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 Herald-Citizen, which is a newspaper of general circulation in Putnam County, Tennessee, on or before 07/15/2026 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 TN Heart Cardiovascular Surgery Center, LLC, a/an Ambulatory Surgical Treatment Center (ASTC) – Single Specialty owned by The Stern Cardiovascular Center, P.A. with an ownership type of Professional Association and to be managed by Atria Health Services of the South, LLC intends to file an application for a Certificate of Need for the establishment of an ASTC limited to the initiation of diagnostic and therapeutic cardiovascular catheterization and diagnostic and therapeutic electrophysiology procedures, including cardiac rhythm device implantation procedures, electrophysiology studies, and cardiac ablation procedures, that the Centers for Medicare & Medicaid Services has approved for performance in the ASTC setting. The address of the project will be 999 S. Willow Avenue, Cookeville, Putnam County, Tennessee, 38501. The estimated project cost will be $11,835,798.

The anticipated date of filing the application is 08/03/2026

The contact person for this project is Mr. Jeffrey Stofko who may be reached at Ascendient Healthcare Advisors Inc - 1335 Environ Way, Chapel Hill, North Carolina, 27517 – Contact No. 919-403-3300.

Jeffrey Stofko	07/10/2026	jeffreystofko@ascendient.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 .

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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 TN Heart Cardiovascular Surgery Center, LLC, a/an Ambulatory Surgical Treatment Center (ASTC) – Single Specialty owned by The Stern Cardiovascular Center, P.A. with an ownership type of Professional Association and to be managed by Atria Health Services of the South, LLC intends to file an application for a Certificate of Need for the establishment of an ASTC limited to the initiation of diagnostic and therapeutic cardiovascular catheterization and diagnostic and therapeutic electrophysiology procedures, including cardiac rhythm device implantation procedures, electrophysiology studies, and cardiac ablation procedures, that the Centers for Medicare & Medicaid Services has approved for performance in the ASTC setting. The address of the project will be 999 S. Willow Avenue, Cookeville, Putnam County, Tennessee, 38501. The estimated project cost will be $11,835,798.

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CRITERIA AND STANDARDS

Overview and Context

On July 1, 2026, Tennessee Heart, PLLC ("TN Heart"), an established cardiology physician practice in the Upper Cumberland region, entered into a strategic partnership with Atria Health Services of the South, LLC ("Atria Health") and The Stern Cardiovascular Center, P.A. ("Stern")[1] to create a cardiovascular center of excellence in Cookeville, expand access to care, recruit new physicians to the area, and provide innovative cardiology services. Together, they propose to develop a single-specialty, cardiovascular ambulatory surgical treatment center ("ASTC") in Cookeville, Tennessee (Putnam County). Like Stern's recently approved ASTC CON application for a single-specialty cardiovascular ASTC in Shelby County (CN2605-013A), this ASTC, TN Heart Cardiovascular Surgery Center, seeks to offer the following cardiovascular services:

Scope of Services for TN Heart Cardiovascular Surgery Center

Cardiac Catheterizations		
Diagnostic	***Therapeutic***	
Coronary Angiography	**Percutaneous Coronary Interventions (PCI)**	
Right Heart Catheterization	Coronary Balloon Angioplasty	Coronary Stenting
Left Heart Catheterization		
Diagnostic Measurements		

Electrophysiology (EP) Procedures		
Diagnostic	***Therapeutic***	
Electrophysiology Studies	**Cardiac Ablations**	
	Ablation of Atrial Fibrillation	Ablation of Atrial Flutter
	Supraventricular Tachycardia Ablation	Atrioventricular Node Ablation
	Cardioversion	

Cardiac Rhythm Device Implantation
Pacemaker Implantation and Generator Changes
Subcutaneous ICD Implantation and Generator Changes
Implantable Cardioverter Defibrillator (ICD) Implantation and Generator Changes
Loop Recorder Implantation and Replacement

Peripheral Vascular Services	
Diagnostic	***Therapeutic***
Peripheral Angiography	Balloon Angioplasty
	Stent Placement
	Atherectomy
	Lithotripsy
	Vein Procedures

Cardiovascular Imaging Services
Intra-Procedure Fluoroscopy
Transesophageal Echocardiography (TEE)

[1] Please note that Stern is managed by Atria Health.

The detailed list of the scope of services for the proposed project shown above is also included as Attachment 1N-1.1. Throughout this application, including in Attachment 1N, this table is intended to clarify the types and classifications of procedures that TN Heart seeks to perform in the proposed ASTC.

The need for accessible, lower-cost cardiovascular care in the Upper Cumberland region of Tennessee is substantial and growing. According to the most recent available mortality data from the Tennessee Department of Health, cardiovascular disease remains the leading cause of death in all four primary service area counties (Cumberland, Overton, Putnam, and White), in part driven by the demographics of those counties, all of which are both aging and heavily rural.[2] In addition, cardiac catheterization utilization data in the proposed service area confirm that patients lack adequate access to the full spectrum of cardiac catheterization services. Service area patients, particularly Medicare beneficiaries, need access to a convenient, high-quality outpatient provider of cardiovascular services. This project addresses that need directly – a need that the HFC already acknowledged July 22, 2026, when it unanimously approved Stern's parallel project, Stern Cardiovascular Surgery Center, LLC, (CN2605-013A), to establish a single-specialty, cardiovascular ASTC in Shelby County delivering diagnostic and therapeutic cardiac catheterizations, diagnostic and therapeutic electrophysiology ("EP") procedures, cardiac rhythm device implantations, and diagnostic and therapeutic peripheral vascular services. This approval built upon the 2022 approval of Karing Hearts Cardiology Heart and Vascular Center's ("Karing Hearts") (CN2207-033A) project to provide diagnostic cardiac catheterization, cardiac device implantation, and related procedures in a freestanding ASTC, which solidified the benefit of performing cardiac catheterization and device implantation services in the outpatient surgery center setting across Tennessee.

Outside Tennessee, multiple southeastern states with active CON programs have similarly permitted select therapeutic cardiac catheterization procedures in ambulatory settings. By proposing the initiation of the services noted in the table above, procedures the Centers for Medicare & Medicaid Services ("CMS") has approved for reimbursement in an ASTC setting in 2026, the project ensures Tennessee patients have broader access to more affordable cardiac catheterization care in an ASTC setting.

The proposed scope of services is also fully consistent with the quality standards for cardiac catheterization care endorsed by leading professional organizations. These services will be delivered by TN Heart physicians, who, as outlined in more detail below and throughout the application, have extensive experience providing cardiovascular services in the Upper Cumberland region of Tennessee. Additionally, any qualified cardiologists, vascular surgeons, and anesthesiologists that meet the proposed project's privilege requirements and credentialing processes will be offered the opportunity to provide services at the facility.

Like the Shelby County area, the Upper Cumberland region has a documented and growing need for accessible, lower-cost cardiac catheterization services. TN Heart and Stern are also uniquely positioned to deliver on this opportunity, bringing physicians with deep existing roots in the service area and across Tennessee and a scope of services aligned with CMS reimbursement policy and national quality standards. Combined with Stern's approved Shelby County CON, approving this application will further extend a proven care model to Tennessee patients who need it most.

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[2] Tennessee Department of Health. "Leading Causes of Death: Counties with Populations of 20,000 or Greater." 2021. Accessed at https://www.tn.gov/health/pha/statistics.html.

About TN Heart and Stern

TN Heart is an existing Cookeville-based cardiology group comprised of 11 cardiologists and five advanced practitioners. TN Heart has served the Upper Cumberland region for over 30 years, delivering care at three clinic locations in Cumberland, Overton, and Putnam counties, as well as at Cookeville Regional Medical Center ("CRMC") in Putnam County. Stern is one of the largest and most renowned cardiology physician practices in Tennessee and the entire country. Founded in Memphis in 1920, Stern has grown to encompass nearly 130 cardiovascular care providers delivering care at more than two dozen locations across Tennessee, Mississippi, and Arkansas.

Recently, TN Heart entered into a strategic partnership with Stern, further adding to Stern's footprint of board-certified cardiologists in Tennessee. The affiliation between TN Heart and Stern follows TN Heart's and Stern's entry into strategic partnerships with Atria Health in July 2026 and January 2026, respectively, to enhance their access to clinical expertise, operational support, and care innovation resources. Atria Health was founded in 2022 with the goal of empowering cardiovascular practitioners through assisting with the expansion and operation of cardiovascular facilities and services. Atria Health, which assists cardiovascular practices nationwide, promotes a "just right" model for physician-owned and physician-led practices by offering infrastructural support to ensure partnering cardiology practices can focus on delivering the best possible care. Atria Health's wide reach and significant experience assisting multiple cardiovascular practices nationwide make it an ideal partner to develop the services proposed in this application.

The affiliation between TN Heart and Stern will create a center of excellence in cardiovascular care in the Upper Cumberland region, bringing together a team of experienced cardiology providers with knowledge of all facets of cardiovascular care and a well-established regional presence in central and western Tennessee. TN Heart has served patients in the Upper Cumberland region for more than three decades, developing a multidisciplinary team of board-certified cardiologists providing general cardiology, interventional cardiology, EP services, cardiac imaging, and vascular services that is equipped to manage the full breadth of patients' cardiovascular needs. TN Heart has also worked to develop various specialized programs, including a structural heart program, EP lab, and cardiac imaging, all of which are unique offerings in the Upper Cumberland region that allow area residents to receive advanced cardiovascular care close to home. Through the proposed project, TN Heart's existing patients will gain access to outpatient cardiovascular care in an ASTC setting and to Stern's expansive network of nationally recognized cardiovascular providers.

Evolution of Cardiac Catheterization Procedures in an Ambulatory Setting

The current Standards and Criteria for Cardiac Catheterization services, developed by the Tennessee State Health Planning Division and regulated by the HFC, were drafted in 2009 and reference clinical guidelines dating from 2007 – nearly two decades old. As HFC staff acknowledged at the July 22, 2026 meeting approving Stern's parallel Shelby County ASTC project, cardiac catheterization technology and practices have evolved considerably since then, becoming safer, faster, and more effective and diagnosing and treating cardiovascular disease.[3]

This evolution has fundamentally changed where cardiac catheterization can be safely delivered.

[3] "Types of Percutaneous Coronary Interventions." Stanford Medicine. Accessed December 4, 2025, at https://stanfordhealthcare.org/medical-treatments/p/percutaneous-coronary-revascularization/types.html.

CMS has progressively expanded the procedures approved for reimbursement in the ASC setting, adding diagnostic catheterization codes in 2019 and 2020, and cardiac catheter ablation procedures, effective January 1, 2026.[4,5] This expansion places cardiovascular procedures alongside the already large list of services considered safe in an outpatient setting, such as orthopedic and GI endoscopy procedures. A portion of the current list of CMS-approved cardiac catheterization codes for the ASTC setting is provided in Attachment 1N-1.3.

Professional guidance supports this regulatory expansion. Guidelines from the Society for Cardiovascular Angiography & Intervention ("SCAI"), 2021 *Expert Consensus Update on Best Practices in the Cardiac Catheterization Laboratory*, confirmed that diagnostic and interventional procedures, including PCIs, performed on appropriately screened patients in an ASC achieve outcomes comparable to the hospital setting, with no difference in short- or long-term adverse effects.[6] A 2023 SCAI follow-up report specifically addressing PCI in facilities without on-site cardiac surgical backup found that complication rates were "very low" and largely unchanged or declining over time, with emergency surgery required in as few as 0.1% of cases.[7] SCAI's published patient selection criteria, which identify the specific conditions warranting deferral to a hospital setting, are provided in Attachment 1N-1.4 and will govern patient screening at the proposed ASTC, as discussed further below. Similarly, in 2026, the American College of Cardiology ("ACC") noted that the safety record of ambulatory PCI supported outpatient ablation procedures as well, citing a recent study finding no difference in complication rates between hospital and ambulatory settings.[8]

This guidance confirms two key conclusions. First, **the risk of adverse events during diagnostic cardiac catheterization is exceptionally low.** According to American Heart Association ("AHA") data, such adverse outcomes occur in less than 0.1 percent of procedures, with a separate 2023 study confirming a major complication rate under one percent.[9,10] A 2012

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4 Ibid.

5 "2026 Hospital OPPS Proposed Rule Released; CMS Proposes Adding Ablation to ASC Setting." American College of Cardiology. July 15, 2025, accessed at https://www.acc.org/Latest-in-Cardiology/Articles/2025/07/15/21/56/2026-Hospital-OPPS-Proposed-Rule-Relea. Also see "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency." Centers for Medicare & Medicaid Services, *Federal Register*, July 17, 2025, accessed at https://www.federalregister.gov/documents/2025/07/17/2025-13360/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical.

6 Naidu, Srihari S. et al. "SCAI Expert consensus update on best practices in the cardiac catheterization laboratory." *Catheterization & Cardiovascular Interventions.* 2021; 98: 255-276. Accessed via Wiley Periodicals. See p. 257.

7 Grines, Cindy L. et al. "SCAI Expert Consensus on Percutaneous Coronary Intervention Without On-Site Surgical Backup." *JSCAI*. January 20, 2023, accessed at https://doi.org/10.1016/j.jscai.2022.100560.

8 Kramer, Christopher M.; Blackwell, Jerry; Jones IV, Samuel O.; and Kenigsberg, David. "Cardiovascular ASCs: Transforming Cardiovascular Procedural Care Through High Value Ambulatory models." *JACC*, American College of Cardiology Foundation. January 2026. Accessed at https://acrobat.adobe.com/id/urn:aaid:sc:us:3060f492-4260-400c-86aa-4abe954f2370?viewer%21megaVerb=group-discover, p. 1.

9 Al-Hijji, Mohammed et al. "Safety and Risk of Major Complications with Diagnostic Cardiac Catheterization." *Circulation: Cardiovascular Interventions*. July 9, 2019, Volume 12, Number 7. Accessed at https://doi.org/10.1161/CIRCINTERVENTIONS.119.007791.

10 Manda, Yugandhar R. and Baradhi, Krishna M. "Cardiac Catheterization Risks and Complications." StatPearls Publishing, last updated June 5, 2023, accessed at

study in the *New England Journal of Medicine* similarly found no significant difference in outcomes between PCI procedures performed at hospitals with and without on-site cardiac surgery, confirming these procedures can be performed safely and effectively without that capability.[11]

Second, **Tennessee's own hospitals support these research findings, as cardiac catheterization procedures are being performed at Tennessee sites without on-site open heart surgery capabilities *today***. According to the 2024 Joint Annual Report ("JAR"), of the 143 Tennessee hospitals without open heart surgery capabilities, 32 provide diagnostic cardiac catheterization, 30 provide therapeutic catheterization, and 15 provide EP procedures, including hospitals in rural counties similar to those the proposed project will serve. The proposed ASTC's careful patient screening protocols, discussed in more detail below, will promote safety even further.

Cumulatively, this body of clinical evidence includes national guidelines, peer-reviewed outcomes research, and real-world experience across dozens of Tennessee hospitals already performing these procedures without on-site cardiac surgery, leaving no clinical basis for withholding these cardiac catheterization and EP services from a properly equipped, appropriately staffed ASTC.

Current Status of ASTC-Based Cardiac Catheterization Regulation in Tennessee and Other States

Since 2022, the HFC has approved two projects authorizing the provision of cardiac catheterization and related cardiovascular services in a non-hospital-based, freestanding ambulatory setting. First, in 2022, Karing Hearts Cardiology and Vascular Center proposed the development of a single-specialty ASTC (CN2207-033A). The HFC issued a Certificate of Need for "[t]he establishment of a single-specialty ambulatory surgical treatment center ('ASTC') and the initiation of diagnostic cardiac catheterization services," with the project seeking "licensure from the [HFC] as a single-specialty ambulatory surgical treatment center limited to cardiac device implantation and related procedures, and diagnostic cardiac catheterization." This application was approved and, according to the most recent JAR for ASTCs, the Karing Hearts ASTC became licensed on August 7, 2024.

Most recently, on July 22, 2026, the HFC unanimously approved Stern's project to develop Stern Cardiovascular Surgery Center (CN2605-013A), a single-specialty cardiovascular ASTC that will offer diagnostic and therapeutic cardiac catheterizations, diagnostic and therapeutic EP procedures, cardiac rhythm device implantations, and diagnostic and therapeutic peripheral vascular services in Shelby County. Like Stern's Shelby County project, the proposed TN Heart cardiovascular ASTC will bring these much-needed high-quality, lower cost outpatient cardiovascular services to patients in the Upper Cumberland region.

Both of these approvals are aligned with broader regional trends. Multiple nearby states, including those with CON programs, have recognized the safety and efficacy of performing both diagnostic and select therapeutic cardiac catheterization procedures in ASCs. For example, Arkansas and Missouri allow both diagnostic and therapeutic procedures such as PCIs to be performed in any appropriately equipped facility.[12] Mississippi formally authorized PCI procedures in ASCs through

https://www.ncbi.nlm.nih.gov/books/NBK531461/.

[11] Aversano, Thomas; Lemmon, Cynthia C.; and Liu, Li. "Outcomes of PCI at Hospitals with or without On-Site Cardiac Surgery." *New England Journal of Medicine*, May 10, 2021, Volume 266, No. 19. Accessed at https://www.nejm.org/doi/full/10.1056/NEJMoa1114540.

[12] See Code of Arkansas Rules, 20 CAR § 255-103. Scope of review.

amendments to its State Health Plan in 2020, permitting cardiac catheterizations in cardiac ambulatory surgical facilities established for the purpose of providing cardiac catheterization procedures.[13] North Carolina's CON laws explicitly allow ASCs to perform diagnostic and some interventional cardiac catheterization procedures, including electrophysiology procedures and PCI.[14] In short, cardiovascular-focused surgery centers are consistently being developed and licensed in Tennessee and surrounding states.[15] Approving Stern's Cookeville project will ensure more Tennesseans are able to access comprehensive cardiovascular care, including diagnostic and therapeutic cardiac catheterization and EP procedures, in the ASTC setting.

Tennessee CON Statutes Support Cardiac Catheterization in an ASTC Setting

All Tennessee CON applications are evaluated according to three criteria: (1) Need, (2) Quality, and (3) Consumer Advantage. This application to establish a single-specialty cardiovascular ASTC satisfies all three criteria. Specifically, the proposed project (1) meets a demonstrated and urgent need for such services in the proposed service area; (2) will deliver high-quality care governed by rigorous safety protocols; and (3) will improve access to cardiovascular care while generating significant cost savings for consumers.

Need

As discussed throughout the application, Stern-affiliated cardiologists operate in multiple locations across Tennessee. Within the service area, TN Heart cardiologists currently operate at three clinics in Cookeville, Crossville, and Livingston and also perform cardiovascular procedures at CRMC, the sole provider of cardiac catheterization services in Putnam County and one of only two providers of cardiac catheterization in the service area. The other cardiac catheterization provider is Cumberland Medical Center in Cumberland County. Both cardiac catheterization providers in the proposed service area – CRMC and Cumberland Medical Center – are hospital-based. Outside CRMC and Cumberland Medical Center, there are two other hospitals in the four-county service area: Saint Thomas Highlands Hospital (White County) and Livingston Regional Hospital (Overton County); however, neither operates any cardiac catheterization labs nor has

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https://codeofarrules.arkansas.gov/Rules/Rule?levelType=section&titleID=20&chapterID=98&subChapterID=129&partID=470&subPartID=4098&sectionID=25363, as well as Missouri CON State Regulations, 19 CSR 60-50.400 Letter of Intent Process. https://health.mo.gov/information/boards/certificateofneed/pdf/19c60-50.pdf.

[13] FY 2022 Mississippi State Health Plan, 515.06 Policy Statement Regarding Certificate of Need Applications for the Establishment of Cardiac Ambulatory Surgical Facilities. https://msdh.ms.gov/page/resources/16691.pdf.

[14] *2026 SMFP*, Chapter 15A. Cardiac Catheterization Equipment. https://info.ncdhhs.gov/dhsr/ncsmfp/2026/02_2026%20SMFP_post.pdf. Of note, the requirement of an approved CON application to develop an ASC in North Carolina expired in November 2025.

[15] In an additional example, several ambulatory facilities in Virginia have already been established to specifically provide cardiac catheterization service. See "Staff Analysis: COPN Request No. VA-8693." *Virginia Department of Health, Office of Licensure and Certification, Division of Certificate of Public Need*. May 19, 2023, https://www.vdh.virginia.gov/content/uploads/sites/96/2023/06/COPN-Request-No.-VA-8693-Case-Decision.pdf, and "Staff Analysis: COPN Request No. VA-8716." *Virginia Department of Health, Office of Licensure and Certification, Division of Certificate of Public Need*. December 15, 2025. https://www.vdh.virginia.gov/content/uploads/sites/96/2024/02/COPN-Request-No.VA-8716-Case-Decision.pdf; Honeycutt, Ann E. "Expanding Access to Care: A Virginia ASC with a Cardiac Service Line." *CathLab Digest*. February 2025. https://www.hmpgloballearningnetwork.com/site/cathlab/interview/expanding-access-care-virginia-asc-cardiac-service-line.

open heart surgery capabilities.

In projecting utilization at the proposed facility (detailed in Attachment 6N) TN Heart identified patients who would benefit from treatment in an outpatient surgery center setting by evaluating outpatient-appropriate procedures performed by TN Heart cardiologists at CRMC. The total weighted outpatient-appropriate cardiovascular procedures performed by TN Heart cardiologists have grown by 12.0 percent from 2024 through 2025, as shown in the table below. As stated above, the historical cardiovascular procedures shown in the table below conservatively include only those procedures that have been identified as ASTC-appropriate and therefore represent only a portion of TN Heart's total historical volume of cardiovascular procedures.

2024-2025 Historical Volume of TN Heart Cardiologists' Weighted Cardiology Procedures

Procedure Category	*2024*	*2025*	*% Change*
Cardiac Ablations	462	576	
Diagnostic Cardiac Catheterizations	1,038	942	
Electrophysiology Studies and Cardiac Rhythm Device Implantations	488	719	
Loop Procedures	146	180	
Therapeutic Cardiac Catheterizations	217	185	
Peripheral Vascular Catheterizations	12	44	
Total	**2,363**	**2,646**	**12.0%**

Source: Internal TN Heart data.

This growth substantially exceeds the overall projected population growth of the four service area counties, which have historically represented nearly three-quarters of TN Heart's patient population in the Upper Cumberland region. According to population projections from the Boyd Center at the University of Tennessee (compiled in Attachment 3N), the total population of Cumberland, Overton, Putnam, and White counties is projected to grow at a compound annual growth rate ("CAGR") of 2.8 percent from 2026 through 2030. TN Heart's cardiovascular procedure volume is thus outpacing population growth by a factor of more than four to one – clear evidence of rising demand for cardiovascular services that the proposed project will address.

The rising demand for these services is also reflected in the overall utilization of the two providers of cardiac catheterization services in the proposed service area counties: combined, the two existing cardiac catheterization providers, CRMC and Cumberland Medical Center, are operating well above state capacity standards. As detailed in the response to #8 below, as well as in the response to Question 5N and the corresponding Attachment 5N, the three existing cardiac catheterization laboratories in Cumberland County and Putnam County[16] averaged more than 10,552 weighted procedures from 2022 through 2024, according to hospitals JAR data. In other words, these existing cardiac catheterization laboratories are operating nearly 176 percent higher than the state's full capacity standard of 2,000 weighted cases, averaging approximately 3,520 cases per catheterization laboratory. This is more than 2.5 times higher than the state's optimum standard for cardiac catheterization laboratories of 1,400 weighted cardiac catheterization cases per year. Thus, the need for additional cardiac catheterization capacity in the service area is clear

[16] Please note that there are no existing cardiac catheterization labs in Overton or White counties.

and significant.

Historical Cardiac Catheterization Utilization – Service Area Counties
2022-2024

County	*Cath Labs*	*2022-2024 Avg. Weighted Diagnostic Caths*	*Diagnostic Caths per Lab*	*2022-2024 Avg. Weighted Therapeutic Caths*	*Therapeutic Caths per Lab*	*2022-2024 Avg. Weighted Diagnostic and Therapeutic Caths*	*% Full Capacity (2,000 Cases)*	*% Optimum Capacity (1,400 Cases)*
Cumberland	1	199	198.5	278	277.7	476.2	23.81%	34.01%
Putnam	2	4,332	2,165.9	5,745	2,872.3	10,076.5	251.91%	359.88%
Total	**3**	**4,530**	**1,510.11**	**6,022**	**2,007.44**	**10,552.67**	**175.88%**	**251.25%**

Source: Hospital JARs, 2022-2024.
Note: Overton County and White County have no catheterization labs.

Further, for the purposes of evaluating the need for the proposed project, even these utilization figures are likely understated. Cumberland Medical Center did not report any adult outpatient EP procedures in 2022, 2023, or 2024 – procedures that will be performed at the proposed ASTC. When analyzing service area capacity, providers that do not perform the same range of outpatient procedures as the proposed project are less meaningful comparators. While there is some overlap, they do not serve the same patient populations and, therefore, do not accurately reflect demand for the proposed project's services. Thus, it is more appropriate to evaluate capacity utilizing only providers whose service offerings align with the proposed ASTC.

When the utilization analysis is limited to CRMC – the location at which TN Heart cardiologists offer services today and the only provider of open heart surgery services in the four-county service area – the lack of capacity in the service area is even more severe. As shown above, the CRMC cardiac catheterization labs operate at 252 percent of full capacity and 360 percent of optimal capacity. This is an average of more than 5,000 cases per cardiac catheterization lab, offering a more accurate picture of the capacity constraints patients face in accessing cardiovascular services in the proposed service area. For example, TN Heart patients frequently experience critical delays in obtaining necessary outpatient cardiovascular procedures, including pacemaker implants, diagnostic cardiac catheterizations, and cardiac ablations.

Analysis of CRMC's 2022-2024 JAR data reveals that a significant number of the cardiovascular procedures performed in its catheterization labs are outpatient and could be appropriate for an outpatient surgery center setting. JAR data show that outpatient procedures accounted for more than half of CRMC's cardiovascular procedure volume in each of the last three years, ranging from 53.0 to 57.7 percent, as shown in the table below.

Share of CRMC Outpatient Cardiovascular Procedures
2022-2024

Cardiac Catheterization Type	*2022*	*2023*	*2024*
Outpatient Cardiovascular Procedures	2,977	3,155	2,707
Total Cardiovascular Procedures	5,162	5,957	4,997
Share of Total Cardiovascular Procedures that were Outpatient	57.7%	53.0%	54.2%

Source: Hospital JARs, 2022-2024.
Note that the figures above are not weighted procedures.

These numbers support that transitioning safe and appropriate outpatient procedures to an ASTC setting would alleviate current capacity constraints at CRMC and ensure that patients receive care in a setting that aligns with their clinical needs.

The demographic profile of Cumberland, Overton, Putnam, and White counties further demonstrates the need for additional cardiovascular services. As detailed in the following sections, the Upper Cumberland region is experiencing high population growth and also has a population facing significant socioeconomic disparities that are strongly associated with elevated cardiovascular risk. As shown in Attachment 3N, all four counties are projected to grow by 2.8 percent from 2026 to 2030, with Putnam County projected to grow by 3.7 percent over that period.

More notably, the aging population in the proposed service area is rapidly increasing. According to Boyd Center population projections, the population age 65 and over is projected to grow 6.4 percent from 2026 to 2030 – a rate of growth more than double that of the population overall.[17] Given that the Upper Cumberland region is seen as a retirement destination,[18] it is likely that this accelerating aging will continue beyond 2030. This aging is significant for the proposed project, as older residents face greater risk of cardiovascular events. According to the CDC, the rate of heart disease increases by age cohort: prevalence is highest among those age 75 and over.[19] The AHA also notes that the average age of the first heart attack is 65.6 for males and 72.0 for females.[20] Thus, it is important that the aging population of Cumberland, Overton, Putnam and White counties have access to outpatient cardiovascular services, such as those the proposed project will offer.

Further, the four counties in the proposed service area – as well as the entirety of the Upper Cumberland region – are highly rural. As shown in Attachment 3N, none of the four service area counties has a population greater than 100,000 residents; Putnam County's population is the largest at 86,309, while Overton County has a population of only 23,407.

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17 Accessed via the Boyd Center Population Projections, The University of Tennessee Knoxville, https://tnsdc.utk.edu/estimates-and-projections/boyd-center-population-projections/.

18 For example, "Cookeville among American's 100 best places to retire." *Upper Cumberland Business Journal,* December 4, 2018, accessed at https://www.ucbjournal.com/cookeville-among-americas-100-best-places-to-retire/.

19 "Heart Disease Prevalence." CDC, National Center for Health Statistics. Last reviewed August 4, 2024, accessed at https://www.cdc.gov/nchs/hus/topics/heart-disease-prevalence.htm.

20 "2024 Heart Disease and Stroke Statistics Update Fact Sheet." American Heart Association. Accessed June 16, 2026, at https://www.heart.org/-/media/PHD-Files-2/Science-News/2/2024-Heart-and-Stroke-Stat-Update/2024-Statistics-At-A-Glance-final_2024.pdf.

The largest urban area in the service area is Cookeville – the location of the proposed project – a city with a population of approximately 36,000; in contrast, Nashville, the next largest city to Cookeville by mileage, has a population of over 700,000. Indeed, based on Boyd Center data, all four service area counties are considered rural.[21] Compared to patients in urban areas, rural patients are more likely to suffer from chronic diseases and worse health outcomes, which leads to elevated rates of morbidity and excess mortality.[22] Residents in these areas also face multiple barriers to accessing vital medical care, including longer travel distances to healthcare providers, higher uninsured rates, and poorer health literacy.[23]

The rurality described above correlates to these counties lagging behind the state on key socioeconomic measures. For example, median household income falls short of the state average for all four service area counties, and the uninsured rate is higher compared to Tennessee in three of the four counties. Putnam County in particular experiences some of the most significant disparities: its poverty rate (18.4 percent) represents roughly 15,800 residents and exceeds Tennessee's statewide poverty rate by nearly 5.0 percent. All four counties have poverty rates that exceed or equal that of Tennessee overall, as shown in the table below.

Socioeconomic Indicators, Service Area Counties

County	*Median Household Income*	*Poverty Rate*	*Proportion of Uninsured Under Age 65*
Cumberland	$60,375	13.2%	11.5%
Overton	$48,959	13.5%	12.6%
Putnam	$58,912	18.4%	12.0%
White	$52,188	11.6%	12.9%
Tennessee	**$69,595**	**13.5%**	**11.6%**

Source: U.S. Census Bureau, QuickFacts. Accessed at https://www.census.gov/quickfacts/fact/table/US/PST045225

A substantial and growing body of research shows that socioeconomic disadvantages affect cardiovascular risk and outcomes. In a 2018 review, the AHA concluded that socioeconomic position, as measured by income, educational attainment, employment status, and neighborhood environment, can shape cardiovascular risk to a degree comparable with established clinical factors such as high blood pressure and diabetes.[24] In 2023, a study analyzing national data reached a similar conclusion: after controlling for sex, age, race, and conventional cardiovascular risk factors (such as weight), adults in the lowest household income tier were six times more likely to die from a cardiac event. Additionally, relative to adults in the top income tier, their overall

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21 "Tennessee County Geographic Classifier Reference File." Tennessee State Data Center, Boyd Center for Business and Economic Research, The University of Tennessee at Knoxville. February 5, 2025, accessed April 13, 2026, at https://tnsdc.utk.edu/2023/09/28/2023-tennessee-county-geographic-classifier-reference-file/.

22 Cohen, Steven A and Greaney, Mary L. "Aging in Rural Communities." *Current Epidemiology Reports*, 2023, 10(1), pp. 1-16. Published online November 9, 2022. Accessed April 13, 2026, at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9644394/.

23 "Healthcare Access in Rural Communities." *Rural Health Information Hub*. Last updated November 9, 2023. Accessed April 13, 2026, at https://www.ruralhealthinfo.org/topics/healthcare-access#barriers.

24 Schultz, William M. et al. "Socioeconomic Status and Cardiovascular Outcomes: Challenges and Interventions." Circulation, vol. 137, 2018, pp. 2166–2178. Accessed at https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.117.029652.

mortality risk was nearly four times higher. Cumulatively, the study found that, as income levels increased, the incidence rates of coronary artery disease, heart failure, and stroke declined.[25] More recently, a 2025 study reiterated the compounding impacts of income and education on health outcomes: among adults in the bottom four-fifths of income earners, those without a college degree faced substantially elevated health risks compared to those in the highest earing, college-educated group. The odds of heart failure were more than six times greater, and the odds of stroke were more than three times higher; these gaps persisted even after accounting for demographic and clinical differences.[26] Lack of healthcare insurance carries similar health risks: a national registry study of more than 3,700 heart attack patients found that uninsured individuals, along with insured patients who reported financial concerns about paying for care, took significantly longer to seek emergency treatment after symptom onset than fully insured patients without such concerns – a delay with serious clinical consequences.[27]

These findings have also been studied and confirmed at the county level: a 2023 analysis spanning more than 3,100 U.S. counties found that income, food security, and housing stability were among the strongest predictors of cardiovascular mortality nationwide.[28] By expanding access to lower cost, high-quality cardiovascular care resources in Cumberland, Overton, Putnam, and White counties, the project will directly address the unique health burdens that service area patients experience due to these disparities.

Quality

TN Heart Cardiovascular Surgery Center will operate under comprehensive internal policies and processes, ensuring optimal outcomes and safe care delivery at every step. Atria Health, the project's management partner, has demonstrated expertise in developing policies and procedures that maintain the safety of cardiac procedures in an ambulatory setting and measure established clinical quality targets. These same proven policies will govern the services offered at the proposed ASTC. All patient care decisions, including determining the appropriate site of care for patients, will be directed by TN Heart physicians' clinical judgement and knowledge, combined with robust and clear patient selection protocols.

An admission/treatment policy will govern the project's ambulatory cardiovascular services, identifying the specific patients for whom outpatient cardiovascular care is not appropriate, subject to the attending TN Heart physician's oversight and final clinical decision.[29] This policy's exclusions and limitations will ensure that only clinically appropriate patients receive outpatient

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25 Minhas, Abdul Mannan Khan et al. "Family Income and Cardiovascular Disease Risk in American Adults." Scientific Reports, vol. 13, article 279, 2023. Accessed at https://www.nature.com/articles/s41598-023-27474-x.

26 Abdalla, Salma M. et al. "Income, Education, and the Clustering of Risk in Cardiovascular Disease in the US, 1999–2018: An Observational Study." The Lancet Regional Health – Americas, vol. 44, article 101039, 2025. Accessed at https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(25)00049-3/fulltext.

27 Smolderen, Kim G. et al. "Health Care Insurance, Financial Concerns, and Delays to Hospital Presentation in Acute Myocardial Infarction." *JAMA*, vol. 303, no. 14, 2010, pp. 1392–1400. Accessed at https://jamanetwork.com/journals/jama/fullarticle/185673.

28 Son, Heejung et al. "Social Determinants of Cardiovascular Health: A Longitudinal Analysis of Cardiovascular Disease Mortality in US Counties From 2009 to 2018." *Journal of the American Heart Association*, vol. 12, no. 2, 2023, e026940. Accessed at https://www.ahajournals.org/doi/10.1161/JAHA.122.026940.

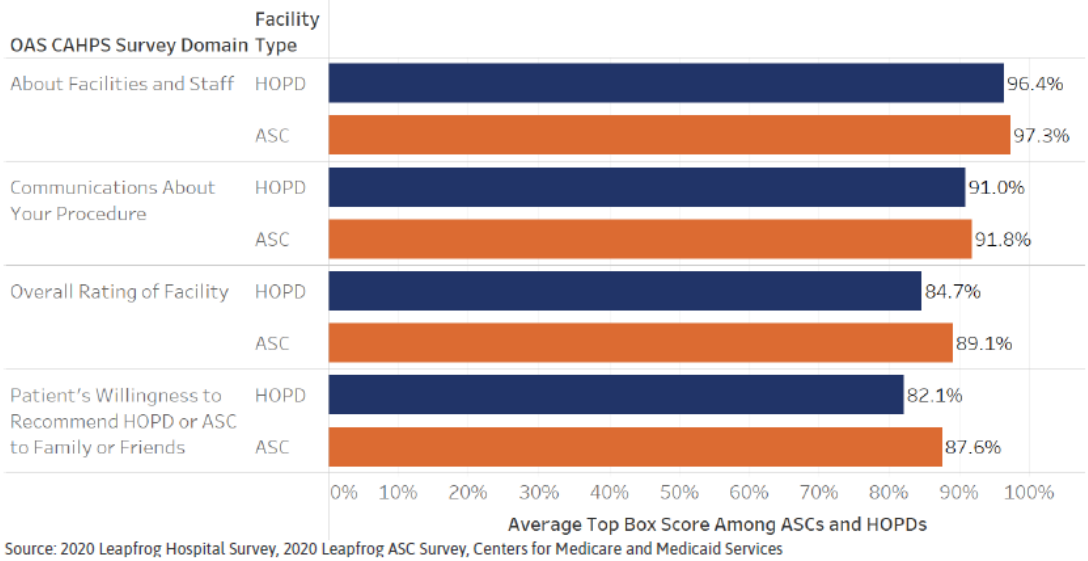
29 Please note that Atria Health outpatient facilities admit and treat all patients without regard to race, color, national origin, handicap, religious or fraternal organization, or age.

cardiovascular procedures at the proposed ASTC. These same restrictions will apply to services offered at the ASTC, ensuring that patients receive care in the most appropriate setting at all times. As an additional safety measure, TN Heart will require all patients to undergo a pre-operative screening call to confirm that none of the clinical exclusion criteria apply. See Attachment 1N-1.2 for the complete collection of quality-of-care policies maintained and utilized by Atria Health.

TN Heart will also maintain a comprehensive Patient Safety Plan that defines the roles and responsibilities of the Patient Safety Officer, ensuring that serious patient events are immediately and effectively managed. Patient safety is further governed by a Patient Safety Committee overseen by the Patient Safety Officer. This committee evaluates all safety reports, reviews the effectiveness of implemented patient safety measures, and makes recommendations to prevent future events. This patient safety framework will apply in full to the proposed project.

Providing cardiovascular services in an ASTC also aligns with a larger body of evidence suggesting that patients prefer ambulatory care settings – and that those preferences reflect meaningfully better experiences. For example, a survey of adult patients conducted by The Leapfrog Group, a nonprofit healthcare organization that collects and disseminates data on safety practices in hospitals and ASCs, found that patients preferred ASCs over hospital-based outpatient departments ("HOPDs") in every single category measured.[30] This included the quality of each facility's staff and campus, the quality of each facility's communications, the overall rating of each facility, and the patient's likelihood to recommend the facility to a family member or friend. Across every measure patients were asked to evaluate, the ASC setting outperformed the hospital setting – a consistent, unambiguous result. The Leapfrog Group's diagram summarizing these results has been reproduced below; please note that this survey measured all types of care across ASCs, not only cardiovascular services.

Figure 3: Average Top Box Score (percent of patients who gave the most favorable response) on the same-day surgery patient experience (OAS CAHPS) Survey (*n=363 ASCs, 1,252 hospitals providing outpatient care*)



Source: 2020 Leapfrog Hospital Survey, 2020 Leapfrog ASC Survey, Centers for Medicare and Medicaid Services

30 The Leapfrog Group. "What Patients Think About Their Hospitals and Ambulatory Surgery Centers: An Analysis of Patient Experience Surveys." 2021, p. 3.

Given the weight of regulatory guidance and patient-based evidence supporting ambulatory care, as well as the rigorous internal guidelines that will govern the proposed project's operations, TN Heart Cardiovascular Surgery Center is well-positioned to deliver safe, high-quality care to patients.

Consumer Advantage

The project benefits both service area patients and the broader healthcare delivery system. As discussed in the "Need" section above, existing cardiac catheterization laboratories in the service area operate above optimum capacity. In addition, a significant portion of the cases performed at the two service area hospitals are outpatient. As a result, service area patients experience significant delays in treatment and are receiving less timely care in a setting that is misaligned with their clinical needs. For example, in some cases TN Heart patients are waiting up to eight months for an ASTC-appropriate procedure. These delays contribute to unnecessary readmissions, treatments, and medical care costs for patients and stem from service area hospitals' capacity constraints and need to prioritize higher-acuity and emergent cases.

The proposed project decompresses the hospitals in the service area, allowing them to focus their already limited capacity and resources on providing the cardiovascular care that can only be provided in an inpatient setting – mainly, emergent care, care requiring overnight, inpatient boarding, and higher-risk outpatient cases. At the same time, by transitioning appropriate outpatient cardiovascular procedures to the ASTC setting, the proposed project enables patients to receive more timely care in a setting that is aligned with their clinical needs. Indeed, even if the proposed project is approved, cardiac catheterization utilization in the service area will remain well-above state standards – more than 1.3 times full capacity and nearly two times optimal capacity. Thus, by enabling providers to focus on the care they are best equipped to deliver, the project will cumulatively improve the service area's healthcare delivery system.

As discussed above, the proposed project will also be the only outpatient option for cardiovascular care in the service area. Currently, service area patients can only receive cardiovascular care in the hospital setting, regardless of whether their condition is emergent. Hospitals can often be a source of anxiety and discomfort for patients who are not experiencing critical conditions. Seeking care in a setting where emergent care is present – as opposed to an outpatient facility where only lower-acuity, elective procedures are performed – can make a patient's healthcare experience far more stressful than necessary. The proposed project therefore reflects sound system-level care design and directly responds to patients' own stated preferences. The development of such a setting will greatly benefit patients in the service area by ensuring they have access to a lower-stress setting.

Additionally, the development of the proposed project will deliver concrete, measurable, and substantial consumer savings. For example, federal reimbursement for procedures performed in an ASC setting is 58 percent lower than in the HOPD setting,[31] generating significant savings for both the Medicare program and patients.[32] With respect to cardiac catheterization services specifically, CMS reimburses ASCs approximately 40 percent less for angioplasties than it does

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[31] Ambulatory Surgery Center Association. "Medicare Cost Savings Tied to Ambulatory Surgery Centers," p. 7.

