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

RELOCATION EXEMPTION STAFF REVIEW

PROJECT NUMBER:	RE2505-003
NAME OF PROJECT:	New West Tennessee Healthcare Bolivar Hospital 550 Vildo Road Bolivar (Hardeman County), TN 38008
LEGAL OWNER:	Bolivar General Hospital, Inc. 650 Nuckolls Road Bolivar (Hardeman County), TN 38008
SUBMITTER:	Victoria Lake, Director, Community Health Institute West Tennessee Healthcare Vicki.lake@wth.org
DATE FILED:	May 19, 2025

This staff review is an analysis of the statutory criteria, including data verification and accuracy of the original application and, if applicable, supplemental responses submitted by the applicant.

DESCRIPTION

This application is for the relocation of a hospital from 650 Nuckolls Road, Bolivar (Hardeman County), Tennessee 38008 to 550 Vildo Road, Bolivar (Hardeman County), Tennessee 38008 a distance of 3.8 miles. The applicant describes the need for the relocation as being driven by the age and size of the existing hospital being unsuited to the needs of its patients due infrastructure limitations which cause operational inefficiencies that have proven to be cost prohibitive to resolve. The existing hospital is 51 years old and 33% larger (42,483 square feet) in terms of square footage than the proposed new hospital.

NEW LOCATION SITE CONTROL

The proposed facility will be located at 550 Vildo Road, Bolivar (Hardeman County), Tennessee 38008. The applicant has provided the quitclaim deed for the 8.27 acre property identified as Map 061 Parcel 010.00, Sp Int. 001.

The single story facility will be 28,179 square feet. The newly constructed hospital will include (6) inpatient rooms, (2) negative pressure ventilated rooms, (12)

emergency department rooms to include (1) Sexual Assault Nurse Examiner (SANE) room, (1) one room for individuals of size, (1) behavioral health room, and (1) observation room, a decontamination area, pharmacy, laboratory, cardiac and physical rehabilitation space, food service, administrative, lobby space, and a helipad. The new hospital will have diagnostic imaging services including x-ray, ultrasound, mammography, and computed tomography (CT).

DISTANCE FROM ORIGINAL LOCATION TO NEW LOCATION

The new location is approximately 3.8 miles northwest from the existing location.

SERVICE AREA

The applicant provides Zip Code level utilization data for the period of July 2023 – June 2024 and its projected utilization in its second full year of operation at the new location (July 2028 – June 2029). This historical utilization data was not confirmed through any data reports provided by the Tennessee Department of Health, Office of Informatics and Analytics, therefore it is not possible to verify the utilization data provided by the applicant through a public source. None of the ZIP Codes included in the applicant's utilization tables have populations above the 20,000 threshold required by the Tennessee Department of Health's Data Release Policy for providing unsuppressed utilization data. Based upon the applicant's internal data, it will continue serving over 95% of its patient base from the same combination of the top (13) Zip Codes which it is currently serving (see Application Item 2E.). The proposed Zip Code for the project site (38008) is the same ZIP Code as the existing site. The majority of patients are still projected to be residents of 38008 (Bolivar – Hardeman County) where the facility will be located. Minor shifts are projected to occur in the total utilization on a percentage basis for the following ZIP Codes from 2023 to 2028:

- 38068 – Somerville (Fayette County): 1 (1.7%) to 6 (8.3%) of patients
- 38044 – Hornsby (Hardeman County): 5 (8.3%) to 5 (6.9%) of patients
- 38052 – Middleton (Hardeman County): 5 (8.3%) to 5 (6.9%) of patients
- 38075 – Whiteville (Hardeman County): 3 (5.0%) to 5 (6.9%) of patients

PAYOR MIX

The applicant's projected payor mix for the second full year of the project, July 2028 – June 2029 includes similar percentages of Medicare/Medicare Advantage (35.1% vs. 35.8%), TennCare/Medicaid (22.3% vs. 22.2%); Commercial/Other Managed Care (31.6% vs. 32.1%); and Self-Pay (11.0% vs. 9.9%) as the latest full year, July 2023 – June 2024. This payor mix was not confirmed through an HFC staff request to the Tennessee Department of Health, Office of Informatics and Analytics as data for the thirteen ZIP Codes in the applicant's service area are below the 20,000 minimum population threshold referenced above. The applicant has provided an unpublished copy of the 2024 JAR for the hospital which HFC

staff has confirmed matches the applicant's historical payor mix as submitted. The applicant has not listed any projected Charity Care for its existing hospital or the new hospital. Based upon the applicant's 2024 Joint Annual Report Schedule E.5., there was no Inpatient – Charity Care reported by the applicant. Therefore the applicant's (0%) rate for the new facility is consistent with its historically reported payor mix for inpatient services. The applicant did report $198,900 in outpatient Charity Care in the 2024 JAR.

CONSUMER ACCESS

The applicant states that the new facility will not reduce or impact consumer access as it will expand upon the existing services available at the current hospital. The new facility will still be located in the same ZIP Code as the existing facility, but will be located outside of the Bolivar town center. The new facility will add a Sexual Assault Nurse Examiner (SANE) room, behavioral health room in the emergency department, and rooms for individuals of size. The applicant states that it will have the ability to centralize cardiac monitoring and telehealth with its network of cardiac, pulmonary and neurology specialists. The new hospital will continue to be certified as a Basic Pediatric Emergency Facility and will also pursue chest pain certification. The facility will continue to provide perinatal services on an emergency basis only.

ADDITIONAL COMMENTS

There is an outstanding Certificate of Need - Baptist Memorial Hospital Fayette County (CN2501-002A) for a new hospital facility to be constructed in Fayette County which is adjacent to Hardeman County where the applicant's proposed relocation will occur. The proposed Fayette County Hospital will be located less than 35 miles from the applicant's proposed relocation site. In response to a supplemental question related to the applicant's intention to maintain its status as a Critical Access Hospital the applicant states the following: *"Our plan is to relocate West Tennessee Bolivar Hospital as a critical access hospital. This hospital is important to our mission to improve the health and well-being of the communities we serve. In the event that our status as a critical access hospital is affected by Baptist Memorial Hospital in Fayette County, we are prepared to pivot and believe that the design of this hospital is versatile and allows for an easy shift to other provider types."*

Submitted by

Tom Pitt, HFC Health Planner
Date: 5/27/2025

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

A CERTIFICATE OF NEED RELOCATION EXEMPTION

The Publication of Intent is to be published in Bolivar Bulletin Time which is a newspaper of general circulation in Hardeman County, Tennessee, on or before 05/08/2025 for one day.

This is to provide official notice to the Health Facilities Commission and all interested parties, in accordance with T.C.A. §68-11-1601 et seq., and the Rules of the Health Facilities Commission, that New West Tennessee Healthcare Bolivar Hospital, a/an Hospital owned by Bolivar General Hospital, Inc. with an ownership type of Corporation (Not-for-Profit) and to be managed by itself intends to file a request for a Relocation Exemption for West Tennessee Healthcare Bolivar Hospital, an existing Critical Access Hospital owned by Bolivar General Hospital, Inc. with an ownership type of non-profit corporation and managed by N/A intends to request a Relocation Exemption for the construction and operation of a new critical access hospital. The current hospital location is 650 Nuckolls Road, Bolivar, Tennessee, 38008. The new location of the Hospital will be 550 Vildo Road, Bolivar, Tennessee 38008, and is adjacent to State Highway 64. The new hospital will have six inpatient rooms (two being negative pressure), twelve emergency department patient rooms (two being negative pressure), diagnostic imaging (mammography, ultrasound, XRay, computed tomography (CT)), pharmacy, food service, lobby, cardiac, physical rehabilitation and administrative space. Emergency room will operate 24/7/365. The total square footage of the new hospital is 27,064 square feet. There will be no reduction in services at the new location..

The anticipated date of filing the request is 05/27/2025

The contact person for this request is Director, Community Health Institute Victoria Lake who may be reached at West Tennessee Healthcare - 620 Skyline Drive, Jackson, Tennessee, 38301 – Contact No. 731-984-2160.

Victoria Lake	05/08/2025	vicki.lake@wth.org
Signature of Contact	**Date**	**Contact's Email Address**

File this form at the following email address: hsda.staff@tn.gov.

The published Letter of Intent must contain the following statement: Any health care institution wishing to oppose a Certificate of Need Relocation Exemption application must file a written notice with the Health Facilities Commission no later than fifteen (15) days after the application, supporting documentation, and staff review have been posted on the HFC's website; any opposition must be limited to the basis for review detailed in HFC Rule 0720-10-.06. Written notice of opposition may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 503 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov.

State of Tennessee
Health Facilities Commission

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

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

PUBLICATION OF INTENT

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

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED RELOCATION EXEMPTION

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 New West Tennessee Healthcare Bolivar Hospital, a/an Hospital owned by Bolivar General Hospital, Inc. with an ownership type of Corporation (Not-for-Profit) and to be managed by itself intends to file a request for a Relocation Exemption for West Tennessee Healthcare Bolivar Hospital, an existing Critical Access Hospital owned by Bolivar General Hospital, Inc. with an ownership type of non-profit corporation and managed by N/A intends to request a Relocation Exemption for the construction and operation of a new critical access hospital. The current hospital location is 650 Nuckolls Road, Bolivar, Tennessee, 38008. The new location of the Hospital will be 550 Vildo Road, Bolivar, Tennessee 38008, and is adjacent to State Highway 64. The new hospital will have six inpatient rooms (two being negative pressure), twelve emergency department patient rooms (two being negative pressure), diagnostic imaging (mammography, ultrasound, XRay, computed tomography (CT)), pharmacy, food service, lobby, cardiac, physical rehabilitation and administrative space. Emergency room will operate 24/7/365. The total square footage of the new hospital is 27,064 square feet. There will be no reduction in services at the new location..

The anticipated date of filing the request is 05/27/2025.

The contact person for this request is Director, Community Health Institute Victoria Lake who may be reached at West Tennessee Healthcare - 620 Skyline Drive, Jackson, Tennessee, 38301 – Contact No. 731-984-2160.

The published Letter of Intent must contain the following statement: Any health care institution wishing to oppose a Certificate of Need Relocation Exemption application must file a written notice with the Health Facilities Commission no later than fifteen (15) days after the application, supporting documentation, and staff review have been posted on the HFC's website; any opposition must be limited to the basis for review detailed in HFC Rule 0720-10-.06. 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.

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
RELOCATION EXEMPTION REQUEST

1A. Name of Facility, Agency, or Institution

New West Tennessee Healthcare Bolivar Hospital
Name

550 Vildo Road | Hardeman County
Street or Route | **County**

Bolivar | Tennessee | 38008
City | **State** | **ZIP**

https://www.wth.org/locations/bolivar-hospital/
Website Address

00000062
License Number (If Applicable)

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. Submitter

Victoria Lake | Director, Communit Health Institute
Name | **Title**

West Tennessee Healthcare | vicki.lake@wth.org
Company Name | **Email Address**

620 Skyline Drive
Street or Route

Jackson | Tennessee | 38301
City | **State** | **ZIP**

employee | 731-984-2160
Association with Owner | **Phone Number**

3A. Name of Owner of the Facility, Agency, or Institution

Bolivar General Hospital, Inc.
Name

650 Nuckolls Road | 731-659-0218
Street or Route | **Phone Number**

Bolivar | Tennessee | 38008
City | **State** | **ZIP**

4A. 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)

5A. Legal Interest in the Site

Check the appropriate box and submit the following documentation.

The legal interest described below must be valid on the date of the Executive Director considers the exemption request.

- ☑ 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)

EXECUTIVE SUMMARY

1E. Overview

Please provide an overview not to exceed **ONE PAGE** in total explaining each item point below.

- **Service Area** – Address if at least ninety-five percent (95%) of patients to be served are reasonably expected to reside in the same zip codes as the existing patient population.
  RESPONSE: The service area for the proposed new West Tennessee Healthcare Bolivar is primarily Hardeman County, Tennessee with additional patient discharges from Fayette, Madison, and McNairy counties in Tennessee. The zip code analysis shows that the current and projected inpatient discharges percentages are not expected to change and the service area will remain very similar. All, 100 percent) inpatient discharges in FY2024 came from Hardeman, Fayette, Madison and McNairy counties.
- **Medicaid/TennCare Participation** – Address any changes as a result of the relocation.
  RESPONSE: For FY2024, Medicaid/TennCare represents 22.6 percent of gross revenue for West Tennessee Healthcare Bolivar Hospital. Medicaid/TennCare is expected to be 22.2 percent of gross revenue for the Hospital during the second full year of operation.

- **Access to Consumers** – Address if the relocation will reduce or impact access to consumers, particularly those in underserved communities; those who are uninsured or underinsured; women and racial and ethnic minorities; TennCare or Medicaid recipients; and low income groups.

  RESPONSE: The new West Tennessee Healthcare Bolivar Hospital will be located on Vildo Road, off State Highway 64. It remains in the City of Bolivar, accessible to patients in Hardeman, McNairy and Fayette counties. The hospital will be accessible to consumers through inpatient services consisting of medical/surgical needs, swing beds, 24-hour emergency care, hospitalist, and respiratory care. Outpatient services include Cardiac Holter monitor, EKGs, cardiac rehab, an outpatient physical therapy. Diagnostic services are laboratory and pathology services; radiology (X-ray), mammography (screening and diagnostic), ultrasound, and CT scan. Other services include pharmacy and health information.

2E. Patients by Zip Code

Complete the following tables, if applicable.

Current Location (Latest Full Year) Year 2023 **Beginning Month** July

Service Area ZIP Codes	Historical Utilization - ZIP Code Patients	% of Total Current Patients
38375	3	5.00
38052	5	8.33
38067	2	3.33
38068	1	1.67
38042	3	5.00
38075	3	5.00
38039	1	1.67
38301	1	1.67
38008	32	53.33
38044	5	8.33
38381	2	3.33
38057	1	1.67
38315	1	1.67

Total	60	95% or More

Proposed Location (2nd Full Year of Operation) Year 2028 **Beginning Month** July

Service Area ZIP Codes	Projected Utilization - ZIP Code Patients	% of Total Projected Patients
38057	1	1.39
38301	1	1.39
38039	1	1.39
38075	5	6.94
38067	2	2.78
38052	5	6.94
38042	3	4.17
38315	1	1.39
38008	37	51.39
38044	5	6.94
38375	3	4.17
38381	2	2.78
38068	6	8.33

Total	72	95% or More

3E. Payor Mix

List the provider's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients that are currently being served at the current location. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the second full year of new proposed location by completing the table below.

Payor Mix, Current Location (Latest Full Year) Year **2023** **Beginning Month** **July**

Payor Source	Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	$14,098,698	35.13%
TennCare/Medicaid	$8,950,297	22.30%
Commercial/Other Managed Care	$12,672,987	31.58%
Self-Pay	$4,409,385	10.99%
Other (Specify) _____		31.58%
Total	$40,131,366	100.00%
Charity Care	$0	

Payor Mix, Proposed Location (2nd Full Year of Operation) Year **2028** **Beginning Month** **July**

Payor Source	Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	$15,945,048	$35.80
TennCare/Medicaid	$9,887,711	22.20%
Commercial/Other Managed Care	$14,297,096	32.10%
Self-Pay	$4,409,385	9.90%
Other (Specify) _____		0.00%
Total	$44,539,239	100.00%
Charity Care	$0	

4E. Publication

A proof of publication of notice of the exemption request is required in a newspaper of general circulation in both the county of the existing facility or service and the county where the service or facility is to be relocated.

Attach the full page of the 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.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
ANDREW JOHNSON TOWER, 5TH FLOOR
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243

BILL LEE
GOVERNOR

RALPH ALVARADO, MD, FACP
COMMISSIONER

July 18, 2023

Dear Ms. Ruby Kirby,

Thank you for your application in response to Tennessee's Healthcare Resiliency Program's Capital Investments arm (HRP-CI). The State has completed the evaluation of all applications and is making final awards.

Congratulations! Your project has been selected to be funded.

Specifically, Bolivar General Hospital, Inc. has been selected for a full award of $9,610,000.

Our team will be reaching out on next steps, but I wanted to be the first to congratulate you on putting together a project that will improve access to healthcare for low-income, minority, and rural populations in Tennessee.

We appreciate your interest in doing business with the State of Tennessee and hope that you will respond to future solicitations.

This notice is NOT a guarantee of funding. The state retains the right to reject any application. This notice shall NOT create rights, interests, or claims of entitlement in the above-named or any applicant. No applicant shall acquire any such right unless and until a contract is fully signed by the contract parties and approved, in accordance with applicable U.S. and Tennessee laws and regulations.

Grantees are strongly cautioned not to begin procurement until you have a fully executed grant contract. Failure to comply with Federal procurement guidelines may jeopardize some or all of the grant funding.

