE AVENUE, NASHVILLE TN 37209
(615) 622-7300 | WWW.CATALYSTDG.COM

TRISTAR CLARKSVILLE HOSPITAL

NEW HOSPITAL
CLARKSVILLE, TN - 25135.00 - 2025-05-27

C1 OF 1
OVERALL
SITE PLAN

ESa

Attachment 4E

Equipment List > $50,000

TriStar Clarksville New Hospital Over $50K Med. EQ -- FILTERED

Item Description	Vendor	Dept	Space		Cost
KITCHEN; FOOD SERVICES QUOTE	INMAN FOODSERVICES GROUP, LLC	FOOD SERVICE	KITCHEN - 100 BEDS - TOTAL	1	$1,700,000.00
MRI, USCAN SIGNA ARTIST 1.5T 64 CHANNEL SYSTEM (March 2022 Config)	GE PRECISION HEALTHCARE LLC	IMAGING	MRI - 1.5T	1	$1,548,000.00
AZURION 5 C12 _ CEILING MOUNTED *BCL*	PHILIPS HEALTHCARE-IMAGING	CATHETERIZATION LAB	CATH LAB BASIC	2	$925,932.00
CATH LAB. ALLIA IGS 520 (CSG STANDARDIZED CONFIGURATION)	GE PRECISION HEALTHCARE LLC	CATHETERIZATION LAB	CATH LAB BASIC	2	$665,549.54
CT REVOLUTION ASCEND 64 CHANNEL, 128 SLICE	GE PRECISION HEALTHCARE LLC	IMAGING	CT - REVOLUTION ASCEND 64 CHANNEL	1	$649,000.00
X-RAY, R/F - PRECISION RF180 80KW GENERATOR, WALLSTAND	GE PRECISION HEALTHCARE LLC	IMAGING	R/F PRECISION RF180	1	$553,000.00
G.E. SENOGRAPHE 2000D	GE PRECISION HEALTHCARE LLC	IMAGING	MAMMOGRAPHY DIGITAL W/ CAD	1	$466,805.11
Nuclear Medicine - 830 SPECT DUAL HEAD CAMERA	GE PRECISION HEALTHCARE LLC	NUCLEAR MEDICINE	GE NM 830 SPECT DUAL HEAD CAMERA	1	$284,301.00
SURGICAL INSTRUMENTS (PLACEHOLDER) - QUOTE CONFIGURED BY FACILITY	TBD-EQUIPMENT	SURGERY	OR - ORTHOPEDIC	1	$250,000.00
DISHMACHINE - HOBART	BARING INDUSTRIES INC	FOOD SERVICE	DISHWASHING	1	$232,504.00
HERMAN MILLER MODULAR CASEWORK	HERMAN MILLER	LABORATORY	MODULAR CASEWORK HERMAN MILLER 99-250 BEDS	1	$218,000.00
CART WASHER, VISION 1327	STERIS CORPORATION	CENTRAL STERILE SUPPLY	DECONTAMINATION	1	$214,000.00
VIDEO EQUIPMENT - ENDO PROCEDURE - COMPLETE SYSTEM - PER QUOTE	OLYMPUS AMERICA	ENDOSCOPY	ENDO PROCEDURE ROOM	2	$205,000.00

SURGICAL INSTRUMENTS (PLACEHOLDER) - QUOTE CONFIGURED BY FACILITY	TBD-EQUIPMENT	SURGERY	OR - GENERAL	3	$200,000.00
LIGHTS & BOOMS	STRYKER COMMUNICATIONS- (HPG-4661 Booms/Lights) (HPG-75788 Integra) Contract 20/60/20	SURGERY	OR - GENERAL	3	$200,000.00
LIGHTS & BOOMS	STRYKER COMMUNICATIONS- (HPG-4661 Booms/Lights) (HPG-75788 Integra) Contract 20/60/20	SURGERY	OR - ORTHOPEDIC	1	$200,000.00
VIDEO INTEGRATION, SURGICAL	STRYKER COMMUNICATIONS- (HPG-4661 Booms/Lights) (HPG-75788 Integra) Contract 20/60/20	SURGERY	OR - GENERAL	3	$200,000.00
VIDEO INTEGRATION, SURGICAL	STRYKER COMMUNICATIONS- (HPG-4661 Booms/Lights) (HPG-75788 Integra) Contract 20/60/20	SURGERY	OR - ORTHOPEDIC	1	$200,000.00
Ultrasound, Echo/ICE - Vivid E95 4D Ultra Edition	GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag	IMAGING	ECHO CARDIOLOGY ROOM	1	$187,014.00
VIDEO EQUIPMENT, ARTHROSCOPIC / LAPAROSCOPIC - 1788	STRYKER ENDOSCOPY	SURGERY	OR - GENERAL	3	$180,000.00
VIDEO EQUIPMENT, ARTHROSCOPIC / LAPAROSCOPIC - 1788	STRYKER ENDOSCOPY	SURGERY	OR - ORTHOPEDIC	1	$180,000.00
PORTABLE X-RAY OPTIMA XR240 WITH 30KW	GE PRECISION HEALTHCARE LLC	IMAGING	PORTABLE OPTIMA XR240 WITH 2 FLASHPAD HD PLATES	2	$171,438.00
C-ARM - Elite CFD 21cm Super-C with OEC Touch ESP	GE HEALTHCARE - OEC MEDICAL SYSTEMS INC	SURGERY	OR - ORTHOPEDIC	1	$171,130.50
X-RAY, RAD. DEFINIUM TEMPO PRO - 65KW GEN RAD ROOM W/FLASHPAD HD 3543	GE PRECISION HEALTHCARE LLC	IMAGING	RAD ROOM DEFINIUM TEMPO	1	$153,000.00
INFANT SECURITY SYSTEM- HUGS	SECURITAS HEALTHCARE, LLC	ENGINEERED SYSTEMS	_GENERAL_LINE_ITEMS	1	$150,000.00
STERILIZER, LOW TEMP - V-PRO MAX 2 W TRAYS AND INSTALL	STERIS CORPORATION	CENTRAL STERILE SUPPLY	PROCESSING/PACKING	1	$149,926.00
WASHER 7053SP 460-480V 3PH 60 HZ W ACCESSORIES AND INSTALL	STERIS CORPORATION	CENTRAL STERILE SUPPLY	DECONTAMINATION	2	$140,992.61
Digital Imaging System, Opthalmic - Retcam Shuttle Wide-Field 20-000515	NATUS SENSORY INC	NURSERY	SPECIAL TECHNOLOGY	1	$126,406.14

ULTRASOUND - LOGIQ E10 XDCLEAR	GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag	IMAGING	ULTRASOUND LOGIQ E10 4D XDCLEAR	2	$123,663.30
HEMODYNAMIC MONITORING SYSTEM - MACLAB ALTIX	GE PRECISION HEALTHCARE LLC	CATHETERIZATION LAB	CATH LAB BASIC	2	$122,000.00
STERILIZER, MEDIUM - AMSCO 600 26.5X26.5X63	STERIS CORPORATION	CENTRAL STERILE SUPPLY	PROCESSING/PACKING	2	$121,098.56
PORTABLE X-RAY - AMX NAVIGATE	GE PRECISION HEALTHCARE LLC	SURGERY	PORTABLE X-RAY	1	$113,257.00
TABLE, SURGICAL FACTURE/ORTHO - HANA	MIZUHO OSI	SURGERY	OR - ORTHOPEDIC	1	$102,000.00
DxH800 Cellular Analysis System*	BECKMAN COULTER, INC.	LABORATORY	HEMATOLOGY	1	$101,400.00
MONITOR, MRI - EXPRESSION (MR400) HIGH ACUITY	PHILIPS HEALTHCARE - MONITORING	IMAGING	MRI - 1.5T	1	$96,942.30
C-ARM, MINI SURGICAL - TAU 2020	ORTHOSCAN	SURGERY	SPECIAL INSTRUMENTS	1	$95,500.00
INNOWAVE PRO SONIC IRRIGATOR 60 LUMENS W FILTERS BASKET HOSE AND INSTALL	STERIS CORPORATION	CENTRAL STERILE SUPPLY	DECONTAMINATION	1	$94,467.04
ANESTHESIA MACHINE - AISYS CS2 w/ B850 MONITOR	GE HEALTHCARE DATEX-OHMEDA	SURGERY	OR - GENERAL	3	$86,562.84
ANESTHESIA MACHINE - AISYS CS2 w/ B850 MONITOR	GE HEALTHCARE DATEX-OHMEDA	SURGERY	OR - ORTHOPEDIC	1	$86,562.84
CASEWORK, PHARMACY/LAB	HERMAN MILLER	PHARMACY	MODULAR CASEWORK	1	$75,000.00
TELEMETRY	GE MEDICAL SYSTEMS IT	ENGINEERED SYSTEMS	_GENERAL_LINE_ITEMS	1	$75,000.00
ULTRASOUND, POC - VENUE	GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag	CATHETERIZATION LAB	CATH LAB BASIC	2	$67,732.13
ULTRASOUND, POC - VENUE	GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag	ICU/CCU	SPECIALTY EQUIPMENT	1	$67,732.13

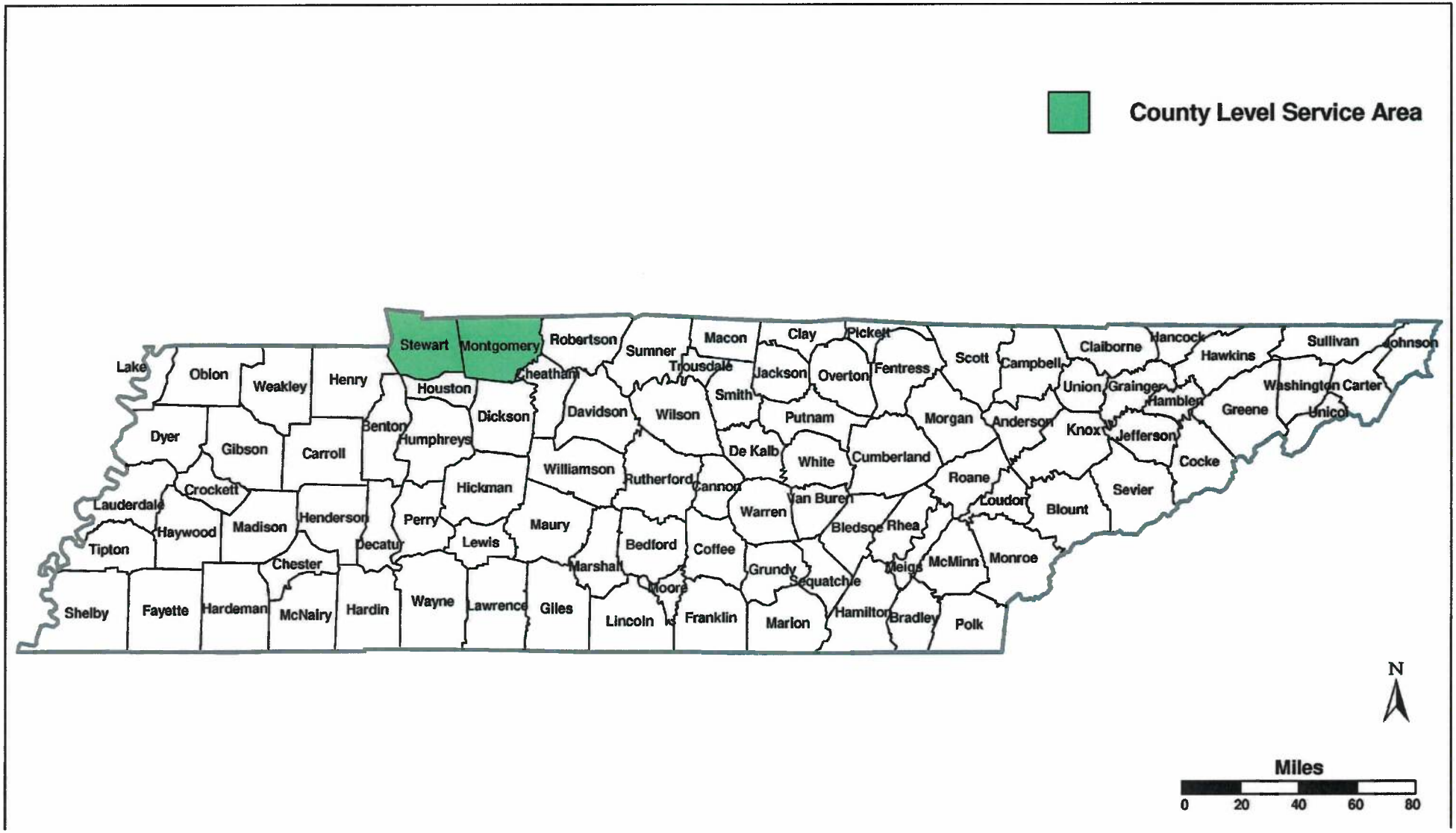
ULTRASOUND, POC - VENUE	GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag	SURGERY	SPECIAL INSTRUMENTS	1	$67,732.13
ANESTHESIA MACHINE; AISYS	GE HEALTHCARE DATEX-OHMEDA	BIRTHING CENTER	DELIVERY ROOM / C-SECTION	2	$64,545.00
TEMP MANAGEMENT SYSTEM - ARCTIC SUN STAT	BARD MEDICAL DIVISION-OR DIVISION	ICU/CCU	SPECIALTY EQUIPMENT	1	$64,000.00
ADVANTAGE PLUS ENDOSCOPE REPROCESSOR W/OUT COMPRESSOR	MEDIVATORS	ENDOSCOPY	SCOPE CLEAN	1	$63,000.00
AESTIVA/5 MRI	GE HEALTHCARE DATEX-OHMEDA	IMAGING	MRI - 1.5T	1	$60,480.00
BEHRING ITEM COAG ANALYZER AUTOMATED*	SIEMENS HEALTHCARE DIAGNOSTICS - NET 30 ON POs	LABORATORY	COAGULATION AUTOMATED	1	$60,000.00
TISSUE PROCESSOR - SAKURA TISSUE-TEK VIP 6 AI	CARDINAL HEALTH (LAB) - Transfer Funds	LABORATORY	HISTOLOGY	1	$57,795.00
BALLOON PUMP (IABP), CARDIOSAVE HYBRID	GETINGE USA SALES LLC	ICU/CCU	SPECIALTY EQUIPMENT	1	$55,775.00
BALLOON PUMP (IABP), CARDIOSAVE HYBRID	GETINGE USA SALES LLC	CATHETERIZATION LAB	CATH LAB BASIC	2	$55,775.00
ESU, ARGON COAGULATION - VIO 3 & APC 3	ERBE USA, INC	ENDOSCOPY	ENDO PROCEDURE ROOM	2	$51,200.00
INJECTOR, CT - MEDRAD STELLANT FLEX	BAYER HEALTHCARE LLC	IMAGING	CT - REVOLUTION ASCEND 64 CHANNEL	1	$51,000.00
INSTRUMENTATION (PLACEHOLDER) - QUOTE CONFIGURED BY FACILITY	TBD-EQUIPMENT	BIRTHING CENTER	DELIVERY ROOM / C-SECTION	2	$50,000.00

X-RAY, RAD. DEFINIUM TEMPO PRO - 65KW GEN RAD ROOM W/FLASHPAD HD 3543	EMERGENCY	1-145-GEN RAD	1	$138,500.00
PORTABLE X-RAY - AMX NAVIGATE	EMERGENCY	1-207-IMAGING ALCOVE	1	$117,812.00
SHELVING/BINS/CARTS	EMERGENCY	1-0B-FINISHES	1	$100,000.00
ULTRASOUND, MULTIPURPOSE - LOGIQ TOTUS w/ VSCAN AIR	EMERGENCY	1-162-EQUIP ALCOVE	1	$55,406.80
MINI C-ARM - OEC MINIVIEW MAX	EMERGENCY	1-207-IMAGING ALCOVE	1	$55,000.00
EMS RADIO	EMERGENCY	1-0A-ENGINEERED SYSTEMS	1	$52,000.00

Attachment 2N

County Level Service Area Map

TriStar Clarksville Hospital

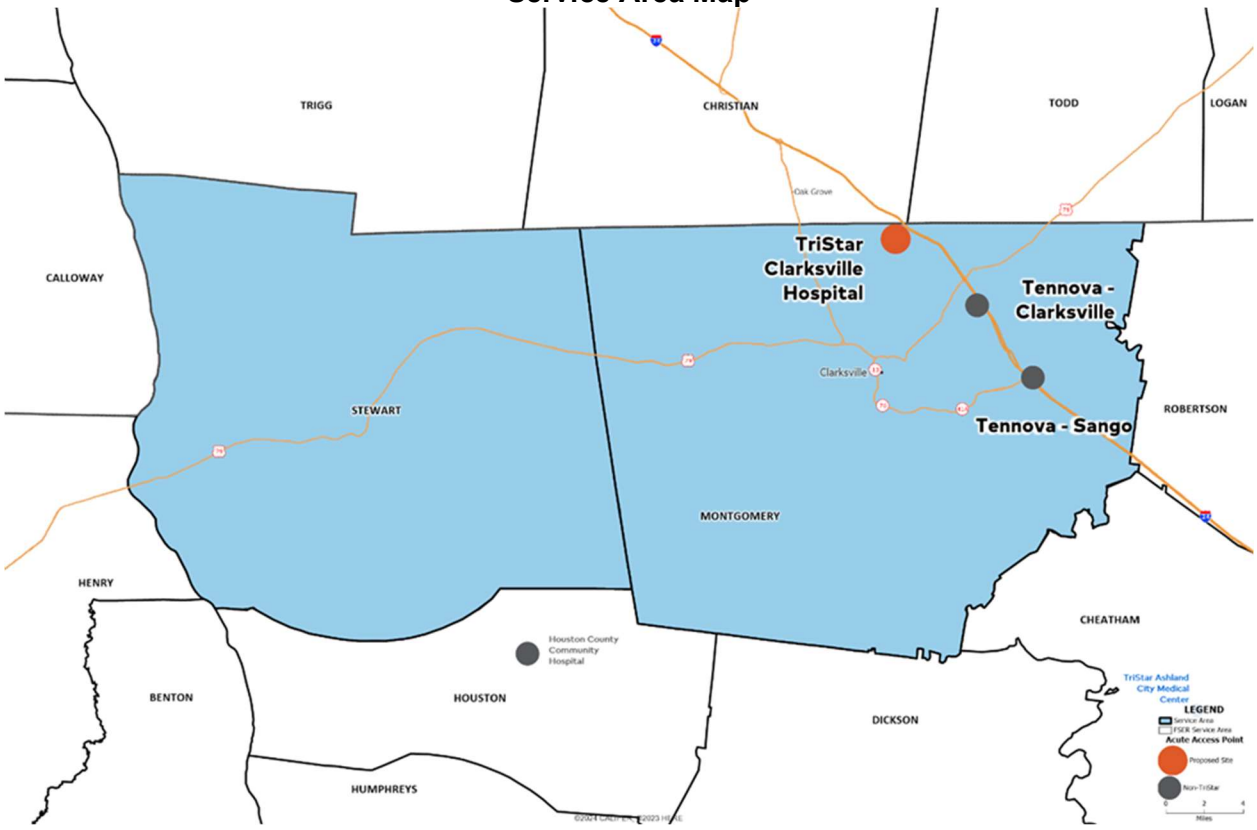


2N. Identify the proposed service area and provide justification for its reasonableness. Submit a county level map for the Tennessee portion and counties boarding the state of the service area using the supplemental map, clearly marked, and shaded to reflect the service area as it relates to meeting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

Service Area

The proposed Service Area for TCH is Montgomery and Stewart Counties ("Service Area"). The following map presents the Service Area relative to that region. The two counties are approximately 1,000 square miles and are situated in the northwest Middle Tennessee, adjacent to the Kentucky border.

Exhibit 1
Service Area Map



As discussed below, in determining the Service Area, the Applicant considered the proposed services, population dynamics, infrastructure and road systems, current migration patterns and the location of providers in the Service Area.

Overview of TriStar Clarksville Hospital

The proposed TCH will be located at an unaddressed site on Tiny Town Road approximately 1,000 feet west of the intersection of Tiny Town Rd and Sandpiper Rd in Clarksville. Tiny Town Road is also known as State Route 236, a major local east-west road providing access to Fort Campbell and serving the local area. This location is in north Clarksville and accessible from Interstate 24 and US Highway 41A as well as secondary roads in the area.

Below is a rendering of the hospital followed by a proposed site plan. The site plan shows the proposed area of construction and site circulation from Tiny Town Road.

The 68-bed hospital will be approximately 213,500 square feet. The floor plans for the proposed three-story hospital are included in **Attachment 10A**. A summary of the functions on each floor is as follows:

- First Floor: The first floor will include 12 emergency treatment rooms, 4 surgery suites, 2 endoscopy suites, 2 cardiac catheterization labs, a pre and post-operative unit, imaging, full service laboratory, pharmacy, dietary services, support departments, admitting and the lobby. There are also future expansion zones for emergency room, surgery, imaging, pharmacy, lab and support areas.
- Second Floor: The second floor includes an 8-bed ICU, 10 LDRP rooms, 2 C-section rooms, 8-bed NICU, well baby nursery, respiratory therapy and support spaces for ICU, obstetrics and neonatal services. There is also space for horizontal expansion adjacent to the ICU.
- Third Floor: The third floor includes 42-bed private medical/surgical patient rooms, therapy, inpatient dialysis and med/surg support spaces; there is also an expansion zone on this floor, above the expansion zone on the second floor.

TCH will be appropriately licensed and accredited by the Joint Commission. It will seek accreditation as an Advanced Primary Stroke Center, certification as a Chest Pain Center, and designation as a Level III Trauma center.

TCH is designed to meet future population growth and patient demand well into the next decades. This will include the ability to add additional floors and beds above the proposed hospital plan identified herein, in addition to the expansion zones noted on the first, second and third floors. Specifically, while its bed count is currently 68, it is designed to incrementally expand to 224 beds with associated ancillary department expansions. The current design of support spaces will accommodate these future expansions. These future additions will be available for programming and services based on demand for services after initial licensure and years of operation.

Service Area

The Service Area includes both Montgomery and Stewart Counties, which are each described below. Its demographic and economic characteristics are presented in response to **Question 3N** which follows.

Montgomery County

Montgomery County is in northern Middle Tennessee, along the Tennessee-Kentucky border, and is part of the Clarksville, TN-KY Metropolitan Statistical Area. It is one of the fastest-growing counties in the State and has a mix of suburban, urban, and rural communities. Its county seat and largest city is Clarksville, Tennessee's 5th largest and a rapidly growing urban center. It borders Christian County, Kentucky to the north. It is located about 50 miles northwest of Nashville, making it part of the Middle Tennessee region. The Cumberland River runs through Clarksville and plays a role in local recreation and history.

It currently has more than 251,000 residents, having increased from 135,000 in 2000, and 220,000 in 2020. The population of Montgomery County is projected to surpass 300,000 by 2034. Population growth is driven by economic opportunities, military presence, and its proximity to Nashville. Major economic drivers in the community include manufacturing, healthcare, education and logistics. It is also home to Austin Peay State University (APSU), a public university in Clarksville.

Additionally, Fort Campbell is the second largest U.S. Army base in the United States by population and is expected to soon be the largest. Fort Campbell straddles the Tennessee-Kentucky border extending from northern Montgomery County well into Christian County, Kentucky. Fort Campbell is home to the 101st Airborne Division (Air Assault), The 160th Special Operations Aviation Regiment, and the 5th Special Forces Group. Many Montgomery County residents are active duty military personnel, veterans, or family members. Moreover, many Fort Campbell retirees settle in Clarksville and Montgomery County.

In Montgomery County, the transportation infrastructure includes Interstate 24, running southeast to northwest connecting Clarksville with Nashville to the southeast and Clarksville to Paducah, KY to the north west. US Highways include US Route 41A, a major north-south route through Clarksville, connecting to Fort Campbell, Nashville, and other localities; and U.S. Route 79, an east-west route across the northern part of the county, providing access from Dover, Stewart County to Clarksville. State Routes ("SR") include SR 236 (Tiny Town Road) on which TCH is located and a major local east-west road in Clarksville, serving the area near Fort Campbell; SR 13, which runs concurrently with US 79 for a portion; SR 48, north-south, connecting to Dickson County; SR 76, crossing through Clarksville and intersecting with US 41A and I-24; SR 374 (101st Airborne Division Parkway), a loop around Clarksville, acting as a bypass and connector for I-24 traffic. In addition, there are notable local roads, including Wilma Rudolph Boulevard – a segment of US 79 and a major commercial corridor in Clarksville – and Trenton Road (SR 48) – a north-south road connecting neighborhoods and I-24.

Montgomery County is the 7th largest county in the State. Yet it only has 1 acute care hospital. Its hospitals per 100,000 population is the 2nd lowest in the State at 0.40 and its population per hospital number is 251,815 compared to the statewide rate of 65,000 persons per hospital. The following Exhibit presents this information for all counties in the State with 2025 population counts of approximately 60,000 or more.

Exhibit 2
Acute Care Hospitals Per 100,000 Population

County	Hospitals	2025 Population	Hospitals/ 100,000 Population	Rank Based on Population
Shelby	11	911,049	1.21	1
Davidson	9	728,443	1.24	2
Knox	6	508,654	1.18	3
Rutherford	3	388,909	0.77	4
Hamilton	7	385,843	1.81	5
Williamson	1	277,193	0.36	6
Montgomery	1	251,815	0.40	7
Sumner	2	215,234	0.93	8
Wilson	1	171,708	0.58	9
Sullivan	3	164,002	1.83	10
Blount	1	144,400	0.69	11
Washington	2	140,553	1.42	12
Maury	1	116,119	0.86	13
Bradley	1	113,913	0.88	14
Sevier	1	101,026	0.99	15
Madison	2	99,089	2.02	16
Putnam	1	85,418	1.17	17
Anderson	1	80,627	1.24	18
Robertson	1	77,700	1.29	19
Greene	1	72,656	1.38	20
Hamblen	1	66,340	1.51	21
Cumberland	1	65,861	1.52	22
Tipton	1	62,044	1.61	23
Coffee	2	61,896	3.23	24
Loudon	1	61,596	1.62	25
Statewide	112	7,242,733	1.55	--

Source: Joint Annual Reports, TN Licensing information, Boyd State Data Center.

Montgomery County has had one hospital since 1954. At that time, it opened as Clarksville Memorial Hospital and served as the primary hospital for the county for decades on Madison Street in the downtown area. In 1996, Clarksville Memorial Hospital was replaced by Gateway Medical Center. Now known as Tennova Healthcare – Clarksville ("Tennova Clarksville"), 651 Dunlop Lane, Clarksville, 37040, it is the same singular hospital serving Montgomery County today. It is owned by Community Health Systems with Vanderbilt University Medical Center ("VUMC") having a minority position. In December 2021, it received CON approval to establish a small satellite hospital (relocation of 12 inpatient beds) at 2275 Trenton Road approximately ten minutes and four miles west from the existing hospital. Despite approval of the CON nearly four years ago, no visible development activity to date has occurred on the site. This hospital also has a freestanding emergency room 13 minutes and 7 miles to its south, also in Clarksville (37043) in an area referred to as Sango. Tennova is the only hospital provider in Montgomery County. Sango is the same community where Ascension St. Thomas has announced that it is seeking a CON to establish a 44-bed inpatient hospital from the HFC. Both HCA/TriStar and Ascension/St. Thomas see that there is need for more hospitals in Clarksville/Montgomery County.

Patient migration patterns of Montgomery County residents confirm that nearly 54 percent leave the county to access hospital services; excluding specialty services (behavioral health and rehabilitation), the rate is 49 percent. When just considering short term hospitals, 47 percent out-migrate. For counties with population greater than 175,000, Montgomery County has the 2nd highest out-migration of any of such counties in the State, and more than 3 times the average of these counties. The out-migration percentages and more importantly the number of patients (8,400+ to short term hospitals and counting) who out-migrate confirm that more hospital capacity and additional choice of providers are needed to mitigate these dramatic patient outflows and improve access for Service Area patients.

Stewart County

Stewart County is a rural county located in northwestern Middle Tennessee, known for its natural beauty, outdoor recreation, and historical significance, especially from the Civil War era. It lies just west of Montgomery County, and also borders Houston, Benton, and Henry Counties, as well as Calloway County, Kentucky. It borders the Tennessee River and Kentucky Lake on the west. It is part of the Clarksville Metropolitan Statistical Area, though far more rural and less developed than neighboring Montgomery County. Its county seat and largest town is Dover. Today, the entire county has approximately 14,200 residents. As of the 2020 Census, the population was around 13,700, making it one of the smaller counties in Tennessee by population. Most of the county is made up of small towns and rural areas, with low population density.

The economy is largely based on forestry, agriculture and tourism/recreation. Land Between the Lakes National Recreation Area, a massive federal recreation area partially lies in Stewart County, and offers hiking, camping, fishing, boating, and wildlife viewing. Additionally, Fort Donelson National Battlefield, a major Civil War site, where Union forces won a pivotal victory early in the war (1862), is preserved as a national park.

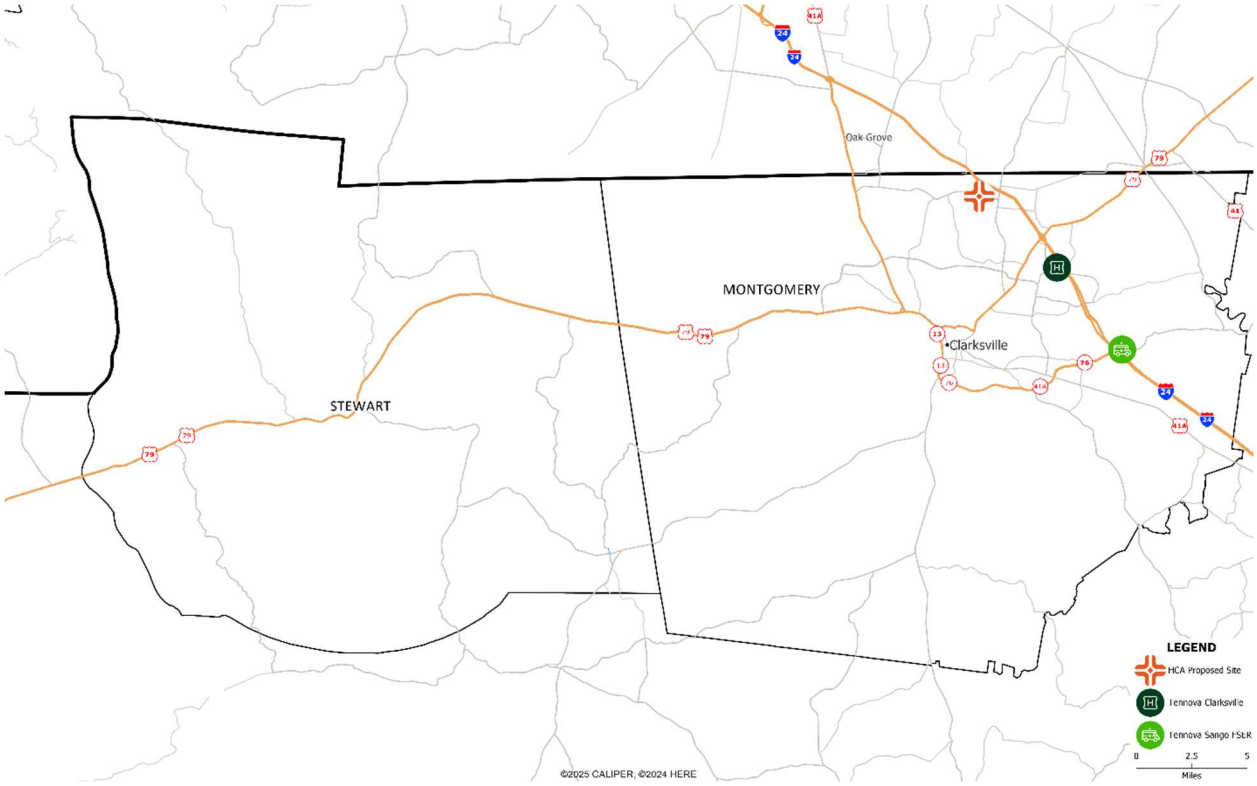
State highways TN-49 and US-79 serve as the main routes through Stewart providing access to neighboring counties, including Montgomery.

There are not any hospitals in Stewart County resulting in no patient draw into Stewart County, and 100 percent out-migration from Stewart County for inpatient and emergency room services. Approximately one-third of Stewart County patients utilize Montgomery County resources with the rest traveling to other counties throughout Middle Tennessee.

Location of Existing Hospital

TCH has defined its Service Area as Stewart and Montgomery Counties which are outlined in the next Exhibit. Also shown in the Exhibit below is the proposed location of TCH on Tiny Town Road as denoted by the orange cross. This location is approximately 8 miles from Tennova Clarksville and 12 miles from Tennova Sango ER, both also shown on the map in black and green, respectively. The bold line on the map is the state border as well as the border of the two Service Area counties. The lighter black lines provide the rest of the county borders.

Exhibit 3



Note: Ascension St. Thomas' proposed hospital is located at the green marker, next to Tennova Sango ER.

The city of Clarksville has three zip codes. TCH is in zip code 37042, which is the largest of the Clarksville zip codes. Tennova Clarksville and Tennova Sango ER are each located in the other two Clarksville zip codes – 37040 and 37043, respectively. The centroid of zip code 37042 is 12.5 miles and between 20 and 45 minutes from Tennova Clarksville. The introduction of an additional hospital access point in Montgomery County in an alternate location than the existing hospital will shorten travel times and distances for those residing in north Clarksville. This will be favorable enhancement for the Service Area population.

Furthermore, having only one hospital provider in the county has resulted in significant outmigration for its residents to access alternative hospital services. Adding an additional hospital, with alternative practicing physicians, will be a consumer advantage.

County and zip code population and proximities to the existing and proposed hospital are discussed in **Attachment 1N** and **Question 3N and 4N** below.

Service Area Discussion

The Service Area was defined through a series of analyses that included, but not limited to, the following:

- Evaluation of patient utilization patterns of residents of Montgomery County, Stewart County and all bordering counties for the past several years using both THA data sets and KHA data sets, to determine patient flow patterns across counties, hospitals/locations of choice, service lines and related hospital access.
- Evaluation of EMS runs amongst the counties using the biospatial proprietary data set to account for trends in transports of residents of the area requiring emergency treatment.
- Patient transfer information from Montgomery, Stewart and bordering counties for the past several years using TriStar Health data from its transfer center.
- Evaluation of patient zip code utilization within Montgomery County, including consideration of the individual Clarksville zip codes in which the majority of Montgomery population resides.
- Evaluation of the patient utilization patterns at Tennova Clarksville Hospital reported in its Joint Annual Reports from 2019 through 2023, including patient origin, patient transfers, emergency room utilization, among other schedules.
- Evaluation of patient utilization patterns at Tennova Clarksville Hospital and Tennova Sango ER utilizing THA data sets from 2019 through 2024 focusing on patient draw, service line utilization and utilization trends.
- Population throughout the region including historical, current, projected and associated growth patterns.
- Location of and services provided by existing healthcare resources throughout the region and their patient draw by county.
- Timing to access the existing healthcare resources throughout the region.
- Consideration of interstates, US routes, and State Routes traversing the counties and how access may be accomplished.

Based on these evaluations and assessments, it was concluded that the TCH Service Area will comprise Montgomery and Stewart Counties. An estimated 75 to 76 percent of patients are expected to reside in Montgomery County, 4 to 5 percent reside in Stewart County and the balance of 20 percent will reside outside the Service Area. This Service Area is reasonable and supportable based on the following facts:

- There is only one community hospital to provide services to more than one quarter million people, the 2nd highest population per hospital count which equates to the 2nd lowest rate of hospital access in the State; this compares to an average of 65,000 people per hospital.
- Indeed, there are just two access points with a single provider (one hospital and one ER) which also makes it the 2nd lowest rate per population in the State.
- From a consumer perspective, they are not afforded any choice in hospital system including inpatient, outpatient or emergency room services.
- Beds per population indicate Montgomery County is the lowest of any high population county in the State.
- ER treatment rooms indicate Montgomery County is one of the lowest of any high population county in the State.
- 47 percent of Montgomery residents leave Montgomery County for short term hospital services; this totals more than 8,400 out-migrating discharges each year in addition to the unknown quantity out-migrating for outpatient services
- The only hospital in the Service Area admits approximately 85 percent of its patients from these two Counties.
- Roadways and infrastructure provide ready access to north Clarksville including from Montgomery County neighborhoods and adjacent Stewart County.
- TCH is accessible to Interstate 24 to its each, US 79 to its south and east and US 41A to its west. These major roadways provide expedited access to the Tiny Town area and TCH.

- The area has a significant population base and has experienced dramatic growth during the past 10 to 15 years.
- The anticipated population increase in Montgomery County is near the highest in the State. Given that growth, Montgomery County population will exceed 300,000 by 2034.
- Stewart County is due west of Montgomery County and has roadway access into Montgomery County via SR 79.
- Stewart County has no hospital facilities.
- Currently only one-third of Stewart County patients access the existing Montgomery County hospital, with the majority traveling further to access other hospitals including TriStar Health affiliates. Choice of providers will mitigate this greater travel time outside of the area.
- Both the current and forecasted population support need for an additional hospital.
- Establishment of TCH will enhance access for Service Area residents through the creation of a hospital and emergency room access point designed to reduce geographic and programmatic inaccessibility to serve the healthcare needs of this population.