[32] Between 2008 and 2011, the lower rate of reimbursement at ASCs generated a total of $7.5 billion in savings for the Medicare program and its beneficiaries. $6 billion of these savings were realized by the federal Medicare program, while $1.5 billion was saved by Medicare beneficiaries themselves. See "Medicare Cost Savings Tied to Ambulatory Surgery Centers," p. 8.

HOPDs.[33] According to estimates from CMS, a migration of just five percent of the 700,000 annual Medicare coronary interventions performed would result in $20 million of savings in Medicare payments and five million dollars of savings in patient co-pays.[34] Medicare data also indicates that a patient would save at least 300 dollars out of pocket when receiving a diagnostic cardiac catheterization procedure at an ASC instead of an HOPD.[35] Based on Medicare.gov's Procedure Price Lookup tool, nearly all cardiac catheterization procedures included in CMS's most current list of Medicare-covered ASC procedures will result in, on average, lower out-of-pocket costs for Medicare patients. The specific price-saving figures for all cardiac catheterization procedures included in CMS's list of Medicare-covered ASC procedures are shown in the table below.

Estimated Average Payments for Medicare Cardiac Catheterization Procedures

CPT Code	Cath Type	Patient Payment		Facility Fee		Savings Calculations		
		ASTC	Hospital	ASTC	Hospital	Patient Savings	Total Savings	% Patient Savings
93451	Diagnostic	$511	$1,033	$1,707	$3,312	$522	$1,605	50.5%
93452	Diagnostic	$516	$1,038	$1,707	$3,312	$522	$1,605	50.3%
93453	Diagnostic	$563	$1,085	$1,707	$3,312	$522	$1,605	48.1%
93454	Diagnostic	$516	$1,038	$1,707	$3,312	$522	$1,605	50.3%
93455	Diagnostic	$536	$1,058	$1,707	$3,312	$522	$1,605	49.3%
93456	Diagnostic	$559	$1,081	$1,707	$3,312	$522	$1,605	48.3%
93457	Diagnostic	$579	$1,101	$1,707	$3,312	$522	$1,605	47.4%
93458	Diagnostic	$543	$1,065	$1,707	$3,312	$522	$1,605	49.0%
93459	Diagnostic	$558	$1,080	$1,707	$3,312	$522	$1,605	48.3%
93460	Diagnostic	$582	$1,104	$1,707	$3,312	$522	$1,605	47.3%
93461	Diagnostic	$606	$1,128	$1,707	$3,312	$522	$1,605	46.3%
92920	Interventional	$846	$1,239	$3,849	$5,814	$393	$1,965	31.7%
92928	Interventional	$1,553	$1,828*	$7,308	$11,794	$275	$4,486	15.0%
93650	Interventional	$1,287	$1,692*	$5,943	$7,968	$405	$2,025	23.9%
93653	Interventional	$3,977	$1,878*	$19,175	$26,703	-$2,099	$7,528	N/A*
93654	Interventional	$4,067	$1,907*	$19,482	$26,703	-$2,160	$7,221	N/A*
93656	Interventional	$4,212	$1,897*	$20,255	$26,703	-$2,315	$6,448	N/A*

Source: "Procedure Price Lookup," Medicare.gov, Centers for Medicare & Medicaid Services, accessed July 2, 2026, at https://www.medicare.gov/procedure-price-lookup//.

Note: Estimated pricing information is not yet available for CPT codes 93655 and 93657.

* Medicare.gov's Procedure Price Lookup tool for these codes reflects pricing for a limited subset of Medicare patients that CMS is in the process of updating. For Medicare patients without supplemental insurance coverage, Medicare caps copayments at $1,676 in hospital outpatient departments, which may apply to this procedure. Nonetheless, the savings will still be realized by approximately 94 percent of patients, according to the Medicare Payment Advisory Commission ("MedPAC").

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33 Modern Healthcare. "Medicare payment change will shift lucrative heart procedures out of the hospital," March 21, 2020.

34 Department of Health and Human Services Centers for Medicaid Services. Changes to hospital outpatient prospective payment and ambulatory surgical center payment systems and quality reporting programs, etc. 2019; (84 Fed. Reg. 61142): 61142-61492.

35 See https://www.medicare.gov/procedure-price-lookup/cost/92928, which notes a patient paying $1,553 (on average) versus $1,828 (on average) at an ambulatory center and a hospital outpatient department, respectively, for a percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch. Accessed July 2, 2026.

TN Heart's own experience providing outpatient cardiac catheterization procedures reinforces these cost savings. According to internal data and applying the 2026 Medicare payment rate schedule, moving clinically appropriate cardiac catheterization procedures from a hospital-based setting to an outpatient surgery center setting would reduce the total cost of care by up to 60 percent, depending on the cardiac catheterization procedure performed. Cumulatively, based on an analysis of various payors' reimbursement rates for the procedures that will be performed in the proposed surgery center, the project will result in significant annual cost savings for patients and payors.

Conclusion

In sum, this project responds to a documented and growing unmet need for outpatient cardiovascular services in the proposed service area. Demand for these services is increasing at more than four times the rate of the underlying population. At the same time, existing service area catheterization labs have no capacity to meet that demand, operating well-above full capacity. Without the proposed project, patients cannot get the timely cardiovascular care they need. This is exacerbated by the service area's demographic profile, including its aging and rural patient population and socioeconomic conditions, such as higher rates of poverty and uninsurance, which correlate with worse health outcomes. This is especially true in Putnam County, from which the project will draw the majority of its projected patients.

In addition to expanding access to essential cardiovascular care for a population in acute need, the proposed project will deliver meaningful cost savings to patients and payors alike. In this way, the proposed project addresses documented capacity constraints, serves a community with demonstrated unmet need for outpatient cardiovascular care, and aligns with patient preferences.

APPENDIX B. Revised and Updated Standards and Criteria for Cardiac Catheterization services

STATE OF TENNESSEE

STATE HEALTH PLAN

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

CARDIAC CATHETERIZATION SERVICES

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide cardiac catheterization services. Rationale statements for each standard are provided in an appendix. Existing providers of cardiac catheterization services are not affected by these standards and criteria unless they take an action that requires a new certificate of need (CON) for such services.

These standards and criteria are effective immediately as of November 18, 2009, the date of approval and adoption by the governor of the State Health Plan. Applications to provide cardiac catheterization services that were deemed complete by HSDA prior to this date shall be considered under the Guidelines for Growth, 2000 Edition.

Definitions

Cardiac Catheterization: An invasive medical procedure performed within a cardiac catheterization laboratory and used as a diagnostic or therapeutic tool for heart and circulatory conditions. During a catheterization procedure a catheter is inserted into .a blood vessel and is manipulated by a physician to travel along the course of the vessel in the chambers or vessels of the heart. Imaging equipment is used as an aid in placing the catheter tip in the desired position. Once in place the physician is able to perform various diagnostic and/or therapeutic procedures. Cardiac catheterization services include diagnostic cardiac catheterizations, therapeutic cardiac catheterizations, and electrophysiological (EP) studies, both diagnostic and therapeutic.

Cardiac Catheterization Laboratory: A room or suite of rooms in a hospital,

freestanding facility, or a mobile laboratory that has the equipment, staff, and support services to function as an integrated unit for the purposes of performing cardiac catheterization procedures.

Diagnostic Cardiac Catheterization: The performance of cardiac catheterization for the purpose of detecting and identifying defects in the great arteries or veins of the heart, or abnormalities in the heart structure, whether congenital or acquired. Diagnostic cardiac catheterization services include, but are not limited to, left heart catheterizations, right heart catheterizations, left ventricular angiography, coronary procedures, and other cardiac catheterization services of a diagnostic nature. Post-operative evaluation of the effectiveness of prostheses also can be accomplished through a diagnostic catheterization procedure.

Therapeutic Cardiac Catheterization: The performance of cardiac catheterization for the purpose of correcting or improving certain conditions that have been determined to exist in the heart or great arteries or veins of the heart. This includes Percutaneous Coronary Interventions (PCI) or any catheter-based treatment procedures for relieving coronary artery narrowing. Included within this definition are procedures such as rotational atherectomy, directional atherectomy, extraction atherectomy, laser angioplasty, implantation of intracoronary stents, brachytherapy, and other catheter treatments for treating coronary atherosclerosis.

Cardiac Catheterization Procedure: A medical diagnostic or therapeutic intervention during which a catheter is manipulated by a physician to travel along the course of a blood vessel into the chambers or vessels of the heart. When the catheter is in place, the physician is able to perform various diagnostic studies and/or therapeutic procedures in the heart. For the purposes of measuring operator/physician volume under Standard 7, each procedure performed during a cardiac catheterization case following the catheterization shall count toward that operator/physician's volume.

Electrophysiological (EP) Study: An invasive procedure that tests the heart's electrical system through a catheter typically from the groin to the heart. Once the catheter is placed in the heart by the physician, electrical signals are sent through the catheter to the heart tissue to evaluate the electrical conduction system contained within the heart muscle tissue. An EP study can be performed solely for diagnostic purposes to pinpoint the exact location of electrical signals (cardiac mapping) or in conjunction with a therapeutic procedure called catheter ablation. The procedures (both diagnostic and therapeutic studies) are performed in a specially equipped laboratory and under controlled clinical circumstances by cardiologists and nurses who sub-specialize in electrophysiology.

Diagnostic Electrophysiological Study: An invasive test performed that allows an electrophysiologist to determine the details of abnormal heartbeats, or arrhythmias. Measurements related to the electrical system within the hea11 are

made at baseline and during stimulation to provide information about the exact location and type of arrhythmia so that specific treatment can be given. During this testing, cardiac mapping through the use of catheter manipulation or 3-dimensional systems may take place. The arrhythmia may start from any area of the heart's electrical conduction system.

Therapeutic Electrophysiological Study: In conjunction with the diagnostic electrophysiological study, a therapeutic procedure called catheter ablation may be performed. Catheter ablation is most commonly done through the delivery of radio-frequency energy or cryo-energy to an area of the heart to selectively destroy cardiac tissue.

Peripheral Vascular Catheterization: An invasive medical procedure that may be performed within a cardiac catheterization laboratory. The procedure involves the inse11ion of a catheter into a peripheral artery or vein for diagnostic or therapeutic purposes. This procedure is used to evaluate the presence of plaque build-up (Atherosclerosis) in the peripheral arteries - meaning the arteries to the lower abdomen, kidneys, arms, legs, head, neck and feet.

Diagnostic Peripheral Vascular Catheterization: An invasive diagnostic test in which a catheter is inserted into a peripheral vein or artery to inject dye (contrast medium). X-rays are taken of the dye within the arteries, allowing clear visualization of the blood flow inside the artery where peripheral vascular disease can occur. This test may be performed within a cardiac catheterization laboratory.

Therapeutic Peripheral Vascular Catheterization: A procedure that can be used to dilate (widen) narrowed or blocked peripheral arteries or to remove a clot or plaque from arteries. In conjunction with or subsequent to peripheral vascular catheterization, a therapeutic procedure may be performed by various means that include balloon angioplasty, stenting, and atherectomy or other mechanical intervention to restore blood flow to the effected organ or tissue. These procedures may be performed within a cardiac catheterization laboratory.

a) Balloon Angioplasty: A thin tube called a catheter with a deflated balloon on its tip is passed into the narrowed artery segment. The balloon is then inflated, compressing the plaque and dilating the narrowed artery so that blood can flow more easily. The balloon is then deflated and the catheter is withdrawn.
b) Peripheral Stenting: A cylindrical, wire mesh tube that expands and locks open - may be placed in the narrowed artery with another catheter to keep the diseased artery open.
c) Catheter-based Atherectomy: A procedure for opening up an artery using a specialized catheter inserted into a blocked artery to remove a buildup of plaque. The catheter may contain a sharp rotating blade ("burr" device), dissectional device (grinding bit), or laser filament to remove the plaque. It may be used as a complement to angioplasty and stenting.

Note: Additional procedures may be added as technology evolves.

Cardiac Catheterization Case: For the purposes of measuring a facility's volume of cardiac catheterization procedures under Standards 11, 14, 19, and 22, a "case" shall mean one visit to a cardiac catheterization laboratory or another procedure room by one patient, regardless of the number of procedures performed during that visit.

Cardiac Catheterization Weighted Case: For the purposes of these standards and criteria and for measuring laboratory capacity, a "weighted case" shall mean one visit to a cardiac catheterization laboratory or another procedure room by one patient. If multiple procedures are performed between admission and discharge to the laboratory or procedure room, the weighted case is equal to the highest weighted diagnostic-equivalent procedure performed during the case.

Diagnostic-Equivalent Procedure and Weights: For the purposes of measuring laboratory capacity, the following weights will be assigned to each of the following procedure categories. All procedures that fall under the following categories shall count towards measuring laboratory capacity, but only diagnostic and therapeutic cardiac catheterization procedures as defined in these Standards and Criteria may count towards Standards 11, 14, 19, and 22 regarding minimum volume.

Category	Procedures Included	Weight
Diagnostic Cardiac Catheterization	Left heart catheterization, right heart catheterization, left/right heart catheterization, intravascular ultrasound, endomyocardial biopsy	1.0
Diagnostic Peripheral Vascular Catheterization	Abdominal angioplasty with runoff, carotid, renal, bilateral extremity	1.5
Therapeutic Cardiac Catheterization	PCI, atherectomy, ASD/PFO closures, Impella, IABP, valvuloplasty	2.0
Therapeutic Peripheral Vascular Catheterization	All of the procedures in the diagnostic peripheral category with either angioplasty, stent placement, atherectomy, thrombolysis	3.0
Diagnostic Electrophysiological Studies	Atrial and ventricular pacing and recording, device placement	2.0
Therapeutic Electrophysiological Studies	Ablations, lead revision	4.0
Pediatrics	Any cardiac catheterization procedure performed on a person less than 18 years of age	Double the adult weight

Cardiac Catheterization Laboratory Capacity: The capacity of dedicated and multipurpose cardiac catheterization laboratories is equal to 2000 weighted cases per year. This number is based on 50 weeks of 40 hours each, assuming an average case time, including room turnover and setup, of 60 minutes.

Pediatric Cardiac Catheterization Laboratory: A room or suite of rooms in an acute care hospital that has the equipment, staff, and support services to function as an integrated unit for the purposes of performing cardiac catheterization procedures on a person under 15 years of age. Pediatric cardiac catheterization laboratories should only be situated in facilities offering full pediatric cardiac medical and cardiac surgical capabilities, including pediatric open heart surgery.

Mobile Cardiac Catheterization Laboratory: A cardiac catheterization laboratory and transporting equipment that is moved to provide services at two or more host acute care campuses, including facilities located in adjoining or contiguous states of the Continental United States. Mobile cardiac catheterization laboratories shall perform diagnostic procedures only, unless they are permanently fixed at an acute care hospital with on-site open heart surgery capability. However, facilities approved to perform therapeutic cardiac catheterizations without on-site open heart surgery backup may temporarily perform these procedures in a mobile laboratory on the hospital's campus during construction impacting the fixed laboratories.

Mobile Cardiac Catheterization Laboratory Capacity: The capacity measures of a mobile cardiac catheterization laboratory are the same as a regular dedicated or multipurpose cardiac catheterization laboratory; however, capacity shall be measured on a pro-rated schedule per week day of operation (400 weighted cases per week day of operation).

Freestanding Facility: Any professional or business undertaking, whether for profit or not for profit, which offers or proposes to offer any clinical health service in a setting which is not on the campus of an acute care facility. Freestanding facilities may perform diagnostic procedures only.

Service Area: The geographic area defined in terms of counties represented by the applicant as the reasonable area to which the cardiac catheterization laboratory intends to provide services and in which at least 75% of its recipients reside. At least 75% of the population of a service area for cardiac catheterizations should reside within 60 miles driving distance of the .facility.

Age Group-Specific Historical State Utilization Rate: For the purposes of defining need in areas with no existing cardiac catheterization services, applicants should base their projected utilization on age group-specific historical state utilization rates. The age group-specific historical state utilization rates shall be calculated as follows based upon information from the Hospital Discharge Data System and the population estimates maintained by the Department of Health:

- Each age group is defined by the following age intervals: <18, 18-29, 30-39, 5 year intervals for 40-84 (i.e., 40-44, 45-49), and >85.
- For each age group, multiply the number of state residents in that age category by the corresponding number of cardiac catheterization

procedures performed on patients in that age category.

- Determine the age group-specific historical state utilization rate based upon the average of single-year rates calculated from the most recent three years of available data.

The age group-specific historical state utilization rate will be calculated separately for diagnostic and therapeutic catheterization cases and will be a running average. The Department of Health shall maintain the ongoing age group-specific historical state utilization rate to avoid breaches of patient confidentiality.

Standards and Criteria Regarding Certificate of Need Applications for All Cardiac Catheterization Services

Applicants proposing to provide any type of cardiac catheterization services must meet the following minimum standards:

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: The applicant so attests.

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: TN Heart Cardiovascular Surgery Center is required to be licensed and will be licensed as a Class C ASTC through the Tennessee Health Facilities Commission. Stern will also seek accreditation through The Joint Commission ("TJC"), which is consistent with Atria Health's established practice of obtaining TJC accreditation for its ASTCs in other states.

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: The proposed facility will be located in Cookeville (Putnam County). CRMC, the only hospital that provides open heart surgery within a 60-minute drive time of the proposed ASTC is also located in Cookeville (Putnam County) and is well within the required 60-minute transfer window. CRMC is approximately a 10-minute drive from the location of the proposed project, and as such can accessibly receive emergency transfers from the TN Heart Cardiovascular Surgery Center as necessary.

   Should any patient at TN Heart Cardiovascular Surgery Center require open heart surgery services, TN Heart will maintain formalized protocols and transfer agreements for immediate and efficient transfer to this facility. TN Heart will also perform regular mock codes to ensure that its staff is able to execute these protocols according to the policies and procedures. These protocols, including both non-emergency and emergency transfer policies, are collected in Attachment 1N-1.2.

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: Both TN Heart and Atria Health maintain comprehensive policies and

procedures governing the safe and high-quality provision of cardiovascular care. See the previously referenced Attachment 1N-1.2, which includes the quality assurance and performance policies applicable to services at TN Heart Cardiovascular Surgery Center.

Stern also agrees to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, as appropriate.

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: The applicant so attests.

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/qual ityand science/cl in ical/consensus/angiography/dirIndex.htm. 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: As evidenced by the discussion of the proposed project's alignment with ACC guidelines and standards above, the applicant so attests.

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: TN Heart Cardiovascular Surgery Center will employ 13.6 FTEs in its first full project year, including 10.6 FTEs in direct patient care positions and 3.0 FTEs in non-patient care positions. Because the project is a proposed new facility, no existing FTEs are reported. Of note, one or more anesthesiologists would be granted privileges to support patient care; however, these providers will provide services at the proposed ASTC through their own provider number, and as such are not included in the staffing figures above. See the response to Question 8Q for the detailed staffing table.

   TN Heart is an established cardiovascular physician group with a long history of delivering care to patients in the proposed service area. By joining Stern's comprehensive network of cardiovascular providers with more than two dozen locations across Tennessee, Mississippi, and Arkansas, the project will be supported by two providers with the operational experience necessary to recruit qualified staff. Further, the project's manager, Atria Health, has experience managing multiple cardiovascular practices across the country, which will also aid in staffing the proposed project.

   Both TN Heart and Atria Health have staffing guidelines for ambulatory facilities and

internal employment policies that will apply to the services offered at TN Heart Cardiovascular Surgery Center. Please see the policies included in Attachment 1N-1.2, which detail the staffing requirements for each procedure to be performed at the proposed ASTC. Attachment 1N-1.2 also contains the general employment policies for Atria Health, which will apply to the proposed project.

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: According to the 2024 JAR for hospitals, the most recent year for which data are available, two providers of cardiac catheterization services operate in the proposed service area: Cumberland Medical Center, located in Cumberland County; and CRMC, located in Putnam County. No existing ASTC provides cardiac catheterization services in the proposed service area.

   JAR data establish that there is a clear need for the proposed project. The providers in the proposed service area operated at 251.25 percent of state optimum standards from 2022 to 2024, with each lab providing an average of more than 3,500 weighted cases per year. This is 176 percent of the state's full capacity standard.

Historical Cardiac Catheterization Utilization – Service Area Counties
2022-2024

Cath Labs	*2022-2024 Avg. Weighted Diagnostic Caths*	*Diagnostic Caths per Lab*	*2022-2024 Avg. Weighted Therapeutic Caths*	*Therapeutic Caths per Lab*	*2022-2024 Avg. Weighted Diagnostic and Therapeutic Caths*	*% Full Capacity (2,000 Cases)*	*% Optimum Capacity (1,400 Cases)*
3	4,530	1,510.11	6,022	2,007.44	10,552.67	175.88%	251.25%

Source: Hospital JARs, 2022-2024.
Note: Fayette County and Tipton County have no cardiac catheterization labs.

As discussed above, however, these utilization figures are likely understated, as Cumberland Medical Center did not perform adult outpatient EP procedures in 2022, 2023, or 2024 – procedures that will be performed at the proposed ASTC. Only the two cardiac catheterization labs at CRMC offer similar services to the proposed project. In 2024, CRMC's catheterization labs operated at 252 percent of full capacity and 360 percent of optimal capacity, averaging over 5,000 cases per cardiac catheterization lab. These figures more accurately reflect the capacity constraints patients face in accessing necessary outpatient cardiovascular services. The proposed project must be approved to provide these critical services and address the access challenges in the service area.

Additionally, and as noted in the response to both Question 5N and Question 3C, Stern has also provided Hospital Discharge Data System ("HDDS") data from the Tennessee Department of Health for cardiac catheterization services in the proposed service area in Attachment 5N. However, the data from the JARs and from HDDS differ significantly. For example, JAR data indicate that CRMC performed 4,220 weighted cases of outpatient cardiac procedures and 4,196 weighted cases of inpatient cardiac procedures, including 1,296 outpatient cardiac catheterizations and 899 inpatient cardiac catheterizations. By contrast, HDDS data indicate that the hospital performed zero inpatient cardiac

catheterizations and fewer than five outpatient cardiac catheterizations. It is clear that this is not possible and does not accurately reflect service area cardiac catheterization utilization.

As with Stern's recently unanimously approved Shelby County project (CN2605-013A), there is no question JAR data offer a more reliable basis for analyzing the utilization of existing providers in the service area. JAR data follow a transparent methodology that allow the weighting of procedures to be verified against the definitions set forth in the Standards and Criteria for Cardiac Catheterization Services. HDDS data, by contrast, are released by the Tennessee Department of Health as weighted procedure counts with no accompanying documentation of how weights were applied. Additionally, HDDS data sets only include records with a revenue code designating the cardiac catheterization lab within a hospital or facility setting. In explaining the HDDS data request results for the proposed project, Tennessee Department of Health staff stated that although CRMC appeared to have performed catheterization procedures, because the claims lacked the specific revenue code, the claims were excluded from the HDDS data pull. As a result, it is not possible to confirm whether the HDDS weighting methodology aligns with the definitions established in the Standards and Criteria and to reconcile the volumes with the JAR data. The JAR data, which can be verified against those definitions, clearly demonstrate that existing providers are operating well above full capacity and support that an additional provider of cardiac catheterization services is needed.

The need for a new provider is also supported by the range of qualitative factors previously discussed, including cost savings for patients and payors, improved convenience and access for the communities served, and quality measures that demonstrate Stern's ability to deliver superior outcomes.

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. The proposed service area contains existing cardiac catheterization services.

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;

       Response: Putnam County is a Medically Underserved Population Low Income area. Cumberland, Overton, and White counties are all designated as Medically Underserved Areas.[36]

    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;

       Response: The total and age 18-and-older populations of all four counties in the proposed service area are projected to experience growth and aging through 2030, as shown in Attachment 3N. Moreover, compared to Tennessee overall, patients in each of these counties experience disparities in social determinants of health, such as lower median household incomes, higher levels of poverty, and higher rates of disability and uninsurance,[37] that are closely associated with increased risk for hypertension, diabetes, obesity, and heart disease.[38]

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

       Response: Not applicable.

    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: The proposed project will contract with TennCare and Medicare.

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[36] As identified using the HRSA Find MUA/P tool, accessed at https://data.hrsa.gov/topics/health-workforce/shortage-areas/mua-find.

[37] U.S. Census Bureau QuickFacts. Accessed July 7, 2026 at https://www.census.gov/quickfacts/fact/table/TN,putnamcountytennessee/PST045225.

[38] Schultz, William M. et al. "Socioeconomic Status and Cardiovascular Outcomes: Challenges and Interventions." Circulation, vol. 137, 2018, pp. 2166–2178. Accessed at https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.117.029652.

Specific Standards and Criteria for the Provision of Diagnostic Cardiac Catheterization Services Only

If an applicant does not intend to provide therapeutic cardiac catheterization services, the HSDA should place a condition on the resulting CON limiting the applicant to providing diagnostic cardiac catheterization services only. Applicants proposing to provide only diagnostic cardiac catheterization services should meet the following minimum standards:

11. Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 300 diagnostic cardiac catheterization cases per year by its third year of operation. 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. if the applicant is proposing services in a rural area where the HSDA determines that access to diagnostic cardiac catheterization services has been limited, and if the applicant is pursuing a partnership with a tertiary facility to share and train staff, the Agency may determine that a minimum volume of 200 cases per year is acceptable. Only cases including diagnostic cardiac catheterization procedures as defined by these Standards and Criteria may count towards meeting this minimum volume standard.

    Response: Not applicable. The proposed project will not provide only diagnostic cardiac catheterization services.

12. High Risk/Unstable Patients: Such applicants should (a) delineate the steps, based on the ACC Guidelines, that will be taken to ensure that high-risk or unstable patients are not catheterized in the facility, and (b) certify that therapeutic cardiac catheterization services will not be performed in the facility unless and until the applicant has received Certificate of Need approval to provide therapeutic cardiac catheterization services.

    Response: Not applicable. The proposed project will not provide only diagnostic cardiac catheterization services.

13 Minimum Physician Requirements to Initiate a New Service: The initiation of a new diagnostic cardiac catheterization program should require at least one cardiologist who performed an average of 75 diagnostic cardiac catheterization 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: Not applicable. The proposed project will not provide only diagnostic cardiac catheterization services.

Specific Standards and Criteria for the Provision of Therapeutic Cardiac Catheterization Services

Applicants proposing to provide therapeutic cardiac catheterization services must meet the following minimum standards:

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: The projected weighted cardiovascular procedures for TN Heart Cardiovascular Surgery Center by its second full project year (2029) are presented in the table below.

Projected Weighted Cardiology Procedures
TN Heart Cardiovascular Surgery Center

Procedure Category	*2028 (PY1)**	*2029 (PY2)**
Cardiac Ablations	294	592
Diagnostic Cardiac Catheterizations	480	967
Electrophysiology Studies and Cardiac Rhythm Device Implantations	367	738
Loop Procedures	92	185
Therapeutic Cardiac Catheterizations	94	189
Peripheral Vascular Catheterizations	22	45
Total	**1,349**	**2,716**

* Project year.

Please see Attachment 6N for a detailed discussion of the assumptions used to project the utilization shown above. Please also see the previously referenced Attachment 1N-1.1 for the scope of services to be provided at TN Heart Cardiovascular Surgery Center, which includes the procedures above.

Using the projected procedures above, the two-year average of diagnostic cardiac catheterization procedures for TN Heart Cardiovascular Surgery Center's first two full project years is 724 weighted procedures, and the two-year average of therapeutic cardiac catheterization procedures for TN Heart Cardiovascular Surgery Center's first two full project years is 142 weighted procedures.

Projected Weighted Cardiology Procedures
Assessment of Performance Standard

Procedure Type	*Two-Year Weighted Procedure Average PY2-PY3*
Diagnostic Cardiac Catheterizations	724
Therapeutic Cardiac Catheterizations	142
Total	**866**

These projections confirm that TN Heart Cardiovascular Surgery Center exceeds the minimum volume standard: it will perform significantly more than 400 total diagnostic and therapeutic cardiac catheterization cases by its third year of operation and well over 75 of those cases will be therapeutic cardiac catheterization cases, as required.

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

    Therapeutic procedures should not be performed in freestanding cardiac catheterization laboratories, whether fixed or mobile. Mobile units may, however, perform therapeutic procedures provided the mobile unit is located on a hospital campus and the hospital has on-site open heart surgery. In addition, hospitals approved to perform therapeutic cardiac catheterizations without on-site open heart surgery backup may temporarily perform these procedures in a mobile laboratory on the hospital's campus during construction impacting the fixed laboratories.

    Response: As discussed in the "Overview and Context" section above, accepted industry guidelines – including the most current SCAI expert consensus statements and CMS policy – establish that certain therapeutic procedures, including those that the project proposes to provide as listed in Attachment 1N-1.1, can be safely performed in a freestanding surgery center setting. Multiple states, including Tennessee with its recent approval of Stern Cardiovascular Surgery Center in Shelby County (CN2605-013A), have authorized freestanding sites of cardiac catheterization care consistent with this guidance. Additionally, according to the 2024 hospital JAR data, the most recent year for which hospital JAR data are available at the time of drafting this application, of the 143 hospitals in Tennessee that do *not* have open heart surgery capabilities, 30 provided therapeutic cardiac catheterization procedures. This further demonstrates that these procedures can be performed safely in a setting without immediate open heart surgery capabilities.

    See also the project's detailed emergency transfer policy, included in the previously referenced Attachment 1N-1.2, which would apply in the event a patient required open heart 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: TN Heart has multiple board-certified cardiologists who have pledged support to perform procedures at TN Heart Cardiovascular Surgery Center. TN Heart currently anticipates that eight existing TN Heart diagnostic and interventional cardiologists will perform procedures at the proposed facility: Dr. Mariano Battaglia, Dr. Stacy D. Brewington, Dr. Alex Case, Dr. Vertilio M. Cornielle, Dr. Brent Klinkhammer, Dr. Carlos Podesta, Dr. Noel Torres, and Dr. Mark Wathen. However, all TN Heart cardiologists, as well as outside physicians, will be eligible to provide care at the proposed ASTC. Of these TN Heart cardiologists, Dr. Carlos Podesta performed an average of 75 therapeutic procedures over the most recent five-year period.

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: The project will not provide emergent therapeutic cardiac catheterization procedures. As established in the “Overview and Context” section above, multiple professional organizations – including SCAI, ACC, and AHA – have determined that certain therapeutic cardiac catheterization procedures can be performed safely in an outpatient surgery center setting, with outcomes comparable to those achieved in a hospital setting, even if such services are not available on a 24/7 basis. As previously discussed, TN Heart will establish a transfer agreement with CRMC, where TN Heart cardiologists have privileges and which is the only hospital in the proposed service area that provides open heart surgery procedures, to ensure immediate access to emergency or higher-acuity care should any patient require it. This is also consistent with the standards recommended by multiple professional organizations, demonstrating the project’s commitment to ensure the appropriate level of care is provided in the appropriate patient setting.

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. TN Heart Cardiovascular Surgery Center is not an existing provider of diagnostic cardiac catheterization services.

Specific Standards and Criteria for the Provision of Pediatric Cardiac Catheterization Services

Applicants proposing to provide pediatric cardiac catheterization services should meet the following minimum standards:

19. Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 100 cases per year by its third year of operation. 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 that include diagnostic and therapeutic cardiac catheterization procedures as defined by these Standards and Criteria shall count towards meeting this minimum volume standard.

    Response: Not applicable. The proposed project will not provide pediatric cardiac catheterization services.

20. Minimum Physician Requirements to Initiate a New Service: The initiation of a new pediatric cardiac catheterization program should require at least two cardiologists with at least one cardiologist having performed an average of 50 pediatric cardiac catheterization procedures over the most recent five year period. Pediatric cardiac catheterization procedures should be performed only by board.

    Response: Not applicable. The proposed project will not provide pediatric cardiac catheterization services.

21. **Open Heart Surgery Availability:** Such applicants should offer full pediatric cardiac medical and cardiac surgical capabilities, including pediatric open heart surgery.

    Response: Not applicable. The proposed project will not provide pediatric cardiac catheterization services.

Specific Standards and Criteria for the Offering of Mobile Cardiac Catheterization Services

The need for mobile cardiac catheterization services should be based upon the following minimum standards:

22. **Minimum Volume Standard:** Such applicants should demonstrate that the proposed service utilization will be a minimum of 60 cardiac catheterization cases per day of operation per year by its third year of operation. 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. If the applicant is proposing services in a rural area where the HSDA determines that access to diagnostic cardiac catheterization services has been limited, and if the applicant is pursuing a partnership with a tertiary facility to share and train staff, the Agency may determine that a minimum volume of 40 cases per day of operation per year is acceptable. Only cases that included diagnostic cardiac catheterization
procedures may count towards meeting this minimum volume standard.

    Response: Not applicable. The proposed project will not provide mobile cardiac catheterization services.

23. **Limitations on Procedure Types in Mobile Facilities:** No therapeutic or pediatric cardiac catheterization procedures should be performed using a mobile laboratory unless the mobile unit is located on a hospital campus with on-site open heart surgery capability and, in the case of a pediatric procedure, offers full pediatric cardiac medical and cardiac surgical capabilities. On a temporary basis, however, the same scope of services offered in a fixed laboratory may be offered in a mobile laboratory only for the duration of construction impacting the fixed laboratory.

    Response: Not applicable. The proposed project will not provide mobile cardiac catheterization services.

24. **Non-Cardiologist Physician and Staff Competence:** In cases where attending cardiologists live more than 30 minutes from the mobile laboratory and/or typically leave after performing a procedure, the applicant should document that a sufficient number of physicians and support staff at the facility have an understanding of the potential complications of cardiac catheterization and are an integral part of the program's management process.

    Response: Not applicable. The proposed project will not provide mobile cardiac catheterization services.

The proposed project also seeks licensure as an ASTC in order to operate as an ambulatory surgery center for purposes of CMS certification and to facilitate compliance with any HFC Division of Licensure and Regulation requirements and applicable quality standards. As such, the Standards and Criteria for Ambulatory Surgical Treatment Centers have been completed and included below. Please note that TN Heart does not propose to develop operating rooms or procedure rooms to be used for surgical or non-surgical procedures other than the cardiovascular procedures described throughout this application.

STATE OF TENNESSEE

STATE HEALTH PLAN

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

AMBULATORY SURGICAL TREATMENT CENTERS

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to establish or expand Ambulatory Surgical Treatment Centers (ASTCs). Existing ASTCs are not affected by these standards and criteria unless they take an action that requires a new certificate of need (CON) for the establishment or expansion of an ASTC.

These standards and criteria are effective immediately as of May 23, 2013, the date of approval and adoption by the Governor of the State Health Plan changes for 2013. Applications to establish or expand an ASTC that were deemed complete by the HSDA prior to this date shall be considered under the Guidelines for Growth, 2000 Edition.

Definitions

1. "Ambulatory Surgical Treatment Center" (ASTC) shall have the meaning set forth in the Rules of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-08-12, or its successor.

2. "Full Capacity" shall mean:
   For a dedicated outpatient Operating Room: 1,263 Cases per year[1]
   For a dedicated outpatient Procedure Room: 2,667 Cases per year

3. “Operating Room” shall mean a room at an ASTC where general and/or Monitored Anesthesia Care (MAC) (the ability to administer general anesthesia) is employed. Any level of sedation or anesthesia can be utilized in Operating Rooms as the anesthesia equipment is present in the room.

4. "Procedure Room" shall mean a room at an ASTC where local and/or intravenous sedation is employed.

    1. If an applicant intends to utilize an Operating Room or Procedure Room for types of sedation other than are set forth in the above definitions or for no type of sedation, it must provide information in its application setting forth the reasons for employing such different sedation type(s) (or lack thereof) and identify the types of Cases so impacted.

5. “Optimum Utilization” shall mean:
    2. For a dedicated outpatient Operating Room, 70% of Full Capacity
    3. For a dedicated outpatient Procedure Room: 70% of Full Capacity

6. “Service Area” shall mean the county or counties represented by the applicant as the reasonable area to which the facility intends to provide services and/or in which the majority of its service recipients reside.

7. “Specialty ASTC” shall mean an ASTC that limits its Surgical Cases to specific types.

8. “Case” shall mean one visit to an Operating Room or to a Procedure Room by one patient, regardless of the number of surgeries or procedures performed during that visit.

Assumptions in Determination of Need

The need for an ambulatory surgical treatment center shall be based upon the following assumptions:

1. Operating Rooms
    a. An operating room is available 250 days per year, 8 hours per day.
    b. The estimated average time per Case in an Operating Room is 65 minutes.
    c. The average time for clean up and preparation between Operating Room Cases is 30 minutes.
    d. The optimum utilization of a dedicated, outpatient, general-purpose Operating Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 95 minutes = 884 Cases per year.

2. Procedure Rooms
    a. A procedure room is available 250 days per year, 8 hours per day.
    b. The estimated average time per outpatient Case in a procedure room is 30 minutes.
    c. The average time for clean up and preparation between Procedure Room Cases is 15 minutes.
    d. The optimum utilization of a dedicated, outpatient, general-purpose outpatient

Procedure Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 45 minutes = 1867 Cases per year.

Specific Standards and Criteria for Ambulatory Surgical Treatment Centers

Determination of Need

1. Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need.[2] An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

   Response: The proposed project is a single-specialty cardiovascular ASTC that will provide the cardiovascular services listed in Attachment 1N-1.1. These are specialized procedures that differ from the surgical procedures that would typically be performed in a procedure room, both in terms of the expertise required and the time required to perform such procedures. Given these differences, this criterion is not applicable. However, for information purposes, utilization by cardiac catheterization lab, operating room, and procedure room is provided.

   As stated previously in the Standards and Criteria for Ambulatory Surgical Treatment Centers included as Attachment 1N, the cardiac catheterization lab, Class 3 Operating Room, and procedure room shown in the floor plan for the proposed ASTC (Attachment 10A) will not be used for any procedures other than the cardiovascular procedures identified in Attachment 1N-1.1 and described throughout this application: i.e., diagnostic and select therapeutic cardiac catheterizations, diagnostic and select therapeutic electrophysiology services, cardiac rhythm device implantations, and diagnostic and therapeutic peripheral vascular services.

   The cardiac catheterization lab will be utilized for all diagnostic and therapeutic cardiac catheterization procedures and peripheral vascular catheterizations. The Class 3 OR will be utilized for electrophysiology procedures and cardiac ablations. The procedure room will be utilized for procedures, like loop recorder implantations, that do not clinically require an operating room setting.

   Please see the table below for the projected utilization at TN Heart Cardiovascular Surgery Center by room. These projections reflect the volume of procedures by procedure category included as Attachment 6N. The procedure room volume was obtained by subtracting the relevant procedures from the total number of cardiac rhythm device implantations projected in Table 6N-5 of Attachment 6N. Stern assumed an operating volume of 185 procedures per year in its one procedure room in PY2; Stern halved this volume in PY1 to account for its ramp-up period.

Procedure	*Cath Lab*	*OR*	*PR*	*Total*
Project Year 1 (2028)				
Cardiac Ablations	--	294	--	294
Diagnostic Cardiac Catheterizations	480	--	--	480
Electrophysiology Studies and Cardiac Rhythm Device Implantations	--	367	--	367
Loop Procedures	--	--	92	92
Therapeutic Cardiac Catheterizations	94	--	--	94
Peripheral Vascular Catheterizations	22	--	--	22
Total	**597**	**661**	**92**	**1,349**
Project Year 2 (2029)				
Cardiac Ablations	--	592	--	592
Diagnostic Cardiac Catheterizations	967	--	--	967
Electrophysiology Studies and Cardiac Rhythm Device Implantations	--	738	--	738
Loop Procedures	--	--	185	185
Therapeutic Cardiac Catheterizations	189	--	--	189
Peripheral Vascular Catheterizations	45	--	--	45
Total	**1,201**	**1,330**	**185**	**2,716**

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

   Response: The proposed project is a single-specialty cardiovascular ASTC that will provide the cardiovascular services listed in Attachment 1N-1.1. It does not propose to perform surgeries or other types of procedures, as that term is typically used in reference to ASTCs. As such, this criterion is not applicable. Please see the response to #14 of the Standards and Criteria for Cardiac Catheterization Services above, as well as Attachment 6N, for the projected utilization of TN Heart Cardiovascular Surgery Center for its first two years of operation.

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available)[3] OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should

provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data is available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

Response: The proposed project is a single-specialty cardiovascular ASTC that will provide the cardiovascular services detailed in Attachment 1N-1.1. There are currently no ASTCs that provide such services in the proposed service area, and as such there are currently no existing comparable outpatient operating rooms or procedure rooms in the service area. Stern has nevertheless provided the historical utilization of all ASTCs in the proposed service area in Attachment 5N, as requested.

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Response: No ASTC in the proposed service area currently provides the cardiovascular services proposed at TN Heart Cardiovascular Surgery Center. Accordingly, no existing ambulatory surgical services comparable to those proposed are available in the service area.

Notably, JAR data confirm that the two existing providers of cardiac catheterization services in the proposed service area collectively operated at 176 percent of the cardiac catheterization maximum capacity standard of 2,000 weighted cases per cardiac catheterization lab, substantially exceeding both the maximum capacity and the optimum capacity threshold. This demonstrates a clear need for additional cardiac catheterization services. Further, as discussed in the "Overview and Context" section above, existing providers will continue to operate above the state's maximum and optimum capacity standards even if the project is approved. See Attachment 5N.

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and should provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

Response: The proposed project is a single-specialty cardiovascular ASTC that will

provide the cardiovascular services listed in Attachment 1N-1.1. Please see the response to #14 of the Standards and Criteria for Cardiac Catheterization Services, above, as well as Attachment 6N, for the projected utilization of TN Heart Cardiovascular Surgery Center for its first two years of operation.

Notably, JAR data confirm that the two existing providers of cardiac catheterization services in the proposed service area – both hospitals – operated at 176 percent of the 2,000-case cardiac catheterization maximum capacity standard, substantially exceeding both the full capacity and the optimum capacity threshold. Additionally, and as discussed in the "Overview and Context" section above, only one of these two hospitals, CRMC, provides the same scope of services as the proposed ASTC, which includes adult outpatient EP procedures. If Cumberland Medical Center is excluded from the analysis above, the two cardiac catheterization labs at CRMC operated at 252 percent cardiac catheterization utilization per 2,000 weighted cases on average from 2022 through 2024. This demonstrates a clear and sustained need for additional cardiac catheterization capacity. See Attachment 5N.