Sincerely,

Ralph Alvarado, MD, FACP
Commissioner

RA/mhp

GOVERNM

HARDEMAN COUNTY ARREST REPORT

Joshua Dean Ausmer, DOB: 11/18/2002, Southaven, MS, Violation of Probation (Circuit), Court Date/Time: 05/08/2025 08:30, $0 Bond, (held)

Joshua Ryan Barkley, DOB: 07/24/1992, Toone, Theft From $1,000 Less Than $10,000, Court Date/Time: 05/06/2025 08:30, $10000 Bond, (held)

Robert Wayne Carroll, DOB: (releas

Jata
DOB:
on Rev
Bond,

Dyl
05/31/
tic A
05/06/
(held)

Ash
06/03/
Under
Impair
Single
05/16/
DRIVI
SAID
100 F
MARC
DRIV
GINN
BE
SUBD
OF R
PAGE
OFFI
COU
SU
FOR
AGE
CORI
TH
BEIN
PRIO
TH
PROI
TOR
RAN
DEE
REG
DEM
SEE.
MA
CEL
Pa
Co
lywo
3800
Th
numb
prope

05/16/2025 08:30, $2500 Bond, (released)

Richard Lee Nathan, DOB: 07/31/1972, Bolivar, Driv on Rev/Sus/Can DL, No Insurance, Violation of Registration, Court Date/Time: 05/16/2025 08:30, $0 Bond, (released)

Tika Leann Newman, DOB: 01/01/1992, Toone, Aggravated Child Abuse and Neglect, Court Date/Time: 05/06/2025 08:30, $150000 Bond, (held)

Walter NMN Pirtle Jr, DOB: 08/29/1983, Whiteville, Viola-tion of Probation (Circuit), Court

successors and assigns, and appearing of record on September 19, 2022, in the Register's Office of Hardeman County, Tennessee, at Deed of Trust Book 804, Page 111, and Instrument Number 231570.

WHEREAS, the beneficial interest of said Deed of Trust was last transferred and assigned to Planet Home Lending, LLC, the party entitled to enforce said security interest; and having appointed Clear Recon LLC, the undersigned, as Substitute Trustee by instrument filed or being filed for record in the Register's Office of Hardeman County, Tennessee, with all of the rights, powers, and privileges of the original Trustee named in said Deed of Trust.

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust, and that the undersigned, Clear Recon LLC, as Substitute Trustee or his duly appointed agent, by virtue of the power, duty, and authority vested and imposed upon said Substitute Trustee will, on May 22, 2025, at 2:00 PM, local time, at the West Door of the Hardeman County C ated in Bolivar, T

subject to any applicable rights of redemption held by the entity as required by 26 U.S.C. § 7425 and/ or Tennessee Code § 67-1-1433.

All right and equity of redemption, statutory and otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good; however, the undersigned will sell and convey only as Substitute Trustee.

The transfer shall be AS IS, WHERE IS, AND WITH ALL FAULTS, and without warranties of any kind, express or implied, as to the condition of the Property and the improvements located thereon, including merchantability or fitness for particular purpose. Trustee shall make no covenant of seisin or warranty of title, express or implied, and will sell and convey the subject real property by Substitute Trustee's Deed only.

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

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substi-

THE TOWN OF HORNSBY WILL HOLD A SPECIAL CALLED MEETING ON TUESDAY, MAY 20, 2025, AT 6:00PM FOR THE 2ND READING OF THE BUDGET AMENDMENT FOR FISCAL YEAR 2024-2025

A PLANNING SESSION WILL BE HELD IMMEDIATELY FOLLOWING THE MEETING FOR THE 2025-2026 FISCAL BUDGET

THE PUBLIC IS WELCOME TO ATTEND

The City of Bolivar is requesting quotes for landscaping from July 1, 2025 through June 30, 2026. The person or company must be licensed and bonded. Bid information can be picked up at City Hall located at 211 North Washington Street.

This institution is an equal opportunity provider and employer. In

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED RELOCATION EXEMPTION

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 West Tennessee Healthcare Bolivar Hospital, an existing Critical Access Hospital owned by Bolivar General Hospital, Inc. with an ownership type of non-profit corporation and managed by N/A intends to request a Relocation Exemption for the construction and operation of a new critical access hospital. The current hospital location is 650 Nuckolls Road, Bolivar, Tennessee, 38008. The new location of the Hospital will be 550 Vildo Road, Bolivar, Tennessee 38008, and is adjacent to State Highway 64. The new hospital will have six inpatient rooms (two being negative pressure), twelve emergency department patient rooms (two being negative pressure), diagnostic imaging (mammography, ultrasound, XRay, computed tomography (CT)), pharmacy, food service, lobby, cardiac, physical rehabilitation and administrative space. Emergency room will operate 24/7/365. The total square footage of the new hospital is 27,064 square feet. There will be no reduction in services at the new location.

The anticipated date of filing the request is May 27, 2025.

The contact person for this request is Victoria S. Lake, Director Community Health Institute who may be reached at West Tennessee Healthcare, 620 Skyline Drive, Jackson, Tennessee 38301; (731) 984-2160.

Any health care institution wishing to oppose a Certificate of Need Relocation Exemption application must file a written notice with the Health Facilities Commission no later than fifteen (15) days after the application, supporting documentation, and staff review have been posted on the HFC's website; any opposition must be limited to the basis for review detailed in HFC Rule 0720-10-.06. 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.

PREPARED BY:
HORNSBY TITLE
101 N MAIN STREET
BOLIVAR, TN 38008

QUITCLAIM DEED

KNOW ALL MEN BY THESE PRESENTS: That for and in consideration of the sum of TEN ($10.00) DOLLARS, and other good and valuable consideration, cash in hand paid, the receipt of which is hereby acknowledged the **CITY OF BOLIVAR**, does hereby convey and quitclaim unto **BOLIVAR GENERAL HOSPITAL, INC.**, its successors and assigns, forever, all its interest in and to the following described real estate situated in Hardeman County, Tennessee, to-wit:

Beginning at a ½ inch iron rod found in the south right-of-way line of Highway 64, on the most northerly corner of the George White and wife, Nancy White, property of record in Deed Book 61, Page 408, shown on Tax Map # 061 as Parcel # 010.02, and on the most easterly corner of the herein described 8.27 acres, a portion of the Albert L. Keller & Alice V. Keller Living Trust property of record in Deed Book J-17, Page 167, shown on Tax Map # 061 as Parcel # 010.00; runs thence with White, the following 3 calls: 1) South 39 degrees 23 minutes 57 seconds West 308.01 feet to a ½ inch iron rod found; 2) South 43 degrees 58 minutes 23 seconds West 337.77 feet to a ½ inch iron rod found; 3) South 63 degrees 09 minutes 59 seconds West 153.74 feet to a point in the apparent centerline of Vildo Road, said point witnessed by a ½ inch iron rod found bearing northeasterly 25.50 feet on the last described line; Thence with Vildo Road, North 26 degrees 42 minutes 40 seconds West 543.12 feet; Thence with right-of-way line (State of Tennessee, Deed Book S-15, Page 327) the following 6 calls: 1) North 69 degrees 46 minutes 55 seconds East 24.63 feet to a concrete right-of-way marker found; 2) North 17 degrees 13 minutes 58 seconds West 152.22 feet to a ½ inch iron rod found by concrete right-of-way marker; 3) North 27 degrees 13 minutes 38 seconds West 93.68 feet to a ½ inch iron rod found by a concrete right-of-way marker found; 4) North 84 degrees 22 minutes 45 seconds East 140.41 feet to a ½ inch iron rod found; 5) South 82 degrees 48 minutes 11 seconds East 377.85 feet to a ½ inch iron rod found; 6) along a curve to the right 388.53 feet, having a radius of 1312.39 feet, and a chord bearing and distance of South 69 degrees 04 minutes 15 seconds East 387.11 feet to the **Point of Beginning** containing **8.27 acres** more or less.

Per Certificate of Survey of Matt Goodrum, RLS-2942, on May 12, 2025.

All bearings noted herein are grid bearings referenced to the Tennessee State Plane Coordinate system, North American Datum 1983.

Together with and subject to any covenants, easements, or restrictions of record and 0.31 acres of right-of-way rights in Vildo Road.

This being the same property conveyed to the City of Bolivar by deed of record in Deed Book _____, Page _____, in the Registers Office of Hardeman County, Tennessee.

PORTION OF Tax Map # 061 as Parcel # 010.00, Sp Int. 001

IN TESTIMONY WHEREOF, grantor has hereunto set its signature on this the 15th day of May, 2025.

CITY OF BOLIVAR

BY: _____
JULIAN A. MCTIZIC, SR.,
MAYOR

STATE OF TENNESSEE
COUNTY OF HARDEMAN

Personally appeared before me, the undersigned Notary Public in and for said County and State, the within named Julian A. McTizic, Sr., with whom I am personally acquainted, or proved to me on the basis of satisfactory evidence, and who, upon oath, acknowledged himself to be the Mayor of the City of Bolivar, the within named bargainor, and that he as such Mayor executed the foregoing Instrument for the purposes therein contained by signing the name of the City of Bolivar by himself as Mayor.

WITNESS my hand and seal of office at Bolivar, Tennessee, on this the 15th day of May, 2025.

Chloey Daniel
Notary Public

CHLOEY DANIEL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF HARDEMAN

My Com. Exp. 07-29-2028

DISCLAIMER

PREPARER OF THIS DOCUMENT MAKES NO WARRANTIES AS TO TITLE ON THE PROPERTY HEREIN CONVEYED. THIS DEED WAS PREPARED FROM INFORMATION FURNISHED TO PREPARER AND PREPARER MAKES NO WARRANTIES AS TO THE ACCURACY OF INFORMATION FURNISHED.

****

OATH

I, or we, hereby swear or affirm that the actual consideration to this transfer, or value of the property or interest in property transferred, whichever is greater, is **$.00.**

Affiant

Subscribed and sworn to before me this the 15th day of May, 2025.

Chloey Daniel
Notary Public or Register

My Com. Exp. 07-29-2028

CHLOEY DANIEL
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF HARDEMAN

Mail Tax Bills To:
Bolivar General Hospital, Inc.
620 Skyline Drive
Jackson, TN 38301

Property Address:
550 Vildo Road
Bolivar, TN 38008

File #25-180

Drawn By: Author
Checked By: Checker
Approved By: Approver

NOTES

1. MAXIMUM ALLOWABLE SQUARE FOOTAGE OF A SMOKE COMPARTMENT IS 40,000 SQUARE FEET, PER MOST STRINGENT REQUIREMENTS OF NFPA 101 SECTION 18.3.7.1(3) AND IBC SECTION 407.5.

2. OCCUPANT LOAD FACTOR IS DETERMINED PER MOST STRINGENT REQUIREMENTS OF NFPA 101 TABLE 7.3.1.2 AND IBC TABLE 1004.5.

3. OCCUPANT LOAD IS DETERMINED PER MOST STRINGENT REQUIREMENTS OF NFPA 101 SECTION 18.1.7 AND IBC SECTION 1004.

4. EGRESS CAPACITY WIDTH FACTOR IS DETERMINED PER MOST STRINGENT REQUIREMENTS OF NFPA 101 TABLE 7.3.3.1 AND IBC SECTION 1005.

5. MINIMUM CLEAR EXIT EGRESS WIDTH REQUIRED IS 41.5 INCHES, PER MOST STRINGENT REQUIREMENTS OF NFPA 101 SECTION 18.2.3.6 AND IBC SECTION 1010.1.1.

6. MAXIMUM TRAVEL DISTANCE FROM "THE MOST REMOTE POINT IN A HEALTH CARE SLEEPING ROOM" TO "AN EXIT ACCESS DOOR" IS 50 FEET, PER MOST STRINGENT REQUIREMENTS OF NFPA 101 SECTION 18.2.6.2.3

7. MAXIMUM TRAVEL DISTANCE FROM "ANY ROOM DOOR REQUIRED AS AN EXIT ACCESS" TO "AN EXIT" IS 200 FT, PER NFPA 101 SECTION 18.2.6.2.1 AND IBC TABLE 1017.2.

8. MAXIMUM TRAVEL DISTANCE FROM "THE MOST REMOTE POINT IN A ROOM" TO "A DOOR INTO AN ADJACENT SMOKE COMPARTMENT" IS 200 FEET, PER MOST STRINGENT REQUIREMENTS OF NFPA 101 SECTION 18.3.7.1(5) AND IBC SECTION 407.5.

9. AREAS OF SMOKE COMPARTMENTS IN EXISTING CONSTRUCTION PROVIDED TO ARCHITECT BY OWNER HAVE NOT BEEN VERIFIED.

GENERAL NOTES FOR LIFE SAFETY PLANS

G200. NOT USED

G201. THE LIFE SAFETY PLANS ARE "DIAGRAMMATIC ONLY". THEIR PURPOSE IS SOLELY TO REPRESENT THE LIFE SAFETY COMPONENTS FOR THE PROJECT (AS INCLUDED IN THE CONSTRUCTION DOCUMENTS PREPARED BY THE ARCHITECT AND ENGINEERS). THE CONTRACTOR SHALL USE THE CONSTRUCTION DOCUMENTS (NOT THE LIFE SAFETY PLANS) FOR THE IMPLEMENTATION OF THE REQUIRED LIFE SAFETY COMPONENTS INTO THE PROJECT.

G202. THE CONTRACTOR SHALL ADVISE THE ARCHITECT IMMEDIATELY UPON DISCOVERY OF ANY LIFE SAFETY COMPONENT THAT IS SHOWN ON THE LIFE SAFETY PLANS BUT HAS NOT BEEN INCLUDED IN THE CONSTRUCTION DOCUMENTS PREPARED BY THE ARCHITECT AND/OR ENGINEERS

G203. THE CONTRACTOR SHALL BE RESPONSIBLE FOR FIELD VERIFYING THAT THE REQUIRED VISIBILITY FOR EACH EXIT SIGN SHALL BE VISIBLE, WITHOUT DIMINISHMENT IN THE DIRECTION OF TRAVEL.

G204. THE CONTRACTOR SHALL BE RESPONSIBLE FOR STENCILING EACH "WALL/PARTITION/BARRIER" CLASSIFICATION IN RED LETTERS ABOVE THE FINISH CEILING ON EACH SIDE OF ALL PARTITIONS.

G205. ALL CORRIDORS IN HOSPITALS SHALL (AT A MINIMUM) BE ENCLOSED WITH "SMOKE PARTITIONS" WHICH COMPLY WITH THE REQUIREMENTS OF THE APPLICABLE BUILDING CODE

CALCULATIONS FOR OCCUPANT LOADS AND EXIT EGRESS

SMOKE COMPARTMENT NUMBER	GROSS AREA	÷	OCCUPANT LOAD FACTOR (S.F. per occupant) [Note 1]	=	OCCUPANT LOAD (# of occupants)	X	STAIRWAYS / OTHER COMPONENTS: WIDTH FACTOR [Note 3]	=	WIDTH REQUIRED (Inches) [Note 4]	VS	WIDTH PROVIDED [Inches]
SC 1A	13,658		100 (INSTITUTIONAL INPATIENT TREATMENT)		136.58		.2		27"		249"
SC 1B	4,455 SF		100 (INSTITUTIONAL INPATIENT TREATMENT)		44.55		.2		09"		48"
SC 1C	8,852 SF		100 (INSTITUTIONAL INPATIENT TREATMENT)		88.52		.2		18"		186"

NOTES

1. OCCUPANT LOAD FACTOR IS DETERMINED BY IBC TABLE 1004.1.1

3. EGRESS CAPACITY FACTORS ARE DETERMINED BY IBC TABLE 1005.1.

4. MINIMUM CLEAR EXIT EGRESS WIDTH REQUIRED IS PER IBC SECTION 1005.

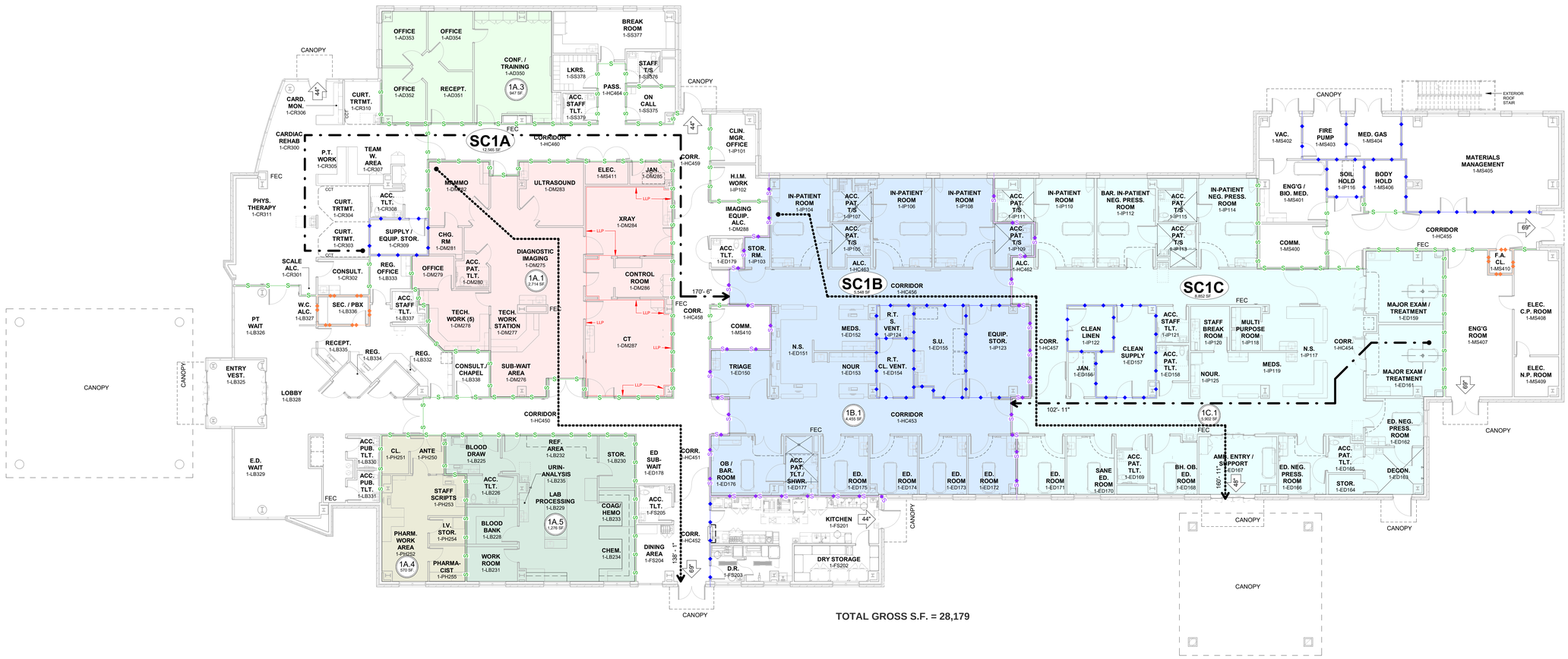
5. MAXIMUM TRAVEL DISTANCE FROM "THE MOST REMOTE POINT IN A ROOM" TO "AN EXIT" IS PER IBC SECTION 1016 AND IBC TABLE 1016.1 FOR SPRINKLERED OCCUPANCY.