Please see additional detailed discussion of hospital access problems and extent of TriStar Health affiliate access for residents of the Service Area provided in **Attachment 1N** and **Questions 4N and 5N** herein.

Service Area Historical and Projected Utilization – TriStar Clarksville Hospital

The Service Area definition is based on the detailed analysis discussed above. TCH has no historical utilization. TCH anticipates 80 percent of its inpatients and outpatients will reside in the Service Area, with the balance (20 percent) coming from outside the Service Area. The tables include in-migration from outside of the proposed Service Area.

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

The following charts provide forecasted utilization for TCH for its first three years of operation. Provided are total discharges anticipated and total emergency room utilization including both outpatients and those who are expected to be admitted to the hospital. Outpatient cardiac catheterizations are also provided for the three projection years.

Unit Type: X - Patient Discharges and X - ED VISITS: Year 1				
	Forecasted ER Utilization	% of Total	Forecasted Discharges	% of Total
Montgomery County	7,957	74.8%	1,822	75.3%
Stewart County	550	5.2%	114	4.7%
Service Area Total	**8,507**	**80.0%**	**1,936**	**80.0%**
All Other	2,127	20.0%	484	20.0%
Total	10,634	100.0%	2,420	100.0%

Discharges include medical/surgical, obstetrics and neonatology discharges.

Unit Type: X - Patient Discharges and X - ED VISITS: Year 2				
y	Forecasted ER Utilization	% of Total	Forecasted Discharges	% of Total
Montgomery County	12,246	74.9%	2,725	75.3%
Stewart County	830	5.1%	171	4.7%
Service Area Total	**13,076**	**80.0%**	**2,896**	**80.0%**
All Other	3,269	20.0%	724	20.0%
Total	16,345	100.0%	3,620	100.0%

Discharges include medical/surgical, obstetrics and neonatology discharges.

Unit Type: X - Patient Discharges and X - ED VISITS: Year 3				
Zip Code	Forecasted ER Utilization	% of Total	Forecasted Discharges	% of Total
Montgomery County	16,737	75.3%	3,666	75.6%
Stewart County	1,045	4.7%	213	4.4%
Service Area Total	**17,781**	**80.0%**	**3,879**	**80.0%**
All Other	4,445	20.0%	970	20.0%
Total	22,227	180.0%	4,849	100.0%

Discharges include medical/surgical, obstetrics and neonatology discharges.

Forecasted Cardiac Catheterizations at TriStar Clarksville Hospital			
	2029	**2030**	**2031**
Service Area			
Montgomery County	291	464	543
Stewart County	21	31	37
Service Area Total	**312**	**494**	**580**
Out of Area (20%)	78	124	145
Total Utilization	**390**	**618**	**725**

Please see the projected utilization assumptions provided in response to **Question 6N** below.

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

The following section describes in detail the demographics of the population of the proposed Service Area.

Population Trends

TCH will be located on Tiny Town Road in Clarksville, Montgomery County, 37042. Its zip code is the 2nd largest populated zip code in the State and will continue to be that through at least 2030. It had the 4th largest increase of any other zip code in the State between 2010 and 2025 and is expected to have the 2nd largest increase between 2025 and 2030. Similarly, Clarksville has experienced significant growth increasing more than 56,000 people since 2010 at a rate of 42.6 percent. It is forecasted to increase another near 10 percent in the next five years. Montgomery County is the 3rd fastest growing county in terms of population count and percentage in Tennessee. **Exhibit 4** provides population of each of these areas for 2010 through 2030 are

Exhibit 4
Population of TCH Zip Code, City and County

Geography	2010	2020	2025	2030	# Change 2010-2025	# Change 2025-2030	% Change 2010-2025	% Change 2025-2030
37042-Clarksville	66,033	83,573	93,580	101,989	27,547	8,409	41.7%	9.0%
City of Clarksville	132,929	166,722	189,500	208,000	56,571	18,500	42.6%	9.8%
Montgomery County	172,331	220,069	251,815	279,340	79,484	27,525	46.1%	10.9%

Sources: TN Comptroller, Boyd State Data Center, Claritas for zip code, and analysis

The defined Service Area of Montgomery and Stewart Counties has important population dynamics which are important when considering that healthcare utilization increases with age. **Exhibit 5** provides the Service Area by age cohort for 2010 through 2030. While Montgomery County increased at an overall rate of 46.1 percent from 2010 to 2025, the age categories have had varying growth ranging from 38.1 percent to 104.5 percent. Of note, the 65 to 74 age group had a growth rate of 104.5 percent rate. Other senior age groups increased between 70 and 78 percent. With respect to Stewart County, its growth rate was 6.8 percent from 2010 to 2025, although those 65 and older increased between 25 and 42 percent depending on the cohort. Overall, Montgomery County is forecasted to increase another 10.9 percent during the next five years and the Service Area is expected to increase 10.4 percent.

Exhibit 5
Service Area Population by County and Age Cohort, 2010 through 2030

County	2010	2020	2025	2030	# Change 2010-2025	# Change 2025-2030	% Change 2010-2025	% Change 2025-2030
Montgomery County								
<18	48,447	59,447	66,974	74,863	18,527	7,889	38.2%	11.8%
18 to 44	74,208	92,912	108,643	117,879	34,435	9,236	46.4%	8.5%
45 to 64	35,885	45,811	49,556	55,463	13,671	5,907	38.1%	11.9%
65 to 74	8,181	13,971	16,733	18,729	8,552	1,996	104.5%	11.9%
75 to 84	4,299	6,021	7,667	9,526	3,368	1,859	78.3%	24.2%
85+	1,311	1,907	2,242	2,880	931	638	71.0%	28.5%
Total	172,331	220,069	251,815	279,340	79,484	27,525	46.1%	10.9%
Stewart County								
<18	3,018	2,901	2,909	2,868	-109	-41	-3.6%	-1.4%
18 to 44	4,072	3,961	4,413	4,495	341	82	8.4%	1.9%
45 to 64	4,011	4,012	3,879	3,823	-132	-56	-3.3%	-1.4%
65 to 74	1,339	1,710	1,810	1,859	471	49	35.2%	2.7%
75 to 84	663	853	943	1,036	280	93	42.2%	9.9%
85+	221	220	277	337	56	60	25.3%	21.7%
Total	13,324	13,657	14,231	14,418	907	187	6.8%	1.3%
Service Area Total								
<18	51,465	62,348	69,883	77,731	18,418	7,848	35.8%	11.2%
18 to 44	78,280	96,873	113,056	122,374	34,776	9,318	44.4%	8.2%
45 to 64	39,896	49,823	53,435	59,286	13,539	5,851	33.9%	10.9%
65 to 74	9,520	15,681	18,543	20,588	9,023	2,045	94.8%	11.0%
75 to 84	4,962	6,874	8,610	10,562	3,648	1,952	73.5%	22.7%
85+	1,532	2,127	2,519	3,217	987	698	64.4%	27.7%
Total	185,655	233,726	266,046	293,758	80,391	27,712	43.3%	10.4%

Sources: US Census and Boyd State Data Center.

With seniors being the greatest utilizers of healthcare resources and hospitals in particular, evaluation of the senior population confirms that it is increasing overall and as a percentage of the total population. Exhibit 6 identifies that the 65+ Montgomery population increased from 8 percent to 10.6 percent of total population, an increase of 2.6 points between 2010 and 2025. This was a result of the 65+ growing two times as fast as the County (93.2 versus 46.1) during this period. In the next five years, the 65+ will continue to increase at 16.9 percent versus overall population at 10.9 percent, causing the 65+ to reach 11.1 percent of total population.

With respect to Stewart County, it has been and will continue to be an older community in comparison with Montgomery County. Its seniors represented 16.7 percent of the population in 2010 and increased by 4.6 points to 21.3 in 2025. Its rate of change was 36.3 percent (more than five times the county's overall rate), confirming a significant aging of Stewart County residents. The 65+ group is expected to increase another 1.1 points by 2030, with the 65+ population accounting for 22.4 percent of the county's residents, and increasing 5 times the county rate. See **Exhibit 6** below.

Exhibit 6
Service Area 65 and Older Population, 2010 through 2030

County	2010	2020	2025	2030	# Change 2010-2025	# Change 2025-2030	% Change 2010-2025	% Change 2025-2030
Montgomery County								
65+	13,791	21,899	26,642	31,135	12,851	4,493	93.2%	16.9%
Total	172,331	220,069	251,815	279,340	79,484	27,525	46.1%	10.9%
Percent 65+	8.0%	10.0%	10.6%	11.1%	2.6%	0.6%	--	--
Stewart County								
65+	2,223	2,783	3,030	3,232	807	202	36.3%	6.7%
Total	13,324	13,657	14,231	14,418	907	187	6.8%	1.3%
Percent 65+	16.7%	20.4%	21.3%	22.4%	4.6%	1.1%	--	--
Service Area Total								
65+	16,014	24,682	29,672	34,367	13,658	4,695	85.3%	15.8%
Total	185,655	233,726	266,046	293,758	80,391	27,712	43.3%	10.4%
Percent 65+	8.6%	10.6%	11.2%	11.7%	2.5%	0.5%	--	--

Sources: US Census and Boyd State Data Center.

The rapid growth and aging of the Service Area population will result in increased demand for healthcare services. This was also confirmed in our analysis of Service Area use rates by age cohort presented in response to **Question 6N**.

Approximately 42 percent of the Service Area population is between the ages of 18 and 44. This includes large numbers of families residing in and expected to move into the Service Area dictating the corresponding need for accessible maternal health services. Accordingly, TCH will provide a meaningful and programmatically accessible women's health program at this new hospital with an OB unit of 10 beds and a Level II NICU with 8 beds. The primary population utilizing an obstetrics service are women between the ages of 18 and 44. **Exhibit 7** is the projected population for this sex and age cohort for the same years as presented above. Also provided for reference is TCH's home zip code. Zip code 37042 has the 2nd largest count of female population in this age cohort in 2025 and will increase to the largest populous by 2030.

Exhibit 7
Female Population Age 18 to 44, 2010 through 2030

Geography	2010	2020	2025	2030	# Change 2010-2025	# Change 2025-2030	% Change 2010-2025	% Change 2025-2030
37042-Clarksville	15,665	18,788	20,896	21,751	5,231	855	33.4%	4.1%
Service Area								
Montgomery County	37,589	46,381	52,327	54,490	14,738	2,163	39.2%	4.1%
Stewart County	1,999	1,905	2,106	2,240	107	134	5.4%	6.4%
Service Area Total	39,588	48,286	54,433	56,730	14,845	2,297	37.5%	4.2%

Sources: Claritas and Boyd State Data Center.

The female population age 18 to 44 increased approximately 12.7 percent in the past five years (2020 to 2025) and is expected to increase an additional 4.2 percent during the next five years. Incorporating an accessible women's program in the Service Area will provide consumers with a choice of providers and programs and avoid unnecessary out-migration for birthing mothers.

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).

TCH has defined the Service Area as Montgomery and Stewart Counties. Both counties are included in the 3B chart. Notably, the Service Area overall is growing at 8.3 percent compared to the State at 3 percent. It also has nearly 48,000 TennCare enrollees, or 17.9 percent of its population. This information is provided on the following page.

Demographic Variable/Geographic Area	Department of Health/Health Statistics							Census Bureau				TennCare	
	Total Population-Current Year 2025	Total Population-Projected Year 2029	Total Population-% Change 2025-2029	*Target Population-All Ages Current Year 2025	Target Population-All Ages Project Year 2029	Target Population-% Change, 2025-2029	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Montgomery County	251,815	273,822	8.7%	251,815	273,822	8.7%	100%	32.5	$72,365	31,729	12.6%	44,785	17.8%
Stewart County	14,231	14,397	1.2%	14,231	14,397	1.2%	100%	44.6	$62,052	1,836	12.9%	2,970	20.9%
Service Area Total	**266,046**	**288,219**	8.3%	**266,046**	**288,219**	8.3%	100%			**33,564**	12.6%	**47,755**	17.9%
State of TN Total	7,242,733	7,462,831	3.0%	7,242,733	7,462,831	3.0%	100%	39.1	$67,097	1,013,983	14.0%	1,414,667	19.5%

Source: Tennessee Department of Health; Census.gov Quick Facts accessed May 2025; and Division TennCare, Enrollment as of March 2025 (latest available in May 2025). ACST 1 year for median age.

"Target Population" is the population that the project will primarily serve, defined here as Total Population.
"Persons Below Poverty Level" computed from census.gov quick facts poverty level times Tennessee Department of Health current year population estimates for county and state; poverty level percent for zip code areas is from census.gov multiplied times current year population estimates for zip code area poverty counts.

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.

Summary of Need

TriStar Clarksville Hospital is needed to provide inpatient hospital care to Clarksville, Montgomery County, Stewart County and the surrounding communities. Clarksville is the 5th largest city in Tennessee, and it has only one (1) hospital. Fifty percent (50%) of Montgomery County patients eschew their local hospital and seek their inpatient care in Nashville and elsewhere. Clarksville is one of the fastest growing cities in the nation, both historically and expected into the future. Clarksville's population is nearly the same as Chattanooga, but it only has 1 acute care hospital while Chattanooga 6 acute care med-surg hospitals. Specifically, TCH will address special needs of the Service Area, by:

- Offer a different hospital provider with alternative medical staff;
- Provide access to unavailable services;
- Address population growth;
- Reduce travel time to services;
- Reduce patient out-migration; and
- Eliminate patient transfers; and
- Reduce EMS transports.

The underlying factors that support the need for the proposed hospital include the following:

Service Area is Underserved

- Clarksville, a city with 189,500 people, is the 5th largest city in Tennessee and has only one (1) underutilized hospital.
- Its population has grown dramatically from 104,045 in 2000 to 189,500 in 2025. This growth occurred at a rapid pace of 2.38 percent per year. Clarksville is on track to reach a milestone population of 200,000 by 2028, nearly double what it was in 2000.
- Montgomery County with more than 250,000 people is the7th largest county in the State. Yet, it has only one hospital to serve nearly 1,000 square miles (Montgomery and Stewart County combined).
- On average, hospitals in the State serve smaller populations with the average population per hospital at approximately 65,000. In the case of Montgomery County, it has 251,000 population per hospital.
- Clarksville is almost the size of Chattanooga (population 190,671), but Chattanooga six (6) acute care hospitals, while Clarksville has only one (1).
- TCH will not only bring a second hospital to Clarksville but also will bring one to an area that is geographically isolated from other hospitals in the region, the Tiny Town community in northern Montgomery County.
- In Tennessee, there is an average of 296 licensed beds per 100,000 population. Montgomery County's rate is 107 beds, just 36 percent of the statewide average.
- Given that approximately half of the Service Area residents seek hospital services outside the Service Area, with at least 1 in 4 admitted to a TriStar Health hospital, material access improvements will to be realized with the licensure of TCH.
- TCH is needed to improve access to emergency care. This part of Clarksville, zip code 37042, is the 2nd most populated zip code in Tennessee and has no readily accessible emergency care. The nearest ER is at Tennova Clarksville, 12.5 miles and between 20 and 45 minutes from the centroid of the zip code. Having another access point closer to where a multitude of people live will greatly enhance the effectiveness of the emergency care that these receive.

- Currently, local EMS units transport emergencies from Clarksville/Montgomery County to hospitals in other cities a total of 930+ times per year. Redirection of some of these EMS transports to TCH will improve access for the patients and their families, reduce out-migration, reduce EMS transport costs, and provide local EMS with increased presence and availability in Clarksville to respond to the next incident.
- The live birth rate in the community confirms Level II NICU beds are needed in Clarksville and the Criteria and Standards are met for additional cardiac catheterization and MRI services.
- TCH will improve access by: (1) establishing a hospital in a part of the Service Area where none exists; (2) bringing inpatient, emergency and specialized services to a community with needs for such services; (3) reducing travel time to hospital services, including emergency services; (4) reducing out-migration to hospitals in other cities; and (5) reducing EMS transports out of the area.
- TCH will bring needed hospital services into the community where patients live. With only one hospital in Clarksville, community residents confront geographic and programmatic access challenges and lengthy times to reach existing similar services. The proposed hospital will provide inpatient, emergency, ICU, cardiac cath, and NICU services, all of which are only available services at the lone hospital in Clarksville.
- It will bring a choice of providers and convenience to the community. The added choice is highlighted by the fact that approximately 47% percent of Montgomery County residents (8,400+ annually to short term hospitals) leave Montgomery County for inpatient hospital care.

Community Size and Population Dynamics (3N)

- Clarksville has three zip codes, the most populated of which is 37042, where TCH will be located. This zip code population is nearly 94,000 people and expected to increase to almost 102,000 by 2030, the 2nd most populous zip code in the State. All jurisdictions (counties and cities) of this size have their own hospitals; and all rural communities with hospitals have population much less than 94,000.
- The 3 Clarksville zip codes combined contain a population of 224,000 population in 2025, which is anticipated to increase to 245,000 in 2030. Clarksville totals approximately 89 percent of the Montgomery County population.
- Montgomery County population exceeds 251,000 and is the 3rd fastest growing county in the State, expected to reach 279,340 population in 2030.
- Stewart County adjoining to the west of Montgomery County has a population of 14,231, increasing to 14,418 in 2030.

Access Challenges and Excessive Travel Times

- With only one acute care hospital in the Service Area, there is significant outmigration which could be based on a series of factors, including but not limited to hospital preference, physician provider preference, patient/family preference, availability of services, continuity of care, among others. With such a large population (more than 250,000 in Montgomery County), out-migration of inpatients exceeded 8,400+ in 2023. This number will only increase as there is significant population growth expected to continue into the future.
- Outmigration from Montgomery County of non-tertiary med surg patients totaled approximately 415,000 minutes or 6,900 hours in CY 2023.
- Outmigration from Montgomery County of obstetrics patients totaled approximately 93,000 minutes or 1,550 hours in CY 2023.
- Outmigration from Stewart County (excluding those who were admitted in Montgomery County) total 71,000 minutes for non-tertiary patients and 5,700 for obstetrics patients, or 1,183 and 96 hours, respectively.
- Given the distance from Montgomery and Stewart Counties to out-of-Service Area hospitals and the number of hospital discharges, its residents collectively travel excessive miles to reach services resulting in some of the significant aggregate travel miles to reach a hospital in the region.
- Residents of Montgomery and Stewart Counties travel significant distances to access inpatient care, with such travel times being exacerbated each year by the continued population increases.

Out-Migration is Indicative of Access and Availability Challenges

- A very large percentage (almost 50 percent) of Montgomery County patients eschew their local hospital and seek their inpatient care in Nashville and elsewhere. Conversely, Hamilton County has 12 licensed hospitals, of which 7 are acute care med-surg hospitals, and it has less than 5 percent outmigration.
- Likewise, when considering counties with population greater than 175,000, Montgomery County has the 2nd highest out-migration of any of these counties. Furthermore, it is more than 3 times the average of these counties.[5]
- Of the 8,454 med-surg patients leaving Montgomery County, 2,477 or 29 percent, were treated at TriStar Health facilities. Seventy percent of these were admitted to TriStar Centennial and TriStar Skyline, an additional 7 percent to other TriStar hospitals in Davidson County, 11 percent to TriStar Northcrest, 8 percent to TriStar Horizon and the balance to other TriStar hospitals.
- Outmigration from the Service Area for inpatient cardiac procedures is 54 percent from Montgomery County and 68 percent from Stewart County.
- Outmigration from the Service Area for non-tertiary discharges[6] is 48 percent from Montgomery County and 70 percent from Stewart County.
- Outmigration from the Service Area for obstetrics discharges is approximately 40 percent from both Montgomery County and Stewart County.
- The out-migration percentages and more importantly the number of patients (8400+ and counting) who out-migrate confirm that effective healthcare planning is needed to mitigate these dramatic patient flows and improve access for Service Area patients.

Travel Times Necessitate Access Improvement

- Travel miles (product of distance and frequency) to access both inpatient med/surg care and obstetrics services for Service Area residents is excessive; more importantly is the time it takes to travel those miles.
- Non-tertiary and obstetrics outmigration from Montgomery County totaled 6,900 and approximately 1,550 hours, respectively, in CY 2023.
- Stewart County out-migration, excluding those who went to Montgomery County, totaled 1,183 and 96 hours, respectively for non-tertiary med-surg and obstetrics hospitalizations.
- These counts exclude those who traveled to access outpatient services at counties throughout Middle Tennessee.

Hospital Transfers Verify Need

- Tennova Clarksville transfers more acute patients from its emergency room than any other hospital in the State, transferring 1,720 in CY 2023.
- Of those, 641 were transferred outside the Service Area to TriStar Health hospitals, the balance to other hospitals also outside the Service Area.
- Blanchfield Army Community Hospital also transfers a significant number of patients to TriStar Health hospitals, averaging 200 per year.
- If 70 percent of these transfers out of the area could be avoided that would meaningfully enhance access and create savings in terms of transport costs, and other hardship on patients and families leaving the Service Area.
- In addition to these Montgomery transfers out of the Service Area, hospitals outside the Service Area in adjacent and near-adjacent counties transfer hundreds of patients each year to TriStar Health hospitals. TCH will be a closer TriStar hospital for Jennie Stuart Medical Center (Christian County,

[5] County migration patterns from THA data are based on 2022 data since 2023 is masked due to THA policy; county data from the JARs are based on 2023 data.

[6] Tertiary medical surgical cases are defined as transplants, trauma care, cardiac surgery, thoracic surgery, neurosurgery, burns, radiotherapy, neonatology and other complex interventions. Non-tertiary medical-surgical are the remaining inpatient services, excluding specialty services (behavioral health and medical rehabilitation). Obstetrics is also considered non-tertiary but is separately analyzed throughout this CON Application.

Kentucky), Trigg County Hospital (Trigg County, Kentucky) and Houston County Hospital (TN) thereby enhancing access for these transferred patients and their families. Patients from these communities comprise part of the out of Service Area factor in the utilization analysis.

EMS Transports Support Need

- EMS transports from scenes to a hospital in Montgomery County were approximately 13,200 in the most recent 12-month period; combined with Stewart County, there were nearly 14,000 EMS scene transports to a hospital. Of the transports, the majority were taken to Tennova Clarksville.
- 938 were transported out of the Service Area including to TriStar Horizon, TriStar Skyline, TriStar Centennial, Houston County Community, VUMC, Murray Calloway County Hospital (Calloway County, Kentucky), and Blanchfield Army Community Hospital.
- Based on travel time to the out of area facilities, an estimate of EMS out of the Service Area totals 68,000 minutes travel time. Travel each way is included; offload time is not included.
- When TCH as an alternative hospital provider is available, local EMS providers will be able to reduce time spent out of the Service Area. TCH will positively impact the EMS services by being accessible and available more rapidly to meet local needs.
- Access for families will be enhanced. When some of these patients are no longer diverted out of the area, families will have improved access and relative short travel times to be with their family and participate in any recovery.

State Health Plan Criteria Are Met

- The State Health Plan Standards and Criteria includes a Bed-Need Formula, however, the HFC "has the discretion to approve new hospital beds even when not warranted under the State Health Plan criteria when there is a compelling reason to do so, and the Commission has done so when there was demonstrated need for additional health services in a particular community."[7] The situation in the Service Area detailed throughout this CON application demonstrates compelling reasons for TCH's approval.[8]
- The bed need formula for Level II NICU beds confirms the need for additional Level II NICU beds in the Service Area.
- The cardiac catheterization services utilization formula confirms the need for additional cardiac catheterization laboratories in Montgomery County.
- TCH will cure geographic isolation and inaccessibility through providing Service Area residents with an accessible and available inpatient hospital thereby enhancing access as demonstrated through health planning metrics and community support.
- Establishment of TCH will foster quality of care and cost effectiveness through more rapid treatment of the thousands of patients leaving the Service Area each year (and expected to increase), being transported from scenes each year to out of area facilities, minimizing impact on EMS to transport these patients out of the area, reducing the cost to the EMS system, and decreasing the costs to the Service Area residents. More rapid treatment leads to lives being saved.
- The economic impact to the Service Area with bringing a $286 million hospital to the community is meaningful and demonstrates a Consumer Advantage based on its construction and the ongoing impact of its operations.
- Community leaders and residents alike (the "community") state there is an overwhelming need for another hospital in Clarksville. Their current impetus is based on the tremendous population growth, traffic patterns extending travel time to service and the need for improved access to inpatient hospital services including obstetrics services.

[7] VRH-2 Final Order, February 29, 2024; TriStar Spring Hill Hospital, CN2404-010.

[8] The Bed Need Formula for acute beds has diminished relevancy since licensed hospitals can add beds at will. Therefore, facility specific bed capacity challenges no longer require CON approval. Providing compelling reasons for an additional hospital access point results in approval of beds at a new location.

I strongly support HCA TriStar Health's plan to build a comprehensive, high-quality hospital in Montgomery County … As one of the fastest-growing areas in the country, our families need greater access to the essential care the TriStar Clarksville Hospital would provide.

Mayor Wes Golden
Montgomery County Mayor

TriStar Health's effort to expand access to quality healthcare in our region is a welcome development for our growing community … I support the TriStar Clarksville Hospital as an important investment in the health and well-being of local families.

Senator Bill Powers
Tennessee State Senator

- Consumer Advantage is meaningfully demonstrated by the community support for TCH as expressed by city leaders, large community employers, business leaders, physicians, referral sources, elected officials, prior patients and others with personal knowledge and experiences in the Service Area.

I am pleased to hear that TriStar Health is interested in bringing a multimillion-dollar healthcare facility to our community… Their investment will result in expanded healthcare options for our citizens and Fort Campbell families.

Mayor Joe Pitts
Clarksville Mayor

Each of the above underlying reasons to approve the proposed TriStar Clarksville Hospital are discussed in response **to Questions 2N and 3N**, on the following pages or in **Attachment 1N, Acute Care Beds**, as noted.

TCH Will Provide Much Needed Access to the Patients of the Service Area

Second Lowest Hospital Access Ratios in the State

TCH will address the inpatient acute care needs of the Service Area population. The fact that approximately 50 percent of patients leave the Service Area to receive appropriate acute services confirms that its population is underserved. Montgomery County has the second lowest statewide rate of hospitals per 100,000 population. Defined herein as "Hospital Access Ratio" by computing Hospitals per 100,000 population. Similarly, considering these factors, one can compute population per hospital. Here, too, Montgomery County is second lowest at 251,815 people per hospital compared to statewide average of 64,667. This geography is underserved as evidenced in **Exhibit 8** below.

Exhibit 8
Top 25 Populated Counties in Descending Population Order

County	Hospitals	2025 Population	Hospitals/ 100,000 Population	Population per Hospital
Shelby	11	911,049	1.21	82,823
Davidson	9	728,443	1.24	80,938
Knox	6	508,654	1.18	84,776
Rutherford	3	388,909	0.77	129,636
Hamilton	7	385,843	1.81	55,120
Williamson	1	277,193	0.36	277,193
Montgomery	1	251,815	0.40	251,815
Sumner	2	215,234	0.93	107,617
Wilson	1	171,708	0.58	171,708
Sullivan	3	164,002	1.83	54,667
Blount	1	144,400	0.69	144,400
Washington	2	140,553	1.42	70,277
Maury	1	116,119	0.86	116,119
Bradley	1	113,913	0.88	113,913
Sevier	1	101,026	0.99	101,026
Madison	2	99,089	2.02	49,545
Putnam	1	85,418	1.17	85,418
Anderson	1	80,627	1.24	80,627
Robertson	1	77,700	1.29	77,700
Greene	1	72,656	1.38	72,656
Hamblen	1	66,340	1.51	66,340
Cumberland	1	65,861	1.52	65,861
Tipton	1	62,044	1.61	62,044
Coffee	2	61,896	3.23	30,948
Loudon	1	61,596	1.62	61,596
Statewide	112	7,242,733	1.55	64,667

Source: JARS

As evidenced in the table, at a rate of 0.40 hospitals per 100,000 population, Montgomery County ranks second lowest in the State for having hospital access. Given the distance from Montgomery County to

Davidson County (where most out migrate for care), the access issue is more extreme in Montgomery County than any other. To have more than one quarter million people and only have one hospital is demonstration of insufficient options for inpatient hospital care. When just considering the high population counties in the State, the deviation is even more pronounced as shown in **Exhibit 9.**

Exhibit 9
Hospitals per 100,000 Population and Population per Hospital
in Counties with 175,000 or Greater Population

County	Hospitals	2025 Population	Hospitals / 100,000 Population	Population per Hospital
Williamson	1	277,193	0.36	277,193
Montgomery	1	251,815	0.40	251,815
Rutherford	3	388,909	0.77	129,636
Knox	6	508,654	1.18	84,776
Shelby	11	911,049	1.21	82,823
Davidson	9	728,443	1.24	80,938
Sumner	3	215,234	1.39	71,745
Hamilton	7	385,843	1.81	55,120
Statewide Average	112	7,242,733	1.55	64,667

Source: JARS.

With the addition of TCH in Montgomery County, its rate increases to 0.79, still approximately one-half the statewide average. Population per hospital decreases to 125,908, still almost double the State's average. This is shown in the next exhibit.

Exhibit 10
Hospitals per 100,000 Population and Population per Hospital
in Counties with 175,000 or Greater Population
With the Addition of TCH in Montgomery County

County	Hospitals	2025 Population	Hospitals / 100,000 Population	Population per Hospital
Williamson	1	277,193	0.36	277,193
Rutherford	3	388,909	0.77	129,636
Montgomery	2	251,815	0.79	125,908
Knox	6	508,654	1.18	84,776
Shelby	11	911,049	1.21	82,823
Davidson	9	728,443	1.24	80,938
Sumner	3	215,234	1.39	71,745
Hamilton	7	385,843	1.81	55,120
Statewide Average	113	7,242,733	1.56	64,095

Source: JARS. Note: In the above computation, Montgomery moves into 3rd lowest position by a slight margin; however, the Rutherford County rate of 0.77 increases to 1.03 with the implementation of VRH-2 and the population per hospital decreases to 97,000.

Not only is Montgomery County the 2nd lowest rate in higher population counties, it is also the 2nd lowest rate of any county with a hospital statewide. Being the 3rd fastest growing county statewide, Clarksville being the 5th largest city, and TCH's zip code (37042) being the 2nd most populated zip code in the State, having just one hospital (0.4 hospitals per 100,000 population) demonstrates underservice.

Bed to Population Ratio

The geographic area is also underserved when one factors in the beds at each of the hospitals per 1,000 population. **Exhibit 11** provides this information. Here again, Montgomery County is the lowest rate for higher population counties.

Exhibit 11
Beds per 1,000 Population in Counties with 175,000 or Greater Population

		Beds		Beds/1,000 Population	
County	2025 Population	Licensed	Staffed	Licensed	Staffed
Montgomery	251,815	270	237	1.07	0.94
Williamson	277,193	337	337	1.22	1.22
Rutherford	388,909	513	487	1.32	1.25
Sumner	215,234	350	306	1.63	1.42
Knox	508,654	1,870	1,690	3.68	3.32
Shelby	911,049	4,132	3,039	4.54	3.34
Hamilton	385,843	1,674	1,381	4.34	3.58
Davidson	728,443	3,936	3,399	5.40	4.67
Statewide	7,242,733	21,470	16,175	2.96	2.23

Source: JARS adjusted to 337 beds for Williamson County and 24 additional beds in Sumner County. Exhibit excludes behavioral health hospitals, long term acute care hospitals and rehabilitation hospitals.

The 2.96 beds per 1,000 population in Exhibit 11 equates to an average of 296 beds per 100,000 population. This contrasts with Montgomery having 1.07 beds per 1,000 population (107 beds per 100,000). With the addition of TCH's 68 beds, the Montgomery County rate increases but is still far below comparable counties and the statewide average. **Exhibit 12** presents this information with the TCH beds added to the county.

Exhibit 12
Beds per 1,000 Population in Counties with 175,000 or Greater Population
With the Addition of TCH's 68 Beds in Montgomery County

Montgomery	251,815	338	305	1.34	1.21
Williamson	277,193	337	337	1.22	1.22
Rutherford	388,909	513	487	1.32	1.25
Sumner	215,234	350	306	1.63	1.42
Knox	508,654	1,870	1,690	3.68	3.32
Shelby	911,049	4,132	3,039	4.54	3.34
Hamilton	385,843	1,674	1,381	4.34	3.58
Davidson	728,443	3,936	3,399	5.40	4.67
Statewide	7,242,733	21,538	16,243	2.97	2.24

Source: Source: JARS adjusted to 337 beds for Williamson County and 24 additional beds in Sumner County. Exhibit excludes behavioral health hospitals, long term acute care hospitals

and rehabilitation hospitals.

TCH Will Address the Rampant Population Growth

As discussed in response to Question 3N, TCH is in zip code 37042. This zip code is the 2nd largest populated zip code in the state and will continue to be that through at least 2030. It has the 4th largest increase of any other zip code in the state between 2010 and 2025 and is expected to have the 2nd largest increase between 2025 and 2030. Similarly, Clarksville has experienced significant growth increasing more than 56,000 people since 2010 at a rate of 42.6 percent. It is forecasted to increase another near 10 percent in the next five years. Montgomery County is the 3rd fastest growing county in terms of population count and percentage.

The defined Service Area of Montgomery and Stewart Counties has important population dynamics by age cohort, important when factoring healthcare utilization increases with age. While Montgomery County increased at an overall rate of 46.1 percent from 2010 to 2025, the age cohort changes are notable, ranging up to 104.5 percent. The 104.5 percent rate is the 65 to 74 age group. Other seniors increased between 70 and 78 percent. With respect to Stewart County which is rural as noted, its growth rate was 6.8 percent during this period although those 65 and older increased between 25 and 42 percent depending on the cohort. Overall, Montgomery County is forecasted to increase another 10.9 percent during the next five years and the Service Area is expected to increase 10.4 percent.

The rapid growth and aging of the Service Area population will result in increased demand for healthcare services. This is particularly true for the elderly population, which has been documented to have a higher incidence of emergency conditions and hospitalizations than any other age cohort.

Approximately 42 percent of the Service Area population is between the ages of 18 and 44. This includes a large numbers of families residing in and expected to move into the Service Area dictating the corresponding need for accessible maternal health services. Accordingly, TCH will provide a meaningful and programmatically accessible women's health program at this new hospital with an OB unit of 10 beds and a Level II NICU with 8 beds. The primary population utilizing an obstetrics service are women between the ages of 18 and 44. Zip code 37042 has the 2nd largest count in the State of female population in this age cohort in 2025 and will increase to the largest populous by 2030.

TCH Will Enhance Access as Expectant Mothers Experience Geographic Inaccessibility

As noted, by 2030, zip code 37042 will have nearly 102,000 people with more than 21,700 females between the ages of 18 and 44. This will be the most populous zip code in State for this cohort. TCH's maternity program, described in Attachment 1N, Acute, is needed in the Service Area to provide residents with an alternative provider, model of care, and physicians. It is also needed to reduce out-migration and simultaneously enhance access for the Service Area.

As discussed in the obstetrics out-migration, approximately 40 percent of birthing mothers leave the Service Area to deliver their babies. Offering an alternative locally will benefit the mother, child, and family. To demonstrate how long the travel times are for expectant mothers to access hospitals for deliveries when leaving their home county, the Applicant undertook an analysis of obstetrics cases for the Service Area and identified travel distance and time from the county (centroid) to the hospital in which the patient was admitted.

Exhibit 13

Montgomery Obstetrics Outmigration				
Destination Hospital	**Hospital County**	**2021**	**2022**	**2023**
Vanderbilt University	Davidson	483	556	Masked
TriStar Centennial	Davidson	190	208	187
Saint Thomas Midtown	Davidson	147	177	Masked
Jennie Stuart Medical Center	Christian KY	31	23	Masked
TriStar NorthCrest	Robertson	115	75	41
TriStar Horizon	Dickson	10	24	29
TriStar Summit	Davidson	8	8	15
TriStar Hendersonville	Sumner	11	15	14
TriStar StoneCrest	Rutherford	6	17	10
All Other	Numerous	44	34	37
Total Transfers		1,045	1,137	1,206
Travel Times to Out-Migrated Facilities	**Hospital County**	**Time**		
Vanderbilt University	Davidson	78		
TriStar Centennial	Davidson	80		
Saint Thomas Midtown	Davidson	82		
Jennie Stuart Medical Centr	Christian KY	47		
TriStar NorthCrest	Robertson	62		
TriStar Horizon	Dickson	63		
TriStar Summit	Davidson	88		
TriStar Hendersonville	Sumner	78		
TriStar StoneCrest	Rutherford	96		
All Other	Average of above	75		
Potential Saved Time for Out-Migration (One Way)	**Hospital County**	**2021**	**2022**	**2023**
Vanderbilt University	Davidson	37,674	43,368	Masked
TriStar Centennial	Davidson	15,200	16,640	14,960
Saint Thomas Midtown	Davidson	12,054	14,514	Masked
Jennie Stuart Medical Centr	Christian KY	1,457	1,081	Masked
TriStar NorthCrest	Robertson	7,130	4,650	2,542
TriStar Horizon	Dickson	630	1,512	1,827
TriStar Summit	Davidson	704	704	1,320
TriStar Hendersonville	Sumner	858	1,170	1,092
TriStar StoneCrest	Rutherford	576	1,632	960
All Other	--	3,304	2,553	2,779
Total		79,587	87,824	93,115

Source: THA data and Googlemaps for time estimates.

Total travel time from their home county to the hospital for obstetrics patients now exceeds 93,000 minutes, increasing 17 percent from two years ago.

While much smaller, Stewart County has a similar negative impact on its birthing mothers and their families as shown in **Exhibit 14**.