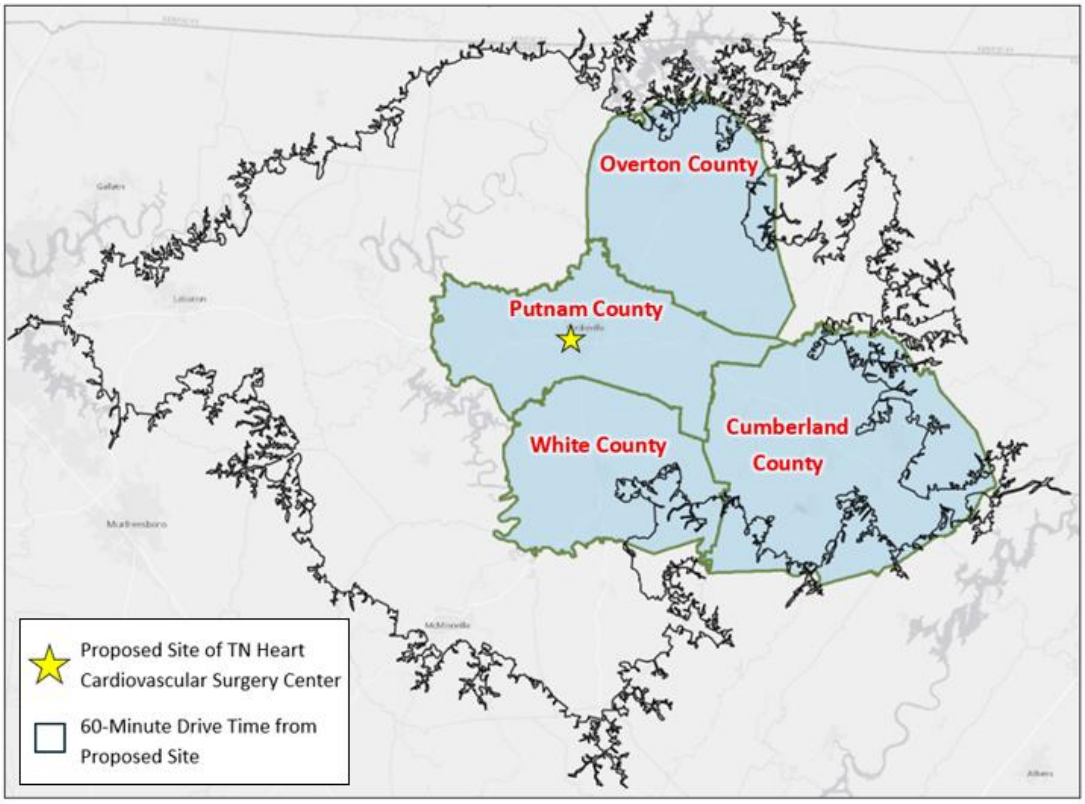
Because no ASTC currently provides cardiac catheterization services in the proposed service area, the proposed project will not impact existing ambulatory surgical service providers.

Other Standards and Criteria

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

   Response: As the map below demonstrates, the proposed location of TN Heart Cardiovascular Surgery Center is well within a 60-minute drive time of the majority of Cumberland, Overton, Putnam, and White counties. Clay, Smith, Jackson, DeKalb, and Wilson counties are also largely within this 60-minute drive time area, as well as parts of Van Buren, Warren, and Cannon counties. As demonstrated by the response provided in 2N, projected patient origin includes residents from these counties.

TN Heart Cardiovascular Surgery Center – 60-Minute Drive Time



7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

   Response: The nearest public transportation routes to the proposed ASTC are the Blue Route, Green Route, and Red Route of the Upper Cumberland Human Resource Agency ("UCHRA") Public Transportation. The nearest Monday through Friday weekday stops for these routes are located at distances of half a mile or farther from the proposed ASTC location. Because patients will receive conscious sedation or anesthesia during cardiovascular procedures, it will not be safe for patients to drive themselves or take public transportation following discharge. As such, these patients must have a family member or caregiver provide automobile transportation to and from the ASTC, as discussed in the response to Question 11A.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Response: See the response to Question 2N for the detailed patient origin projections and Attachment 6N for the utilization projections for the proposed ASTC, which will exclusively provide cardiovascular services. See also Attachment 5N for a list of existing ASTCs in the proposed service area and their utilization.

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Response: Please see the table below, which segments the utilization provided in response to #14 of the Standards and Criteria for Cardiac Catheterization Services by quarter. The figures presented in the table below equate to totals provided in response to #14.

Procedure	*PY1 (2028)*					*PY2 (2029)*				
	Q1	**Q2**	**Q3**	**Q4**	**Total PY1**	**Q1**	**Q2**	**Q3**	**Q4**	**Total PY2**
Cardiac Ablations	73	73	73	73	294	148	148	148	148	592
Diagnostic Cardiac Catheterizations	120	120	120	120	480	242	242	242	242	967
Electrophysiology Studies and Cardiac Rhythm Device Implantations	92	92	92	92	367	185	185	185	185	738
Loop Procedures	23	23	23	23	92	46	46	46	46	185
Therapeutic Cardiac Catheterizations	24	24	24	24	94	47	47	47	47	189
Peripheral Vascular Catheterizations	6	6	6	6	22	11	11	11	11	45
Total	**337**	**337**	**337**	**337**	**1,349**	**679**	**679**	**679**	**679**	**2,716**

10. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.[4]

Response: TN Heart Cardiovascular Surgery Center will be licensed through the Tennessee Health Facilities Commission as a Class C ASTC. TN Heart will also seek accreditation through The Joint Commission ("TJC"), which is consistent with Atria Health's established practice of obtaining TJC accreditation for its ASTCs in other states.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

Response: Please see the response to #16 of the Standards and Criteria for Cardiac Catheterization Services. Multiple board-certified TN Heart cardiologists have pledged their support to perform procedures at TN Heart Cardiovascular Surgery Center. TN Heart currently anticipates that eight of its diagnostic and interventional cardiologists will perform cardiac catheterization procedures at the proposed facility: Dr. Mariano Battaglia, Dr. Stacy D. Brewington, Dr. Alex Case, Dr. Vertilio M. Cornielle, Dr. Brent Klinkhammer, Dr. Carlos Podesta, Dr. Noel Torres, and Dr. Mark Wathen. However, any qualified cardiologists, vascular surgeons, and anesthesiologists that meet the proposed project's privilege requirements and credentialing processes will be offered the opportunity to provide services at the facility.

11. Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," 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;

       Response: Putnam County is a Medically Underserved Population Low Income area. Cumberland, Overton, and White counties are all designated as Medically Underserved Areas.[39]

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

       Response: Not applicable.

    c. 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; or

       Response: The applicant will contract with TennCare (Medicaid) and Medicare for the proposed ASTC.

    d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

       Response: Not applicable.

[39] As identified using the HRSA Find MUA/P tool, accessed at https://data.hrsa.gov/topics/health-workforce/shortage-areas/mua-find.

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

TN Heart Cardiovascular Surgery Center, LLC
Name

999 S. Willow Avenue — Putnam County
Street or Route — **County**

Cookeville — Tennessee — 38501
City — **State** — **Zip**

N/A
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

Jeffrey Stofko — Senior Manager
Name — **Title**

Ascendient Healthcare Advisors, Inc. — jeffreystofko@ascendient.com
Company Name — **Email Address**

1335 Environ Way
Street or Route

Chapel Hill — North Carolina — 27517
City — **State** — **Zip**

Consultant — 919-403-3300
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: 07/10/26

Date LOI was Published: 07/11/26

RESPONSE: The letter of intent for the proposed project was published in the Herald-Citizen, a newspaper of general circulation in Putnam County, on Saturday, July 11, 2026. Please see Attachment 3A.

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)
- [ ] 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
- [ ] 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)*

- [ ] Hospital
- [ ] Ambulatory Surgical Treatment Center (ASTC) – Multi-Specialty
- [x] 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 -

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

The Stern Cardiovascular Center, P.A.

Name

8060 Wolf River Blvd		901-271-1000
Street or Route		**Phone Number**
Germantown	Tennessee	38138
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) Professional Association

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: See Attachment 7A for the ownership documentation for the proposed project. The proposed project, TN Heart Cardiovascular Surgery Center, LLC, will be wholly owned by The Stern Cardiovascular Center, P.A. ("Stern"), an established cardiovascular physician group that has been serving patients at more than two dozen locations across Tennessee, Mississippi, and Arkansas for over 100 years. In July 2026, Tennessee Heart, PLLC ("TN Heart"), an experienced Cookeville cardiology group providing care throughout Tennessee's Upper Cumberland region and southern Kentucky, partnered with Stern and Atria Health Services of the South, LLC ("Atria Health") to create a cardiovascular center of excellence in Cookeville and the Upper Cumberland region. Through this partnership, TN Heart will operate as a Stern-affiliated location serving patients in the Upper Cumberland region. In addition, TN Heart and Atria will develop and operate the proposed project, TN Heart Cardiovascular

Surgery Center, LLC, a single-specialty ambulatory surgical treatment center ("ASTC"). The project will be supported through a management service agreement between Stern and Atria Health. Stern and TN Heart do not currently operate any other ASTCs or cardiac catheterization laboratories in Tennessee or in any other states.

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

Atria Health Services of the South, LLC

Name

507 Prudential Rd		Montgomery
Street or Route		**County**
Horsham	Pennsylvania	19044
City	**State**	**Zip**

https://www.atriahealth.co/

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)

Option to Lease

RESPONSE: See Attachment 9A for a copy of the Option to Lease between Sparrow Ventures and Atria Health Services of the South, LLC, signed July 28, 2026.

10A. Floor Plan

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

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

RESPONSE: See Attachment 10A for the project's floor plan.

11A. Public Transportation Route

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

RESPONSE: The proposed project site occupies an easily accessible location along S. Willow Avenue, which forms part of State Route 135, one of the most highly trafficked north-south corridors in Putnam County. Due to safety policies and procedures, patients will be required to provide transportation (i.e., not take public transportation) both to and from their procedure. Patients who are unable to arrange their own ride may schedule non-emergency medical transportation (e.g., MyRide TN, Tennessee Carriers, Caliber Care+Transport), some of which offer a low-income subsidy. The facility itself is designed with patient convenience and experience in mind. The ASTC will be housed in a single-story building dedicated to TN Heart Cardiovascular Surgery Center, which will feature ample parking (a total of 47 parking spaces), fully ADA-compliant ramps, and covered walkways to protect patients during inclement weather. A clearly marked entrance will simplify wayfinding for patients and caregivers alike. Compared to existing hospital-based cardiac catheterization services in the service area, the ASTC will offer a more streamlined experience with easier facility access and navigation that reduces the burden on patients and their families.

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 for the site plan, which shows the acreage, the building where the project will be located, and the names of the streets that border the site.

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:

  Tennessee Heart, PLLC ("TN Heart") is an established cardiology physician practice that has served the Upper Cumberland region for over 30 years, delivering care at three clinic locations in Cumberland, Overton, and Putnam counties, as well as at Cookeville Regional Medical Center ("CRMC") in Putnam County. On July 1, 2026, TN Heart entered into a strategic partnership with The Stern Cardiovascular Center, P.A. ("Stern") and Atria Health Services of the South, LLC ("Atria Health") to create a cardiovascular center of excellence in Cookeville, expand access to care, recruit new physicians to the area, and provide innovative cardiology services. The proposed project will develop a single-specialty cardiovascular ASTC, TN Heart Cardiovascular Surgery Center, that will exclusively provide diagnostic and select therapeutic cardiac catheterization services, diagnostic and select therapeutic electrophysiology services, cardiac rhythm device implantations, and diagnostic and therapeutic peripheral vascular services. The ASTC will perform only those procedures that the Centers for Medicare & Medicaid Services ("CMS") has deemed safe and approved for the ambulatory surgical center setting. By offering a dedicated outpatient-only setting for scheduled cardiovascular procedures, the ASTC will relieve ongoing capacity constraints at existing service area providers of cardiac catheterization and support more timely treatment for all service area patients.

- Ownership structure

  RESPONSE: The project will be wholly owned by The Stern Cardiovascular Center, P.A ("Stern"). The development and operation of the project will be supported through a management service agreement between Stern and Atria Health Services of the South, LLC. ("Atria Health"). Atria Health is wholly owned by Atria Health Opco, Inc. Tennessee Heart, PLLC ("TN Heart"), which partnered with Stern and Atria in July 2026, will operate the ASTC as a Stern-affiliated location.

- Service Area

  RESPONSE: The project's primary proposed service area includes Cumberland, Overton, Putnam, and White counties, which form part of the Upper Cumberland region of Tennessee. TN Heart cardiologists within the service area have historically provided cardiovascular services at clinic locations in Crossville (Cumberland County), Livingston (Overton County), and Cookeville (Putnam County) as well as at Cookeville Regional Medical Center ("CRMC"). Based on TN Heart's historical patient origin data at these locations, the project's secondary service area will also include the surrounding counties identified in response to Questions 2N and 6N.

- Existing similar service providers

  RESPONSE: There are currently no ASTCs that provide outpatient cardiovascular services in the proposed service area. As such, there are no similar service providers in the proposed service area. There are two acute care hospitals in the proposed service area that perform cardiac catheterization services: Cumberland Medical Center in Cumberland County and CRMC in Putnam County.

- Project Cost

  RESPONSE: Project costs are estimated to be $11,835,798. This includes a $2,000,000 net construction cost, after $6,136,750 in tenant improvement allowances have been applied. See Attachment 1E for a letter from the architect verifying these costs for the proposed project.

- Staffing

  RESPONSE: The project will require 13.6 FTEs in the first project year, including 10.6 FTEs of direct patient care positions and 3.0 FTEs of non-patient care positions.

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: There is demonstrable, urgent need for the proposed project. Cardiovascular procedure volumes in the proposed service area that are appropriate for the ASTC setting are increasing and service area patients face extended wait times for this care. Specifically, ASTC-appropriate procedure volumes performed by cardiologists at TN Heart increased by 12.0 percent from 2024 through 2025, more than four times the projected 2.8 percent population growth rate in the service area counties for 2026 through 2030. Critically, as demonstrated in Attachment 5N, existing cardiac catheterization labs in Putnam County are operating at 252 percent of the state's full capacity standard. Cumulatively, the three existing cardiac catheterization labs in the proposed service area are operating at 175 percent of full capacity. A majority of these procedures are outpatient-based and appropriate for the ASTC setting. Compounding the effects of this high and growing utilization of cardiovascular services is the growth of both the overall and age 65 and over populations in the four-county service area (Cumberland, Overton, Putnam, and White counties), which are increasing at rates that exceed state averages. Not only will population growth result in greater demand for cardiac catheterization procedures, but the health factors and socioeconomic status of the service area will also contribute to the demand for the proposed project. Indeed, compared to state averages, a significantly higher percentage of service area residents fall below the federal poverty level, experience a lower rate of economic development, live in rural areas, are over the age of 65, and are uninsured; these factors are frequently correlated with higher risk for developing cardiovascular disease such as hypertension, diabetes, and obesity. Because services delivered in an outpatient ASTC setting are more affordable than the equivalent services delivered in a hospital, the proposed project eases the cost burden of accessing cardiovascular care for underserved patient populations in the service area, including low-income, uninsured, or underinsured patients. Thus, approving the proposed project is a necessary step toward delivering accessible cardiovascular care to a community experiencing higher clinical risks and health disparities.

- Quality Standards

  RESPONSE: TN Heart and Stern are established cardiovascular physician practices serving patients at over two dozen locations. Together, they have a proven track record of delivering high-quality cardiovascular care throughout these communities in both the outpatient and inpatient setting. TN Heart's board-certified cardiologists have a long history of providing cardiovascular care at hospitals and clinics throughout the service area. In addition to this combined cardiovascular expertise, the project's development partner, Atria Health, brings demonstrated expertise developing and managing outpatient cardiovascular facilities alongside its physician partners, including implementing rigorous policies and procedures to ensure that cardiovascular care delivered in an ambulatory setting is both safe and effective. TN Heart and Stern are established cardiovascular physician practices serving patients at over two dozen locations. Together, they have a proven track record of delivering high-quality cardiovascular care throughout these communities in both the outpatient and inpatient setting. TN Heart's board-certified cardiologists have a long history of providing cardiovascular care at hospitals and clinics throughout the service area. In addition to this combined cardiovascular expertise, the project's development partner, Atria Health, brings demonstrated expertise developing and managing outpatient cardiovascular facilities alongside its physician partners, including developing rigorous policies and procedures to ensure that cardiovascular care delivered in an ambulatory setting is both safe and effective.

- Consumer Advantage
  - Choice

    RESPONSE: No provider of non-hospital-based outpatient cardiac catheterization services currently operates in the proposed service area. Robust clinical evidence establishes that cardiac catheterization procedures, including all procedures identified in Attachment 1N-1.1, are safe in ambulatory settings and that the quality and outcomes are comparable to those of hospitals. By establishing the first cardiovascular-focused ASTC in the service area, the proposed project will meaningfully expand consumers' choice of providers in the service area.

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

    RESPONSE: Today, service area patients face significant delays of up to eight months for scheduled cardiovascular care, including elective diagnostic catheterization procedures and outpatient-appropriate ablations. These delays cause unnecessary readmissions, treatments, and medical care costs for patients and stem from service area hospitals' capacity constraints and need to prioritize higher-acuity and emergent cases. By offering a dedicated, outpatient-only setting for scheduled cardiovascular procedures, the proposed ASTC relieves these capacity constraints, allowing hospitals to allocate their limited catheterization lab time and staff to the higher-complexity, higher-acuity cases that require a hospital setting. At the same time, patients needing scheduled, lower-acuity procedures gain access to a facility built specifically for their care. The result is more timely treatment for all service area patients – those requiring urgent, complex care and those requiring routine, outpatient care – and a meaningfully expanded set of care options for patients who currently have no alternative to the hospital setting for necessary cardiovascular care.

  - Affordability

    RESPONSE: Services delivered in a freestanding ASTC setting are more cost-effective than the same services delivered in a hospital environment. On average, based on Medicare data, procedures performed in ASTCs cost 58 percent less than in hospital outpatient department ("HOPD") settings. Additionally, according to estimates from CMS, a migration of just five percent of the 700,000 annual Medicare percutaneous coronary interventions ("PCIs") performed in a hospital setting to an ASTC setting would result in $20 million of savings in Medicare payments and five million dollars of savings in patient co-pays. Thus, the proposed project will result in significant healthcare cost savings for patients and payors alike. The "Estimated Average Payments for Medicare – Cardiac Catheterization Procedures" table in the "Consumer Advantage" section of the "Overview and Context" introduction in Attachment 1N outlines facility costs by procedure in ASTC versus hospital outpatient settings, illustrating that out-of-pocket expenses for cardiac catheterization services performed in ASTCs are nearly half those for similar services performed in a hospital.

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	$160,000
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$129,413
3. Acquisition of Site	
4. Preparation of Site	
5. Total Construction Costs	$2,000,000
6. Contingency Fund	$557,871
7. Fixed Equipment (Not included in Construction Contract)	$1,578,406
8. Moveable Equipment (List all equipment over $50,000 as separate attachments)	$2,000,305
9. Other (Specify): Sales Tax for Items 4-8	$567,634
B. Acquisition by gift, donation, or lease:	
1. Facility (inclusive of building and land)	$2,224,045
2. Building only	
3. Land only	
4. Equipment (Specify):	
5. Other (Specify):	
C. Financing Costs and Fees:	
1. Interim Financing	$2,591,553
2. Underwriting Costs	
3. Reserve for One Year's Debt Service	
4. Other (Specify):	
D. Estimated Project Cost (A+B+C)	$11,809,227
E. CON Filing Fee	$26,571
F. Total Estimated Project Cost (D+E) **TOTAL**	$11,835,798

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:

Please see Attachment 1N, which includes completed Standards and Criteria for both Cardiac Catheterization Services and Ambulatory Surgical Treatment Centers.

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

RESPONSE:

The project's proposed service area includes Cumberland, Overton, Putnam, and White counties. A map depicting the proposed service area, with these counties shaded, is included as Attachment 2N.

The service area is reasonable and well-supported by the care that TN Heart cardiologists have historically provided. As shown in Attachment 6N, over 70 percent of TN Heart's patients originate from Cumberland, Overton, Putnam, and White counties. As such, these four counties represent the geographic core of the existing Tennessee patient population of TN Heart's Upper Cumberland physician practices.

As previously stated, TN Heart's partnership with Stern and the development of a freestanding outpatient provider of cardiac catheterization and other cardiovascular surgical services will generally expand access to cardiovascular care in the Upper Cumberland region. Over time, this may increase the base of patients to whom outpatient cardiovascular care, including cardiac catheterization services, can be provided. In the table below, TN Heart has provided projected patient origin for all counties from which it expects to serve patients, including a small subset of patients originating from counties outside of Tennessee. TN Heart has historically provided cardiovascular services to a small percentage of patients residing outside Tennessee in areas geographically proximate to the Upper Cumberland region, particularly those from southern Kentucky; therefore, the applicant expects that the proposed project will serve a similar percentage of non-Tennessee patients from these areas. As previously stated, TN Heart's partnership with Stern and the development of a freestanding outpatient provider of cardiac catheterization and other cardiovascular surgical services will generally expand access to cardiovascular care in the Upper Cumberland region. Over time, this may increase the base of patients to whom outpatient cardiovascular care, including cardiac catheterization services, can be provided. The detailed assumptions underlying these projections are set forth in Attachment 6N.

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

PROJECTED UTILIZATION

Unit Type: ☐ Procedures ☐ Cases ☐ Patients ☑ Other Weighted Cardiovascular Procedures

Service Area Counties	Projected Utilization Recent Year 1 (Year = 2028)	% of Total
Overton	156	11.56%
Hamilton	3	0.22%
Bedford	1	0.07%
Cumberland	172	12.75%
Jackson	72	5.34%
Sequatchie	1	0.07%
Rutherford	3	0.22%
Roane	3	0.22%
Macon	3	0.22%
Davidson	1	0.07%
Rhea	2	0.15%
Sumner	1	0.07%
Pickett	38	2.82%
Morgan	7	0.52%
Bledsoe	12	0.89%
DeKalb	35	2.59%
White	136	10.08%
Other State	35	2.59%
Fentress	80	5.93%
Putnam	501	37.14%
Van Buren	23	1.70%
Clay	25	1.85%
Warren	19	1.41%
Smith	18	1.33%
Wilson	2	0.15%
Total	1,349	100%

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

RESPONSE:

The proposed ASTC will serve adult patients 18 and older who are appropriate to receive care in the ASTC. The demographic profile of the proposed service area underscores the critical need for this project. As detailed in the "Overview and Context" section of Attachment 1N, the total and age 65 and over populations of Cumberland, Overton, Putnam, and White counties are projected to grow over the next four years. Moreover, the proposed service area is rural, and rural patients disproportionately face disparities in social determinants of health, such as lower median household incomes, higher levels of poverty, and higher rates of disability and uninsurance, creating greater risks for developing chronic conditions, such as hypertension, diabetes, obesity, and heart disease. These same disparities also shape patients' ability to access and afford the ongoing cardiovascular care these conditions require, reinforcing the need for a lower-cost, more accessible outpatient option in the service area, as further discussed in Attachment 1N. Further demographic details are provided in Attachment 3N. Of note, the 2026 and 2030 population statistics provided in Attachment 3N were derived from University of Tennessee Boyd Center population projections.

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 Attachment 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:

Patients in the proposed service area face acute health disparities that necessitate expanded access to cardiovascular care. As detailed in Attachment 1N and as discussed in response to #4 of the Standards and Criteria for Cardiac Catheterization Services, the demographic profiles of Cumberland, Overton, Putnam, and White counties support the urgent need for the proposed project.

Not only are the four proposed service area counties experiencing population growth – most at rates exceeding Tennessee's 2.9 percent projected growth – they are also rapidly aging, with the age 65 and over populations projected to grow at a rate more than two times faster than the service area's overall population (6.4 percent versus 2.9 percent). Because the Upper Cumberland Region is considered a national retirement destination[1], this accelerated aging is likely to continue. The four service area counties are also highly rural, with no single county having a population over 86,000 residents.

Because aging populations and rural populations are more likely to experience socioeconomic disparities, they are also at greater risk of developing chronic diseases. Compared to Tennesseans overall, these disparities include lower median household incomes, higher levels of poverty, and higher rates of disability and uninsurance. According to U.S. Census data, all four of the service area counties have poverty rates exceeding or equal to that of Tennessee overall, with Putnam County having a particularly high poverty rate of 18.4 percent.[2]

Extensive research consistently links socioeconomic status to chronic conditions, including cardiovascular disease. A 2018 review in *Circulation*, published by the American Heart Association, found that socioeconomic status significantly affected cardiovascular health. Low socioeconomic status, reflected in income, education, employment, and neighborhood conditions, can raise cardiovascular risk as much as traditional factors like hypertension and diabetes.[3] A 2023 analysis of nationally representative data reinforced this link. After adjusting for age, sex, race, and traditional cardiovascular risk factors, researchers found that individuals in the lowest family income bracket faced more than six times the risk of cardiac death and nearly four times the risk of death from any cause, compared to individuals in the highest income bracket. The study also found that coronary artery disease, congestive heart failure, and stroke declined steadily as family income rose.[4] A more recent 2025 study confirmed that low-income and limited education compound cardiovascular risk. Individuals in the bottom 80 percent of income earners who had not graduated college faced more than six times the risk of congestive heart failure and more than three times the risk of stroke, compared to the highest earning college graduates, even after adjusting for demographic and clinical risk factors.[5]

The proposed ASTC will directly address these known disparities in Tennessee's Upper Cumberland region by providing an accessible, high-quality, lower-cost alternative for cardiovascular care for communities most in need. The project's policies and procedures ensure that care will be provided to all who need it, regardless of background, income, or insurance status. For example, the Admission/Treatment Policy included in Attachment 1N-1.2 confirms this commitment.

[1] For example, "Cookeville among American's 100 best places to retire." *Upper Cumberland Business Journal*, December 4, 2018, accessed at https://www.ucbjournal.com/cookeville-among-americas-100-best-places-to-retire/.

[2] U.S. Census Bureau QuickFacts. "Putnam County, Tennessee; Tennessee." Accessed July 7, 2026 at https://www.census.gov/quickfacts/fact/table/TN,putnamcountytennessee/PST045225.

[3] Schultz, William M. et al. "Socioeconomic Status and Cardiovascular Outcomes: Challenges and Interventions." *Circulation*, vol. 137, 2018, pp. 2166–2178. Accessed at https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.117.029652.

[4] Minhas, Abdul Mannan Khan et al. "Family Income and Cardiovascular Disease Risk in American Adults." *Scientific Reports*, vol. 13, article 279, 2023. Accessed at https://www.nature.com/articles/s41598-023-27474-x.

[5] Abdalla, Salma M. et al. "Income, Education, and the Clustering of Risk in Cardiovascular Disease in the US, 1999–2018: An Observational Study." *The Lancet Regional Health – Americas*, vol. 44, article 101039, 2025. Accessed at https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(25)00049-3/fulltext.

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:

No existing ASTC provider of cardiac catheterization services operates in the proposed service area. The two existing or approved freestanding cardiovascular-focused ASTCs in Tennessee are Karing Hearts Cardiology Heart and Vascular Center in East Tennessee (existing) and Stern Cardiovascular Surgery Center in Shelby County (CN2605-013A). The proposed project would be the first facility to offer these cardiovascular services in a freestanding ambulatory surgical setting within Cumberland, Overton, Putnam, or White counties and the surrounding Upper Cumberland region.

Although Question 5N only seeks information on existing and approved but *unimplemented* services in the service area, TN Heart compiled comprehensive historical utilization data for all cardiac catheterization providers located in the proposed service area. These data are included as Attachment 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 Attachment 6N for the projected utilization for the proposed project, as well as all assumptions used to project utilization.

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:

On July 22, 2026, the HFC unanimously approved the CON application for Stern Cardiovascular Surgery Center, LLC (CN2605-013A). The project will establish a single-specialty cardiovascular ASTC in Shelby County providing diagnostic and therapeutic cardiac catheterizations, diagnostic and therapeutic EP procedures, cardiac rhythm device implantations, and diagnostic and therapeutic peripheral vascular services.

Stern's Shelby County project and the proposed TN Heart project are separate projects, both owned by The Stern Cardiovascular Center, P.A. As previously stated in the response to Question 7A, TN Heart entered into a partnership with Stern and Atria Health in July 2026. Under this partnership, TN Heart Cardiovascular Surgery Center, LLC will represent a Stern-affiliated location. The scope of services offered at the proposed TN Heart project will be the same as those offered in the recently approved Stern Cardiovascular Surgery Center. Both facilities will be staffed by board-certified cardiologists. Of note, the proposed Putnam County ASTC is separated from the approved Shelby County ASTC by a 4.5-hour car ride, such that the two ASTCs will serve two separate and distinct patient populations.

CON Number	Project Name	Date Approved	Expiration Date
CN2605-013	Stern Cardiovascular Surgery Center LLC	7/22/2026	7/22/2028

CONSUMER ADVANTAGE ATTRIBUTED TO COMPETITION

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

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

RESPONSE: As discussed in the response to #3 of the Standards and Criteria for Cardiac Catheterization Services included as Attachment 1N, the applicant will obtain a transfer agreement with CRMC, located approximately ten minutes away from the proposed ASTC and the only service area hospital that currently provides open heart surgery. The non-emergency and emergency transfer policies that will apply to the proposed ASTC are included in Attachment 1N-1.2.

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

- [x] Aetna Health Insurance Company
- [x] Ambetter of Tennessee Ambetter
- [x] Blue Cross Blue Shield of Tennessee
- [x] Blue Cross Blue Shield of Tennessee Network S
- [x] Blue Cross Blue Shiled of Tennessee Network P
- [ ] BlueAdvantage
- [ ] Bright HealthCare
- [x] 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: At this time, and based on TN Heart's historical patient populations, the project will be contracted with the commercial payors identified above. Contracting with additional commercial payors will be evaluated on an ongoing basis, depending on patients' insurance coverage. In addition, this project will seek Single Procedure Agreements with out-of-network payors to provide access to patients with an out-of-network insurance carrier in the event that an in-network agreement cannot be secured for a less common payor in a timely fashion.

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:

There are currently no ASTCs providing cardiac catheterization services in the proposed service area; as such, the proposed project will not duplicate service area cardiovascular services. The two existing providers of cardiac catheterization services in the proposed service area are both hospitals. Given the high utilization of cardiovascular services in the proposed service area, evidenced by extended wait times for scheduled treatment and the growing volume of ASTC-appropriate procedures performed by TN Heart cardiologists, there is an urgent need for additional cardiovascular services in the Upper Cumberland region. The development of an ASTC providing outpatient cardiovascular care not only adds much-needed capacity to the service area, it also enhances patient care and the efficiency of care delivery by offering a freestanding surgery center option and allowing hospitals to dedicate their limited resources to serving higher acuity patients. This ensures that hospitals have more capacity for medically complex surgical cases.

Of note, the projected utilization at TN Heart Cardiovascular Surgery Center, detailed in Attachment 6N, is only a fraction of the total outpatient catheterization procedures performed at service area hospitals, including CRMC. Indeed, following development of the proposed project, cardiac catheterization utilization in the service area will remain well-above state standards – more than 1.3 times full capacity and nearly two times optimal capacity. As outlined in detail in the Standards and Criteria for Cardiac Catheterization Services included as Attachment 1N, in contrast to existing hospital providers, the project will generate significant cost savings for patients and payors and ensure that patients are treated in a setting that better aligns with their care needs.

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 stated above, TN Heart and its 11 cardiologists and five advanced practitioners partnered with Stern and Atria Health to enhance cardiovascular services in the Upper Cumberland Region. Collectively, this brings the applicant's provider network to nearly 130 cardiovascular care providers, including 59 board-certified cardiologists and 68 advanced practice providers, forming a broad geographic footprint of specialized cardiovascular providers with deep experience serving Tennessee patients.

In the Upper Cumberland region, TN Heart cardiologists provide cardiovascular care at clinics throughout Cumberland, Putnam, and Overton counties, including three clinics in Cookeville, Crossville, and Livingston, as well as at CRMC in Putnam County.

The applicant's ability to successfully recruit qualified staff draws directly on the combined strength of its partners. Atria Health manages a national network of cardiovascular practices, giving it established recruitment infrastructure, industry relationships, and a track record of successfully staffing cardiovascular programs across multiple markets. The proposed ASTC will be able to draw on these resources directly. TN Heart physicians and staff have significant experience operating in the Upper Cumberland service area today, giving the project a base of existing clinical relationships and community familiarity. Together, Atria Health's proven recruitment capabilities and TN Heart's existing local footprint position the proposed ASTC to recruit and retain the qualified staff necessary to operate successfully.

The facility will be open staffed; therefore, any qualified cardiologists, vascular surgeons, and anesthesiologists who undergo the required credentialing processes will have the opportunity to provide services at the ASTC. As noted in the Standards and Criteria for Cardiac Catheterization Services included as Attachment 1N, the proposed ASTC will be staffed primarily by TN Heart cardiologists. TN Heart currently anticipates that eight of its diagnostic and interventional cardiologists will perform cardiac catheterization procedures at the proposed facility: Dr. Mariano Battaglia, Dr. Stacy D. Brewington, Dr. Alex Case, Dr. Vertilio M. Cornielle, Dr. Brent Klinkhammer, Dr. Carlos Podesta, Dr. Noel Torres, and Dr. Mark Wathen. However, all TN Heart cardiologists, as well as outside physicians that meet the proposed ASTC's privilege requirements, will be eligible to provide care at the proposed ASTC.

Some of the project's administrative staff may be transferred from existing TN Heart locations, but all clinical FTEs will be new hires. For the reasons outlined above, TN Heart does not anticipate having challenges hiring all necessary clinical staff.

Atria Health has staffing and employment policies that are utilized at its existing ASTC in Pennsylvania that ensure delivery of a high standard of care. Similar to the recently approved Stern Cardiovascular Surgery Center project, TN Heart and Atria Health have worked together to review and modify these policies and procedures to ensure their applicability to the proposed Cookeville project. Please see Attachment 1N-1.2 for a sample of the general employment policies followed by Atria Health.

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:

The project will be licensed as a Class C ambulatory surgical treatment center limited to cardiovascular procedures, including cardiac catheterizations, electrophysiology procedures, cardiac rhythm device implantations, and peripheral vascular services. The facility will seek TennCare and Medicare certification and accreditation from The Joint Commission.

Please see Attachment 1N-1.2 for the policies and procedures that address quality and safety standards that will apply to the proposed project.

PROJECTED DATA CHART

☑ Project Only
☐ Total Facility

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

	Year 1	Year 2
	2028	2029
A. Utilization Data		
Specify Unit of Measure: Other : Weighted Cardiovascular Procedures	1349	2716
B. Revenue from Services to Patients		
1. Inpatient Services	$0.00	$0.00
2. Outpatient Services	$18,907,879.00	$33,366,846.00
3. Emergency Services	$0.00	$0.00
4. Other Operating Revenue (Specify) N/A	$0.00	$0.00
Gross Operating Revenue	$18,907,879.00	$33,366,846.00
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$12,791,180.00	$22,572,671.00
2. Provision for Charity Care	$756,315.00	$1,334,674.00
3. Provisions for Bad Debt	$255,256.00	$450,452.00
Total Deductions	$13,802,751.00	$24,357,797.00
NET OPERATING REVENUE	$5,105,128.00	$9,009,049.00

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	$14,016.22	$12,285.29	0.00
Deduction from Revenue *(Total Deductions/Utilization Data)*	$0.00	$0.00	$10,231.84	$8,968.26	0.00
Average Net Charge *(Net Operating Revenue/Utilization Data)*	$0.00	$0.00	$3,784.38	$3,317.03	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:

Proposed charges are provided in response to Question 8C above. Because the proposed project is a new facility, there are no "existing patient charges" that can be impacted by the project. Generally, charges and reimbursement for cardiovascular procedures will be lower in the outpatient surgery center setting. Please see Attachment 1N for a discussion of the cost effectiveness of the proposed project.

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:

Charges for cardiovascular services are not publicly available, and as noted throughout the application, there are currently no providers of outpatient cardiac catheterization services in a surgery center setting in Cumberland, Overton, Putnam, and White counties. Thus, the project's proposed charges cannot be compared to existing service area facilities.

As discussed in the Standards and Criteria for Cardiac Catheterization Services included as Attachment 1N and supported by Medicare.gov's Procedure Price Lookup tool, the out-of-pocket fees for the services Medicare patients receive in an outpatient surgery center setting are less costly than those delivered in a hospital-based outpatient department. According to internal data and applying the 2026 Medicare payment rate schedule, moving clinically appropriate cardiovascular procedures identified in Attachment 1N-1.1 from a hospital-based setting to an outpatient surgery center setting reduced the total cost of care by up to 60 percent, depending on the cardiovascular procedure performed.

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

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

Applicant's Projected Payor Mix

Project Only Chart

Payor Source	Year-2028		Year-2029	
	Gross Operating Revenue	**% of Total**	**Gross Operating Revenue**	**% of Total**
Medicare/Medicare Managed Care	$14,180,909.00	75.00	$25,025,135.00	75.00
TennCare/Medicaid	$567,236.00	3.00	$1,001,005.00	3.00
Commercial/Other Managed Care	$3,592,497.00	19.00	$6,339,701.00	19.00
Self-Pay	$189,079.00	1.00	$333,668.00	1.00
Other(Specify)	$378,158.00	2.00	$667,337.00	2.00
Total	$18,907,879.00	100%	$33,366,846.00	100%
Charity Care	$756,315.00		$1,334,674.00	

**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: Stern will contract with TennCare and Medicare for the proposed ASTC.

QUALITY STANDARDS

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

- [x] Yes
- [ ] No

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

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

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

  - [x] Yes
  - [ ] No

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

Credential	Agency	Status (Active or Will Apply)	Provider Number or Certification Type
Licensure	☑ Health Facilities Commission/Licensure Division ☐ Intellectual & Developmental Disabilities ☐ Mental Health & Substance Abuse Services	Will Apply	Not applicable
Certification	☑ Medicare ☑ TennCare/Medicaid ☐ Other _____	Will Apply Will Apply	Not applicable Not applicable
Accreditation(s)	TJC - The Joint Commission	Will Apply	Not applicable

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

Please Explain
RESPONSE: Stern anticipates contracting with all Middle Tennessee-based MCOs identified in Question 4Q, including Wellpoint – Middle Tennessee (formerly known as Amerigroup), BlueCare – Middle Tennessee, UnitedHealthcare Community Plan – Middle Tennessee, TennCare Select – Middle Tennessee, and all TennCare plans. Stern will also contract with other MCOs in Tennessee as appropriate. Additionally, the project will serve all clinically appropriate patients, regardless of their ability to pay.

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 Nurse (RN)	0.00	6.30
Licensed Practical Nurse (LPN)	0.00	1.00
Surgical Technician	0.00	3.30
Total Direct Patient Care Positions	N/A	10.6

B. Non-Patient Care Positions		
Check-In / Check-Out	0.00	1.00
ASTC Administrator	0.00	1.00
Director of Nursing	0.00	1.00
Total Non-Patient Care Positions	N/A	3
Total Employees *(A+B)*	0	13.6

C. Contractual Staff		
Contractual Staff Position	0.00	0.00
Total Staff *(A+B+C)*	0	13.6

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		09/23/26
2. Building Construction Commenced	90	12/21/26
3. Construction 100% Complete (Approval for Occupancy)	395	10/22/27
4. Issuance of License	456	12/22/27
5. Issuance of Service	518	02/22/28
6. Final Project Report Form Submitted (Form HR0055)	559	04/03/28

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

10150 Garage Sales

YARD SALE
3348 Timber View Ln.
Cookeville
SAT 7/11
7AM - 4
Furniture, antiques, clothing (newborn - adult XL), shoes, toys, books, seasonal items, home decor, kitchen items.

Estate Sale
July 10-11 8-5
Friday and Saturday
3436 Officers Chapel Road
Cookeville
Estate of the late Janice Parish. A Huge Sale!!! House, garage, and shed are completely full! Items to include: Quilts, pottery, Blue Willow China, China Cupboard, console table, mirror, GE washer, Dresser, Shelving units, Chenille spread, Antique toys, luggage, costume jewelry, McCoy, vintage Pyrex, antique radio, Linens, antique fans, dresser sets, books, sheet music, office chair, desks, sewing machine, wonderful lamps, shells, file cabinets, toy cars, vacuums, shredders, pillows, Longerberger baskets, doilies, Albums, TVs, children's books, Paintings, Xmas, easter and Halloween decor, vintage Halloween masks, baskets, recliner, sofa, wing back chair, Yamaha Keyboard, cameras, glider, sweetgrass baskets, Pioneer stack stereo and speakers, Wonderful dulcimer, vintage wedding dress, cleaning supplies, golf clubs, bassinet, Lots of Vera Bradley pieces, Pots and Pans, bakeware, electronics, dishes, small appliances, sewing supplies, musical items, lots and lots of tools, tool boxes, vintage baseball glove, coolers, license plates, vintage wooden sleds, bird bath, picnic table, outdoor furniture, grill, ladders, wheelchair, walker, garden tools, stained glass windows, steamer trunk, great antique wooden carpenters box, and so much more! Note: there are several pocket knives and ammunition
For more information call
Patti Ross (931) 808-6535
See pictures at
Estatesales.net

GARGE SALE
1401 COUNTRY CLUB PL
FRI 7/10 & SAT 7/11
7:00AM TO 5:00PM
Christmas, Halloween, Easter, Valentine, and home decor, men's clothes size L-3XL pants size 40-46, women's clothes size M-XL, men's shoes 9-13, women's size 8 1/2 to 9 1/2, golf clubs, golf bags, coolers and much more.
Let us fit all your family needs!