SUITES:

1A.1	IMAGING	2,714 SF.
1A.3	ADMIN.	947 SF.
1A.4	PHARMACY	570 SF.
1A.5	LAB	1,276 SF.
1B.1	E.R. / INPAT. I	4,455 SF.
1C.1	E.R. / INPAT. II	5,902 SF.

LEGEND

- NON-RATED PARTITION
- NON- RATED SMOKE RESISTANT PARTITION
- ONE HOUR FIRE PARTITION/BARRIER
- ONE HOUR FIRE/SMOKE BARRIER
- TWO HOUR FIRE PARTITION/BARRIER
- TWO HOUR FIRE/SMOKE BARRIER
- THREE HOUR FIRE BARRIER
- THREE HOUR FIRE/SMOKE BARRIER
- FOUR HOUR FIRE BARRIER
- SC1A — SMOKE COMPARTMENT DESIGNATION
- SMOKE COMPARTMENT LETTER
- FLOOR LEVEL
- 1A.1 — SUITE DESIGNATION
- SUITE NUMBER
- SMOKE COMPARTMENT LETTER
- FLOOR LEVEL
- 29" — CLEAR WIDTH OF EGRESS DOOR (IN INCHES)
- 144'-8" — TRAVEL DISTANCE TO EXIT DOOR
- 144'-8" — TRAVEL DISTANCE TO DOOR INTO ADJACENT SMOKE COMPARTMENT
- EXIT LIGHTS (ARROWS INDICATE DIRECTION OF EGRESS)
- FE — FIRE EXTINGUISHER / FIRE EXTINGUISHER CABINET
- HAZARDOUS STORAGE (OPTIONAL)
- SUITE EXIT (OPTIONAL)
- SHADING INDICATES SUITE BOUNDARY
- SP — STANDPIPE
- F — FIRE ALARM PULL STATION
- FH — FIRE ALARM COMBINATION HORN AND FLASHING LIGHT
- FC — FIRE ALARM COMBINATION CHIME AND FLASHING LIGHT
- F — FIRE ALARM FLASHING LIGHT ONLY
- FB — FIRE ALARM COMBINATION BELL AND FLASHING LIGHT
- H — FIRE ALARM HORN ONLY
- F — FIRE ALARM FLASHING LIGHT, CEILING MOUNTED
- FS — FIRE ALARM SPEAKER, CEILING MOUNTED
- S — FIRE ALARM COMBINATION HORN AND FLASHING LIGHT, CEILING MOUNTED



TOTAL GROSS S.F. = 28,179

PLAN NORTH

1 FIRST FLOOR - LIFE SAFETY PLAN
1" = 10'-0"
0' 5' 10' 20' 30'

Gresham Smith
GreshamSmith.com
222 Second Avenue South
Suite 1400
Nashville, TN 37201
615.770.8100

I.C. Thomasson Associates, Inc.
A Salas O'Brien Company

West Tennessee Health
Bolivar Micro Hospital
550 Vildo Road,
Bolivar, TN. 38008

NOT FOR CONSTRUCTION

Revision

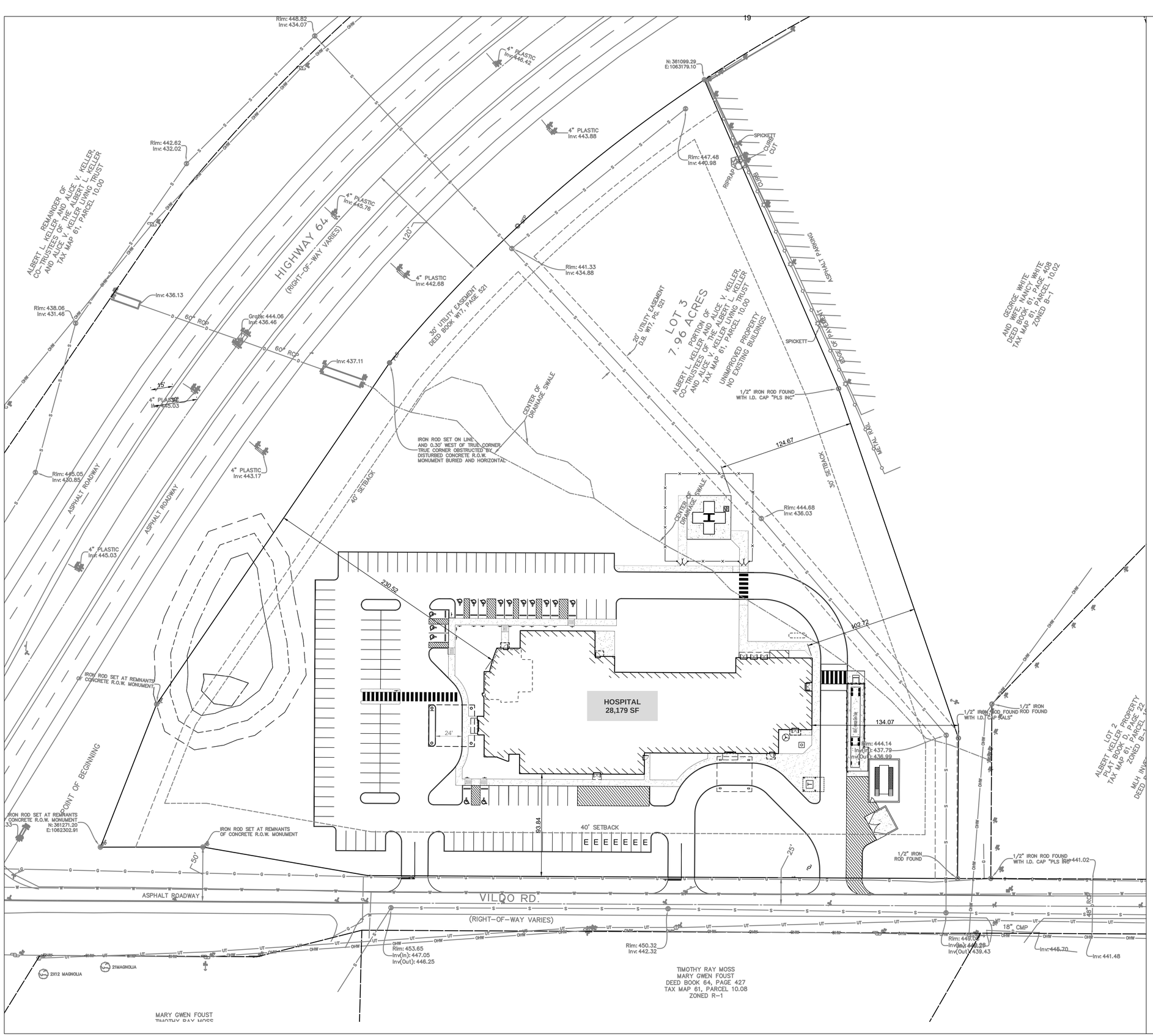
No.	Date	Description

FIRST FLOOR - LIFE SEFETY PLAN

AL201

49781.00
05.13.2025

This Line is 3 Inches When Printed Full Size



Gresham Smith
GreshamSmith.com
222 Second Avenue South
Suite 1400
Nashville, TN 37201
615.770.8100

I.C. Thomasson Associates, Inc.
A Salas O'Brien Company

West Tennessee Health
Bolivar Micro Hospital

Enter address here

NOT FOR CONSTRUCTION

Revision

No.	Date	Description

NORTH

40' 0 40' 80'
GRAPHIC SCALE

SITE PLAN

C201

49781.00
03/28/25

This Line Is 3 Inches When Printed Full Size

3/24/2025 3:11:47 PM
C:\Users\dretch\DC\ACCDocs\Gresham Smith\49781.00 West TN Health - Bolivar Micro Hosp R24\Project Files\C3D\Sheets\49781.00_C201.dwg - Bruce Dretchen - 5/21/2025 6:31:41 AM

Tennessee Department of Health

Health Statistics
2nd Floor, Andrew Johnson Tower
710 James Robertson Pkwy
Nashville, TN 37243
Telephone: (615)253-4702 - Fax: (000)000-0000

Joint Annual Report of Hospital

Contacts

Trent Sansing
Email: Trent.Sansing@tn.gov
Call: (615)253-4702
For: ACLF, ASTC, Hospitals, Hospice, Nursing Home, ODC

Ashley Blasen
Email: Ashley.Blasen@TN.gov
Call: (615)532-7456
For: Home Health agencies

Barth Ihenacho
Email: Barth.Ihenacho@TN.gov
Call: (615)741-5845
For: ACLF

2024

Federal Tax I.D. # 621624171
Medicare ID # 440181
TN Medicaid ID # 0440181

1. Name of Hospital: **West Tennessee Healthcare Bolivar Hospital**
   Did your facility name change during the reporting period? ○ YES ◉ NO
   If yes, list former name of your facility
   County: Hardeman

2. Address of Facility Street: 650 Nuckolls Road
   City: Bolivar State: Tennessee Zip: 38008

3. Telephone Number (731)658-3100 (Only enter 10 consecutive digits, no special characters)
   Area Code Number

4. Name of Chief Executive Officer Ruby (First Name) Kirby (Last Name)
   Signature of Chief Executive Officer Signature Required on Printed Form

5. Name of person coordinating form completion Derek (First Name) Johnson (Last Name)
   Telephone Number (731)512-1515 (Only enter 10 consecutive digits, no special characters)
   Area Code Number
   Email Address derek.johnson@wth.org

6. Reporting period used for this facility: Beginning Date 07/01/2023 Ending Date 06/30/2024

7. Does your hospital own or operate other hospitals licensed as satellites of your hospital? ○ YES ◉ NO
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	OWN	OPERATE	OWN AND OPERATE
1			○	○	○
2			○	○	○
3			○	○	○
4			○	○	○
5			○	○	○

8. Does your hospital have another independently licensed facility housed inside your hospital? ○ YES ◉ NO
   If yes, what type of service (e.g. psychiatric, long term acute care, rehabilitation, etc.)?
   Name State ID Type of Service
   Name State ID Type of Service
   Name State ID Type of Service

1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital.

1. Government-Non-Federal	2. Government-Federal	3. Nongovernmental, not-for-profit	4. Investor-owned, for-profit
○ **11 State**	○ **17 Armed Forces**	○ **20 Church-operated**	○ **23 Individual**
○ **12 County**	○ **18 Veterans Admin.**	○ **21 Other Nonprofit Corporation**	○ **24 Partnership**
○ **13 City**	○ **19 Other**	○ **22 Other not-for-profit,**	○ **25 Corporation**
○ **14 City-County**			
◉ **15 Hospital district or authority**			

19. Other please specify: _____

22. Other not-for-profit please specify: _____

B. Is the hospital part of a health system? ◉ YES ○ NO
If yes, please provide the name and location of the health system.
Name West Tennessee Healthcare City Jackson State Tennessee

C. Does the controlling organization lease the physical property from the owner(s) of the hospital? ○ YES ◉ NO

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?
Jackson-Madison County General Hospital District

E. Is the hospital a division of a holding company? ○ YES ◉ NO

F. Does the hospital itself operate subsidiary corporations? ○ YES ◉ NO

G. Is the hospital managed under contract? ○ YES ◉ NO If YES, length of contract From _____ To _____

If yes, please provide name, city, and state of the organization that manages the hospital.
Name _____ City _____ State _____
Name _____ City _____ State _____

H. Does this hospital have a particular clinical unit/area that is managed under contract? ○ YES ◉ NO
If yes, please provide name, city and state of the organization that manages the unit/area.
Name _____ City _____ State _____
Length of contract: From _____ To _____

I. Is the hospital part of a health network? ◉ YES ○ NO (see definition of network)
If yes, please provide the the name, city, and state of the network.
Name VHAN City Nashville State _____
Name _____ City _____ State _____

2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

◉ **01 General medical and surgical**	○ **07 Rehabilitation**
○ **02 Pediatric**	○ **08 Orthopedic**
○ **03 Psychiatric**	○ **09 Chronic disease**
○ **04 Tuberculosis and other respiratory diseases**	○ **10 Alcoholism and Other Substance Use Disorders**
○ **05 Obstetrics and gynecology**	○ **11 Long term acute care**
○ **06 Eye, ear, nose and throat**	○ **12 Other-specify treatment area**

_____

B. Does your hospital own or have a contract with any of the following?

	(1) Yes	(2) No	Specify one: 1) Own	2) Contract	Number of Physicians	FTE Physicians
1. Independent Practice Association	○	◉	○	○		
2. Open Panel Physician-Hospital Organization (PHO)	○	◉	○	○		
3. Closed Panel Physician-Hospital Organization (PHO)	○	◉	○	○		
4. Management Services Organization (MSO)	○	◉	○	○		
5. Integrated Salary Model	○	◉	○	○		
6. Foundation	○	◉	○	○		

3. In regard to question 2B, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payers or shared responsibility for financial risk or clinical performance between the hospital and physician? (arrangement may be at the hospital, system or network level)
Number of physicians

4. Does your hospital have a formal written contract that specifies the obligations of each party with:
A. Health Maintenance Organization (HMO)? ○ YES ◉ NO
1. How many do you contract with?
2. Number of different contracts

B. Preferred Provider Organization (PPO)? ◉ YES ○ NO
1. How many do you contract with? 17
2. Number of different contracts 39

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?
If the hospital does not participate in any capitated arrangement, please enter "0". 0.00 %

6. How many covered lives are in your capitation agreements?

7. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined or shared risk basis? ○ YES ◉ NO

8. Has your hospital or health care system established an accountable care organization (ACO)? ○ YES ◉ NO

   A. If yes, please indicate the patient population that participates in the ACO. (Check all that apply):
      a. ☐ Medicaid
      b. ☐ Medicare
      c. ☐ Private insured
      d. ☐ Other, please specify _____

   B. Does your hospital or health care system participate in other accountable care organizations (ACO)? ◉ YES ○ NO
      If yes, please specify the organizations names: Connected Care of Tennessee

9. Does your hospital participate in a bundled payment program involving inpatient, physician, and/or post acute care services where the hospital receives a single payment from a payer for a package of services and then distributes payments to participating providers of care (such as asingle fee for hospital and physician services for a specific procedure, e.g. hip replacement, CABG)?

   ○ **YES** ◉ **NO**

   If yes, is the hospital the contracting entity that receives and distributes the payment? ○ YES ○ NO

10. Does your hospital have its National Provider Identifier (NPI) from the National Plan and Provider Enumeration System?
    ◉ **YES** ○ **NO**

    If yes, please report the ten digit NPI 1518957950

11. Does your hospital also have a Subpart NPI? ◉ YES ○ NO
    If yes, please report the Subpart NPI and provide the relevant taxonomy code to indicate the type of service provided.
    If you have multiple Subpart NPIs please report them all.