Exhibit 14

Stewart Obstetrics Outmigration, Excluding Montgomery County				
Destination Hospital	**Hospital County**	**2021**	**2022**	**2023**
Vanderbilt University	Davidson	15	18	Masked
Henry County	Henry	20	14	Masked
TriStar Centennial	Davidson	1	4	6
Murray Calloway County Hospital	Calloway	1	5	Masked
TriStar NorthCrest	Robertson	1	0	3
TriStar Horizon	Dickson	9	6	23
All other	Numerous	9	5	2
Total Transfers		56	52	69
Travel Times to Out-Migrated Facilities	**Hospital County**	**Time**		
Vanderbilt University	Davidson	109		
Henry County	Henry	67		
TriStar Centennial	Davidson	107		
Murray Calloway County Hospital	Calloway	57		
TriStar NorthCrest	Robertson	98		
TriStar Horizon	Dickson	73		
All Other	Average of above	85.2		
Potential Saved Time for Out-Migration (One Way)	**Hospital County**	**2021**	**2022**	**2023**
Vanderbilt University	Davidson	1,635	1,962	Masked
Henry County	Henry	1,340	938	Masked
TriStar Centennial	Davidson	107	428	642
Murray Calloway County Hospital	Calloway	57	285	Masked
TriStar NorthCrest	Robertson	98	0	294
TriStar Horizon	Dickson	657	438	1,679
All Other	--	767	426	170
Total		4,661	4,477	5,774

Source: THA data and Googlemaps for time estimates.

With population increases resulting in more deliveries, more out-migration and more congested roadways, these times will only increase without the establishment of TCH's maternity program.

TCH Will Enhance Access as All Inpatients Face Inadequate Access

Like the analysis conducted for expectant mothers by county and hospital destination outside the Service Area, we also identified non-tertiary discharges by county. For each county, discharges were identified for the past three years and similarly mapped to the hospitals at which the patient was admitted. **Exhibit 15** provides travel time for non-tertiary patients leaving their home county.

Exhibit 15

Montgomery Non-Tertiary Outmigration				
Destination Hospital	**Hospital County**	**2021**	**2022**	**2023**
Vanderbilt University	Davidson	2,246	2,337	Masked
TriStar Centennial	Davidson	807	814	732
Saint Thomas West	Davidson	524	523	Masked
Saint Thomas Midtown	Davidson	409	444	Masked
TriStar Skyline	Davidson	503	466	446
TriStar NorthCrest	Robertson	107	134	190
TriStar Horizon	Dickson	103	111	159
TriStar Summit	Davidson	53	71	77
TriStar Hendersonville	Sumner	46	67	69
TriStar Southern Hills	Davidson	40	69	51
Tri-Star Greenview Regional Hospital	Warren, KY	10	23	9
TriStar StoneCrest	Rutherford	15	17	8
All other	Numerous	337	405	331
Total Transfers		5,200	5,481	5,376
Travel Times to Out-Migrated Facilities	**Hospital County**	**Time**		
Vanderbilt University	Davidson	78		
TriStar Centennial	Davidson	80		
Saint Thomas West	Davidson	77		
Saint Thomas Midtown	Davidson	82		
TriStar Skyline	Davidson	68		
TriStar NorthCrest	Robertson	62		
TriStar Horizon	Dickson	63		
TriStar Summit	Davidson	88		
TriStar Hendersonville	Sumner	78		
TriStar Southern Hills	Davidson	89		
Tri-Star Greenview Regional Hospital	Warren, KY	106		
TriStar StoneCrest	Rutherford	96		
All Other	Average of above	81		
Potential Saved Time for Out-Migration (One Way)	**Hospital County**	**2021**	**2022**	**2023**
Vanderbilt University	Davidson	175,188	182,286	Masked
TriStar Centennial	Davidson	64,560	65,120	58,560
Saint Thomas West	Davidson	40,348	40,271	Masked
Saint Thomas Midtown	Davidson	33,538	36,408	Masked
TriStar Skyline	Davidson	34,204	31,688	30,328
TriStar NorthCrest	Robertson	6,634	8,308	11,780
TriStar Horizon	Dickson	6,489	6,993	10,017
TriStar Summit	Davidson	4,664	6,248	6,776
TriStar Hendersonville	Sumner	3,588	5,226	5,382
TriStar Southern Hills	Davidson	3,560	6,141	4,539
Tri-Star Greenview Regional Hospital	Warren, KY	1,060	2,438	954
TriStar StoneCrest	Rutherford	1,440	1,632	768
All Other	--	27,157	32,636	26,673
Total		402,430	425,395	414,896

Source: THA data and Googlemaps for time estimates.

Reflected above, total travel time is approximately 415,000 minutes (6,900 hours) having increased 3 percent in the past two years. **Exhibit 16** provides similar information for Stewart County residents leaving the Service Area. The total minutes of 71,000 equals more than 1,180 hours.

Exhibit 16

Stewart Non-Tertiary Outmigration, Excluding Montgomery County				
Destination Hospital	**Hospital County**	**2021**	**2022**	**2023**
Vanderbilt University	Davidson	185	168	Masked
Henry County	Henry	139	126	Masked
TriStar Centennial	Davidson	67	78	88
Saint Thomas West	Davidson	74	56	Masked
Saint Thomas Midtown	Davidson	35	59	Masked
Murray Calloway County Hospital	Calloway	13	31	Masked
Houston County Community	Houston	45	55	Masked
TriStar Skyline	Davidson	37	36	50
TriStar NorthCrest	Robertson	5	10	6
TriStar Horizon	Dickson	36	53	57
TriStar Summit	Davidson	4	11	13
TriStar Hendersonville	Sumner	4	10	6
TriStar Southern Hills	Davidson	3	12	6
Tri-Star Greenview Regional Hospital	Warren, KY	3	1	1
TriStar StoneCrest	Rutherford	0	1	0
All other	Numerous	75	81	36
Total Transfers		725	788	766
Travel Times to Out-Migrated Facilities	**Hospital County**	**Time**		
Vanderbilt University	Davidson	109		
Henry County	Henry	67		
TriStar Centennial	Davidson	107		
Saint Thomas West	Davidson	109		
Saint Thomas Midtown	Davidson	103		
Murray Calloway County Hospital	Calloway	57		
Houston County Community	Houston	34		
TriStar Skyline	Davidson	101		
TriStar NorthCrest	Robertson	98		
TriStar Horizon	Dickson	73		
TriStar Summit	Davidson	117		
TriStar Hendersonville	Sumner	106		
TriStar Southern Hills	Davidson	116		
Tri-Star Greenview Regional Hospital	Warren, KY	131		
TriStar StoneCrest	Rutherford	125		
All Other	Average of above	97		
Potential Saved Time for Out-Migration (One Way)	**Hospital County**	**2021**	**2022**	**2023**
Vanderbilt University	Davidson	20,165	18,312	Masked
Henry County	Henry	9,313	8,442	Masked
TriStar Centennial	Davidson	7,169	8,346	9,416
Saint Thomas West	Davidson	8,066	6,104	Masked
Saint Thomas Midtown	Davidson	3,605	6,077	Masked
Murray Calloway County Hospital	Calloway	741	1,767	Masked
Houston County Community	Houston	1,530	1,870	Masked
TriStar Skyline	Davidson	3,737	3,636	5,050
TriStar NorthCrest	Robertson	490	980	588
TriStar Horizon	Dickson	2,628	3,869	4,161
TriStar Summit	Davidson	468	1,287	1,521
TriStar Hendersonville	Sumner	424	1,060	636
TriStar Southern Hills	Davidson	348	1,392	696
Tri-Star Greenview Regional Hospital	Warren, KY	393	131	131
TriStar StoneCrest	Rutherford	0	125	0
All Other	--	7,265	7,846	3,487
Total		66,342	71,244	71,032

Source: THA data and Googlemaps for time estimates.

With continuing expected increases in population and associated discharges, travel miles will continue to increase without the approval of TCH.

Cardiac Patients Will Benefit from the Availability of TCH

The existing cardiac catheterization laboratory in Montgomery County is at optimal capacity according to the criteria. There is also significant outmigration for this service. The degree of heart muscle damage from a heart attack is associated with how long it takes from when heart attack symptoms start to when patients receive an artery-clearing procedure called percutaneous coronary intervention, or PCI. The longer the time before PCI, called symptom-to-balloon time, the more significant and damaging the heart attack. Symptom-to-balloon time directly correlates with the amount of time the myocardium/heart muscle undergoes inadequate blood supply. Reducing such time should reduce the degree of damage and ultimately improve patient outcomes. Shorter symptom to balloon times for individual patients is also associated with lower mortality at 30-days and at 1 year.

For patients experiencing myocardial infarction (MI)/heart attack, the American College of Cardiology ("ACC"), the American Heart Association ("AHA"), and the European Society of Cardiology have all concluded that the earlier therapy is initiated, the better the outcome.

Per the travel times presented in response to Question 4N herein, time to reach hospitals outside of the Service Area range from 62 to 106 minutes (see **Exhibit 15**). The availability of TCH and its proposed catheterization laboratories would save these patients between 36 and 80 minutes in the symptom to balloon time. Time is muscle, and these minutes could be critical in patient outcomes.

While total inpatient cardiac procedures out-migrate from Montgomery County at a rate of 54 percent, when just considering cardiac catheterizations including outpatient, the rate is 42 percent. Inpatient and outpatient catheterizations being performed outside Montgomery County are shown in the next exhibit.

Exhibit 17

Inpatient and Outpatient Cardiac Catheterization						
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
Montgomery County Residents						
Number of Patients Who Out-Migrated	1,002	999	Masked	39.8%	41.6%	Masked
Number of Patients to TriStar Centennial	200	177	176	7.9%	7.4%	Masked
Number of Patients to Tristar Other	58	70	78	2.3%	2.9%	Masked
Out-Migration to Other Providers	744	752	Masked	29.5%	31.3%	Masked
Stewart County Residents						
Number of Patients Who Out-Migrated	154	170	Masked	54.8%	57.6%	Masked
Number of Patients to TriStar Centennial	21	20	17	7.5%	6.8%	Masked
Number of Patients to Tristar Other	19	13	17	6.8%	4.4%	Masked
Out-Migration to Other Providers	114	137	Masked	40.6%	46.4%	Masked

Source: THA data for the respective years. 2023 data is thus masked per the THA data use policy.

An average of 1,000 Montgomery County residents each year out-migrate from that county. An additional 170 out-migrated from Stewart County. This confirms the lack of access in the Service Area.

TCH Will Reduce Outmigration from the Service Area.

Implementing TCH, a full-service community hospital, will improve access for patients who leave the Service Area to access care at hospitals away from the areas where they live.

To TriStar Health Facilities

TCH will improve geographic and programmatic access for patients who are already receiving care at TriStar Health facilities.

As shown in **Exhibit 18**[9] below, TriStar Health facilities is a significant source of care in the Service Area. More specifically, of the Montgomery County residents requiring acute care hospitalization, an average of 15 percent sought services at TriStar Health hospitals during the past three years. This represents nearly 35 percent of all patients out-migrating from that County. With respect to Stewart County, between 14 and 22 percent sought services at TriStar Health hospitals. This represents 22 to 26 percent of total out-migrating. Combined, approximately 31 percent of those out-migrating were admitted to TriStar Health hospitals. In total, there were approximately 2,600 annual Service Area discharges from TriStar Health.

[9] This three-year trend represents discharges at acute care hospitals and includes medical/surgical, obstetrics and neonatology cases. Specialty hospitals such as behavioral health, rehabilitation and long-term acute care are excluded from this analysis as are behavioral health and rehab discharges from acute care hospitals.

Exhibit 18
Outmigration of Total Med-Surg, Obstetrics and NICU Discharges to TriStar Hospitals

County and Hospital Destination	CY 2021	CY 2022	CY 2023
Montgomery County			
TriStar Centennial	1,193	1,204	1,107
TriStar Skyline	580	535	519
TriStar Northcrest	238	223	235
TriStar Horizon	117	145	197
All Other TriStar	202	305	277
All Other Hospitals	4,968	5,243	Masked
Total Outmigration	7,298	7,655	Masked
Percent Outmigration to TriStar	15.2%	15.4%	14.4%
Percent to TriStar of Those Who Outmigrated	34.6%	34.8%	Masked
Stewart County			
TriStar Centennial	81	100	118
TriStar Skyline	47	42	61
TriStar Northcrest	6	10	10
TriStar Horizon	46	60	87
All Other TriStar	14	37	27
All Other Hospitals	685	695	Masked
Total Outmigration	879	944	Masked
Percent Outmigration to TriStar	14.4%	18.1%	21.5%
Percent to TriStar of Those Who Outmigrated	22.1%	26.4%	Masked
Total Service Area			
TriStar Centennial	1,274	1,304	1,225
TriStar Skyline	627	577	580
TriStar Northcrest	244	233	245
TriStar Horizon	163	205	284
All Other TriStar	216	342	304
All Other Hospitals	5,653	5,938	Masked
Total Outmigration	8,177	8,599	Masked
Total To TriStar Health Hospitals	2,524	2,661	2,638
Percent Outmigration to TriStar	15.1%	15.6%	14.9%
Percent to TriStar of Those Who Outmigrated	30.9%	30.9%	Masked

Source: THA data.

This redirection of patients from TriStar Health hospitals to TCH will not impact existing providers as these patients are already bypassing other facilities in favor of TriStar Health facilities.

County Out-Migration

TCH will improve access to care for Montgomery and Stewart County residents who are already seeking care outside of where they reside. In 2023, approximately 47 percent of patients in Montgomery County out-migrated to short term hospitals. Out-migration of this magnitude indicates inadequate access, including problematic geographic and programmatic access to hospital facilities and services. **Exhibit 19** provides med/surg hospital discharges for counties with a population exceeding 175,000 throughout the State.

Exhibit 19
Med-Surg Outmigration from Higher Population Counties

County	% Med Surg Who Admitted in Home County	% Med Surg Who Outmigrated	2025 Population	Med-Surg Admits, Total	Med-Surg Outmigrating Admits
Williamson County	38.9%	61.1%	271,521	14,025	8,571
Montgomery County	53.4%	46.6%	248,933	18,152	8,454
Sumner County	56.6%	43.4%	214,222	19,768	8,575
Rutherford County	66.0%	34.0%	378,969	26,283	8,931
Knox County	91.4%	8.6%	511,340	42,560	3,645
Davidson County	93.2%	6.8%	718,553	67,920	4,626
Hamilton County	95.6%	4.4%	388,064	33,421	1,481
Shelby County	98.9%	1.1%	902,243	92,705	1,021
Weighted Average	85.6%	14.4%	3,633,845	314,834	45,304

Source: Joint Annual Report Summary file. Excludes behavioral health, LTAC and rehab hospitals.

Montgomery County has the 2nd highest out-migration of any of these higher population counties. Furthermore, it is more than 3 times the average of these counties. Of the 8,454 med-surg patients leaving Montgomery County, 2,477 or 29 percent, were treated at TriStar Health facilities. Seventy percent of these were admitted to TriStar Centennial and TriStar Skyline, an additional 7 percent to other TriStar hospitals in Davidson County, 11 percent to TriStar Northcrest, 8 percent to TriStar Horizon and the balance to other TriStar Health hospitals.

When considering those with the most out-migration, three of the four counties are contiguous to Davidson County where most out-migrating patients are admitted. In contrast, Montgomery County residents have to cross Robertson, Cheatham or Dickson Counties to reach Davidson County.

Contrasting Rutherford County with Montgomery County, Montgomery County is 58 miles to Davidson County, while Rutherford is 40 miles. Travel time from Montgomery to Davidson County is 80 to 90+ minutes; Rutherford is 45 to 90+ minutes. Despite the similarities, an additional 12.6 percent of inpatient admissions occur in Rutherford County's **two** hospitals[10] than Montgomery County's **one** hospital (Tennova Clarksville). Contrasting Sumner County to Montgomery County, Sumner County is 30 to 50+ minutes closer being contiguous to Davidson County where most out-migrating patients are admitted.

Service Area Out-Migration, Total Patients

Evaluating Service Area hospital utilization patterns is informative given the fact that Montgomery County is the third fastest growing county in the State. In approximately 2020, the existing provider affiliated with VUMC, with VUMC becoming a 20% owner of Tennova Clarksville. Expectations that such an investment in the community would increases services 'at home' were not fulfilled. In fact, evaluation of migration trends from 2019 (prior to the partnership) to 2023 tells a unique story. Overall, outmigration did not reduce; the primary difference was VUMC increased its share of the outmigration by just 1 to 2 points. **Exhibit 20** provides total discharges including all service lines for the Service Area counties and the outmigration percentage.

[10] St. Thomas Westlawn opened in 2023, but it only was responsible for 4 admissions per the JARS summary file. A fourth hospital (VRH) has also been approved to, among other reasons, reduce out-migration to Davidson County.

Exhibit 20
Total Discharges by County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Total Discharges						
Montgomery County	17,585	16,721	17,416	17,883	18,508	923
Stewart County	1,610	1,494	1,476	1,503	1,571	-39
Out-Migration						
Montgomery County	53.6%	52.4%	52.7%	53.8%	Masked	0.2%
Stewart County	66.2%	67.3%	67.5%	70.7%	Masked	4.5%

Source: THA data for the respective years. Includes all services lines.

Removing behavioral health and rehabilitation service lines from the total discharges shown above, out-migration approximates 49 percent reflecting an 0.9 percent increase since 2019. **Exhibit 21** provides this information.

Exhibit 21
Discharges Excluding Behavioral Health and Rehabilitation by County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Discharges without Behavioral Health and Rehabilitation						
Montgomery County	15,684	14,945	15,577	15,929	16,531	847
Stewart County	1,484	1,368	1,361	1,383	1,419	-65
Out-Migration						
Montgomery County	48.0%	47.1%	47.7%	48.9%	Masked	0.9%
Stewart County	63.3%	64.3%	65.5%	69.0%	Masked	5.6%

Source: THA data for the respective years. Includes all services lines except behavioral health and rehab.

However, when considering some of the community services that are important to keep close to home, there has been a notable increase in outmigration. This is particularly evident when evaluating cardiac procedures, obstetrics, and neonatology – three signature programs that will be offered at TCH. With respect to inpatient cardiac procedures, **Exhibit 22** provides the discharges and migration patterns for cardiac procedure discharges. Outmigration increased during the past years by 5 to 6 points.

Exhibit 22
Total Cardiac Procedure Discharges by County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Cardiac Procedure Discharges						
Montgomery County	1,243	1,085	1,066	1,179	1,250	7
Stewart County	75	53	66	68	71	-4
Out-Migration Cardiac Procedures						
Montgomery County	48.1%	52.5%	51.8%	54.3%	Masked	6.2%
Stewart County	62.7%	71.7%	65.2%	67.6%	Masked	5.0%

Source: THA data for the respective years.

With respect to obstetrics and neonatology services, similar trends are observed from before to after the Tennova Clarksville – VUMC partnership. **Exhibit 23** provides the similar discharge pattern for the obstetrics and neonatology service lines for Montgomery County; **Exhibit 24** provides it for Stewart County. 2023 demonstrates further increases in out-migration; however that data is masked due to THA

policy. As with the above analysis, while 100 percent out-migrate from Stewart County, this information identifies outmigration from the Service Area.

Exhibit 23
Total Obstetrics and Neonatology Discharges for Montgomery County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Montgomery County Total Discharges						
Obstetrics	2,568	2,603	2,721	2,977	2,848	280
Neonatalogy	538	506	551	504	618	80
Montgomery County Out-Migration						
Obstetrics	31.8%	35.7%	38.0%	38.1%	Masked	6.3%
Neonatalogy	57.6%	56.9%	65.3%	66.7%	Masked	9.0%

Source: THA data for the respective years.

Exhibit 24
Total Obstetrics and Neonatology Discharges for Stewart County and Outmigration

	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	Change
Stewart County Total Discharges						
Obstetrics	156	141	138	129	139	-17
Neonatalogy	36	37	21	23	31	-5
Stewart County Out-Migration						
Obstetrics	26.9%	34.0%	40.6%	40.3%	Masked	13.4%
Neonatalogy	58.3%	59.5%	52.4%	65.2%	Masked	6.9%

Source: THA data for the respective years

Establishment of TCH as a community provider will reverse these outmigration trends enhancing access for Service Area residents while providing necessary services close to home.

Service Area Out-Migration, Medical-Surgical Patients

More than half of patients leaving the Service Area to access hospital services confirm the existence of geographic and programmatic challenges experienced by Service Area residents. TCH will be a full-service community hospital primarily serving the inpatient acute care needs of non-tertiary med-surg and obstetrics patients. Therefore, the migration analysis presented herein is separated into non-tertiary medical surgical and obstetrics migration patterns.[11] The next exhibit presents this information: the non-tertiary medical surgical patients of the Service Area and their respective migration patterns.

[11] Tertiary medical surgical cases are defined as transplants, trauma care, cardiac surgery, thoracic surgery, neurosurgery, burns, radiotherapy, neonatology and other complex interventions. Non-tertiary medical-surgical are the remaining inpatient services, excluding specialty services (behavioral health and medical rehabilitation). Obstetrics is also considered non-tertiary but is separately analyzed throughout this CON Application.

Exhibit 25
Non-Tertiary Med-Surg Hospital Discharges by County – Migration Patterns

		CY 2021	CY 2022	CY 2023
Montgomery County				
	To Montgomery County Hospitals	6,069	5,940	Masked
	Outmigration from Montgomery County	5,200	5,481	Masked
	Total Montgomery Discharges	11,269	11,421	11,922
	Percent Outmigration from Montgomery County	46.1%	48.0%	Masked
Stewart County				
	To Montgomery County Hospitals	365	339	Masked
	Outmigration from Service Area	725	788	Masked
	Total Stewart Discharges	1,090	1,127	1,143
	Percent Outmigration from Montgomery County	66.5%	69.9%	Masked

Source: THA data for the respective years

The outmigration analysis for Stewart County identifies the Montgomery County discharges as not out-migrating as both counties are in the defined TCH Service Area. This information confirms that the out-migration from the TCH Service Area is not only excessive but also results in non-tertiary patients traveling lengthy distances to access available community hospital services elsewhere. TCH will mitigate out-migration, improve access and provide available community hospital services in the Service Area.

Service Area Out-Migration, Obstetrics Patients

Obstetrics patients are defined as those being categorized within major diagnostic category (MDC) 14,[12] Pregnancy, Childbirth & the Puerperium. Most obstetrics cases are deliveries of infants. In addition, there are admissions for false labor, antepartum complications and other conditions associated with a pregnancy. Like total acute hospital patients and those with non-tertiary diagnoses, obstetrics patients experience significant out-migration from their home area for services. As shown in **Exhibits 23 and 24**, obstetric patients from Montgomery County out-migrate at a 38 percent rate while Stewart County out-migrates at a 67 percent rate.

As with med/surg cases, a primary reason for obstetrics patients leaving the area for care is the lack of availability of services. TCH will not only provide OB services that are currently unavailable to the residents of the Service Area but also TCH will be distinguishable from existing services in the Service Area as it will incorporate 24/7 laborist services, which can include midwifery, doula, water immersion and other specialty programming to reduce out of area travel to access specialized obstetrics services.

TCH Will Reduce Emergency Medical Services (EMS) and Other Transports Out of the Area

Emergency Transports from the Field

Biospatial is a proprietary vendor with which TriStar Health contracted for EMS data analytics. Biospatial combines EMS electronic patient care reports (ePCR) from its network of thousands of Emergency Medical Services (EMS) providers with other electronic healthcare data sources using proprietary artificial intelligence (AI) to support the missions of public sector and commercial healthcare entities. The data available from biospatial includes EMS transport data collected from jurisdictions and providers. Data collection includes EMS transports by counties and zip codes, transport destination facility, patient

[12] DRGs in MDC 14 include 768, 769, 770, 783-788, 796-798, and 817-819.

condition and other variables. It is essentially a claims data base that access is contracted by healthcare providers and others to utilize the data as a tool to assess various market dynamics.[13]

As part of its analysis of the Service Area, TCH acquired this described biospatial EMS data by county to identify the level of transports from Montgomery and Stewart Counties. A total 13,942 patients were transported during the past 12 months. Of those, 938 were taken outside of Montgomery County. Evaluation of the data by destination within the county or leaving the county was conducted. The following exhibit provides the EMS transports counts from the two counties that were not delivered to Tennova for emergency services. The exhibit also quantifies the time an EMS vehicle and its personnel were out of the county and not available for an alternate emergency call. Time is computed from the county centroid to the destination hospital, and accounts for travel in both directions.

[13] Biospatial was founded to commercialize a research and development program sponsored by the Department of Homeland Security and managed by the University of North Carolina at Chapel Hill (UNC). The National Collaborative for Bio-Preparedness (NCBP) focused on identifying health-related data sources that could provide early warning of biological weapon attacks and infectious disease outbreaks. The NCBP program discovered that while many relevant health-related data sources exist, electronic Patient Care Reports (ePCR) collected by Emergency Medical Services (EMS) are the ideal foundational data source to support early warning of threats from chemical, biological, radiological, and nuclear (CBRN) agents.

Exhibit 26

Destination Hospital	Hospital County	EMS Scene Transports from: Montgomery County	Stewart County	Total
TriStar Horizon Medical Center	Dickson	100	35	135
TriStar Skyline Medical Center	Davidson	44	8	52
TriStar Centennial Medical Center	Davidson	3	1	4
Houston County Community Hospital	Houston	0	144	144
Vanderbilt University Medical Center	Davidson	131	26	157
Murray Calloway County Hospital	Calloway, KY	0	13	13
Blanchfield Army Community Hospital	Christian, KY	433	0	433
Count Outside Service Area		711	227	938
Average per Week Transports		14	4	18

Travel Times to Out of Area	Hospital County	Montgomery County to:	Stewart County to:
TriStar Horizon Medical Center	Dickson	63	73
TriStar Skyline Medical Center	Davidson	70	101
TriStar Centennial Medical Center	Davidson	80	107
Houston County Community Hospital	Houston	49	34
Vanderbilt University Medical Center	Davidson	78	109
Murray Calloway County Hospital	Calloway, KY	78	57
Blanchfield Army Community Hospital	Christian, KY	26	48

Potential Saved EMS Time Out of Service Area (Each Way)	Hospital County	Montgomery Origination	Stewart Origination	Total
TriStar Horizon Medical Center	Dickson	12,600	5,110	17,710
TriStar Skyline Medical Center	Davidson	6,160	1,616	7,776
TriStar Centennial Medical Center	Davidson	480	214	694
Houston County Community Hospital	Houston	0	9,792	9,792
Vanderbilt University Medical Center	Davidson	20,436	5,668	26,104
Murray Calloway County Hospital	Calloway, KY	0	1,482	1,482
Blanchfield Army Community Hospital	Christian, KY	22,516	0	22,516
Total		62,192	23,882	86,074

Source: biospatial proprietary database, May 2025

Biospatial advises that its data is not 100 percent reported. It therefore estimates by county the percentage of transports in its database that it represents of the total using its proprietary algorithm. For Montgomery and Stewart Counties, its algorithms suggest the above transports represent between 78 and 82 percent of total transports. As a result, the Service Area transports above (and in its database) are the minimum occurring and could conceivably be 18 to 22 percent greater. The total travel time of 86,000 minutes equates to more than 1,400 hours, some of which could be eliminated with the establishment of TCH.

Transports to TriStar Health Hospitals

TCH will improve geographic and programmatic access for patients who are already receiving care at TriStar Health facilities.

As shown in **Exhibit 27** below, TriStar Health facilities is a significant source of care in the Service Area. More specifically, of the Montgomery County residents requiring acute care hospitalization, an average

of 15 percent sought services at TriStar Health hospitals during the past three years. This represents nearly 35 percent of all patients out-migrating from that County. With respect to Stewart County, between 14 and 22 percent sought services at TriStar Health hospitals. This represents 22 to 26 percent of total out-migrating. Combined, approximately 31 percent of those out-migrating were admitted to TriStar Health hospitals. In total, there were approximately 2,600 annual Service Area discharges from TriStar Health.

Exhibit 27
Outmigration of Total Med-Surg, Obstetrics and NICU Discharges to TriStar Hospitals

County and Hospital Destination	CY 2021	CY 2022	CY 2023
Montgomery County			
TriStar Centennial	1,193	1,204	1,107
TriStar Skyline	580	535	519
TriStar Northcrest	238	223	235
TriStar Horizon	117	145	197
All Other TriStar	202	305	277
All Other Hospitals	4,968	5,243	Masked
Total Outmigration	7,298	7,655	Masked
Percent Outmigration to TriStar	15.2%	15.4%	14.4%
Percent to TriStar of Those Who Outmigrated	34.6%	34.8%	Masked
Stewart County			
TriStar Centennial	81	100	118
TriStar Skyline	47	42	61
TriStar Northcrest	6	10	10
TriStar Horizon	46	60	87
All Other TriStar	14	37	27
All Other Hospitals	685	695	Masked
Total Outmigration	879	944	Masked
Percent Outmigration to TriStar	14.4%	18.1%	21.5%
Percent to TriStar of Those Who Outmigrated	22.1%	26.4%	Masked
Total Service Area			
TriStar Centennial	1,274	1,304	1,225
TriStar Skyline	627	577	580
TriStar Northcrest	244	233	245
TriStar Horizon	163	205	284
All Other TriStar	216	342	304
All Other Hospitals	5,653	5,938	Masked
Total Outmigration	8,177	8,599	Masked
Total To TriStar Health Hospitals	2,524	2,661	2,638
Percent Outmigration to TriStar	15.1%	15.6%	14.9%
Percent to TriStar of Those Who Outmigrated	30.9%	30.9%	Masked

Source: THA data.

This redirection of patients from TriStar Health hospitals to TCH will not impact existing providers as these patients are already bypassing other facilities in favor of TriStar Health facilities.

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.

In the defined Service Area, there is 1 acute care hospital: Tennova Clarksville. This hospital is licensed for 270 beds and staffs only 237 of those beds. Its most recent three-year occupancy trend is provided in **Exhibit 28.**

Exhibit 28
Tennova Clarksville Hospital Occupancy Trend, 2021 through 2023

Facility	County	2023 Licensed Beds	Bed Days Available	Patient Days			Licensed Occupancy			% Change in Patient Days 2021-2023
				2021	2022	2023	2021	2022	2023	
Tennova Clarksville	Montgomery	270	98,550	48,063	45,716	49,206	49%	46%	50%	2%
Facility	**County**	**2023 Staffed Beds**	**Bed Days Available**	**Patient Days**			**Staffed Occupancy**			**% Change in Patient Days 2021-2023**
				2021	**2022**	**2023**	**2021**	**2022**	**2023**	
Tennova Clarksville	Montgomery	237	86,505	48,063	45,716	49,206	56%	57%	57%	2%
Patient Days Including Observation Days in Staffed Beds				**Patient + Observation Days**			**Staffed Occupancy**			
Tennova Clarksville	Montgomery	237	86,505	50,895	49,327	53,866	59%	61%	62%	6%

When considering both staffed beds and the fact the observation patients are treated in these beds, occupancy is currently at 62 percent (2023). Notwithstanding that fact, with only one provider and one hospital serving more than 250,000 people in the county, it is clearly underserved. When one factors in the significant out-migration from the county, it is evident that Tennova Clarksville is not meeting their needs and consumers are selecting alternate providers. **Exhibit 29** shows the number of beds needed in the Service Area based on Montgomery and Stewart County resident utilization of hospital services.

Exhibit 29
Montgomery and Stewart County Bed Need

COUNTY	2023		CURRENT*	SERVICE AREA POPULATION			PROJECTED 2025		PROJECTED 2029		2023 ACTUAL BEDS		SHORTAGE/SURPLUS	
Montgomery County	INPATIENT DAYS	ADC	NEED	2023	2025	2029	ADC-2025	NEED 2025	ADC-2029	NEED 2029	LICENSED	STAFFED	LICENSED	STAFFED
Montgomery Patient Days	49,206	135												
Montgomery Observation Day	4,660	13												
Montgomery Outmigration	37,370	102												
TOTAL	91,236	237	273	240,745	251,815	273,822	248	285	270	308	270	237	15	71
Stewart County	INPATIENT DAYS	ADC	NEED	2023	2025	2029	ADC-2025	NEED 2025	ADC-2029	NEED 2029	LICENSED	STAFFED	LICENSED	STAFFED
Stewart Patient Days	0	0												
Stewart Observation Days	0	0												
Stewart Outmigration	8,060	22												
TOTAL	8,060	22	33	14,088	14,231	14,397	22	33	23	34	0	0	33	34

With the continued expected growth in the Service Area, the 105 beds reflected above will continue to increase during the next decades. TCH planning for future expansions as demand warrants throughout the 2030s and beyond is a benefit to the Service Area residents.

Within the hospital's licensed bed capacity is a 12-bed Level II NICU. The occupancy trend of its NICU is shown in **Exhibit 30**.

Exhibit 30
Tennova Clarksville Level II NICU Occupancy Trend, 2021 through 2023

Facility	County	2023 Licensed Beds (Neonatal Unit)	Bed Days Available	Patient Days			Licensed Occupancy		
				2021	2022	2023	2021	2022	2023
Tennova Clarksville	Montgomery	12	4,380	1,216	1,206	1,126	28%	28%	26%

The majority of neonates requiring intensive care are transferred from Montgomery County which is evidenced in Tennova Clarksville occupancy rate. This out-migration puts additional stress and disruption on the birthing mother and family as they are no longer in the same hospital or nearby upon discharge. The live birth rate indicates there is a need for an additional 28 beds which confirms the above occupancy rate is not reflective of the Service Area need for Level II beds.

Tennova Clarksville also operates a cardiac catheterization lab. Based on its most recent utilization (2023), it is currently operating at optimal capacity as shown in **Exhibit 31.**

Exhibit 31
Tennova Clarksville 2023 Cardiac Cath Lab Utilization

Procedure Type	Setting	Procedure Weight	# Labs	# Cases	Weighted Cases (Adult)	Total Cases	Total Weighted Cases	Weighted Cases Per Lab	Utilization per 2,000 Cases (Full Capacity)	Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity)
Diagnostic Cardiac Catheterization	Inpatient	1.0	2	430	430	430	430	215		
	Outpatient	1.0	2	767	767	767	767	383.5		
Therapeutic Cardiac Catheterization	Inpatient	2.0	2	310	620	310	620	310		
	Outpatient	2.0	2	484	968	484	968	484		
Total			2	1,991	2,785	1,991	2,785	1,393	70%	99%

In addition to the one hospital in the Service Area, Tennova Clarksville was approved to implement a 12-bed hospital approximately 4 miles to its west via the relocation of 12 beds from Tennova Clarksville. If implemented, since it has been approximately four years with no site activity, the 12-bed hospital will be the same provider and with limited services. This will not increase bed capacity nor mitigate out-migration from the Service Area.

There are no hospitals in Stewart County. Adjacent to the Service Area is Blanchfield Army Community Hospital ("Blanchfield"). Blanchfield is a military hospital located within Fort Campbell. It is situated across the State line within Kentucky. TriStar hospitals support Blanchfield through continuing education opportunities, best practice sharing opportunities to observe/shadow, Mom/Baby support (NICU), and Emergency Preparedness. Through formal resource-sharing and care collaboration agreements, Blanchfield physicians now provide surgical services at multiple TriStar facilities and work closely with our clinical teams—enhancing both military and civilian care delivery across the region. These arrangements will be extended to TCH which will become the closest TriStar hospital to BACH.

TCH will introduce another hospital provider to the Service Area. Approximately one in four patients who out-migrate seek services at TriStar Health hospitals. Therefore, TCH will bring that care closer to home. Additionally, TCH will seek Level III designation as a trauma center, also accreditation as a primary stroke center and certification as a chest pain center. The existing hospital is neither a trauma center nor does it have any level of stroke certification.

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 and Forecasted Service Area Utilization

The proposed project is for a new acute care community hospital, so it does not have historical utilization and occupancy statistics. The Applicant's projected annual utilization for three years following completion is summarized in **Exhibit 32** and detailed with assumptions throughout this section.

Exhibit 32

TriStar Clarksville Hospital Forecasted Utilization Discharges and Patient Days 2029 through 2031			
	2029 (Year 1)	**2030 (Year 2)**	**2031 (Year 3)**
Med-Surg Discharges			
Total Med-Surg Discharges	1,894	2,912	3,960
Average Length of Stay		3.80	
Med-Surg Patient Days	7,199	11,066	15,048
Med-Surg Average Daily Census	19.7	30.2	41.2
Obstetrics Discharges			
Total OB Discharges	482	650	816
Average Length of Stay		2.35	
OB Patient Days	1,133	1,527	1,917
OB Average Daily Census	3.1	4.2	5.3
Level II NICU Discharges			
Total Level II NICU Discharges	43	58	73
Average Length of Stay	4.00	6.00	8.00
NICU Patient Days	174	351	587
NICU Average Daily Census	0.5	1.0	1.6
Total Discharges			
Total Discharges	2,420	3,620	4,849
Total Patient Days	8,506	12,943	17,552
Total Average Daily Census	23.3	35.4	48.1

To forecast volume for the proposed hospital, the Applicant assessed historical tertiary and non-tertiary inpatient utilization by zip code and age cohort.

Service Area Historical and Forecasted Utilization

The Service Area emergency room, non-tertiary medical surgical, and obstetrics utilization were analyzed and based on use rates and future population were forecasted to the first 3 years of TCH operation, 2029 through 2031.[14] The Service Area historical and forecasted utilization are presented in the next series of exhibits.