MULTI FAMILY YARD SALE
1715 Denton Ave. Cookeville
July 10 - 12
7 - ?
Men's, women's, kids, appliances, too much to list.

10200 Employment

Communications and Marketing Generalist Specialist II, Printing Services, Tennessee Tech University.
Complete position summary and application procedure available at https://jobs.tntech.edu. The application screening date is July 20, 2026; open until filled. Tennessee Tech is an Equal Opportunity/Affirmative Action employer.

CR Electric Services
is interviewing experienced electricians.
Please call 931-644-1146 or 931-528-0017
if you are interested.

10500 Merchandise

I buy used
American Made tools
Mechanics & Machinists
Call David the tool recycler
931-250-7406.

10600 Real Estate For Rent

1009 Brown Avenue
2BDR/1.5BA;
$1,050 monthly.
Appliances furnished
W/D hook ups
Wood & tile flooring.
NO PETS/ NO SMOKING.
931-239-6938

NEWLY RENOVATED
University apt.
333 East 12th St.
2BDR/ 1BA
W/D hook ups;
Appliances furnished;
$1100 monthly
NO PETS/ NO SMOKING
931-239-6938

10700 Real Estate For Sale

SUNDAY, JULY 12
1-2:30 PM
1581 Bayview Drive
COOKEVILLE
$475,000
Hosting Agent: Fred Pugh
931-239-3155
Listing Agent: Gina Key
Directions from PCCH: S. on Jefferson Ave, L on E. Veterans Dr/S Maple, Cross Hwy. 111 to Old Sparta Rd, L on Bayview Dr, House on right
See our display ad in Saturday, July 11 Herald-Citizen Classifieds for more details.
American Way R. E.
931-526-9581-Office
931-267-3271 Gina

10900 Legals

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 June 10, 2024, executed by SEAN PROCTOR, an unmarried man, to Chaffin Title & Escrow, as Trustee for MORTGAGE ELECTRONIC REGISTRATION SYSTEMS, INC., AS BENEFICIARY, AS NOMINEE FOR FAIRWAY INDEPENDENT MORTGAGE CORPORATION, its successors and assigns, recorded on June 10, 2024 in Book 1546, Page 503, in Instrument Number: 299045, in the Register of Deeds Office for Putnam County, Tennessee, to which reference is hereby made; and
WHEREAS, SELECT PORTFOLIO SERVICING, INC., hereinafter "Creditor", the party entitled to enforce said security interest, having appointed Robertson, Anschutz, Schneid, Crane & Partners, PLLC, as Substitute Trustee.
NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable, and that Robertson, Anschutz, Schneid, Crane & Partners, PLLC, as Substitute Trustee, or its agent, by virtue of the power, duty, and authority vested in and imposed upon said Substitute Trustee, will, on August 11, 2026, at 11:00 AM local time, at the Putnam County Courthouse, 300 East Spring Street, Cookeville, TN 38501, in Putnam County, Tennessee, offer for sale certain property hereinafter described to the highest bidder for cash or certified funds paid at the conclusion of the sale, or credit bid from a bank or other lending entity preapproved by the Substitute Trustee. The property to be sold is described as follows:
A CERTAIN TRACT OR PARCEL OF LAND LOCATED IN THE FIFTEENTH CIVIL DISTINCT OF PUTNAM COUNTY, TENNESSEE, DESCRIBED AS FOLLOWS TO-WIT: BEING LOT NO. 1 OF ROBINSON ESTATES, A PLAT OF WHICH IS OF RECORD IN PLAT CABINET D., SLIDE 20, IN THE REGISTER'S OFFICE OF PUTNAM COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREIN REFERRED FOR A MORE COMPLETE DESCRIPTION.
Commonly known as: **3404 WJ ROBINSON RD COOKEVILLE, TN 38506**
Parcel number(s): 15-008-J - 008-J -A-001.00- - 000
In the event of a discrepancy between the legal description, the street address, and/or the parcel number(s), the legal description shall control.
The sale is subject to the following: tenant(s)/occupant(s) rights in possession, if any; all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory rights of redemption of any state or federal governmental agency; any prior liens or encumbrances; any priority created by a fixture filing; and any matter that an accurate survey of the property might disclose. Additionally, the following parties might claim an interest in the property: **SEAN PROCTOR; CROSS RIVER BANK** .
If the United States, the State of Tennessee, or any agency thereof have any liens on the property and are named herein as interested parties, timely notice has been given to them in accordance with applicable law, and the sale will be subject to any applicable rights of redemption held by such entities, as required by 26 U.S.C. § 7425 and/or T.C.A. § 67-1-1433.
The property will be sold AS IS, WHERE IS, WITH ALL FAULTS, and without warranty of any kind, express or implied, as to the condition of the property or any improvements thereon, including but not limited to merchantability or fitness for a particular purpose. The Substitute Trustee makes no covenant of seisin or warranty of title, express or implied, and will only convey the property by Substitute Trustee's Deed. Except as noted above, all right and equity of redemption, statutory or otherwise, homestead, and exemption are expressly waived in the Deed of Trust.
The sale held pursuant to this notice is subject to the express reservation that it may be rescinded by the Substitute Trustee at any time. If the sale is rescinded for any reason, the purchaser shall only be entitled to a refund of funds tendered to purchase the subject property, and shall have no further or other recourse against Creditor, the Substitute
Trustee, or their successor(s), assign(s), agent(s), and attorney(s). The right is reserved to adjourn 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. Notice of such adjournment will also be mailed to interested parties when required by applicable law.
If you have any questions or concerns, please contact:
Robertson, Anschutz, Schneid, Crane & Partners, PLLC
Attn: TN Foreclosure
13010 Morris Rd, Ste 450
Alpharetta, GA 30004
(423) 498-7400
tnfc@raslg.com
Please reference file number 26-409261 when contacting our office.
Investors website:
https://www.rascranesalesinfo.com and
https://BetterChoiceNotices.com
THIS OFFICE MAY BE ACTING AS A DEBT COLLECTOR ATTEMPTING TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE
7/11, 7/18

10900 Legals

NOTICE
Notice is hereby given that on **July 27, 2026 at 10:00 a.m.** the following vehicle(s) will be sold to the highest bidder to satisfy garagekeeper's lien(s) currently being held by
SOS Towing & Recovery Services, LLC.
Service on said vehicles:

2004 STRN S12
VIN 1G8AJ52F24Z231090
2004 STRN VUE
VIN 5GZCZ53414S832289
2018 VOLK TGN
VIN 3VV4B7AXXJM217068

Said sale will take place at SOS Towing & Recovery Services, LLC., 20 CC Camp Rd., Cookeville, TN and will be sold as is.
SOS Towing & Recovery Services, LLC shall reserve the right to reject any bid below the amount of invoiced garagekeeper's lien.
7/11

LEGAL ADVERTISEMENT
The Board of Commissioners for Highlands Residential Services will meet in a regular session on Thursday, July 16, 2026 at Noon at Highlands Residential Services, 235 W Jackson, Cookeville, Tennessee.
By: Robert Owens Chairman
7/11

NOTICE
The Board of Commissioners for Double Springs Utility District has rescheduled their monthly meeting for July 13th, 2026, 10:00am at the District's office. The office is located at 2677 West Broad Street, Cookeville, TN. To be placed on the Board's agenda, please contact the office at (931) 526-3827.
7/8 (online), 7/11

10900 Legals

NOTICE
EMILEE BELLE LEDBETTER
The State of Tennessee, Department of Children's Services, has filed a Petition for Termination of Parental Rights as to J.L. It appears that ordinary process of law cannot be served upon you because your whereabouts are unknown. You are hereby ORDERED to serve upon Michael Rocco, Attorney for the Tennessee Department of Children Services, Cumberland County, Tennessee 38555, an Answer to the Petition for Termination of Parental Rights filed by the Tennessee Department of Children Services, within thirty (30) days of the last day of publication of this notice, and pursuant to Rule 39(e)(l) of the Tenn. R. Juv. P. you must also appear in the Juvenile Court of Cumberland County, Tennessee at Cumberland, Tennessee on the 26th day of August, 2026, at 8:30 a.m., for the Hearing on the Petition for Termination of Parental Rights by the State of Tennessee, Department of Children's Services If you fail to do so, a default judgment will be taken against you pursuant to Tenn. Code Ann.§ 36-l-l 17(n) and Rule 55 of the Tenn. R. of Civ. P. for the relief demanded in the Petition. You may view and obtain a copy of the Petition and any other subsequently filed legal documents at the Juvenile Court Clerk's Office, Cumberland Tennessee.
6/27, 7/4, 7/11, 7/18

NOTICE TO CREDITORS
ESTATE OF
GARY DOUGLAS ALLEN, DECEASED
Notice is hereby given that on 30th day of JUNE 2026, Letters ADMINISTRATION in respect of the Estate of GARY DOUGLAS ALLEN deceased who died NOVEMBER 2ND 2025 were issued to the undersigned by the Probate Court of Putnam County, Tennessee. All persons, resident and non-resident, having claims, matured or unmatured, against the estate are required to file same with the Clerk of the above-named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1)(A) Four (4) months from the date of the first publication of this notice if the creditor received an actual copy of this notice to creditors at least sixty (60) days before the date that is four (4) months from the date of the first publication; or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication as described in (1)(A): or
(2) Twelve (12) months from the decedent's date of death.
This 30th day of JUNE 2026.
Signed CHARLOTTE LYNNE ALLEN EXECUTRIX
Attorney for the Estate
ALEXANDER G, BAKER
220 KING STREET
COOKEVILLE TN 38501
Jennifer Wilkerson,
Circuit and Probate Clerk
421 East Spring Street
Cookeville, TN 38501
931-528-1508
7/11, 7/18

NOTICE TO CREDITORS
ESTATE OF ANNE CATHERINE CARKNER, DECEASED
Notice is hereby given that on 30th day of JUNE 2026, Letters TESTAMENTARY in respect of the Estate of ANNE CATHERINE CARKNER, deceased who died MARCH 13TH 2026 were issued to the undersigned by the Probate Court of Putnam County, Tennessee.
All persons, resident and non-resident, having claims, matured or unmatured, against the estate are required to file same with the Clerk of the above-named Court on or before the earlier of the dates prescribed in (1) or (2) otherwise their claims will be forever barred:
(1)(A) Four (4) months from the date of the first publication of this notice if the creditor received an actual copy of this notice to creditors at feast sixty (60) days before the date that is four (4) months from the date of the first publication; or
(B) Sixty (60) days from the date the creditor received an actual copy of the notice to creditors if the creditor received the copy of the notice less than sixty (60) days prior to the date that is four (4) months from the date of first publication as described in (1)(A): or
(2} Twelve (12) months from the decedent's date of death.
This 30th day of JUNE 2026
Signed JACKILYN YORK EXECUTRIX
Attorney for the Estate
ALEXANDER G. BAKER
220 KING STREET
COOKEVILLE TN 38501
Jennifer Wilkerson,
Circuit and Probate Clerk
421 East Spring Street
Cookeville, TN 38501
931-528-1508
7/11, 7/18

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 TN Heart Cardiovascular Surgery Center, LLC, a/an Ambulatory Surgical Treatment Center (ASTC) – Single Specialty owned by The Stern Cardiovascular Center, P.A. with an ownership type of Professional Association and to be managed by Atria Health Services of the South, LLC intends to file an application for a Certificate of Need for the establishment of an ASTC limited to the initiation of diagnostic and therapeutic cardiovascular catheterization and diagnostic and therapeutic electrophysiology procedures, including cardiac rhythm device implantation procedures, electrophysiology studies, and cardiac ablation procedures, that the Centers for Medicare & Medicaid Services has approved for performance in the ASTC setting. The address of the project will be 999 S. Willow Avenue, Cookeville, Putnam County, Tennessee, 38501. The estimated project cost will be $11,835,798.
The anticipated date of filing the application is 08/03/2026
The contact person for this project is Mr. Jeffrey Stofko who may be reached at Ascendient Healthcare Advisors Inc - 1335 Environ Way, Chapel Hill, North Carolina, 27517 – Contact No. 919-403-3300.
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.

Delaware

The First State

I, CHARUNI PATIBANDA-SANCHEZ, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "TN HEART CARDIOVASCULAR SURGERY CENTER, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE EIGHTH DAY OF JULY, A.D. 2026.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "TN HEART CARDIOVASCULAR SURGERY CENTER, LLC" WAS FORMED ON THE SEVENTH DAY OF JULY, A.D. 2026.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.

C. J. Sanchez

Charuni Patibanda-Sanchez, Secretary of State

10689437 8300

Authentication: 204469230

SR# 20263663547

Date: 07-08-26

You may verify this certificate online at corp.delaware.gov/authver.shtml

Delaware

The First State

I, CHARUNI PATIBANDA-SANCHEZ, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "TN HEART CARDIOVASCULAR SURGERY CENTER, LLC", FILED IN THIS OFFICE ON THE SEVENTH DAY OF JULY, A.D. 2026, AT 3:40 O`CLOCK P.M.

C. P. Sanchez

Charuni Patibanda-Sanchez, Secretary of State

10689437 8100
SR# 20263645131

Authentication: 204468362
Date: 07-08-26

You may verify this certificate online at corp.delaware.gov/authver.shtml

CERTIFICATE OF FORMATION
OF
TN HEART CARDIOVASCULAR SURGERY CENTER, LLC

This Certificate of Formation of TN Heart Cardiovascular Surgery Center, LLC is to be filed with the Secretary of State of the State of Delaware pursuant to Section 18-201 of the Delaware Limited Liability Company Act.

1. The name of the limited liability company is TN Heart Cardiovascular Surgery Center, LLC.

2. The registered office of the limited liability company in the State of Delaware is located at 1209 Orange Street, City of Wilmington, County of New Castle, Delaware 19801. The name of the registered agent at such address upon whom process against this limited liability company may be served is The Corporation Trust Company.

3. This Certificate is to be effective upon filing.

Dated as of this 7th day of July, 2026.

/s/ Brenna Johnson
Brenna Johnson, Authorized Person

State of Delaware
Secretary of State
Division of Corporations
Delivered 03:40 PM 07/07/2026
FILED 03:40 PM 07/07/2026
SR 20263645131 - File Number 10689437

Division of Business and Charitable Organizations
Department of State
State of Tennessee
312 Rosa L. Parks Avenue, 6th Floor
Nashville, Tennessee 37243
Phone: 615-741-2286
tncab.tnsos.gov/portal/

Tre Hargett
Secretary of State

Capital Filing Service
992 DAVIDSON DRIVE SUITE B
NASHVILLE, TN 37205, USA

07/20/2026

Request Type: Certificate of Existence/Authorization

Issuance Date: 07/20/2026

Request #: C2026079806

Document Receipt

Order Number: C2026079806		Verification #: 24D69003	
Receipt #: 2026-714700		Filing Fee:	$20.00
Payment: Credit Card - 3924444293			$20.00

Entity Name:	TN HEART CARDIOVASCULAR SURGERY CENTER, LLC		
SOS Control #:	002128329	Initial Filing Date:	07/09/2026
Entity Type:	Foreign Limited Liability Company (LLC)	Formation Locale:	Delaware
Status:	Active	Duration Term:	Perpetual
Fiscal Year Close:	December	Annual Report Due:	04/01/2027
Business County:	Putnam		
Managed By:	Member Managed		
Obligated Member Entity:	No		

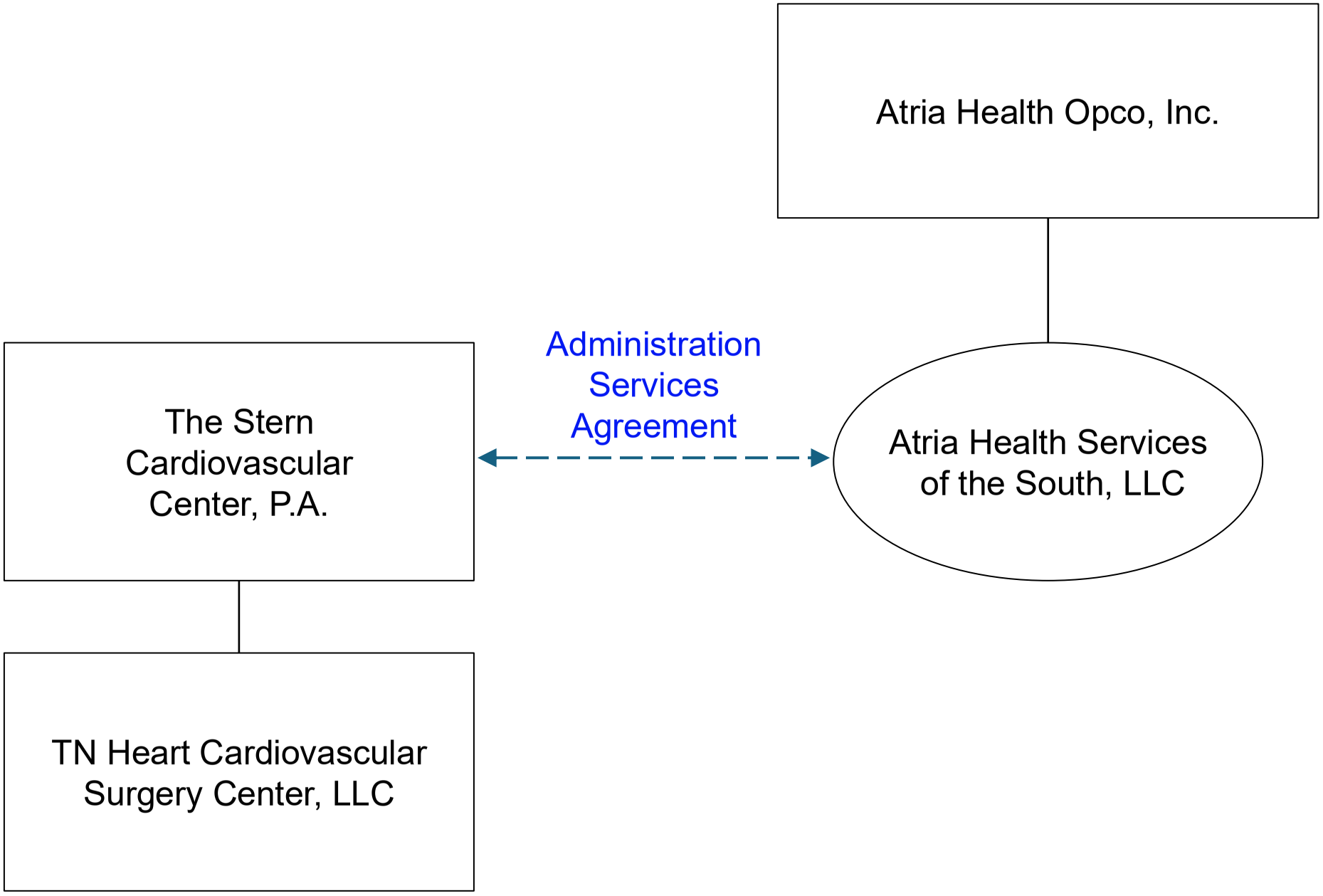
CERTIFICATE OF AUTHORIZATION

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

TN HEART CARDIOVASCULAR SURGERY CENTER, LLC

* is a Limited Liability Company formed in the jurisdiction set forth above and is authorized to transact business in this State;
* 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 an Application for Certificate of Withdrawal.

Tre Hargett
Secretary of State


Atria Health Opco, Inc.
Administration Services Agreement
The Stern Cardiovascular Center, P.A.
Atria Health Services of the South, LLC
TN Heart Cardiovascular Surgery Center, LLC

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement (the "Agreement") is entered into on January 1, 2026, by and between Atria Health Services of the South, LLC, a Delaware limited liability company (the "Contractor"), and The Stern Cardiovascular Center, P.A., a Tennessee corporation (the "Company"). The Company and the Contractor are collectively referred to herein as the "Parties".

RECITALS

A. The Company is engaged in the provision of professional medical and related services (the "Practice") in Tennessee, Mississippi, and Arkansas and the Company's physicians and other clinical staff (collectively, the "Clinical Professionals") hold all licenses and permits necessary to provide such professional medical and related services in such jurisdictions.

B. The Company desires to engage the Contractor to provide and arrange for certain non-clinical administrative, business support and back-office services.

AGREEMENT

In consideration of the premises and the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties, intending to be legally bound, hereby agree as follows:

ARTICLE I
ENGAGEMENT AND AUTHORITY

1.1 Engagement of the Contractor. On the terms and subject to the conditions contained in this Agreement, the Company hereby engages the Contractor, and the Contractor hereby accepts engagement by the Company, to provide and/or to arrange for the provision to the Company of the Administrative Services. The Company expressly acknowledges that the Contractor may subcontract with third-parties for the performance of certain Administrative Services.

1.2 Relationship of Parties. In performing their respective duties and obligations under this Agreement, the Parties are independent contractors. The Parties will not be deemed to be joint venturers, partners or employees of each other.

1.3 Conduct of Professional Practice. The Company will solely and exclusively control the provision of professional clinical services, and the Contractor will neither have nor exercise any control or discretion over the methods by which the Company or Clinical Professionals render professional clinical services. Nothing in this Agreement will be construed to alter or otherwise affect the legal, ethical or professional relationships between and among the Company, the Clinical Professionals and their patients, nor does anything in this Agreement abrogate any right, privilege or obligation arising from or related to the physician-patient relationship.

1.4 Company Action. Unless otherwise specified in this Agreement, when this Agreement calls for the approval, consent, direction or other action by the Company, the action of any officer of the Company will constitute the action of the Company. In each instance, the Contractor may assume that all consents and approvals required by the Company's articles of incorporation and bylaws (the "Company Governing Documents") have been obtained.

ARTICLE II
ADMINISTRATIVE SERVICES

2.1 General Authority.

(a) On the terms and subject to the limitations set forth in this Agreement, the Contractor will provide or arrange for the provision of the non-clinical administrative, business support, and other services set forth in this Article II and Exhibit A solely to the extent applicable to the New Services (the "Administrative Services") and the Contractor will be the Company's exclusive third party provider of Administrative Services during the Term. For the sake of clarity, the Company is permitted to engage Stern MSO for the provision of Legacy Services.

(b) The Company expressly authorizes the Contractor to perform the Administrative Services in the manner that the Contractor deems reasonably appropriate to meet the day-to-day business needs of the Company. The Company will not prevent the Contractor from providing, or causing to be provided, and the Contractor will provide or cause to be provided, the Administrative Services in a business-like manner and in compliance with (i) all applicable Laws, (ii) all Orders by which the Parties are bound or to which the Parties are subject, and (iii) the standards, rules and regulations of the United States Department of Health and Human Services and any other federal, state or local government agency or Third-Party Payor exercising authority with respect to, accrediting, or providing reimbursement for, the Company or the Practice. The Contractor will not provide any service that would constitute the clinical practice of medicine or which the Contractor is not otherwise authorized or permitted to perform under applicable Law.

2.2 Services the Contractor May Not Provide. Notwithstanding anything to the contrary herein, the Contractor will not provide any of the following services to the Company:

(a) assigning or designating clinical providers to specific locations or to treat specific patients,

(b) assuming responsibility for the care of patients,

(c) deciding what professional clinical service should be provided to patients or how

such services should clinically be provided,

(d) engaging in any activity that constitutes the practice of medicine or any other profession or that would subject the Contractor to professional licensure under applicable state Laws or that would otherwise be prohibited by applicable Law, or

(e) providing the Company with any inducement or remuneration in exchange for recommending to patients any services provided by the Contractor.

2.3 No Marketing or Referrals. None of the Administrative Services obligate the Contractor to engage in any marketing activities or otherwise generate patient flow or business for the Company in violation of applicable Law.

ARTICLE III
GENERAL OBLIGATIONS

3.1 Duty to Cooperate. The Parties acknowledge that mutual cooperation is critical to the performance of their respective duties and obligations under this Agreement. To ensure the communication necessary for mutual cooperation, the Company will permit a representative designated by the Contractor (the "Contractor Representative") to attend and participate (in a non-voting observer capacity), either in person or via teleconference, in meetings of the Company's board of directors or equivalent governing body and meetings of the Company's equityholders called pursuant to the Company Governing Documents or as otherwise required by applicable Law for the purpose of discussing the performance of the Parties' respective duties and obligations under this Agreement. The Company will give the Contractor at least five (5) calendar days' prior written notice of each such meeting, specifying the date, time and place of the meeting and, if the meeting is a special meeting, the purposes for which the meeting is called.

3.2 Clinical Professionals. The Company will employ or engage all Clinical Professionals necessary to conduct, manage and operate in a proper and efficient manner the Practice.

3.3 Business Associate Provisions. The Contractor acknowledges and agrees that the Company may be a "*covered entity*" (as defined under HIPAA) if it engages in standardized electronic transactions (e.g., direct billing for services), and the Contractor therefore may be a "*business associate*" (as defined under HIPAA) of the Company if the Contractor provides services to the Company that involve the disclosure of "*protected health information*" (as defined under HIPAA) by the Company or its business associates to the Contractor. The Contractor agrees to perform any services that involve the disclosure of protected health information by the Company or its business associates to the Contractor in accordance with the Business Associate Provisions set forth on Exhibit B.

3.4 Service and Specialty Requirements; Standards. The Company will be solely responsible for (x) supervising the Clinical Professionals' submission to the Company of complete, accurate and timely documentation for coding and billing services provided in the Practice, and (y) overseeing, developing and implementing policies of a purely professional nature (including medical records documentation, clinical communications with patients and the determination of resources to be used for particular patients).

3.5 Regulatory Matters.

(a) The Clinical Professionals will be free, in their sole discretion, to exercise their professional judgment in the course of treating patients of the Company, and nothing in this Agreement permits the Contractor to affect or influence the professional judgment of any Clinical Professional.

(b) The Parties agree to cooperate with one another in the fulfillment of their respective obligations under this Agreement, and to comply with (i) all Laws applicable to the Company or the Clinical Professionals and all Orders by which the Company or the Clinical Professionals are bound or to which the Company or the Clinical Professionals are subject (including Laws and Orders relating to the practice of medicine, institutional and professional licensure, pharmacology and dispensing medicines or controlled substances, medical documentation, medical record retention, laboratory services, unprofessional conduct, fee-splitting, referrals, billing and submission of false or fraudulent claims, claims processing, quality, safety, medical necessity, medical privacy and security, patient confidentiality and informed consent and the hiring of employees or acquisition of services or supplies from Persons excluded from participation in any Federal Health Care Program, the federal anti-kickback statute and the applicable regulations thereunder, the federal self-referral statute and the applicable regulations thereunder, and all applicable state anti-kickback and self-referral laws and regulations), and (ii) the requirements of any insurance company insuring the Company, the Clinical Professionals or the Contractor against liability for injury or accident in or on the premises of the Company or the Practice.

3.6 Books and Records. During the Term and continuing until the seventh anniversary of the expiration or termination of this Agreement, each Party will retain and provide the other Party with full and unrestricted access to its books and records (including work papers in the possession of its accountants) to the extent reasonably related to the services provided or to be provided hereunder, subject to the disclosing Party's reasonable confidentiality requirements or other privileged documents. Each Party shall give the other Party reasonable advance notice of a request for access and shall, and shall cause its agents and representatives to, conduct any inspections or reviews in a manner to minimize interference with the operations of the other Party's business.

ARTICLE IV
COMPENSATION OF THE CONTRACTOR AND DEFICIT FUNDING

4.1 Services Fee. Upon the terms and subject to the conditions contained in this Agreement, the Company will pay the Contractor the fee (the "Services Fee") set forth in Exhibit C during the Term in consideration of the Administrative Services rendered by the Contractor pursuant to this Agreement.

(a) The Parties acknowledge and agree that the Services Fee paid hereunder has been determined through good faith and arm's-length bargaining to constitute fair market value compensation for the Administrative Services, without consideration of the proximity of the Company to any referral sources or the volume or value of any referrals from the Contractor or any of its Affiliates to the Company or the Clinical Personnel or from the Company or the Clinical Personnel to the Contractor or any of its Affiliates, that is reimbursed under any government or private health care payment or insurance program, including any Federal Health Care Program.

(b) Payment of the Services Fee and any other amounts payable to the Contractor under this Agreement is not conditioned upon a requirement that the Company or the Clinical Personnel make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the Contractor or any of its Affiliates or a requirement that the Contractor or any of its Affiliates make referrals to, be in a position to make or influence referrals to, or otherwise generate business for the Company or the Clinical Personnel. The Services Fee does not include any discount, rebate, kickback, or other reduction in charge.

4.2 Expense Reimbursement. [Redacted]

4.3 Priority of Payments. [Redacted]

4.4 Failure to Pay. The Company's failure to pay any portion of the Services Fee or reimbursable expenses when due will be a material breach of this Agreement by the Company.

4.5 Deficit Funding Loan Agreement. If the Company does not have sufficient cash to pay for its liabilities or financial obligations (including any portion of the Services Fee or reimbursable expenses owed to Contractor hereunder), then (a) at any time before the fifth anniversary of the date of this Agreement, Contractor shall loan to the Company, upon request of the Company, funds ("Advances") in an amount to enable the Company to pay its liabilities and its financial obligations, subject to the terms and conditions of that certain Deficit Funding Loan Agreement of even date herewith ("Deficit Funding Loan Agreement") and (b) on and after the fifth anniversary of the date of this Agreement, Contractor may, in its sole discretion, loan to the Company, upon request of the Company, Advances in an amount to enable the Company to pay its liabilities and its financial obligations, subject to the terms and conditions of the Deficit Funding Loan Agreement. Funded Advances will be added to the amounts owed by the Company to Contractor pursuant to the Deficit Funding Loan Agreement and will bear interest as set forth therein. The Company will repay funded Advances in accordance with the terms of the Deficit Funding Loan Agreement.

ARTICLE V
TERM AND TERMINATION

5.1 Initial Term; Automatic Renewals. The initial term of this Agreement commences on the date of this Agreement and ends [Redacted], subject to earlier termination in accordance with Section 5.2 (the "Initial Term" and, together with all Renewal Terms, the "Term"). After the Initial Term, this Agreement will automatically renew for [Redacted] (each a "Renewal Term") unless (i) either Party delivers written notice to the other Party of its intent not to renew this Agreement at least 180 calendar days before the end of the Term or (ii) this Agreement is otherwise terminated in accordance with Section 5.2.

5.2 Termination. This Agreement may be terminated during the Term:

(a) by mutual agreement of the Parties,

(b) [Redacted]

(c) [Redacted]

5.3 Effect of Expiration or Termination.

(a) The expiration or termination of this Agreement in accordance with Section 5.2 will automatically relieve and release each Party from the executory portion of such Party's obligations under this Agreement; *provided, however, that* all obligations expressly extended beyond the Term by the terms of this Agreement (including this Article V, Article VI, Article VII and Article IX) will survive the expiration or termination of this Agreement.

(b) After the expiration or termination of this Agreement, to effect an orderly wind up of the contractual relationship between the Parties:

(i) Promptly (but in any event within 10 calendar days) after the expiration or termination of this Agreement, the Company will, and will cause its Affiliates, directors, managers, officers, equityholders, employees, agents, successors and permitted assigns to, either return to the Contractor or destroy, delete or erase all written, electronic or other tangible forms of Confidential Information as required under Section 6.2,

(ii) The Company will cooperate with the Contractor to surrender and deliver promptly and orderly to the Contractor any property or other assets owned by Contractor that are in the possession or control of the Company, in the same order and condition as when received (ordinary wear and tear excepted), and

(iii) [Redacted]

ARTICLE VI
RESTRICTIVE COVENANTS

6.1 Restrictive Covenants. In the course of receiving the Administrative Services, each Party will have access to the most sensitive and most valuable trade secrets, proprietary information and other confidential information, including management reports, marketing studies, marketing plans, business plans, financial statements, feasibility studies, financial, accounting and statistical data, price and cost information, customer lists, contracts, policies and procedures, internal memoranda, reports and other materials or records of a proprietary or confidential nature of the other Party (collectively, "Confidential Information"), which constitute valuable business assets of such Party and its Affiliates, and the use, application or disclosure of such Confidential Information will cause substantial and possibly irreparable damage to the business and asset value of the disclosing Party. Therefore, as an inducement for the Parties to enter into this Agreement and to protect the Confidential Information and other business interests of the Parties, each Party agrees to be bound by the restrictive covenants contained in this Article VI.

6.2 Disclosure of Confidential Information. After the date of this Agreement, each Party will, and will cause its Affiliates, directors, managers, officers, equityholders, employees, agents, successors and permitted assigns to, keep confidential and not disclose to any other Person or use for its own benefit or the benefit of any other Person, other than in connection with the services described herein, any of the other Party's Confidential Information; *provided, however, that* the obligations under this Section 6.2 will not apply to Confidential Information that (i) is or becomes generally available to the public without breach of the commitments contemplated by this Section 6.2, (ii) was available to the receiving Party or its Affiliates, directors, managers, officers, equityholders, employees or agents on a non-confidential basis before the date of this Agreement, (iii) is disclosed to a Party's accountants, attorneys or other financial advisors, or (iv) is required to be disclosed by any Law or Order; *provided that* as soon as practicable before such disclosure, the receiving Party gives the other Party prompt written notice of such disclosure to enable the other Party, at its cost and expense, to seek a protective order or otherwise preserve the confidentiality of such information. Promptly after the expiration or termination of this Agreement, upon the request of the disclosing Party, the other Party will, and will cause its Affiliates, directors, managers, officers, equityholders, employees, agents, successors and permitted assigns to, (i) either return to the disclosing Party or destroy, delete or erase (with written certification of such destruction, deletion or erasure provided to the disclosing Party by the other Party) all written, electronic or other tangible forms of the disclosing Party's Confidential Information. After the expiration or termination of this Agreement, each Party will not, and will cause its Affiliates, directors, managers, officers, equityholders, employees, agents, successors and permitted assigns not to, retain any copies, summaries, analyses, compilations, reports, extracts or other materials containing or derived from any Confidential Information of the disclosing Party. Notwithstanding such return, destruction, deletion or erasure, all oral Confidential Information and the information embodied in all written Confidential Information will continue to be held confidential pursuant to the terms of this Section 6.2.

6.3 Covenant Not to Compete. [Redacted]

6.4 Covenant Not to Solicit. [Redacted]

6.5 Non-Disparagement.

(a) After the date of this Agreement, the Company will not, directly or indirectly, make any disparaging, derogatory, negative or knowingly false statement about any Company Group entity or any of their respective directors, managers, officers, equityholders, employees, agents, representatives (including the Contractor Representative), successors and permitted assigns, or any of their respective businesses, operations, financial condition or prospects, except as required by applicable Law or Order.

(b) After the date of this Agreement, the Contractor will direct its senior executive

management team to not, directly or indirectly, make any disparaging, derogatory, negative, or knowingly false statement about the Company or any of its directors, managers, officers, equityholders, employees, agents, successors and permitted assigns, or any of their respective businesses, operations, financial condition or prospects, except as required by applicable Law or Order.

6.6 Scope of Covenants; Equitable Relief. Each Party acknowledges and agrees that (i) the restrictive covenants contained in this Article VI and the territorial, time, activity and other limitations set forth herein are commercially reasonable and do not impose a greater restraint than is necessary to protect the goodwill and legitimate business interests of the other Party and its businesses, (ii) any breach of the restrictive covenants in this Article VI will cause irreparable injury to the non-breaching Party and that actual damages may be difficult to ascertain and would be inadequate and (iii) if any breach of any such covenant occurs, then the non-breaching Party will be entitled to injunctive relief in addition to such other legal and equitable remedies that may be available (without limiting the availability of legal or equitable, including injunctive, remedies under any other provisions of this Agreement) and (iv) the breaching Party hereby waives the claim or defense that an adequate remedy at law exists for such a breach.

6.7 Equitable Tolling. If either Party breaches any covenant in this Article VI, then the duration of such covenant will be tolled for a period of time equal to the time of such breach and, if the other Party seeks injunctive relief or other remedies for any such breach, then the duration of such covenant will be tolled for a period of time equal to the pendency of such proceedings (including all appeals).

ARTICLE VII
INDEMNIFICATION AGAINST PROFESSIONAL LIABILITIES

7.1 Indemnification Against Professional Liabilities. The Company will indemnify, defend and hold harmless the Contractor, its Affiliates and their respective directors, managers, officers, equityholders, employees, contractors, agents (including the Contractor Representative), successors and permitted assigns (collectively, the "Contractor Indemnified Parties") from and against all losses, liabilities, demands, claims, actions or causes of action, regulatory, legislative or judicial proceedings or investigations, assessments, levies, fines, penalties, damages, costs and expenses (including reasonable attorneys', accountants', investigators' and experts' fees and expenses) incurred in connection with the defense or investigation of any claim ("Damages") sustained or incurred by any Contractor Indemnified Party arising from or related to the provision of professional services by the Company or any of its personnel (whether employees or independent contractors).

7.2 Cooperation and Settlement. The Company and the Contractor will coordinate the defense and settlement of actions in which they are named.

7.3 Other Remedies. The provisions of this Article VII are in addition to, and not in derogation of, any statutory, equitable or common law remedies that the Contractor may have with respect to this Agreement or the subject matter of this Agreement.

7.4 Survival. The Company's indemnification obligations under this Article VII will survive the termination or expiration of this Agreement.

ARTICLE VIII
DEFINITIONS

For purposes of this Agreement, the following terms have the following meanings:

"Administrative Services" is defined in Section 2.1(a).

"Advances" is defined in Section 4.5.

"Affiliate" means, with respect to a particular Person, (i) any other Person that, directly or indirectly, controls, is controlled by or is under common control with such Person, (ii) any of such Person's spouse, siblings (by law or marriage), ancestors and descendants and (iii) any trust for the primary benefit of such Person or any of the foregoing. The term "control" means possession, direct or indirect, of the power to direct or cause the direction of the management and policies of another Person, whether through the ownership of voting securities or equity interests, by contract or otherwise.

"Agreement" is defined in the preamble to this Agreement.

"Budget" means the Company's budget for the New Services, which shall be prepared by the Contractor prior to the beginning of each fiscal year. The Budget shall be subject to review by the Company. Thereafter, the Company and the Contractor will meet monthly to discuss expenses and performance metrics.

"Business Day" means a day that is not a Saturday, Sunday or legal holiday on which banks are authorized or required to be closed in New York, New York.

"Clinical Professionals" is defined in Recital A.

"Company" is defined in the preamble to this Agreement.

"Company Governing Documents" is defined in Section 1.4.

"Company Group" means, collectively, the Contractor and its Affiliates, and those Persons for which the Contractor and its Affiliates provide business, administrative and back office services, including the Company.

"Competing Services" is defined in Section 6.3.

"Confidential Information" is defined in Section 6.1.

"Contractor" is defined in the preamble to this Agreement.

"Contractor Indemnified Parties" is defined in Section 7.1.

"Contractor Representative" is defined in Section 3.1.

"Damages" is defined in Section 7.1.

"Deficit Funding Loan Agreement" is defined in Section 4.5.

"Legacy Services" means all services provided by the Company other than New Services. The following shall be Legacy Services and not New Services: (i) clinical research, (ii) clinical co-management agreements, medical director agreements, call coverage agreements or other professional services agreements between the Company or any Clinical Professional and a hospital or other provider, and (iii) the replacement of any of the Company's equipment provided under that certain Administrative Services Agreement, of even date herewith, by and between the Company and Stern MSO, unless otherwise

agreed to by the Company.

"Federal Health Care Program" means any "*federal health care program*" as defined in 42 U.S.C. § 1320a-7b(f), including Medicare, state Medicaid programs, state CHIP programs, TRICARE and similar or successor programs with or for the benefit of any government authority.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and its implementing regulations (45 C.F.R. parts 160-164).

"Initial Term" is defined in Section 5.1.

"Law" means any federal, state, local, municipal, foreign, international, multinational or other constitution, statute, law, rule, regulation, ordinance, code, principle of common law or treaty.

"New Services" means any of the Company's new ventures or service lines established after the date of this Agreement that are managed by Contractor pursuant to this Agreement, as mutually agreed upon by Company and Contractor.

"Operating Account" means the Company's operating bank account.

"Order" means any order, injunction, judgment, decree, ruling, assessment or arbitration award of any governmental authority or arbitrator.

"Parties" is defined in the preamble to this Agreement.

"Person" means any natural individual, corporation, partnership, limited liability company, joint venture, association, bank, trust company, trust or other entity, whether or not legal entities, or any governmental entity, agency or political subdivision.

"Practice" is defined in Recital A.

"Renewal Term" is defined in Section 5.1.

"Restricted Period" means the shorter of (i) the period from the date of this Agreement until the 2nd anniversary of the termination of this Agreement or (ii) the longest time period after the date of this Agreement that is permitted by applicable Law if two (2) years after the termination of this Agreement is not permitted.

"Restricted Person" is defined in Section 6.4(a).

"Restricted Territory" means anywhere (i) in Tennessee, Mississippi or Arkansas or (ii) within a 10 mile radius around any location at which the Company Group then conducts Competing Services or with respect to which the Company Group has taken concrete steps to expand its Competing Services.

"Services Fee" is defined in Section 4.1.

"Stern MSO" means Stern Management Services Organization, LLC, a Delaware limited liability company

"Term" is defined in Section 5.1.

"Third-Party Payors" means all Federal Health Care Programs and all other state or local governmental insurance programs and private, non-governmental insurance and managed care programs with which the Company contracts to provide services and products or through which the Company receives reimbursements for services rendered and products provided.

ARTICLE IX
GENERAL PROVISIONS

9.1 Force Majeure. Neither Party will be liable for any failure or inability to perform, or delay in performing, such Party's obligations under this Agreement if such failure, inability or delay arises from an extraordinary cause beyond the reasonable control of the non-performing Party; *provided that* such Party diligently and in good faith attempts to cure such non-performance as promptly as practicable.