Subpart NPI 1	1689665754	Taxonomy Code	02
Subpart NPI 2		Taxonomy Code	
Subpart NPI 3		Taxonomy Code	
Subpart NPI 4		Taxonomy Code	
Subpart NPI 5		Taxonomy Code	
Subpart NPI 6		Taxonomy Code	
Subpart NPI 7		Taxonomy Code	
Subpart NPI 8		Taxonomy Code	
Subpart NPI 9		Taxonomy Code	
Subpart NPI 10		Taxonomy Code	

Taxonomy Codes

Ambulatory Health Care Facility	01
Medicare Defined Swing Bed Unit	02
Psychiatric Unit	03
Rehabilitation Unit	04
Rehabilitation, Substance Use Disorder	05
Laboratory	06
Nursing and Custodial Care Facility	07
Residential Treatment Facility	08
Respite Care Facility	09
Other	10

1. ACCREDITATIONS:

A. The Joint Commission (TJC)	(•) YES ( ) NO
Date of most recent accrediting letter or survey	11/19/2022
If Yes, Is the hospital accredited under either/both of the following manuals:	
1. Comprehensive Accreditation Manual for Hospitals (CAMH)	(•) YES ( ) NO
2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)	( ) YES (•) NO
3. Other manuals, please specify	
B. Commission on Accreditation of Rehabilitation Facilities (CARF)	( ) YES (•) NO
Date of most recent accrediting letter or survey	
C. American College of Surgeons Commission on Cancer	( ) YES (•) NO
D. American College of Surgeons Metabolic and Bariatric Surgery	( ) YES (•) NO
E. American College of Surgeons Nat. Accreditation Program for Breast Centers	( ) YES (•) NO
F. Other, please specify	

2. CERTIFICATIONS:

Medicare Certification	(•) YES ( ) NO

3. OTHER:

A. THA Membership	(•) YES ( ) NO
B. Hospital Alliance of Tennessee, Inc. Membership	( ) YES (•) NO
C. American Hospital Association Membership	(•) YES ( ) NO
D. American Medical Association Approval for Residencies (and Internships)	( ) YES (•) NO
E. State Approved School of Nursing: Registered Nurses	( ) YES (•) NO
Licensed Practical Nurses	( ) YES (•) NO
F. Medical School Affiliation	( ) YES (•) NO
G. Tennessee Association of Public and Teaching Hospitals (TNPath)	( ) YES (•) NO
H. Children's Hospital Association of Tennessee (CHAT)	( ) YES (•) NO
I. America's Essential Hospitals	(•) YES ( ) NO
J. Other, please specify	

1. CERTIFICATE OF NEED:

Do you have an approved, **outstanding,** certificate of need (CON) ? ○ YES ◉ NO
If yes, please specify:

Name of Service or Activity Requiring the CON	# of Beds (if applicable)	Date of Approval
Specify Other Service:		
Specify Other Service:		
Specify Other Service:		

2. Does your hospital own or operate Tennessee physician primary care clinics? ○ YES ◉ NO If yes, how many?

How many physicians practice in these clinics?

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ○ YES ◉ NO If yes, how many?

How many physicians practice in these clinics?

4. Does your hospital own or operate a blood bank? ○ YES ◉ NO
If yes, please indicate:
A. Distributes blood within the hospital ○ **YES** ○ **NO**
B. Collects blood within the hospital ○ **YES** ○ **NO**
C. Distributes blood outside the hospital ○ **YES** ○ **NO**
D. Collects blood from outside the hospital ○ **YES** ○ **NO**

5. Does your hospital own or operate an ambulance service? ○ **YES** ◉ **NO**
If yes, please specify the counties where services are located.

Please specify the type of service and ownership relationship: (mark all that apply)

A. Land Transport	○ **YES**	○ **NO**	If yes, ○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**
B. Helicopter	○ **YES**	○ **NO**	If yes, ○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**
C. Special Neonatal Helicopter	○ **YES**	○ **NO**	If yes, ○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**
D. Special Neonatal Land Transport	○ **YES**	○ **NO**	If yes, ○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**

6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ○ YES ◉ NO
If yes, please complete the following (mark all that apply).

Name of Clinic: County City:

○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

Name of Clinic: County City:

○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

7. Does your hospital operate a Federally Qualified Health Center (FQHC) in Tennessee? ○ YES ◉ NO
If yes, please complete the following (mark all that apply).
Name of Center: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

Name of Center: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following (mark all that apply).
Name of Center: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

Name of Center: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

9. Does your hospital own or operate an off-site outpatient physical therapy rehabilitation center located in Tennessee? ○ YES ◉ NO
If yes, please complete the following (mark all that apply).
Name of Center: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

Name of Center: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

10. Does your hospital own or operate an urgent care center? ○ YES ◉ NO
If yes, please complete the following (mark all that apply).
Name of Center: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

Name of Center: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**

11. Does your hospital own or operate a freestanding emergency department (ED)? ○ YES ◉ NO
If yes, please complete the following (mark all that apply).
Name of ED: _____ County: _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**
Patients: _____ # Visits: _____

Name of ED: _____ County _____ City: _____
○ **own** ○ **operate** ○ **contract** ○ **own in joint venture**
Patients: _____ # Visits: _____

12. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (exclude swing beds)? ○ YES ◉ NO If yes, please complete the following:

Name of SNF: _____ Number of Licensed Beds _____ Number of Staffed Beds _____
Number of Admissions _____ Number of Patient Days _____

13. Does your hospital operate a hospital-based rehabilitation unit that is reimbursed by Medicare as an independent Inpatient Rehabilitation Facility (IRF)? ○ YES ◉ NO If yes, please complete the following:

Name of IRF: _____ Number of Licensed Beds _____ Number of Staffed Beds _____
Number of Admissions _____ Number of Patient Days _____

14. Does your hospital operate a hospital-based inpatient physical rehabilitation unit? ○ YES ◉ NO
If yes, please complete the following:

Number of Beds Approved by CON _____ Number of Staffed Beds _____
Number of Admissions _____ Number of Patient Days _____

A. Do you have a dedicated outpatient physical rehabilitation unit? ○ YES ◉ NO

15. Does your hospital own or operate any of the following off-site facilities:

Ambulatory Surgery Center	○ YES ◉ NO	If yes, name:	State ID	
	○ YES ◉ NO	If yes, name:	State ID	
Outpatient Diagnostic Center	○ YES ◉ NO	If yes, name:	State ID	
	○ YES ◉ NO	If yes, name:	State ID	
Hospice Agency	○ YES ◉ NO	If yes, name:	State ID	
	○ YES ◉ NO	If yes, name:	State ID	
Assisted-Care Living Facility	○ YES ◉ NO	If yes, name:	State ID	
	○ YES ◉ NO	If yes, name:	State ID	
Home Health Agency	○ YES ◉ NO	If yes, name:	State ID	
	○ YES ◉ NO	If yes, name:	State ID	
Nursing Home	○ YES ◉ NO	If yes, name:	State ID	
	○ YES ◉ NO	If yes, name:	State ID	

16. Does your hospital own, operate or contract any of the following mobile equipment units for Certificate Of Need covered services
(MRI, PET, megavoltage radiation) that comes to your facility for diagnosis and treatment of patients on-site?

	Yes/No	Number of Mobile Units	Number days per week mobile services are provided	Number Procedures Inpatient	Outpatie
Magnetic Resonance Imaging (MRI)	○ Yes ◉ No				
Positron Emission Tomography (PET)	○ Yes ◉ No				
Megavoltage Radiation Therapy (MRT)	○ Yes ◉ No				

17. Does your hospital own, operate or contract a mobile unit for other non-Certificate Of Need covered services (e.g. mammography, x-ray, ultrasound) that operates in Tennessee? ○ YES If yes, please complete the following:
◉ NO

A. List actual mobile services provided (mark all that apply):

1		○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**
2		○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**
3		○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**
4		○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**
5		○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**
6		○ **own**	○ **operate**	○ **contract**	○ **own in joint venture**

B. List counties served (where you take the service):
List counties for service 1 in 17A on line 1, for service 2 on line 2, etc.

1						
2						
3						
4						
5						
6						

18. HOSPITAL-BASED DETAILED SERVICES

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number	Total
A. Renal:							
Extracorporeal Shock Wave Lithotripsy	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
# of days per week (Mobile units)							
Renal Dialysis	○	◉					
# of dedicated stations							
Hemodialysis	○	◉	Patients		Patients		0
			Treatments		Treatments		0
Peritoneal Dialysis	○	◉	Patients		Patients		0
			Treatments		Treatments		0
B. Oncology/Therapies:							
Chemotherapy	○	◉	Patients		Patients		0
			Treatments		Treatments		0
Hyperthermia	○	◉	Patients		Patients		0
			Treatments		Treatments		0
C.1. Radiology, Diagnostic:							
Computerized Tomographic (CT) Scanner	◉	○					
# fixed units inside hospital 1			Procedures	45	Procedures	3132	3,177
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
# days per week (mobile units)							
Multi-slice spiral CT (< 64 slice)	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
# days per week (mobile units)							

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number	Total
Multi-slice spiral CT (64 or > slice)	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
# days per week (mobile units)							
Electron Beam CT (EBCT)	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		
# of mobile units			Procedures		Procedures		0
# days per week (mobile units)							
Single Photon Emission CT (SPECT)	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
Positron Emission Tomography (PET ONLY), CON Service	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
PET/CT Combination Procedures	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
Magnetic Resonance Imaging (MRI), CON Service	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
Dedicated Breast MRI, CON Service	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number	Total
Dedicated Extremity MRI, CON Service	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
Dedicated Multi-Position MRI, CON Service	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
Magnetoencephalography (MEG)	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
Diagnostic Radioisotope Facility	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number	Total
Ultrasound	◉	○					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units	2		Procedures	5	Procedures	748	753
# days per week (mobile units)	5						
Bone Densitometry	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
# of mobile units			Procedures		Procedures		0
# days per week (mobile units)							

C.2.Radiology, Therapeutic:

Megavoltage Radiation Therapy (MRT) Delivered by Linear Accelerator, CON Services

Linear Accelerators Delivering Stereotactic Radiotherapy (SRT)	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
Linear Accelerators Delivering Stereotactic Radiotherapy/Stereotactic Body Radiotherapy (SRT/SBRT)	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
Proton Beam Therapy	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
Gamma Knife	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
Cyberknife	○	◉					
# fixed units inside hospital			Procedures		Procedures		0
# fixed units off site			Procedures		Procedures		0
Other Radiation Therapy			Procedures		Procedures		0
Specify							

C.3.Mammography

Mammography (non FFDM)					
# of fixed units (non FFDM)		# of Screening Exams		# of Diagnostic Exams	
# of mobile (non FFDM) units		# of Screening Exams		# of Diagnostic Exams	
# of days per week (mobile units)					
Mammography (FFDM)					
# of fixed units (FFDM)	1	# of Screening Exams	508	# of Diagnostic Exams	0
# of mobile (FFDM) units		# of Screening Exams		# of Diagnostic Exams	

SCHEDULE D - SERVICES (continued)

35215 - West Tennessee Healthcare Boliva Hospital

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	Inpatient Cath Lab Setting Unit of Measure	Number	Outpatient Cath Lab Setting in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number

D. Cardiac:

A Case shall mean one visit to a surgical, laboratory, or another procedure room by one patient, regardless of the number of procedures performed during that visit. (See CON standards)

***Note: Pediatric = a patient less than 18 years of age.**

Number of Cath Labs 0

Date Cardiac Cath Lab Initiated _____

Diagnostic Cardiac Catheterization	○	◉	Adult Cases	Adult Cases
			Pediatric Cases	Pediatric Cases
Therapeutic Cardiac Catheterization	○	◉	Adult Cases	Adult Cases
			Pediatric Cases	Pediatric Cases
Electrophysiological (EP) Study				
Diagnostic EP Study	○	◉	Adult Cases	Adult Cases
			Pediatric Cases	Pediatric Cases
Therapeutic EP Study	○	◉	Adult Cases	Adult Cases
			Pediatric Cases	Pediatric Cases
Peripheral Vascular Catheterization				
Diagnostic Peripheral Vascular	○	◉	Adult Cases	Adult Cases
			Pediatric Cases	Pediatric Cases
Therapeutic Peripheral Vascular	○	◉	Adult Cases	Adult Cases
			Pediatric Cases	Pediatric Cases
Thrombolytic Therapy	○	◉	Adult Cases	Adult Cases
			Pediatric Cases	Pediatric Cases

			To Inpatients	To Outpatients
Open Heart Surgery			*Note: Pediatric = a patient less than 15 years of age.	
# dedicated O.R.'s _____	○	◉	Adult Cases	
			Pediatric Cases	

Utilization of Selected Services

E. Surgery:

Inpatient ONLY

Dedicated Operating Rooms 0

Dedicated Procedure Rooms 0

Outpatient (one day) ONLY

Dedicated Operating Rooms 0

Dedicated Procedure Rooms 0

Shared Rooms-Used for Inpatients and Outpatients

Dedicated Operating Rooms 0

Dedicated Procedure Rooms 0

***if a patient is having multiple surgery types in the same visit, please count the surgery type in the category for the patient's PRIMARY reason for surgery**

A Case shall mean one visit to a surgical, laboratory, or another procedure room by one patient, regardless of the number of procedures performed during that visit. (See CON standards)

	Is This Service Provided In Your Hospital?		Adults				Pediatrics				
			To Inpatients		To Outpatients in hospital outpatient departments or off-site hospital-based clinics		To Inpatients		To Outpatients in hospital outpatient departments or off-site hospital-based clinics		
	Yes	No	Unit of Measure	Number	Unit of Measure	Number	Unit of Measure	Number	Unit of Measure	Number	Total
Answer Yes or No to ALL Services											
Acupuncture	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Cosmetic Surgery	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Dental	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Ear, Nose & Throat (ENT)	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Endoscopy	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
General Surgery	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Gynecology	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Neurology	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Obstetrics	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Oncology	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Ophthalmology	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Oral Surgery	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Orthopedics	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Pain Management	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Podiatry	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Pulmonary	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Urology	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Vascular	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Other 1, specify	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Other 2, specify	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0
Other 3, specify	○	◉	Cases	0	Cases	0	Cases	0	Cases	0	0

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number
F. Rehabilitation:						
Cardiac	○	◉	Patients		Patients	
					Visits	
Substance Use Disorder (SUD)	○	◉	Patients		Patients	
					Visits	
Nutritional Counseling	◉	○	Patients	16	Patients	0
					Visits	0
Pulmonary	○	◉	Patients		Patients	
					Visits	
G. Physical Rehabilitation:						
Occupational Therapy	◉	○	Patients	1	Patients	0
					Visits	0
Orthotic Services	○	◉	Patients		Patients	
					Visits	
Physical Therapy	◉	○	Patients	17	Patients	185
					Visits	400
Prosthetic Services	○	◉	Patients		Patients	
					Visits	
Speech/Language Therapy	○	◉	Patients		Patients	
					Visits	
Therapeutic Recreational Service	○	◉	Patients		Patients	
					Visits	
H. Pain Management: Does your hospital offer inpatient or outpatient programs or services to admit or treat patients for the management of chronic, nonmalignant pain diagnoses?	○	◉	Patients		Patients	
					Visits	

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number
I. Transplants:						
Organs						
Total Donors			Donors			
Total Harvested	○	◉	Organs			
Transplants	○	◉	Transplants			
Type of Organ:						
Heart	○	◉	# Transplanted			
Liver	○	◉	# Transplanted			
Lung	○	◉	# Transplanted			
Kidneys	○	◉	# Transplanted			
Pancreas	○	◉	# Transplanted			
Intestine	○	◉	# Transplanted			
Any Other _____	○	◉	# Transplanted			
Tissues						
Total Donors			Donors	5		
Total Harvested	◉	○	Tissues	110		
Transplants	○	◉	Transplants			
Type of Tissue:						
Eye	○	◉	# Transplanted		# Transplanted	
Bone	○	◉	# Transplanted		# Transplanted	
Bone Marrow	○	◉	# Transplanted		# Transplanted	
Connective	○	◉	# Transplanted		# Transplanted	
Cardiovascular	○	◉	# Transplanted		# Transplanted	
Stem Cell	○	◉	# Transplanted		# Transplanted	
Other _____	○	◉	# Transplanted		# Transplanted	

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number
J. Hyperbaric Oxygen Therapy	○	◉	Patients		Patients	
K. Intensive/Intermediate:						
Burn Care Unit	○	◉	Patients		Patients	
# beds			Patient Days			
Cardiac Care Unit	○	◉	Patients			
# beds			Patient Days			
Medical Intensive Care Unit	○	◉	Patients			
# beds			Patient Days			
Mixed Intensive Care Unit	○	◉	Patients			
# beds			Patient Days			
Pediatric Intensive Care Unit	○	◉	Patients			
# beds			Patient Days			
Stepdown ICU	○	◉	Patients			
# beds			Patient Days			
Stepdown CCU	○	◉	Patients			
# beds			Patient Days			
Surgical Intensive Care Unit	○	◉	Patients			
# beds			Patient Days			
Other, specify	○	◉	Patients			
Number of beds			Patient Days			
Other, specify	○	◉	Patients			
Number of beds			Patient Days			

**Note: If your hospital has a designated psychiatric/gero-psychiatric unit in your facility, DO NOT enter information here. You will enter that information in Schedule H.