Historical and Forecasted Service Area Emergency Room Utilization

In calendar year 2023, there were 103,490 emergency room visits made by residents of the Service Area. Utilization of ERs continue to increase and most recently increased nearly 12 percent in the Service Area. To forecast future year ER visits, the actual CY 2023 emergency room visit rate per 1,000 population at the county and age cohort level was computed. These 2023 use rates were applied to future year population estimates by county and age cohort to conclude on expected annual ER visits by county. **Exhibit 33** presents historical emergency room encounters by Service Area residents by county for CY 2021 through CY 2023 and that which is forecasted for each of the three planning years.

Exhibit 33

TriStar Clarksville Hospital Service Area
Historical and Forecasted Emergency Room Encounters
Historical CY 2021 through 2023 and Forecasted 2029 through 2031

	Historical				Forecasted			
County	CY 2021	CY 2022	CY 2023	% Change 2021 to 2023	Year 1	Year 2	Year 3	% Change '29 to '31
Montgomery County	86,922	92,727	97,227	11.9%	109,911	112,214	114,509	4.2%
Stewart County	5,649	5,838	6,263	10.9%	6,451	6,472	6,490	0.6%
Total Service Area	92,571	98,565	103,490	11.8%	116,362	118,686	121,000	4.0%

Source: Historical represents THA data for the respective years.

The future estimates of ER utilization by Service Area county and year incorporate the anticipated significant population increase and associated aging in Service Area population.

Historical and Forecasted Service Area Non-Tertiary Hospital Utilization

During the most recent year for which utilization data is available (CY 2023), there were a total of 14,034 med-surg discharges of Service Area residents of which 13,099 were non-tertiary. The Applicant's non-tertiary definition is appropriate for a community hospital and excludes behavioral health, neonatology, burns, trauma, transplants, neurosurgery, radiotherapy, burns, cardiac surgery, other complex interventions and comprehensive medical rehabilitation.[15] Additionally, obstetrics is separately analyzed so not included in the non-tertiary analysis. For both total and non-tertiary cases, approximately 46 percent were 65 and older. The proposed hospital will significantly improve seniors' safety as well as provide them with an easier, less congested route to navigate compared to travel to existing hospitals.

[14] The three years represents the 12 months ending October 31, 2029, 2030 and 2031.
[15] Obstetrics is excluded from the non-tertiary med-surg presentation as it is separately analyzed given its distinct programming. Therefore, it is also excluded from the computation of non-tertiary as a percent of total med-surg discharges.

Historical discharge use rates are much higher in the older age cohorts compared to the younger cohorts. The most recently available 2023 use rates by age cohort and county were applied to forecasted population resulting in the forecasted Service Area non-tertiary utilization in the planning years presented above.

Based on anticipated population growth and aging of the population, coupled with historical discharge use rates per 1,000 population for both total medical-surgical and non-tertiary medical-surgical discharges, it is expected that there will be 15,400 non-tertiary medical-surgical discharges originating from the Service Area in Year 1. This represents an increase of more than 2,000 non-tertiary med-surg discharges during the next six years. This increase is largely driven by the population dynamics discussed previously. The next exhibit presents historical non-tertiary med-surg discharges by Service Area residents by county for CY 2021 through CY 2023 and the forecasts for each of the three planning years.

Exhibit 34

TriStar Clarksville Hospital Service Area
Historical and Forecasted Non-Tertiary Discharges
Historical CY 2021 through 2023 and Forecasted 2029 through 2031

	Historical				Forecasted			
County	**CY 2021**	**CY 2022**	**CY 2023**	**% Change 2021 to 2023**	**Year 1**	**Year 2**	**Year 3**	**% Change '29 to '31**
Non-Tertiary Discharges								
Montgomery County	11,299	11,453	11,956	5.8%	14,176	14,545	14,909	5.2%
Stewart County	1,090	1,127	1,143	4.9%	1,224	1,232	1,241	1.4%
Total Service Area	12,389	12,580	13,099	5.7%	15,400	15,777	16,150	4.9%

Source: Historical Data Source: THA.
Note: Non-tertiary excludes obstetrics, newborns, behavioral health, burns, trauma, transplants, neurosurgery, cardiac surgery and comprehensive medical rehabilitation. Also excludes long-term care hospitals and comprehensive medical rehabilitation hospitals.

Overall Service Area increases in Montgomery County exceed that of Stewart although both had meaningful two year increases average 5.7 percent. The non-tertiary med-surg discharges are utilized to estimate future utilization at TCH.

Historical and Forecasted Service Area Obstetrics Utilization

Obstetrics discharges include both delivery and non-delivery discharges within MDC 14. Of the two counties, the majority of the increase is in Montgomery County, which had a 4.4 percent 2-year obstetrics growth rate; Stewart County was less than one percent during this period. . A similar approach to forecasting Service Area obstetrics discharges was taken. The obstetrics use rate applied to females age 18 to 44 was analyzed on a historical basis. **Exhibit 35** presents historical obstetrics discharges by Service Area county for CY 2021 through CY 2023 and those forecasted for years 2029 through 2031.

Exhibit 35

TriStar Clarksville Hospital Service Area Forecasted Obstetrics Discharges Historical CY 2021 through 2023 and Forecasted 2029 through 2031								
	Historical				Forecasted			
County	CY 2021	CY 2022	CY 2023	% Change 2021 to 2023	Year 1	Year 2	Year 3	% Change '29 to '31
Montgomery County	2,733	2,979	2,854	4.4%	3,089	3,113	3,138	1.6%
Stewart County	138	129	139	0.7%	152	154	156	2.4%
Total Service Area	2,871	3,108	2,993	4.2%	3,241	3,267	3,294	1.6%

Source: Historical Data Source: THA.

The obstetrics discharges are utilized to estimate future utilization at TCH based on its anticipated patient utilization rate.

Forecasted TriStar Clarksville Hospital Utilization

Need for the project is substantiated by the compelling reasons presented throughout this CON Application and TCH meeting the Acute Care, NICU, and Cardiac Catheterization Service Criteria and Standards as presented throughout this CON Application. The facts substantiate individually and collectively, that when weighing and balancing these criteria, TCH should be approved. The Service Area needs accessible and available acute care beds in a new access point to alleviate issues of interfacility transports, geographic accessibility, excessive drive times, senior driving issues, ER bypass, provide relief to EMS and meet the growing community's needs well into the future.

In forecasting percent of Service Area patient utilization for the proposed hospital, the Applicant evaluated historical inpatient migration patterns and transfer patterns. Other factors considered in forecasting percent of Service Area patients to utilize the proposed hospital was population dynamics by zip code and county, current and expected travel times, community requests, each county and zip code's geographic proximity to the closest existing acute care hospital, EMS transports from the area and the significant out-migration of Service Area residents.

TCH Non-Tertiary Projected Utilization

Factors incorporated into the forecasted non-tertiary patient utilization rate include historical utilization by provider Montgomery and surrounding counties, out-migration by county and zip code, availability of services, travel times to reach existing providers, level of transfers from Tennova Clarksville, EMS transports out of the area, and consumer support for TCH. Based on the above considerations, the Applicant's forecasted non-tertiary med/surg patient utilization by Service Area county for each of the first three years of operation are presented blow in **Exhibit 36**.

Exhibit 36

TriStar Clarksville Hospital Forecasted Percent Patient Utilization by Service Area County 2029 through 2031			
County	**Year 1**	**Year 2**	**Year 3**
Percent of Non-Tertiary			
Montgomery County	10.0%	15.0%	20.0%
Stewart County	8.0%	12.0%	15.0%
Total Service Area	9.8%	14.8%	19.6%

The above non-tertiary patient utilization estimates are reasonable and achievable given the existing and forecasted Service Area patient utilization, level of out-migration, level of intra facility transports, and community need for a full-service hospital. The non-tertiary patient utilization rates presented above were applied to the forecasted non-tertiary med-surg discharges previously presented resulting in the following forecasted TCH med/surg discharges for the first three years of operation:

Exhibit 37

TriStar Clarksville Hospital Forecasted Discharges by Service Area Zip Code 2029 through 2031			
County	**Year 1**	**Year 2**	**Year 3**
Non-Tertiary Med/Surg			
Montgomery County	1,418	2,182	2,982
Stewart County	98	148	186
Total Service Area	1,516	2,330	3,168
Out of Area	379	582	792
Total Discharges	1,894	2,912	3,960

The above forecasted med-surg discharges are reasonable particularly when considering that more than 8,400+ patients currently receive services outside Montgomery County and 1,741 (CY 2023) non-tertiary med-surg Service Area patients were discharged from TriStar Health hospitals.

TCH Obstetrics Projected Utilization

Obstetrics utilization was considered separately from med-surg utilization in the analysis. Developing a distinguishable obstetrics program at TCH is a significant objective, particularly given the Service Area is underserved. Given the normal gestation period associated with pregnancy, achieving a stabilized patient utilization rate is expected to take somewhat longer than medical-surgical rate.

The maternity program at TCH will have an open medical staff as there are several obstetrical practices in the community and this provides those physicians and their patients a choice in providers. TCH's program will be distinguishable as it will include laborists. A laborist program is a hospital-based model of care where a dedicated obstetrician (laborist) employed to provide in-hospital care exclusively for laboring patients. The laborist's primary responsibility is to manage labor and delivery for all patients in the hospital, regardless of whether they are privately insured or under the care of another provider. This program will also include midwifery as a laborist under the physician's supervision. This program ensures immediate response to obstetric emergencies or labor needs. Care is often more standardized and protocol-driven, with quicker interventions when necessary. This

is also a benefit for community obstetricians who may rely on laborists to handle their patients' deliveries, particularly during off-hours or when unavailable.

Labor and Delivery at TCH will include the following:

- An early familiarity with the obstetrics unit, including tour and meeting the staff.
- Each patient will be in a spacious, private room during labor and postpartum, with remote monitoring devices available if you want to move around.
- The program will support a variety of birth choices and pain management options.
- Patient can access immersion tubs, aromatherapy diffusers, luxurious blankets, swedish bars, rebozo technique, birth stool, birth balls, bassinets that snuggle up to the bed, and plush robes.

Establishment of the obstetrics and neonatal programs at TCH will decrease out-migration from the Service Area to birthing centers and other obstetrics programs in Middle Tennessee. Based on the above considerations, the Applicant's forecasted obstetrics utilization by Service Area county for each of the first three years of operation are presented in the following exhibit.

Exhibit 38

TriStar Clarksville Hospital Forecasted Percent Patient Utilization by Service Area County 2029 through 2031			
County	**Year 1**	**Year 2**	**Year 3**
Percent of Obstetrics			
Montgomery County	12.0%	16.0%	34.0%
Stewart County	10.0%	14.0%	18.0%
Total Service Area	11.9%	15.9%	24.8%

The above obstetrics patient utilization estimates are reasonable and achievable given the community support and anticipated distinguishable programming at TCH. The obstetrics utilization rates presented above were applied to the forecasted obstetrics discharges previously presented resulting in the following forecasted TCH OB discharges for the first three years of operation:

Exhibit 39

TriStar Clarksville Hospital Forecasted Discharges by Service Area Zip Code 2029 through 2031			
County	**Year 1**	**Year 2**	**Year 3**
Obstetrics			
Montgomery County	371	498	628
Stewart County	15	22	25
Total Service Area	386	520	653
Out of Area (25%)	96	130	163
Total Obstetrics Discharges	482	650	816

The above forecasted OB discharges are reasonable particularly when considering the proposed programming planned for the hospital, community support and the level of out-migration experienced by the Service Area.

Total obstetrics discharges were used to estimate the number of Level II neonatal intensive care babies to be admitted to TCH. Based on evaluation of the experience of other area hospitals as well as that of Pediatrix, the neonatologists who will manage the NICU, it is estimated that 9 percent of the obstetrics utilization will result in Level II NICU admissions at the proposed hospital. This is presented in the following exhibit.

Exhibit 40

TriStar Clarksville Hospital Forecasted Utilization Year 1 through Year 3			
	Year 1	**Year 2**	**Year 3**
Obstetrics			
Total OB Discharges	482	650	816
Level II NICU			
Level II NICU Discharges	43	58	73

Given the anticipated planning and programming for this women's health service at TCH, these forecasts are reasonable and consistent with the program to be implemented.

TCH Project Cardiac Catheterization Services

TCH proposes to implement two cardiac catheterization laboratories at the hospital to meet the current and expected increasing needs of Service Area residents. This will improve access for Service Area residents and reduce the current high level of out-migration. 42 percent of patients out-migrate from Montgomery and 58 percent from Stewart Counties. Approximately one in four of these patients have their cardiac caths at TriStar Health hospitals.

Currently practicing within Clarksville, there are two providers affiliated with Tennessee Heart & Vascular ("THV") and one affiliated with Centennial Heart Cardiovascular Consultants. ("Centennial Heart"). THV is one of the leading cardiac practices in Northern Middle Tennessee. In 1984, THV began with Dr. Tracy Callister and Dr. Donald Russo in Hendersonville, Tennessee. Since that time, THV's practice has grown to include 14 providers serving patients in 12 locations, which includes a satellite clinic in Montgomery County. THV providers have been treating patients at its clinic off Center Pointe Drive in Clarksville since December 2010. The two physicians currently practicing at this clinic are Christopher Conley, MD and Terry Ketch, MD. THV providers include non-invasive cardiologists, invasive cardiologists, and interventional cardiologists, all of whom practice exclusively in Middle Tennessee. THV providers currently operate at the cardiac catheterization labs at TriStar Skyline Medical Center, TriStar NorthCrest Medical Center and TriStar Hendersonville Medical Center.

Additionally, Centennial Heart practices at other TriStar Health affiliated hospitals in Middle Tennessee. This physician group includes 45 non-invasive cardiologists, invasive cardiologists, and interventional cardiologists, most of whom are located in Middle Tennessee. Bryan Doherty, MD with Centennial Heart also has been treating patients at his clinic in Clarksville. More information on THV and Centennial Heart is provided in **Attachment 1N, Cardiac**.

TriStar Cardiology Partners (THV and Centennial) are engaged in the planning for TCH's proposed cardiac catheterization program. The plan for TCH includes non-invasive cardiologists, invasive cardiologists, interventional cardiologists including EP physicians, and heart failure physician specialists supported by their extenders. Interventional cardiologists will staff the cardiac catheterization lab, while being supported by advance practice providers. In addition, the TCH and

the TriStar Cardiology Partners will coordinate with TriStar Skyline and TriStar Centennial for staffing and recruitment of additional providers as needed.

Current THV physicians named at this early stage to be practicing at TCH include Christopher Conley, MD and Terry Ketch, MD. An advanced practice provider will be selected to work with these physicians. In addition, other TriStar Cardiology Partners providers may be rotated among other TriStar hospitals and TCH to provide for continuity and collaboration of cardiac catheterization services amongst the practitioners and hospitals.

Based on evaluation of migration patterns and associated anticipated percent of patients to seek services at the proposed hospital, the following percent of patients are estimated to utilize the proposed cardiac catheterization laboratories at TCH.

Exhibit 41

Estimated Percent of TriStar Clarksville Hospital Patients			
	Year 1	**Year 2**	**Year 3**
Cardiac Catheterizations			
Montgomery County	9.0%	14.0%	16.0%
Stewart County	7.0%	10.0%	12.0%
Service Area Total	8.8%	13.7%	15.7%

Applying the above rates to the forecasts accounts for 80 percent of the forecasted patient population, with the remaining 20 percent emanating from outside the Service Area. **Exhibit 42** provides forecasted utilization at TSHH.

Exhibit 42

Forecasted Cardiac Catheterizations at TriStar Clarksville Hospital			
	Year 1	**Year 2**	**Year 3**
Service Area			
Montgomery County	291	464	543
Stewart County	21	31	37
Service Area Total	**312**	**494**	**580**
Out of Area (20%)	78	124	145
Total Utilization	**390**	**618**	**725**

The above forecasted utilization includes both diagnostic and therapeutic catheterizations. Based on experience, it is estimated that diagnostic catheterizations will represent 75 percent of cases and therapeutic catheterizations will represent 25 percent of cases. This results in the following catheterization counts by year.

Exhibit 43

Diagnostic and Therapeutic Catheterization Distribution			
	Year 1	**Year 2**	**Year 3**
Diagnostic Catheterizations	293	463	544
Therapeutic Catheterizations	98	154	181
Total Catheterizations	390	618	725

Forecasted utilization confirms greater than 400 total cases per year by year two. In addition, therapeutic cases exceed 75 per year.

TCH Emergency Room Projected Utilization

TCH's emergency room is expected to meet the Service Area emergency needs including its home zip code which will have nearly 102,000 people in the next five years. Service Area emergency room encounters were forecasted based on actual use rates in the Service Area. TCH's emergency room utilization was estimated considering its expected inpatient utilization, number of patients admitted who arrive via the emergency room versus a direct admit (i.e. obstetrics or scheduled surgery) and the level of outpatient encounters based on the Service Area and TriStar Health experience. Applying these metrics to the above utilization and forecasted Service Area ER visits results in the following expected ER visits at TCH.

Exhibit 44

TriStar Clarksville Hospital
Forecasted TriStar Clarksville ER Encounters by Service Area County
2029 through 2031

	Year 1	Year 2	Year 3
Montgomery County	7,957	12,356	16,737
Stewart County	550	830	1,045
Total Service Area	8,507	13,186	17,782
Out of Area	2,127	3,269	4,445
Total ER Visits	10,634	16,455	22,227

This represents approximately 15 percent of Service Area patients utilizing the TCH emergency room by Year 3.

Summary of TriStar Clarksville Hospital Inpatient Utilization

The above discharges by program were utilized to estimate total patient days and census at TCH. Applied to the discharges is the anticipated average length of stay ("ALOS") by program. The anticipated ALOS is based upon the ALOS for the Service Area patients, ALOS experienced by TriStar Health hospitals, ALOS of previously transported patients, and programmatic discussions with physicians.

Exhibit 45

TriStar Clarksville Hospital Forecasted Utilization Discharges and Patient Days Year 1 through Year 3			
	Year 1	**Year 2**	**Year 3**
Med-Surg Discharges			
Total Med-Surg Discharges	1,894	2,912	3,960
Average Length of Stay		3.80	
Med-Surg Patient Days	7,199	11,066	15,048
Med-Surg Average Daily Census	19.7	30.2	41.2
Obstetrics Discharges			
Total OB Discharges	482	650	816
Average Length of Stay		2.35	
OB Patient Days	1,133	1,527	1,917
OB Average Daily Census	3.1	4.2	5.3
Level II NICU Discharges			
Total Level II NICU Discharges	43	58	73
Average Length of Stay	4.00	6.00	8.00
NICU Patient Days	174	351	587
NICU Average Daily Census	0.5	1.0	1.6
Total Discharges			
Total Discharges	2,420	3,620	4,849
Total Patient Days	8,506	12,943	17,552
Total Average Daily Census	23.3	35.4	48.1

The average daily census ("ADC") by program in the above chart was utilized to estimate the number of needed beds to accommodate the TCH patients. With continuing population growth, the above daily census will continue to increase. As it increases, additional beds will be added in the defined expansion zones to meet the future Service Area needs.

Bed Need Computation

To compute the number of needed beds by program, the formula included in the Acute Care Beds Standard and Criteria is applied to the average daily census. That formula is the projected average daily census +2.33 X square root of projected ADC. This formula is incorporated into the next exhibit by bed function and in the total column.

Exhibit 46

TriStar Clarksville Hospital Utilization Summary and Bed Need (HFC Formula)				
Year 3 Utilization	**Medical/Sugical**	**Obstetrcs**	**Level II NICU**	**Total**
Admissions	3,960	816	73	4,849
Patient Days	15,048	1,917	587	17,552
Average Daily Census	41.2	5.3	1.6	48.1
Computed Beds Needed	56.2	10.6	4.6	64.2
Proposed Beds	*50*	*10*	*8*	*68*

The overall HFC formula applied to the average daily census of 48 equates to a need for 64.2 beds. When the formula is applied individually to the various units, the total increases to a need for 71 beds to address varying occupancy and utilization throughout the year. The planned programming and distribution of beds is reasonable and consistent with forecasted utilization. The available bed and ancillary expansions that are programmed into TCH will be implemented as demand warrants in the future.

With respect to the Level II NICU, the number of needed beds computes to 5 NICU beds. Given the bed need in the Service Area based on live births, the Applicant is seeking approval for 8 beds at this time. However, the Applicant intends on staging the licensure and opening of the beds with seeking to license the first five beds at initial licensure and expanding the Level II NICU as demand warrants.

Attachment 1C

Sample Transfer Agreement

FACILITY TRANSFER AGREEMENT (Revised 04-2011)

This Transfer Agreement (the "Agreement") is made as of this __ day of _____, 20____, by and between: _____, doing business as _____ and _____, each individually referred to herein as "facility," or "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities;

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. **Transfer of Patients.** In the event any patient of either facility is deemed by that facility (the "Transferring Facility") as requiring the services of the other facility (the "Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. **Responsibilities of the Transferring Facility.** The Transferring Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer;

(B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;

(C) Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;

(D) Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;

(E) Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

(F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

(G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

(H) Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

(I) Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

(J) Notify the Receiving Facility of the estimated time of arrival of the patient;

(K) Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(N) Recognize the right of a patient to refuse consent to treatment or transfer;

(O) Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred;

(P) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

(Q) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. **Responsibilities of the Receiving Facility.** The Receiving Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within _____ minutes after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

(B) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred and maintain a call roster of physicians at the Receiving Facility;

(C) Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

(D) Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

(E) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

(F) Provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

(G) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

(H) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

(I) Provide for the return transfer of patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to the Transferring Facility, provide the items and services specified in Section 2 of this Agreement;

(J) Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(K) Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Complete, execute, and return the memorandum of transfer form to the Transferring Facility; and,

(N) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. **Billing**. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. *In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made at _____% of charges or in accordance with the payment fee schedule, labeled as Exhibit _____, attached hereto and incorporated herein by this reference.* In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. **Transfer Back; Discharge; Policies.** At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the agreed upon location. If the patient is to be transferred back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility. Such transfers shall be conducted in accordance with HCA Healthcare Corporation Ethics and Compliance Policies and Procedures (*e.g., Discharge Planning and Referrals of Patients to Post Discharge Providers Policy, LL.HH.016 and EMTALA – Transfer Policy, EM.001*).

6. **Compliance with Law.** Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. **Indemnification; Insurance.** The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. **Term; Termination.** The term of this Agreement shall be a minimum of one (1) year, commencing on the ____ day of _____, 20____, and ending on the ____ day of _____, 20____, unless sooner terminated as provided herein. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. In addition, this Agreement may be terminated immediately upon the occurrence of any of the following events:

(A) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or

(B) Either facility loses its license, or Medicare certification.

This Agreement may be renewed for subsequent one (1) year terms upon the mutual written consent of the parties.

9. **Arbitration.** Any dispute or controversy arising under, out of or in connection with, or in relation to this Agreement, or any amendment hereof, or the breach hereof shall be determined and settled by arbitration in _____, _____, in accordance with the rules of the American Health Lawyers Association Alternative Dispute Resolution Services and applying the laws of the state specified in section 11 below. Any award rendered by the arbitrator shall be final and binding upon each of the parties, and judgment thereof may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both parties. During the pendency of any such arbitration and until final judgment thereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated provided hereunder.

10. **Entire Agreement; Modification.** This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

11. **Governing Law.** This Agreement shall be construed in accordance with the laws of the State of _____ in which the facility affiliated with HCA is located.

12. **Partial Invalidity.** If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

13. **Notices.** All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to: _____
_____
_____
Attention: Chief Executive Officer

Copy to: One Park Plaza, P.O. Box 550
Nashville, Tennessee 37202-0550
Attention: _____, Operations Counsel

If to: _____
_____
_____
Attention: Chief Executive Officer

or to such other persons or places as either party may from time to time designate by written notice to the other.

14. **Waiver.** A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

15. **Assignment; Binding Effect.** Each facility shall not assign or transfer, in whole or in part, this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

16. **Change in Law.** Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within thirty (30) days after said notice was given, this Agreement shall terminate as of midnight on the thirtieth (30th) day after said notice was given.

17. **Warranty of Non-Exclusion.** Each party represents and warrants to the other that the party, its officers, directors and employees (i) are not currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. §1320a-7b(f) (the "federal healthcare programs"), (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services but have not yet been excluded, debarred, or otherwise declared ineligible to participate in the federal healthcare programs, and (iii) are not, to the best of its knowledge, under investigation or otherwise aware of any circumstances which may result in the party or any such individual being excluded from participation in the federal healthcare programs. This shall be an ongoing representation and warranty during the term of this Agreement and each party shall immediately notify the other of any change in the status of the representations and warranty set forth in this section. Any breach of this section shall give the other party the right to terminate this Agreement immediately for cause.

18. **HIPAA Compliance Requirements.** To the extent applicable to this Agreement, Contractor agrees to comply with the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), the

Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d through d-8 ("HIPAA") and any current and future regulations promulgated under either the HITECH Act or HIPAA, including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162 and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transactions Regulations"), all as may be amended from time to time, and all collectively referred to herein as "HIPAA Requirements." Contractor agrees to enter into any further agreements as necessary to facilitate compliance with HIPAA Requirements.

19. **Access To Records.** Pursuant to the requirements of 42 CFR §420.300 et seq., each party agrees to make available to the Secretary of Health and Human Services ("HHS"), the Comptroller General of the Government Accounting Office ("GAO") or their authorized representatives, all contracts, books, documents and records relating to the nature and extent of costs hereunder for a period of four (4) years after the furnishing of Services hereunder for any and all Services furnished under this Agreement. In addition, each party hereby agrees to require by contract that each subcontractor makes available to the HHS and GAO, or their authorized representative, all contracts, books, documents and records relating to the nature and extent of the costs thereunder for a period of four (4) years after the furnishing of Services thereunder.

20. **Execution of Agreement.** This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

_____
_____
_____

By:_____
Its:_____

_____
_____
_____

By:_____
Its:_____

Attachment 4C

EMTALA Policies

EMTALA – MODEL Facility Policy

POLICY NAME: Tennessee EMTALA – Transfer Policy

DATE: (facility to insert date here)

NUMBER: (facility to insert number here)

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

PURPOSE: To establish guidelines for either accepting an appropriate transfer from another facility or providing an appropriate transfer to another facility of an individual with an emergency medical condition ("EMC"), who requests or requires a transfer for further medical care and follow-up to a receiving facility as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

POLICY: Any transfer of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf or by a physician order with the appropriate physician certification as required under EMTALA. EMTALA obligations regarding the appropriate transfer of an individual determined to have an EMC apply to any emergency department ("ED") or dedicated emergency department ("DED") of a hospital whether located on or off the hospital campus and all other departments of the hospital located on hospital property.

A hospital with specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) shall accept from a transferring hospital an appropriate transfer of an individual with an EMC who requires specialized capabilities if the receiving hospital has the capacity to treat the individual. The transferring hospital must be within the boundaries of the United States.

The transfer of an individual shall not consider age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law, except to the extent that pre-existing medical condition

or physical or mental handicap is significant to the provision of appropriate medical care to the individual.

The CEO must designate in writing an administrative designee by title responsible for accepting transfers in conjunction with a receiving physician. The CEO designee in conjunction with the ED physician has authority to accept the transfer if the hospital has the capability and capacity to treat the individual.

Note: Movement of an individual to another part of the same hospital is not considered a transfer for EMTALA purposes.

1. **Transfer of Individuals Who Have Not Been Stabilized**

   a. If an individual who has come to the emergency department has an EMC that has not been stabilized, the hospital may transfer the individual only if the transfer is an appropriate transfer and meets the following conditions:
      i. The individual or a legally responsible person acting on the individual's behalf requests the transfer, after being informed of the hospital's obligations under EMTALA and of the risks and benefits of such transfer. The individual must have received complete and accurate information about matters pertaining to the transfer decision, including: medical necessity of the movement; availability of appropriate services at both the transferring and receiving hospitals; the availability of indigent care at the hospital initiating the transfer and the facility's legal obligations to provide medical services without regard to the patient's ability to pay; and any obligation of the hospital through its participation in government medical assistance programs to accept such program's reimbursement as payment in full for needed medical care. The request must be in writing and indicate the reasons for the request as well as indicate that the individual is aware of the risks and benefits of transfer; or
      ii. A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of the woman in labor, to the woman or the unborn child, from being transferred. The certificate must contain a written summary of the risks and benefits upon which it is based; or
      iii. If a physician is not physically present in the DED at the time the individual is transferred, a qualified medical person ("QMP") has signed a certification after a physician in consultation with the QMP, agrees with the certification and subsequently countersigns the certification. The certification must contain a written summary of the risks and benefits upon which it is based.
      Note: The date and time of the physician or QMP certification should match the date and time of the transfer.

b. A transfer will be an appropriate transfer if:
   i. The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
   ii. The receiving facility has available space and qualified personnel for the treatment of the individual and a physician at the receiving facility has agreed to accept the transfer and to provide appropriate medical treatment;
   iii. The transferring hospital sends the receiving hospital copies of all medical records related to the EMC for which the individual presented that are available at the time of transfer as well as the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
   iv. The transfer is effected through qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transport.

   Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized EMCs that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the necessary capability and capacity to care for the unstabilized EMC.

c. Higher Level of Care. A higher level of care should be the more likely reason to transfer an individual with an EMC that has not been stabilized. The following are examples of a higher level of care:
   i. A receiving hospital with **specialized capabilities or facilities** that are not available at the transferring hospital (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) must accept an appropriate transfer of an individual with an EMC who requires specialized capabilities or facilities if the hospital has the capacity to treat the individual.
   ii. If there is a local, regional or state plan for hospital care for designated populations such as individuals with psychiatric disorders or high risk neonates, the transferring hospital must still provide an MSE and stabilizing treatment prior to transferring to the hospital so designated by the plan.

2. **Additional Transfer-Related Situations**

a. Diagnostic Facility. If an individual is moved to a diagnostic facility located at another hospital for diagnostic procedures not available at the transferring hospital and the hospitals arrange to return the individual to the transferring hospital, the transfer requirements must still be met by the sending hospital. The receiving hospital is not obligated to meet the EMTALA transfer requirements when implementing an appropriate transfer back to the transferring hospital. The recipient hospital will send or communicate the results of the tests performed to the transferring hospital.

b. Off-Campus hospital-based facilities to nonaffiliated hospital. A transfer from a hospital-based facility located off-campus to a nonaffiliated hospital must still comply with the requirements of an appropriate transfer as defined by EMTALA. A Memorandum of Transfer must be used in such situations.

> Note: Off-Campus Provider-based EDs or DED. A movement of a patient from an off-campus provider-based ED or DED to the main hospital ED is a movement and not a transfer.

c. Pre-Existing Transfer Agreements. Appropriate transfer agreements should be in place and in writing between the hospital, including any outpatient or other off-campus departments where care is provided and other hospitals in the area where the outpatient or off-campus departments are located. Even if there are pre-existing transfer agreements between transferring and receiving hospitals, a physician certification is required for any medically indicated transfer for an unstable individual. Transfer Agreements shall not include financial provisions for transfer but may include reciprocal provisions for transferring the individual back to the original transferring hospital when the higher level of care is no longer required.

d. Transfers for High Risk Deliveries. A hospital that is not capable of handling the delivery of a high-risk woman in labor must still provide an MSE and any necessary stabilizing treatment as well as meet the requirements of an appropriate transfer even if a transfer agreement is in place. In addition, a physician certification that the benefits of transfer outweigh the risks of transfer is required for the transfer of the woman in labor.

e. Diversion/Exceeded Capacity. If the transferring hospital has the capability but lacks the capacity to treat the individual, then the individual would likely benefit from the transfer and it would be permissible if all other conditions of an appropriate transfer are met. In addition, the hospital may transfer an individual due to bed shortage or overcrowding, if it has exhausted all its capabilities, even if the individual does not require any specialized capabilities of the receiving hospital. The receiving hospital must accept the transfer of the individual if it has the capacity and capability to do so. In communities with a community-wide emergency services system, the receiving hospital must accept the individual being transferred from a hospital on diversionary status if it has the capacity and capability. After acceptance, the receiving hospital may attempt to validate that the transferring hospital has, in fact, exhausted all its capabilities prior to transfer.

f. Lateral Transfers. Transfers between hospitals of comparable resources and capabilities are not permitted unless the receiving facility would offer enhanced care benefits to the patient that would outweigh the risks of the transfer. Examples of such situations include a mechanical failure of equipment or no ICU beds available.

g. Women in Labor. For a woman in labor, a transfer may be made only if the woman in labor or her representative requests the transfer, or if a physician signs a certification that the benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual or the unborn child. A hospital cannot cite State law or practice as the basis for transfer. A woman in labor who requests transfer to another facility may not be discharged against medical advice to go to the other facility. The risks associated with such a disposition must be thoroughly explained to the patient and documented. If the patient still insists on leaving to go to another facility, the facility should take all reasonable steps to obtain the patient's request in writing and take all reasonable steps to have the patient transported using qualified personnel and transportation equipment. Transporting a woman in labor by privately-owned vehicle is not an appropriate form of transportation.

h. Observation Status. An individual who has been placed in observation status is not an inpatient, even if the individual occupies a bed overnight. Therefore, an individual placed in an observation status who came to the hospital's DED for example, does not terminate the EMTALA obligations of that hospital or a recipient hospital toward an individual who remains in unstable condition at the time of transfer. The EMTALA obligation does not end until the patient has been stabilized, appropriately transferred, or discharged. Therefore, any transfer of a patient in observation status who initially presented to a DED must meet all the requirements of an EMTALA transfer.

3. Authority to Decline a Transfer Request

The ED physician, working in conjunction with the CEO, Administrator-on-Call (AOC), or a hospital leader who routinely takes administrative call has the authority to decline a transfer request based on a determination that the facility does not have the capability and/or capacity to accept such transfer. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor, or other similarly titled position is not considered to be an equivalent of the AOC.

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. Transfer Center Use

Hospitals may utilize a Transfer Center to facilitate the transfer of any individual from or to the Emergency Department of the transferring facility to the receiving facility. The transferring physician, after discussion with the individual patient or his or her legally authorized representative, determines the appropriate receiving facility for providing the care necessary to stabilize and treat the individual's emergent condition. The Transfer Center then facilitates the transfer from the transferring facility to the facility selected by the transferring physician and/or the patient. Transfer Centers do not: 1) diagnose or determine treatment for medical conditions; 2) make independent decisions regarding the feasibility of transfer; 3) make independent decisions as to where the individual will be transferred; or 4) determine how a transfer shall be effected.

At the ED Physician's request, the Transfer Center must facilitate a discussion between the ED Physician and the on-call physician of the receiving facility. The on-call physician does not have the authority to refuse an appropriate transfer on behalf of the facility.

The Transfer Center may, at the transferring ED Physician's request, provide a list of the receiving facilities with capability and capacity for accepting the individual in need of transfer. The list should include geographic distances and specific capabilities of the receiving facilities. The ED Physician and the individual to be transferred then make the decision on the receiving facility.

The Transfer Center may, at the request of the transferring facility, provide information on the availability of EMS or transport options for transfer of an individual. However, the Transfer Center does NOT select the level of care provided by the transferring facility. The transfer acceptance cannot be predicated upon the transferring facility using a mode of transportation chosen by the receiving facility or a Transfer Center.

6. Bed Management/Transfer Center Facility

If the Transfer Center has real time access to necessary data elements documenting capability and capacity, the facility, the ED physician, and the Transfer Center representatives may develop criteria and algorithms for allowing the Transfer Center to accept a transfer request on behalf of the facility and the ED physician in order to expedite the transfer process. Such documents allowing a Transfer Center to accept a patient on behalf of a facility shall be in writing in the ED and on file in the Transfer Center. However, prior to completing the transfer process, the Transfer Center should validate the acceptance with the receiving ED and notify the facility of the transfer to ensure that the capability and capacity status has not changed and that the on-call physician is available when needed. A Transfer Center may not make any independent decisions

to refuse a transfer request, except that a bed management Transfer Center may refuse a request with respect to capacity.