9.2 Notices. All notices and other communications required or permitted under this Agreement (a) must be in writing, (b) will be duly given (i) when delivered personally to the recipient or sent to the recipient by e-mail (with delivery confirmation retained) or (ii) one Business Day after being sent to the recipient by nationally recognized overnight private carrier (charges prepaid) and (c) addressed as follows (as applicable):

If to the Company:

The Stern Cardiovascular Center, P.A.
8060 Wolf River Blvd.
Germantown, TN 38138
Attn: Steven S. Gubin, M.D.
Email: steven.gubin@sterncardio.com

with a copy (not constituting notice) to:

Maynard Nexsen PC
1901 6th Avenue North, Suite 1700
Birmingham, Alabama 35203
Attn: Joel C. Porter
Email: jporter@maynardnexsen.com

If to the Contractor:

Atria Health Services of the South
4031 Aspen Grove Dr
Suite 635
Franklin, TN 37067

with a copy (not constituting notice) to:

McDermott Will & Schulte LLP
333 SE 2nd Avenue, Suite 4500
Miami, FL 33131-2184
Attn: Joshua E. Spielman and Patrick Martinez
Email: jspielman@mwe.com;
pmartinez@mwe.com

or to such other respective address as each Party may designate by notice given in accordance with this Section 9.2.

9.3 Entire Agreement. This Agreement constitutes the complete agreement and understanding among the Parties regarding the subject matter of this Agreement and supersedes any prior understandings, agreements or representations regarding the subject matter of this Agreement.

9.4 Amendments. The Parties may amend this Agreement only pursuant to a written agreement executed by the Parties.

9.5 Non-Waiver. The Parties' respective rights and remedies under this Agreement are cumulative and not alternative. Neither the failure nor any delay by any Party in exercising any right, power or privilege under this Agreement will operate as a waiver of such right, power or privilege, and no single or partial exercise of any such right, power or privilege will preclude any other or further exercise of such right, power or privilege or the exercise of any other right, power or privilege. No waiver will be effective unless it is in writing and signed by an authorized representative of the waiving Party. No waiver given will be applicable except in the specific instance for which it was given. No notice to or demand on a Party will constitute a waiver of any obligation of such Party or the right of the Party giving such notice or demand to take further action without notice or demand as provided in this Agreement.

9.6 Assignment. Neither Party may assign this Agreement or any rights under this Agreement, or delegate any duties under this Agreement, without the other Party's prior written consent; *provided, however, that* the Contractor may freely assign this Agreement or any rights under this Agreement, or delegate any duties under this Agreement without the Company's consent (a) as a collateral assignment to the Contractor's lenders or (b) to any Person (i) into which the Contractor merges or consolidates, (ii) acquiring all or substantially all of the Contractor's assets, or (iii) acquiring control of the Contractor by equity or membership interest purchase.

9.7 Binding Effect; Benefit. This Agreement will inure to the benefit of and bind the Parties and their respective successors and permitted assigns. Nothing in this Agreement, express or implied, may be construed to give any Person other than the Parties and their respective successors and permitted assigns any right, remedy, claim, obligation or liability arising from or related to this Agreement. This Agreement and all of its provisions and conditions are for the sole and exclusive benefit of the Parties and their respective successors and permitted assigns.

9.8 Severability. If any court of competent jurisdiction or arbitrator holds any provision of this Agreement invalid or unenforceable, then the other provisions of this Agreement will remain in full force and effect. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable. If any court of competent jurisdiction or arbitrator holds the geographic or temporal scope of any restrictive covenant contained in Article VI invalid or unenforceable, then such restrictive covenant will be construed as a series of parallel restrictive covenants and the geographic or temporal scope of each such restrictive covenant will be deemed modified (including by application of any "blue pencil" doctrine under applicable Law) to the minimum extent necessary to render such restrictive covenant valid and enforceable.

9.9 Changes in Law. If any change in applicable Law occurs that does or is reasonably likely to affect adversely the manner in which any Party may perform or be compensated for its services under this Agreement or render this Agreement unlawful or illegal, then the Parties will cooperate in good faith with advice from knowledgeable legal counsel to amend this Agreement as necessary to comply with such change in applicable Law while preserving as closely as possible the economic arrangements and other terms of this Agreement in effect before such change in applicable Law.

9.10 References. The headings of Sections are provided for convenience only and will not affect the construction or interpretation of this Agreement. Unless otherwise provided, references to "Section(s)" and "Exhibit(s)" refer to the corresponding section(s) and exhibit(s) of this Agreement. Reference to a statute refers to the statute, any amendments or successor legislation and all rules and

regulations promulgated under or implementing the statute, as in effect at the relevant time. Reference to a section of any statute, listing rule, rule, standard, regulation or other law includes any successor to such section. Reference to a contract, instrument or other document as of a given date means the contract, instrument or other document as amended, supplemented and modified from time to time through such date.

9.11 Construction. Each Party participated in the negotiation and drafting of this Agreement, assisted by such legal and tax counsel as it desired, and contributed to its revisions. Any ambiguities with respect to any provision of this Agreement will be construed fairly as to all Parties and not in favor of or against any Party. All pronouns and any variation thereof will be construed to refer to such gender and number as the identity of the subject may require. The terms "include" and "including" indicate examples of a predicate word or clause and not a limitation on that word or clause.

9.12 Counterparts. The Parties may execute this Agreement in multiple counterparts, each of which will constitute an original and all of which, when taken together, will constitute one and the same agreement. The Parties may deliver executed signature pages to this Agreement by facsimile or e-mail transmission. No Party may raise as a defense to the formation or enforceability of this Agreement, and each Party forever waives any such defense, either (a) the use of a facsimile or email transmission to deliver a signature or (b) the fact that any signature was signed and subsequently transmitted by facsimile or email transmission.

9.13 Governing Law. THIS AGREEMENT IS GOVERNED BY THE LAWS OF THE STATE OF TENNESSEE, WITHOUT REGARD TO CONFLICT OF LAWS PRINCIPLES.

9.14 Arbitration. Except as expressly provided below in this Section 9.14, all controversies, claims and disputes arising from or relating to this Agreement will be resolved by final and binding arbitration before a single neutral arbitrator located in Wilmington, Delaware, conducted under the applicable rules of the American Arbitration Association. The arbitrator's award will be final and binding upon the Parties and judgment may be entered on the award. Each Party expressly waives its right to hav any controversies, claims or dispute arising from or related to this Agreement decided by a court or jury. Nothing in this Section 9.14 will prohibit or prevent either Party from seeking or obtaining injunctive or other equitable relief in court to enforce the restrictive covenants in Article VI or any other agreement between the Parties. The Parties and the arbitrator will maintain in confidence the existence of the arbitration proceeding, all materials filed in conjunction therewith and the substance of the underlying dispute unless and then only to the extent that disclosure is otherwise required by applicable Law.

9.15 Waiver of Trial by Jury. EACH PARTY HEREBY WAIVES ITS RIGHT TO A JURY TRIAL IN CONNECTION WITH ANY SUIT, ACTION OR PROCEEDING IN CONNECTION WITH ANY MATTER RELATING TO THIS AGREEMENT.

[SIGNATURE PAGE IMMEDIATELY FOLLOWS]

The Parties execute this Agreement as of the date first written above.

COMPANY:

THE STERN CARDIOVASCULAR CENTER, P.A.

By: _____
Name: Steven Gubin, M.D.
Title: President

The Parties execute this Agreement as of the date first written above.

CONTRACTOR:

ATRIA HEALTH SERVICES OF THE SOUTH, LLC.

Signed by:

By: _____
4CC586FA33BF45C...
Name: Matthew Eakins
Title: Chief Executive Officer

NAI Geis Realty Group, Inc.
Commercial Real Estate Services, Worldwide.

tel 610 989 0300
fax 610 989 0234
www.geisrealty.com

996 Old Eagle School Road
Suite 1117
Wayne PA 19087

July 28, 2026

Petar Poucki
Business Development
J&S Construction
1844 Foreman Dr
Cookeville, TN

Re: Proposal – Willow Site

Dear Petar;

NAI Geis Realty Group, Inc. is pleased to advise Atria Health Services of the South in the evaluation and selection of a qualified developer ("Developer") for the design, construction and lease of a +/- 10,000 sqft – 13,000 sqft single story medical office building to be located at the Willow Site. This Request for Proposal ("RFP") is intended to identify key terms for the design and construction of a new medical office facility.

Please review the following and provide us with a response by July 28, 2026_. Any questions regarding this RFP should be directed to Daniel Moller at: 215.701.0722; Dmoller@geisrealty.com or Tom Hummel 215.568.2505; thummel@geisrealty.com

Thank you for all your efforts, we look forward to receiving your information.

Sincerely,

Daniel J. Moller

Deal Terms

Site:	999 S Willow Ave Cookeville TN. Landlord to provide site plan and area slated for development.
Tenant Entity:	Atria Health Services of the South, LLC
Premises:	Stand alone building approximately 10k SF – 13k SF
Ownership/Developer:	Sparrow Ventures or affiliated entity
Use:	Premises may be used for any medical office, ASC, general office, general administrative and any other legally permitted use.
Lease Term:	15 Year Lease Term
Lease Commencement:	15 days following receipt of Certificate of Occupancy, estimated to be 16 months from lease execution date.
Rent Commencement:	The rent shall commence 15 days following Landlord's receipt of a Certificate of Use & Occupancy from local municipality.
Early Access:	Tenant shall be permitted to enter the Premises 45 days prior to the estimated completion of the build out for the purpose of FF&E and tele-data installation. Such an event shall not commence the Lease Term.
Rental Rate:	Starting Rent shall be $41/sf plus NNN costs. Base Rent shall increase by 2% annually starting in month 13 of the Lease Term.
Tenant/Landlord Contributions:	Tenant shall fund $2 million towards the project. 50% of Tenant's contribution shall be paid within 30 days of lease execution and the remaining 50% shall be paid within 30 days of substantial completion. Landlord shall fund any additional costs above tenant's contribution. Final scope and costs shall be mutually agreed upon.
Utilities:	At Developer's sole cost and expense, Developer shall be responsible for all public utilities to be brought to the site and connect to the building. Tenant shall be responsible for payment of actual usage during the term of the lease.
Renewal Option:	Tenant requests Three (3), Five (5) year renewal options at the then current Fair Market Rate for surgery center transactions in the Greater Cookeville market.
Right To Assign Or Sublease:	Any assignment or sublease of the Premises, in whole or in part — whether to an affiliate of Tenant or to any third party — shall require the prior written consent of Landlord, which consent will not be unreasonably withheld, conditioned, or delayed. No assignment or sublease shall be permitted, and Landlord's consent may be withheld, if such assignment or sublease would in any way restrict, encumber, or interfere with Landlord's unrestricted right to lease, sell, purchase, develop, or otherwise convey or acquire any property (as outlined in the attached Exhibit A) within this development or any other property owned or

controlled by Landlord, whether now or in the future. Tenant shall provide Landlord with the identity of the proposed assignee or subtenant, together with such information as Landlord may reasonably request, prior to the effective date of any assignment or sublease. No assignment or sublease shall release Tenant from its obligations under the Lease.

Exclusivity:

Landlord shall not have the ability to lease to any other cardiovascular or cardiology specific practices at the development as outlined in the attached Exhibit A. This will not restrict other hospital or multi specialties, that may have cardiovascular or cardiology as part of their services. This exclusivity shall only cover the term of the lease.

Advisory Fee:

This request for proposal is submitted on the understanding that NAI Geis Realty Group, Inc. through its designated local advisor represents the Tenant and should receive from Landlord one full commission equal to four percent of the net rent as stated above, over the initial term of the lease. The payment of which shall be paid ¼ upon the commencement of construction of the building shell, ¼ upon lease commencement and the following ½ within 6 months of lease commencement in accordance with the terms and conditions set forth in a separate agreement.

Note: These above terms are not intended to be contractual in nature. It is only an expression of the basis on which Tenant would consider entering into a lease for the subject space, Tenant shall have no obligation to lease the subject space unless and until a written lease, in form and substance satisfactory to Tenant, has been prepared and executed by both Tenant and the Landlord. Any reliance by Landlord on the possibility that the Tenant might enter into such a lease shall be at Landlord's sole risk and expense.

Atria Health

"TENANT"

DocuSigned by:
BY: Eric Nichols
9E3E03B931064E1...

NAME: Eric Nichols

DATE: July 28, 2026

Sparrow Ventures

"LANDLORD"

DocuSigned by:
BY: Jack Stites
AB7EEAFFF5564EF...

NAME: Jack Stites

DATE: July 28, 2026

Exhibit A

TITLE COMMITMENT EXCEPTIONS

As shown on Schedule B Section II on the Fidelity National Title Insurance Company Title Commitment File No.15135920.TN Effective date: May 11, 2015 at 8:00 AM:

1. Not addressed during ALTA Survey.
2. Not addressed during ALTA Survey.
3. Not addressed during ALTA Survey.
4. Not addressed during ALTA Survey.
5. Not addressed during ALTA Survey.
6. Not addressed during ALTA Survey.
7. Not addressed during ALTA Survey.
8. Not addressed during ALTA Survey.
9. Not addressed during ALTA Survey.
10. As shown on ALTA Survey.
11. Not addressed during ALTA Survey.
12. As shown on ALTA Survey.
13. No longer affects property.
14. Not shown on ALTA Survey specific location of easement can not be shown.
15. As Shown on ALTA Survey.
16. Not shown on ALTA Survey specific location of easement can not be shown.
17. As shown on ALTA Survey.
18. As shown on ALTA Survey.

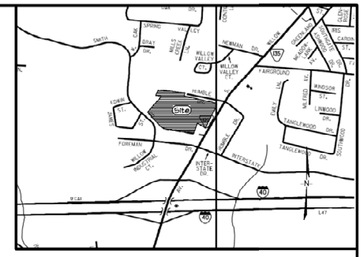
Minimum Building Setbacks

CG Zoning

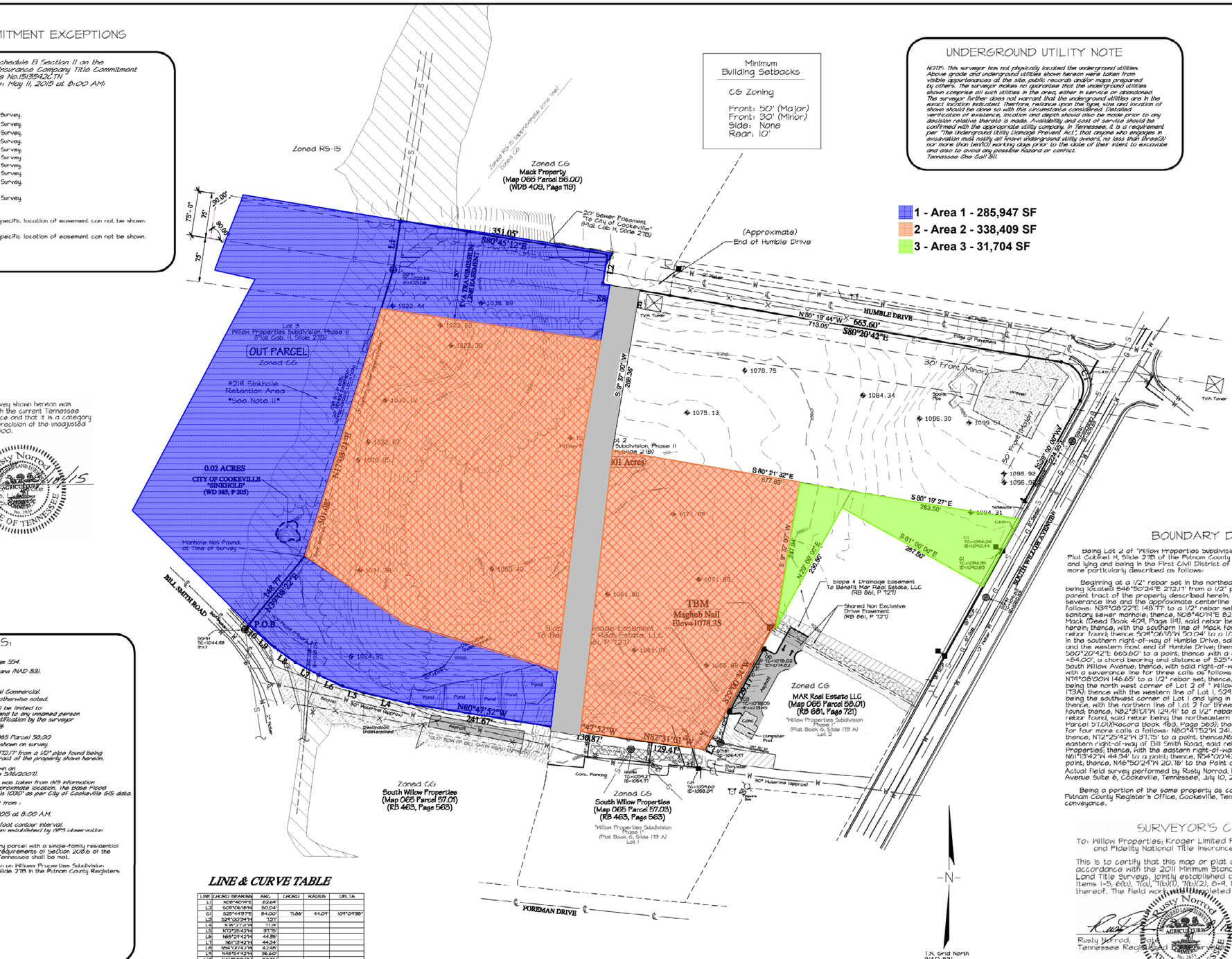
Front: 50' (Major)
Front: 30' (Minor)
Side: None
Rear: 10'

UNDERGROUND UTILITY NOTE

NOTE: This surveyor has not physically located the underground utilities. Above grade and underground utilities shown hereon were taken from visible appurtenances at the site, public records and/or maps prepared by others. The surveyor makes no guarantee that the underground utilities shown comprise all such utilities in the area, either in service or abandoned. The surveyor further does not warrant that the underground utilities are in the exact location indicated. Therefore, reliance upon the type, size and location of shown should be done so with this circumstance considered. Detailed verification of existence, location and depth should also be made prior to any decision relative thereto is made. Availability and cost of service should be confirmed with the appropriate utility company. In Tennessee, it is a requirement per "The Underground Utility Damage Prevent Act", that anyone who engages in excavation must notify all known underground utility owners, no less than three(3) nor more than ten(10) working days prior to the date of their intent to excavate and also to avoid any possible hazard or conflict. Tennessee One Call 811.



Vicinity (N.T.S.)



LEGEND

SSMH		Sanitary Sewer Manhole
STMH		Storm Drain Manhole
		Power/Telephone/Utility Pole
		Light Pole
		Guy Wire
		1/2" Rebar Found (or other as noted)
		1/2" Rebar Set
FH		Fire Hydrant
WV		Water Valve
GV		Gas Valve
		Water Meter
		Gas Meter
		Electric Meter
		Telephone Pedistal
		Bore Hole Locations
CB	=	Catch Basin
CI	=	Curb Inlet
C&G	=	Curb and Gutter
RCP	=	Reinforced Concrete Pipe
CMP	=	Corrugated Metal Pipe
Approx.	=	Approximate
HW	=	Headwall
ET	=	Electric Transformer
CO	=	Clean Out
Conc.	=	Concrete
POB	=	Point of Beginning
W		Water Line (Approximate)
G		Gas Line (Approximate)
S		Sewer Line (Approximate)
E		Overhead Electric
		Wood Line

BOUNDARY DESCRIPTION

Being Lot 2 of "Willow Properties Subdivision, Phase II" a plat of which is of record in Plat Cabinet H, Slide 21B of the Putnam County Register's Office, Cookeville, Tennessee, and lying and being in the First Civil District of Putnam County, Tennessee and being more particularly described as follows:

Beginning at a 1/2" rebar set in the northeastern right-of-way of Bill Smith Road, said rebar being located S46°50'24"E 27.21' from a 1/2" pipe found being the western most corner of the parent tract of the property described herein; thence, leaving said right-of-way and with a severance line and the approximate centerline of a 12" sanitary sewer line for three calls as follows: N39°08'22"E 148.71' to a 1/2" rebar set; thence, N17°08'21"E 501.08' to the center of a sanitary sewer manhole; thence, N08°40'19"E 82.84' to a 1/2" rebar set in the southern line of Kevin Mack (Deed Book 409, Page 119), said rebar being the northwest corner of the property described herein; thence, with the southern line of Mack for three calls as follows: S80°45'12"E 351.05' to a 1/2" rebar found; thence S09°06'10"W 50.04' to a 1/2" rebar found; thence, S80°20'42"E 114.01' to a point in the southern right-of-way of Humble Drive, said point being the southeastern corner of Mack and the western most end of Humble Drive; thence, with the southern right-of-way of said road, S80°20'42"E 665.60' to a point, thence with a curve having a Radius = 44.01', an arc distance =84.00', a chord bearing and distance of S25°44'37"E 71.88' to a point in the western right-of-way of South Willow Avenue; thence, with said right-of-way S28°54'08"W 181.44' to a 1/2" rebar set; thence, with a severance line for three calls as follows: N60°21'40"W 127.54' to a 1/2" rebar set; thence, N71°08'00"W 146.65' to a 1/2" rebar set; thence, S29°00'34"W 342.45' to a 1/2" rebar found, said rebar being the north west corner of Lot 2 of "Willow Properties Subdivision" as recorded in (PC 6, Slide 173A); thence with the western line of Lot 1, S29°00'34"W 229.17' to a 1/2" rebar found, said rebar being the southwest corner of Lot 1 and lying in the northern line of Lot 2 of said subdivision; thence, with the northern line of Lot 2 for three calls as follows: S29°00'34"W 7.57' to a 1/2" rebar found; thence, N82°31'01"W 129.41' to a 1/2" rebar found; thence, N80°41'52"W 130.87' to a 1/2" rebar found, said rebar being the northeastern corner of South Willow Properties (Tax Map 65 Parcel 57.01)(Record Book 463, Page 563); thence, with the northern line of South Willow Properties for four more calls a follows: N80°41'52"W 241.67' to a point; thence, N76°27'21"W 77.19' to a point; thence, N72°25'42"W 97.75' to a point; thence,N69°29'42"W 44.35' to a 1/2" rebar found in the eastern right-of-way of Bill Smith Road, said rebar being the northwest corner of South Willow Properties; thence, with the eastern right-of-way of said right-of-way for four calls as follows: N61°13'42"W 44.94' to a point; thence, N54°00'43"W 42.95' to a point; thence, N40°54'42"W 36.60' to a point; thence, N46°50'24"W 20.76' to the Point of Beginning. Containing 15.801ACRES, by survey.

Actual field survey performed by Rusty Norrod, R.L.S. #2635, Clinton Surveying, LLC, 380 South Lone Avenue Suite 6, Cookeville, Tennessee, July 10, 2015, Job #15-099.

Being a portion of the same property as conveyed to in Record Book 131 Page 554 of the Putnam County Register's Office, Cookeville, Tennessee, which is the previous and last conveyance.

SURVEYOR'S CERTIFICATE

To: Willow Properties; Kroger Limited Partnership I, an Ohio limited partnership; and Fidelity National Title Insurance Company.

This is to certify that this map or plat and survey on which it is based were made in accordance with the 2011 Minimum Standard Detail Requirements for ALTA/ACSM Land Title Surveys, jointly established and adopted by ALTA and NSPS, and includes items 1-5, 6(b), 7(a), 7(b)(1), 7(b)(2), 8-9, 11(a), 11(b), 13, 17, 21, and 22 on Table A thereof. The field work was completed on July 10, 2015.

Rusty Norrod, Registered Land Surveyor, TN # 2635

NOTES:

1. Source of Title: A Portion of RB 131, Page 554.
2. Basis of bearings is Tennessee State Plane (NAD 83).
3. Area of property = 15.801 Acres.
4. Property is currently zoned CG - General Commercial.
5. All corners are 1/2" rebar found, unless otherwise noted.
6. Surveyor's liability for this document shall be limited to the original purchaser and does not extend to any unnamed person or entities without an expressed RE Certification by the surveyor whose signature appears upon this survey.
7. Tax Information: A Portion of Tax Map 065 Parcel 58.00
8. There are no encroachments except as shown on survey.
9. The P.O.B. being located S46°50'24"E 27.21' from a 1/2" pipe found being the western most corner of the parent tract of the property shown hereon.
10. Property lies within Flood Zone X as shown on Community Panel 47177C0320 D (Effective 3/16/2007).
11. The sinkhole retention area shown hereon was taken from GIS information from the City of Cookeville, and is an approximate location. The Base Flood Elevation of the sinkhole retention area is 1080' as per City of Cookeville GIS data.
12. This surveyor relied upon title commitment from : Fidelity National Title Insurance Company File No.: 15135920.TN Effective May 11th, 2015 at 8:00 A.M.
13. The elevations shown hereon are at a 2 foot contour interval. The elevations are on the NAVD 88 datum established by GPS observation using TDOT GPSS Reference Network.
14. When adjoining a residential district or any parcel with a single-family residential structure the Screening and buffer yard requirements of Section 2016.6 of the Zoning Code for the City of Cookeville, Tennessee shall be met.
15. This survey is subject to all matters shown on Willows Properties Subdivision Phase II as recorded in Plat Cabinet H Slide 21B in the Putnam County Registers Office, Cookeville, Tennessee.

I hereby certify that the survey shown hereon was preformed in compliance with the current Tennessee Minimum Standards of Practice and that it is a category "I" survey and the ratio of precision of the unadjusted survey is greater that 1:10,000.

Rusty Norrod R.L.S. #2635
Clinton Surveying Services, LLC
380 South Lone Avenue Suite 6
Cookeville, TN 38501

LINE & CURVE TABLE

LINE	CHORD BEARING	ARC	CHORD	RADIUS	DELTA
L1	N08°40'19"E	82.84'			
L2	S09°06'10"W	50.04'			
C1	S25°44'37"E	84.00'	71.88'	44.01'	109°19'38"
L3	S28°54'08"W	181'			
L4	N71°08'00"W	111.91'			
L5	N72°25'42"W	97.75'			
L6	N69°29'42"W	44.35'			
L7	N61°13'42"W	44.24'			
L8	N54°00'43"W	42.95'			
L9	N40°54'42"W	36.60'			
L10	N46°50'24"W	20.76'			

Drawn By	Checked By	Date	Description
RN	GT	07-13-2015	Preliminary Issue
RN	GT	08-18-2015	Final Issue

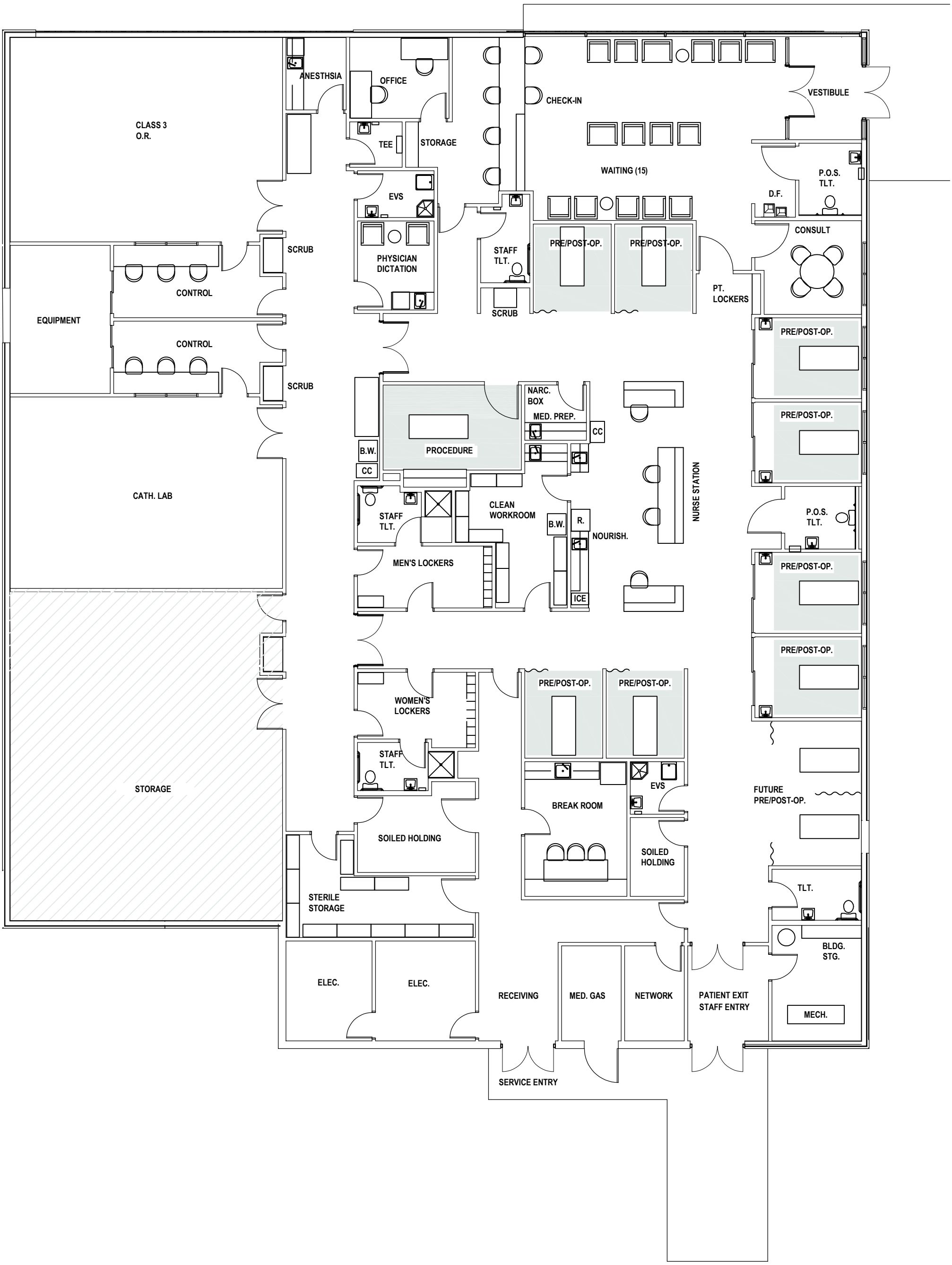
SHEET 1 OF 1
Project # 15-099

ALTA/ACSM LAND TITLE SURVEY FOR Willow Properties

Willow Properties
Portion of Tax Map 065 Parcel 058.00
Cookeville, Tennessee
First Civil District, Putnam County, Tennessee

GRAPHIC SCALE 1"=80'
0 80 160 240

Clinton Surveying
Land Surveying Services
380 South Lone Ave., Suite # 6
Cookeville, Tennessee 38501
931-372-0421



b o t t l e t r e e
design group, l.l.c.

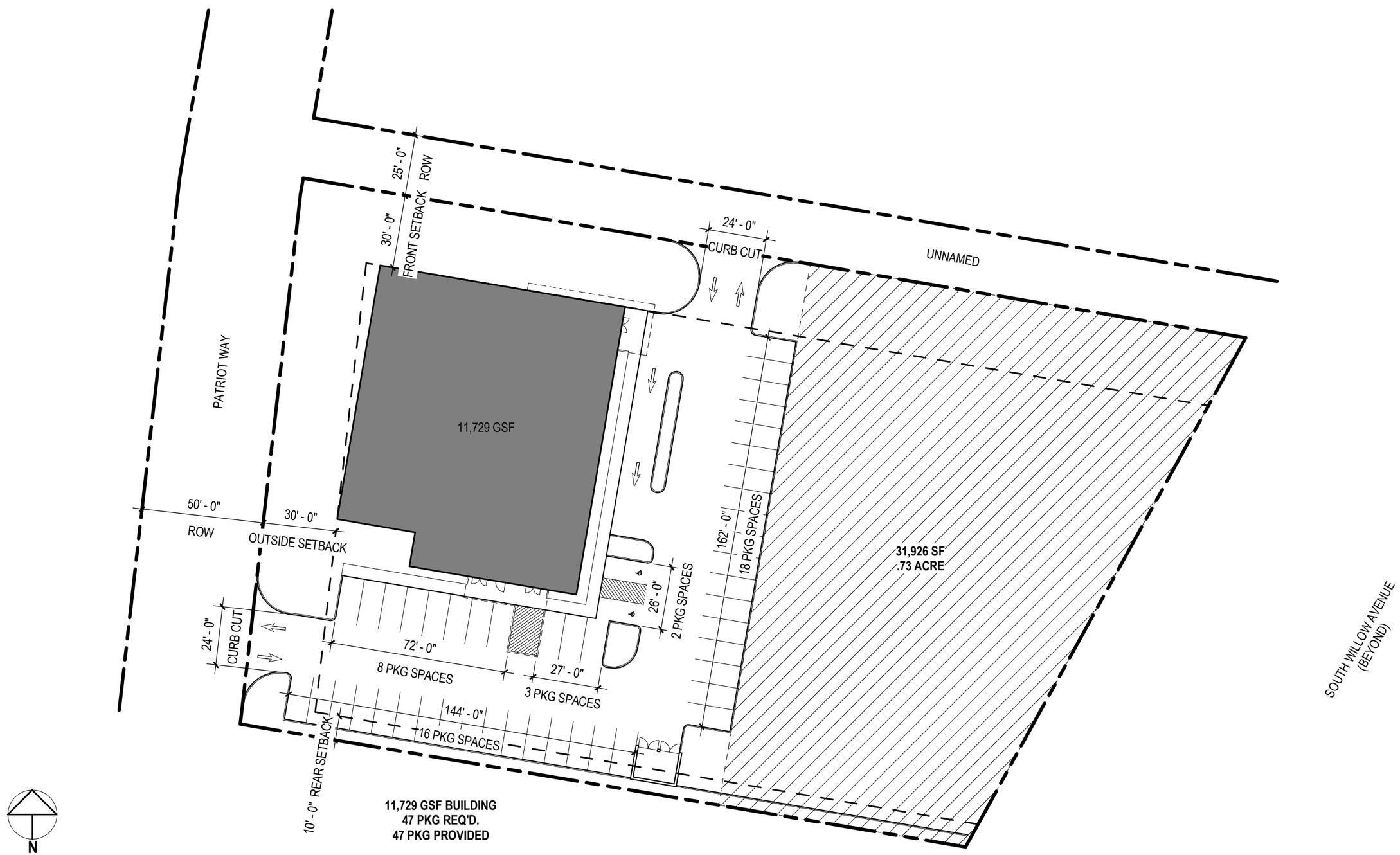
2709 Lombardy Avenue
Memphis, Tennessee 38111
Phone: 901-481-4743

Project Name:

Tennessee Heart ASC

Cookville, TN

Date
05.15.26



11,729 GSF BUILDING
47 PKG REQ'D.
47 PKG PROVIDED

46,155 SF / 1.06 ACRE

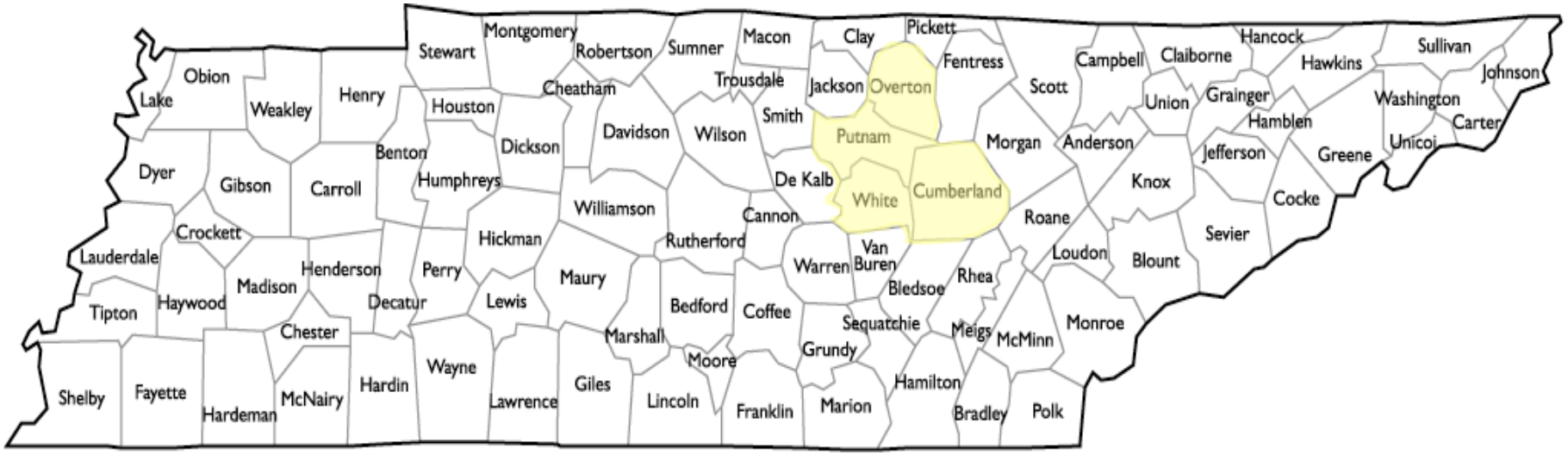
URBANARCH ASSOCIATES
SITE PLAN
JOB: 26020
DATE: 07/30/26
SCALE: 1" = 40'-0"

TENNESSEE HEART ASC

COOKEVILLE, TN

Urban ARCH associates, pc

TENNESSEE COUNTY MAP



Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Census Bureau				TennCare	
	Total Population Current Year (2026)*	Total Population Projected Year (2030)*	Total Population % Change	Target Population** Current Year (2026)	Target Population** Projected Year (2030)	Target Population % Change	Target Population Projected Year as % of Total	Median Age^	Median Household Income	Persons Below Poverty Level*	Persons Below Poverty Level as % of Total	TennCare Enrollees^^	TennCare Enrollees as % of Total
Cumberland	66,450	68,249	2.7%	54,677	56,412	3.2%	82.7%	53.5	$60,375	8,771	13.2%	11,978	18.0%
Overton	23,407	23,605	0.8%	18,164	18,407	1.3%	78.0%	43.7	$48,959	3,160	13.5%	4,727	20.2%
Putnam	86,309	89,465	3.7%	65,646	68,196	3.9%	76.2%	36.0	$58,912	15,881	18.4%	17,759	20.6%
White	28,708	29,216	1.8%	22,077	22,534	2.1%	77.1%	43.5	$52,188	3,330	11.6%	6,874	23.9%
Service Area Total	**204,874**	**210,535**	**2.8%**	**160,564**	**165,549**	**3.1%**	**78.6%**	**43.6**	**$57,307**	**31,142**	**15.2%**	**41,338**	**20.2%**
State of TN Total	**7,300,003**	**7,513,757**	**2.9%**	**5,971,045**	**6,148,143**	**3.0%**	**81.8%**	**38.9**	**$69,595**	**985,500**	**13.5%**	**1,361,893**	**18.7%**

*Calculated using Boyd Center Data.

** As noted in 3N-A, the target population of the proposed project is those age 18 and over. Please note that data from the Boyd Center is only segmentable from age 19 and over; as such residents in that cohort have been presented above.

^ County-specific information gathered via the most recently available American Consumer Survey (ACS) 5-Year Estimate Subject Tables, 2020-2024, accessed via https://data.census.gov/. State totals are calculated via weighted average, and as such may not precisely sum.
^^ Most recent data set at time of drafting of application is from May 2026.