L. Psychiatric Partial Hospitalization	○	◉	Patients			
M. Psychiatric Intensive Outpatient Care	○	◉			Patients	

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients in hospital outpatient departments or off-site hospital-based clinics. Unit of Measure	Number
N. Electroconvulsive Treatment	○	◉	Patients		Patients	
			Treatments		Treatments	
O. Negative Pressure Ventilated Room:	◉	○				
If yes, number of beds 3						

P. Cancer Patients:

1. How many patients were diagnosed with cancer at your facility during this reporting period?
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during the reporting period?
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period?

Q. Other:

Auxiliary	○	◉
Children's Wellness Program	○	◉
Community Health Education	◉	○
Community Outreach	◉	○
Enabling Services	○	◉
Fitness Center	○	◉
Health Fair	◉	○
Health Screenings	◉	○
Health Research	○	◉
Immunization Program	○	◉
Indigent Care Clinic	○	◉
Meals on Wheels	○	◉
Mobile Primary Care Health Services	○	◉
Teen Outreach Services	○	◉
Tobacco Cessation Program	○	◉
Transportation for Elderly to Health Services	○	◉

**Note: FREESTANDING PSYCHIATRIC HOSPITALS: Should complete this schedule in its entirety. Do NOT complete the financial data section in Schedule H.
**Note: ACUTE CARE HOSPITALS: Complete this section in its entirety.

Also, if you are an acute care hospital with a psychiatric unit you must also complete the financial data section in Schedule H.
**Note: All Revenue associated with normal newborns should be included in all data EXCEPT for item 3a.

Dates covered from 07/01/2023 to 06/30/2024 Use zeros where applicable. Do not leave blank lines in this schedule.

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar.)

1. Government	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue
a) Medicare Inpatient - Fee for Service	$529340	-	$0	=	$529340
b) Medicare Advantage - Inpatient	$275102	-	$169984	=	$105118
c) Medicare Outpatient - Fee for Service	$4348826	-	$3105924	=	$1242902
d) Medicare Advantage - Outpatient	$8806182	-	$5451688	=	$3354494
e) Medicaid/TennCare Inpatient*(for EAH use 7.c.1)	$108043	-	$82177	=	$25866
i. United Health Care Community Plan	$0	-	$0	=	$0
ii. Amerigroup	$0	-	$0	=	$0
iii. Blue Care	$0	-	$0	=	$0
iv. TennCare Select	$0	-	$0	=	$0
v. TennCare, MCO (Not Specified)	$0	-	$0	=	$0
vi. Other State Medicaid	$0	-	$0	=	$0
f) Medicaid/TennCare Outpatient* (for EAH use 7.c.1)	$8725247	-	$7897812	=	$827435
i. United Health Care Community Plan	$0	-	$0	=	$0
ii. Amerigroup	$0	-	$0	=	$0
iii. Blue Care	$0	-	$0	=	$0
iv. TennCare Select	$0	-	$0	=	$0
v. TennCare, MCO (Not Specified)	$0	-	$0	=	$0
vi. Other State Medicaid	$0	-	$0	=	$0
g) CoverKids	$28118	-	$25429	=	$2689
h) Other (Include TRICARE/CHAMPUS)	$120962	-	$97699	=	$23263
i) Total Government Sources	$22941820	-	$16830713	=	$6111107

*If unable to break out A1e i-vi Medicaid/TennCare Inpatient and A1f i-vi Medicaid/TennCare Outpatient, place totals in e) Medicaid/TennCare Inpatient and f) Medicaid/TennCare Outpatient
****For All schedules that contain the financial Medicare/Tenncare "breakout" section, data entered in the "breakout" lines will automatically override data entered on the main Medicare/Tenncare line once the Schedule is Saved.

A. CHARGES (continued)

	Gross Patient Charges		Adjustments To Charges		Net Patient Revenue
2. Nongovernment					
a) Self-Pay (Does not include charity care)	$ 3873962	-	$ 3840808	=	$33154
b) Blue Cross Blue Shield	$ 4146693	-	$ 3104449	=	$1042244
c) Commercial Insurers (excludes Workers Comp)	$ 8655885	-	$ 6047512	=	$2608373
d) *COMBINED Blue Cross Blue Shield and Commercial Insurers (excludes Workers Comp)	$ 12802578	-	$ 9151961	=	$3650617
e) Workers Compensation	$ 349689	-	$ 267152	=	$82537
f) Other	$ 26351	-	$ 26351	=	$0
g) Total Nongovernment Sources	$17052580	-	$13286272	=	$3766308
3. Totals					
a) Total Inpatient (excludes ONLY NORMAL Newborn)	$ 1146741				
b) Normal Newborns	$ 0				
c) Total Inpatient (includes Normal Newborn) (A3a + A3b)	$1146741	-	$ 296011	=	$850730
d) Total Outpatient	$ 38847658	-	$ 29820973	=	$9026685
e) Grand Total (A1i + A2g)	$39994400	-	$30116985	=	$9877415

4. Bad Debt		
a) Medicare Fee for Service Enrollees	$ 0	
b) Medicare Advantage Enrollees	$ 0	
c) CoverKids	$ 0	
d) TennCare/Medicaid	$ 0	
e) Other government	$ 0	
f) Self Pay	$ 0	
g) Blue Cross and Commercially Insured Patients	$ 0	
h) All Other	$ 2565514	
i) Total Bad Debt	$2565514	
5. Nongovernment Adjustments to Charges		
a) Charity Care-Inpatient	$ 0	
b) Charity Care-Outpatient	$ 198900	
Total Charity (A5a + A5b)		$198900
c) Other Adjustments, specify types	$ 0	
d) Amount of Medicare bad debt that was not reimbursed by Medicare	$ 0	
Total Charity plus Total Bad Debt (A4i + A5a + A5b)		$2764414

6. Amount of mandated discounts provided to uninsured patients $ 2741940

* Line item, 2.d. should be completed ONLY if the hospital cannot break out the data separately for Blue Cross Blue Shield and Commercial. If you complete line item 2.d. (Blue Cross Blue Shield and Commercial Insurers), items 2.b. (Blue Cross Blue Shield) and 2.c. (Commercial Insurers) should be left BLANK.

A. CHARGES (continued)

7. Other Operating Revenue	
a) Tax appropriations	$ 0
b) Local government contributions:	
1) Amount designated to offset indigent care	$ 0
2) Amount used for other	$ 0
3) Total Local Government	$ 0
c) State government contributions:	
1) Virtual DSH payments	$ 0
2) Charity Care Payments	$ 606188
a) Charity & Self-Pay Payments	$ 30716
b) Other Charity payments	$ 575472
3) Critical Access Hospital (CAH) payments	$ 1123340
a) cost based reimbursement payments	$ 723352
b) charity care payments	$ 399988
4) Medicaid Disproportionate Share Hospital (DSH)	$ 0
5) Medicaid Graduate Medical Education (GME)	$ 0
6) Medicaid Directed Payments	$ 0
7) Trauma Care Pool	$ 0
8) Public Hospital Supplemental Payment (PHSP) pool	$ 0
9) Amount used for other or amount designated for offset indigent care	$ 0
10) Total State Government	$ 1729528
d) Direct Federal government contributions	
1) Funds designated to offset financial impact during a public health emergency	$ 0
2) Amount used for other	$ 0
3) Total Direct Federal Goverment	$ 0
e) Other (include cafeteria, gift shop, etc.)	$ 34494
f) Retail Pharmacy Revenue	$ 16627
g) Total other operating revenue (A7a + A7b3 + A7c10 + A7d3 + A7e + A7f)	$ 1780649
8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2i.)	
a) Contributions	$ 0
b) Grants	$ 246631
c) Interest Income	$ 0
d) TennCare Shared Savings Payment-Hospital Only	$ 0
e) Other	$ 446219
f) Total nonoperating revenue (add A8a through A8e)	$ 692850
9. TOTAL REVENUE (Net A3e + A7g + A8f)	$ 12350914

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)	
a) Physicians and dentists (include only salaries)	$ 0
b) Medical and dental residents (include medical and dental interns)	$ 0
c) Trainees (medical technology, x-ray therapy, administrative, and so forth)	$ 0
d) Registered and licensed practical nurses	$ 1069368
e) All other personnel	$ 2919770
f) Total payroll expenses (add B1a through B1e)	$ 3989138
2. Nonpayroll Expenses	
a) Employee benefits (social security, group insurance, retirement benefits)	$ 971065
b) Professional fees	$ 1020198
1) Medical professional fees	$ 1020198
2) Other professional fees (dental, legal, auditing, consultant and so forth)	$ 0
c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies)	$ 45438
d) Depreciation expense	$ 521085
e) Interest expense	$ 105
f) Energy expense	$ 127360
g) TennCare Shared Risk Payment-Hospitals Only	$ 0
h) Retail Pharmacy Expenses	$ 0
i) All other expenses (supplies, purchased services, non-operating expenses, and so forth)	$ 2369117
j) Total non-payroll expenses (add B2a through B2i)	$ 5054368
3. TOTAL EXPENSES (add B1f + B2j)	$ 9043506
4. Net Profit or Loss (A9. Total Revenue - B3. Total Expenses)	$ 3307408
5. Are system overhead/affiliate management fees allocated to this hospital?	(•) YES ( ) NO
If yes, specify amount.	$ 1091781
Is this amount included in the expenses above?	(•) YES ( ) NO
Are system overhead/**NON-**affiliate management fees allocated to this hospital?	( ) YES (•) NO
If yes, specify amount.	$
Is this amount included in the expenses above?	( ) YES (•) NO

C. CURRENT ASSETS
1. What was your cash balance on the last day of your reporting period? $ 111095
2. What was your net accounts receivable on the last day of your reporting period? $ 1496362
3. What were your other current assets on the last day of your reporting period? $ 367627

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased)
1. Gross plant and equipment assets (including land, building, and equipment) $ 9362647
2. LESS: Deduction for accumulated depreciation $ 7548162
3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet) $ 1814485

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets)
What were your other assets on the last day of your reporting period (specified in Schedule A, Question 6)? $ 0

F. TOTAL ASSETS
Total Assets is the sum of current assets, fixed assets and other assets (F = C.1-3. + D.3 + E).
What were your total assets on the last day of your reporting period (specified in Schedule A, Question 6)? $ 3789569

G. CURRENT LIABILITIES
Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year.
What were your current liabilities on the last day of your reporting period? $

H. LONG TERM LIABILITIES
1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year.
What were your long term liabilities on the last day of your reporting period? $
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid.
What was your long term debt on the last day of your reporting period? $

I. OTHER LIABILITIES
Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).
What were your total other liabilities on the last day of your reporting period (specified in Schedule A, Question 6)? $

J. CAPITAL ACCOUNT
Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds.
The Capital Account is the excess of assets over its liabilities.
What was your capital account on the last day of your reporting period? $ 3789569

K. Total Liabilities plus Capital Account $ 3789569
Note: TOTAL ASSETS SHOULD EQUAL LIABILITIES PLUS CAPITAL ACCOUNT (i.e. item F = G + H.1 + H.2 + I + J).

L. 1. Federal Income Tax: $

2. Local Property Taxes Paid During the Reporting Period:
a) Taxes on the Inpatient Facility $
b) Taxes on all Other Property $

3. Other Local, State, or Federal Taxes: (exclude sales tax) $

M. Does your hospital bill include charges incurred for the following professional services?
Radiology - ○ YES ◉ NO Pathology - ○ YES ◉ NO Anesthesiology - ○ YES ◉ NO
Surgery - ○ YES ◉ NO Urology - ○ YES ◉ NO Emergency Department - ○ YES ◉ NO

Other - Specify

1. PLEASE GIVE THE NUMBER OF:
   A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD (exclude beds in a sub-acute unit that are licensed as nursing home beds) 25
   B. The number of adult and pediatric staffed beds set up, staffed and in use on a typical day. 17
   C. Licensed Beds that were not staffed during the reporting period. 8
   D. Licensed beds that could not be put into use within 24-48 hours 0

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):
   Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ○ YES ◉ NO
   If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

Bed change (+ or -)	Bed change (+ or -)	Bed change (+ or -)	Bed change (+ or -)
Date: Month Day Year	Date: Month Day Year	Date: Month Day Year	Date: Month Day Year

3. SWING BEDS:
   A. Does your facility utilize swing beds? ◉ YES ○ NO
   If yes, number of Acute Care beds designated as Swing Beds. 2
   B. PLEASE SPECIFY THE FOLLOWING FOR SWING BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay		
TennCare		
Other		
Total	0	0

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial	0	0
Blue Cross	0	0
Medicare	9	128
Private Pay	0	0
Other	0	0
Total	9	128

4. A. Number of Beds Set up and Staffed on a Typical Day	Number of Beds
Burn	
Cardiology (TOTAL)	0
Cardiology - adult patients	
Cardiology - pediatric patients	
Substance Use Disorder (TOTAL)	0
Substance Use Disorder specifically for children and youth patients	
Substance Use Disorder specifically for adult patients	
Substance Use Disorder specifically for geriatric patients	
Chronic/Extended Care	
Eye	
Gynecological	
Intensive Care (excluding neonatal)	
Medical	15
Medical/Surgical	
Licensed Neonatal Care/NICU (Level II-IV)	
Neurology	
OB/GYN	
Obstetrics	
Orthopedic	
Palliative Care Inpatient Unit	
Pediatric	
Psychiatric (TOTAL)	0
Psychiatric specifically for children and youth patients	
(specific age range based on hospital's preference)	
Psychiatric specifically for adult patients	
(specific age range based on hospital's preference)	
Psychiatric specifically for geriatric patients	
(specific age range based on hospital's preference)	
Pulmonary	
Rehabilitation	
Surgical	
Swing Beds (for long term skilled or intermediate care)	2
Urology	
Other, specify . .	
Unassigned	
TOTAL (This total should equal 1.B.)	17

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. 1

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for observation? (•) YES ( ) NO
If yes, number of beds 15 number of patients 99 number of patient days 100

B. Do you have beds assigned to a dedicated observation unit? ( ) YES (•) NO
If yes, number of beds _____ number of patients _____ number of patient days _____

C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and observation? ( ) YES (•) NO
If yes, number of beds _____ number of patients _____ number of patient days _____

1. INPATIENT UTILIZATION (include normal newborns)
Patient Census Records:
Please indicate whether you are reporting
Admissions and Inpatient Days ○ **or Discharges and Discharge Patient Days** ◉

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System	1	4
02 Eye	0	0
03 Ear, Nose, Mouth and Throat	1	1
04 Respiratory System	13	31
05 Circulatory System	1	2
06 Digestive System	3	29
07 Hepatobiliary System & Pancreas	8	18
08 Musculoskeletal Sys. & Connective Tissue	5	100
09 Skin, Subcutaneous Tissue & Breast	2	5
10 Endocrine, Nutritional & Metabolic	1	2
11 Kidney & Urinary Tract	11	28
12 Male Reproductive System	0	0
13 Female Reproductive System	0	0
14 Pregnancy, Childbirth & the Puerperium	0	0
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period	0	0
16 Blood and Blood Forming Organs and Immunological Disorders	1	1
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms	0	0
18 Infectious & Parasitic Diseases	9	21
19 Mental Diseases & Disorders	0	0
20 Alcohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders	0	0
21 Injuries, Poisoning, & Toxic Effects of Drugs	0	0
22 Burns	0	0
23 Factors Influencing Health Status and Other Contacts with Health Services (Rehabilitation hospitals enter data here)	4	37
24 Multiple Significant Trauma	0	0
25 Human Immunodeficiency Virus Infections	0	0
26 Other DRGs Associated with All MDCs	0	0
TOTAL	60	279

3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns -- see Instructions)

Patients should be categorized according to primary payer and counted only once.