PROCEDURES:

1. **Transfers of Individuals Who Are Not Medically Stable**

   Requirements Prior to Transfer. After the hospital has provided medical treatment within its capability to minimize the risks to the health of an individual with an EMC who is not medically stable, the hospital may arrange an appropriate transfer for the individual to another more appropriate or specialized facility. Evaluation and treatment shall be performed and transfer shall be carried out as quickly as possible for an individual with an EMC which has not been stabilized or when stabilization of the individual's vital signs is not possible because the hospital does not have the appropriate equipment or personnel to correct the underlying process. The following requirements must be met for any transfer of an individual with an EMC that has not been stabilized:

   a. Minimize the Risk. Before any transfer may occur, the transferring hospital must first provide, within its capacity and capability, medical treatment to minimize the risks to the health of the individual or unborn child.

   b. Individual's Request or Physician's Order. Any transfer to another medical facility of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf or by a physician order with the appropriate physician or QMP and Physician certification as required under EMTALA. Any written request for a transfer to another medical facility from an individual with an EMC or the legally responsible person acting on the individual's behalf shall indicate the reasons for the request and that he or she is aware of the risks and benefits of the transfer. The individual must have received complete and accurate information about matters pertaining to the transfer decision, including: medical necessecity of the movement; availability of appropriate services at both the transferring and receiving hospitals; the availability of indigent care at the hospital initiating the transfer and the facility's legal obligations to provide medical services without regard to the patient's ability to pay; and any obligation of the hospital through its participation in government medical assistance programs to accept such program's reimbursement as payment in full for needed medical care.

   c. Request To Transfer Made to Receiving Facility. The transferring hospital must call the receiving hospital or the Transfer Center if the facility is part of a Transfer Center network to verify the receiving hospital has available space and qualified personnel for the treatment of the individual. A physician at the receiving hospital must agree to accept the transfer and provide appropriate treatment. The transferring hospital must obtain permission from the receiving hospital to transfer an individual. This may be facilitated by a Transfer Center. Such permission should be documented on the medical record by

the transferring hospital, including the date and time of the request and the name and title of the person accepting transfer. The transferring physician shall ensure that a receiving hospital has appropriate services and has accepted responsibility for the individual being transferred. If utilizing the services of a Transfer Center, the Transfer Center may assist in determining whether the receiving hospital has the appropriate services.

d. Document the Request. The transferring hospital must document its communication with the receiving hospital, including the request date and time and the name of the person accepting the transfer.

e. Send Medical Records. The transferring hospital must send to the receiving hospital copies of all medical records available at the time of transfer related to the EMC and continuing care of the individual. The transferring hospital may provide the Face Sheet with the appropriate information to the Transfer Center to assist Transfer Center in facilitating the transfer. But, the Transfer Center generally may not provide any information to, or respond to questions from, to the receiving facility or physician at the receiving facility, from the Face Sheet regarding whether or not the patient has insurance, or the type of insurance, or other information regarding the patient's ability to pay for services prior to acceptance of the patient except as required by a state or local plan for providing care to certain patient populations where insurance coverage is a determining factor in where the patient may receive care. Documentation sent to the receiving hospital must include:

- Copies of the available history, all records related to the individual's EMC, observations of signs or symptoms, patient's condition at the time of transfer, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests, monitoring and assessment data, any other pertinent information, and the informed written consent for transfer of the individual or the certification of a physician or QMP.
- The name and address of any on-call practitioner who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
- The individual's vital signs which should be taken immediately prior to transfer and documented on the Memorandum of Transfer Form.
- Copies of available records must accompany the individual; and
- Copies of other records not available at the time of transfer must be sent to the receiving hospital as soon as practical after the transfer.

Medical and other records related to individuals transferred to or from the hospital must be retained in their original or legally reproduced form in hard copy, microfilm, or electronic media for a period of five years from the date of transfer.

f. Physician Certification of Risks and Benefits. A physician must sign an express written certification that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a

woman in labor, to the unborn child, from being transferred. The certification should meet the following requirements:

- The certification must state the reason for transfer. The narrative rationale need not be a lengthy discussion of the individual's medical condition as this can be found in the medical record but should be specific to the condition of the patient upon transfer.
- The certification must contain a complete picture of the benefits to be expected from appropriate care at the receiving facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer.
- The date and time of the physician certification should closely match the date and time of the transfer.
- Certifications may not be backdated.

g. QMP Certification. If a physician is not physically present at the time of the transfer, a QMP may sign the certification, after consultation with a physician, and transfer the individual as long as the medical benefits expected from transfer outweigh the risks. If a QMP signs the certification, a physician shall countersign it within 24 hours or a reasonable time period specified by the hospital bylaws, rules or regulations.

h. Send Memorandum of Transfer. A Memorandum of Transfer must be completed for every patient who is transferred to another separately licensed hospital. The Memorandum of Transfer and the patient's medical record must be sent with the patient at the time of the transfer. A copy of the Memorandum of Transfer shall be retained by the transferring hospital and incorporated into the patient's medical record.

2. **Transfers that are requested by the individual but not medically indicated**

If a medically unstable individual, or the legally responsible person, requests a transfer to another hospital that is not medically indicated, the individual or the legally responsible person must first be fully informed of the risks of the transfer; the alternatives (if any) to the transfer; and the hospital's obligations to provide further examination and treatment sufficient to stabilize the individual's EMC.

Components of the Individual's Request for Transfer. The transfer is appropriate only when the request meets all of the following requirements:

- is in writing and indicates the reasons for the request;
- contains a statement of the hospital's obligations under EMTALA and the benefits and risks that were outlined to the person signing the request;
- indicates the individual is aware of the availability of appropriate services at both the transferring and receiving hospitals, the availability of indigent care at the transferring

hospital, and any obligation of the hospital to accept government medical assistance program reimbursement as payment in full;

- indicates that the individual is aware of the risks and benefits of the transfer;
- is made part of the individual's medical record, and a copy of the request should be sent to the receiving facility when the individual is transferred; and
- is not made through coercion or by misrepresenting the hospital's obligations to provide an MSE and treatment for an EMC or labor.

Note: Once the transfer is accepted, the Memorandum of Transfer and the patient's medical record must be sent with the patient.

3. **Refusal to Consent to Transfer**

If an individual, or the legally responsible person acting on the individual's behalf, refuses to consent to the hospital's offer to transfer the individual to another facility for services the hospital does not provide and informs the individual, or the legally responsible person, of the risks and benefits to the individual of the transfer, all reasonable steps must be taken to secure a written refusal from the individual or the person acting on the individual's behalf. The individual's medical record must contain a description of the proposed transfer that was refused by the individual or the person acting on the patient's behalf, a statement that the individual was informed of the risks and benefits and the reason for the individual's refusal to consent to the transfer.

4. **Transfer of Individuals Who Are Medically Stable**

EMTALA does not apply to an individual who has been medically stabilized. The hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized or who has been admitted as an inpatient.

a. Any individual who has been medically stabilized may be transferred upon request or pursuant to a physician's order via a pre-arranged transfer or treatment plan according to hospital policy.

b. **Document Stable Condition**. The stability of the individual is determined by the ED physician or QMP in consultation with the physician. After it is determined that the individual is medically stable, the physician or QMP must accurately and thoroughly document the parameters of such stability.

   i. A woman who is in labor is considered to be stabilized only after she has been delivered of the child and the placenta.

   ii. An individual presenting with psychiatric symptoms is considered to be stabilized when he/she is protected and prevented from harming self or others.

iii. If there is a disagreement between the treating physician and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual is stable for transfer, the medical judgment of the physician who is treating the individual at the transferring facility DED takes precedence over that of the off-site physician.

5. **Recipient Hospital Responsibilities**

a. A participating hospital that has specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) may not refuse to accept an appropriate transfer from a transferring hospital within the boundaries of the United States, of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

b. The requirement to accept an appropriate EMTALA transfer applies to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a DED. All licensed hospitals in Tennessee are required to accept appropiate transfers from other hospitals if the receiving hospital has space and capability, without regard to the patient's source of payment or ability to pay.

c. The recipient hospital's EMTALA obligations do not extend to individuals who are inpatients at another hospital.

d. If an individual arrives through the DED as a transfer from another hospital or health care facility, the hospital has a duty to have a physician or QMP, not a triage nurse, perform an appropriate MSE to determine whether the patient's condition deteriorated during the transport. The MSE must be documented in the medical record.

e. A recipient hospital with specialized capabilities that delays the treatment of an individual with an EMC who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances of the delay.

f. An individual on an EMS stretcher in the DED must be provided an MSE without delay. EMTALA regulations apply as soon as the individual arrives on the facility's campus even if the EMS service has not formally turned the individual over to the DED care providers.

g. The receiving hospital may handle the receipt and subsequent assessment of the transferred emergency patient in a number of ways, including:
   i. For example, the transferring facility may contact the individual or department designated by the CEO as the coordinator for transfers such as the House Supervisor or the Transfer Center. After the receiving hospital's designated transfer coordinator is contacted, this individual or Transfer Center will then coordinate any transfer

requests with the Administrator On-Call and the ED Physician as necessary. Once it has been determined that the receiving facility has agreed to accept the patient, the patient may be transferred directly to a designated specialty unit such as a SICU, PICU, Cardiac Catheterization Lab, Burn Center, or other Specialty Unit if there is capacity and a physician with the appropriate specialty credentials is available to assess the patient within a reasonable timeframe (generally, within 30 minutes). Upon acceptance into the specialty unit as an inpatient, the Conditions of Participation govern the patient's care, including the history and physical and establishment of a plan of care.

ii. If the receiving facility participates in a community wide cardiac or stroke alert system inclusive of pre-hospital patient management by EMS Services under the direction of a qualified physician that allows for diagnosis of an emergent medical condition prior to arrival at the receiving facility, the EMS service may take the patient directly to the Interventional Radiology Suite or the Cardiac Catheterization Lab if the stroke or cardiac alert team, including the appropriately credentialed physician, is present upon arrival of the patient. The awaiting physician in the Unit would perform the additional evaluation and treatment and document such findings in the medical record. The Interventional Radiology Suite or Cardiac Cath Lab would be responsible for ensuring the registration as an emergency patient thus ensuring the patient appears on the Central/EMTALA log.

iii. If a facility's transfer coordinator receives a request from a transferring hospital and no specialty bed is available but the DED has capacity and capability to further treat and stabilize the individual and an on-call physician is available, the receiving facility should accept the transfer as an ED to ED transfer. If the Emergency Department of the receiving hospital has exceeded its capacity and capability with individuals waiting to be seen and patients being held on stretchers in the hallways because no beds are available, then the receiving ED can refuse the transfer based upon no capacity and capability if that has been their practice in the past based on the same capacity.

iv. Each specialty unit shall be responsible for entering the transferred patient's name and pertinent data into the appropriate log as per hospital policy.

6. **Review Process for Any Refused Transfers**

For those situations in which the hospital refuses to accept a transfer from another facility, the hospital and Transfer Center must have in place a procedure to review potential refusals and/or to monitor any refusals of transfer from other facilities.

7. Reporting Potential EMTALA Violations

Each Transfer Center employee working with the DED, medical staff member, house staff member, hospital employee, or contracted individual who works in the DED or other area where EMTALA requirements are applicable and who has reason to believe that a potential violation of the law has resulted in an inappropriate transfer to the hospital as a receiving hospital or from the hospital as a transferring hospital must report the incident to the CEO or CEO's designee such as the Risk Manager or the ECO immediately for investigation.

a. **Receiving Hospitals**. Receiving hospitals have a duty to report any inappropriate transfer received from a transferring institution. A hospital that suspects it may have received an improperly transferred individual (transfer of an unstable individual with an EMC who was not provided an appropriate transfer according to 42 C.F.R. § 489.24(e)(2)), is required to promptly report the incident to the Centers for Medicare & Medicaid Services ("CMS") or the state agency within 72 hours of the occurrence. Failure to report within 72 hours may result in an EMTALA violation by the receiving facility.

b. **Transferring Hospitals**. A participating hospital may not penalize or take adverse action against a physician or a QMP because the physician or QMP refuses to authorize the transfer of an individual with an EMC that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of the EMTALA obligations.

8. Declared Emergencies

Sanctions under EMTALA for an inappropriate transfer during a national emergency do not apply to a hospital with a DED located in an area that has been declared a national emergency area. Please review the requirements for transfers during a National Emergency contained in the EMTALA – Definitions and General Requirements Policy, LL.EM.001, and consult with the hospital's Disaster and Emergency Preparedness Plan as well as Operations Counsel for additional guidance.

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

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

b. **Waiver Limitations**.

i. An EMTALA waiver can be issued for a hospital only if:
   - the President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act;
   - the Secretary of HHS has declared a PHE; and
   - the Secretary of HHS invokes his or her waiver authority including notifying Congress at least 48 hours in advance.

ii. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.

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).

PHYSICIAN

Emergency Medical Condition (EMC) Identified: (Mark appropriate box; have physician certify if I.c or I.d selected and then go to Section II.)

I. **MEDICAL CONDITION:** **Diagnosis:**_____

a. ☐ **No Emergency Medical Condition Identified:** This patient has been examined and an EMC has not been identified.
Screening Physician Signature:_____ *Date:* ____/____/____ *Time:*_____ *AM/PM*

b. ☐ **Unstable Patient, Request for Transfer:** The patient has been examined and an EMC has been identified and the patient is not stable. The hospital has the capability and capacity to provide the care needed but the patient has specifically requested to be transferred to another facility after being notified that the hospital can and is willing to provide the care needed to stabilize and treat the EMC.

c. ☐ **Patient Stable For Transfer:** The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

d. ☐ **Patient Unstable:** The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

I.c and I.d Physician Certification: *I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.*
Physician Signature:_____ *Date:* ____/____/____ *Time:*_____ *AM/PM*
Signature applies to any checked boxes.

II. **REASON FOR TRANSFER:**
☐ Medically Indicated ☐ Patient Requested (see patient request documentation: Section VII)
☐ On-call physician refused or failed to respond within a reasonable period of time
On-Call Physician Name: _____ Address _____

III. **RISKS AND BENEFITS FOR TRANSFER:**

Medical Benefits:	**Medical Risks :**
☐ Obtain level of care/ service unavailable at this facility. Service: _____	☐ Deterioration of condition in route
☐ Medical Benefits outweigh the risks.	☐ Worsening of condition or death if you stay here.
☐ Other _____	☐ Risk of traffic delay/accident resulting in condition deterioration or death.
	☐ Other _____

IV. **MODE/SUPPORT DURING TRANSFER AS DETERMINED BY PHYSICIAN:**
Mode of transportation for transfer: ☐ BLS ☐ ALS ☐ Helicopter ☐ Neonatal Unit ☐Other_____
Agency: _____ Name/Title of accompanying hospital employee if required: _____
Support/Treatment during transfer: ☐ Cardiac Monitor ☐ Oxygen: _____ ☐ IV Pump
☐ IV Fluid: _____Rate: _____ ☐ Restraints – Type: _____ ☐ Other: _____ ☐ None

Transferring Physician Signature if different from Certifying Physician:_____ Date: ___/___/___ Time: ____ AM/PM
If no physician immediately available, transfer authorized by Qualified Medical Provider per Dr. _____
QMP Signature _____ Date: ___/___/___ Time: ____ AM/PM
Authorizing Physician Signature _____ Date: ___/___/___ Time: ____ AM/PM

NURSING

V. **RECEIVING FACILITY AND INDIVIDUAL:** The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility: _____Person accepting TXFR: _____ Date: ___/___/___Time:____ AM/PM

Receiving MD_____ Date: ___/___/___Time:____ AM/PM

Questions regarding Medication Reconciliation Information may be directed to _____or Transferring Physician.

VI. **ACCOMPANYING DOCUMENTATION** sent via: ☐ Patient/Responsible Party ☐ Fax ☐ Transporter
Documentation includes: ☐ Copy of Medical Record ☐ Lab/ EKG/ X-Ray ☐ Copy of Transfer Form
☐Medication Reconciliation Information ☐ Advanced Directive ☐ Other _____
Report given to: (Person/title): _____
Time of Transfer: _____ Date: _____ Nurse Signature: _____Transferring Unit:_____
Vital Signs Just Prior to Transfer: Temp: _____ Pulse_____ R_____ BP_____ spO2%_____ FHT_____ Time:____ AM/PM

PATIENT

VII. **PATIENT CONSENT TO MEDICALLY INDICATED TRANSFER or PATIENT REQUEST FOR TRANSFER (Mark appropriate box a. or b.):**

a. ☐ I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits of this transfer.

b. ☐ I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's EMTALA responsibilities that have been explained to me, the availability of appropriate care, the medical risks and benefits of transfer and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician or anyone associated with the hospital. I agree to accept the risks associated with my decision.

The reason I request transfer is: _____
Signature of: ☐ Patient ☐ Responsible Person_____ Relationship to patient_____
Witness_____ Title _____ Date: ___/___/___Time:____ AM/PM

PATIENT LABEL

EMTALA - MODEL Facility Policy

POLICY NAME: Tennessee EMTALA – Medical Screening Examination and Stabilization Policy

DATE: (facility to insert date here)

NUMBER: (facility to insert number here)

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

Purpose: To establish guidelines for providing appropriate medical screening examinations ("MSE") and any necessary stabilizing treatment or an appropriate transfer for the individual as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

Policy: An EMTALA obligation is triggered when an individual comes to a dedicated emergency department ("DED") and:

1. the individual or a representative acting on the individual's behalf requests an examination or treatment for a medical condition; or
2. a prudent layperson observer would conclude from the individual's appearance or behavior that the individual needs an examination or treatment of a medical condition.

Such obligation is further extended to those individuals presenting elsewhere on hospital property requesting examination or treatment for an emergency medical condition ("EMC"). Further, if a prudent layperson observer would believe that the individual is experiencing an EMC, then an appropriate MSE, within the capabilities of the hospital's DED (including ancillary services routinely available and the availability of on-call physicians), shall be performed. The MSE must be completed by an individual (i) qualified to perform such an examination to determine whether an EMC exists, or (ii) with respect to a pregnant woman having contractions, whether the woman is in labor and whether the treatment requested is explicitly for an EMC. If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as defined by and required by EMTALA. Stabilization treatment shall be applied in a non-discriminatory manner (*e.g.*, no different level of care because of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law).

Procedure:

1. **When an MSE is Required**

A hospital must provide an appropriate MSE within the capability of the hospital's emergency department, including ancillary services routinely available to the DED, to determine whether or not an EMC exists: (i) to any individual, including a pregnant woman having contractions, who requests such an examination; (ii) an individual who has such a request made on his or her behalf; or (iii) an individual whom a prudent layperson observer would conclude from the individual's appearance or behavior needs an MSE. An MSE shall be provided to determine whether or not the individual is experiencing an EMC or a pregnant woman is in labor. An MSE is required when:

a. The individual ***comes to a DED*** of a hospital and a request is made by the individual or on the individual's behalf for examination or treatment for a medical condition, including where:
   i. The individual requests medication to resolve or provide stabilizing treatment for a medical condition.
   ii. The individual arrives as a transfer from another hospital or health care facility. Upon arrival of a transfer, a physician or qualified medical person ("QMP") must perform an appropriate MSE. The physician or QMP shall provide any additional screening and treatment required to stabilize the EMC. The MSE of the individual must be documented. This type of screening cannot be performed by the triage nurse. If an EMC is determined to exist and the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under EMTALA ceases.

   Note: The MSE and other emergency services need not be provided in a location specifically identified as a DED. The hospital may use areas to deliver emergency services that are also used for other inpatient or outpatient services. MSEs or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the DED.

b. The individual arrives on the ***hospital property other than a DED*** and makes a request or another makes a request on the individual's behalf for examination or treatment for an EMC.
   i. Screening where the individual presented: If an individual is initially screened in a department or location on-campus other than the DED, the individual may be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being a transfer. The hospital shall not move the individual to an off-campus facility or department (such as an urgent care center or satellite clinic) for an MSE.
   ii. Transporting to the DED: The hospital may determine that movement of an individual to the hospital's DED may be necessary for screening. However, common sense and individual judgment should prevail. When determining how best to transport the individual to the DED (means of transport, accompanying qualified personnel, equipment, etc.), the following factors should be taken into account but shall not be determinative:
      - Whether the hospital DED has the personnel and resources necessary to render adequate medical treatment to all existing patients in the DED,
      - Whether responding to the emergency could send hospital personnel into harm's way or unreasonably endanger or jeopardize the lives or health of such personnel, and

- Whether non-hospital paramedics, emergency medical technicians, or other qualified personnel are more appropriate to respond.

iii. Transporting to other hospital property: The facility may direct individuals to other hospital-based facilities that are on hospital property and operated under the hospital's provider number. However, the hospital should not move an individual to a hospital-based facility located off-campus, such as a rural health clinic or physician office, for an MSE or other emergency services. Individuals should only be moved to the hospital-based on-campus facility when the following conditions are met:

- all persons with the same medical condition are moved to this location regardless of their ability to pay for treatment,
- there is a bona fide medical reason to move the individual, and
- QMP accompany the individual.

Note: Unless outpatient testing is associated with an individual presenting to the DED with a request for an emergency medical screening, it should not be performed in the emergency department. Individuals presenting for outpatient testing should be registered as outpatients and not as emergency patients.

Note: Anyone may make the request for an MSE or treatment described in both a. and b. above. Specifically,

- A minor (child) can request an examination or treatment for an EMC. Hospital personnel should not delay the MSE by waiting for parental consent. If, after screening the minor, it is determined that no EMC is present, the staff may wait for parental consent before proceeding with further examination and treatment. **Note:** For additional information regarding treatment of minors, please consult your operations counsel.
- Emergency Medical Services (EMS) personnel may request an evaluation or treatment on an individual's behalf.

Example: If an individual is on a gurney or stretcher or in an ambulance or on a helipad at the hospital and EMS personnel, the individual, or a legally responsible person acting on the individual's behalf, requests examination or treatment of an EMC from hospital staff, an MSE must be provided.

c. The individual arrives ***on the hospital property***, either in the DED or property other than the DED, ***and no request is made*** for evaluation or treatment, but the appearance or behavior of the individual would cause a prudent layperson observer to believe that the individual needed such examination or treatment.

d. An individual is in a ***ground or air ambulance*** for purposes of examination and treatment for a medical condition at a hospital's DED, and the ambulance is either:
   i. *owned and operated by the hospital,* even if the ambulance is not on hospital grounds, or
   ii. neither owned nor operated by the hospital, but *on hospital property.*

e. A ***community-wide plan*** exists for specific hospitals to treat certain EMCs (*e.g.*, psychiatric, trauma, physical or sexual abuse). Prior to transferring the individual to the community plan hospital, an MSE must be performed and any necessary stabilizing treatment rendered.

f. If a ***law enforcement official*** requests hospital emergency personnel to provide ***medical clearance*** for incarceration, the Hospital has an EMTALA obligation to provide an MSE to determine if an EMC exists. If an EMC is found to exist and is stabilized, the Hospital has met its EMTALA obligations and additional requests for assessment or testing are not required. All facilities must remain in compliance with federal and state HIPAA regulations.

g. If a ***law enforcement official*** brings a person who is exhibiting behavior that suggests that he or she is intoxicated to the DED for ***drawing of the blood alcohol*** and asks for an MSE, or if a prudent layperson observer would believe that the individual needed examination or treatment for a possible EMC, then an MSE must be performed. This is required because some medical conditions could present behaviors similar to those of an inebriated individual.

h. If an individual presents to a facility which does not have the capability to perform a rape kit when one is needed, the hospital's obligation is to provide an appropriate MSE without disturbing the evidence and transfer the individual to a hospital that has the capability to gather the evidence. Transfer must occur only in compliance with hospital policies and procedures that are Medicare Hospital Conditions of Participation (CoP) and licensure compliant.

i. ***Born Alive Infant.*** When an infant is born alive in the DED, if a request is made on the infant's behalf for screening for a medical condition or if a prudent layperson would conclude based on the infant's appearance or behavior that the infant needed examination or treatment for a medical condition, the hospital and physician must provide an MSE. If the infant is born alive elsewhere on the hospital's campus and a prudent layperson observer would conclude based on the born alive infant's appearance or behavior that the infant was suffering from an EMC, the hospital and medical staff must perform an MSE to determine whether or not an EMC exists. If an EMC exists, the hospital must provide for stabilizing treatment or an appropriate transfer.

j. ***Off-Campus Provider-Based Emergency Department.*** **An off-campus provider based-emergency department is a department of the hospital, located no more than 35 miles from the main hospital, that meets all the provider-based requirements, holds the same Medicare provider number as the main hospital and either is (i) licensed by the state as an Emergency Department, (ii) is advertised as providing care for emergency medical conditions on an urgent basis without appointment, or (iii) provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring previously scheduled appointments.** If an individual presents to an off-campus provider-based emergency department (should not be referred to as a "free-standing" emergency department), he or she must be provided an appropriate MSE just as he or she would if the presentation was at the main campus emergency department. Should the individual require additional screening for stabilizing care by a physician specialist, he or she will be moved to the main campus or another non-HCA facility for the additional care required. Such movement would be via an appropriate transport vehicle as designated by the ED Physician with appropriate equipment and personnel as determined by the ED Physician.

2. **When an MSE is NOT Required**

a. If an individual **presents to a DED** in the following circumstances only, **no MSE is required by EMTALA:**

i. ***The individual requests services that are NOT examination or treatment for an EMC,*** *such as preventive care services or drugs that are not required to stabilize or resolve an EMC;*

Example: An individual presents to the DED and tells the clerk that he needs a flu shot because it is now flu season. The hospital is not obligated to provide an MSE under EMTALA because the request for a flu vaccine is a preventive care service.

ii. ***The individual requests services that are NOT for an EMC such as gathering of evidence for criminal law cases*** (sexual assault, blood alcohol). When the request made is only to collect evidence, not to analyze the results or otherwise examine or treat the individual, no EMTALA obligation exists;

iii. ***When an individual appears for non-emergency tests*** or pursuant to a previously scheduled visit. The hospital must ensure and document that no EMC was present or that no request was made to examine or treat the individual for an EMC.

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.
   i. *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.
   ii. *Individuals with psychiatric or behavioral symptoms:* The medical records should indicate both medical and psychiatric or behavioral components of the MSE. The MSE for psychiatric purposes is to determine if the psychiatric symptoms have a physiologic etiology. The psychiatric MSE includes an assessment of suicidal or homicidal thoughts or gestures that indicates danger to self or others.

Non-discrimination. The hospital must provide an MSE and necessary stabilizing treatment to any individual regardless of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law.

4. **Who May Perform the MSE**

a. Only the following individuals may perform an MSE:
   i. A qualified physician with appropriate privileges;
   ii. Other qualified licensed independent practitioner (LIP) with appropriate competencies and privileges; or
   iii. A qualified staff member who:
      - is qualified to conduct such an examination through appropriate privileging and demonstrated competencies;
      - is functioning within the scope of his or her license and in compliance with state law and applicable practice acts (*e.g.*, Medical or Nurse Practice Acts);
      - is performing the screening examination based on medical staff approved guidelines, protocols or algorithms; and
      - is approved by the facility's governing board as set forth in a document such as the hospital bylaws or medical staff rules and regulations, which document has been approved by the facility's governing body and medical staff. It is not acceptable for the facility to allow informal personnel appointments that could change frequently.

b. **Qualified Medical Personnel.** QMPs may perform an MSE if licensed and certified, approved by the hospital's governing board through the hospital's bylaws, and only if the scope of the EMC is within the individual's scope of practice.

   i. The designation of QMP is set forth in a document approved by the governing body of the hospital. Each individual QMP approved to provide an MSE under EMTALA must be appropriately credentialed and must meet the requirements for annual evaluations set forth in the protocol agreements with physicians and the State's medical practice act, nurse practice act or other similar practice acts established to govern health care practitioners. Only appropriately credentialed APRNs, PAs and physicians may perform MSEs in the DED.

   ii. **Psychiatric QMP.** The ED physician shall consult the QMP providing the behavioral assessment for psychiatric purposes but shall remain the primary decision-maker with regard to transfer and discharge of the individual presenting to the DED with psychiatric or behavioral emergencies. Should an individual with a psychiatric or behavioral emergency present to a behavioral department of a hospital that meets the requirements of a DED, that department is responsible for ensuring that the individual has the appropriate MSE, including any behavioral examination, and providing necessary stabilizing treatment.

   iii. **Labor and Delivery QMP.** QMPs in the labor and delivery DED may be appropriately-approved RNs and must communicate their findings as to whether or not a woman is in labor to the obstetrician on call, the laborist, or the ED physician.

   iv. **Limitations.** The hospital has established a process to ensure that:
      a) a physician examines all individuals whose conditions or symptoms require physician examination;
      b) an ED physician on duty is responsible for the general care of all individuals presenting themselves to the emergency department; and

c) the responsibility remains with the ED physician until the individual's private physician or an on-call specialist assumes that responsibility, or the individual is discharged.

5. **No Delay in Medical Screening or Examination**

a. **Reasonable Registration Process.** An MSE, stabilizing treatment, or appropriate transfer will not be delayed to inquire about the individual's method of payment or insurance status, or conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered. The facility may follow reasonable registration processes for individuals for whom examination or treatment is required. Reasonable registration processes may include asking whether the individual is insured, and if so, what that insurance is, as long as these procedures do not delay screening or treatment or unduly discourage individuals from remaining for further evaluation. The hospital may seek non-payment information from the individual's health plan about the individual, such as medical history. In the case of an individual with an EMC, once the hospital has conducted the MSE and has initiated stabilizing treatment, it may seek authorization for all services from the plan as long as doing so does not delay completion of the stabilizing treatment.

b. **Managed Care.** For individuals who are enrolled in a managed care plan, prior authorization from the plan shall NOT be required or requested before providing an appropriate MSE and initiating any further medical examination and necessary stabilizing treatment.

c. **EMS.** A hospital has an obligation to see the individual once the individual presents to the DED whether by EMS or otherwise. A hospital that delays the MSE or stabilizing treatment of any individual who arrives via transfer from another facility, by not allowing EMS to leave the individual, could be in violation EMTALA and the Hospital CoP for Emergency Services. Even if the hospital cannot immediately complete an appropriate MSE, the hospital must assess the individual's condition upon arrival of the EMS service to ensure that the individual is appropriately prioritized based on his or her presenting signs and symptoms to be seen for completion of the MSE.

d. **Contacting the individual's physician.** An ED physician or non-physician practitioner may contact the individual's personal physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to medical treatment and screening of the individual, so long as this consultation does not inappropriately delay services.

e. **Financial Responsibility Forms.** The performance of the MSE and the provision of stabilizing treatment will NOT be conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered.

f. **Financial Inquiries.** Individuals who inquire about financial responsibility for emergency care should receive a response by a staff member who has been well trained to provide information regarding potential financial liability. The staff member who provides information on potential financial liability should clearly inform the individual that the hospital will provide an MSE and

any necessary stabilizing treatment, regardless of his or her ability to pay. Individuals who believe that they have an EMC should be encouraged to remain for the MSE.

Note: There is no delay in the provision of an MSE or stabilizing treatment if: (i) there is not an open bed in the DED; (ii) there are not sufficient caregivers present to render the MSE and/or stabilizing treatment; and (iii) the individual's condition does not warrant immediate screening and treatment by a physician or QMP.

6. **Refusal to Consent to Treatment**

   a. **Written Refusal – Partial Refusal of Care or Against Medical Advice.** If a physician or QMP has begun the MSE or any stabilizing treatment and an individual refuses to consent to a test, examination or treatment or refuses any further care and is determined to leave against medical advice, after being informed of the risks and benefits and the hospital's obligations under EMTALA, reasonable attempts shall be made to obtain a written refusal to consent to examination or treatment using the form provided for that purpose or document the individuals refusal to sign the Partial Refusal of Care or the Against Medical Advice Form (see Partial Refusal of Care or Against Medical Advice Form previous). 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 previous.

   c. **Documentation of Information.** If an individual refuses to sign a consent form, the physician or nurse must document that the individual has been informed of the risks and benefits of the examination and/or treatment but refused to sign the form.

   d. **Documentation of Unannounced Leave.** If an individual leaves the facility without notifying facility personnel, this must be documented upon discovery. The documentation must reflect that the individual had been at the facility and the time the individual was discovered to have left the premises. Triage notes and additional records must be retained. If the individual leaves prior to transfer or leaves prior to an MSE, the information should be documented on the individual's medical record. If an individual has not completed a Sign-In Sheet, an ED staff member should complete a sheet and if the individual's name is not known a description of the individual leaving should be entered on the form. All individuals presenting for evaluation or treatment must be entered into the Central Log.

7. **Stabilizing Treatment Within Hospital Capability**

The determination of whether an individual is stable is not based on the clinical outcome of the individual's medical condition. An individual has been provided sufficient stabilizing treatment

when the physician treating the individual in the DED has determined, within reasonable clinical confidence, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an EMC of a woman in labor, that the woman has delivered the child and placenta; or in the case of an individual with a psychiatric or behavioral condition, that the individual is protected and prevented from injuring himself/ herself or others. For those individuals who are administered chemical or physical restraints for purposes of transfer from one facility to another, stabilization may occur for a period of time and remove the immediate EMC, but the underlying medical condition may persist and, if not treated for longevity, the individual may experience exacerbation of the EMC. Therefore, the treating physician should use great care when determining if the EMC is in fact stable after administering chemical or physical restraints.

a. **Stable.** The physician or QMP providing the medical screening and treating the emergency has determined within reasonable clinical confidence, that the EMC that caused the individual to seek care in the DED has been resolved although the underlying medical condition may persist. Once the individual is stable, EMTALA no longer applies. (The individual may still be transferred; however, the "appropriate transfer" requirement under EMTALA does not apply.)

b. **Stabilizing Treatment Within Hospital Capability and Transfer.** Once the hospital has provided an appropriate MSE and stabilizing treatment within its capability, an appropriate transfer may be effected by following the appropriate transfer provisions. (See Transfer Policy.) If there is a disagreement between the physician providing emergency care and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual has been provided sufficient stabilized treatment to effect a transfer, the medical judgment of the transferring physician takes precedence over that of the off-site physician.

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

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

8. **When EMTALA Obligations End**

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

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

Note: A hospital's EMTALA obligation ends when the individual has been admitted in good faith as an inpatient, whether or not the individual has been stabilized.* An individual is considered to be an inpatient when the individual is formally admitted to the hospital by a physician's order. A hospital continues to have a responsibility to meet the patient's emergency needs in accordance with hospital CoPs. A patient in observation status is not considered admitted as an inpatient, therefore, EMTALA obligations continue.

*Case law provides that EMTALA does apply to inpatients who have not been stabilized in Kentucky, Tennessee, Ohio and Michigan. *Moses v. Providence Hospital and Medical Centers, Inc. and Paul Lessem, 6th Circuit Court of Appeals, April 6, 2009.*

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.

EMTALA - MODEL Facility Policy

POLICY NAME: EMTALA – Provision of On-Call Coverage Policy

DATE: (facility to insert date here)

NUMBER: (facility to insert number here)

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be easily identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

PURPOSE: To establish guidelines for the hospital, including a specialty hospital, and its personnel to be prospectively aware of which physicians, including specialists and sub-specialists, are available to provide additional medical evaluation and treatment necessary to stabilize individuals with emergency medical conditions ("EMCs") in accordance with the resources available to the hospital as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal and State regulations and interpretive guidelines promulgated thereunder.

POLICY: The hospital must maintain a list of physicians on its medical staff who have privileges at the hospital or, if it participates in a community call plan, a list of all physicians who participate in such plan. Physicians on the list must be available after the initial examination to provide treatment necessary to stabilize individuals with EMCs who are receiving services in accordance with the resources available to the hospital. The cooperation of the hospital's medical staff members with this policy is vital to the hospital's success in complying with the on-call provisions of EMTALA. The hospital should make its privileged physicians aware of their legal obligations as reflected in this policy and the Medical Staff Bylaws and should take all necessary steps to ensure that physicians perform their obligations as set forth herein and in each document.

PROCEDURE:

Develop an On-Call Schedule. The facility's governing board must require that the medical staff be responsible for developing an on-call rotation schedule that includes the name and direct telephone number or direct pager of each physician who is required to fulfill on-call duties. Practice group names and general office numbers are not acceptable for contacting the on-call physician. Individual physician names with accurate contact information, including the direct telephone number or direct pager where the physician can be reached, are to be put on the on-call list. The hospital MUST be able to contact the on-call physician with the number provided on the list. If the on-call physician decides to list an answering service number as the preferred method of contact, his/her mobile phone number must be

provided to the hospital as a backup number to reach the on-call physician. The backup number will be used by hospital and Transfer Center personnel when the On-Call Physician does not respond to calls in a timely manner. Each physician is responsible for updating his or her contact information as necessary. Each hospital shall provide a copy of the daily on-call schedule to the Transfer Center.

The on-call schedule may be by specialty or sub-specialty (*e.g.*, general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the hospital and implemented by the relevant department chairpersons. The Medical Executive Committee ("MEC") shall review the on-call schedule and make recommendations to the CEO when formal changes are to be made or when legal and/or operational issues arise.

The hospital shall keep local Emergency Medical Services advised of the times during which certain specialties are unavailable.

Only physicians that are available to physically come to the ER may be included on the on-call list. A physician available via telemedicine does not satisfy the on-call requirements under EMTALA.

Specialty Hospital Call. A specialty hospital such as a psychiatric, orthopedic, or heart hospital that does not operate an emergency department is still subject to EMTALA requirements, and must maintain an on-call list and accept appropriate transfers when requested to do so.

Records. The hospital must keep a record of all physicians on-call and on-call schedules for at least five years. Any on-call list must reflect any and all substitutions from the time of first posting of the list. These records may be in electronic or hardcopy format.

Maintain a List. Each hospital must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The Medical Staff Bylaws or appropriate policy and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with an EMC. Factors to consider in developing the on-call list include: the level of trauma and emergency care afforded by the hospital; number of physicians on the medical staff who are holding the privileges of the specialty; other demands on the physicians; frequency with which the physician's services are required; and the provisions the hospital has made for situations where the on-call physician is not available or not able to respond due to circumstances beyond his or her control. The hospital is expected to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available.

In addition, the on-call list requirement applies to any hospital with specialized capabilities that is participating in the Medicare program regardless of whether the hospital has a DED. Specialty Hospitals must have appropriate on-call specialists available for receiving those individuals transferred pursuant to EMTALA. Hospitals should verify that the privileges of each on-call physician are current as to the procedures that each on-call physician is able to perform and the services that each on-call physician may provide.

The on-call list maintained for the main hospital Emergency Department shall be the on-call list for the hospital, including any Off-Campus Provider-based Emergency Departments.

Physician's Responsibility. The hospital has a process to ensure that when a physician is identified as being "on-call" to the DED for a given specialty, it shall be that physician's duty and responsibility to assure the following:

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 Transfer Center is being utilized to contact the on-call physician, the on-call physician must respond to the Transfer Center within a reasonable timeframe (generally, within 30 minutes).
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. Any transfer request which may be declined must first be reviewed with this individual before a final decision to refuse acceptance is made. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor or other similarly titled position is not considered to be an equivalent of the AOC.

Financial Inquiries. Medical Staff Members who are on-call and who are called to provide treatment necessary to stabilize an individual with an EMC may not inquire about the individual's ability to pay or source of payment before coming to the DED and no facility employee, including Transfer Center employees, may provide such information to a physician on the phone.