JARs Data: Item 5N - Service Area Historical Utilization

Service Area County	# Cath Labs	2022-2024 Avg. Weighted Diagnostic Catheterizations	Diagnostic Catheterizations per Lab	2022-2024 Avg. Weighted Therapeutic Catheterizations	Therapeutic Catheterizations per Lab	2022-2024 Avg. Weighted Diagnostic and Therapeutic Catheterizations	Utilization per 2,000 Cases (Full Capacity)	Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity)
Cumberland	1	199	198.5	278	277.67	476.17	23.81%	34.01%
Overton	0	0	0	0	0	0	0.00%	0.00%
Putnam	2	4,332	2,165.92	5,745	2,872.33	10,076.50	251.91%	359.88%
White	0	0	0	0	0	0.00	0.00%	0.00%
TOTAL	**3**	**4,530**	**1,510.11**	**6,022**	**2,007.44**	**10,552.67**	**175.88%**	**251.25%**

Source: JARs

JARs Data: Weighted Average Calculation Tool 2024

Facility Name	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)
Cookeville Regional Medical Center	Diagnostic Cardiac Catheterization	Inpatient	1.0	2	739	739	0	0	739	739	369.50		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	2	1,138	1,138	0	0	1,138	1,138	569.00		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	2	80	160	0	0	80	160	80.00		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	2	79	158	0	0	79	158	79.00		
	Diagnostic EP	Inpatient	2.0	2	6	12	0	0	6	12	6.00		
	Diagnostic EP	Outpatient	2.0	2	18	36	0	0	18	36	18.00		
	Therapeutic EP	Inpatient	4.0	2	90	360	0	0	90	360	180.00		
	Therapeutic EP	Outpatient	4.0	2	2	8	0	0	2	8	4.00		
	Diagnostic Peripheral Vascular	Inpatient	1.5	2	800	1,200	0	0	800	1,200	600.00		
	Diagnostic Peripheral Vascular	Outpatient	1.5	2	1,020	1,530	0	0	1,020	1,530	765.00		
	Therapeutic Peripheral Vascular	Inpatient	3.0	2	515	1,545	0	0	515	1,545	772.50		
	Therapeutic Peripheral Vascular	Outpatient	3.0	2	434	1,302	0	0	434	1,302	651.00		
	Thrombolytic Therapy	Inpatient	3.0	2	60	180	0	0	60	180	90.00		
	Thrombolytic Therapy	Outpatient	3.0	2	16	48	0	0	16	48	24.00		
	Total			**2**	**4,997**	**8,416**	**0**	**0**	**4,997**	**8,416**	**4,208.00**	**210.40%**	**300.57%**
Cumberland Medical Center, Inc.	Diagnostic Cardiac Catheterization	Inpatient	1.0	1	149	149	0	0	149	149	149.00		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	1	125	125	0	0	125	125	125.00		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	1	147	294	0	0	147	294	294.00		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	1	29	58	0	0	29	58	58.00		
	Diagnostic EP	Inpatient	2.0	1	0	0	0	0	0	0	0.00		
	Diagnostic EP	Outpatient	2.0	1	0	0	0	0	0	0	0.00		
	Therapeutic EP	Inpatient	4.0	1	3	12	0	0	3	12	12.00		
	Therapeutic EP	Outpatient	4.0	1	1	4	0	0	1	4	4.00		
	Diagnostic Peripheral Vascular	Inpatient	1.5	1	3	5	0	0	3	5	4.50		
	Diagnostic Peripheral Vascular	Outpatient	1.5	1	0	0	0	0	0	0	0.00		
	Therapeutic Peripheral Vascular	Inpatient	3.0	1	1	3	0	0	1	3	3.00		
	Therapeutic Peripheral Vascular	Outpatient	3.0	1	0	0	0	0	0	0	0.00		
	Thrombolytic Therapy	Inpatient	3.0	1	0	0	0	0	0	0	0.00		
	Thrombolytic Therapy	Outpatient	3.0	1	0	0	0	0	0	0	0.00		
	Total			**1**	**458**	**650**	**0**	**0**	**458**	**650**	**649.50**	**32.48%**	**46.39%**
Total	Diagnostic Cardiac Catheterization	Inpatient	1.0	3	888	888	0	0	888	888	296.00		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	3	1,263	1,263	0	0	1,263	1,263	421.00		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	3	227	454	0	0	227	454	151.33		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	3	108	216	0	0	108	216	72.00		
	Diagnostic EP	Inpatient	2.0	3	6	12	0	0	6	12	4.00		
	Diagnostic EP	Outpatient	2.0	3	18	36	0	0	18	36	12.00		
	Therapeutic EP	Inpatient	4.0	3	93	372	0	0	93	372	124.00		
	Therapeutic EP	Outpatient	4.0	3	3	12	0	0	3	12	4.00		
	Diagnostic Peripheral Vascular	Inpatient	1.5	3	803	1,205	0	0	803	1,205	401.50		
	Diagnostic Peripheral Vascular	Outpatient	1.5	3	1,020	1,530	0	0	1,020	1,530	510.00		
	Therapeutic Peripheral Vascular	Inpatient	3.0	3	516	1,548	0	0	516	1,548	516.00		
	Therapeutic Peripheral Vascular	Outpatient	3.0	3	434	1,302	0	0	434	1,302	434.00		
	Thrombolytic Therapy	Inpatient	3.0	3	60	180	0	0	60	180	60.00		
	Thrombolytic Therapy	Outpatient	3.0	3	16	48	0	0	16	48	16.00		
	Total			**3**	**5,455**	**9,066**	**0**	**0**	**5,455**	**9,066**	**3,021.83**	**151.09%**	**215.85%**

JARs Data: Weighted Average Calculation Tool 2023

Facility Name	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)
Cookeville Regional Medical Center	Diagnostic Cardiac Catheterization	Inpatient	1.0	2	806	806	0	0	806	806	403.00		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	2	1,283	1,283	0	0	1,283	1,283	641.50		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	2	117	234	0	0	117	234	117.00		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	2	192	384	0	0	192	384	192.00		
	Diagnostic EP	Inpatient	2.0	2	27	54	0	0	27	54	27.00		
	Diagnostic EP	Outpatient	2.0	2	125	250	0	0	125	250	125.00		
	Therapeutic EP	Inpatient	4.0	2	346	1,384	0	0	346	1,384	692.00		
	Therapeutic EP	Outpatient	4.0	2	6	24	0	0	6	24	12.00		
	Diagnostic Peripheral Vascular	Inpatient	1.5	2	956	1,434	0	0	956	1,434	717.00		
	Diagnostic Peripheral Vascular	Outpatient	1.5	2	1,148	1,722	0	0	1,148	1,722	861.00		
	Therapeutic Peripheral Vascular	Inpatient	3.0	2	506	1,518	0	0	506	1,518	759.00		
	Therapeutic Peripheral Vascular	Outpatient	3.0	2	388	1,164	0	0	388	1,164	582.00		
	Thrombolytic Therapy	Inpatient	3.0	2	44	132	0	0	44	132	66.00		
	Thrombolytic Therapy	Outpatient	3.0	2	13	39	0	0	13	39	19.50		
	Total			**2**	**5,957**	**10,257**	**0**	**0**	**5,957**	**10,428**	**5,214.00**	**260.70%**	**372.43%**
Cumberland Medical Center, Inc.	Diagnostic Cardiac Catheterization	Inpatient	1.0	1	78	78	0	0	78	78	78.00		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	1	126	126	0	0	126	126	126.00		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	1	147	294	0	0	147	294	294.00		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	1	29	58	0	0	29	58	58.00		
	Diagnostic EP	Inpatient	2.0	1	0	0	0	0	0	0	0.00		
	Diagnostic EP	Outpatient	2.0	1	0	0	0	0	0	0	0.00		
	Therapeutic EP	Inpatient	4.0	1	0	0	0	0	0	0	0.00		
	Therapeutic EP	Outpatient	4.0	1	0	0	0	0	0	0	0.00		
	Diagnostic Peripheral Vascular	Inpatient	1.5	1	0	0	0	0	0	0	0.00		
	Diagnostic Peripheral Vascular	Outpatient	1.5	1	0	0	0	0	0	0	0.00		
	Therapeutic Peripheral Vascular	Inpatient	3.0	1	0	0	0	0	0	0	0.00		
	Therapeutic Peripheral Vascular	Outpatient	3.0	1	0	0	0	0	0	0	0.00		
	Thrombolytic Therapy	Inpatient	3.0	1	0	0	0	0	0	0	0.00		
	Thrombolytic Therapy	Outpatient	3.0	1	0	0	0	0	0	0	0.00		
	Total			**1**	**380**	**556**	**0**	**0**	**380**	**556**	**556.00**	**27.80%**	**39.71%**
Total	Diagnostic Cardiac Catheterization	Inpatient	1.0	3	884	884	0	0	884	884	294.67		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	3	1,409	1,409	0	0	1,409	1,409	469.67		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	3	264	528	0	0	264	528	176.00		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	3	221	442	0	0	221	442	147.33		
	Diagnostic EP	Inpatient	2.0	3	27	54	0	0	27	54	18.00		
	Diagnostic EP	Outpatient	2.0	3	125	250	0	0	125	250	83.33		
	Therapeutic EP	Inpatient	4.0	3	346	1,384	0	0	346	1,384	461.33		
	Therapeutic EP	Outpatient	4.0	3	6	24	0	0	6	24	8.00		
	Diagnostic Peripheral Vascular	Inpatient	1.5	3	956	1,434	0	0	956	1,434	478.00		
	Diagnostic Peripheral Vascular	Outpatient	1.5	3	1,148	1,722	0	0	1,148	1,722	574.00		
	Therapeutic Peripheral Vascular	Inpatient	3.0	3	506	1,518	0	0	506	1,518	506.00		
	Therapeutic Peripheral Vascular	Outpatient	3.0	3	388	1,164	0	0	388	1,164	388.00		
	Thrombolytic Therapy	Inpatient	3.0	3	44	132	0	0	44	132	44.00		
	Thrombolytic Therapy	Outpatient	3.0	3	13	39	0	0	13	39	13.00		
	Total			**3**	**6,337**	**10,984**	**0**	**0**	**6,337**	**10,984**	**3,661.33**	**183.07%**	**261.52%**

JARs Data: Weighted Average Calculation Tool 2022

Facility Name	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)
Cookeville Regional Medical Center	Diagnostic Cardiac Catheterization	Inpatient	1.0	2	739	739	0	0	739	739	369.50		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	2	965	965	0	0	965	965	482.50		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	2	455	910	0	0	455	910	455.00		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	2	338	676	0	0	338	676	338.00		
	Diagnostic EP	Inpatient	2.0	2	25	50	0	0	25	50	25.00		
	Diagnostic EP	Outpatient	2.0	2	116	232	0	0	116	232	116.00		
	Therapeutic EP	Inpatient	4.0	2	256	1,024	0	0	256	1,024	512.00		
	Therapeutic EP	Outpatient	4.0	2	791	3,164	0	0	791	3,164	1,582.00		
	Diagnostic Peripheral Vascular	Inpatient	1.5	2	220	330	0	0	220	330	165.00		
	Diagnostic Peripheral Vascular	Outpatient	1.5	2	317	476	0	0	317	476	237.75		
	Therapeutic Peripheral Vascular	Inpatient	3.0	2	435	1,305	0	0	435	1,305	652.50		
	Therapeutic Peripheral Vascular	Outpatient	3.0	2	420	1,260	0	0	420	1,260	630.00		
	Thrombolytic Therapy	Inpatient	3.0	2	55	165	0	0	55	165	82.50		
	Thrombolytic Therapy	Outpatient	3.0	2	30	90	0	0	30	90	45.00		
	Total			**2**	**5,162**	**11,131**	**0**	**0**	**5,162**	**11,386**	**5,692.75**	**284.64%**	**406.63%**
Cumberland Medical Center, Inc.	Diagnostic Cardiac Catheterization	Inpatient	1.0	1	35	35	0	0	35	35	35.00		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	1	78	78	0	0	78	78	78.00		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	1	37	74	0	0	37	74	74.00		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	1	18	36	0	0	18	36	36.00		
	Diagnostic EP	Inpatient	2.0	1	0	0	0	0	0	0	0.00		
	Diagnostic EP	Outpatient	2.0	1	0	0	0	0	0	0	0.00		
	Therapeutic EP	Inpatient	4.0	1	0	0	0	0	0	0	0.00		
	Therapeutic EP	Outpatient	4.0	1	0	0	0	0	0	0	0.00		
	Diagnostic Peripheral Vascular	Inpatient	1.5	1	0	0	0	0	0	0	0.00		
	Diagnostic Peripheral Vascular	Outpatient	1.5	1	0	0	0	0	0	0	0.00		
	Therapeutic Peripheral Vascular	Inpatient	3.0	1	0	0	0	0	0	0	0.00		
	Therapeutic Peripheral Vascular	Outpatient	3.0	1	0	0	0	0	0	0	0.00		
	Thrombolytic Therapy	Inpatient	3.0	1	0	0	0	0	0	0	0.00		
	Thrombolytic Therapy	Outpatient	3.0	1	0	0	0	0	0	0	0.00		
	Total			**1**	**168**	**223**	**0**	**0**	**168**	**223**	**223.00**	**11.15%**	**15.93%**
Total	Diagnostic Cardiac Catheterization	Inpatient	1.0	3	774	774	0	0	774	774	258.00		
	Diagnostic Cardiac Catheterization	Outpatient	1.0	3	1,043	1,043	0	0	1,043	1,043	347.67		
	Therapeutic Cardiac Catheterization	Inpatient	2.0	3	492	984	0	0	492	984	328.00		
	Therapeutic Cardiac Catheterization	Outpatient	2.0	3	356	712	0	0	356	712	237.33		
	Diagnostic EP	Inpatient	2.0	3	25	50	0	0	25	50	16.67		
	Diagnostic EP	Outpatient	2.0	3	116	232	0	0	116	232	77.33		
	Therapeutic EP	Inpatient	4.0	3	256	1,024	0	0	256	1,024	341.33		
	Therapeutic EP	Outpatient	4.0	3	791	3,164	0	0	791	3,164	1,054.67		
	Diagnostic Peripheral Vascular	Inpatient	1.5	3	220	330	0	0	220	330	110.00		
	Diagnostic Peripheral Vascular	Outpatient	1.5	3	317	476	0	0	317	476	158.50		
	Therapeutic Peripheral Vascular	Inpatient	3.0	3	435	1,305	0	0	435	1,305	435.00		
	Therapeutic Peripheral Vascular	Outpatient	3.0	3	420	1,260	0	0	420	1,260	420.00		
	Thrombolytic Therapy	Inpatient	3.0	3	55	165	0	0	55	165	55.00		
	Thrombolytic Therapy	Outpatient	3.0	3	30	90	0	0	30	90	30.00		
	Total			**3**	**5,330**	**11,609**	**0**	**0**	**5,330**	**11,609**	**3,869.50**	**193.48%**	**276.39%**

Cardiac Cath - Cookeville Regional Medical Center (ID: 7120)
Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2022-2024

Inpatient Services

Diagnostic Cardiac Caths				
Age Group	Diagnostic Total	Service Categories		
		CC	PV	EP
ALL	0.0	0.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

Therapeutic Cardiac Caths				
Age Group	Therapeutic Total	Service Categories		
		CC	PV	EP
ALL	0.0	0.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

Outpatient Services

Diagnostic Cardiac Caths				
Age Group	Diagnostic Total	Service Categories		
		CC	PV	EP
ALL	1.0	1.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.3	0.3	0.0	0.0
55 - 59	0.3	0.3	0.0	0.0
60 - 64	0.3	0.3	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

Therapeutic Cardiac Caths				
Age Group	Therapeutic Total	Service Categories		
		CC	PV	EP
ALL	2.0	0.7	0.0	1.3
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	1.3	0.0	0.0	1.3
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.7	0.7	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

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

Source: Tennessee Department of Health, Division of Population Health Assessment.
Hospital Discharge Data System, 2022-2024. Nashville, TN.

Cardiac Cath - Cumberland Medical Center, Inc (ID: 1822)
Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2022-2024

Inpatient Services

Diagnostic Cardiac Caths				
Age Group	Diagnostic Total	Service Categories		
		CC	PV	EP
ALL	203.3	202.7	0.0	0.7
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.7	0.7	0.0	0.0
30 - 39	4.0	4.0	0.0	0.0
40 - 44	4.3	4.3	0.0	0.0
45 - 49	7.0	7.0	0.0	0.0
50 - 54	13.0	13.0	0.0	0.0
55 - 59	18.3	18.3	0.0	0.0
60 - 64	28.7	28.7	0.0	0.0
65 - 69	30.7	30.7	0.0	0.0
70 - 74	29.0	29.0	0.0	0.0
75 - 79	31.3	31.3	0.0	0.0
80 - 84	26.3	26.3	0.0	0.0
85 +	10.0	9.3	0.0	0.7

Therapeutic Cardiac Caths				
Age Group	Therapeutic Total	Service Categories		
		CC	PV	EP
ALL	30.3	16.0	13.0	1.3
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	2.0	2.0	0.0	0.0
40 - 44	1.0	0.0	1.0	0.0
45 - 49	1.0	0.0	1.0	0.0
50 - 54	0.7	0.7	0.0	0.0
55 - 59	4.3	3.3	1.0	0.0
60 - 64	4.3	3.3	1.0	0.0
65 - 69	8.3	1.3	7.0	0.0
70 - 74	1.3	1.3	0.0	0.0
75 - 79	3.3	1.3	2.0	0.0
80 - 84	4.0	2.7	0.0	1.3
85 +	0.0	0.0	0.0	0.0

Outpatient Services

Diagnostic Cardiac Caths				
Age Group	Diagnostic Total	Service Categories		
		CC	PV	EP
ALL	124.7	124.7	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.3	0.3	0.0	0.0
30 - 39	2.0	2.0	0.0	0.0
40 - 44	2.7	2.7	0.0	0.0
45 - 49	2.7	2.7	0.0	0.0
50 - 54	7.7	7.7	0.0	0.0
55 - 59	12.3	12.3	0.0	0.0
60 - 64	14.7	14.7	0.0	0.0
65 - 69	25.0	25.0	0.0	0.0
70 - 74	21.3	21.3	0.0	0.0
75 - 79	20.7	20.7	0.0	0.0
80 - 84	12.0	12.0	0.0	0.0
85 +	3.3	3.3	0.0	0.0

Therapeutic Cardiac Caths				
Age Group	Therapeutic Total	Service Categories		
		CC	PV	EP
ALL	14.0	14.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	1.3	1.3	0.0	0.0
55 - 59	0.7	0.7	0.0	0.0
60 - 64	2.0	2.0	0.0	0.0
65 - 69	5.3	5.3	0.0	0.0
70 - 74	1.3	1.3	0.0	0.0
75 - 79	2.7	2.7	0.0	0.0
80 - 84	0.7	0.7	0.0	0.0
85 +	0.0	0.0	0.0	0.0

CC - Cardiac Catheterization PV - Peripheral Vascular Catheterization EP - Electrophysiological Studies

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

Source: Tennessee Department of Health, Division of Population Health Assessment.
Hospital Discharge Data System, 2022-2024. Nashville, TN.

JARs Data: Item 5N - Service Area Historical Utilization

			Most Recent 3 Years Reported			
Facility Name	**County**	**Single or Multi-Specialty**	**Total ASTC Cases 2023**	**Total ASTC Cases 2024**	**Total ASTC Cases 2025**	**Total ASTC 2023-2025**
Cataract and Laser Center	Cumberland	Single Specialty	1,234	2,288	2,602	6,124
Plateau Surgery Center	Cumberland	Single Specialty	2,096	1,195	1,199	4,490
The Cookeville Surgery Center	Putnam	Multiple Specialties	2,457	1,852	1,970	6,279
Perimeter Surgery Center	Putnam	Single Specialty	3,704	3,662	3,985	11,351
Tier 1 Surgery Center	Putnam	Multiple Specialties	N/A	N/A	N/A	0
TOTAL			**9,491**	**8,997**	**9,756**	**28,244**

Source: Joint Annual Report for ASTCs

Attachment 6N: Projected Utilization and Methodology

The Stern Cardiovascular Center, P.A. ("Stern") is an established cardiovascular physician practice that currently serves patients at nearly two dozen locations across Tennessee, Mississippi, and Arkansas. On July 1, 2026, Tennessee Heart, PLLC ("TN Heart"), an established cardiology physician practice serving patients in the Upper Cumberland region for over 30 years, entered into a strategic partnership with Stern and Atria Health Services of the South, LLC ("Atria Health") to create a cardiovascular center of excellence in Cookeville in Putnam County, expanding access to care, physician recruitment, and innovative cardiology services. Within the proposed service area, TN Heart has its main office location in Cookeville (Putnam County) and two additional clinic locations in Crossville (Cumberland County) and Livingston (Overton County). TN Heart cardiologists have privileges and perform all cardiovascular procedures at Cookeville Regional Medical Center ("CRMC"), the only hospital with cardiac catheterization labs in Putnam County. With the addition of TN Heart's clinicians, Stern's comprehensive network now consists of nearly 130 cardiovascular care providers, including 59 board-certified cardiologists and 68 advanced practitioners.

To generate utilization projections for the proposed project, Stern analyzed the historical volume of cardiovascular procedures performed by TN Heart cardiologists in calendar years ("CY") 2024 and 2025. Applying its clinical expertise alongside Atria Health's operational experience, Stern then analyzed the historical procedure volumes to identify the proportion of procedures that could be safely and appropriately performed in an outpatient surgery center setting – the same approach Stern and Atria Health utilized to identify the ambulatory surgical treatment center ("ASTC")-appropriate procedures for its recently approved Shelby County cardiovascular ASTC project (CN2605-013A). The ASTC-appropriate procedures identified are a conservative estimate of the total cardiovascular procedures TN heart cardiologists historically performed in each procedure category. Finally, Stern weighted each procedure per the definition for Cardiac Catheterization diagnostic-equivalent procedures provided in the Standards and Criteria for Cardiac Catheterization Services. The resulting historical data is presented in Table 6N-1 below. Please note that the categories below are consistent with the scope of services defined for the proposed project as detailed in Attachment 1N-1.1.

Table 6N-1: 2024-2025 Historical Volume of TN Heart Cardiologists' Weighted Outpatient-Appropriate Procedures

Procedure Category	*2024*	*2025*	*% Change*
Cardiac Ablations	462	576	
Diagnostic Cardiac Catheterizations	1,038	942	
Electrophysiology Studies and Cardiac Rhythm Device Implantations	488	719	
Loop Procedures	146	180	
Therapeutic Cardiac Catheterizations	217	185	
Peripheral Vascular Catheterizations	12	44	
Total	**2,363**	**2,646**	**12.0%**

Source: Internal TN Heart data.

As Table 6N-1 demonstrates, total weighted outpatient-appropriate cardiovascular procedures performed by TN Heart cardiologists grew by 12.0 percent from 2024 through 2025. This growth

rate substantially exceeds the projected population growth for the four primary service area counties (Cumberland, Overton, Putnam and White), which, as shown in Attachment 3N, are projected to grow at a combined 2.8 percent rate from 2026 through 2030. Thus, procedure volumes are increasing more than four times faster than the population itself – clear evidence of rising demand for cardiovascular services in the service area.

Despite this strong historical growth of TN Heart's procedures in the Upper Cumberland region, Stern adopted a deliberately conservative approach for projecting the future utilization of this project. Rather than applying the 12.0 percent growth, Stern used a lower growth rate tied to population trends in the Tennessee counties where TN Heart has historically served patients. The distribution of TN Heart's Tennessee patients by county of residence for the weighted cardiovascular procedures in Table 6N-1 is shown in Table 6N-2 below.

Table 6N-2: TN Heart 2025 Historical Patient Origin by County (Tennessee Only)

County	*Percent of Total Patients (Tennessee Only)*
Anderson	0.03%
Bedford	0.10%
Bledsoe	0.89%
Clay	1.91%
Cumberland	13.07%
Davidson	0.05%
DeKalb	2.68%
Fentress	6.09%
Hamilton	0.20%
Jackson	5.45%
Jefferson	0.03%
Macon	0.22%
Madison	0.03%
Morgan	0.52%
Overton	11.89%
Pickett	2.90%
Putnam	38.16%
Rhea	0.14%
Roane	0.25%
Rutherford	0.20%
Scott	0.03%
Sequatchie	0.06%
Smith	1.34%
Sumner	0.10%
Van Buren	1.72%
Warren	1.44%
White	10.38%
Wilson	0.13%
Total	**100.00%**

Source: Internal TN Heart data.

Stern then calculated a weighted average population compound annual growth rate ("CAGR") for the 28 Tennessee counties identified in Table 6N-2, using Tennessee Department of Health 2024-2028 population CAGR projections. The data used to calculate this weighted population CAGR is shown in Table 6N-3 below.

Table 6N-3: 2025 Projected Weighted Population Growth Rate
TN Heart Patients in Tennessee

County	*Percentage of Total Patients*	*2024 Population*	*2028 Population*	*2024-2028 CAGR*	*Weighted CAGR**
Anderson	0.03%	78,892	79,863	0.3%	0.0001%
Bedford	0.10%	52,573	54,810	1.0%	0.0010%
Bledsoe	0.89%	15,679	16,038	0.6%	0.0049%
Clay	1.91%	7,659	7,654	0.0%	0.0003%
Cumberland	13.07%	64,464	66,753	0.9%	0.1114%
Davidson	0.05%	727,642	746,905	0.7%	0.0003%
DeKalb	2.68%	21,454	21,988	0.6%	0.0161%
Fentress	6.09%	19,032	19,155	0.2%	0.0095%
Hamilton	0.20%	383,109	393,234	0.7%	0.0013%
Jackson	5.45%	12,055	12,175	0.2%	0.0132%
Jefferson	0.03%	56,988	58,374	0.6%	0.0001%
Macon	0.22%	25,925	26,960	1.0%	0.0021%
Madison	0.03%	98,816	99,089	0.1%	0.0000%
Morgan	0.52%	21,727	21,932	0.2%	0.0012%
Overton	11.89%	23,089	23,508	0.5%	0.0521%
Pickett	2.90%	4,990	4,910	-0.4%	-0.0114%
Putnam	38.16%	84,778	88,381	1.0%	0.3883%
Rhea	0.14%	34,243	34,929	0.5%	0.0007%
Roane	0.25%	54,007	53,893	-0.1%	-0.0001%
Rutherford	0.20%	371,864	404,640	2.1%	0.0042%
Scott	0.03%	22,151	22,142	0.0%	0.0000%
Sequatchie	0.06%	15,754	16,256	0.8%	0.0005%
Smith	1.34%	20,764	21,151	0.5%	0.0060%
Sumner	0.10%	208,192	220,197	1.4%	0.0014%
Van Buren	1.72%	5,903	5,836	-0.3%	-0.0048%
Warren	1.44%	41,992	42,251	0.2%	0.0022%
White	10.38%	28,600	29,381	0.7%	0.0683%
Wilson	0.13%	160,783	172,941	1.8%	0.0023%
Total	**100.00%**				**0.7%****

Source: Internal TN Heart data (Percentage of Total Patients), Tennessee Department of Health (2024 and 2028 population data).
* Weighted CAGR = 2024-2028 CAGR x Percentage of Total Patients.
** Total Weighted CAGR = Sum of all Weighted CAGRs. Total weighted CAGR is rounded to the tenths place.

The weighted projected population CAGR for the counties identified in Table 6N-2 is 0.7 percent. Because this rate of growth is significantly lower than the historical 12.0 percent growth rate of TN Heart's cardiovascular procedure volumes shown in Table 6N-1 above, it is a conservative means of estimating the project's weighted cardiovascular procedure volume in the first two project years.

When all weighted procedures in Table 6N-1 are grown at a CAGR of 0.7 percent through CY 2029, the resulting projected utilization for the first two project years, 2028 and 2029, is shown in Table 6N-4 below.

Table 6N-4: Projected Weighted Cardiovascular Procedures
TN Heart Cardiovascular Surgery Center

Procedure Category	*2025*	*2026*	*2027*	*2028 (PY1)**	*2029 (PY2)**	*CAGR*
Cardiac Ablations	576	580	584	588	592	0.7%
Diagnostic Cardiac Catheterizations	942	948	954	961	967	0.7%
Electrophysiology Studies and Cardiac Rhythm Device Implantations	719	724	728	733	738	0.7%
Loop Procedures	180	181	182	184	185	0.7%
Therapeutic Cardiac Catheterizations	185	186	187	188	189	0.7%
Peripheral Vascular Catheterizations	44	44	45	45	45	
Total	**2,646**	**2,662**	**2,680**	**2,698**	**2,716**	**0.7%**

Source (2025 utilization): Internal TN Heart data.
* Project year.
Please note that 2025 through 2027 projects are shown for demonstrative purposes; the project will begin operations in 2028.

As an additional conservative step and to account for the project's gradual ramp-up in its first year of operations, Stern assumed the proposed project would serve 50 percent of the projected utilization from Table 6N-4 in PY1 (2028), increasing to 100 percent of the projected volume in PY2 (2029). These adjusted totals are shown in Table 6N-5 below.

Table 6N-5: Projected Weighted Cardiovascular Procedures
With Ramp-Up
TN Heart Cardiovascular Surgery Center

Procedure Category	*2028 (PY1)**	*2029 (PY2)*
Cardiac Ablations	294	592
Diagnostic Cardiac Catheterizations	480	967
Electrophysiology Studies and Cardiac Rhythm Device Implantations	367	738
Loop Procedures	92	185
Therapeutic Cardiac Catheterizations	94	189
Peripheral Vascular Catheterizations	22	45
Total	**1,349**	**2,716**

* 2028 weighted procedures = 2028 weighted procedures in Table 6N-4 x 50 percent.

Due to TN Heart's established presence and multiple clinic locations in the service area, it is reasonable to assume the ramp-up shown in the table above. As discussed in the response to #14 of the Standards and Criteria for Cardiac Catheterization Services included as Attachment 1N, projected utilization meets State Health Plan minimum volume standards. The project's immediate utilization is also consistent with the service area's significant capacity constraints discussed in #8 of the Standards and Criteria for Cardiac Catheterization Services.

TN Heart has historically provided cardiovascular services to a small percentage of patients residing outside Tennessee in areas geographically proximate to the Upper Cumberland region, particularly those from southern Kentucky; therefore, the applicant expects that the proposed project will serve a similar percentage of non-Tennessee patients from these areas. As such, Stern generated the total projected patient utilization by county for the project by applying the 2025 historical distribution of TN Heart patients by county for all weighted, outpatient-appropriate cardiovascular procedures to the total procedures projected in Table 6N-5. The resulting utilization projections by county for 2028 and 2029, the first two full years of the project, are shown in Table 6N-6 below.

Table 6N-6: Projected Patient Origin
TN Heart Cardiovascular Surgery Center

County	*Share of Total Patients*	*2028 (PY1)**	*2029 (PY2)*
Putnam	37.12%	501	1,008
Cumberland	12.72%	172	345
Overton	11.57%	156	314
White	10.10%	136	274
Fentress	5.92%	80	161
Jackson	5.31%	72	144
Pickett	2.82%	38	77
DeKalb	2.61%	35	71
Clay	1.86%	25	50
Van Buren	1.67%	23	45
Warren	1.40%	19	38
Smith	1.30%	18	35
Bledsoe	0.87%	12	24
Morgan	0.51%	7	14
Roane	0.25%	3	7
Macon	0.21%	3	6
Hamilton	0.20%	3	5
Rutherford	0.20%	3	5
Rhea	0.14%	2	4
Wilson	0.12%	2	3
Sumner	0.10%	1	3
Bedford	0.10%	1	3
Sequatchie	0.06%	1	2
Davidson	0.05%	1	1
Anderson	0.02%	0	1
Jefferson	0.02%	0	1
Scott	0.02%	0	1
Madison	0.02%	0	1
Other – Out of State	2.72%	35	74
Total	**100.00%**	**1,349**	**2,716**

Source (Share of Total Patients): Internal TN Heart data.
* Project year.

Holding historical patient origin consistent through the first two project years is reasonable and well-supported. TN Heart is and will continue to be an established provider in the Upper Cumberland region, with longstanding relationships with patients and referring providers.

INDEX OF ADDITIONAL ATTACHMENTS

TN HEART CARDIOVASCULAR SURGERY CENTER

Attachment 1E. Architect Letter

Attachment 1N-1.1. Scope of Services for TN Heart Cardiovascular Surgery Center

Attachment 1N-1.2. Collected Policies and Procedures

Attachment 1N-1.3. Portion of Outpatient Cardiac Catheterization Procedures Approved by CMS for Outpatient Settings

Attachment 1N-1.4. SCAI Patient Selection Criteria and Deferral Protocols

Urban ARCH architecture

July 29, 2026

RE: 999 S. Willow Avenue, Cookeville, TN 38501 (Putnam County)
Project: TN Heart ASTC

To whom it may concern:

On behalf of our client, TN Heart we are pleased to address certain issues related to the proposed construction (ground up) of the above-referenced project.

Description of the Project-The proposed ASTC will be a single-specialty facility limited to cardiovascular surgery procedures. The proposed ASTC facility will be located in Cookeville TN and will be a ground up construction. Based on our preliminary floor plan and plot plan showing the building design (also being submitted with the CON Application) the total space for the ASTC will be approximately 10,849 useable square feet. The proposed ASTC space includes one (1) operating room, (1) cath lab, waiting room and reception area, administrative (business) office, Pre-Op/Post-Op Area with eight (8) stations supervised by a central nursing station, consult room, equipment storage room, and other appropriate support areas. Please refer to floor plan for the project for additional information.

Estimate of Project Construction Cost-Based on our previous experience and knowledge with the construction of medical buildings and healthcare facilities and considering the current healthcare construction cost market for similar projects, it is our professional opinion that a projected construction cost of $8,136,750.00 is a reasonable estimate for the completion and buildout of the space for the ASTC facility. This is based on our preliminary floor plan design for the ASTC of approximately 10,849 useable square feet at a construction cost rate of approx. $750.00 per square foot (exclusive of land and site development costs. That said, we understand that the tenant will be responsible for $2M of this construction cost – the remainer to be borne by the developer. The proposed site design layout and plot plan provides for approx. 47 total parking spaces and two(2) handicapped parking spaces for the surgery center.

Attestation- We attest that the physical environment and all aspects of the ASTC project will conform to all applicable federal standards, manufacturer's specifications, and licensing agencies' requirements including the local and state building codes and Facility Guidelines Institute for Outpatient Health Care Facilities in current use by the licensing authority.

Sincerely,

Brian Bullard, AIA, NCARB
Principal - UrbanArch Associates, P.C.
TN License #101492

Cardiac Catheterizations		
Diagnostic	***Therapeutic***	
Coronary Angiography	**Percutaneous Coronary Interventions (PCI)**	
Right Heart Catheterization	Coronary Balloon Angioplasty	Coronary Stenting
Left Heart Catheterization		
Diagnostic Measurements		

Electrophysiology (EP) Procedures		
Diagnostic	***Therapeutic***	
Electrophysiology Studies	**Cardiac Ablations**	
	Ablation of Atrial Fibrillation	Ablation of Atrial Flutter
	Supraventricular Tachycardia Ablation	Atrioventricular Node Ablation
	Cardioversion	

Cardiac Rhythm Device Implantation
Pacemaker Implantation and Generator Changes
Subcutaneous ICD Implantation and Generator Changes
Implantable Cardioverter Defibrillator (ICD) Implantation and Generator Changes
Loop Recorder Implantation and Replacement

Peripheral Vascular Services	
Diagnostic	***Therapeutic***
Peripheral Angiography	Balloon Angioplasty
	Stent Placement
	Atherectomy
	Lithotripsy
	Vein Procedures

Cardiovascular Imaging Services
Intra-Procedure Fluoroscopy
Transesophageal Echocardiography (TEE)

TN HEART CARDIOVASCULAR SURGERY CENTER CON SPECIFIC POLICY AND PROCEDURES

JULY 2026

ADMISSION/TREATMENT POLICY

Policy Name:	**ADMISSION/TREATMENT POLICY**
Section:	Admission
Purpose:	To establish protocol for patient admissions

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

It is the policy of the Center to admit and treat all persons without regard to race, color, national origin, handicap, religious or fraternal organization, or age. The same requirements are applied to all, and patients are assigned without regard to race, color, national origin, handicap, religious or fraternal organization, or age. All services are available without distinction to patients and visitors regardless of race, color, national origin, handicap, religious or fraternal organization or age. All persons and organizations having occasion to refer people for services or to recommend the Center are advised to do so without regard to the person's race, color, national origin, handicap, religious or fraternal organization, or age.

EXCEPTIONS

Due to accreditation, patient safety, and equipment restrictions, the Center cannot accept the following patients for admission:

Patients with brittle diabetes (unstable diabetes that results in disruption of life and recurrent admissions to hospital).
Alcohol dependence who is at risk for withdrawal syndrome.
Patients who have a history of severe latex allergy.
Pregnancy.
Patients with a history of malignant hyperthermia.
Moderate to severe uncontrolled obstructive sleep apnea.
Patients with a total BMI >55.
Bleeding disorder requiring replacement factor or blood products to correct a coagulation defect.
Patients who are in PS 4, 5, or 6 categories as assessed by physician
Uncooperative/unreliable.
No responsible person at home.
Patients not cleared by the provider.

ADVANCE NOTIFICATION TO PATIENTS

Policy Name:	**ADVANCE NOTIFICATION TO PATIENTS**
Section:	Admission
Purpose:	To comply with CMS standards

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

Patient Rights and Responsibilities and Grievance protocols are posted in the reception area, and patients are educated on these rights prior to their procedure.

Written Notice: The physician's office will give the patient a brochure that will contain a written copy of their rights, responsibilities, grievance procedure, and advance directive policy, and disclosure of ownership. This will be done prior to the procedure.

Verbal Notice: The pre-operative nurse will notify the patients during the pre-op call that takes place prior to the scheduled procedure to educate the patient on their rights, responsibilities, grievance procedure, and advance directive policy. For patients who do not receive a pre-operative phone call, the pre-operative nurse will notify the patients during the pre-op assessment that takes place prior to the scheduled procedure to educate the patients on their rights.

When the patient is admitted to the Center, they will sign an attestation statement that says they received a copy of the advance notice brochure prior to their procedure.

ADVANCE NOTICE BROCHURE

PATIENT RIGHTS

As a Patient, You Have the Right to:

To have access to the patient rights and responsibilities established by this Center;

Be treated with respect, consideration, and dignity;

The right to effective communication;

The right to be respected for your cultural and personal values, beliefs, and preferences;

To be provided appropriate, security and privacy;

The right to pain management;

The right to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation;

The right to receive care in a safe setting;

The right to information in a manner tailored to the patient's age, language, and ability to understand;

The Center provides interpreting and translation services;

The Center communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that fits the patient's needs.

To be free from all forms of abuse, harassment, or neglect;

To be fully informed about a treatment or procedure, agree with their care, and the expected outcome before the procedure is performed;

Have the right to be involved with all aspects of their care including refusing care and treatment and resolving problems with care decisions;

Have the right to have access to spiritual care while at the Center if desired;

The Center respects the patient's right to receive care in a safe setting;

Appropriate information regarding the absence of malpractice insurance coverage.

If a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf;

If a state court has not adjudged a patient incompetent, any legal representative designated by the patient, in accordance with the state law, may exercise the patient's rights to the extent allowed by state law;

To see posted written notice of the patient rights in a place or places within the Center likely to be noticed by patients (or their representative, if applicable) waiting for treatment. The written poster will include name, address, and telephone number of a representative of the state agency to whom the patient can report complaints, as well as the web site for the Office of the Medicare Beneficiary Ombudsman;

Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or a legally authorized person.

Patients are informed of their right to change their provider if other qualified providers are available.

Patients are given the opportunity to participate in decisions involving their healthcare, treatment, or services, except when such participation is contraindicated for medical reasons.

The Center involves the patient's family in care, treatment, or services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.

The Center provides the patient, or surrogate decision-maker, with information about the outcomes of care, treatment, or services that the patient needs to participate in current and future health care decisions.

The Center informs the patient, or surrogate decision-maker, about unanticipated outcomes of care, and treatment.

Marketing or advertising regarding the competence and capabilities of the Center is not misleading to patients.

Patients are informed about procedures for expressing suggestions, complaints, and grievances, including those required by state and federal regulations.

The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished.

The patient has the right to exercise his or her rights without being subject to coercion, discrimination, reprisal, or interruption of care that could adversely affect the patient.

Patient rights, conduct and responsibilities;

Services available at the Center;

Provisions for after-hours emergency care;

Fee for services;

Payment policies;

Patient's right to refuse participation in experimental research;

Advance directives, as required by state and/or federal law and regulations;

The credentials of health care professionals.

Patient Responsibilities

Prior to receiving care, patients are informed of their responsibilities. These responsibilities require the patient to:

Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over the counter products and dietary supplements and any allergies or sensitivities;

Follow the treatment plan prescribed by his/her provider;

Provide a responsible adult to transport him/her home from the Center and remain with him/her for twenty-four (24) hours, if required by his/her provider;

Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care;

Accept personal financial responsibility for any charges not covered by his/her insurance;

Be respectful of all the health care providers and staff, as well as other patients.

Advance Directive: Statement of Limitation

This Center does not provide implementation of advance directives; based on conscience (the scheduled procedure is an elective procedure), regardless of the contents of any advance directive or instructions from a health care surrogate or attorney. If an adverse event occurs at this facility, we will initiate resuscitative or other stabilizing measures and transfer patients to an acute care hospital for further evaluation. The receiving hospital will implement further treatment or withdrawal of treatment measures already begun in accordance with patient wishes, advance directive or healthcare power of attorney.

Disclosure of Ownership

The TN HEART CARDIOVASCULAR SURGERY CENTER is a Limited Liability Corporation (LLC), which is owned by: TN HEART, LLC.

Grievance Policy

The Center strives to provide high quality care and achieve patient satisfaction. Patient grievances/complaints provide a means to measure achievement of this goal and to identify a need for performance improvement.

Grievance/Complaint: Grievances are defined as care that the Center provided or allegedly failed to provide.

Neglect – Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 CFR 488.301).

Abuse – The willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish (42 CFR 488.301).

All complaints received by the Center personnel shall be forwarded to the clinical director or his/her designee immediately, at least the same day. The clinical director will respond to the grievance within 48 hours of receiving it.

For a full copy of the grievance procedure, please ask any Center personnel.

Advance Notice Rights

All patients will be advised, in advance of the procedure, the Center's policies on patient rights, patient responsibilities, patient grievance, advance directives, and disclosure of ownership. The patient has the right to receive this information in a language and manner that the patient or the patient's representative understands. The Center gives brochures to each patient being admitted with the Center's written policies regarding this information. The nurse making the preoperative call informs the patient verbally of this information.

To Report a Concern:

Clinical Director: _____

TENNESSEE Department of Health
710 James Robertson Parkway
Nashville, TN 37243
800-852-2187
Report a Concern
Complaint Hot Line 877-287-0010

The TJC (The Joint Commission)
Mailing address:
Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181
Email: complaint@jointcommission.org
Online:
http://www.jointcommission.org/report_a_complaint.aspx.

Office of the Medicare Beneficiary Ombudsman
Online: http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Visit the website listed above or call 1-800-MEDICARE (1-800-633-4227) for more information, to ask questions, and to submit complaints about Medicare to the Office of the Medicare Ombudsman. TTY users should call 1-877-486-2048

CULTURAL DIVERSITY

Policy Name:	**CULTURAL DIVERSITY**
Section:	Admission
Purpose:	To provide guidelines for staff

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

Patient Assessment: As part of the admission nursing assessment, the RN will assess the patient's cultural/health beliefs. If a patient identifies a cultural/health need, it will be documented into the patient's chart.

Some questions the RN will ask might include, but not limited to:

How does the patient stay healthy?
- Special foods, drinks, objects or clothes
- Avoidance of certain foods, people or places
- Customary rituals or people used to treat the illness

What are the expectations for medicine usage?
- Past experiences with medicine usage
- Will the patient take medicine even when he/she doesn't feel sick?
- Is the patient taking other medicines or anything else to help them feel well?

Family and Community Relationships
- Are illnesses treated at home or by a community member?
- Who in the family makes decisions about healthcare?

Language Barriers
- Can the patient understand limited English?
- Consider literacy level
- Use visual aids and demonstrate procedures
- Check understanding
- Is an interpreter necessary? If yes, follow Center guidelines by using a trained medical interpreter. Avoid using family members.

Body Language
Is there cultural significance for:
- Eye contact
- Touching
- Personal space
- Privacy / modesty

Other Cultural Factors to Consider
- Gender

- Wealth or social status
- Presence of a disability
- Sexual orientation

Religious / Spiritual Beliefs
Are there sensitivities / beliefs associated with:
- Birth, death
- Certain treatments, blood products
- Prayer, meditation and worship
- Food preparation, clothing, special objects, and gender practices

DISABLED ACCOMMODATIONS

Policy Name:	**DISABLED ACCOMMODATIONS**
Section:	Admission
Purpose:	To provide guidelines for disabled patients/family

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

The Center will accommodate individuals' language barriers, visual, hearing, and/or mobility impairment, to meet the needs of the patient.

Visual, hearing-impaired persons

Trained animals will be allowed to remain with their master until the time the patient is escorted to the surgical area, at which time the animal will be turned over to a family member.

A family member or interpreter will be allowed into the pre-operative area with disabled persons.