Please indicate whether you are reporting **Admissions and Inpatient Days** ○ **or Discharges and Discharge Patient Days** ◉

	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
I. Government:			
a. Medicare Inpatient - Fee for Service	21	172	0
b. Medicare Advantage - Inpatient	18	60	0
c. Medicare Outpatient - Fee for Service	0	0	1452
d. Medicare Advantage - Outpatient	0	0	2980
e. Medicaid/TennCare Inpatient	6	14	0
i. United Health Care Community Plan	3	8	0
ii. Amerigroup	1	3	0
iii. Blue Care	0	0	0
iv. TennCare Select	2	3	0
v. TennCare, MCO (Not Specified)	0	0	0
vi. Other State Medicaid	0	0	0
f. Medicaid/TennCare Outpatient	0	0	3845
i. United Health Care Community Plan	0	0	1160
ii. Amerigroup	0	0	862
iii. Blue Care	0	0	1660
iv. TennCare Select	0	0	95
v. TennCare, MCO (Not Specified)	0	0	0
vi. Other State Medicaid	0	0	68
g. CoverKids - Inpatient	0	0	0
h. CoverKids - Outpatient	0	0	10
i. Other (Include TRICARE/CHAMPUS)	0	0	42
II. Nongovernment:			
a. Self-Pay - Inpatient	2	4	0
b. Self-Pay - Outpatient	0	0	1208
c. Blue Cross Blue Shield - Inpatient	3	5	0
d. Blue Cross Blue Shield - Outpatient	0	0	1523
e. Commercial Insurers (excludes Workers Compensation) - Inpatient	10	24	0
f. Commercial Insurers (excludes Workers Compensation) - Outpatient	0	0	3304
g. *COMBINED Blue Cross Blue Shield and Commercial Insurers (excludes Workers Comp) - Inpatient	13	29	0
h. *COMBINED Blue Cross Blue Shield and Commercial Insurers (excludes Workers Comp) - Outpatient	0	0	4827
i. Workers Compensation - Inpatient	0	0	0
j. Workers Compensation - Outpatient	0	0	138
k. Other - Inpatient	0	0	0
l. Other - Outpatient	0	0	8
TOTAL	60	279	14510

* Should include onsite emergency department visits and hospital outpatient visits. (This total should be greater than the ED total, Schedule I.)

Total in #3 should match Grand Total in #4

*** FOR OUTPATIENT CATEGORIES, REPORT UNDUPLICATED NUMBER OF PATIENTS RECEIVING OUTPATIENT SERVICES IN THIS COLUMN.

**Line item, II.d. should be completed ONLY if the hospital cannot break out the data separately for Blue Cross Blue Shield and Commercial.

If you complete line item II.d. (Blue Cross Blue Shield and Commercial Insurers), items II.b. (Blue Cross Blue Shield) and II.c. (Commercial Insurers) should be left BLANK.

*Outpatient visits refers to the number of individual/independent encounters for a patient in the outpatient setting, regardless of the numbers of procedures. The intent is to capture the number of times a patients presents to an outpatient setting, not the number of procedures.

Year 2024

SCHEDULE G - UTILIZATION (continued)

35215 - West Tennessee Healthcare Bolivar Hospital

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns -- see Instructions)

Please indicate whether you are reporting

Admissions and Inpatient Days ○ **or Discharges and Discharge Patient Days** ◉

Age	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*	FREESTANDING EMERGENCY DEPARTMENT VISITS
Under 15 years	0	0	1546	0
15-17 years	0	0	373	0
18-64 years	27	56	9272	0
65-74 years	7	17	1907	0
75-84 years	18	103	1065	0
85 years & older	8	103	347	0
GRAND TOTAL	60	279	14510	0

* Should include onsite emergency department visits and hospital outpatient visits and visits to off-site hospital-based clinics.

5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)
Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting **Admissions and Inpatient Days** ○ **or Discharges and Discharge Patient Days** ◉

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
1	Anderson		
2	Bedford		
3	Benton		
4	Bledsoe		
5	Blount		
6	Bradley		
7	Campbell		
8	Cannon		
9	Carroll		
10	Carter		
11	Cheatham		
12	Chester		
13	Claiborne		
14	Clay		
15	Cocke		
16	Coffee		
17	Crockett		
18	Cumberland		
19	Davidson		
20	Decatur		
21	DeKalb		
22	Dickson		
23	Dyer		
24	Fayette	2	4
25	Fentress		
26	Franklin		
27	Gibson		
28	Giles		

5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger		
30	Greene		
31	Grundy		
32	Hamblen		
33	Hamilton		
34	Hancock		
35	Hardeman	52	259
36	Hardin		
37	Hawkins		
38	Haywood		
39	Henderson		
40	Henry		
41	Hickman		
42	Houston		
43	Humphreys		
44	Jackson		
45	Jefferson		
46	Johnson		
47	Knox		
48	Lake		
49	Lauderdale	1	2
50	Lawrence		
51	Lewis		
52	Lincoln		
53	Loudon		
54	McMinn		
55	McNairy	4	11
56	Macon		
57	Madison	1	3
58	Marion		
59	Marshall		
60	Maury		
61	Meigs		
62	Monroe		

5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery		
64	Moore		
65	Morgan		
66	Obion		
67	Overton		
68	Perry		
69	Pickett		
70	Polk		
71	Putnam		
72	Rhea		
73	Roane		
74	Robertson		
75	Rutherford		
76	Scott		
77	Sequatchie		
78	Sevier		
79	Shelby		
80	Smith		
81	Stewart		
82	Sullivan		
83	Sumner		
84	Tipton		
85	Trousdale		
86	Unicoi		
87	Union		
88	Van Buren		
89	Warren		
90	Washington		
91	Wayne		
92	Weakley		
93	White		
94	Williamson		
95	Wilson		
96	TN County Unknown		
	Tennessee Total	60	279

5. PATIENT ORIGIN (continued)

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital.

If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

State County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify) 1)	0	0
2)	0	0
Other Alabama Counties	0	0
Alabama Total	0	0
GEORGIA COUNTIES: (Specify) 1)	0	0
2)	0	0
Other Georgia Counties	0	0
Georgia Total	0	0
MISSISSIPPI COUNTIES: (Specify) 1)	0	0
2)	0	0
Other Mississippi Counties	0	0
Mississippi Total	0	0
ARKANSAS COUNTIES: (Specify) 1)	0	0
2)	0	0
Other Arkansas Counties	0	0
Arkansas Total	0	0

5. PATIENT ORIGIN (continued)

State County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
MISSOURI COUNTIES: (Specify) 1)	0	0
2)	0	0
Other Missouri Counties	0	0
Missouri Total	0	0
KENTUCKY COUNTIES: (Specify) 1)	0	0
2)	0	0
Other Kentucky Counties	0	0
Kentucky Total	0	0
VIRGINIA COUNTIES: (Specify) 1)	0	0
2)	0	0
Other Virginia Counties	0	0
Virginia Total	0	0
NORTH CAROLINA COUNTIES: (Specify) 1)	0	0
2)	0	0
Other North Carolina Counties	0	0
North Carolina Total	0	0
OTHER STATES: (Specify) 1)	0	0
2)	0	0
All Other States and Counties	0	0
RESIDENCE UNKNOWN:	0	0
GRAND TOTAL*	60	279

*Grand Total should equal the sum of each state total including Tennessee total.

1. TYPE OF UNIT-PSYCHIATRIC:
A. Do you have a dedicated psychiatric unit? ○ YES ◉ NO
If yes, please complete items on this page and on the next page
1. Total number of licensed beds _____
2. Total number of staffed beds _____
3. Year unit opened _____

2. COMPOSITION OF PSYCHIATRIC UNITS:
A. Do you have a Gero-psychiatric unit? ○ YES ○ NO If yes, please answer the following
1. Total number of licensed beds _____
2. Total number of staffed beds _____
3. Year unit opened _____

B. Do you have a child and/or adolescent psychiatric unit? ○ YES ○ NO If yes, please answer the following
1. Total number of licensed beds _____
2. Total number of staffed beds _____
3. Year unit opened _____

3. UTILIZATION BY AGE GROUPS:
Please indicate if you are reporting ○ **Admissions and Inpatient Days** or ○ **Discharges and Discharge Patient Days**

	Inpatient		Partial Care		Intensive Outpatient (IOP)		
AGE GROUPS	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Patients	Number of Service Days	Number of Visits	Number of Patients	Number of Service Days
Ages 0-12								
Ages 13-17								
Ages 18-64								
Ages 65 and older								
Total	0	0	0	0	0	0	0	0

4. Is the psychiatric service managed under a management contract different from the hospital itself? ○ YES ○ NO
If yes,please specify name of organization that manages the unit _____

5. Does the hospital use the following: If Yes, please complete

		Total Hours				**Total Inpatient Days**			
Choices	Ages	0-12	13-17	18-64	65+	0-12	13-17	18-64	65+
A. Restraints ○ YES ○ NO									
B. Seclusion ○ YES ○ NO									

6. Does your facility accept involuntary admissions? ○ YES ○ NO

*If Yes, what is the number of involuntary admissions accepted during the reporting period? _____

*Note: Patients deeemed involuntary at the time of the initial admission to the facility.

Note: ACUTE CARE HOSPITALS: Complete this section in its entirety if you are an acute care hospital with a psychiatric unit.
Note: FREESTANDING PSYCHIATRIC HOSPITALS: Complete items 1-6 of this schedule. Do NOT complete this financial data section in Schedule H.

All financial data should be reported in Schedule E ONLY.

7. FINANCIAL DATA-PSYCHIATRIC

1. Government	Inpatient Charges		Outpatient Charges		Gross Patient Charges		Adjustments to Charges		Net Patient Revenue
a) Medicare Inpatient-Fee for Service	0	+	0	=	$ 0	-	0	=	$ 0
b) Medicare Advantage-Inpatient	0	+	0	=	$ 0	-	0	=	$ 0
c) Medicare Outpatient-Fee for Service	0	+	0	=	$ 0	-	0	=	$ 0
d) Medicare Advantage-Outpatient	0	+	0	=	$ 0	-	0	=	$ 0
e) Medicaid/TennCare Inpatient	0	+	0	=	$ 0	-	0	=	$ 0
i) United Health Care Community Plan	0	+	0	=	$ 0	-	0	=	$ 0
ii.) Amerigroup	0	+	0	=	$ 0	-	0	=	$ 0
iii.) Blue Care	0	+	0	=	$ 0	-	0	=	$ 0
iv.) TennCare Select	0	+	0	=	$ 0	-	0	=	$ 0
v.) TennCare MCO (Not Specified)	0	+	0	=	$ 0	-	0	=	$ 0
vi.) Other State Medicaid	0	+	0	=	$ 0	-	0	=	$ 0
f) Medicaid/TennCare Outpatient	0	+	0	=	$ 0	-	0	=	$ 0
i) United Health Care Community Plan	0	+	0	=	$ 0	-	0	=	$ 0
ii.) Amerigroup	0	+	0	=	$ 0	-	0	=	$ 0
iii.) Blue Care	0	+	0	=	$ 0	-	0	=	$ 0
iv.) TennCare Select	0	+	0	=	$ 0	-	0	=	$ 0
v.) TennCare MCO (Not Specified)	0	+	0	=	$ 0	-	0	=	$ 0
vi.) Other State Medicaid	0	+	0	=	$ 0	-	0	=	$ 0
g.) Coverkids	0	+	0	=	$ 0	-	0	=	$ 0
h.) Tricare/Champus	0	+	0	=	$ 0	-	0	=	$ 0
i.) Other	0	+	0	=	$ 0	-	0	=	$ 0
j.) Total Government Sources	$ 0	+	$ 0	=	$ 0	-	$ 0	=	$ 0
2. Non Government									
a.) Self-Pay	0	+	0	=	$ 0	-	0	=	$ 0
b.) Blue Cross Blue Shield	0	+	0	=	$ 0	-	0	=	$ 0
c.) Commercial Insurers (excludes Workers Comp)	0	+	0	=	$ 0	-	0	=	$ 0
d.) Combined BlueCross Blue Shield and Commercial Insurers	0	+	0	=	$ 0	-	0	=	$ 0
e.) Workers Compensation	0	+	0	=	$ 0	-	0	=	$ 0
f.) Other	0	+	0	=	$ 0	-	0	=	$ 0
g.) Total Nongovernment Sources	$ 0	+	$ 0	=	$ 0	-	$ 0	=	$ 0

8. Do you have contracts with an entity where you accept full or partial financial risk for the care of a group of patients
○ Yes ○ No

If yes, please list with whom. _____

*If unable to break out 7 1e i-vi Medicaid/TennCare Inpatient and 7 1f i-vi Medicaid/TennCare Outpatient, place totals in e) Medicaid/TennCare Inpatient and f) Medicaid/TennCare Outpatient

For All schedules that contain the financial Medicare/Tenncare "breakout" section, data entered in the "breakout" lines will automatically override data entered on the main Medicare/Tenncare line once the Schedule is Saved

1. TYPE OF UNIT-SUBSTANCE USE DISORDER(SUD):
A. Do you have a dedicated SUD unit? ○ YES ◉ NO If yes, please complete items on this page and on the next page
2. BED:
A. Total number of assigned beds _____
B. Year unit opened _____

	Inpatient		Partial Care			Intensive Outpatient (IOP)			Residential Care	
AGE GROUPS	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Patients	Number of Service Days	Number of Visits	Number of Patients	Number of Service Days	Number of Patients	Number of Patient Days
Ages 0-12										
Ages 13-17										
Ages 18-64										
Ages 65 and older										
Total	0	0	0	0	0	0	0	0	0	0

4. Is the substance use disorder managed under a management contract different from the hospital itself? ○ YES ○ NO
If yes,please specify name of organization that manages the unit _____

5. Does the hospital use the following: If Yes, please complete

	Total Hours				**Total Inpatient Days**			
Choices	Ages0-12	13-17	18-64	65+	0-12	13-17	18-64	65+
A. Restraints ○ YES ○ NO								
B. Seclusion ○ YES ○ NO								

6. Does your facility accept involuntary admissions? ○ YES ○ NO

*If Yes, what is the number of involuntary admissions accepted during the reporting period? _____

*Note: Patients deeemed involuntary at the time of the initial admission to the facility.

Note: ACUTE CARE HOSPITALS: Complete this section in its entirety if you are an acute care hospital with a psychiatric unit.
Note: FREESTANDING PSYCHIATRIC HOSPITALS: Complete items 1-6 of this schedule. Do NOT complete this financial data section in Schedule H.

All financial data should be reported in Schedule E ONLY.

7. FINANCIAL DATA-SUBSTANCE USE DISORDER (SUD)

1. Government	Inpatient Charges		Outpatient Charges		Gross Patient Charges		Adjustments to Charges		Net Patient Revenue
a) Medicare Inpatient-Fee for Service		+		=	$ 0	-		=	$ 0
b) Medicare Advantage-Inpatient		+		=	$ 0	-		=	$ 0
c) Medicare Outpatient-Fee for Service		+		=	$ 0	-		=	$ 0
d) Medicare Advantage-Outpatient		+		=	$ 0	-		=	$ 0
e) Medicaid/TennCare Inpatient		+		=	$ 0	-		=	$ 0
i) United Health Care Community Plan		+		=	$ 0	-		=	$ 0
ii.) Amerigroup		+		=	$ 0	-		=	$ 0
iii.) Blue Care		+		=	$ 0	-		=	$ 0
iv.) TennCare Select		+		=	$ 0	-		=	$ 0
v.) TennCare MCO (Not Specified)		+		=	$ 0	-		=	$ 0
vi.) Other State Medicaid		+		=	$ 0	-		=	$ 0
f) Medicaid/TennCare Outpatient		+		=	$ 0	-		=	$ 0
i) United Health Care Community Plan		+		=	$ 0	-		=	$ 0
ii.) Amerigroup		+		=	$ 0	-		=	$ 0
iii.) Blue Care		+		=	$ 0	-		=	$ 0
iv.) TennCare Select		+		=	$ 0	-		=	$ 0
v.) TennCare MCO (Not Specified)		+		=	$ 0	-		=	$ 0
vi.) Other State Medicaid		+		=	$ 0	-		=	$ 0
g.) Coverkids		+		=	$ 0	-		=	$ 0
h.) Tricare/Champus		+		=	$ 0	-		=	$ 0
i.) Other		+		=	$ 0	-		=	$ 0
j.) Total Government Sources	0	+	0	=	0	-	0	=	0
2. Non Government									
a.) Self-Pay		+		=	$ 0	-		=	$ 0
b.) Blue Cross Blue Shield		+		=	$ 0	-		=	$ 0
c.) Commercial Insurers (excludes Workers Comp)		+		=	$ 0	-		=	$ 0
d.) Combined BlueCross Blue Shield and Commercial Insurers		+		=	$ 0	-		=	$ 0
e.) Workers Compensation		+		=	$ 0	-		=	$ 0
f.) Other		+		=	$ 0	-		=	$ 0
g.) Total Nongovernment Sources	$ 0	+	$ 0	=	$ 0	-	$ 0	=	$ 0

8. Do you have contracts with an entity where you accept full or partial financial risk for the care of a group of patients
○ YES ○ NO
If yes, please list with whom. _____

*If unable to break out 7 1e i-vi Medicaid/TennCare Inpatient and 7 1f i-vi Medicaid/TennCare Outpatient, place totals in e) Medicaid/TennCare Inpatient and f) Medicaid/TennCare Outpatient
For All schedules that contain the financial Medicare/Tenncare "breakout" section, data entered in the "breakout" lines will automatically override data entered on the main Medicare/Tenncare line once the Schedule is Saved

1. Does your hospital operate an emergency department? (•) YES ( ) NO If NO, skip to Schedule J.

2. What is the direct telephone number into your emergency department? 7316950240

3. Is the Emergency Department managed under a management contract different from the hospital itself? ( ) YES (•) NO
If yes, with whom is the contract held?