Physician Appearance Requirements. If a physician on the on-call list is called by the hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable timeframe, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Social Security Act. If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person within a reasonable amount of time. For those physicians who do not respond within a reasonable amount of time, the Chain of Command Policy should be initiated.

Note: Each facility should define a reasonable timeframe – generally that timeframe should not be greater than 30 minutes.

If, as a result of the on-call physician's failure to respond to an on-call request, the hospital must transfer the individual to another facility for care, the hospital must document on the transfer form the name and address of the physician who refused or failed to appear.

Call by Non-Physician Practitioners. The ED physician must be able to first confer with the on-call physician. Midlevel practitioners (usually physician assistants or advanced practice registered nurses) who are employed by and have protocol agreements with the on-call physician, may appear at the hospital and provide further assessment or stabilizing treatment to the individual only after the on-call physician and ED physician confer and the on-call physician so directs the licensed non-physician practitioner to appear at the hospital. The individual's medical needs and capabilities of the hospital, along with the State scope of practice laws, hospital bylaws, and rules and regulations, must be thoroughly reviewed prior to implementing this process. The designated on-call physician remains ultimately responsible for providing the necessary services to the individual in the DED regardless of who makes the first in-person visit. If the ED physician does not believe that the non-physician practitioner is the appropriate practitioner to respond and requests the on-call physician to appear, the on-call physician must come to the hospital to see the individual.

Selective Call and Avoiding Responsibility. Medical Staff Members may not relinquish specific clinical privileges for the purpose of avoiding on-call responsibility. The Board of Trustees is responsible for assuring adequate on-call coverage of specialty services in a manner that meets the needs of the community in accordance with the resources available to the hospital. Exemptions for certain medical staff members (*e.g.*, senior physicians) would not per se violate EMTALA-related Medicare provider agreement requirements. However, if a hospital permits physicians to selectively take call ONLY for their own established patients who present to the DED for evaluation, then the hospital must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement.

Providing Elective Surgeries or Other Therapeutic or Diagnostic Procedures While On-Call. The hospital shall have in place policies and procedures to ensure that specialty services are available to meet the needs of any individual with an EMC if the hospital permits on-call physicians to schedule elective surgeries during the time that they are on-call. An on-call physician who undertakes an elective surgery while on-call must arrange for an appropriate physician with comparable hospital privileges to serve as back-up to provide on-call coverage and notify the facility of such determination. The facility will ensure that the DED is familiar with the back-up arrangement for any physician performing elective procedures.

Simultaneous Call. Physicians are permitted to have simultaneous call at more than one hospital in the geographic area; however, the physician must provide the hospital with the physician's on-call schedule so that the hospital can have a plan in place to meet its EMTALA obligation to the community. This plan could include back-up call by an additional physician or the implementation of an appropriate transfer. An on-call physician may not choose the hospital in which to treat a patient purely for the physician's convenience (*e.g.*, if a physician is on-call for both Hospitals A and B, is at Hospital B, but

is requested to come to Hospital A by the Hospital A ED physician, the on-call physician is obligated to treat the patient at Hospital A).

Back-up Plans and Transfers. The hospital shall have in place a written plan for transfer and/or back-up call coverage by a physician of the same specialty or subspecialty for situations in which a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond the physician's control. The ED physician shall determine whether to attempt to contact another such specialist or immediately arrange for a transfer. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.

Appropriate transfer agreements shall be in place for those occasions when an on-call specialist is not available within a reasonable period of time to provide care for those individuals who require specialty or subspecialty physician care and a transfer is necessary. A list of facilities with which the hospital has transfer arrangements and the specialties represented shall be available to the individual or Transfer Center responsible for facilitating the transfer. The transfer agreements shall not include financial provisions for EMTALA transfers.

Transfer to Physician's Office. When a physician who is on-call is in his or her office, the hospital may NOT refer individuals receiving treatment for an EMC to the physician's office for examination and treatment. The physician must come to the hospital to examine the individual if requested by the treating physician.

Community Call Plan. A community call plan is designed to meet the needs of the communities served utilizing the resources within the region. A community call plan facilitates appropriate transfers to the hospital providing the specialty on-call services pursuant to the plan, but does not relieve any hospital of any EMTALA obligations with respect to transfer. Even though a hospital may participate in a community call plan, the hospital must still accept appropriate transfers from non-participating hospitals.

Any community call plan must be approved by Operations Counsel and meet all applicable federal and state regulations and guidelines.

EMTALA - MODEL Facility Policy

POLICY NAME: Tennessee EMTALA – Central Log Policy

DATE: (facility to insert date here)

NUMBER: (facility to insert number here)

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

Purpose: To establish guidelines for tracking the care provided to each individual seeking care in a dedicated emergency department ("DED") for a medical condition or seeking care in areas on hospital property other than a DED for an emergency medical condition ("EMC") as required of any hospital with an emergency department by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

Policy: The hospital will maintain a Central Log containing information on each individual who comes on the hospital campus requesting assistance or whose appearance or behavior would cause a prudent layperson observer to believe the individual needed examination or treatment, whether he or she left before a medical screening examination ("MSE") could be performed, whether he or she refused treatment, whether he or she was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged.

The Central Log includes the patient logs from the traditional ED and, either by direct or indirect reference, patient logs from any other areas of the hospital that may be considered DEDs or where an individual may present for emergency services or receive an MSE, such as Labor and Delivery.

Procedure:

1. All hospitals must maintain the Central Log in an electronic format. An electronic template that includes all federal requirements for EMTALA is available on Meditech for each market or division to customize.

2. All ancillary logs maintained by all hospital departments, including the DEDs, labor & delivery, behavioral health, pediatric EDs, and catheterization labs, are incorporated by reference and become part of the facility's EMTALA Central Log.

3. The Central Log, including all additional logs incorporated into the Central Log by reference, shall be maintained in the same manner and with the same central core of information. The logs must contain at a minimum, the name of the individual, the date and time of arrival, the record number, and whether the individual:

   - refused treatment,
   - was refused treatment,
   - was transferred,
   - was admitted and treated,
   - was stabilized and transferred,
   - was discharged, or
   - expired.

4. A log entry for all individuals who have come to the hospital seeking medical attention or who appear to need medical attention must be made by the appropriate individual. Further, in non-DED departments of the hospital where an individual may present with an EMC, the department will provide the necessary information from the point of contact to the DED for logging purposes.

5. The Central Log of individuals who have come to the hospital seeking medical attention or who appear to need medical attention will be available within a reasonable amount of time for surveyor review and must be retained for a minimum of five years from the date of disposition of the individual.

6. Duplicate accounts created for the same patient who visits the hospital on more than one occasion must be consolidated so that only one medical record number per patient exists in the Central Log.

EMTALA – MODEL Facility Policy

POLICY NAME: Tennessee EMTALA – Signage Policy

DATE: (facility to insert date here)

NUMBER: (facility to insert number here)

This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

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

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

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

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

The contents of the signage must:

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

The signage content must include the following language:

IT'S THE LAW!

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

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

This hospital (does/does not) participate in the Medicaid program.

INFORMED REFUSAL FOR PARTIAL REFUSAL OF CARE AND AMA

The sections below for **Partial Refusal of Care** and for **Against Medical Advice** are only applicable for those individuals who have been triaged and an ED physician or QMP has begun a Medical Screening Examination or any stabilizing treatment. NOT APPLICABLE FOR INDIVIDUALS WHO LPT OR LPMSE. Pregnant women in labor who are transferred to another facility should be transferred using a MOT and Physician certification.

☐ *PARTIAL REFUSAL OF CARE*

I acknowledge that I have begun receiving a medical screening examination and have decided that I do not want the tests, exams or treatments listed below. I acknowledge that I have been informed and do understand that the risks associated with my refusal of the test(s), examination(s) and/or treatment(s) or my withdrawal of consent to this test(s), examination(s) and/or treatment(s) may seriously harm my health or life, and if I am pregnant, the health and life of my unborn child.

I acknowledge that treatment options; the risk of refusal of the test(s), examination(s) and/or treatment(s) listed below; and the purpose and benefit of the test(s), examination(s) and/or treatment(s listed below were all explained to me,

I asked the questions I wanted to ask and that I still refuse the test(s), examination(s) and/or treatment(s) as follows:

	Test, Exam or Treatment Refused	Risk of such Refusal of Care
A.		
B.		
C.		

☐ *AGAINST MEDICAL ADVICE*

INFORMED REFUSAL OF CARE

A Physician, other Qualified Medical Provider and/or an appropriate Clinical Staff Member of the ED has explained the risks to me of my leaving **Against Medical Advice** and my refusal of the care offered. I understand that if I am pregnant, this informed refusal of care applies to both me and my unborn child.

I understand the risks that were discussed with me and further understand that my refusal of further examination and/or treatment or my withdrawal of consent to a medical screening examination and/or treatment and leaving **Against Medical Advice** may result in serious harm to my body functions or serious harm to any organ or body part or may place my health or life in serious danger. Knowing these serious risks, knowing and understanding the treatment options explained to me and the risks and benefits of the treatment options, I still elect to leave **Against Medical Advice**,

I accept full responsibility for the refusal of further examination and/or selected medical treatment or tests (or this withdrawal of consent to permit further medical examination and/or treatment) for my medical condition. Because I am leaving **Against Medical Advice**, I hereby release and hold harmless, the hospital, its personnel, the physician(s), and any other persons participating in my care from any responsibility whatsoever for unfavorable or adverse results which I understand may occur as a consequence of my refusing any further examination or treatment offered and leaving against medical advice.

I also understand that I **may return** to this Hospital at any time in the event that I change my mind or if my condition worsens.

Describe examination or specific treatment modalities recommended by Physician or QMP and refused by individual:

A. _____
B. _____
C. _____

I acknowledge that I understand that my Refusal of further recommended Examination and/or Treatment or my refusal to Consent to recommended Examination/Treatment by the Emergency Physician and/or Specialists may result in injury to me, including death or severe and permanent disability or deformity as otherwise specified below:

A. _____
B. _____
C. _____

I acknowledge that I understand that the Benefits of Examination/Treatment Offered could include completion of a medical screening examination, further diagnostic evaluation and treatment for the condition for which I presented to the hospital, stabilizing and other medical and/or surgical treatment, and as otherwise specified below:

A. _____
B. _____
C. _____

INDIVIDUAL or LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE:

Individual or Legally Authorized Representative	Relationship to Individual
Witness	Date Time AM / PM

CLINICAL SIGNATURES:

The signature of the Physician certifies that the patient or the individual acting on the patient's behalf has the mental capacity to understand the risks and benefits of a partial refusal of care and/or leaving against medical advice and that the patient or caregiver has had an opportunity to ask questions about the benefits or risk of the refusal of care and/or leaving against medical advice.

Physician	Date Time AM / PM
Health Care Personnel	Date Time AM / PM

CERTIFICATION OF INTERPRETATION:

I certify that I have read the foregoing to the signor hereof in the _____ language.

_____
Interpreter

_____
Date Time AM / PM

PATIENT

PART A – PATIENT INFORMATION – PLEASE COMPLETE PART A AND PART B

Today's Date: ___/___/___ Have you received care at this Facility before? ☐Yes ☐No

I came to the Emergency Department today because: _____

_____

TIME STAMP :(Facility Use Only)

Last Name: _____ First Name: _____ Middle Initial: ____ Check one: ☐Male ☐Female

Address: _____ _____ ____ _____

(Number/Street) (City) (State) (Zip) Date of Birth: ___/___/___

Phone: (___)_____ Soc Sec Number: _____-_____-_____ Family Physician: _____

FOR FEMALE PATIENTS ONLY: Are you pregnant? ☐ Yes ☐ No

Last menstrual period: ___/___/___ Have you had a baby within the past 6 weeks? ☐ Yes ☐ No

Form completed by: ☐ Self ☐ Other: _____ Relationship: _____

PART B – CURRENT SYMPTOMS

Please check any of the following symptoms you currently have:

- ☐ Persistent cough greater than 3 weeks
- ☐ Fever greater than 100.4°F
- ☐ Night Sweats
- ☐ Cough with blood production
- ☐ Fatigue
- ☐ History of TB or Positive TB Skin Test
- ☐ Close contact with person who has TB
- ☐ Sore Throat
- ☐ Body aches
- ☐ Cough (not related to allergies or COPD)
- ☐ Rash
- ☐ Nasal congestion (not related to allergies or sinus infections)
- ☐ Close contact with person who has influenza-like illness
- ☐ Unexplained weight loss

FACILITY

PART C - TRIAGE INFORMATION (For Facility Use Only)

1st Call for Triage at:	2nd Call for Triage at:	3rd Call for Triage at:	4th Call for Triage at:
____:____ AM PM	____:____ AM PM	____:____ AM PM	____:____ AM PM

Triage Nurse Notes:

PART D – RAPID (INITIAL) TRIAGE (For Facility Use Only)

Time: _____ **First Point of Contact Screening Positive:** Y N **Patient requested to mask?** Y N

AIRWAY: ☐ Patent ☐ Impaired **BREATHING – Respiratory Distress:** ☐ None ☐ Mild ☐ Moderate ☐ Severe

CIRCULATION: ☐ Warm/Dry/Normal Color ☐ Pale ☐ Diaphoretic

Pulse Rate: ☐ WNL ☐ Rapid **Capillary Refill:** ☐ < 2 seconds ☐ > 2 seconds

DEFORMITY/DISABILITY – Loss of Consciousness: ☐ Yes ☐ No ☐ No Neuro Deficits ☐ Neuro Changes

Extremity: Neurovascular Integrity Intact: ☐ Yes ☐ No ☐ N/A

CHIEF COMPLAINT: _____

TRIAGE ACUITY:	1 Resuscitation	2 Emergent	3 Urgent	4 Semi Urgent	5 Non Urgent

DISPOSITION: ☐ Immediate Bed ☐ Stable – To Waiting Area after Instructions

Comments: _____

_____ Triage Nurse Signature: _____

Sign-in Sheet for Emergency Services

Patient Identification Label

☐ WAIVER OF RIGHT TO MEDICAL SCREENING EXAMINATION

SECTION 1: This section is only applicable for those individuals who leave prior to Triage (LPT) or who leave prior to Medical Screening Examination (LPMSE). Check either LPT to LPMSE to indicate the individual's status at the time the individual leaves the ED.

◯ Patient LPT ◯ Patient LPMSE

I, _____, came to the Emergency Department (ED) at (Facility Name to be inserted here) asking for examination and treatment for a medical problem, but I have now decided against being examined or treated and waive my right to receive a medical screening examination.

I understand that if I am pregnant, the waiver of my right to a medical screening examination and any necessary stabilizing treatment applies to both me and my unborn child.

I understand that a medical screening examination would benefit me and let me know whether or not I have an emergency medical condition and that a determination as to the seriousness of any medical problem I may be experiencing cannot be made if I do not have a medical screening examination.

I understand that if I have an emergency medical condition and do not receive a medical screening examination, my health, or the health of my unborn child, may get worse which could cause serious harm to my body, organs or even result in my death.

I know that I have a right to receive a medical screening examination to determine if I have an emergency medical condition and necessary stabilizing treatment regardless of my ability to pay for it.

I also understand that I may come back to the hospital at any time if I change my mind.

If this form was provided to me by a non-clinical staff member I acknowledge that I was provided the opportunity to discuss the risks and benefits related to my decision with a clinical staff member.

Finally, I am aware of the possible risks of waiving my right to a medical screening and any necessary stabilizing treatment. I accept these risks, accept the responsibility of my decision and release the hospital, its personnel, physicians and others who would participate in my care, from any responsibility whatsoever should I experience a bad outcome related to these risks.

SIGNATURE OF INDIVIDUAL Waiving a medical screening examination and treatment:

_____	_____	
Individual	Date	Time AM / PM
_____	_____	
Witness	Date	Time AM / PM

CLINICAL SIGNATURES:

_____	_____	
Health Care Personnel or Registration Personnel	Date	Time AM / PM
_____	_____	
Physician (*if applicable*)	Date	Time AM / PM

CERTIFICATION OF INTERPRETATION:

I certify that I have read the foregoing to the signor hereof in the _____ language.

_____

Interpreter

_____

Date Time AM / PM

Attachment 5C

QAPI Plan

TriStar Centennial MEDICAL CENTER | TriStar Ashland City MEDICAL CENTER

Origination:	*01/2016*
Last Approved:	*09/2023*
Last Revised:	*09/2023*
Next Review:	*09/2024*
Owner:	*Lisa Moore: VP Quality/Risk Mgmt*
Policy Area:	*Hospital Plans*
Locations:	*TriStar Centennial & Ashland City Medical Centers*
Applicability:	*TriStar Centennial and Ashland City Policy Library*

2023 Plan for Improvement of Organizational Performance and Patient Safety

SECTION I.MISSION AND VALUES

Mission: Above all else, we are committed to the care and improvement of human life by caring for those we serve with integrity, compassion, a positive attitude, respect and exceptional quality.

In pursuit of our mission, we believe the following value statements are essential and timeless:

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.
- We display the ICARE philosophy with all internal and external customers.

SECTION II.PHILOSOPHY/OBJECTIVES/SCOPE OF SERVICES

A. PHILOSOPHY

The Performance Improvement/ Patient Safety Program's underlying philosophy:

- Utilizes a planned, systematic, hospital-wide approach to design, measurement, assessment and improvement in performance and processes.
- Offers facility leaders, medical staff, and facility staff objective information, which they can use for purposes of review, patient management, and quality measurement.
- Facilitates activities that are collaborative and interdisciplinary in order to respond to the needs of the patient, physician, staff and community.
- Promotes integration and communication between hospital departments, medical staff, and Senior Leadership to continuously improve processes which affect patient care.

B. OBJECTIVES

The objectives of this plan are to preserve/improve the quality of patient care, enhance appropriate utilization of resources, and to reduce or eliminate unnecessary risks and hazards within the facility by promoting:

1. The employment of qualified, competent, and effectively supervised personnel for patient care,

utilizing clear channels of supervision, responsibility, and accountability.

2. Patient care, which is appropriate to the ages and needs of patients, is delivered as follows:
   - in a safe and timely manner
   - within the range of available resources
   - in a cost-efficient manner as possible
   - consistent with achievable goals
   - properly documented to facilitate evaluation and effective communication
   - continuously evaluated and improved
3. A system in which the same level of care is provided to all patients and is subject to periodic review (prospective or concurrent) with the use of pre-established objective indicators and documentation of findings.
4. A system in which the findings of patient care monitoring and evaluation are utilized by the hospital in concrete ways to fulfill the objectives of the Performance Improvement/ Patient Safety Program.
5. The maintenance of a continuing education program utilizing, in part, results of patient care monitoring and evaluation.
6. Continuous evaluation and improvement of customer satisfaction (patients/family/community, physicians, employees).

C. SCOPE OF SERVICES

The scope of this plan includes monitoring and evaluation activities which address patients of all ages served by the hospital and all services and settings owned by the hospital.

SECTION III.LEADERSHIP'S ROLE AND RESPONSIBILITY FOR IMPROVEMENT OF ORGANIZATIONAL PERFORMANCE AND PATIENT SAFETY

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

Leaders are responsible for establishing a policy and procedure for serious safety events, educating staff on serious safety events events, and responding appropriately when they occur. The policy shall include a process for conducting a timely serious event analysis that focuses on processes and systems, and the development of risk reduction strategies and an action plan that includes evaluating the effectiveness of the actions taken.

Leaders set a positive Performance Improvement/Patient Safety culture in the organization through planning, education in tools, approaches, methods), providing support, such as time and resources (staff, information systems, etc), and empowering staff as appropriate. Leaders also actively participate in interdisciplinary PI and patient safety activities, as appropriate.

The Performance Improvement/ Patient Safety Program is the shared responsibility of the Board of Trustees,

the Medical Staff, and the Senior Leadership of the hospital with specific areas of the program delegated to each. The program involves the Board, medical and other professional staff, administrative, technical and all support services, and includes education concerning the approaches and methods of Performance Improvement.

A. BOARD OF TRUSTEES

The Board shall require specific review and evaluation of activities to assess and improve the overall quality, safety and efficiency of patient care in the hospital. While maintaining overall responsibility, the Board delegates operational authority to the Medical Staff and Senior Leadership. In exercising its supervisory responsibility, the Board will:

- Receive, review and accept or reject periodic reports on findings, conclusions, recommendations, actions and results of program activities.
- Assess the program's effectiveness and efficiency and require modification in organizational structure and systems where necessary to improve program performance.
- Provide for resources and support systems for Performance Improvement and functions related to patient care and safety.
- Verify that the overall goal of patient care enhancement is being achieved.
- Require a process designed to assure that all individuals responsible for the assessment, treatment or care of patients are competent.

B. MEDICAL EXECUTIVE COMMITTEE

1. The Medical Executive Committee of the Medical Staff is accountable to the Board of Trustees for oversight of the monitoring and evaluation functions to determine that the same level of medical care is rendered to all patients in the hospital through Performance Improvement monitoring, actions taken when indicated, and by reporting these activities to the Board of Trustees.
2. The Medical Executive Committee shares the responsibility for the operations of the monitoring and evaluation functions with the Medical Staff, Quality Council and the appropriate Medical Staff Committees. The Credentials Committee is delegated the responsibility for evaluation of the results of monitoring and evaluation functions at the time of reappointment to the Medical Staff.

C. SENIOR LEADERSHIP

Senior Leadership, through the Chief Executive Officer (CEO) and the Quality Council, is accountable to the Board of Trustees for the quality of care provided and patient safety. The CEO will:

- Promote the participation of the appropriate members of professionals and technical staffs and departments in the program through interdisciplinary monitoring and evaluation of patient care and patient safety activities through the Quality Council.
- Establish and maintain operational linkages between Risk Management, Patient Safety, and Performance Improvements functions.
- Assure that sufficient resources and personnel are provided to support Patient Safety and Performance Improvement activities and that staff are provided adequate time to participate in Performance Improvement and Patient Safety activities.

D. QUALITY MANAGEMENT DEPARTMENT

Senior Leadership will provide adequate resources to conduct Quality, Performance Improvement and Patient Safety functions. These resources will be directed through the Quality/Risk Management Department. This department will provide at least the following services and functions:

1. Orientation and training on programs, functions and tools related to Performance Improvement and Patient Safety.
2. Reports of changes in regulations, laws, and accreditation standards to Senior Leadership, the Medical Staff Leaders and Employees.
3. Conduct data retrieval functions.
4. Aggregate Performance Improvement findings for presentation to Leadership, Medical Staff, and hospital staff.
5. The Vice President of Quality/Risk will be responsible for ensuring that appropriate actions are implemented within established time frames.
6. The Vice President of Quality/Risk or other Quality Management Department Staff will be a member of Medical Staff Committees, Medical Executive Committee, Quality Council, Infection Prevention , Environment of Care Committees, and Board of Trustees.

SECTION IV: PLAN

TriStar Centennial Medical Center participates in collaborative, interdisciplinary monitoring of patient care activity processes and outcomes. Performance improvement activities include how the hospital designs, measures, assesses, and improves important processes and outcomes. All Performance Improvement activities are incorporated into a collaborative, interdisciplinary approach through interdisciplinary monitoring and Performance Improvement Teams.

A. Performance Improvement MODEL
TriStar Centennial Medical Center will utilize proven Performance Improvement tools and methodologies in its improvement efforts. Our primary Improvement Model will be Focus PDSA.
Find a process to improve
Organize a team that knows the process
Clarify the current knowledge of the process
Understand the causes of process variation
Select the process improvement
Plan the improvement and continued data collections
Do the improvement, data collection and analysis
Study and check the results
Act to hold the gain and to continue to improve the process
Leadership supports the use of data driven, scientific approaches to process improvement and the necessary hospital wide planning and prioritization of resources required to achieve and sustain desired results. A variety of improvement tools are utilized. Opportunities involving large scale and complex inter-departmental processes are reviewed, prioritized and resourced through the Quality Council with representatives from Clinical Operations, Quality, Risk, Medical Staff and Senior Leadership.

B. HOSPITAL-WIDE PRIORITIES
Priorities for hospital-wide Performance Improvement activities at TriStar Centennial Medical Center will be designed to improve processes and patient outcomes. These priorities will be developed by the Quality Council, with participation of all hospital disciplines, and approved by the Medical Executive Committee and Board of Trustees. High priority will be given to processes/outcomes which are:

1. High risk (including patient safety issues)
2. High volume/Low volume

3. Problem prone

2023 Patient Safety/Quality Improvement/Risk Management Priorities:

In addition to the ongoing improvement efforts outlined by the quality improvement/patient safety indicators, the organization has identified Patient Safety and Quality Improvement operational strategies. These strategic initiatives were developed from trends of quality improvement data, current industry literature, and proactive initiatives derived from our mission and values statements. Priority focus areas will include (1) reduction in Hospital Acquired Infections, (2) evaluation and maintenance of safety for behavioral health patients, (3) Improving overall outcomes (mortality and complications) for patients (4) a review of all Sentinel Events to evaluate ongoing sustainability of corrective action plans (5) in-house pressure ulcer .

	Area of Focus	2023 Goals	Goal Source
Eliminate Harm & Mitigate Organizational Risk	CMS CLABSI	goal 0.485	CMS Hospital Compare
	CMS CAUTI	goal 0.342	
	MRSA HO LabID	goal 0.559	
	CDIFF LabID	goal 0.210	
	SSI HYST	goal 0.250	
	SSI COLO	goal 0.327	
	TOTAL HAIs	TOTAL HAIs	
Optimize Care Effectiveness & Efficiency	Stoke DTN	goal 80%	CMS Hospital Compare
	NTSV C-Section Rate	goal 23.68%	
	SEP-1	goal 69%	
	1 Hour Bundle	goal 65%	
	3 Hour Bundle	goal 75%	
	Mortality Index	goal 0.72%	
	PCI Mortality	goal 2.12%	
Elevate Care Experience & Care Team Engagement	ER Satisfaction	goal 66.3%	Press Ganey
	HCAHPS Inpatient Overall rating	goal 69.8%	

Reprioritizing: The priorities may be reprioritized periodically in response to unusual or urgent events such as those identified through Performance Improvement monitoring and evaluation, changing regulatory requirements, significant patient/staff needs, changes in patient population, changes in the environment of care, changes in the community, or in response to sentinel events.

SECTION V: DESIGN

When a need or opportunity to establish new services, extend product lines, occupy a new facility, or significantly change existing functions or processes, the following factors will be considered:

A. The process meets the needs of individuals served, staff, and others.

B. It will incorporate the results of performance improvement activities, when available.

C. It will incorporate available information to minimize potential risks to patients affected by the new or redesigned process, function, or service.

D. Design or redesign of the service will be based on current knowledge and relevant information from literature and/or clinical guidelines.

E. Information about sentinel events will be considered, when available and relevant.

F. Testing/Analysis will be done to determine if the proposed design/redesign is an improvement.

G. Leaders will collaborate with staff and appropriate stakeholders to design services.

H. The process will be consistent with the hospital's mission, vision, values, goals and plans.

Consideration of these factors will provide basic performance expectations that can be measured, assessed, and improved over time. All disciplines which will be involved in the new service, product line, function, or process will be included in the design.

SECTION VI. MEASURE

Measurement is the basis for determining the level of performance of existing processes and the outcomes resulting from these processes. Continuous and ongoing measurement activities will include:

A. Measurement of both processes and outcomes

B. Measurement of patient safety issues incorporated into the monitors

C. Measurement of high volume, high risk, and problem prone processes/outcomes

D. Measurement of areas identified for focused or targeted data collection

E. Establishment of a performance baseline

F. Comparison of outcomes to external databases, when available, as appropriate

G. Measurement will focus on sustaining improvement

MEDICAL STAFF MONITORING AND EVALUATION

A. The Medical Staff is responsible for participating in interdisciplinary ongoing physician practice evaluation and focused physician practice evaluation. Medical staff responsibilities include, but are not limited to:

   1. Participate in identification of interdisciplinary indicators, collection of data for each indicator, reaching conclusions, making recommendations and initiating actions.
   2. Communicate findings, conclusions, recommendations and actions, effectiveness of actions taken to department members and Medical Executive Committee.
   3. Assess the effectiveness of actions and document improvement in patient care.
   4. Make recommendations to the Credentials Committee for clinical privileges.
   5. Participate on Performance Improvement Teams.
   6. Work collaboratively to review and evaluate the Performance Improvement findings.

B. All Performance Improvement activities will be reported to the Medical Staff, as appropriate, and the Medical Executive Committee. The Medical Executive Committee is responsible for participating in and evaluation of Performance Improvement activities. All Performance Improvement activities are reported to the Board of Trustees.

SECTION VII. AGGREGATE AND ANALYZE

1. AGGREGATE AND ANALYZE PROCESS

Aggregating and analyzing data allows the organization to use information to draw conclusions about the

stability of a process or the predictability of an outcome in relation to performance expectations. Accumulated data are analyzed in such a way that current performance levels, patterns, or trends can be identified. This is supported by the following data use principles:

- Collected data are aggregated and analyzed
- Data are aggregated at the frequency appropriate to the activity or process being studied.
- Statistical tools and techniques are used to analyze and display data
- Data are analyzed and compared internally overtime and externally with other sources of information when available (benchmarking)
- Comparative data are used to determine if there is excessive variability or unacceptable levels of performance when available.

B.Intensive Analysis

Intensive analysis will be conducted when the following factors are identified:

1.Important single events, performance, and patterns or trends vary significantly from expectations
2.Performance varies significantly and undesirably from other hospitals
3.Performance varies significantly and undesirably from recognized standards
4.When a sentinel event has occurred
5.Confirmed transfusion reactions
6.Significant adverse drug reactions
7.Significant medication errors and hazardous conditions
8.Major discrepancies between pre and post-operative diagnoses in pathology reports
9.Adverse events during anesthesia, moderate or deep sedation
10Staffing effectiveness issues
11Core measures data which identify the hospital as a negative outlier for three or more consecutive quarters

C.Analysis Findings Relevant to Individual Performance

When the findings of the analysis process are relevant to an individual's performance, the following process will be followed:

1. **Credentialed Practitioners/Medical Staff Members:** Peer review process will be utilized for individual Medical Staff/Credentialed practitioner performance. The case will be referred to the appropriate Professional Practice Evaluation Committee and reviewed by a peer, as defined by the peer review policy and an improvement strategy, such as education, letter , etc., determined as necessary. Any recommended action on privileges and/or membership will be referred to the MEC for recommendations to the Board of Trustees. Peer Practice Evaluation Committee findings are maintained in individual Medical Staff Quality Files by the Quality Risk Management staff.
2. **Hospital Staff:** The Department Leadership will review information relevant to individual staff performance and an improvement strategy determined as necessary. Documentation of this action will be maintained in individual employee files and utilized in the performance evaluation process, as appropriate.

D.Use of Dimensions of Performance and Scientific Tools

The following definitions of dimensions of performance will be utilized in assessing how performance was improved:

DIMENSIONS OF PERFORMANCE
I. **Doing the Right Thing**

- The **efficacy** of the procedure or treatment in relation to the patient's condition. Efficacy is the degree to which the care/intervention for the patient has been shown to accomplish the desired/ projected outcome (s).
- The **appropriateness** of a specific test, procedure, or service to meet a patient's needs. Appropriateness is the degree to which the care/intervention provided is relevant to the patient's clinical needs, given the current state of knowledge.

II.Doing the Right Thing Well

- The **availability** of a needed test, procedure, treatment, or service to the patient who needs it. Availability is the degree to which appropriate care/intervention is available to meet the patient's needs.
- The **timeliness** with which a needed test, procedure, treatment, or service is provided to the patient. Timeliness is the degree to which the care/intervention is provided to the patient at the most beneficial or necessary time.
- The **effectiveness** with which tests, procedures, treatment, or service is provided to the patient. Effectiveness is the degree to which care/intervention is provided in the correct manner, given the current state of knowledge, in order to achieve the desired/projected outcome for the patient.
- The **continuity** of the services provided to a patient with respect to other services, practitioners, and providers, and over time. Continuity is the degree to which care/intervention for the patient is coordinated among practitioners, among organizations, and over time.
- The **safety** of the patient (and others) to whom the services are provided. Safety is the degree to which the risk of an intervention and risk in the care environment are reduced for the patient and others, including the health care provider.
- The **efficiency** with which services are provided. Efficiency is the relationship between the outcomes (results of care) and the resources used to deliver patient care.
- The **respect and caring** with which services are provided. Respect and caring is reflected by the degree to which the patient or a designee is involved in his/her own care decisions and to which those providing services do so with sensitivity and respect for patients' needs, expectations, and individual differences.

Various scientific tools may be used to assist in assessment, including flowcharts, Pareto charts (bar graphs), histograms, cause-and-effect diagrams (fishbone diagram), and run charts.

E.Reference Databases

The hospital will utilize state and national patient outcome database reports (including CMS reports) to compare the hospital's performance with other facilities. In addition, the hospital provides data to external databases for comparative patient outcome studies comparing our hospital to other peer hospitals and national rates. This information will be utilized to determine areas for improvement.

Comparative databases used by TriStar Centennial Medical Center include but are not limited to:

- NHSN national databank with the CDC
- Q-Source, Inc.
- American College of Cardiology – Cath/PCI and ICD
- Getting with the Guidelines
- HCAHPS- Patient Satisfaction
- ORYX
- COMET – outcomes measurement for core measures
- American College of Radiology

- American College of Pathology
- American Association of Blood Banks
- Leapfrog
- Institute of Healthcare Improvement
- National Quality Forum
- Vermont Oxford Network
- Society of Thoracic Surgeons
- Agency for Healthcare Research and Quality
- Centers for Medicare and Medicaid Services

SECTION VIII. IMPROVE

Monitoring activities identify a variety of opportunities for improvement. These include improving existing processes, designing new processes, and/or reducing variation or eliminating undesirable variation in processes or outcomes. Improved changes which are made will be implemented into standard operating procedures and monitored for sustained improvement. Staff will be educated about redesigned processes or changes. The following reporting structure is utilized for Performance Improvement reporting:

A. DECISIONS FOR IMPROVEMENTS

Decisions for making improvements are made by the Quality Council based on the following factors:

1. Opportunities to improve processes within the important functions.
2. Results of autopsies, risk management activities, and performance improvement activities.
3. Resources needed to improve, such as staffing, facilities, training, equipment, etc.
4. Organization's mission and priorities.

   Opportunities to improve care may be referred to the Quality Council from the following sources:

   - Patients/ Families/Community Members
   - Board of Trustees
   - Medical Staff/ Credentialed Practitioners
   - Employees/Volunteers/Students/Vendors
   - Senior Leadership
   - Committees
   - Corporate or Divisional Office
   - Risk Management Activities

B. ACTIONS FOR IMPROVEMENT

Once results have been evaluated and the decision is made that improvement is necessary, the Quality Council will determine actions to be implemented for the improvement. When action is taken to improve a process:

1. The action may be tested on a trial basis
2. The action's effectiveness is evaluated using the dimensions of performance
3. When the initial action is not effective, a new action will be taken and may include the formation of a PI Team, if appropriate.
4. Successful actions are implemented

C. QUALITY COUNCIL REPORTING

Reports of findings, conclusions, recommendations and actions will be reported to the Medical Executive Committee and the Board of Trustees, as well as back to other Medical Staff/hospital committees and departments as appropriate.

D. PERFORMANCE IMPROVEMENT TEAMS

The hospital may utilize Performance Improvement teams to study processes which occur in the hospital, design new processes, and to make improvements. The processes may be studied because a problem was determined or because the process can be improved even if a problem has not been identified. The Performance Improvement Teams are interdisciplinary and include members from all involved departments and Medical Staff members, as necessary.

The following factors will be utilized in determining when to use a team:

TEAM DECISION	INDIVIDUAL MANAGER'S DECISION
• The need exists to combine old and new information - requires brainstorming, data-gathering, and innovation • The situation doesn't require an immediate solution • Consensus is needed to make the solution work • When the problem is a process problem • When the process crosses departmental boundaries • When the process seems to be very complex	• No need for extensive data-gathering • Quick decision is required • Consensus is not needed • When the problem is a people or performance problem

The Performance Improvement Teams are groups of people who work together for a common objective. The teams identify processes or problems needing improvement, and, then study the processes methodically to improve them by eliminating root causes of problems. Team meetings will be conducted as often as determined necessary by the team to work on the process. Each team will have a team leader/facilitator. Department Managers will encourage employees to serve on Performance Improvement Teams as needed for Performance Improvement functions.

SECTION IX. SENTINEL EVENTS

Leaders of the organization will be responsible for defining the policy and procedure for responding to a sentinel event. If a sentinel event occurs, a serious event analysis will be conducted in accordance with current policy and procedure. Once the serious event analysis has been conducted, the team will develop an appropriate action plan to address any variations identified and establish measures for any changes made. Once resolved, Performance Improvement indicators may be continued to ensure that the problem remains corrected.

Proactive Risk Reduction

Annually at least one acute care high-risk process is selected to perform a proactive risk assessment. The process is then reviewed using a Failure Mode and Effects Analysis (FMEA). The FMEA process includes:

- Identification of steps that could fail in a process and how
- Identification of possible effects a process could have on patients
- Prioritization of the potential process failures by severity
- Determination of why priority failures could occur through the completion of a serious event analysis
- Redesign of the process/system to manage the risk of effects on patients
- Testing and implementation of the redesigned process

- Monitoring the effectiveness of the redesigned process

SECTION X. MANAGEMENT OF INFORMATION

A. INFORMATION SYSTEMS

The hospital utilizes a number of systems to assist in the management of information for the Performance Improvement/ Patient Safety Program. Performance improvement data and reports will only be accessible to those participating in the performance improvement program and by those agencies responsible for ascertaining the existence of an ongoing and effective performance improvement program. All medical staff quality files and measurement/assessment data will be secured in the Quality Department.