For a visually impaired patient, the rights and responsibilities and grievance policies of the Center will be read to the patient.

Non-English-Speaking Persons

When caring for a patient who has difficulty communicating in the English language, the policy of this Center is to communicate in a manner that meets the patient's needs, to include, but not limited to:

Providing interpretation and translation services, as necessary

Utilizing pictures and gestures when a translator is not available or cannot be found.

Advance Notice

This Center is committed to providing information in a manner tailored to the patient's age, language, disabilities, and ability to understand. Our Center provides the patient, or his or her surrogate decision-maker, with verbal and written notice of the patient’s rights in advance of the procedure and in a language and manner that the patient or his or her surrogate decision-maker understands. The notice of rights includes contact information for reporting complaints to the state agency and the website for the Office of the Medicare Beneficiary Ombudsman.

Mobility Impaired Persons

A ramp and designated parking area will be provided into the building.
Public bathrooms are suitable to accommodate wheelchairs.

EFFECTIVE COMMUNICATION

Policy Name:	**EFFECTIVE COMMUNICATION**
Section:	Admission
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

Effective communication is essential among individuals and groups within the Center, and between the Center and external parties. Communication supports safety and quality throughout the Center. When changes in the environment occur, the Center communicates those changes through the methods listed below. Effective communication is timely, accurate, and usable by the audience. Leaders evaluate the effectiveness of communication methods at a regular annual planning meeting of the governing body and medical advisory committee.

Communication is encouraged by, but not limited to:

Regular in-service staff meetings
Notification forms (from PI Plan in QAPI book)
Quarterly committee meetings
Policy and Procedure
Employee Lounge bulletin board

TRANSFER TO HOSPITAL: NON-EMERGENCY ADMISSION

Policy Name:	**TRANSFER TO HOSPITAL: NON-EMERGENCY ADMISSION**
Section:	PACU
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

Patients will only be transferred to the hospital by physician order as part of continued treatment plan for the patient. The physician is responsible for informing the patient of the impending transfer.

PROCEDURE

Call hospital admission office with the following information:

Patient name.

Patient birth date and age.

Patient admitting diagnosis.

Admitting physician's name.

Insurance information.

Copy and send complete patient records, including any copy or written documentation concerning advance directives, if applicable, with patient to the hospital. See Patient Transfer to Hospital: Non-Emergency form.

Direct patient and family to hospital admitting office.

FORM: PATIENT TRANSFER TO HOSPITAL: NON-EMERGENCY

PATIENT INFORMATION:

Patient's Full Name:		
Patient's Address:		
Patient's DOB/Age:	DOB:	Age:
Patient's Family Physician/Address	Dr.	Address:

ADMITTING INFORMATION:

Admitting Diagnosis:	
Surgery Performed:	
Allergies/Reactions:	
Physician Performing Surgery:	
Reason for Transfer:	
Comments:	

TRANSFER INFORMATION:

Transferred From/Address/Phone:	
Transferred via: (i.e.; Ambulance, Family, etc.)	
Accompanied By:	
Date and Time of Transfer:	
Hospital Transferred to:	

PROCEDURE:

Chart Copied for Hospital:	
Physician Order for Transfer:	
Family Advised:	
Personal Belongings Given to Family:	
Hospital Advised of Transfer, Patient Accepted:	
Instructions Given:	
R.N. Signature:	
Physician Signature:	

EMERGENCY TRANSFER

Policy Name:	**EMERGENCY TRANSFER**
Section:	Emergency
Purpose:	To ensure continuity of care to a patient being transferred from this Center.

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

All patients with a physician's order to transfer from this Center to another facility, such as a hospital, will be managed by an efficient and expedient transfer process.

PROCEDURE

In the case of a medical emergency, the Emergency Medical System will be immediately activated, by calling 911. Paramedics responding to the call will manage the medical emergency once they arrive in the Center and execute the hospital transfer.

The physician will notify the patient's family and/or guardian of the transfer.

Ensure the completeness of the emergency management documentation.

Complete the Transfer Report in duplicate.

Place Transfer Report and any other approved documents in an envelope, with the Center's heading and address. Write the name of the hospital, and the patient's name on the front of the envelope.

Ready the patient's belongings for transfer. Give the documents to the paramedics taking the patient to the hospital.

TRANSFER DOCUMENTATION

A physician's order is required for the transfer of a patient.

A Transfer Report is to be completed by the nursing staff. A copy remains on the chart. The original is sent to the patient.

A photocopy of the history and physical are to be routinely sent with the patient, along with all other medical documentation of the current surgical encounter, (physician order, anesthesia record, procedure/operating room record, nursing notes, discharge summary, code blue record, etc.) and any preoperative diagnostic test results.

Nursing notes should include:

The date and time of transfer/discharge.

Mode of transfer – ambulance.

Name of individuals transferring patient - ambulance company, paramedics, relatives, etc.

Information sent with patient.

Signature and title.

Medication Reconciliation Sheet.

Any other forms requested by the new facility or facility physicians are to be approved by the transferring physician.

In the event a patient who was transferred is subsequently found to have an infection requiring monitoring, treatment and/or isolation the Center's Infection Control Nurse will notify the institution, along with attending physician, immediately with the diagnosis via telephone.

STAFF TRAINING

Staff are trained at orientation and as needed related to the policy on emergency transfer.

FORM: EMERGENCY TRANSFER

Date and Time: _____

Patient Sticker: _____
Height/Weight: _____
Allergies: _____
Procedure: _____
Reason For Transfer: _____
_____
_____
Vital Signs at Time of Transfer: _____
Medications Administered at Center:
_____
_____
Home Medications Taken by Patient Today:
_____
_____

Transfer To: **Cookeville Regional Medical Center, 1 Medical Center Blvd, Cookeville, TN**

Transferring Physician: _____

Physician Certification: (complete each subsection)

Risks and benefits of transfer (or refusal of transfer) have been explained by me to the patient/legally responsible representative as follows:

Summary of benefits of transfer:

- ❑ Specialized Treatment of Care
- ❑ Improved Possibility of Retaining Life or Limb
- ❑ Continuity of Care
- ❑ Further Medical Exam
- ❑ Radiological Procedures Not Available Here
- ❑ Invasive Procedures/Testing Not Available Here
- ❑ Other: _____

Summary of risks of transfer:

- ❑ Death
- ❑ Pain
- ❑ Delivery in Route
- ❑ Worsening of Condition
- ❑ Motor or Other Vehicle Accident
- ❑ Loss of Function of Afflicted Body Part
- ❑ Other: _____

Summary of risks non-transfer:

_____
_____
_____

Questions regarding the Medication Reconciliation Form should be directed to the Transferring Physician. 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 of the transfer to the patient.

- ❑ **Report Given to Accepting MD**
- ❑ **N/A (Transferring Physician is Accepting Physician)**

Transferring Physician Signature: _____
Accepting Physician: _____
Accepting Physician Signature: _____

- ❑ **RN Traveling with Patient to Hospital**
- ❑ **Reporting given to RN at Hospital via Telephone**
- ❑ **Family / Significant other notified**

RN Signature: _____

Time of Transfer: _____

Belongings sent with Patient or given to family?	**Yes**	**No**
Copy of Chart sent with Patient?	**Yes**	**No**
Copies of studies electronically sent?	**Yes**	**No**

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PLAN

Policy Name:	**QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PLAN**
Section:	QAPI
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

PURPOSE AND MISSION

The QAPI program at the TN Heart Cardiovascular Surgery Center is a systematic, continuous program to monitor, evaluate, and improve clinical quality, patient satisfaction, operational performance, and regulatory compliance.

Our goal is to deliver superior quality patient care and produce optimal patient outcomes, through the efficient management of our material and human resources. A variety of processes are incorporated in this QAPI plan in order to achieve this goal.

COMMITMENT TO PERFORMANCE

The Governing Body, administration, management, employees, and medical staff of the Center are committed to continually seeking ways to improve the quality of services provided. It is believed that improvement in performance is possible and as an organization, we will strive to meet or exceed all reasonable expectations. We believe we can improve overall performance by taking actions that result in measurable change, to positively impact patient outcomes.

Quality Improvement at the TN Heart Cardiovascular Surgery Center includes the following components:

Performance Improvement

Performance improvement is proactive in nature and seeks to enhance quality through processes which identify and act upon opportunities for improvement. Performance improvement is dynamic and ongoing, based on the premise that quality is dynamic in nature. Each day the quality of our performance in every dimension is relatively better or worse. Successful implementation of this plan demands an unrelenting commitment on the part of every member of the Center staff and its leaders, to identify and pursue opportunities for improvement and then ensure and validate that performance improvement.

Quality Assurance

Quality assurance is retrospective in nature, reviewing specific indicators to identify problem areas which might include the following:

To objectively and systematically monitor and evaluate the quality and appropriateness of patient care on an ongoing basis to ensure that we meet quality standards.

- To systematically monitor the nursing standards of practice, standards of care, standards of performance

and consumer satisfaction
- To demonstrate effective action in those situations where we have failed to meet standards which result in improved performance
- To show evidence of problem resolution by way of tracking and follow-up
- To promote individual accountability among staff at the Center
- To identify needs for specific educational training of personnel
- To identify environmental hazards and sources of potential infection
- To identify trends
- To identify problems requiring action by the QAPI committee and referring such problems for further investigation and action

Infection Control

Development and implementation of policies and procedures to minimize the risk of infection in the facility

Orientation and ongoing employee education regarding infection control policies and procedures

Identification and tracking of infection trends

A review of all infections identified with follow-up action and/or investigation as warranted

Risk Management

Risk management data will be collected on a monthly basis. The data will be reported quarterly, or more often as needed, to the governing body. The data will include, but not limited to the following areas:

- Transfers to acute care facilities, emergent and non-emergent
- Complications related to procedure
- Adverse drug reactions or medication errors
- Reported infections
- Patients who did not receive prophylactic antibiotic within one hour of surgical incision time
- Radiation exposure >60 minutes
- Patient falls
- Hospital admission post discharge
- Wrong site, side, patient, procedure, implant
- Case cancellations
- Patient satisfaction

The data will be collected from a variety of sources including incident reports, infection reports, tabulation of patient satisfaction surveys, patient/visitor grievance/complaint records.

Peer Review

Review against specific criteria, of a minimum of 5% or 10 (whichever is greater) randomly selected records to include cases in each specialty, performed during the most recent quarter to monitor quality of care provided.

Utilization Review

Collection and review of utilization statistics based on the scope of care, to ensure effective management of human and material resources. Such review may include case volume by surgeon, by specialty, by CPT code, staffing hours, cost per case, and equipment utilization.

Benchmarking

The Center recognizes the value of benchmarking internally, with similar facilities, and/or national industry-wide practices, as available. We strive to improve performance when possible and will participate in benchmarking activities with similar facilities nationally when such activities are relevant to our Center.

Strategic Planning

Strategic planning is essential to our continued growth and success as a healthcare provider. The organizational leadership is committed to an organized and systematic approach to strategic planning. At least annually, the planning process will be implemented to include:

- Assessment of the Center's present situation - strengths and weaknesses, progress against last year's plan and objectives
- Revisit of the Mission/Vision Statement - know what we want, who we are. Have we accurately reflected who we are in our vision statement?
- Confirmation of principles and philosophy - have we been true to our values in working toward our objectives?
- Sales and Marketing
- Clinical
- Development
- Organization and Management
- Financial

The result of this strategic planning process will be the development of specific goals and objectives in five key areas which will become the road map for QAPI activities in the coming year.

QAPI PLAN OBJECTIVES

To improve patient care quality by assessing and improving processes that most affect patient outcomes

To integrate and coordinate quality management and improvement activities throughout the organization

To enhance client satisfaction (internal and external clients)

To ensure organization-wide participation of all aspects in the QAPI process

To provide effective mechanisms to identify and resolve problems as they relate to quality within the organization

To ensure communication and reporting pathways between the facility, the medical staff, administration, and the Governing Body

To continuously expand our knowledge and use of appropriate management and leadership tools that will enable us to meet increasingly challenging standards and expectations

To provide safe opioid prescribing

To monitor exceeding radiation thresholds

AUTHORITY AND ACCOUNTABILITY

The authority and accountability for the QAPI program rests with the Center's leadership which includes the Clinical Director, the QAPI Coordinator, the Medical Advisory Committee and ultimately, the Governing Body. Specific responsibilities are to:

- Set expectations, develop plans, and implement procedures to assess and improve the quality of service, practice and governance
- Become educated regarding the approaches and methods of performance management and improvement
- Set QAPI activities
- Allocate adequate resources to support QAPI activities
- Ensure that staff is educated in assessing and improving the processes that contribute to improved patient care quality
- Develop and participate, individually and jointly, in mechanisms that foster communication and coordination of activities, to include all contracted services
- Analyze and evaluate the effectiveness of their contributions to QAPI

Establish QAPI responsibilities in the organization to include the following:

ADMINISTRATION

Facilitate the design, development and implementation of the organization's QAPI plan

Participate in annual strategic planning to establish priorities and define goals

Allocate adequate financial resources for effective implementation of the QAPI plan.

Review all quality related reporting and information as a basis for planning and development of QAPI activities

Participate in annual review of the efficacy of the QAPI plan

MEDICAL DIRECTOR

Direct and oversee the implementation of the QAPI program

QAPI COORDINATOR

Collaborate with organizational leadership and Center staff to identify and integrate important aspects of care (indicators) and realistic thresholds into the QAPI program

Ensure important aspects of care and service that affect large numbers of patients are of high benefit /high risk for individual patients, and/or are suspected of producing problems for patients or employees are identified and integrated

Set priorities for monitoring the specific aspects of care and service, as well as other feedback that may indicate an opportunity to improve the quality of practice or service, including client satisfaction

Track findings, evaluate results and take appropriate action to ensure improvement and/or resolution

Implement employee education programs to ensure employee understanding of and active participation in the

QAPI program

Facilitate staff communication for the purpose of identifying opportunities for improvement

Utilize the results of QAPI activities in the performance appraisal process

Ensure communication of QAPI activities and their results to relevant individuals and groups. Report quarterly to the Medical Advisory Committee and the Governing Body

EMPLOYEES

Actively participate in the QAPI program activities

Participate in the data collection, assessment and improvement process as requested

Identify and communicate areas of concern and opportunities for improvement related to quality care

GOVERNING BODY

Foster the concepts of QAPI in healthcare through their personal commitment to the success of the QAPI program

Incorporate the findings from QAPI activities in strategic planning

Participate in annual strategic planning to establish priorities and define goals

Approve medical staff appointments with appropriate clinical privileges and eligible applicants

Ensure adequate financial support for effective implementation of the QAPI plan

Review all quality related information and reports to ensure compliance with the intent of the program and to effect constructive change

Evaluate the annual review of the efficacy of the QAPI program and its impact

QAPI COMMITTEE

Monitor and evaluate QAPI activities including, but not limited to:

- Appoint medical and Center staff members to the various QAPI functions and responsibilities, encouraging and facilitating their active participation
- Review and analyze all QAPI reports and findings and recommend appropriate action
- Communicate all QAPI activities and findings to the medical staff and the Governing Body
- Participate in annual strategic planning to establish priorities and define goals
- Provide concurrent review of patient care activities to identify and facilitate opportunities to improve practice or service
- Provide technical assistance to the staff necessary to implement QAPI activities

Organize the structure of the QAPI committee to include:

- Physician (at least one)
- Clinical Director (QAPI Coordinator)
- Others as Assigned

The QAPI meeting will include, but not be limited to, the following designated times:

- Annually for planning session
- Quarterly meetings

COMMUNICATION OF QAPI ACTIVITIES

The communication of QAPI activities occurs at multiple levels throughout the organization. The QAPI Coordinator is responsible for communicating QAPI activities to all employees. The Medical Advisory Committee is responsible for communicating QAPI activities to the medical staff and Governing Body on a quarterly basis (minimum), and at other times as appropriate. This is achieved in the following manner:

- QAPI program activities will be included on the agenda of facility staff meetings where problems and opportunities are identified, suggestions for actions are discussed, and action plans are developed.
- Minutes of quarterly and PRN Committee meetings will be maintained to include all QAPI documentation and reporting, and reports of staff meeting minutes related to QAPI activities.
- QAPI minutes will be forwarded to the Governing Body for review and comment on a quarterly basis.

PROGRAM EVALUATION

The efficacy of the QAPI program will be evaluated annually by the Medical Advisory Committee in conjunction with the QAPI coordinator. A written report of this evaluation is submitted to the Governing Body. This report includes:

- Identified opportunities to improve care
- Corrective actions taken to resolve issues identified and make improvements
- Educational programs related to QAPI activities

Program changes planned as a result of the annual evaluation (changes in scope, organization, objectives, etc.).

CONFIDENTIALITY

All records, data, and knowledge collected for performance improvement are confidential, and all committee members and other persons collecting such information shall preserve its confidentiality.

All data and information acquired and prepared for the performance improvement program are not discoverable, as put forth in state confidentiality statutes (NRS 49.265). See the QAPI Confidentiality Agreement.

PROCEDURAL TIME OUT

Policy Name:	**PROCEDURAL TIME OUT**
Section:	Operating Room
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

To ensure patient safety and to minimize the potential for errors in treatment, each patient undergoing any invasive surgical procedure will be identified using verbal, written, and visual methods.

A verbal “time out” or pause must be done in the location where the procedure is to be performed, immediately prior to the start of the case. Time out involves the immediate members of the procedure team including the surgeon, anesthesia providers, circulating nurse, scrub personnel and other active participants who will be participating in the procedure from the beginning. The circulating RN will document in the medical record that the time out was done.

The information to be included in the time out, but not limited to:

Patient Name
Procedure Scheduled
The Operative Site/Side
Verify Correct Implant Availability
CT Surgeon on Call
Maximum Lidocaine Dose
Any Additional Concerns from Team Members
Pre-op Antibiotic
Patient Allergies
Medications taken today
Medications stopped for procedure
Fire Risk
H&P is within 30 days

A discrepancy at any point in time out must stop the case from proceeding until resolved. All team members must agree on the resolution(s) to the identified discrepancy.

When two or more procedures are being performed on the same patient, and the person performing the procedure changes, a time out will be performed before each procedure is initiated.

PREOPERATIVE CALL

Policy Name:	**PREOPERATIVE CALL**
Section:	Preoperative
Purpose:	To establish protocols for pre-op calls

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

A phone call will be made to all patients prior to any invasive procedure at this Center. If the patient cannot be reached prior to the procedure, the case might be delayed and/or cancelled in order for the nurse to go over the important questions prior to admission. These questions include but are not limited to:

- Verification of Date of Birth
- Verification of surgical procedure and laterality
- Do you have any allergies? Drug and non-drug?
    - Heparin allergy/HIT?
    - IV Contrast allergy
- Medications
    - Do you take any blood thinners?
    - Are you currently taking a GLP1 antagonist?
- Do you have a Primary Care Provider?
- Height and Weight
- Medical History
    - Any history of:
        - Breathing Problems?
        - OSA? Do you wear a CPAP?
        - Blood disorder?
        - Diabetes?
            - Insulin regime?
            - Direction from an endocrinologist?
        - Thyroid condition?
        - Kidney problems?
    - Could you be pregnant?
    - Any recent cold, flu, or any infections?
    - Any recent exposures to infectious diseases such as MRSA/VRE/COVID
- Surgical History
    - Operations and Surgeries
    - Existing Implants
- Any additional medical or surgical history we need to know about?

After all questions have been recorded in the preoperative call record and the patient meets the admission criteria of the Center, they are given the following instructions:

- Bring Insurance card and photo ID
- NPO – after midnight
- Do not bring valuables with you
- Wear comfortable clothes

- No makeup, hairspray, lotions, or jewelry
- Wear glasses, no contacts
- Bring list of current medications
- Directions on where to check in
- Patient/Procedure specific medication instructions given
- Procedures receiving sedation/anesthesia will require someone to drive them home

DIAGNOSTIC CARDIAC CATHETERIZATION

Policy Name:	**DIAGNOSTIC CARDIAC CATHETERIZATION**
Section:	Operating Room
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

Purpose: To establish standardized procedure guidelines and safety protocols for the performance of diagnostic cardiac catheterizations in our Center. This policy aims to ensure this procedure is performed safely by establishing appropriate patient selection, staffing, equipment requirements, and emergency preparedness.

Definitions:

Cardiac Catheterization – A minimally invasive procedure used to evaluate coronary anatomy, measure hemodynamics, and assess structural or valvular disease by advancing catheters through arterial or venous access in the wrist or groin.

Diagnostic Coronary Angiography – the injection of contrast dye into the coronary arteries through a small catheter in the wrist or groin under fluoroscopy to visualize calcium and blockages.

Right Heart Catheterization – the measurement of hemodynamic pressures in the different chambers of the heart. Measurements obtained include right atrial pressure, right ventricular pressure, pulmonary artery pressure, pulmonary artery wedge pressure, and cardiac output. This is performed through venous access.

Left Heart Catheterization – the assessment of coronary anatomy and the measurement of left ventricular pressure through arterial access in the wrist or groin.

Patients appropriate for Diagnostic Cardiac Catheterization at TN Heart Cardiovascular Surgery Center:

- Do not meet any of exclusion criteria in Admission Policy
- Hemodynamically stable at time of admission
- Have adequate social support for post procedure care
- Able to comply with same-day discharge instructions

Patients appropriate for Diagnostic Cardiac Catheterization in an Acute Care Hospital Setting:

- High bleeding risk
- Severe pulmonary disease
- Inadequate support for post procedure care
- Anticipated procedural complexity beyond the Center's capabilities

Criteria for Admission to Center for Diagnostic Cardiac Catheterization

- H&P within 30 days
- CBC and BMP within 30 days

Lab Equipment Requirements

- Daily checks of essential equipment will be performed by staff prior to patient entering procedure room.
- Equipment requiring documented daily checks
    - Defibrillator
    - Fluoroscopy System
    - Hemodynamic Monitoring System
    - Intra-Aortic Balloon Pump (for emergency use only)
    - Ultrasound System
- Staff will document that patient is connected to all monitoring equipment and it is all in working order prior to the start of the procedure

Staffing

- Performing Physician
    - Board certified Interventional Cardiologist
    - All credentialing requirements have been met and are currently up to date
- Nursing and Technical Staff
    - Circulating RN
    - Conscious Sedation RN
    - Scrub Technologist
    - Monitoring Technologist or RN with documented training on Hemodynamic Monitoring system

Emergency Preparedness

- All staff in procedure room are required to be ACLS certified
- Emergency equipment available including
    - Defibrillator
    - Temporary pacemaker
    - Intra-aortic balloon pump
- Transfer agreement in place
- All staff are properly trained on transfer policy
- Annual mock code performed with emergency response team

Pre-Procedure

- Verification of admission requirements (H&P and labs within 30 days)
- Verification of medication list and medications taken day of procedure
- Monitoring equipment placed on patient for HR, BP, Resp, and SPO2
- Vital signs documented and patient's hemodynamic stability verified by physician
- IV access obtained
- Pre-procedure distal pulses documented
- Full nursing assessment completed and documented in EMR.
- Pre Op staff will witness signature of procedural consent by patient with performing physician.

Intra-Procedure

- Upon entering the procedure room, the patient's name, DOB, allergies, and procedure are verified.
- OR staff confirm that H&P and consents are completed in EMR.
- Patient is positioned safely on procedure table with under body warming blanket
- Continuous monitoring of patient's ECG, NIBP, ETCO2, SPO2
- With all staff members present in the room, a procedural time out is performed
- Post vital signs completed and patient transferred to stretcher.
- Patient transferred by RN to post op area where handoff report is given

Post Procedure

- Patient admitted to post Op area by ACLS certified RN
- Continuous monitoring of NIBP, EKG, SPO2, Resp until stable
    - Every 5 minutes x3
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Access sites inspected upon arrival and as follows:
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Ambulation time dependent on closure method and will be entered in post operative orders by physician
- Discharge readiness is assessed
- Patient is discharged to home when physician determines that all discharge criteria have been met

Post Procedure Phone Call

- Patient receives a phone call from a member of the Center's clinical staff the day after the procedure
- Clinical staff confirms no post-operative complications are present
- Staff members reiterate discharge instructions including limitations
- If follow up appointment is necessary, staff member will confirm appointment with patient
- Patient is asked if they have any additional questions or concerns

Quality Assurance and Performance Improvement

- Metrics monitored on a quarterly basis
    - Surgical site infections
    - Access site complications, hematoma/bleeding at site after hemostasis achieved
    - ED visit or hospital transfer with 24 hours of discharge
    - Radiation exposure >60 minutes
    - Wrong site, side, patient, procedure, implant
    - Patient satisfaction
- All findings are reviewed by Medical Director and QAPI committee

INTERVENTIONAL TIME OUT

Policy Name:	**INTERVENTIONAL TIME OUT**
Section:	Operating Room
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

To ensure patient safety and to minimize the potential for errors in treatment, each patient undergoing any invasive surgical procedure will be identified using verbal, written, and visual methods.

An Interventional Time Out will be defined as a verbal pause in the location where the procedure is being performed after the diagnostic portion of the procedure is complete.

Time out involves the immediate members of the procedure team including the surgeon, circulating nurse, scrub personnel and other active participants who will be participating in the intervention. The circulating RN will document in the medical record that the Interventional Time Out was completed.

The Interventional Time Out does not replace the Procedural Time Out.

The information to be included in the time out, but not limited to:

Identified lesion for PCI
Appropriateness of Intervention in outpatient setting (refer to Therapeutic Percutaneous Coronary Intervention Policy)
Necessary equipment availability
Anticoagulant to be administered
Oral anti-platelet to be given post PCI
Confirmation of Defibrillator pads on patient
Confirmation of available emergency equipment
IV access assessment
Confirmation of CT surgeon on call at transfer hospital
Any additional concerns by team members

THERAPEUTIC CARDIAC CATHETERIZATION

Policy Name:	**THERAPEUTIC CARDIAC CATHETERIZATION**
Section:	Operating Room
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

Purpose: To establish standardized procedure guidelines and safety protocols for the performance of therapeutic cardiac catheterizations in our Center. This policy aims to ensure this procedure is performed safely by establishing appropriate patient selection, staffing, equipment requirements, and emergency preparedness.

Definitions:

Therapeutic Percutaneous Coronary Intervention (PCI) – a minimally invasive non-surgical coronary intervention using balloon angioplasty, stent placement, and other intracoronary technologies intended to treat obstructive coronary artery disease

Elective Percutaneous Coronary Intervention – non emergent PCI performed on hemodynamically stable patients without the presence of active chest pain or ischemia.

High Risk PCI – specific clinical presentations listed below in this policy that categorize the PCI as high risk and therefore not appropriate for the center.

Patients appropriate for Therapeutic Cardiac Catheterization at TN Heart Cardiovascular Surgery Center:

- Do not meet any of exclusion criteria in Admission Policy
- Hemodynamically stable at time of admission
- Stable ischemic heart disease
- Have adequate social support for post procedure care
- Able to comply with same-day discharge instructions

Patients appropriate for Therapeutic Cardiac Catheterization in an Acute Care Hospital Setting:

- Hemodynamically unstable
- Acute coronary syndrome
- Unstable angina
- The following conditions warrant the consideration of PCI deferment to the hospital setting:
    - Bifurcation lesions with significant side branch involvement
    - Severe lesion calcification
    - Extremely angulated segment or excessive proximal tortuosity
    - Bypass graft lesions
    - Chronic total occlusions

    - Thrombus in target vessel or lesion
    - Last remaining conduit
    - Possible need for upfront mechanical circulatory support
    - Unprotected left main stenosis or three-vessel CAD
    - Any cardiac or noncardiac signs of clinical instability
    - Significant PAD limiting femoral and radial access
    - Severe aortic stenosis
    - Operator judgment on other condition(s)
- Inadequate support for post procedure care
- Anticipated procedural complexity beyond the Center's capabilities

Criteria for Admission to Center for Therapeutic Cardiac Catheterization

- Patient meets criteria in Center's Admission Policy
- H&P within 30 days
- CBC and BMP within 30 days

Lab Equipment Requirements

- Daily checks of essential equipment will be performed by staff prior to patient entering procedure room.
- Equipment requiring documented daily checks
    - Defibrillator
    - Code Cart
    - Fluoroscopy System
    - Hemodynamic Monitoring System
    - Intra-Aortic Balloon Pump (for emergency use only)
    - Ultrasound System
    - Ability to perform IVUS imaging
- Staff will document that patient is connected to all monitoring equipment and it is all in working order prior to the start of the procedure

Staffing

- Performing Physician
    - Board certified Interventional Cardiologist
    - All credentialing requirements have been met and are currently up to date
    - Current hospital privileges to perform PCI
- Nursing and Technical Staff
    - Circulating RN
    - Conscious Sedation RN
    - Scrub Technologist
    - Monitoring Technologist or RN with documented training on Hemodynamic Monitoring system

Emergency Preparedness

- All staff in procedure room are required to be ACLS certified
- Emergency equipment available including
    - Defibrillator
    - Code Cart
    - Temporary pacemaker
    - Pericardiocentesis kit

    - Intra-aortic balloon pump
- Transfer agreement in place
- All staff are properly trained on transfer policy
- Annual mock code performed with emergency response team

Pre-Procedure

- Verification of admission requirements (H&P and labs within 30 days)
- Verification of medication list and medications taken day of procedure
- Monitoring equipment placed on patient for HR, BP, Resp, and SPO2
- Vital signs documented and patient's hemodynamic stability verified by physician
- IV access obtained
- Pre-procedure distal pulses documented
- Full nursing assessment completed and documented in EMR.
- Pre Op staff will witness signature of procedural consent by patient with performing physician.

Intra-Procedure

- Upon entering the procedure room, the patient's name, DOB, allergies, and procedure are verified.
- OR staff confirm that H&P and consents are completed in EMR.
- Patient is positioned safely on procedure table with under body warming blanket
- Continuous monitoring of patient's ECG, NIBP, ETCO2, SPO2
- With all staff members present in the room, a procedural time out is performed
- After diagnostic procedure is complete and performing moving into therapeutic PCI, an Interventional Time Out will be performed.
- Defibrillator pads placed on patient
- Anticoagulation as directed by physician to reach an ACT >200secs
- Post vital signs completed and patient transferred to stretcher.
- Patient transferred by RN to post op area where handoff report is given

Post Procedure

- Patient admitted to post Op area by ACLS certified RN
- Continuous monitoring of NIBP, EKG, SPO2, Resp
    - Every 5 minutes x3
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Access sites inspected upon arrival and as follows:
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- 12 lead EKG will be performed upon arrival to post op area
- Patient will be monitored in Center for four hours post PCI
- Ambulation time dependent on access site and closure method. Bedrest time will be entered in post operative orders by physician
- Discharge readiness is assessed
- Follow up appointment with physician made before discharge
- Patient given referral for Cardiac Rehab

- Patient is discharged to home when physician determines that all discharge criteria have been met

Post Procedure Phone Call

- Patient receives a phone call from a member of the Center's clinical staff the day after the procedure
- Clinical staff confirms no post-operative complications are present
- Staff member reiterates discharge instructions including limitations
- Follow up appointment confirmed
- Patient is asked if they have any additional questions or concerns

Quality Assurance and Performance Improvement

- Metrics monitored on a quarterly basis
    - Surgical site infections
    - Access site complications, hematoma/bleeding at site after hemostasis achieved
    - EKG completed post procedure before discharge
    - ED visit or hospital transfer within 24 hours of discharge
    - Radiation exposure >60 minutes
    - Wrong site, side, patient, procedure, implant
    - Patient satisfaction
- All findings are reviewed by Medical Director and QAPI committee

DEVICE IMPLANTATION

Policy Name:	**DEVICE IMPLANTATION**
Section:	Operating Room
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

Purpose: To establish standardized procedure guidelines and safety protocols for the performance of device implantations in our Center. This policy aims to ensure this procedure is performed safely by establishing appropriate patient selection, staffing, equipment requirements, and emergency preparedness.

Definitions:

Device Implantation – A surgical procedure implanting a new pacemaker or ICD system under the skin for the monitoring and treatment of irregular heart rhythms.

Pacemaker – A device providing support for bradycardia through atrial, ventricular, or dual-chamber pacing

Implantable Cardioverter Defibrillator (ICD) – A device that is capable of sensing arrhythmias, defibrillation, cardioversion, and traditional pacing

Cardiac Resynchronization Therapy – A type of pacing that attempts to resynchronize the heart's natural rhythm by pacing from multiple chambers of the heart. These devices can be either a pacemaker or an ICD

Generator Change – Replacement of pacemaker or ICD's pulse generator while retaining existing leads.

Patients appropriate for Device Implantation at TN Heart Cardiovascular Surgery Center:

- Do not meet any of exclusion criteria in Admission Policy
- Hemodynamically stable at time of admission
- Meet standard guidelines supported indication for PPM, ICD, or CRT implantation
- No active infection
- Have adequate social support for post procedure care
- Able to comply with same-day discharge instructions

Patients appropriate for Device Implantation in an Acute Care Hospital Setting:

- High bleeding risk
- An abandoned lead that requires extraction
- Severe pulmonary disease
- Known requirement of general anesthesia
- Inadequate support for post procedure care

Criteria for Admission to Center for Device Implantation

- H&P within 30 days
- Echocardiogram within 12 months
- EKG within 30 days
- CBC and BMP within 30 days

Lab Equipment Requirements

- Daily checks of essential equipment will be performed by staff prior to patient entering the operating room.
- Equipment requiring documented daily checks
    - Defibrillator
    - Code Cart
    - Temporary Pacemaker
    - Anesthesia Machine
    - Ultrasound System
    - Fluoroscopy System
- Staff will document that patient is connected to all monitoring equipment and it is all in working order prior to the start of the procedure

Staffing

- Performing Physician
    - Board certified electrophysiologist
    - All credentialing requirements have been met and are currently up to date
    - Current hospital privileges to perform device implantations
- Anesthesia
    - Anesthesia provider MD or CRNA if required
    - Ability to manage deep sedation or general anesthesia care
    - All credentialing requirements have been met and are currently up to date
- Nursing and Technical Staff
    - Circulating RN
    - Conscious Sedation RN (if performed with conscious sedation)
    - Scrub Technologist or RN
    - Monitoring Technologist or RN
- Industry trained device representative

Emergency Preparedness

- All staff in operating room are required to be ACLS certified
- Defibrillator and code cart
- Temporary pacemaker available
- Transfer agreement in place
- All staff properly trained on transfer policy
- Annual mock code performed with emergency response team

Pre-Procedure

- Verification of admission requirements (H&P, ECG, labs within 30 days and echocardiogram within 12 months)
- Verification of medication list and medications taken day of procedure
- Confirmation of anticoagulation course

- Monitoring equipment placed on patient for HR, BP, Resp, and SPO2
- Vital signs documented and patient's hemodynamic stability verified by physician
- IV access obtained
- Defibrillator pads place on patient
- Procedure site prep including hair removal and alcohol wipes
- Full nursing assessment including neuro assessment completed and documented in EMR.
- Pre Op staff will witness signature of procedural consent by patient with performing physician.
- Pre Op staff will witness signature of anesthesia consent by patient with anesthesiologist

Antibiotic Prophylaxis

- IV antibiotic will be administered within 60 minutes of incision
- Cefazolin 2 grams, >120kg 3 grams
- If PCN allergic, vancomycin 1 gram if >90kg 1.5 grams
- Pocket antibiotic envelopes per physician discretion

Intra-Procedure

- Upon entering the operating room, the patient's name, DOB, allergies, and procedure are verified.
- OR staff confirm that H&P and consents are completed in EMR.
- Patient is positioned safely on procedure table with under body warming blanket
- Continuous monitoring of patient's ECG, NIBP, ETCO2, SPO2, temperature
- Patient is prepped using strict sterile procedures
- With all staff members present in the room a procedural time out is performed
- Post operative X-ray taken and arm immobilizer placed
- After the patient is determined to be hemodynamically stable for post op area, patient will be transferred to a stretcher and transported with clinical staff member to post op area where the handoff report will be given to post operative care staff.

Post Procedure

- Patient admitted to post op area by ACLS certified RN
- Continuous monitoring of NIBP, EKG, SPO2, Resp
    - Every 5 minutes x4
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Operative sites inspected upon arrival and as follows:
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Ambulation within four hours depending on closure
- Discharge readiness is assessed
- Patient is discharged to home when physician determines that all discharge criteria have been met

Post Procedure Phone Call

- Patient receives a phone call from a member of the Center's clinical staff the day after the procedure

- Clinical staff confirms no post op complications are present
- Staff members reiterate discharge instructions including limitations
- Follow up appointment with physician is confirmed
- Patient is asked if they have any additional questions or concerns

Quality Assurance and Performance Improvement

- Metrics monitored on a quarterly basis
    - Surgical site infections
    - Antibiotic given within 60 minutes of incision
    - Pocket hematoma requiring intervention
    - Lead revision within 90 days
    - ED visit or hospital transfer with 24 hours of discharge
    - Radiation exposure >60 minutes
    - Wrong site, side, patient, procedure, implant
    - Patient satisfaction
- All findings are reviewed by Medical Director and QAPI committee

CATHETER ABLATION FOR ATRIAL FIBRILLATION

Policy Name:	**CATHETER ABLATION FOR ATRIAL FIBRILLATION**
Section:	Operating Room
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

Purpose: To establish standardized procedure guidelines and safety protocols for the performance of catheter ablation for atrial fibrillation in our Center. This policy aims to ensure this procedure is performed safely by establishing appropriate patient selection, staffing, equipment requirements, and emergency preparedness.

Definitions:

Atrial Fibrillation – A supraventricular tachycardia with disorganized atrial electrical activity and ineffective atrial contraction. It is the most common type of irregular heart rhythm and can lead to blood clots, heart failure, stroke, and additional complications.

Catheter Ablation – A minimally invasive electrophysiology procedure where percutaneous access is obtained to use catheters to disrupt and isolate electrical pathways responsible for atrial fibrillation.

Pulmonary Vein Isolation (PVI) – Electrical isolation of the pulmonary veins from the left atrium.

Pulse Field Ablation – non-thermal ablation technology using short electrical pulses to create electroporation in cardiac cells.

Radiofrequency Ablation – thermal energy technology that delivers continuous radiofrequency current generating heat that creates controlled lesions

Patients appropriate for Catheter Ablation at TN Heart Cardiovascular Surgery Center:

- Do not meet any of exclusion criteria in Admission Policy
- Hemodynamically stable at time of admission
- Have paroxysmal or persistent atrial fibrillation
- Have adequate social support for post procedure care
- Able to comply with same-day discharge instructions

Patients appropriate for Catheter Ablation in an Acute Care Hospital Setting:

- High bleeding risk
- Known structural heart disease that increases periprocedural risk
- Severe pulmonary disease
- Prior complex left atrial ablation procedures
- Advanced heart failure

- Inadequate support for post procedure care
- Anticipated procedural complexity beyond the Center's capabilities

Criteria for Admission to Center for Catheter Ablation for Atrial Fibrillation

- H&P within 30 days
- Echocardiogram within 12 months
- EKG within 30 days
- CBC and BMP within 30 days
- Attestation of adherence to anticoagulation plan

Lab Equipment Requirements

- Daily checks of essential equipment will be performed by staff prior to patient entering the operating room.
- Equipment requiring documented daily checks
    - Defibrillator
    - Anesthesia Machine
    - EP Recording System
    - EP Mapping System
    - ICE System
    - X-ray System
- Staff will document that patient is connected to all monitoring equipment and it is all in working order prior to the start of the procedure

Staffing

- Performing Physician
    - Board certified electrophysiologist
    - All credentialing requirements have been met and are currently up to date
- Anesthesia
    - Anesthesia provider MD or CRNA
    - Ability to manage general anesthesia care
    - All credentialing requirements have been met and are currently up to date
- Nursing and Technical Staff
    - Circulating RN with documented EP training
    - Scrub Technologist or RN with documented EP training
    - Monitoring Technologist or RN with documented training on EP Recording System

Emergency Preparedness

- All staff in operating room are required to be ACLS certified
- Available pericardial tray and ultrasound
- Transfer agreement in place
- All staff are properly trained on transfer policy
- Annual mock code performed with emergency response team

Pre-Procedure

- Verification of admission requirements (H&P, ECG, labs within 30 days and echocardiogram within 12 months)
- Verification of medication list and medications taken day of procedure
- Confirmation of anticoagulation course

- Monitoring equipment placed on patient for HR, BP, Resp, and SPO2
- Vital signs documented and patient's hemodynamic stability verified by physician
- IV access obtained
- Defibrillator pads place on patient
- Pre-procedure distal pulse documented
- Full nursing assessment including neuro assessment completed and documented in EMR.
- Pre Op staff will witness signature of procedural consent by patient with performing physician.
- Pre Op staff will witness signature of anesthesia consent by patient with anesthesiologist

Intra-Procedure

- Upon entering the operating room, the patient's name, DOB, allergies, and procedure are verified.
- OR staff confirm that H&P and consents are completed in EMR.
- Patient is positioned safely on procedure table with under body warming blanket
- Continuous monitoring of patient's ECG, NIBP, ETCO2, SPO2, temperature
- With all staff members present in the room a procedural time out is performed
- Anticoagulation per performing physician's direction
- After patient is determined to be hemodynamically stable for post op area by anesthesia provider, patient will be transferred to stretcher and transported with clinical staff member and anesthesia provider to post op area where handoff report will be given to post operative care staff.