4. Emergency Department:

	Number of Patients	Number of Visits by Payer
1. Government		
a) Medicare - Fee for Service	519	791
b) Medicare Advantage	958	1805
c) Medicaid/TennCare	2024	3184
i. United Health Care Community Plan	553	909
ii. Amerigroup	499	769
iii. Blue Care	853	1358
iv. TennCare Select	62	80
v. TennCare, MCO (Not Specified)		
vi. Other State Medicaid	57	68
d) CoverKids	8	10
e) Other Government	24	31
f) Total Government Sources	3533	5821
2. Non-Government		
a) Self-Pay	785	1109
b) Blue Cross Blue Shield	766	1064
c) Commercial Insurers (excludes Workers Comp)	1357	1915
d) *COMBINED Blue Cross Blue Shield and Commercial Insurers (excludes Workers Comp)	2123	2979
e) Workers Compensation	110	116
f) Other Non-Government	5	7
g) Total Non-Government Sources	3023	4211
3. Total (incl. Government and Non-Government)	6556	10032

*If unable to break out 4.1c i-vi Medicaid/TennCare, place totals in c) Medicaid/TennCare

***For All schedules that contain the financial Medicare/Tenncare "breakout" section, data entered in the "breakout" lines will automatically override data entered on the main Medicare/Tenncare line once the Schedule is Saved

5. Is your Emergency Department staffed 24 hours per day? (•) YES ( ) NO

If no, please give hours covered per day. _____

6. Total number of treatment rooms 9

Of the total number of treatment rooms, how many could NOT be put into use within 24-48 hours? 0

7. Indicate the number of the following personnel available in the hospital on a normal day and how many are available to the Emergency Department.

	ON HOSPITAL CAMPUS	IN EMERGENCY DEPARTMENT
A. PHYSICIANS:		
Board certified in Emergency Medicine		1
Board eligible in Emergency Medicine		
Declared Specialty of Emergency Medicine		
Board Certified Psychiatrists		
Other Physicians Available to Emergency Department		
B. NURSES:		
Nurse Practitioners		
R.N.'s with formal emergency training and experience		
Other R.N.'s	11	8
L.P.N.'s and other nursing support personnel	5	1
Clerical Staff	3	2
C. OTHER:		
E.M.T.		
E.M.T. advanced		
Physician Assistant (PA)		
Dedicated ED Pharmacist		

**Line item, 4.2.d. should be completed ONLY if the hospital cannot break out the data separately for Blue Cross Blue Shield and Commercial.
If you complete line item 4.2.d. (Blue Cross Blue Shield and Commercial Insurers),
items 4.2.b. (Blue Cross Blue Shield) and 4.2.c. (Commercial Insurers) should be left BLANK.

8. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in Emergency Department with Access to:		
Central Emergency Dispatch Center	◉	○
Ambulances	◉	○
Other hospitals	◉	○
B. HELIPORT:	◉	○
C. PHARMACY IN EMERGENCY DEPARTMENT: (Pharmacy=dispensing of drugs to patients for take home use)	○	◉
D. BLOOD BANK (check ONLY one):		
Fully stocked	○	◉
Common blood types only	◉	○

9. Do you have dedicated centers for the provision of specialized emergency care for the following:
   A. Designated Trauma Center ○ YES ◉ NO
      If yes, what level of designation _____
   B. Burns ○ YES ◉ NO
      If yes, do you have a verification by the American Burn Association/American College of Surgeons (ABA/ACS) review program as a Burn Center? ○ YES ○ NO
      If you do not have verification by the ABA/ACS, do you have designation as a burn center by an other agency? ○ YES ○ NO
      If yes, specify the agency name. _____
   C. Pediatrics
      Please specify the classification of pediatric service:

Comprehensive Regional Pediatric Center (CRPC)	○ YES	◉ NO
Basic Pediatric Emergency Facility	◉ YES	○ NO
General Pediatric Emergency Facility	○ YES	◉ NO
Primary Pediatric Emergency Facility	○ YES	◉ NO

   D. Other, specify _____

10. Triage:
   A. Total number of patients who presented in your Emergency Department. 10336
   B. Total number treated in your Emergency Department. 10032
   C. Total number not treated in the Emergency Department but referred to physician or clinic for treatment. 0
   D. Total number of patients admitted to inpatient from Emergency Department. 51
   E. Total number of patients admitted to observation from Emergency Department. 93
   F. Total number of patients screened in the Emergency Department and transferred to another hospital:
      Acute Care Hospital 658
      Specialty Hospital 165

1. Does your hospital operate a freestanding emergency department? ○ YES ◉ NO If NO, skip to Schedule J.
   If yes, name of facility _____

2. Location:
   Street address: _____
   Facility City: _____ State: Empty Zip: _____

   Direct telephone number into your Emergency Department: _____

3. Is the Emergency Department managed under a management contract different from the hospital itself? ○ YES ○ NO
   If yes, with whom is the contract held? _____

4. Emergency Department:

	Number of Patients	Number of Visits by Payer
1. Government		
a) Medicare - Fee for Service		
b) Medicare Advantage		
c) Medicaid/TennCare*		
i. United Health Care Community Plan		
ii. Amerigroup		
iii. Blue Care		
iv. TennCare Select		
v. TennCare, MCO (Not Specified)		
vi. Other State Medicaid		
d) CoverKids		
e) Other Goverment		
f) Total Government Sources	0	0
2. Non-Government		
a) Self-Pay		
b) Blue Cross Blue Shield		
c) Commercial Insurers (excludes Workers Comp)		
d) *COMBINED Blue Cross Blue Shield and Commercial Insurers (excludes Workers Comp)		
e) Workers Compensation		
f) Other Non-Government		
g) Total Non-Government Sources	0	0
3. Total (incl. Government and Non-Government)	0	0

*If unable to break out 4.1c i-vi Medicaid/TennCare, place totals in c) Medicaid/TennCare.

***For All schedules that contain the financial Medicare/Tenncare "breakout" section, data entered in the "breakout" lines will automatically override data entered on the main Medicare/Tenncare line once the Schedule is Saved

5. Is your freestanding emergency department staffed 24 hours per day? ○ YES ○ NO
   If no, please give hours covered per day. _____

6. Total number of treatment rooms _____
   Of the total number of treatment rooms, how many could NOT be put into use within 24-48 hours? _____

7. Indicate the number of the following personnel available in the freestanding emergency department on a normal day.

	On Freestanding ED Campus
A. PHYSICIANS:	
Board certified in Emergency Medicine	
Board eligible in Emergency Medicine	
Declared Specialty of Emergency Medicine	
Board Certified Psychiatrists	
Other Physicians Available to Emergency Department	
B. NURSES:	
Nurse Practitioners	
R.N.'s with formal emergency training and experience	
Other R.N.'s	
L.P.N.'s and other nursing support personnel	
Clerical Staff	
C. OTHER:	
E.M.T.	
E.M.T. advanced	
Physician Assistant (PA)	
Dedicated ED Pharmacist	

**Line item, 4.2.d. should be completed ONLY if the hospital cannot break out the data separately for Blue Cross Blue Shield and Commercial.
If you complete line item 4.2.d. (Blue Cross Blue Shield and Commercial Insurers),
items 4.2.b. (Blue Cross Blue Shield) and 4.2.c. (Commercial Insurers) should be left BLANK.

8. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in Emergency Department with Access to:		
Central Emergency Dispatch Center	○	○
Ambulances	○	○
Other hospitals	○	○
B. HELIPORT:	○	○
C. PHARMACY IN EMERGENCY DEPARTMENT: (Pharmacy=dispensing of drugs to patients for take home use)	○	○
D. BLOOD BANK (check ONLY one):		
Fully stocked	○	○
Common blood types only	○	○

9. Does the freestanding emergency department have dedicated centers for the provision of specialized emergency care for the following:
   A. Trauma ○ YES ○ NO
   B. Pediatrics
      Please specify the classification of pediatric service:
      - Comprehensive Regional Pediatric Center (CRPC) ○ YES ○ NO
      - Basic Pediatric Emergency Facility ○ YES ○ NO
      - General Pediatric Emergency Facility ○ YES ○ NO
      - Primary Pediatric Emergency Facility ○ YES ○ NO

   C. Other, specify _____

10. Triage:
    A. Total number of patients who presented in your freestanding emergency department. _____
    B. Total number treated in your freestanding emergency department. _____
    C. Total number not treated in the freestanding emergency department but referred to physician or clinic for treatment. _____
    D. Total number of patients admitted to inpatient from freestanding emergency department. _____
    E. Total number of patients admitted to observation from freestanding emergency department. _____
    F. Total number of patients screened in the freestanding emergency department and transferred to another hospital:
       Acute Care Hospital _____
       Specialty Hospital _____

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES

	Full Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***	Available in Central Location but not on Hospital Campus
1. Administrators:				
A. Administrators & Assistants . .	1.06	0.00	☐	☐
B. Director, Health Services Research & Assistants	0.00	0.00	☐	☐
C. Marketing & Planning Officer(s) and Assistants	0.00	0.00	☐	☐
D. Financial and Accounting Officers(s)& Assistants	0.00	0.00	☐	☐
2. Physician and Dental Services:				
A. Physicians (TOTAL)	0.00	0.00	☐	☐
I. Hospitalists	0.00	0.00	☐	☐
II. Intensivists	0.00	0.00	☐	☐
III. General Practitioners	0.00	0.00	☐	☐
IV General Internal Medicine	0.00	0.00	☐	☐
V. Family Practice	0.00	0.00	☐	☐
VI. General Pediatrics	0.00	0.00	☐	☐
VII. Obstetrics/Gynecology	0.00	0.00	☐	☐
VIII. Neonatalogists	0.00	0.00	☐	☐
IX. Geriatrics	0.00	0.00	☐	☐
X. General Surgery	0.00	0.00	☐	☐
XI. Surgical Specialists	0.00	0.00	☐	☐
XII. Other Medical Specialists	0.00	0.00	☐	☐
XIII. Other	0.00	0.00	☐	☐
B. Medical Residents(including subspecialty fellows)	0.00	0.00	☐	☐
C. Dentists	0.00	0.00	☐	☐
D. Dental Residents	0.00	0.00	☐	☐

** Full-time + Part-time specified in Full Time Equivalent
*** Please check if contract staff is used.

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES (continued)

	Full Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***	Available in Central Location but not on Hospital Campus
3. Nursing Services:				
A. RN's-Administrative(TOTAL) . . .	1.94	0.99	☐	☐
I. RN's-Administrative-Associates	1.94	0.99	☐	☐
II. RN's-Administrative-Bachelors	0.00	0.00	☐	☐
III. RN's-Administrative-Masters or higher education	0.00	0.00	☐	☐
IV. RN's-Administrative-Clinical Specialists	0.00	0.00	☐	☐
B. RN's-Patient Care/Clinical (TOTAL) . . .	8.98	0.00	☐	☐
I. RN's-Patient Care/Clinical-Associates	5.63	0.00	☑	☐
II. RN's-Patient Care/Clinical-Bachelors	3.35	0.00	☑	☐
C. LPNs . . .	2.65	1.01	☐	☐
D. Ancillary Nursing Personnel . . .	1.88	0.10	☐	☐
4. Certified Nurse Midwives	0.00	0.00	☐	☐
5. Certified Registered Nurse Anesthetists	0.00	0.00	☐	☐
6. Physicians Assistants . . .	0.00	0.00	☐	☐
7. Nurse Practitioners	0.00	0.00	☐	☐

** Full-time + Part-time specified in Full Time Equivalent
*** Please check if contract staff is used.

	Full Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***	Available in Central Location but not on Hospital Campus
8. HIM/HIT Specialists:				
A. Registered Health Information Administrator (RHIA)	0.00	0.00	☐	☐
B. Registered Health Information Technician(RHIT)	0.00	0.00	☐	☐
C. Certified Coding Associate(CCA)	0.00	0.00	☐	☐
D. Certified Coding Specialist(CCS)	0.00	0.00	☐	☐
E. Certified Coding Specialist-Physician-based(CCS-P)	0.00	0.00	☐	☐
F. Certified in Healthcare Privacy and Security(CHPS)	0.00	0.00	☐	☐
G. Certified Documentation Improvement Practitioner(CDIP)	0.00	0.00	☐	☐
H. Certified Professional in Health Information Technology (CPHIT)	0.00	0.00	☐	☐
I. Certified Professional in Electronic Health Records (CPEHR)	0.00	0.00	☐	☐
J. Certified Professional in Health Information Exchange(CPHIE)	0.00	0.00	☐	☐
K. Certified Professional in Operating Rules Administration(CPORA)	0.00	0.00	☐	☐
L. Certified Health Data Analyst(CHDA)	0.00	0.00	☐	☐
M. Certified Healthcare Technology Specialist(CHTS)	0.00	0.00	☐	☐
N. Other Medical Record/HIM Personnel	0.99	1.00	☐	☐

** Full-time + Part-time specified in Full Time Equivalent
*** Please check if contract staff is used.

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES (continued)

	Full Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***	Available in Central Location but not on Hospital Campus
9. Pharmacy:				
A. Pharmacists, Licensed . . .	1.02	0.01	☐	☐
B. Pharmacy Technicians . . .	0.57	0.00	☐	☐
C. Clinical Pharm-D	0.00	0.00	☐	☐
10. Clinical Laboratory Services:				
A. Medical Lab Technologists	4.74	0.00	☑	☐
B. Medical Lab Technicians .	0.00	0.00	☐	☐
C. Other Laboratory Personnel	1.09	0.09	☐	☐
11. Dietary Services:				
A. Dietitians	1.70	0.00	☐	☐
B. Dietetic Technicians	1.81	0.00	☐	☐
12. Radiological Services:				
A. Radiographers (radiologic technologists)	8.14	1.38	☐	☐
B. Radiation Therapy Technologists	0.00	0.00	☐	☐
C. Nuclear Medicine Technologists	0.00	0.00	☐	☐
D. Medical Sonographer . . .	0.00	0.50	☐	☐
E. Other Imaging/Radiologic Personnel	0.00	0.00	☐	☐
13. Therapeutic Services:				
A. Occupational Therapists .	0.01	0.01	☐	☐
B. Occupational Therapy Assistants	0.00	0.00	☐	☐
C. Physical therapists	0.99	0.00	☐	☐
D. Physical Therapy Assistants	0.99	0.00	☐	☐
E. Recreational Therapists .	0.00	0.00	☐	☐
14. Speech and Hearing Services:				
A. Speech Pathologist	0.00	0.00	☐	☐
B. Audiologist	0.00	0.00	☐	☐

** Full-time + Part-time specified in Full Time Equivalent

*** Please check if contract staff is used.

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES (continued)

	Full Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***	Available in Central Location but not on Hospital Campus
15. Respiratory Therapy Services:				
A. Respiratory Therapists . .	2.24	0.00	☐	☐
B. Respiratory Therapy Technicians	0.59	0.29	☐	☐
16. Behavioral Health Services:				
A. Clinical Psychologists . . .	0.00	0.00	☐	☐
B. Psychiatric Social Workers	0.00	0.00	☐	☐
C. Psychiatric Registered nurses	0.00	0.00	☐	☐
D. Psychiatric Advanced Practice Registered Nurses	0.00	0.00	☐	☐
E. Other Mental Health Professionals	0.00	0.00	☐	☐
17. Licensed Clinical Social Workers	0.00	0.00	☐	☐
18. Other Medical Social Workers	0.00	0.00	☐	☐
19. Surgical Technicians . . .	0.00	0.00	☐	☐
20. All other licensed/certified professional & technical	2.67	0.82	☐	☐
21. All other non-certified professional & technical	0.00	0.00	☐	☐
22. All other personnel	12.28	0.36	☐	☐
TOTAL	56.34	6.56		

** Full-time + Part-time specified in Full Time Equivalent
*** Please check if contract staff is used.

1. Report the total number of physicians with privileges at your hospital by type of relationship with the hospital.

	(1) Total Employed	(2) Total Individual Contracts	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) TOTAL PRIVILEGED (sum 1-4)	(6) Total Residents (Do not count in total privileged)
a.Primary Care						
i. Family Practice	0	0	1	0	1	
ii. OB/GYN	0	0	0	0	0	
iii. Other Primary Care	0	0	0	1	1	
b.Emergency Medicine	0	0	1	0	1	0
c.Hospitalist	0	0	0	0	0	0
d.Intensivist	0	0	0	0	0	0
e.Radiologist	0	0	3	1	4	0
f.Pathologist	0	0	0	0	0	0
g.Anesthesiologist	0	0	0	0	0	0
h.General Surgeons	0	0	0	0	0	0
i.Surgical Specialist	0	0	0	0	0	0
j.Other Medical Specialists(excluding primary care listed in a.)	0	0	0	1	1	0
k.Other	0	0	0	0	0	0
L. TOTAL (add 1a-1k)	0	0	5	3	8	0

1A. Name of person completing Perinatal survey: Ruby Kirby

B. Telephone Number: 7316590218

C. Email Address: Ruby.Kirby@wth.org

D. Fax Number:

Please complete the following questions.