SECTION XI. INTEGRATION OF RISK MANAGEMENT and PATIENT SAFETY

A. RISK MANAGEMENT

In order for this Plan to be effective, it is essential that Risk Management functions be integrated with the Performance Improvement functions. Integration of Risk Management functions will be accomplished through the following:

1. Risk Management reports will be presented to the Quality Council at least quarterly.
2. Life Safety Data trends will be reviewed by the EOC Committee as appropriate.

B. PATIENT SAFETY

The Director Patient Safety is also the Patient Safety Officer. The purpose of the hospital Patient Safety program, which is an integral part of Performance Improvement monitoring, is as follows:

- Promote a patient-safe environment that identifies mechanisms that contribute to patient safety, such as review of high-risk patient care processes, collection and analysis of adverse patient incident data, and routine investigation of significant adverse events
- Implement the TJC National Patient Safety Goals and recommendations from the Sentinel Event Alerts.
- Develop proactive patient safety risk reduction strategies for minimizing the occurrence of medical/health care errors using TJC sentinel event information and other published information related to medical/health care errors
- Aggregate patient safety related data and information to improve professional and organizational performance
- Learn about actual and potential medical and healthcare errors and utilize that knowledge to improve patient safety

Patient Safety monitoring will be incorporated into ongoing Performance Improvement monitors, including TJC National Patient Safety Goals and other published information. These will be monitored on an ongoing basis and reported to the Quality Council, Medical Executive Committee and Board of Trustees.

SECTION XII. CONFLICT OF INTEREST AND CONFIDENTIALITY

A. CONFLICT OF INTEREST

No physician will participate in the review of any case in which he/she or his/her partners have been directly or indirectly involved in the provision of care to the patient.

B. CONFIDENTIALITY

Confidentiality shall be maintained, based on full respect of the patient's right to privacy and keeping with hospital policy and state and federal laws/regulations. All employees of TriStar Centennial Medical Center and

outside agencies that are involved in the review process will be made aware of the responsibility. All data shall be considered the property of TriStar Centennial Medical Center and the hospital shall ensure the maximum protection of all confidential data, including any findings, and recommendations or actions.

The Plan for Improvement of Organizational Performance and Patient Safety of TriStar Centennial Medical Center is established based on the facilities professional review function and is designed to comply with TJC standards, applicable federal and state laws, including HIPPA regulations, Tennessee Peer Review Statute and the Healthcare Quality Improvement Act.

In order to safeguard the privacy of our patients and the rights of health care providers practicing within the facility, all information relative to the Plan for Improvement of Organizational Performance and Patient Safety is considered confidential and will be treated as such. Information which identifies individual patients or practitioners will be shared only with those who have a direct responsibility for measuring the performance or services provided by the individuals involved or who can take direct action to resolve identified opportunities for improvement. All other communication regarding quality of services will contain only information which is pertinent to the maintenance of a general awareness of quality issues, the prevention of quality issues in the future and the identification of opportunities to improve patient care and prevent adverse outcomes.

SECTION XIII. ANNUAL APPRAISAL

The Plan for Improvement of Organizational Performance and Patient Safety is evaluated annually to determine the effectiveness of the plan in meeting the objectives. A report of the evaluation is provided to the Medical Executive Committee and the Board of Trustees. The plan is revised when evaluation indicates need for revision, patient and/or staff expectation indicate a need for revision, performance improvement or patient safety indicates a need for revision or if there is a major change to the scope of services, patient population, change in technology or any factor that would have a direct impact on patient care services for which measurement of a process and outcomes would be required.

On an annual basis leadership measures and assesses the effectiveness of their contribution to improving performance and patient safety by setting measurable objectives, assessing effectiveness and evaluating performance in support of sustained improvements.

Definitions:

Action Plan: The product of the serious event analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

Adverse Outcome Distinction: A distinction is made between an adverse outcome that is primarily related to the natural course of the patient's illness or underlying condition (not reviewed by this policy) and a death or major permanent loss of function that is associated with the treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient's illness or underlying condition. In indeterminate cases, the event will be presumed reviewable and the organization's response will be reviewed under this policy according to the prescribed procedure and timeframes without delay for additional information, such as autopsy results.

Failure Mode and Effects Analysis (FMEA): A technique used to identify potential failures in a system or process. The process once flow-charted can be dissected at each step to be reviewed for severity and probability of failure. Each step is then reviewed to determine weakness and detectability. Identified failures are scored and prioritized for determination of the more severe and most probable steps to design appropriate

actions to be taken to prevent failures. The actions are then implemented and tested to assure risk reduction.

Near-Miss: A near-miss is any process variation which did not affect the outcome.

Peer Practice Evaluation : Professional Practice Evaluation is the concurrent or retrospective review of an individual's qualifications and competence, including thorough clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges. Peer review is more completely defined by the Tennessee Peer Review law of 1967 (TCA 63-6-219). A peer is an individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications. An effective peer review process is consistent, timely, defensible, balanced, useful, and ongoing.

Provider: Any person furnishing medical or health care services.

Serious Event Analysis: A process for identifying the basic or causal factors that underling variation in performance, including the occurrence or possible occurrence of a sentinel event. A serious event analysis (SEA) focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and systems that would tend to decrease the likelihood of such events in the future or determines, after analysis that no such improvement opportunities exist.

Sentinel Event: A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: 1) death, 2) permanent harm, or 3) severe temporary harm. Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/ monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition

Significant Medical Error: An unexpected occurrence, within the control of the provider, involving the death or serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function.

Definitions of Dimensions of Quality:

DOING THE RIGHT THINGS RIGHT:

Efficacy:	The degree to which the care or intervention for the patient has been shown to accomplish the desired or projected outcome.
Appropriateness:	The degree to which the care or intervention provided is relevant to the patient's clinical needs, given the current state of the art.

DOING THE RIGHT THINGS WELL:

Availability:	The degree to which appropriate care or intervention is available to meet the patients needs.
Effectiveness:	The degree to which the care or intervention is provided in the correct manner, given the current state of the art, in order to achieve the desired or projected outcome for the patient.
Timeliness:	The degree to which the care or intervention is provided to the patient at the most beneficial or necessary time.

Safety:	The degree to which the risk of an intervention and risk in care environment are reduced for the patient and health care provider.
Efficiency:	The ratio of the outcomes (results of care) for a patient to the resources used to deliver the care.
Continuity:	The degree to which the care or intervention for the patient is coordinated among practitioners, among organizations and across time.
Respect and Caring:	The degree to which the patient, or designee, is involved in his or her own care decisions, and to which those providing services do so with sensitivity and respect for his or her needs, expectations, and individual differences.

Definitions of Quality Improvement Tools and Techniques:

Problem Solving/Problem Statements: Structured processes for acquiring and analyzing data in a way that will identify the root causes of quality problems and remove or reduce those causes. Problem statements are a description in specific/measurable terms of how a particular deficiency affects the quality of an organization. Problem statements never give any pre-conceived indication of what the root cause might be; never state or imply a particular type of solution; and never affix blame for the problem.

Brainstorming: Brainstorming is a group technique for generating new, useful ideas; it uses a few simple rules for discussion that increase the chances for originality and innovation.

Multi-voting: A method by which a group or combination of groups determine the relative importance of a quality improvement need; focuses on proposed solutions.

Consensus: A technique by which quality improvement group members discuss proposed actions and agree upon a direction/solution to the area of identified concern.

Cause and Effect Diagrams: A way to organize theories about the causes of a problem.

Flow Diagrams: Graphic representations of the sequence of steps needed to produce some output.

Control Charts: Graphic representation of data which includes an expected standard of quality.

Histograms: Graphic summary of the variation in a set of data.

Pareto Charts: A graphic display in ranked comparison of factors related to a quality problem which separates the vital few from the useful many.

Scatter Diagrams: A graphic representation of the observed relationship between two variables

Trend Charts: A graphic representation of quality over time.

Storyboarding: A visual display of the activities and results achieved by a quality improvement team.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Lisa Moore: VP Quality/Risk Mgmt	09/2023
Policy Review Committee	Brittany Owen: Dir Performance Improv/Quality	08/2023
Policy Owner	Lisa Moore: VP Quality/Risk Mgmt	08/2023

Applicability

TriStar Centennial and Ashland City Policy Library

Attachment 10C

Financial Assistance Policies

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 1 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

SCOPE:

All Self-Pay patient accounts, excluding elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients will be given an Uninsured Discount.

The following also qualify for the Uninsured Discount::

- Accounts where insurance benefits have been exhausted or terminated
- Medicare outpatient self-administered drugs

NOTE: If a Parallon Client chooses to participate in the uninsured discount process and the processes are different a client specific policy should be developed using this policy as the guideline and making changes as applicable. Use the reference number identifying the client as defined in the Policy and Procedure Development policy PARA.PP.GEN.001.

PURPOSE:

To define the process for selecting the appropriate Self-Pay IPLAN, providing patients with information regarding available discounts and processing discounts for patients assigned one of the Uninsured Discount IPLANS.

POLICY:

All Self-Pay patient accounts will receive an uninsured discount, with the exception of elective cosmetic procedures; facility designated self-pay flat rate procedures, scheduled/discounted procedures for International patients and accounts meeting the charity guidelines. Uninsured discounts will also be applied to accounts where insurance benefits have been exhausted or terminated. Medicare outpatient self-administered drugs will also receive the uninsured discount. Accounts will be assigned one of the following Uninsured Discount IPLANS.

IPLAN	IPLAN Description	LOG ID	IP Proc Code	OP Proc Code
099-40	Uninsured Discount Plan	UINS	920970	920980
099-41	Uninsured Discount Plan – Burn Unit	UINB	920971	920981
099-42	Uninsured Discount Plan – Transplant	UINT	920972	920982
099-44	Uninsured State Specific	(local)	(local)	(local)
099-45	Uninsured ESP – Left or Ref	(local)	(local)	(local)

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 2 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

099-46	Uninsured ESP - Treated	(local)	(local)	(local)
099-47	Uninsured Discount Plan – Patient Non-Compliance	UINS	920970	920980
099-49	Uninsured – Partially Exhausted Benefits	N/A	(local)	(local)
N/A	Uninsured – Medicare Self-Administered Drugs	N/A	N/A	957983

The discount amounts will be provided to each facility in a formal rate schedule document. The patient will receive the Uninsured Discount unless the patient qualifies for a Charity Discount as outlined in the existing Charity Financial Assistance Policy for Uninsured and Underinsured Patients (PARA.PP.OPS.016).

Refer to Uninsured Discount FAQ for more information.

Patient Notification at the time of Registration:
If it is determined the patient is uninsured at the time of registration, the patient/responsible party will be presented with an Uninsured Patient Information document (PARA.FT.OPS.015) that provides information on the Uninsured Discount Policy and other available discounts and payment options. This document will outline the process for uninsured discounts and inform the patient of additional account resolution options (i.e. monthly payments). The patient/responsible party will be asked to sign and date the document. The document will then be scanned into the imaging system and be placed in the imaging Patient Folder document type, as a validation that information regarding discounts has been communicated to all uninsured patients.

Patient Access Responsibilities at the Time of Registration:
Patient Access will be responsible for determining the appropriate IPLAN assignment from the table above and for presenting the Uninsured Patient Information Document (PARA.FT.OPS.015) to the patient/responsible party. Patient Access will explain the process as documented, answering questions related to the document and obtaining a signature from the patient/responsible party documenting that the information regarding available discounts was provided.

All requests for payment will be based on total estimated charges less the uninsured discount.

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 3 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

Patient Access will be responsible for requesting from the patient/responsible party the expected patient liability amount by using a facility specific deposit schedule which has been updated to reflect the Uninsured Discount.

Patient Access will be responsible for asking the patient/responsible party for payment in full or monthly payment arrangements on the patient liability amount.

Inpatient and Outpatient self-pay patients who are able to make payment in full or monthly payment arrangements.

- Assign the appropriate Uninsured Discount IPLAN
- The Uninsured Discount IPLAN should reflect proration of 100% of the total charges for the patient
- A facility/SSC specific prompt pay discount may be applied in addition to the Uninsured Discount as set forth in the PARA.PP.SS.035 Discount Policy for Patients

Inpatient self-pay patients who are not able to make payment in full or monthly payment arrangements and Outpatient self-pay patients will be considered for Medicaid eligibility.

- Assign the facility designated Pending Medicaid IPLAN as the primary payer
  - The Pending Medicaid IPLAN should reflect proration of 100% of the total charges for the patient
- Assign the Pending Charity IPLAN (099-50) as the secondary payer
  - Present the patient with a Financial Assistance Application for Charity consideration; (Note: Patients who are elective will not qualify for Charity, so the Pending Charity I-plan does not need to be added)
- Assign the appropriate Uninsured Discount IPLAN as the tertiary payer

Outpatient self-pay patients who are not able to make payment in full or monthly payment arrangements and do not meet the Medicaid eligibility threshold.

- Assign the Pending Charity IPLAN (099-50) as the primary payer
  - The Pending Charity IPLAN should reflect proration of 100% of the total charges for the patient
  - Present the patient with a Financial Assistance Application for Charity consideration; (Note: Patients who are elective will not qualify for Charity, so the Pending Charity I-plan does not need to be added)
- Assign the appropriate Uninsured Discount IPLAN as the secondary payer

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 4 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

All Inpatient and Outpatient self-pay patients registered for elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients.

- Assign the facility/SSC designated IPLAN for the discounted/flat rate procedure

Emergency Department self-pay patients who opt out to an ESP process will be assigned an Uninsured ESP IPLAN.

- Assign the Uninsured ESP –Left or Referred IPLAN (099-45) as the primary payer if the patient elects to Leave or be Referred during the ESP process
- Assign the Uninsured ESP – Treated IPLAN (099-46) as the primary payer if the patient receives treatment via the ESP process

The default of Self-Pay IPLAN 000-00, due to the absence of an IPLAN, should be avoided once this policy is implemented. All accounts that are not assigned an IPLAN and systematically assigned Self-Pay 000-00 should be reviewed and moved to the appropriate IPLAN. All accounts excluding Client/Industrial accounts must be registered with an appropriate IPLAN for the third party payer, Medicaid Pending, Charity Pending, elective cosmetic/facility designated flat rate plan or an Uninsured Discount Plan. A Business Objects script has been developed to assist in identifying accounts without an IPLAN assignment.

Financial Counselor/ CSO/Collector Responsibilities:
If at any time it is determined that the patient is covered for these services by a health plan, the Uninsured Discount IPLAN should be removed and the Uninsured Discount reversed. The Uninsured Discount is limited to patients who have no third party payer source of payment. The IPLAN assignment of the third party payer should be assigned to the account in place of the Uninsured Discount IPLAN.

Retroactive consideration for Medicaid eligibility or Charity Discount:
Uninsured Discount Plan patients that retroactively are considered for Medicaid eligibility or Charity discounts will have the appropriate Pending Medicaid eligibility and Pending Charity IPLANS assigned as outlined in the Patient Access process above. The Uninsured Discount will be reversed until determination of Medicaid eligibility and Charity can be ruled out.

Insurance Denials for Partially Exhausted Benefits:
Accounts where a denial is applied due to partially exhausted benefits, the Uninsured – Partially Exhausted Benefits IPLAN (099-49) should be applied to the secondary position, after the payer with

PARALLON

partially exhausted benefits. A manual p-line must be performed to adjust the exhausted benefit portion of the account by the facility Uninsured Discount percentage.

Guidelines to determine if an uninsured discount qualifies based on Partially Exhausted Benefits (All three guidelines must be met):

- The remit indicates a Final Denial, or verbiage used on the remit such as "Exhausted Benefits" or "Maximum Coverage Exceeded" and
- The patient was considered for Charity for the remaining balance and not approved and
- Days being considered for the uninsured discount were not covered by insurer; Also, no insurance payment or contractual adjustment was received or posted for a portion of the day's charges

Medicare Outpatient Accounts containing Self-administered Drugs:
Self-administered drugs (SADs) provided to Medicare outpatients are considered a non-covered service by Medicare. SADs will not be tracked using an IPLAN. Charges for SADs will be uniformly discounted 100% for all HCA facilities. Non-HCA will be discounted based on facility Uninsured Discount percentage. A manual p-line using procedure code 957983 must be performed to adjust the SAD portion of the account. Click here for more information.

Insurance Denials for no coverage including pre-existing:
Accounts where the insurance remits a denial of coverage including pre-existing conditions and there are no other insurance coverage's on file will be considered self-pay accounts. The IPLAN for the insurance denial should be removed and the Pending Medicaid IPLAN added as primary (if the account meets local screening guidelines), Pending Charity IPLAN assigned as secondary and the Uninsured Discount IPLAN assigned as tertiary. A Financial Assistance Application will need to be forwarded to the patient/responsible party.

Patient Statements:
Statements should not be sent out until the uninsured discount has been posted. Letters to a Self-Pay patient/responsible party should not include the account balance until the Uninsured Discount has been posted. If you use letters in your Medicaid Pending or Charity Pending process, you will need to remove the account balance reflected on them.

Late Charges:
Accounts with the Uninsured Discount IPLAN as the primary payer should not have late charges posted. If late credits are posted to the account, the Uninsured Discount should be recalculated to

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 6 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

reflect the correct patient liability. The Bill Code master file on Patient Accounting should be modified to reflect no posting of late charges. Late charges after the Late Charge Days have elapsed should be NPST (not posted) from the Late Charge Report.

State Specific requirements
Each SSC should evaluate whether this policy complies with the applicable State regulations regarding Uninsured Discounts, and if it does not, clearly document exceptions to this policy in either a State specific policy or an addendum to this policy.

HCA Trauma Facilities
After all efforts to identify funding for Uninsured patients have been exhausted, the trauma activation charge will be discounted at 100% and then the standard uninsured discount will be applied to the remainder of the account. The discount will be applied automatically when the uninsured IPLAN is applied.

PROCEDURE:

Responsible Party	Action
Self-Pay – Inpatient and Outpatient (able to pay)	
Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. Determines the patient <u>can</u> make payment or establish arrangements for payment. Assigns the Uninsured IPLAN as the primary payer. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Calculates deposit from facility deposit schedule. Collects deposit and documents account.

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 7 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

Self-Pay – Inpatient (unable to pay)	
Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. Determines the patient cannot make payment or establish arrangements for payment. Assigns the Medicaid Pending IPLAN as the primary payer. Assigns the Charity Pending IPLAN as the secondary payer. Assigns the Charity Pending IPLAN as the secondary payer. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Presents the Financial Assistance Application to the patient or responsible party. Documents account.
Self-Pay – Inpatient and Outpatients for an Elective Cosmetic Procedure, Facility Flat Rate or a scheduled/discounted International Patients	
Patient Access	Assigns the facility/SSC designated IPLAN for the elective cosmetic procedure, facility flat rate procedure or scheduled/discounted International Patient procedure. Collects payment for elective cosmetic or facility flat rate procedure. Documents account.
Self-Pay – Non Inpatient (unable to pay and for services that exceed the facility Medicaid Eligibility threshold)	
Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. Determines the patient cannot make payment or arrangements for payment.

PARALLON

	Determines the charges will be over the Medicaid eligibility threshold. Assigns the Medicaid Pending IPLAN as the primary payer. Assigns the Charity Pending IPLAN as the secondary payer. Assigns the Uninsured Discount IPLAN as the tertiary payer. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Presents the Financial Assistance Application to the patient or responsible party. Documents account.
Self-Pay – Non Inpatient (unable to pay and charges for services that may not exceed Medicaid eligibility threshold) Patient Access	Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. Determines the patient cannot make payment or arrangements for payment. Determines the complete charges for services cannot be made at time of registration or Determines the charges will not be over the Medicaid eligibility threshold. Assigns the Charity Pending IPLAN as the primary payer. Assigns the Uninsured Discount IPLAN as the secondary payer.

PARALLON

	Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Presents the Financial Assistance Application to the patient or responsible party. Documents account.
Self-Pay – Emergency Department Registrations	
Patient Access	EMTALA guidelines must be adhered to for all ED patients. Assign the Charity Pending IPLAN as the primary payer. Assign the Uninsured Discount IPLAN as the secondary payer. Documents account accordingly.
Self-Pay – Emergency Department Departures (able to pay)	
Patient Access	Determines the patient can make payment or arrangements for payment. Removes the Charity Pending IPLAN (if assigned at time of registration) Assigns the Uninsured IPLAN as the primary payer. If the patient opts out for the ESP process, assign the appropriate ESP IPLAN. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Calculates deposit from facility deposit schedule. Collects deposit and documents account.
Self-Pay – Emergency Department Departures (unable to pay)	

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 10 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

Patient Access	Determines the patient cannot make payment or arrangements for payment. Ensures the Charity Pending IPLAN is the primary payer Ensures the Uninsured IPLAN is the secondary payer. Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. Documents account.
Monitoring Inpatient and Outpatient Uninsured Discounts	
Operations Support	Reviews Self-Pay accounts with the Uninsured Discount Plan as the primary payer for appropriate posted discount. Notifies Payment Compliance of accounts with Uninsured Discount Plan as the primary payer that are final billed and do not reflect an Uninsured Discount. Ensures that all Statements are held until the Uninsured Discount is posted for patients who have the Uninsured Discount Plan as the primary payer. Ensures that all Letters to a Self-Pay patient/responsible party do not include the account balance until the Uninsured Discount has been posted
Self-Pay - Medicaid Eligibility Denied	
Operations Support staff	Determines the patient IS NOT eligible for Medicaid Coverage.

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 11 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

	Deletes the Medicaid Pending IPLAN and the system will automatically move the Charity Discount IPLAN to the primary position and the Uninsured Discount IPLAN to the secondary position. Considers the patient for a Charity Discount based on PARA.PP.OPS.016 Discount Charity Policy for Patients.
Self-Pay – Charity Discount Denied	
Operations Support Staff	Determines the patient IS NOT eligible for a Charity Discount Deletes the Charity Pending IPLAN and the system will automatically move the Uninsured Discount Plan to the primary position Non-Concuity facilities processes an IZ transaction to ensure that the Uninsured Discount IPLAN Log ID performs discount calculation
Insurance Denials – No Coverage or Pre-existing	
Collections and/or CSO	Third Party payer denies coverage due to no coverage or pre-existing. Remove Third Party IPLAN from account. Add Pending Medicaid as primary payer and Charity Pending 099-50 as secondary payer. Send Financial Assistance Application to patient/RP
Insurance Denials – Partially Exhausted Benefits	

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 12 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

Collections and/or CSO	Third Party Payer denies for partially exhausted benefits. Adds the Uninsured – Partially Exhausted Benefits IPLAN (099-49) into the secondary position following the partially exhausted benefits payer IPLAN. Processes a manual p-line for the facility approved Uninsured Discount on the portion of the account partially denied due to exhausted benefits and re-prorates to patient liability.
Medicare - Self-administered Drugs MSC Process	Will identify billed claims from the billing database that require a SADs uninsured discount. Charges for SADs will be uniformly discounted 100% for all HCA facilities. Non-HCA will be discounted based on facility Uninsured Discount percentage. A p-line using procedure code 957983 will be entered in eTran. The p-line follows the standard approval process defined in eTran. Once the uninsured discount is posted to the account; the accounts follow the normal MSC collection process. Click here for more information. **NOTE: Encounters reaching a zero balance will be moved to zero balance status and will not require an uninsured discount.**

REFERENCE:

PARA.FT.OPS.015 Uninsured Patient Information Document
Facility Specific Uninsured Discount Plan Deposit Schedule
Facility Specific Cosmetic Procedure Plan Policy and Procedure
PARA.PP.SS.035 Discount Policy for Patient
PARA.PP.OPS.016 Discount Charity Policy for Patients
PARA.PP.GEN.001 Policy and Procedure Development
PARA.PP.COLL.053 Non-Compliant COB Policy
Self-Administered Drug Discount effective 04/01/2016

Self-Administered Drugs 04012016.doc

PARALLON

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients
PAGE: 13 of 13	REPLACES POLICY DATED: 11/01/2017, 11/04/2021
APPROVED: 06/17/2022	EFFECTIVE DATE: 06/17/2022
ANNUAL REVIEW DATE: 11/04/2022	REFERENCE NUMBER: PARA.PP.OPS.015

QHP- denial code 8X addendum

QHP denial code 8X specific to collectior

Uninsured Discount FAQ 04/01/2016

Uninsured Discount Plan FAQ 04012016.c

PARALLON

DEPARTMENT: Vendor Collections Management	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 1 of 6	REPLACES POLICY DATED: 11/01/2017
APPROVED: 09/29/2020	EFFECTIVE DATE: 10/1/2020
ANNUAL REVIEW DATE:	REFERENCE NUMBER: PARA.PP.VCM.016
RETIRED DATE:	

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.

PARALLON

DEPARTMENT: Vendor Collections Management	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 2 of 6	REPLACES POLICY DATED: 11/01/2017
APPROVED: 09/29/2020	EFFECTIVE DATE: 10/1/2020
ANNUAL REVIEW DATE:	REFERENCE NUMBER: PARA.PP.VCM.016
RETIRED DATE:	

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.

PARALLON

DEPARTMENT: Vendor Collections Management	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 3 of 6	REPLACES POLICY DATED: 11/01/2017
APPROVED: 09/29/2020	EFFECTIVE DATE: 10/1/2020
ANNUAL REVIEW DATE:	REFERENCE NUMBER: PARA.PP.VCM.016
RETIRED DATE:	

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.

PARALLON

DEPARTMENT: Vendor Collections Management	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 4 of 6	REPLACES POLICY DATED: 11/01/2017
APPROVED: 09/29/2020	EFFECTIVE DATE: 10/1/2020
ANNUAL REVIEW DATE:	REFERENCE NUMBER: PARA.PP.VCM.016
RETIRED DATE:	

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

PARALLON

DEPARTMENT: Vendor Collections Management	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 5 of 6	REPLACES POLICY DATED: 11/01/2017
APPROVED: 09/29/2020	EFFECTIVE DATE: 10/1/2020
ANNUAL REVIEW DATE:	REFERENCE NUMBER: PARA.PP.VCM.016
RETIRED DATE:	

becomes effective for future dates of service. Therefore, it is necessary to continue with the Pending Charity process for visits occurring prior to QHP effective dates.

9) Charity Processing based on Federal Poverty Guidelines:

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

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

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

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

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

Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than $1,500 may be reviewed and a charity write-off applied.

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

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

PARALLON

DEPARTMENT: Vendor Collections Management	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 6 of 6	REPLACES POLICY DATED: 11/01/2017
APPROVED: 09/29/2020	EFFECTIVE DATE: 10/1/2020
ANNUAL REVIEW DATE:	REFERENCE NUMBER: PARA.PP.VCM.016
RETIRED DATE:	

E/M Levels 1-3
201% - 300% - balance capped at $1500
301% - 400% - balanced capped at $1750

E/M Levels 4 +
201% - 300% - balance capped at $2500
301% - 400% - balanced capped at $2750

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

10) Patients Who Are Uninsured:

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

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

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

11) Refunds on Charity Accounts:

The general expectation is that all patients pay for services rendered if they are not fully covered by a third party. Therefore, any amount paid by the patient (even if the patient subsequently meets the charity write-off guidelines for their balance due), will be retained. Only amounts paid by the patient that exceed the amount that patient would have paid had they received the uninsured discount, or that exceed their out of pocket responsibility per their insurance, will be refunded. For those patients that do meet the charity write-off criteria and have made a partial payment, the charity write-off will be posted on the remaining patient balance.

PARALLON

DEPARTMENT: Vendor Collections Management	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 7 of 6	REPLACES POLICY DATED: 11/01/2017
APPROVED: 09/29/2020	EFFECTIVE DATE: 10/1/2020
ANNUAL REVIEW DATE:	REFERENCE NUMBER: PARA.PP.VCM.016
RETIRED DATE:	

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 Vendor Collections Management Director, Hospital Chief Financial Officer or an SSC Executive as defined in the Charity Review Appeal Process policy (PARA.PP.VCM.020).

13) Compliance with State regulations:

Each SSC should evaluate whether this Policy complies with the applicable state law and regulations regarding charity care, e.g., California, Florida. If this Policy does not comply with state law and regulations, each SSC must clearly document exceptions to this policy in either a State specific policy or an addendum to this Policy.

14) Liens:

Under no circumstances will liens be considered on properties less than $300,000 in value.

REFERENCE:

- **PARA.FT.VCM.606 Federal Charity Guidelines**
- **PARA.FT.VCM.638 Financial Assistance Application**
- **PARA.MF.VCM.804 Collection Charity Letters**
- **PARA.PARS.PP.009 Medicare Bad Debt and Recovery Logs Policy**
- **PARA.PP.VCM.019 Utilizing the Artiva Charity Process**

PARALLON
HCA Healthcare

DEPARTMENT: Support Services	**POLICY DESCRIPTION:** Discount Policy for Patients
PAGE: 1	**REPLACES POLICY DATED:** 01/01/2015
APPROVED:	**RETIRED:**
EFFECTIVE DATE: 05/26/2016	**REFERENCE NUMBER: PARA.PP.GEN.043**

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

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

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

Uninsured Patients

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

Insured Patients

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

PARALLON
HCA Healthcare

DEPARTMENT: Support Services	POLICY DESCRIPTION: Discount Policy for Patients
PAGE: 2	REPLACES POLICY DATED: 01/01/2015
APPROVED:	RETIRED:
EFFECTIVE DATE: 05/26/2016	REFERENCE NUMBER: PARA.PP.GEN.043

- **Settlement Offers** – Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the patient liability collection process to settle a delinquent account.

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

PROCEDURE:

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

REFERENCE:
Compliance Alert #15: Beneficiary Inducement Prohibition (updated 06/01/2012)
http://atlas2.medcity.net/portal/site/ethics
Select Compliance Alerts and choose Alert #15
Attachment Q

Attachment Q
01072015.doc

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

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

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

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 Clarksville Health Services, LLC, nor any of its upstream entities are the subject of any pending healthcare regulatory or criminal action.

Bed Count Chart

Attachment – Bed Complement Data

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical/Surgical			42			42
2) Surgical						
3) ICU/CCU			8			8
4) Obstetrical			10			10
5) NICU			8			8
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL			68			68

*Beds approved but not yet in service

**Beds exempted under 10% per 3 year provision

Project Name : TriStar Clarksville Hospital

Supplemental Round Name : 1 **Due Date :** 6/12/2025
Certificate No. : CN2505-018 **Submitted Date :** 6/6/2025

1. **1E. Overview**

What types of surgical services will be offered at the new hospital in Year 1?

Is the facility expected to support in-migration from Kentucky, Houston, Dickson, Cheatham, or Robertson Counties? If so, to what extent?

Please discuss generally the projected use of the new hospital by residents of Fort Campbell and how it is expected to improve access to specific service lines. Does the Blanchfield Community Hospital provide any of the services proposed by the applicant, e.g. labor and delivery, NICU Level II, diagnostic / therapeutic cardiac catheterization, surgery services, etc.?

Response : As a community hospital, TCH expects its physicians to perform non-tertiary surgeries including general, orthopedic, urology, gynecology, obstetrics, vascular, spine, ophthalmic, ENT, GI, plastic/reconstructive, oncology, some cardiac, and some thoracic, among others.

The facility expects that 20 percent of its patients will reside outside Montgomery and Stewart Counties and some of these will reside in contiguous areas of Kentucky, or the Tennessee counties of Houston, Dickson, Cheatham or Robertson Counties. Each contiguous county individually is not expected to generate admissions greater than the Service Area counties' admissions to TCH.

Blanchfield serves over 100,000 TRICARE beneficiaries, including active-duty service members, retirees, and their families. While it offers a range of services such as primary care, specialty care, emergency services, and inpatient care, there are notable limitations, which TCH will help complement. For example,

· Blanchfield does not have a Level II NICU, rather, it operates a Mother-Baby Unit. This unit is designed to provide basic care for healthy newborns and stabilize infants born at 35 weeks of gestation or later who require short-term monitoring or treatment. This means that it is not equipped to handle more complex neonatal conditions or premature infants requiring intensive care. For infants needing higher levels of care, Blanchfield collaborates with other military and civilian hospitals, including TriStar Health hospitals.

· It has a Cardiology Clinic, which provides medical care and diagnostic services to eligible beneficiaries on a referral basis. The range of cardiovascular services offered include electrocardiography (EKGs), ambulatory monitoring, echocardiography, and stress testing (including nuclear). However, the Cardiology Clinic does not operate a cardiac catheterization lab.

· Blanchfield is not a designated trauma center, necessitating the transfer of patients with severe injuries to hospitals in Nashville or other nearby cities for specialized trauma care. With a dedicated trauma network and Level I Trauma Center at TriStar Skyline Medical Center, TCH which will seek Level III Trauma Center designation could provide immediate and comprehensive care for patients with severe injuries, reducing the need for transfers to distant facilities.

· Certain specialized services, such as advanced cardiac care and complex surgical procedures, may require referrals to other hospitals due to resource constraints. TCH will offer a broader range of specialized services, including advanced cardiac care and orthopedic surgery, thereby reducing the need for referrals to hospitals in Nashville.

· With a 47-bed inpatient capacity, Blanchfield may face challenges in accommodating surges in patient volume, leading to potential delays in care. Among other things, TCH will have a larger inpatient capacity, TCH will be better equipped to handle fluctuations in patient volume and can be an additional resource for Blanchfield in the event that it is facing such challenges.

· TCH's emergency department will be equipped to handle a wide range of emergencies, providing immediate care to patients in critical condition.

· Residents and military families have expressed the need for improved healthcare facilities in the Clarksville area.

In sum, TCH can complement the services provided by Blanchfield by addressing existing healthcare gaps. Together, these facilities will enhance the overall healthcare infrastructure for Fort Campbell residents, ensuring timely and comprehensive care close to home.

As noted, Blanchfield serves over 100,000 TRICARE beneficiaries. TRICARE as a payor has many programs and is accepted at community providers like TriStar Health. In calendar year 2024, TriStar Health hospitals throughout Middle Tennessee admitted approximately 800 TRICARE patients who are residents of Montgomery County. It is expected many of the Montgomery County TRICARE patients will utilize TCH as its location is proximate to Fort Campbell and more accessible for Montgomery County TRICARE residents than other TriStar Health hospitals in Middle Tennessee.

2. **3A. Proof of Publication**

The wrong proof of publication appears to be attached. Please revise and resubmit.

Response : The Leaf Chronicle proof of publication has been uploaded into the portal.

3. **4A. Purpose of Review**

If the applicant intends to serve more than 5 patients under the age of 14, please complete the MRI criteria and standards and include a Medical Equipment Information Attachment (for the MRI).

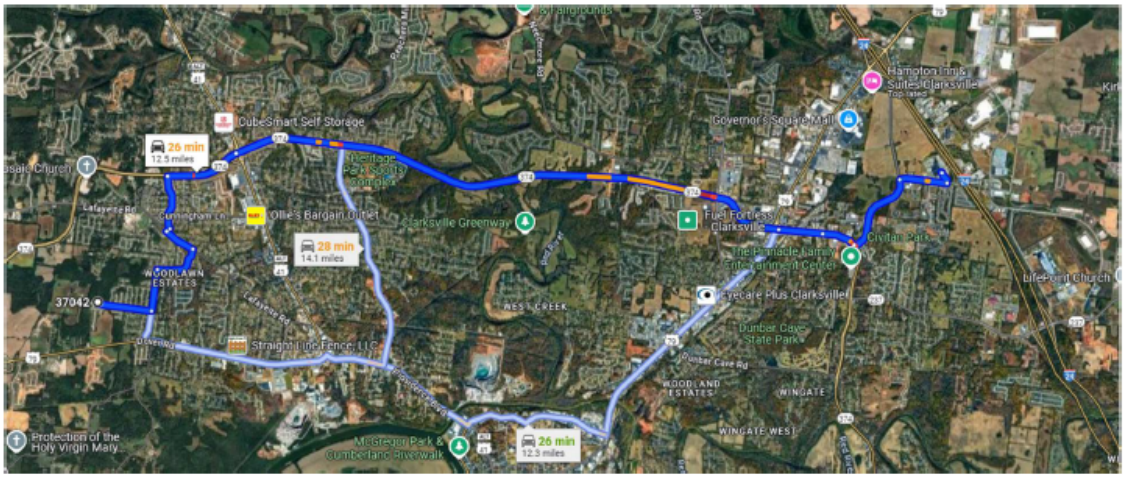
Response : The Applicant does not intend to provide MRI services to more than 5 patients under the age of 14; therefore, MRI criteria and standards are not required.

4. **2E. Rationale for Approval**

It is noted that the nearest ER is at Tennova Clarksville, 12.5 miles and 20 to 45 minutes from the centroid of the zip code. However, HFC staff could not replicate this. The Tennova ER appears to be 7.5 miles and 15 minutes from the center of 37042.

To what extent does the applicant have data to support capacity challenges for specific services at Tennova Clarksville, e.g. time spent on EMS diversion status, wait times for inpatient admission, scheduling challenges for cardiac catheterizations, etc.?

Response : Using Google Maps, which identifies the geographic centroid of the zip code, the distance is 12.5 with the typical range of time noted as 20 to 45 minutes. This result was again generated by Google Maps on June 11, 2025, when this question was being addressed. Following is a screenshot of the query and resulting mileage noted:



The Applicant does not have access to the specific data points referenced including EMS diversion status or metrics internal to Tennova Clarksville such as wait time for admission, if measured, or scheduling for cardiac catheterizations. The only measurable data point which might be informative is the length of stay in an emergency room. However, out-migration is caused by a variety of reasons including but not limited to lack of services, patient choice, availability of alternative providers, perceived quality, continuum of care, provider referral and insurance network.