Post Procedure

- Patient admitted to post Op area by ACLS certified RN
- Continuous monitoring of NIBP, EKG, SPO2, Resp until stable
    - Every 5 minutes x4
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Access sites inspected upon arrival and as follows:
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Ambulation within four hours depending on closure
- Discharge readiness is assessed
- Patient is discharged to home when physician determines that all discharge criteria have been met

Post Procedure Phone Call

- Patient receives a phone call from a member of the Center's clinical staff the day after the procedure
- Clinical staff confirms no post op complications are present
- Staff members reiterate discharge instructions including limitations
- Follow up appointment with physician is confirmed
- Patient is asked if they have any additional questions or concerns

Quality Assurance and Performance Improvement

- Metrics monitored on a quarterly basis
    - Surgical site infections
    - Complications related to the procedure
    - Access site complications, hematoma/bleeding at site after hemostasis achieved
    - Appropriate peri-procedural anticoagulation management
    - ED visit or hospital transfer with 24 hours of discharge
    - Radiation exposure >60 minutes
    - Wrong site, side, patient, procedure, implant
    - Patient satisfaction
- All findings are reviewed by Medical Director and QAPI committee

CATHETER ABLATION OF SUPRAVENTRICULAR TACHYCARDIA

Policy Name:	**CATHETER ABLATION OF SUPRAVENTRICULAR TACHYCARDIA**
Section:	Operating Room
Purpose:	To establish protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

Purpose: To establish standardized procedure guidelines and safety protocols for the performance of right sided catheter ablations in our Center. This policy aims to ensure this procedure is performed safely by establishing appropriate patient selection, staffing, equipment requirements, and emergency preparedness.

Definitions:

Catheter Ablation – A minimally invasive electrophysiology procedure where percutaneous access is obtained to use catheters to disrupt and isolate electrical pathways responsible for supraventricular tachycardias.

Supraventricular Tachycardia – a group of abnormally fast heart rhythms that originate above the ventricles. These typically originate in the Atrioventricular node or the atria.

- AV node reentrant tachycardia (AVNRT)
- AV reentrant tachycardia (AVRT), include accessory pathway
- Atrial tachycardia

Atrial Flutter – a supraventricular tachycardia categorized by a rapid regular atrial rhythm caused by a macro-reentrant electrical circuit within the atria.

AV Node Dysfunction – impairment of electrical conduction through the AV node resulting in varying degrees of atrioventricular block

Radiofrequency Ablation – thermal energy technology that delivers continuous radiofrequency current generating heat that creates controlled lesions

Patients appropriate for Catheter Ablation of Supraventricular Tachycardia at TN Heart Cardiovascular Surgery Center:

- Do not meet any of exclusion criteria in Admission Policy
- Hemodynamically stable at time of admission
- Have adequate social support for post procedure care
- Able to comply with same-day discharge instructions

Patients appropriate for Catheter Ablation of Supraventricular Tachycardia in an Acute Care Hospital Setting:

- High bleeding risk

- Known structural heart disease that increases periprocedural risk
- Severe pulmonary disease
- Advanced heart failure
- Inadequate support for post procedure care
- Anticipated procedural complexity beyond the Center's capabilities

Criteria for Admission to Center for Catheter Ablation of Supraventricular Tachycardia

- H&P within 30 days
- Echocardiogram within 12 months
- EKG within 30 days
- CBC and BMP within 30 days

Lab Equipment Requirements

- Daily checks of essential equipment will be performed by staff prior to patient entering the operating room.
- Equipment requiring documented daily checks
    - Defibrillator
    - Code Cart
    - Anesthesia Machine
    - EP Recording System
    - EP Mapping System
    - Ultrasound System
    - Fluoroscopy System
- Staff will document that patient is connected to all monitoring equipment and it is all in working order prior to the start of the procedure

Staffing

- Performing Physician
    - Board certified electrophysiologist
    - All credentialing requirements have been met and are currently up to date
    - Current hospital privileges to perform right-sided ablations
- Anesthesia
    - Anesthesia provider MD or CRNA
    - Ability to manage deep sedation or general anesthesia care
    - All credentialing requirements have been met and are currently up to date
- Nursing and Technical Staff
    - Circulating RN with documented EP training
    - Scrub Technologist or RN with documented EP training
    - Monitoring Technologist or RN with documented training on EP Recording System

Emergency Preparedness

- All staff in operating room are required to be ACLS certified
- Defibrillator and code cart
- Transfer agreement in place
- All staff are properly trained on transfer policy
- Annual mock code performed with emergency response team

Pre-Procedure

- Verification of admission requirements (H&P, ECG, labs within 30 days and echocardiogram within 12 months)
- Verification of medication list and medications taken day of procedure
- Confirmation of anticoagulation course
- Monitoring equipment placed on patient for HR, BP, Resp, and SPO2
- Vital signs documented and patient's hemodynamic stability verified by physician
- IV access obtained
- Defibrillator pads place on patient
- Pre-procedure distal pulse documented
- Full nursing assessment including neuro assessment completed and documented in EMR.
- Pre Op staff will witness signature of procedural consent by patient with performing physician.
- Pre Op staff will witness signature of anesthesia consent by patient with anesthesiologist

Intra-Procedure

- Upon entering the operating room, the patient's name, DOB, allergies, and procedure are verified.
- OR staff confirm that H&P and consents are completed in EMR.
- Patient is positioned safely on procedure table with under body warming blanket
- Continuous monitoring of patient's ECG, NIBP, ETCO2, SPO2, temperature
- With all staff members present in the room a procedural time out is performed
- Anticoagulation per performing physician's direction
- After patient is determined to be hemodynamically stable for post op area by anesthesia provider, patient will be transferred to stretcher and transported with clinical staff member and anesthesia provider to post op area where handoff report will be given to post operative care staff.

Post Procedure

- Patient admitted to post Op area by ACLS certified RN
- Continuous monitoring of NIBP, EKG, SPO2, Resp
    - Every 5 minutes x4
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Access sites inspected upon arrival and as follows:
    - Every 15 minutes x4
    - Every 30 minutes x2
    - Every hour until discharge
- Ambulation within four hours depending on closure
- Discharge readiness is assessed
- Patient is discharged to home when physician determines that all discharge criteria have been met

Post Procedure Phone Call

- Patient receives a phone call from a member of the Center's clinical staff the day after the procedure
- Clinical staff confirms no post op complications are present
- Staff members reiterate discharge instructions including limitations

- Follow up appointment with physician is confirmed
- Patient is asked if they have any additional questions or concerns

Quality Assurance and Performance Improvement

- Metrics monitored on a quarterly basis
    - Surgical site infections
    - Complications related to the procedure
    - Access site complications, hematoma/bleeding at site after hemostasis achieved
    - Appropriate peri-procedural anticoagulation management
    - ED visit or hospital transfer with 24 hours of discharge
    - Radiation exposure >60 minutes
    - Wrong site, side, patient, procedure, implant
    - Patient satisfaction
- All findings are reviewed by Medical Director and QAPI committee

DISCHARGE POLICY

Policy Name:	**DISCHARGE POLICY**
Section:	PACU
Purpose:	To establish Protocol

Approved Date	Reviewed Date	Revised Date
Click or tap to enter a date.	Click or tap to enter a date.	Click or tap to enter a date.

POLICY

All patients will have a discharge order written by the physician who performed the surgery. (§416.52(c) Standard: Discharge. (2) Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy.) CMS states, "It is permissible for the operating physician to write a discharge order indicating, "The patient may be discharged when stable." (73 FR 68721). In such cases, there must be documentation of when the patient was stable. It is expected that a patient will actually leave the ASC within 15 – 30 minutes of the time when the physician signs the discharge order or when he or she was found to be stable, whichever happens later. All patients will be discharged in the company of a responsible adult. (416.52(c) Standard: Discharge. The ASC must (3) Ensure all patients are discharged in the company of a responsible adult, except those patients exempted by the attending physician.

PROCEDURE

All patients will be discharged only after a physician order from the physician that performed the surgical procedure. An MD/anesthesia provider will assess the patient for anesthesia recovery. An MD/RN/Anesthesia provider will assess the patient for discharge readiness. All assessments will be documented in the patient's chart.

Discharge readiness is assessed per patient. The assessment will include, but not limited to, the following set of ASPAN guidelines. If needs are identified (continuing psychosocial or physical care) during discharge assessment, the patient will be referred to the appropriate organization by the RN/MD.

Discharge Guidelines

Vital signs are stable and consistent with patient age and pre-anesthesia levels.
No evidence of respiratory depression/distress - snoring, croupy cough, stridor.

Patient must be:

Oriented to person, place, time
Able to dress him or herself
Able to walk without assistance or return to preop status
Able to tolerate oral liquids

Patient must not have:

More than minimal nausea or vomiting
Excessive pain
Bleeding

Discharge Instructions - CMS 416.52 (c)(1)

All patients shall receive verbal and written post-operative instructions specific to the surgery performed prior to discharge from the Center. This is to ensure patients receive proper instructions after discharge and understand action to take in case of problems or complications. Instructions include phone numbers, so the patient may contact their physician, or the Center as needed, after leaving the Center.

The patient will be given a date/time for their post-op visit prior to discharge.

The patient/responsible adult with patient will sign the discharge instruction sheet to verify the patient or family has received, reviewed, and understand the discharge instructions.

A copy of the signed discharge instruction sheet is kept in the patient's chart.

Prescriptions associated with their recovery from surgery will be given either before the surgery or before discharge.

Responsible Adult - CMS 416.52 (c)(3)

Patients require a responsible adult to drive after discharge. All patients are discharged in the company of a responsible adult, except those patients exempted with an order from the admitting physician. These exemptions are specific to an individual patient and are documented in discharge orders by the physician.

Supplies Needed

Supplies needed for overnight care are provided by the Center and given to the patient at discharge.

Patient Leaving Center

Patient's escort is instructed to drive his/her car up to the Center's exit where the patient will be discharged. The discharge RN will assess the patient to evaluate if an escort is needed for discharge. If the patient is unable to ambulate, the patient is transported via wheelchair to discharge area.

REFERENCE

(AORN) 2020 Edition, Perioperative Standards and Recommended Practices for Inpatient Ambulatory Services.)

(ASPAN) 2019-2020 Edition American Society of Peri-Anesthesia Nurses; Peri-Anesthesia Nursing Standards, Practice Recommendations and Interpretative Statements.

Portion of Cardiac Catheterization Procedures Approved for Outpatient ASC Setting by CMS

CPT/HCPCS Code*	*HCPCS Short Descriptor*	*Cath Type*
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	Diagnostic
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Diagnostic
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Diagnostic
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	Diagnostic
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	Diagnostic
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	Diagnostic
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	Diagnostic
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	Diagnostic
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	Diagnostic
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	Diagnostic
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	Diagnostic
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	Interventional
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	Interventional
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	Interventional
93653	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac	Interventional

	electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	
93654	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed	Interventional
93655**	Intracardiac catheter ablation of a discrete mechanism of arrhythmia	Interventional
93656	Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed	Interventional
93657**	Additional ablation	Interventional

Source: CMS, Medicare.gov Procedure Price Lookup, https://www.medicare.gov/procedure-price-lookup/.
* Healthcare Common Procedure Coding System.
** At the time of the drafting of this application, CPT codes are not yet available through the Medicare.gov procedure price lookup tool.

SCAI Patient Selection Criteria and Deferral Protocols

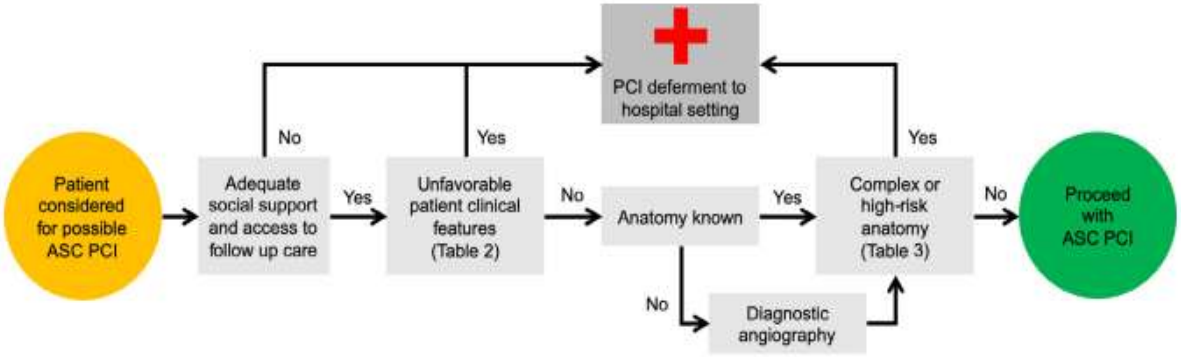


TABLE 2 Unfavorable patient conditions warranting PCI deferment to the hospital setting

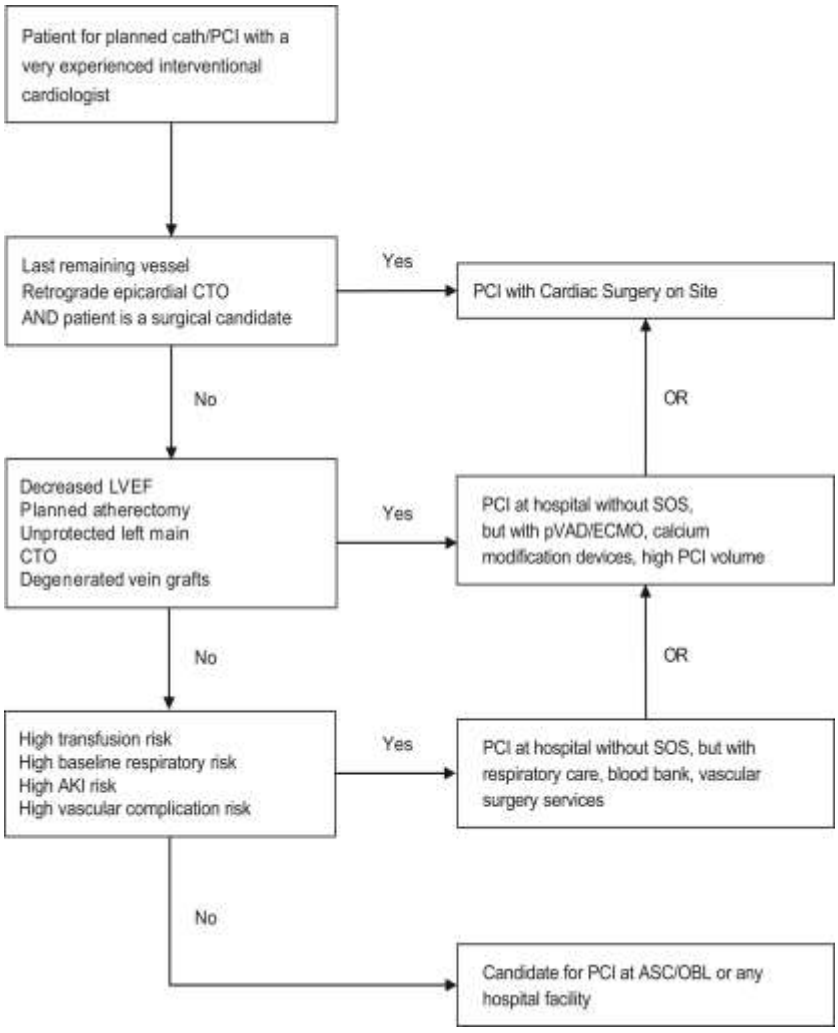
1	Decompensated CHF (NYHA class 3–4)
2	Recent TIA/stroke (<8 weeks)
3	Left ventricular ejection fraction <30%
4	Chronic kidney disease with an estimated glomerular filtration rate < 45 ml/min/1.73 m^2
5	Anemia (Hgb < 9 g/dl) or coagulopathy (eg, INR >1.5 or platelet count <100 K)
6	Acute coronary syndrome
7	Severe pulmonary hypertension or disease (advanced COPD or patients on supplemental oxygen)
8	Unprotected left main stenosis or three-vessel CAD
9	Any cardiac or noncardiac signs of clinical instability
10	Significant PAD limiting femoral and radial access
11	Severe aortic stenosis
12	Severe contrast allergy
13	Operator judgment on other condition(s)

Abbreviations: CAD, coronary artery disease; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; Hgb, hemoglobin; INR, international normalized ratio; PAD, peripheral artery disease; TIA, transient ischemic attack.

TABLE 3 Complex or high-risk lesion characteristics warranting PCI deferment to the hospital setting

1	Bifurcation lesions with significant side branch involvement
2	Severe lesion calcification
3	Extremely angulated segment or excessive proximal tortuosity
4	Bypass graft lesions
5	Chronic total occlusions
6	Other vessel characteristics that the operator judges would impede stent deployment
7	Thrombus in target vessel or lesion
8	Unprotected left main lesions
9	Last remaining conduit
10	Possible need for upfront mechanical circulatory support

Source: https://onlinelibrary.wiley.com/doi/10.1002/ccd.28991.



Source: https://www.jscai.org/article/S2772-9303(22)00600-7/fulltext.

Project Name : TN Heart Cardiovascular Surgery Center, LLC

Supplemental Round Name : 1 **Due Date :** 8/12/2026

Certificate No. : CN2607-017 **Submitted Date :** 8/6/2026

1. **7A. Type of Ownership of Control**

Please explain the key organizational and administrative changes resulting from this partnership. How will the governing body of the ASTC be established and how will clinical oversight change, if at all?

How have the ownership interests changed for the physicians of TN Heart, LLC?

Which facilities are TN Heart cardiologists performing cardiac catheterization procedures at currently? How is that expected to change with the opening of the new facility?

Response : Tennessee Heart, PLLC's ("TN Heart") affiliation with The Stern Cardiovascular Center, P.A. ("Stern") and partnership with Atria Health Services of the South, LLC ("Atria Health") will not result in any fundamental organizational or administrative changes at TN Heart or that affect clinical oversight of the proposed ASTC. TN Heart physicians will operate the proposed project as a Stern-affiliated location and will deliver all clinical care and provide day-to-day oversight of the delivery of all clinical services. Atria Health, in its capacity as a management service organization, provides infrastructure, capital, and administrative services to physician-owned practices, such as the applicant, but does not provide any clinical oversight of medical staff members.

Prior to July 1, 2026, TN Heart physicians were employed by Cookeville Regional Medical Center ("CRMC"). Effective July 1, 2026, TN Heart transitioned to an independent physician practice affiliated with Stern. TN Heart physicians are now employees of Stern but will continue to operate as TN Heart.

TN Heart cardiologists currently perform cardiac catheterization and other cardiovascular procedures at CRMC in Putnam County. Following development of the proposed project, TN Heart cardiologists will retain their privileges at CRMC and will continue to perform cardiovascular procedures, including cardiac catheterizations, at CRMC.

2. **1E. Overview**

What history do the TN Heart, LLC affiliated cardiologists have performing the full range of procedure types identified to be performed at the new ASTC?

Does the applicant anticipate any CMS allowable procedures will not be performed initially at the ASTC facility despite being on the CMS approved list?

Response :

TN Heart cardiologists have experience performing the full range of CMS-approved cardiovascular procedure types that will be performed at the proposed ASTC. TN Heart cardiologists have been performing these procedures for service area patients for over three decades, historically performing these procedures at CRMC, where TN Heart physicians have had, and will continue to have, privileges.

Upon receiving appropriate licensure and accreditation for its ASTC, TN Heart intends to provide CMS-approved, outpatient-appropriate cardiovascular procedures outlined within the application materials. For the list of procedure categories that TN Heart intends to offer at the ASTC, please see Attachment 1N-1.1.

3. **2E. Rationale for Approval**

Please provide any source documentation for the statements regarding patient waitlists (up to eight-months), and increased procedure volumes associated with the selected codes in the service area.

Are the waitlists based on internal records of the practice group, hospital records, etc?

Are there any other cardiology group practices in the region?

Response : The wait times provided in the application are based on TN Heart's procedure scheduling data as of July 2026.

Specific wait times vary across procedure types and are based on current availability at CRMC's two cardiac catheterization labs. For example, TN Heart patients currently wait an average of two to three weeks for elective diagnostic catheterization procedures and an average of eight months for cardiac EP procedures and ablations. Scheduling for cardiac EP procedures and ablations is fully booked for the next eight months; as a result, TN Heart patients' only options are (i) to wait and be placed on the future scheduling or cancellation lists, or (ii) to be referred to cardiologists and facilities outside the Upper Cumberland region, such as acute care facilities in Knoxville and Nashville. None of these options is sustainable or in the best interest of patient care. The procedure volumes provided within the application are based on TN Heart internal data but would also be incorporated within CRMC Joint Annual Report ("JAR") utilization data given that TN Heart physicians have historically performed these procedures at CRMC and hold privileges there.

CRMC has its own employed cardiology group, Cookeville Regional Medical Group Cardiology ("CRMG Cardiology"). Although TN Heart is aware of a few other cardiologists who are not affiliated with either TN Heart or CRMG Cardiology, such as Parkway Cardiology Associates, that have practice locations within the primary four-county service area, it is TN Heart's understanding that many of these cardiologists do not have privileges at CRMC or Cumberland Medical Center ("CMC") and generally refer patients to affiliated facilities in other markets, such as Knoxville or Nashville, for many of the cardiovascular procedures the proposed project seeks to offer. For example, Attachment 5N shows that, in 2024, only 16 weighted EP cases were performed at CMC.

4. **2N. Service Area**

Where are the nearest cardiac catheterization labs located outside of the proposed service area? Are there any located in Kentucky that are within a 60-minute drive from the proposed location?

Is the historical case volume for these types of outpatient appropriate cardiac catheterization procedures and wait times high compared to the applicants experiences in other regions, i.e. West TN or PA?

Are there any cardiac catheterization labs located equidistant or closer to some of the other counties represented in the Projected Utilization Chart on Page 14, specifically those representing 10 or more procedures?

Response : The nearest cardiac catheterization lab located outside the primary four-county proposed service area (Cumberland, Overton, Putnam, and White counties) is located at Covenant Health Roane in Roane County. Covenant Health Roane is located more than a 60-minute drive from the center of Cookeville. With respect to Kentucky, there are no cardiac catheterization labs located within a 60-minute drive from the proposed location.

In its recently approved application to develop Stern Cardiovascular Surgery Center, LLC in Shelby County (CN2605-013A), Stern provided historical total utilization data for the thirty existing cardiac catheterization labs operating in the service area. As outlined in that application, JAR data from 2022 to 2024 show that these labs operated at 92.3 percent of full capacity and 131.8 percent of optimal capacity. By comparison, JAR data for the three existing cardiac catheterization labs in Cumberland and Putnam counties show that these labs operated at much higher percentages of the full capacity and optimal capacity thresholds: 176 percent of full capacity and 251 percent of optimal capacity during the same years. Given these significant capacity constraints, patients in the Upper Cumberland region are more likely to experience longer wait times in obtaining necessary cardiovascular care or to be referred to facilities outside the primary service area. By contrast, at AMS Cardiovascular ASC, an Atria-partnered ambulatory surgery center in Pennsylvania, diagnostic catheterization procedures and EP device implantations have average wait times of one business day.

Of the 13 counties listed in the Projected Utilization Chart included in Question 2N of the application from which TN Heart has projected to perform more than 10 weighted cardiovascular procedures, only three have local access to existing hospital-based cardiac catheterization laboratories: Bledsoe, Smith, and Warren counties. None of these 13 counties have access to a catheterization lab in a freestanding, outpatient surgery center, like the proposed project. Further, TN Heart would note that the counties included in the Projected Utilization Chart are consistent with counties of origin of TN Heart's historical patient population in 2025, as outlined in greater detail in Attachment 6N. TN Heart projects to perform only 49 total weighted cardiovascular procedures for patients originating from Bledsoe, Smith, and Warren counties, accounting for approximately 3.6 percent of the total year one projected weighted cardiovascular procedure volume at TN Heart Cardiovascular Surgery Center.

5. **4N. Special Needs of Service Area**

Do the service area counties have a high rate of cardiovascular disease and death that the applicant can demonstrate through public data sources?

Response : Various public data sources and metrics demonstrate the burden of cardiovascular disease in the primary proposed service area (Cumberland, Overton, Putnam, and White counties). According to Heart Attack Hospitalizations Dashboard data, available through the TN Department of Health, heart attack hospitalizations in the four-county service area occurred at an average age-adjusted rate of 40 per 10,000 population.[1] With respect to mortality, regional data on heart disease deaths show that the Upper Cumberland region's age-adjusted mortality rate of 221.3 deaths per 100,000 population in 2022 exceeds the statewide rate of 218.3

deaths per 100,000 population during the same period.[2] Additionally, the most recent Community Health Needs Assessments and TN Department of Health County Data Packages available for the four primary service area counties report heart disease as the leading causes of death in Cumberland, Putnam and White counties, and the second leading cause of death in Overton County.

[1] Heart Attack Hospitalizations Dashboard accessed at https://healthdata.tn.gov/stories/s/9tax-t68g.

[2] Tennessee Death Statistical File, 2022, Tennessee Department of Health, Division of Vital Records and Statistics.

6. **5N. Unimplemented services**

Please confirm what percentage of historical cardiac catheterization procedure volume at the two existing hospitals with cardiac catheterization labs in the service area has been performed by TN Heart, LLC cardiologists.

Please discuss the applicant's perception of whether the high utilization of the CRMC labs is related more to a capacity issue at the hospital from a physical plant standpoint or a limited number of cardiologists in the region, or both?

Does the applicant have any data reflecting patient migration out of the proposed service area counties? To what extent does the applicant believe the new facility will support greater local retention of these patients?

Response : As noted above, there are two existing providers of cardiac catheterization services in the primary proposed service area: CMC and CRMC, with CRMC accounting for more than 95 percent of cardiac catheterization volume historically (Attachment 5N). TN Heart cardiologists do not hold privileges at CMC and, therefore, do not account for any historic cardiac catheterization volume there. Prior to July 1, 2026, when TN Heart cardiologists transitioned to an independent practice model, TN Heart cardiologists were employed by CRMC. Therefore, TN Heart's cardiologists account for the majority of CRMC's historical cardiac catheterization procedure volume. As of July 1, 2026, CRMC's employed cardiology group, CRMG Cardiology, will also perform cardiac catheterizations and other cardiovascular procedures at CRMC. Going forward, CRMG Cardiology will account for a significant portion of the cardiac catheterization procedures performed at CRMC. As previously stated in the response to Question #1 above, TN Heart cardiologists will retain privileges at CRMC and continue to perform hospital-appropriate catheterizations at this facility following the development of the proposed project. Together, TN Heart and CRMG Cardiology will continue to ensure patients have access to comprehensive cardiovascular care.[3]

2022 to 2024 JAR data showing that CRMC's two cardiac catheterization labs operated well-above full and optimal capacity despite a slight decline in overall cardiac catheterization utilization during this period (Attachment 5N), support that physical constraints at the hospital rather than a limited number of cardiologists are restricting patients' access to care and contributing to longer wait times for care. This is consistent with TN Heart cardiologists' historical cardiovascular procedure volumes at CRMC, including its 12 percent increase in outpatient-appropriate procedures from 2024 to 2025 alone (Attachment 6N). Service area demographic factors, such as a rapidly aging patient population, which increases heart disease prevalence and utilization of cardiovascular care, also support that the limited number of existing cardiac catheterization labs in the proposed service area will continue to be the primary driver of capacity constraints. Further, in recent years,

TN Heart has been successful at recruiting qualified cardiologists to its practice. Approving the proposed project will alleviate these physical plant issues as TN Heart cardiologists are well-equipped to meet patients' cardiovascular needs and expand access to care.

No, TN Heart does not currently have a method for tracking outmigration of ASTC-appropriate patients or have access to data that measures historical outmigration of ASTC-appropriate patients. Hospital JAR data provide patient county of origin for admissions and discharges but not for cardiac catheterization procedures. Anecdotally, TN Heart is aware of service area patients who have traveled outside Cumberland and Putnam counties to undergo procedures that it will offer in the proposed ASTC. This is particularly true for patients in Overton and White counties who have no option but to leave their counties for necessary cardiovascular services. In addition, the historical utilization of CMC's single catheterization lab suggests that patients are likely leaving the proposed service area for cardiovascular procedures.

Service area utilization data, in addition to the fact that none of the proposed service area counties – both primary and secondary – have non-hospital-based cardiac catheterization labs, make clear that the proposed project will support greater local retention of patients. Since total utilization of existing cardiac catheterization labs in Cumberland and Putnam counties exceeds both full capacity and optimal capacity thresholds and many patients face extended wait times for receiving care, another provider will increase access to timely care that is closer to patients' homes. Moreover, as described in the application, a more accessible and more cost-effective freestanding option for care offers patients numerous benefits and an attractive alternative to hospital-based cardiovascular services.

[3] CRMG Cardiology Continues Serving Patients Across the Region, Accessed at https://crmchealth.org/crmg-cardiology-continues-serving-patients-across-the-region/.

7. **2C. Insurance Plans**

Please explain the limited contracting with BCBS and Cigna plans? Does the applicant intend to expand access to additional commercial plans once established?

Response : The commercial payors selected in response to Question 2C reflect the payor coverage of TN Heart's historical patient population. As noted in response to Question 2C, the proposed project, once operational, will evaluate contracting with additional commercial payors on an ongoing basis, depending on the payors providing coverage for its patients; this may include pursuing contracts with additional BCBS and Cigna plans beyond those indicated in response to Question 2C, including BCBS Network P and Network S; TN Heart has revised the response to Question 2C accordingly. In addition, the project will seek Single Procedure Agreements with out-of-network payors to provide access to patients with an out-of-network insurance carrier in the event that an in-network agreement cannot be secured for a less common payor in a timely fashion.

8. **3C. Effects of Competition and/or Duplication**

Please provide any available data on the total volume of appropriate cases in the service area that are on wait lists or are out-migrating to other labs? Does the applicant have access to data on cases outside of its internal records?

Response : As detailed in the previous response to Question #3, specific wait times and the volume of ASTC-appropriate procedures on waitlists vary depending on the procedure type and the availability of CRMC's two cardiac catheterization labs. For example, based on TN Heart procedure scheduling data as of July 2026, TN Heart patients currently wait an average of two to three weeks for elective diagnostic catheterization procedures and

an average of eight months for cardiac EP procedures and ablations. As shown in Attachment 6N, diagnostic cardiac catheterizations represented 36 percent of TN Heart's procedure volume in 2025 and cardiac EP procedures and ablations, including cardiac rhythm device implantations, represented 49 percent of TN Heart's 2025 procedures. Thus, a significant portion of TN Heart's patients are likely to experience critical delays in procedure scheduling.

9. **4C. Accessibility to Human Resources**

Please discuss the integration of Stern Cardiology's clinical policies and procedures with those of TN Heart, LLC through the partnership.

What is the scope of Atria Health's footprint nationally with respect to outpatient cardiac catheterization lab operations and cardiology practices?

Response : The clinical policies and procedures applicable to the proposed project (Attachment 1N-1.2) were drafted in close collaboration with TN Heart and Stern cardiologists and Atria Health. The policies and procedures largely overlap with those applicable to Stern's parallel Shelby County ASTC, Stern Cardiovascular Surgery Center, LLC, but also account for TN Heart's longstanding experience in the proposed service area. As stated in the response to Question #1, TN Heart physicians will operate the proposed project as a Stern-affiliated location and will be responsible for day-to-day oversight of clinical care at the proposed ASTC.

Atria Health is a management service organization that provides operational infrastructure, capital, and administrative services to physician-owned practices, like Stern. Atria Health was founded by experienced healthcare providers and operators with a mission to partner with cardiovascular physician practices to innovate care delivery, while allowing physicians to focus on personalized patient care. Atria Health does not own or directly operate any physician practices or clinical facilities. Rather, it partners with cardiovascular practices, like Stern, ensuring that practices remain physician-owned and physician-led.

In addition to managing Stern's recently approved Shelby County ASTC, Atria Health also currently partners with AMS Cardiology, a Pennsylvania-based cardiology group which was formed in August 2022. In October 2024, AMS Cardiology, supported by Atria Health, opened an ambulatory surgery center in Pennsylvania, AMS Cardiovascular ASC.

10. **5C. License/Certification**

Please explain whether any specific TJC certifications will relate to the operations of an ASTC based cardiac catheterization laboratory.

Response : TN Heart Cardiovascular Surgery Center, LLC anticipates pursuing Ambulatory Health Care accreditation from TJC, which best aligns with the services that will be offered by the proposed project.

11. **10C. Project Only Payor Mix**

Are the projected charity care amounts consistent with the applicant's historical practices? If they are higher, please discuss the situations where this level of charity care is expected to apply to patients of the ASTC.

What payor sources are included under "Other"?

Response : The projected approximately four percent charity care for the proposed project is consistent with the historical proportion of charity care that TN Heart has provided within the service area. TN Heart remains committed to serving medically appropriate patients regardless of their payor source or ability to pay.

The payor sources included in the “Other” category comprise VA/Tricare and collectively represent two percent of total projected payor mix.

12. **9C. Other Facilities Charges**

Please list the price comparison from CMS between the HOPD and ASTC setting for the CPT Codes that will be applicable to the proposed facility.

What are the applicant's projected charges for the procedure codes vs the hospitals in the service area based on chargemasters for CRMC and CMC?

Response : TN Heart analyzed 2025 data for procedures performed by its cardiologists and found that over 90 percent of historical procedure volume was associated with approximately 25 CPT codes. Since the majority of these CPT codes are already included in the Medicare Price Lookup table included in Attachment 1N and Attachment 1N-1.3, for purposes of this question, TN Heart has supplemented the data already provided with price comparisons for the CPT codes below, which represent several procedures that will be commonly performed at the proposed ASTC. Due to CMS updates to pricing data available through the Medicare.gov Price Lookup tool, there are also several codes for which estimated pricing information is not yet available, such as CPT codes 93655 and 93657. In conjunction with the price comparisons already provided in the application, the data below confirm that procedures performed at TN Heart Cardiovascular Surgery Center, LLC will cost less than those performed in a hospital setting.

Estimated Average Payments for Medicare

Cardiovascular Procedures

CPT Code	Procedure Type	Patient Payment		Facility Fee		Savings Calculation		
		ASTC	Hospital	ASTC	Hospital	Patient Savings	Total Savings	% Patient Savings
92960	Cardioversion	$90	$153	$363	$675	$63	$312	41.18%
33208	Pacemaker Insertion	$1,638	$1,827	$7,739	$10,678	$189	$2,939	10.34%
33249	Implant Defibrillator	$5,114	$1,895	$24,775	$32,068	-$3,219	$7,293	N/A*
92920	Angioplasty	$846	$1,239	$3,849	$5,814	$393	$1,965	31.72%
33228	Pacemaker Removal	$1,573	$1,799	$7,554	$10,678	$226	$3,124	12.56%
33285	Cardiac Device Implantation	$1,450	$1,705	$7,175	$8,454	$255	$1,279	14.96%
36556	Cath Insertion	$339	$660	$1,623	$3,225	$321	$1,602	48.64%
33210	Pacemaker Insertion	$924	$1,718	$4,483	$8,454	$794	$3,971	46.22%

*Note: Medicare.gov’s Procedure Price Lookup tool for this code reflects pricing for a limited subset of Medicare patients that CMS is in the process of updating. For Medicare patients without supplemental insurance coverage, Medicare caps copayments for the technical component at $1,676 in hospital outpatient departments, which may apply to this procedure. Nonetheless, the savings will still be realized by approximately 94 percent of patients, according to the Medicare Payment Advisory Commission (“MedPAC”).

To respond fully to the HFC's request, TN Heart attempted to obtain comparable chargemaster-based pricing information for the identified procedure codes from CRMC[4] and CMC[5] using their interactive price transparency tools. For example, TN Heart searched for pricing information for CPT code 93452 (left heart cardiac catheterization). However, both hospitals' publicly available price transparency tools required user-selected variables – including procedure setting and specific insurance plan or payor information – before generating any charge estimate, and, independent of payor selection, neither tool produced a chargemaster-level gross charge for the relevant CPT/procedure codes. The attempt to pull pricing information for CPT code 93452 for CRMC and CMC produced the estimated ranges of $2,723-$3,328 for CRMC and $2,780-$3,397 for CMC. As a result, TN Heart was unable to extract a single, definitive chargemaster figure from either hospital that would allow for an overall comparison against TN Heart's projected charges. Since many payors often base their rates in part on Medicare rates, the comparison of the relative Medicare rates provided in the Standards and Criteria section of the application (Attachment 1N) and the supplemental pricing information provided above is a good indicator of the relative HOPD vs. ASTC charges for the relevant procedures.

TN Heart also respectfully submits that a comparison of chargemaster schedules across facilities is not a meaningful basis for evaluating pricing reasonableness. The hospital chargemaster rates are gross, undiscounted list prices that few, if any, payors actually pay. Actual reimbursement is governed by payor-specific contracts that each facility negotiates independently based on network leverage, service volume, and market conditions, none of which are reflected in a published chargemaster. Two facilities with identical costs and actual collections can post very different chargemaster rates simply due to differing internal pricing methodologies, while facilities with different cost structures can post similar chargemaster rates for unrelated reasons. Because gross charges bear no consistent relationship to negotiated or collected rates, this comparison is not a reliable indicator of pricing competitiveness or financial performance. TN Heart, therefore, asserts that projected net revenue, payor mix, and reimbursement assumptions in the financial feasibility exhibits of the application, including the Medicare pricing data noted above, offer a more appropriate and reliable basis for evaluating pricing reasonableness.

[4] See https://crmchealth.org/pricing/.

[5] See https://www.covenanthealth.com/patients-visitors/price-estimation/.

13. **1N. Criteria and Standards**

Attachment 1N, Cardiac Catheterization, Criteria #8 Definition of Need for New Services

Do the cardiologists of TN Heart, LLC perform procedures at Cumberland Medical Center's lab which appears to have significantly lower utilization than the Cookeville Regional Medical Center lab?

Are there limitations at the CMC lab that result in TN Heart cardiologists scheduling procedures at CRMC instead?

Response : No, TN Heart cardiologists do not hold privileges or perform procedures at CMC. Similarly, TN Heart cardiologists are not aware of any limitations of CMC's cardiac catheterization lab that may affect utilization. JAR data would suggest that Covenant Health's own cardiologists are performing the majority of

their cardiac catheterization procedures at other facilities outside the service area. As detailed in the response to Question #8 in the Standards and Criteria for Cardiac Catheterization Services (Attachment 1N), CMC did not perform adult outpatient EP procedures in 2022, 2023, or 2024 – procedures that will be performed at the proposed ASTC. Because CMC does not offer the full scope of cardiovascular services that will be offered by the proposed project, it is not a comparable facility for purposes of service area utilization comparisons.

14. **1N. Criteria and Standards**

Attachment 1N, Cardiac Catheterization, Criteria #14 Minimum Volume Standard

As an open staffed facility, how many other cardiologists or cardiology practices are expected to utilize the ASTC cardiac catheterization lab?

Response : While the proposed ASTC will be open to any qualified cardiology or vascular surgeons or cardiology practices that meet the facility's privilege requirements and credentialing standards, TN Heart Cardiovascular Surgery Center anticipates that, initially, only TN Heart cardiologists will perform cardiovascular procedures in the proposed ASTC. Of note, TN Heart will grant privileges to qualified anesthesiologists who are not TN Heart employees. However, at this time, the number of non-TN Heart cardiologists or practices that will utilize the ASTC cannot be projected.

Following the project's initial period of operation, TN Heart and its partners anticipate being open to discussions with other community cardiologists or practices who may have an interest in utilizing the ASTC. Because the proposed ASTC will only offer a defined subset of lower acuity cardiovascular procedures, to the extent privileges are extended to non-TN Heart physicians or practices, it will be necessary for those physicians to retain any existing hospital privileges.

15. **1N. Criteria and Standards**

Attachment 1N, Cardiac Catheterization, Criteria #16 Minimum Physician Requirements to Initiate a New Service

Please table the projected volume by cardiologist.

How many of the affiliated cardiologists will perform interventional procedures at the proposed ASTC?

Response : The following table provides TN Heart Cardiovascular Surgery Center, LLC's projected volumes for PY1 and PY2 by physician, based on TN Heart's historical volumes of ASTC-appropriate procedures performed in 2024 and 2025. Except as noted below, the projected volumes for TN Heart proceduralists Dr. Stacy Brewington, Dr. Carlos Podesta, Dr. Mark Wathen, Dr. Robert Case, and Dr. Brent Klinkhammer reflect historical percentages for 2024 to 2025 ASTC-appropriate cardiovascular procedures. The projected volumes for TN Heart non-proceduralists Dr. Vertilio Cornielle, Dr. Noel Torres, and Dr. Mariano Battaglia reflect an even distribution of remaining procedures, excluding cardiac and vascular catheterization, EP device implantations, and ablations.

Projected TN Heart Cardiovascular Surgery Center, LLC

Weighted Procedures by Physician*

TN Heart Physician	*PY1*	*PY2*
Brewington MD, Stacy D.	445	896
Podesta MD, Carlos A.	367	739
Wathen MD, Mark S.	272	547
Case MD, Robert Alex	112	226
Klinkhammer MD, Brent J.	62	125
Battaglia MD, Mariano F.	30	61
Cornielle-Caamano MD, Vertilio M.	30	61
Torres Acosta MD, Noel David	30	61
TOTAL	**1,349**	**2,716**

*Volume for each TN Heart physician is based on 2024-2025 historical procedure volume. The figures are adjusted to account for TN Heart medical staff roster updates and the types of procedures each physician is expected to perform at the proposed ASTC.

Note: Dr. Brent Klinkhammer joined the practice in August 2025. Therefore, the projected volumes provided above are intentionally conservative and assume no growth in volume.

TN Heart currently anticipates that seven of its cardiologists will perform interventional procedures at the proposed facility: Dr. Mariano Battaglia, Dr. Stacy D. Brewington, Dr. Alex Case, Dr. Vertilio Cornielle, Dr. Brent Klinkhammer, Dr. Carlos Podesta, and Dr. Mark Wathen.

16. **3N. Demographics**

The TennCare Enrollment data for Attachment 3NB appears to be incorrect for May 2026. Please revise the column and the % of TennCare Enrollees in the following column.

Response : Please see Attachment 3NR.

17. **6N. Utilization and/or Occupancy Statistics**

It is noted that "TN Heart cardiologists have privileges and perform all cardiovascular procedures at Cookeville Regional Medical Center (“CRMC”), the only hospital with cardiac catheterization labs in Putnam County." Please explain whether this refers to all procedures performed at CRMC overall being done by TN Heart affiliated cardiologists, or whether all of the cardiac catheterization procedures performed by the practice are done at CRMC?

Response :

As discussed in Responses #6 and #13 above, this refers to the fact that all of the cardiac catheterization procedures performed by TN Heart are performed at CRMC; currently, TN Heart-affiliated cardiologists are not the only cardiologists performing procedures at CRMC.