2. Births
   A. Number of infants born alive: 1
      i. Birth weight below 2500 grams (5 lb 8 oz):
      ii. Birth weight below 1500 grams (3 lb 5 oz):
   B. Number of deaths among infants born alive:
   C. Number of fetal deaths (350 grams or 20 weeks or more gestation):

3. Number of babies on Ventilator longer than 24 hours:

4. Number of babies received from referring hospitals for neonatal management:

5. Number of pregnant women received from referring hospitals for maternal-fetal management:

6. Is Medical Director of Obstetrics board certified in maternal-fetal management? ○ **YES** ○ **NO**

7. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal (neonatologist)? ○ **YES** ○ **NO**

8. Do the following subspecialty consultants spend more than 2/3 full time effort at your hospital?

A. OBSTETRICS

- Perinatal Sonologist ○ **YES** ○ **NO**
- Hermatologist ○ **YES** ○ **NO**
- Cardiologist ○ **YES** ○ **NO**

B. NEONATAL:

- Pediatric Radiologist ○ **YES** ○ **NO**
- Pediatric Cardiologist ○ **YES** ○ **NO**
- Pediatric Neurologist ○ **YES** ○ **NO**
- Pathologist ○ **YES** ○ **NO**
- Pediatric Surgeon ○ **YES** ○ **NO**

9. Do you have a designated OB triage area in your hospital? ○ **YES** ○ **NO**

10. Do you have observation for obstetrical patients? ○ **YES** ○ **NO**

If yes, answer the following:

- Number of Beds _____
- Number of Patients _____
- Number Patient Days _____

Utilization of Selected Services	Is this service Provided In Your Hospital?	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Numb
11. Obstetrics					
Obstetrics Level of Care					
Level I	○ YES ○ NO				
Level II	○ YES ○ NO				
Level III	○ YES ○ NO				
Level IV	○ YES ○ NO				
Regional Perinatal Center	○ YES ○ NO				
Total Deliveries		Deliveries:			
		Patient Days:			
Total Cesarean Section Deliveries		Deliveries:			
		Patient Days:			
Total Non C-Section Deliveries		Deliveries:			
		Patient Days:			
Birthing Rooms	○ YES ○ NO	Deliveries:			
		Patient Days:			
# Delivery Rooms					
# LDRP Beds					
# LDR Beds					
Labor Rooms	○ YES ○ NO	Deliveries:			
		Patient Days:			
# Rooms					
Postpartum Services	○ YES ○ NO	Deliveries:		Visits:	
# Rooms					

Utilization of Selected Services	Is this service Provided In Your Hospital?	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Numb

12. Newborn

Neonatal Level of Care (See instructions for allocation)

Level I (well baby bassinet) ○ **YES** ○ **NO** Patients: _____ Patient Days: _____

Level II ○ **YES** ○ **NO** Patients: _____ Patient Days: _____

Level III ○ **YES** ○ **NO** Patients: _____ Patient Days: _____

Level IV ○ **YES** ○ **NO** Patients: _____ Patient Days: _____

Number of Certificate of Need Approved or Assigned Level II-IV Beds. _____

Unduplicated number of newborns treated in level I -IV NICU _____

NewBorn Nursery ○ **YES** ○ **NO** Infant Discharged: _____ Patient Days: _____

 # Bassinets _____

Premature Nursery ○ **YES** ○ **NO** Infant Discharged: _____ Patient Days: _____

 # Bassinets _____

Isolation Nursery ○ **YES** ○ **NO** Infant Discharged: _____ Patient Days: _____

 # Bassinets _____

1. Does your hospital employ physicians? ○ **YES** ◉ **NO**

2. If yes, report the number of employed physicians whose services are billed under the hospital fee schedule or hospital negotiated rate. _____

3. Report the number of physicians that are classified as freestanding whose services are billed under a physician fee schedule (Medicare Part B) or negotiated physician rate. _____

   a. Number of Practices _____
      Total number of physicians employed in hospital owned practices _____
      Primary Care Specialists _____
      Hospitalists _____
      Other Specialists _____

   b. Total number of owned/employed independent practitioners _____
      Primary Care Specialists _____
      Hospitalists _____
      Other Specialists _____

4. Utilization and Financial Data for Employed Physicians - include charges and payments for physician services only

Inpatient	Gross Patient Charges	Adjustments to Charges	Net Revenue	Inpatient - Total Admissions	Inpatient - Total Patient Days
Medicare			$ 0.00		
Medicaid/TennCare			$ 0.00		
CoverKids			$ 0.00		
Other Government			$ 0.00		
BlueCross			$ 0.00		
Commercial Insurers (excludes Workers Comp)			$ 0.00		
*Combined Blue Cross Blue Shield and Commercial (excludes Workers Comp)			$ 0.00		
Self-Pay			$ 0.00		
Workers' Comp			$ 0.00		
Other non-government			$ 0.00		
Total Inpatient	$ 0.00	$ 0.00	$ 0.00	0	0

Outpatient	Gross Patient Charges	Adjustments to Charges	Net Revenue	Outpatient - Total Patients	Outpatient - Total Visits
Medicare			$ 0.00		
Medicaid/TennCare			$ 0.00		
CoverKids			$ 0.00		
Other Government			$ 0.00		
BlueCross			$ 0.00		
Commercial Insurers (excludes Workers Comp)			$ 0.00		
*Combined Blue Cross Blue Shield and Commercial (excludes Workers Comp)			$ 0.00		
Self-Pay			$ 0.00		
Workers' Comp			$ 0.00		
Other non-government			$ 0.00		
Total Outpatient	$ 0.00	$ 0.00	$ 0.00	0	0

*Line item, 4., *COMBINED Blue Cross Blue Shield and Commercial Insurers, should be completed ONLY if the hospital cannot break out the data separately for Blue Cross Blue Shield and Commercial.
If you complete line item 4. (Blue Cross Blue Shield and Commercial Insurers), items Blue Cross Blue Shield and Commercial Insurers should be left BLANK.

All Other Revenue	$
Total Physician Revenue from Employed Physicians	$ 0.00
5. Expenses (excluding facility expenses reported in Schedule E)	
Salaries	$
Benefits	$
Practice Management Expenses	$
All Other Expenses	$
Total Expenses for Employed Physicians	$ 0.00
6. Total Charity Care Charges for Employed Physicians	$

Schedule N no longer required.

The Health Care Consumer Right-to-Know Act of 1998 which was signed by Governor Sundquist in May, 1998 requires hospitals to report to the Department of Health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently - as of the last day of this reporting period - have a valid contract. List each plan separately not just the name of the Company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield of Tennessee.

Plans:

Aetna Better Health (Weakley Co. Locations Only)
Aetna NationalAetna VHANAetna Whole Health
Ambetter of TennesseeWellpoint Community Care
Wellpoint Community Care D-SNPWellpoint CoverKids
AmeriVantageBCBS BlueCareBCBS CoverKids
BCBS Out-of-State Blue Card NetworkBCBS TennCare Select
Blue Cross Blue Shield of TN-Network P
Blue Cross Blue Shield of TN-Network S
Blue Cross Bronze, Silver and Gold PlansBlueAdvantage
BlueCare PlusCigna + OSCARCigna ConnectCigna Local Plus
Cigna MedicareCigna Open Access Plans (OAP)Cigna Surefit
Cigna-HealthSpringGovernment Medicare Part A and Part B
Healthy Blue Missouri (Primary Care Caruthersville Only)
Home State Health MO HealthNet (Caruthersville and Dyersburg Locations)
HS TechnologyHumana Choice Care
Humana Healthy HorizonsHumana Medicare Advantage
Humana Military Healthcare Services (TriCare)
Passport Health Plan (Weakley Co. Locations Only)
Private Healthcare Systems (PHSC)
UHC Community Plan Dual CompleteUHC CoverKids
United Healthcare (UHC)United Healthcare Community Plan
United Healthcare Community Plan (Primary Care Caruthersville Only)
UnitedHealthcare CompassUnitedHealthcare Exchange
VA Community Care Network
WellCare of Kentucky (Weakley Co. Locations Only)

Schedule P is no longer required. Please see CMS link for further detail
https://www.federalregister.gov/documents/2017/04/03/2017-06538/medicaid-program-disproportionate-share-hospital-payments-treatment-of-third-party-payers-in

1.A. Care to the Uninsured

i. Total number of uninsured patients

ii. Total number of patients for whom credible comprehensive insurance coverage exists but is not available for the particular service

iii. Number with limited service insurance(indemnity policy, cancer policy, etc.)

Total(i.-iii.) 0

1.B. Total Charges/Total Payment

	Total Charges			Total Payment	
	Inpatient	Outpatient		Inpatient	Outpatient
i. Uninsured patients					
ii.. Patients with credible comprehensive insurance coverage but is not available for the particular service					
iii. Patients with limited service insurance (indemnity policy, cancer policy, etc.)					
Total (i.-iii.)	$ 0	$ 0		$ 0	$ 0

2.A. Medicaid as payer that is not primary payer

i. Total number of claims with Medicare as primary (Medicaid or Tenncare as additional payer)

ii. Total number of claims with Commercial/Blue Cross Blue Shield as payer (Medicaid or TennCare as additional payer)

iii. Total number of claims with other payer as primary (Medicaid or TennCare as additional payer)

2.B. Total Charges/Total Payment

	Total Charges			Total Payment	
	Inpatient	Outpatient		Inpatient	Outpatient
i. Claims with Medicare as primary (Medicaid or TennCare as additional payer)					
ii.. Claims with Commercial/Blue Cross Blue Shield as payer (Medicaid or TennCare as additional payer)					
iii. Claims with other payer as primary (Medicaid or TennCare as additional payer)					

3. Total facility cost-to-charge ratio from the Medicare Cost Report for this reporting period

Use this section to list additional data as needed. Please indicate Schedule and Question number to reference areas of the report.

Notes:

*Please note: pursuant to T.C.A. 68-11-310, (4) All hospitals that submit a joint annual report to the department of health as designated in this section shall also submit to the department, at the same time they submit the report, a notarized statement from their chief financial officer stating that the financial data reported on the joint annual report is consistent with the audited financials for the hospitals for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the hospital.

Mail notarized statements to:
Department of Health
Health Statistics 5th Floor
710 James Robertson Pkwy
Nashville, TN 37243

Several of the Schedules have multiple pages. Reports that are incomplete will not be accepted. I have reviewed each Schedule and each page for completeness. ☐

By checking the box, you have validated that your JAR has been reviewed and approved. ☐

By checking the box, you have validated that you will submit the JAR with errors. ☐

Date Submitted:

Date Finalized:
For state staff only
Please click on the Display PDF tab and save a copy of your report for your records.

Project Name : New West Tennessee Healthcare Bolivar Hospital

Supplemental Round Name : 1 **Due Date :** 5/28/2025
Certificate No. : RE2505-003 **Submitted Date :** 5/20/2025

1. **1E. Overview**

Please discuss the intention of the applicant to maintain the hospital's status as a Critical Access Hospital. Specifically, please confirm that the new hospital will not be affected by the establishment of the recently approved Baptist Memorial Hospital Fayette County (CN2501-002A) based on the proposed facilities proximity being less than 35 miles from the new hospital.

Response : Our plan is to relocate West Tennessee Bolivar Hospital as a critical access hospital. This hospital is important to our mission to improve the health and well-being of the communities we serve. In the event that our status as a critical access hospital is affected by Baptist Memorial Hospital in Fayette County, we are prepared to pivot and believe that the design of this hospital is versatile and allows for an easy shift to other provider types.

2. **1E. Overview**

Please attach a limited Floor Plan of the proposed hospital identifying the number of beds by type (med/surg, swing, etc.), emergency department treatment rooms, imaging areas, operating/procedure rooms, physicians' offices, etc.

Please identify the proposed square footage of the new hospital.

Please attach a plot plan showing where the facility will be located within Map #061, Parcel #010.00 Sp. Int. 001.

Will the proposed facility have a heliport?

Response : A floor plan has been attached to the application.

The gross square footage of the new hospital is 28,179.

A plot pan has been attached to the application.

The facility will have a helicopter pad.

3. **1E. Overview**

What is the age of the existing hospital.

What are the primary reasons for the decision to relocate the existing hospital from its current location to its new location?

Please provide a comparison of existing service lines available at the hospital to those that will be available at the new hospital.

Please confirm whether perinatal services will be provided at the proposed facility.

Will the new facility still be certified as a Basic Pediatric Emergency Facility?

Response : The West Tennessee Healthcare Bolivar Hospital was constructed 51 years ago in 1974.

The current hospital building is 42,483 square feet, much too large for the Hospital needs' today. The infrastructure of the building is old. The building has continuous sewer back up problems as pipes collapse and lines are not long enough. The costs of heating and cooling such an old building without insulation is becoming cost prohibitive. The Hospital has (2) negative pressure isolation rooms in the emergency room, and more such rooms were greatly needed during COVID-19 surges.

The new transformed West Tennessee Healthcare Bolivar Hospital will eliminate current issues of sewer back up problems, lines not long enough and high costs to heat and cool the building because of lack in insulation, The new Hospital will have negative pressure rooms for COVID-19 and other highly infectious disease patients. Overall, it is more cost effective to build a new hospital that is designed to meet current and future community needs in a rural area of west Tennessee.

The new facility will include:

- Six (6) inpatient rooms, including two negative pressure rooms

· Twelve (12) emergency department rooms, including two negative pressure rooms, two trauma rooms, one Sexual Assault Examiner Room (SANE) room, one room for Obese patients, one behavioral health room, and one observation room

- Comprehensive diagnostic imaging services (mammography, ultrasound, X-ray, and computed tomography (CT))
- Decontamination area
- Pharmacy, lab, cardiac rehabilitation, physical rehabilitation, and food service
- Administrative and lobby space

The current Hospital has inpatient, emergency department, comprehensive diagnostic imaging, pharmacy, lab, cardiac rehabilitation, physical rehabilitation, food services, administrative and lobby areas. The SANE room, behavioral health room, and obesity designated rooms are new.

Perinatal services will only be provided in emergencies.

The new West Tennessee Healthcare Bolivar Hospital will be certified as a Basic Pediatric Emergency Facility. The Hospital will also be chest pain certified.

4. **1E. Overview**

Will the new hospital be able to handle any higher acuity patients than are currently served at the existing hospital? If so, please discuss the expanded capacity of the proposed facility.

Response : Because of the design of the facility and 24\7 availability of a physician, West Tennessee Healthcare Bolivar Hospital will be able to keep some patients with higher acuity. The new Hospital will have the capability and access to centralize cardiac monitoring and telehealth with others specialists, i.e. cardiac, pulmonary and neurologists.

5. **3E. Payor Mix**

The payor mix for 2023 appears to be slightly different from the payor mix reported in the 2023 Joint Annual Report - Schedule E:

JAR 2023 - 62.8% (governmental), 37.1% (non-governmental)

Relocation Application 2023 - 57.4% (governmental), 42.6% (non-governmental)

Please explain the differences.

Response : The data we provided on payor mix was for the time period July 1, 2023 to June 30, 2024 which is our 2024 Joint Annual Report. We have attached the 2024 Joint Annual Report for West Tennessee Healthcare Bolivar Hospital with the application.

6. **2E. Patients by Zip Code**

Please identify the source for the ZIP Code level historical utilization data.

Response : Zip code level historical data were taken from internal decision support system inpatient discharges from the Cerner system.

Project Name : New West Tennessee Healthcare Bolivar Hospital

Supplemental Round Name : 2
Due Date : 5/30/2025
Certificate No. : RE2505-003
Submitted Date : 5/27/2025

1. **2E. Patients by Zip Code**

There appears to be a duplication of ZIP Codes in the historical utilization table - 38042 is listed twice.

The historical utilization table does not include ZIP Code 3804 which is included in the projected utilization Year 2 table. Please revised the utilization tables as necessary in the main relocation application and resubmit.

Response : Zip code table has been corrected.