5. **1C. Transfer Agreements**

Which specific non-affiliate hospitals will transfer agreements be pursued with?

Response : When TCH has patients that require transfer, transfer is typically done based on patient choice, continuity of care, or level of care needed which does not require a transfer agreement. Similarly, transfers to other TriStar Health hospitals are accomplished via TriStar Health's Transfer Center and also does not require a transfer agreement. Because TriStar Health hospitals have comprehensive services, it would be expected many

transfers will be to TriStar Health hospitals. For agreements with non-affiliates, TCH will seek a transfer agreement with VUMC's Children's Hospital due to it being a comprehensive regional pediatric center (CRPC).

6. **2C. Insurance Plans**

Are there any known differences between major commercial plans accepted by the applicant and Tennova - Clarksville?

Response : There are not any known differences between plans.

7. **3C. Effects of Competition and/or Duplication**

The applicant's description of its proposed service lines, specialty care, specific innovative programs is noted. Please summarize the specific services that the applicant will offer that are not available at Tennova Clarksville.

Please describe any specific strategies of the applicant that will support consumer benefits from the proposed facility related to improved quality of care and reduced costs to patients and payors compared to existing providers.

Please identify any known differences in payor sources accepted, charity care rates, between the applicant and the existing hospital in Montgomery County.

Response : The Applicant intends to provide electrophysiology ("EP") procedures and offer spine surgery. It will also have available 24/7 laborists; it is unclear if Tennova Clarksville has that extent of coverage now or will maintain it in the future. In addition, TriStar Health affiliated physicians who will practice at TCH do not have privileges at Tennova Clarksville.

Specific strategies to be employed by TCH that will support consumer benefits related to improved quality of care include the following:

- Every facility has a Quality Council, where the Quality Department discusses Quality/Infection Prevention/Patient Safety results with Hospital Leaders and Providers. Those results are then also shared at Medical Executive Committee and Board of Trustee meetings;
- Each hospital has a Quality Monthly Operating Review ("MOR") with TriStar Division leaders monthly;
- The TriStar Division has a Group Quality MOR with Corporate leaders to discuss facility results quarterly; and
- Each hospital has a Group Quality Deep Dive with the Group's Chief Medical Officer on a yearly basis.

In terms of reduced costs to patients, TCH will also offer a prompt pay discount of 20 percent for patients paying estimated deductible and co-pays at the time of

service. TCH will be part of the 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. TCH will make 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. Further, 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.

There are not any known differences between plans.

In its 2023 JARs, Tennova Clarksville reported $4,355,513 in charity care. The Applicant projections in Question 6C exceed that with estimates of more than $20 million in Year One and $34 million in Year Two.

8. **4C. Accessibility to Human Resources**

What percentage of those 523 employees residing in Montgomery County are expected to accept employment at the new facility?

How will those vacancies be addressed at existing facilities in the region?

Response : Since TCH has not received CON approval and the hospital will not open for three years subsequent to that, the percentage of those employees residing in Montgomery expected to accept employment is not fully known. The vacancies resulted from accepting employment would be spread amongst several affiliates and replaced through normal recruiting processes including TriStar Health's extensive engagement with educational and training programs throughout Middle Tennessee. Its Galen College of Nursing Nashville campus offers a 3-year Bachelor of Science in Nursing, an Associate Degree in Nursing ("ADN") and an LPN to ADN Bridge program. This year, it expects approximately 250 graduates to graduate. It is HCA Healthcare's experience that 55 percent of graduates join an HCA Healthcare hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Health including recruitment for the proposed TCH.

In addition, as noted in Exhibit 47 of the CON Form, Austin Peay State University nursing and radiology tech programs currently have students matriculating and training with TriStar Health. Austin Peay State University and other identified programs with students active at TriStar Health hospitals will also be extended to TCH.

9. **6C. Historical/Projected Data Chart**

Please provide a definition for adjusted admissions as used in response to Item 6C.

Response : Adjusted admissions is a metric used to account for both inpatient and outpatient activity in a hospital to provide a more comprehensive picture of overall service volume than inpatient admissions alone. It adjusts the number of inpatient admissions upward to reflect the additional workload or service volume from outpatient care. It is computed by multiplying inpatient admissions by the product of total gross revenue divided by inpatient gross revenue.

10. **9C. Other Facilities Charges**

The listed amount for Heart Attack Patients at TriStar Hendersonville appears to be incorrect. Please revise.

It is noted that the applicant does not believe that comparison of gross charges is meaningful.

Does the applicant have a data source that will provide a meaningful comparison of the differences between area providers as it relates to costs to patients and payors for the types of services being proposed other than Medicare Compare?

Response : Exhibit 48 has been replaced with the corrected value for TriStar Hendersonville.

The best proxy for comparison would be to have access to internal negotiated rates with payors for different providers. However, the Applicant does not have data for other health systems. As a result, publicly reported Medicare data is the only known meaningful comparison that is available.

11. **10C. Project Only Payor Mix**

What percentage of patients have historically qualified for a self-pay discount and/or Charity Care though TriStar hospitals?

What is included in the Other row?

What percentage of revenue is projected to be for TriCare?

Are there any payor sources that are projected to be higher than in other regions served by TriStar hospitals due to the proximity to Fort Campbell?

Response :

At TriStar Health hospitals, on average 97.4 percent of patients without insurance qualify for either Charity Care or a Self-Pay Discount. When relating this patient count to all ED patients, it equates to an average of 15.5 percent of total ED patients who qualify for these discounts. For inpatient admissions, the average is 6.3 percent. In addition to these patients, there are other patients with insurance (Medicare, TennCare or commercial) as their primary payor but qualify for write offs due to TriStar Health's policy regarding up to 400 percent of the poverty level. Those patients and write offs are in addition to the stated 15.5 percent and 6.3 percent above.

Other payor is primarily TRICARE. This revenue item is 16.11 percent of total revenues in Year 2; the majority of this line item is expected to be TRICARE patients. In calendar year 2024, TriStar Health hospitals throughout Middle Tennessee admitted approximately 800 TRICARE patients who are residents of Montgomery County. It is expected many of the Montgomery County TRICARE patients will utilize TCH as it will be more accessible.

TRICARE as a payor source is expected to be higher than in other regions served by TriStar Health hospitals due to TCH's proximity to Fort Campbell.

12. **7Q. Legal Judgements**

Please address the following:

Tristar Centennial Medical Center Agreed to Pay $725,000 for Allegedly Violating Patient Dumping Statute by Failing to Provide Available Stabilizing Treatment | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services

Response : The December 29, 2021, TriStar Centennial settlement agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services ("OIG") did not involve the imposition of Civil Monetary Penalties ("CMPs") nor an agreement to pay CMPs regarding claims submitted for healthcare items or services. For these reasons, the Applicant did not believe the 2021 TriStar Centennial – OIG settlement was responsive to the 7Q questions and did not include it as part of its CON application.

The 2021 TriStar Centennial – OIG settlement was previously disclosed in response to specific Supplemental Questions asked by HFC staff following the filing of the TriStar Centennial Bellevue FSED CON Application, CN2205-027 likely prompted by the OIG posting a notice about the settlement on its website. The settlement has been included in the response to 7Q in other CON Applications simply because it was included in responses to Supplemental Questions in the Bellevue FSED CON Application. The Applicant elected in this instance to discontinue repeating the disclosure because it was not responsive to the standard questions.

Further, as noted in the response to 7Q posted in the attachment loaded into the portal:

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 Clarksville Health Services, LLC, nor any of its upstream entities are the subject of any pending healthcare regulatory or criminal action.

The following information is provided in response to the HFC's specific Supplemental Question related to the CMC – OIG settlement:

On December 29, 2021, TriStar Centennial entered into a settlement agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services ("OIG"). This settlement was in connection with a 2017 CMS survey that resulted in a Statement of Deficiency (CMS-2567) setting forth CMS's alleged EMTALA violations. TriStar Centennial responded with a Plan of Correction (with no acknowledgement of liability) that CMS accepted. The OIG then cited TriStar Centennial with certain EMTALA violations. TriStar Centennial disputed the OIG's position. However, to avoid the uncertainty and expense of litigation, TriStar Centennial settled with the OIG pursuant to which TriStar Centennial paid the U.S. Department of Health and Human Services $725,000 without any admission of wrongdoing or any concession as to the lack of merit of the allegations by the OIG. This settlement did not involve payment of any civil penalties involving claims related to the provision of healthcare services.

13. **2N. Service Area**

For what percentage of the service area population will this represent the closest hospital facility?

What is the distance and drive time from Dover to the proposed site?

Where is the future population growth in the county projected to occur?

Please table the drive times and distances from the centroid of 37042 to the proposed hospital and the existing Tennova Clarksville - main campus.

The high level of outmigration, 2nd highest among counties 175K+ is noted. What about other counties surrounding Davidson County, such as Dickson, Wilson, and Robertson that have smaller populations with community hospitals?

Response : In terms of Service Area population, it is estimated that between 56 and 60 percent of Montgomery County population is closer and 94 percent of Stewart County is closer. This analysis was based on travel time from the centroid of each zip code in each of these counties. The first table below provides travel time from the zip code centroids of Montgomery County to TCH and Tennova Clarksville; also included on this table is Fort Campbell. While outside the Service Area, given it being contiguous and supportive of TCH, it is relevant to the time and access improvement with TCH.

Zip Code	Geographic Name	TCH	Tennova Clarksville	Difference
37040	Clarksville	27	26	Similar
37042	Clarksville	18	26	TCH Closer
37043	Clarksville	18	15	Tennova Closer
37142	Palmyra	35	34	Similar
37191	Woodlawn	25	32	TCH Closer
37052	Cunningham	37	36	Similar
37171	Southside	41	40	Similar
37010	Adams	25	19	Tennova Closer
42223	Fort Campbell	19	30	TCH Closer

Source: Google Maps, June 11, 2025

Based on quantifying population by zip code, it is estimated between 56 and 60 percent of the population is closer to TCH. The next table provides similar information for those zip codes in Stewart County.

Zip Code	Geographic Name	TCH	Tennova Clarksville	Difference
37079	Indian Mound	35	41	TCH Closer
37050	Cumberland City	48	47	Similar
37058	Dover	47	53	TCH Closer
37023	Big Rock	43	49	TCH Closer
37028	Bumpus Mills	50	57	TCH Closer

Source: Google Maps, June 11, 2025

Based on all zip code centroids being closer to TCH, and one being similar (i.e. split), an estimated 94 percent of Stewart population is closer to TCH.

The distance and drive time from Dover to TCH is 34.5 miles and 39 minutes. From Dover to Tennova Clarksville is 38.1 miles and 47 minutes. TCH is closer for this population center.

Of the zip codes assigned to Montgomery County, the greatest population increase is expected to be in zip code 37042, with an 8,409 population increase. The other two Clarksville zip codes are also expected to increase between 6,263 and 6,493 during this five-year period. The remaining surrounding zip codes represent 7 to 8 percent of the total Clarksville population with each having relatively lower growth as shown below.

Zip Code	Geographic Name	2025	2030	Population Change
37040	Clarksville	67,980	74,243	6,263
37042	Clarksville	93,580	101,989	8,409
37043	Clarksville	62,587	69,080	6,493
37142	Palmyra	2,122	2,226	104
37191	Woodlawn	4,154	4,270	116
37052	Cunningham	3,111	3,263	152
37171	Southside	1,449	1,583	134
37010	Adams	6,119	6,544	425

Source: Claritas, 2025

The following table provides drive times and distances from 37042 centroid to TCH and Tennova Clarksville:

Facility	Distance	Time
TriStar Clarksville Hospital	8.9	18
Tennova Clarksville	12.5	26
Source: Googlemaps, June 11, 2025		

Out-migration from Wilson County is 70.6 percent. It is different than Montgomery County. Wilson County is to the east of Davidson County. TriStar Summit Medical Center is on the eastern edge of Davidson County and just a few miles from the Wilson County line. It provides significant services to Wilson County, including having a freestanding emergency room in Mount Juliet. Indeed, 35 percent of its discharges are Wilson County residents, and part of Wilson County is included in its service area. Of the 70 percent out-migrating, 47 percent of those patients are admitted to TriStar Summit Medical Center. Excluding TriStar Summit Medical Center, the out-migration is 23 percent, the majority of which are admitted to VUMC which owns the hospital in Wilson County.

Robertson County out-migration is 73.1 percent of which 13 percent are admitted to Sumner County. TriStar Hendersonville identifies portions of Robertson County in its service area. The net remaining out-migration is approximately 60 percent. Robertson County is to the north of Davidson County. TriStar Skyline Medical Center is in Davidson County, approximately 10 to 11 miles from the Robertson County line and directly accessible to those residents from I-65 and U.S. 41. This hospital is a tertiary medical center, which includes a comprehensive stroke center, a Level I Trauma program, and a burn unit, and sees a significant number of Robertson County patients, second only to

TriStar NorthCrest Medical Center. Reaching TriStar Skyline Medical Center which admits 16 percent of Robertson County's patients is not comparable to traveling to Davidson County from Montgomery County.

Out-migration from Dickson County is 48 percent with TriStar Horizon Medical Center providing approximately 52 percent of services to Dickson County residents. Most out-migration is to Davidson County with almost half to TriStar Health hospitals. A differentiating factor for Dickson County residents versus Montgomery County residents is that 42 percent of Dickson County residents work outside the county resulting in a higher likelihood that patients are seeking healthcare nearer to their work than home. *See* Tennessee Comptroller of the Treasury's County Profiles; 2023: American Community Survey 5-Year Estimates Subject Table SO801. It is likely that this commuting population contributes to out-migration. In contrast, only 15 percent of Montgomery County residents work outside Montgomery County thereby not impacting out-migration like it does with Dickson County. (*Id*).

14. **3N. Demographics**

Page 22 - Please confirm whether the ZIP Code (37042) or the County will have the 2nd largest increase in population from 2025-2030? How is the ZIP Code level percentage increase less than the county overall or the City of Clarksville overall for 2025-2030?

Can the applicant table this with other Claritas ZIP Code data to support the rankings of 37042?

Response : Zip code 37042 will have the second largest increase in population of any zip code in the State. This is shown in the below table which provides the top 25 zip codes in descending order by 2025 population.

Zip Code	Geographic Name	Total Population			Rank, Largest to Smallest			2025 to 2030 Change #	2025 to 2030 Rank Count Change
		2010	2025	2030	2010	2025	2030		
37013	Antioch	74,889	100,377	104,538	1	1	1	4,161	14
37042	Clarksville	66,033	93,580	101,989	3	2	2	8,409	2
37128	Murfreesboro	42,778	81,155	89,811	20	3	3	8,656	1
37211	Nashville	72,109	80,796	80,663	2	4	6	-133	574
37075	Hendersonville	57,835	76,267	80,955	4	5	5	4,688	13
37122	Mount Juliet	45,119	72,905	81,118	17	6	4	8,213	3
38401	Columbia	54,702	69,571	75,285	5	7	7	5,714	9
37064	Franklin	48,403	68,952	73,745	11	8	12	4,793	12
37167	Smyrna	48,681	68,796	74,392	10	9	9	5,596	11
37129	Murfreesboro	47,244	68,165	73,839	12	10	11	5,674	10
37066	Gallatin	43,053	68,103	75,079	19	11	8	6,976	4
37040	Clarksville	46,103	67,980	74,243	15	12	10	6,263	8
37027	Brentwood	50,176	63,878	66,149	7	13	15	2,271	34
37130	Murfreesboro	51,454	63,219	66,506	6	14	14	3,287	17
37043	Clarksville	39,399	62,587	69,080	31	15	13	6,493	7
37087	Lebanon	40,655	59,441	66,064	25	16	16	6,623	6
37174	Spring Hill	27,712	58,664	65,603	68	17	17	6,939	5
38017	Collierville	49,565	55,689	56,005	9	18	19	316	221
37421	Chattanooga	46,494	55,003	58,190	14	19	18	3,187	19
38305	Jackson	49,805	54,016	55,179	8	20	20	1,163	82
37918	Knoxville	41,769	48,808	51,278	23	21	21	2,470	27
38016	Cordova	40,353	48,232	47,803	27	22	24	-429	587
37363	Ooltewah	32,672	46,237	49,886	49	23	22	3,649	15
38002	Arlington	40,049	45,988	46,402	30	24	26	414	186
37343	Hixson	40,077	45,767	47,987	29	25	23	2,220	35

Source: Claritas, 2025.

Below is provided is a similar table for females 18 to 44 which was discussed in the CON form responses. This shows the top 25 zip codes based on 2025 population size in descending order. Notably the TCH home zip code is currently second largest population by will become the largest by 2030.

Zip Code	Geographic Name	2010 Female Pop 18-44	2020 Female Pop 18-44	2025 Female Pop 18-44	2030 Female Pop 18-44	Rank, Largest to Smallest			2025 to 2030 Change #	2025 to 2030 Rank Count Change
						2010	2025	2030		
37013	Antioch	18,176	21,432	21,054	20,400	1	1	2	-654	610
37042	Clarksville	15,665	18,788	20,896	21,751	3	2	1	855	3
37211	Nashville	16,192	18,930	17,462	16,159	2	3	4	-1,303	612
37128	Murfreesboro	9,905	15,174	17,086	17,969	7	4	3	883	2
37040	Clarksville	10,613	13,785	15,256	15,916	5	5	5	660	7
37130	Murfreesboro	12,439	13,507	14,039	14,231	4	6	6	192	55
37075	Hendersonville	9,968	12,246	13,189	13,575	6	7	9	386	18
37167	Smyrna	9,725	11,601	13,097	13,680	9	8	7	583	9
37129	Murfreesboro	8,677	11,496	12,907	13,579	17	9	8	672	6
37122	Mount Juliet	7,945	10,629	12,416	13,228	27	10	10	812	4
37209	Nashville	8,336	12,593	12,226	11,603	19	11	14	-623	608
38401	Columbia	9,475	10,731	11,893	12,461	10	12	12	568	11
37043	Clarksville	7,244	9,615	11,656	12,236	34	13	13	580	10
37066	Gallatin	7,441	10,146	11,541	12,461	31	14	11	920	1
37064	Franklin	7,988	9,866	10,955	11,382	25	15	16	427	14
37174	Spring Hill	5,750	9,278	10,942	11,558	56	16	15	616	8
37087	Lebanon	7,204	8,637	10,244	10,955	35	17	17	711	5
38016	Cordova	8,719	10,177	9,774	9,216	16	18	23	-558	604
38305	Jackson	9,890	9,635	9,727	9,869	8	19	19	142	70
37027	Brentwood	7,380	9,257	9,674	10,021	33	20	18	347	21
37421	Chattanooga	8,257	9,317	9,609	9,755	20	21	20	146	68
37604	Johnson City	7,178	8,587	9,172	9,603	36	22	21	431	13
38501	Cookeville	7,897	8,415	8,935	9,423	28	23	22	488	12
37920	Knoxville	8,078	8,402	8,903	9,075	22	24	24	172	63
38017	Collierville	8,137	8,787	8,831	8,704	21	25	27	-127	567

Source: Claritas, 2025

Regarding percentage increase, the county data presented throughout the CON application is based on the Boyd State Data Center estimates and projections. The zip code data is from Claritas. As reflected above, the zip code has the 2nd largest numeric increase in total population. This is not the case when contrasting percentages due to the fact it is adding more people (9 percent) to an already large zip code; many smaller zip codes population will increase more than 9 percent, but that is based on a smaller numeric increase divided by a smaller overall 2025 population.

15. **4N. Special Needs of Service Area**

Please identify the new services proposed by the applicant that are unavailable currently.

The comparison between Clarksville and Chattanooga is noted. Please discuss whether the presence of tertiary facilities in Hamilton County vs Montgomery County might affect in-migration rates and inpatient admissions based on other regions of the state with tertiary hospitals.

How many patients are coming to a TriStar facility from the northern Montgomery ZIP Code where this project will be located (37042)?

Does the applicant have HDDS data to support the out-migration analysis in addition to THA data? If so, please provide a DR#.

Why is Stewart County outmigration for cardiac procedures 68% and not 100%? Please explain the methodology.

Response : The Applicant intends to provide electrophysiology (EP) procedures and offer spine surgery. It will also have available 24/7 laborists; it is unclear if Tennova Clarksville has that extent of coverage now or will maintain it in the future. In addition, TriStar Health affiliated physicians who will practice at TCH do not have privileges at Tennova Clarksville.

Hospitals in Hamilton County provide tertiary services such as open heart and neurosurgery. There is also a children’s hospital and a Level I Trauma center. These factors do contribute to in-migration to Hamilton County. Further services not available in Montgomery County contributes to Montgomery County out-migration. With the establishment of TCH, out-migration will be reduced.

Per the THA data, TriStar Health hospitals discharged on average greater than 900 patients residing in zip code 37042 during each of the past three years. It also served more than 3,200 outpatients who reside in 37042 annually.

The Applicant used both JAR data and THA data to support the out-migration; it does not have an HDDS DR#.

Stewart County has 100 percent out-migration from Stewart County. The 68 percent outmigration for cardiac procedures represents outmigration from the Service Area. The difference includes those Stewart patients using Montgomery County hospitals.

16. **4N. Special Needs of Service Area**

Which hospitals are excluded from the analysis in Exhibits 8 - 12?

Exhibit 11 - Are all 377 beds at Williamson Medical Center known to be staffed? Please identify the source of all data that is not based on the Joint Annual Reports.

Exhibit 12 - The number of licensed beds in Davidson County appear to include beds for Saint Thomas Hospital for Specialty Surgery which isn't included in the 8-hospital count for Davidson represented in earlier tables. Please revise.

Exhibit 13 - Please identify the data source used.

Is there any data available on utilization of the available OB beds at Tennova to demonstrate whether the outmigration is a capacity issue (as stated) or a patient choice issue?

Why are 2023 data masked for high volume facilities when it isn't masked for other years?

The data listed in the following Exhibits don't appear to calculate correctly:

Exhibit 13 - Potential Saved Time for Outmigration

All Other and Total Rows: 2021 & 2022

Exhibit 14 - Potential Saved Time for Outmigration

All Other and Total Rows: 2021 & 2022

Many of these drive times to hospitals are the same for Montgomery and Stewart. Is this correct?

Exhibit 15 - Potential Saved Time for Outmigration

All Other and Total Rows: 2021 & 2022

Are these transfers or just admissions for non-tertiary services?

Exhibit 15 - Potential Saved Time for Outmigration

All Other and Total Rows: 2021 & 2022

Please source all the Exhibits.

Page 40 - Is this a high level of outmigration for cardiac catheterizations relative to other counties this size?

Response : Hospitals excluded from Exhibits 8 to 12 are behavioral health hospitals, long term acute care hospitals and rehabilitation hospitals.

The source of the Williamson Medical Center ("WMC") licensed beds is public information including https://internet.health.tn.gov/FacilityListings. The relevant exhibits have been revised to 337 acute beds; the 377 included the 40 rehabilitation beds which have been removed. The Applicant is not aware as to how many are staffed but notes prior to the WMC bed expansion its licensed and staffed beds were the same.

Exhibits 8, 9 and 10 were adjusted to include St. Thomas Hospital for Specialty Surgery. As a result, the beds in Exhibits 11 and 12 continue to include that hospital's beds.

Regarding OB at Tennova Clarksville, per its 2023 JARs, it has 37 OB/GYN beds and 4,700 patient days in Major Diagnostic Categories ("MDC") 13 and 14. This equates to an average daily census of 13. When just considering the 13 beds identified as OB (and not OB/GYN), and MDC 14 patient days, that census is 12.6. Depending on how Tennova Clarksville operates the 13 vs 37 beds, there could be capacity constraints within the OB units. However, overall with a census of 13 and 37 available beds, it would appear patient choice does materially factor into the out-migration.

The THA policy requires that data be masked if not publicly available or is less than three years old. Therefore 2021 and 2022 are allowed to be published whereas 2023 requires masking when identifying individual hospitals. It does not require masking when sorting by other fields such as payor or age.

Sources were added to Exhibits 8 through 16. Exhibits 13 through 16 were corrected for time transposition of some of the time estimates and to assure the total line was properly computing. Exhibits 15 and 16 are total non-tertiary admissions regardless of origin of patient.

For any of the exhibits in 4N that changed and are also presented in Acute 1N, those like exhibits were also updated.

Regarding outmigration for cardiac catheterization, consistent with comparison to Rutherford County, the Applicant evaluated that county's outmigration observing it was 45.6 percent, significantly lower than Montgomery County. The availability of a TCH cardiac catheterization laboratory will reduce out-migration.

17. **4N. Special Needs of Service Area**

Exhibit 20 - The Joint Annual Reports for 2019-2023 report over 50% retention of Montgomery County inpatient admissions. Please explain how the outmigration is over 50% from Montgomery County for each of these years according to THA data?

Please explain the Stewart County outmigration data and what these percentages represent.

Exhibit 23 - Page 45 - Is it known how many of these neonatology discharges that out-migrated were for Level III or IV NICU services?

Exhibit 25 - Please confirm that approximately one-third of Montgomery County discharges from 2021-2023 were for tertiary care.

Page 46 - It is noted that a primary reason for obstetrics patients leaving the area for care is the lack of

availability of services. Please confirm whether 24/7 laborists, midwifery, doula, water immersion and other specialty programming is available at Tennova?

Exhibit 26, Page 48 - What is the basis for the assumption that the level of acuity is going to be appropriate to remain at the proposed facility.

Is the reason for transport out of county provided by Biospatial?

Are a significant number being transported for service in their home county rather than due to diversion or patient preference for a facility other than Tennova - Clarksville?

Response : The THA data in 20 includes total discharges including specialty hospitals (long term acute care, behavioral health and rehabilitation). Excluding behavioral health and rehabilitation as presented in Exhibit 21, the rate decreases to 48.9 percent indicating more than 50 percent retention.

Stewart County has no healthcare facilities so it is accurate that 100 percent of Stewart County residents out-migrate from Stewart County. TCH has identified its Service Area as Stewart and Montgomery Counties. Therefore, the outmigration percentages referenced in the Stewart out-migration are those patients leaving the Service Area (both Stewart and Montgomery Counties).

Regarding neonatology discharges, DRGs do not designate between different NICU Levels of Care.

Exhibit 25 is limited to non-tertiary med surg discharges. The differences between discharges in Exhibit 25 and total discharges by Service Area residents includes obstetrics patients, neonatology, and tertiary patients.

TCH will offer OB services with more comprehensive options including 24/7 laborists, midwifery privileges, doula, water immersion and other specialty programs. TCH believe these services are unique. It will also expand the physician pool working and growing with community OB providers. TCH cannot respond to what Tennova has.

In terms of EMS transports (Exhibit 26), the Applicant reviewed the transports by service line and has observed that the majority of the service line conditions identified could be treated at TCH.

The Applicant is not aware of biospatial data including the reason for transport out of the county.

Diversion data and patient preference is not available in the biospatial data.

18. **6N. Utilization and/or Occupancy Statistics**

How were these projections adjusted to account for proximity to the proposed facility?

Exhibit 46, Page 62 - Where are the ICU beds? Is the ICU expected to have a different ADC than the med/surg beds?

Response : The patient capture rates were adjusted based on an average at the county level to account for proximity and access to TCH.

The medical surgical column in Exhibit 46, page 62 includes the 8 ICU beds and 42 med/surg beds in a combined patient days, average daily census and bed need. The combined ADC is 41.2, with 5.77 in the ICU and 35.45 in the med/surg beds.

19. **1N. Criteria and Standards**

Attachment 1N, Acute Care Bed Services, Criterion #1, Determination of Need

Please utilize the TDH bed need projections:

COUNTY	2023		CURRENT	SERVICE AREA POPULATION			PROJECTED		PROJECTED		2023 ACTUAL BEDS		SHORTAGE/SURPLUS	
	INPATIENT DAYS	ADC	NEED	2023	2025	2029	ADC-2025	NEED 2025	ADC-2029	NEED 2029	LICENSED	STAFFED	LICENSED	STAFFED
Montgomery	48,628	133	167	129,141	133,683	142,706	138	172	147	184	270	237	-98	-53

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Hospital Data from Final JAR-Hospitals Schedules F and G.
Projections and estimates for TN border states obtained from those respective states.

TN Projections Source: Boyd Center for Business and Economic Research, University of Tennessee, Knoxville
Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment
(TN_CoPopProj_2017 series)

Note: Totals may not match due to rounding. Additionally, the totals do not include data from Unknown TN Counties or Other States provided in Utilization, Patient Origin.

A full copy of the excel file from the Tennessee Department of Health will be emailed by HFC staff to the application point of contact.

Response : The TDH bed need projections have been inserted and discussed in 1N, Acute, Criterion #1. Please note, the Montgomery County population in the above table is not correct. This has been revised in the inserted discussion. An updated 1N Acute Attachment has been uploaded in the portal.

20. **1N. Criteria and Standards**

Attachment 1N, Acute Care Bed Services, Criterion #2, Quality Considerations

Please complete the available tables per the instructions in the Criteria and Standards: *"Note: In the event quality data is unavailable for an applicant's existing facility, the applicant should provide data from a comparable, existing facility owned by the applicant. If no comparable data is available, the absence of such information should not disadvantage the applicant over another with available quality data."*

If the applicant intends to compare CMS quality measures to the existing hospital, please do so in response to Criterion #2.

Response :

The Applicant is not an existing facility so therefore has no quality data to provide. A comparable e
owned by the Applicant's ultimate parent is TriStar Horizon Medical Center ("TriStar Horizon"). T
in a contiguous county to the south of Montgomery, Dickson County, approximately 46 miles soutl
is a table which provides TriStar Horizon's quality measures.

Centers for Disease Control & Prevention's (CDC) National Healthcare S Network (NHSN) Measures for TriStar Horizon Medical Center				
Measure	**Source**		**National Benchmark**	**Hospital Standardized Infection Ratio (SIR)**
Catheter associated urinary tract infection (CAUTI)	Hospital Compare: Complications & Deaths – Healthcare-associated infections		Standardized infection ratio (SIR) national benchmark = 1.	0.00
Central line associated blood stream infection (CLABSI)	Hospital Compare: Complications & Deaths – Healthcare-associated infections		Standardized infection ratio (SIR) national benchmark = 1.	0.00
Methicillin resistant	Hospital Compare:		Standardized infection ratio (SIR)	0.714

staphylococcus aureus (MRSA)	Complications & Deaths – Healthcare-associated infections		national benchmark = 1.	
Clostridium difficile (C.diff.)	Hospital Compare: Complications & Deaths – Healthcare-associated infections		Standardized infection ratio (SIR) national benchmark = 1.	0.068
Surgical Site Infections (SSI)				
SSI: Colon		Hospital Compare: Complications & Deaths – Healthcare-associated infections	Standardized infection ratio (SIR) national benchmark = 1.	0.00
SSI: Hysterectomy		Hospital Compare: Complications & Deaths – Healthcare-associated infections	Standardized infection ratio (SIR) national benchmark = 1.	0.00
			National Average	**Tennessee Average**
		Hospital	80.7%	78%

Healthcare work influenza vaccinations	Compare: Timely & Effective Care – Preventive Care		

21. **1N. Criteria and Standards**

Attachment 1N, Acute Care Bed Services, Criterion #4, Relationship to Existing Services

It is noted that *"The 1,720 acute transfers from its emergency room, excluding the Tennova Sango ER, ranks as the highest number of acute transfers from any hospital in the State"*.

What factors does the applicant believe are driving this?

How will the applicant's service lines alleviate the need for transfers?

What percentage of these transfers does the applicant expect to receive?

Exhibit 1N, Acute 21, Page 19 - Can the applicant identify the reasons given by the referring facilities for the transfer to a TriStar facility? What does "service availability" include as a reason for transfer as referenced in the first paragraph of Page 19?

Exhibit 1N, Acute 22, Page 20 - What were the reasons given for the Blanchfield transfers?

Page 24 - Are the labor and delivery rooms heavily utilized at Tennova?

Are there shortages of available obstetricians and laborists working with Tennova and/or operating out of practices based in Montgomery County?

Response : Factors driving the overall level of transfers from Tennova Clarksville are not known. For those being transferred to TriStar Health hospitals, the Applicant has access to detailed information regarding the explanation for transfer. As shown in the table below, the majority of transfers are for due to lack of service availability which is further discussed

after the table. Patient and family preference and continuity of care are the next greatest reasons.

TCH will alleviate the need for transfers out of the area as not all transfers are for tertiary services. Having additional services in the community, alternative providers, and the ability to provide patient choice will reduce the number of transfers out of Montgomery County. TriStar Health's goal is to keep patients close to home for their care. TCH will accomplish this through quality and focus on patient satisfaction.

Many of the TriStar Health's transfers previously referred from Tennova Clarksville may receive care at TCH. In the computation of admissions, we have not determined how many would be transfers from another facility.

The patients reflected as being transferred in Exhibit 1N, Acute – 21 were transferred for the following reasons:

Explanation	2022	2023	2024
CR - Bed NA	169	38	18
CR - Consult	6	11	11
CR - Continuity of Care	31	62	57
CR - Equipment NA	2	3	7
CR - No On Call	0	2	10
CR - Out of MD Scope	1	5	12
CR - Pt/Family Preference	29	30	74
CR - Service NA	376	596	501
Other	2	7	4
Total	**616**	**754**	**694**

Source: Internal data.

Regarding Service NA (Not Available), this indicates that the reason provided for the transfer was that the service was not available at the time of transfer. Within this group, a wide range of service lines were identified. These included cardiology, EP, thoracic surgery, cardiovascular surgery, colorectal surgery, ENT, gastroenterology, general surgery, gynecology, interventional cardiology, interventional radiology, nephrology, neurology, neurosurgery, spine surgery, pulmonology, thoracic surgery, urology and vascular surgery, among others, most of which will be available at TCH.

Approximately 90 percent of the reason for Blanchfield transfers were due to lack of service availability at Blanchfield. The remaining 10 percent were due to consult, continuity of care, out of physician's scope and patient/family preference.

The Applicant does not have knowledge about utilization within Tennova Clarksville's labor and delivery rooms. Please refer to the response to Question 16 above regarding Tennova Clarksville's OB utilization.

Regarding OB/laborist shortage, the Applicant believes there is a shortage of OB/laborist in the community as evidenced by standardized population-based metrics including the range of 1 OB/GYN to between 9,400 and 11,000 population. The Applicant has observed local physicians advertising to recruit additional OB/GYN physicians. As noted in the CON application, TCH will work with the community obstetricians to grow their practices to meet the additional needs of the community.

22. **1N. Criteria and Standards**

Attachment 1N, Acute Care Bed Services, Criterion #5, Services to High Need Populations

Exhibit 1N, Acute 24, Page 25 - Why is 2022 JAR data cited instead of 2023?

Response : The data initially included was 2022; the 2023 data has been substituted in this Exhibit 1N, Acute -24.

23. **1N. Criteria and Standards**

Attachment 1N, Cardiac Catheterization Services, Criterion #3, Emergency Transfer Plan

Where are the nearest open-heart programs? Are any of them within 60 minutes of the proposed facility by ground transport?

Response : The nearest open heart surgery programs to the Service Area are in Davidson County. TriStar Centennial Medical Center is a 56-minute drive. Ascension St. Thomas West and Vanderbilt University Medical Center are both 59-minute drives. In addition, TriStar SkyLife is a helicopter service that can be utilized to transport patients when appropriate.

24. **1N. Criteria and Standards**

Attachment 1N, Cardiac Catheterization Services, Criterion #9, Proposed Service Area with No Existing Service

The response is not required. It can be moved under Criterion #8.

Response : The response has been moved under Criterion #8, continuing from the information that had been presented therein. A revised 1N Cardiac Catheterization has been uploaded in the portal.

25. **1N. Criteria and Standards**

Attachment 1N, NICU Services, Criterion #4, Access

How will this project address the referenced shortage of mental health providers?

Response : By leveraging established relationships with community partners (i.e. Rachel's Gift) and TriStar Health's network of care for Mental Health services, TCH will ensure the mental health needs are met for all patients, but especially for mothers and families facing the challenges around miscarriage, infant loss, post-partum depression, loss of the mother, etc. Additionally, patients will also have access to TriStar Health's tele-behavioral services consults through telemedicine capabilities and may use that platform to connect to other TriStar Health services and providers.

Project Name : TriStar Clarksville Hospital

Supplemental Round Name : 2 **Due Date :** 6/13/2025

Certificate No. : CN2505-018 **Submitted Date :** 6/12/2025

1. **1N. Criteria and Standards**

Attachment 1N, Acute Care Bed Services, Criterion #1, Determination of Need

Please incorporate the Tennessee Department of Health's published bed need projections for Montgomery County in response to Item 1N as provided.

Please revise and resubmit Attachment 1N, Acute Care Bed Services (labeled as Attachment 1NR2 - Acute Care Bed Services).

Response : The information from the Tennessee Department of Health published bed need projections for Montgomery County in response to Item 1N is included in Criterion #1. 1NR2, Acute has been uploaded in the portal.

2. **1N. Criteria and Standards**

Attachment 1N, Acute Care Bed Services, Criterion #2, Quality Considerations

The CMS data provided in the supplemental response table appears to be incorrect for the following:

1. (C-diff.)
2. Healthcare work influenza vaccinations

Please included the table provided in the supplemental response within Attachment 1N - Acute Care Bed Services.

Response : The table correcting these two line items has been included in Criterion #2 in the 1NR2, Acute attachment. It has been uploaded in the portal.