Original Application

Erlanger Medical Center

Erlanger (Bradley Co.)

CN1802-011

erlanger

February 7, 2018

Ms. Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: Erlanger Bradley County
CON Application, Provider Based Satellite ED/Level IV Trauma Center

Dear Ms. Hill:

Enclosed is our Certificate of Need application together with required fee for the above referenced project. We are hopeful that we have provided all information necessary for review; however, should staff have questions or require additional information, we will promptly provide this information.

We look forward to working with you and staff in the review of the proposed project.

Sincerely,

Joseph M. Winick, FACHE
Lead Executive, Erlanger Health System Innovation Center

975 East Third Street, Chattanooga, TN 37403 (423) 778-7000 www.erlanger.org

CERTIFICATE OF NEED APPLICATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Medical Center - Provider Based ED / Trauma Center & Cardiac Catheterization Laboratory

Application To Initiate A

Provider Based (Free Standing) Emergency Department,

Cardiac Catheterization Laboratory

As

Erlanger Medical Center - Provider Based ED / Trauma Center & Cardiac Catheterization Laboratory

(Cleveland, Bradley County, TN)

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Section A

APPLICANT PROFILE

Section A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution.

Chattanooga-Hamilton County Hospital Authority
D / B / A
Erlanger Medical Center - Provider Based
(Satellite) Emergency Department
Located at an unaddressed site, otherwise
described as 2.9, at the southeast
quadrant of Exit 20 northbound on U.S.
Interstate 75, accessed vie Cherokee Gateway
Blvd., Cleveland, Bradley County, Tennessee

Website Address - www.erlanger.org

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*.

2. Contact Person Available For Responses To Questions.

Joseph M. Winick, Lead Executive
Erlanger Health System - Innovation Center
975 East 3rd Street
Chattanooga, TN 37403
(423) 778-8088
(423) 778-5776 -- FAX
Joseph.Winick@erlanger.org -- E-Mail

3. Executive Summary

A. Overview

Please provide an overview not to exceed three pages in total, explaining each numbered point.

Erlanger Bradley County seeks approval to initiate a provider based emergency department with Level IV trauma center designation, and a full service cardiac catheterization laboratory, in Cleveland, Bradley County, Tennessee. The provider based emergency department/trauma center will be integrated into *Erlanger's* "system of care" through *Erlanger's Regional Operations Center*, where medical command is provided for the region and *Erlanger's*

Trauma Network including a Level I trauma center for adults at *Erlanger Medical Center* and Level I trauma center for children (Tennessee designated comprehensive regional pediatric center) at *Children's Hospital @ Erlanger*, both in Hamilton County, Tennessee.

The new trauma center will also include a helipad and cardiac catheterization laboratory to serve those patients where care for a cardiac emergency or higher level of care is required. *Erlanger* has already transported more than 1,200 patients via *LifeForce* air ambulance from its helicopter base in Cleveland, Tennessee, to *Erlanger Medical Center*. There are no trauma facilities in the service area, Bradley and Polk counties in Tennessee. Bradley County EMS must transport patients to Chattanooga when trauma services are required and/or utilize *LifeForce* air ambulance. In 2016, 10,740 patients left Bradley County for emergency service in Hamilton County.

As the following map illustrates, the section of Southeast Tennessee which is most vulnerable due to not having a trauma center located in proximity, is that portion of U.S. Interstate-75 between Chattanooga, Tennessee, and Athens, Tennessee. The proposed Level IV trauma center at Erlanger Bradley County will help ensure appropriate coverage for the trauma system of care in southeast Tennessee.

STARS – Trauma Center Levels

Red – Level 1
Blue – Level 3
Green – Level 4 (Proposed)

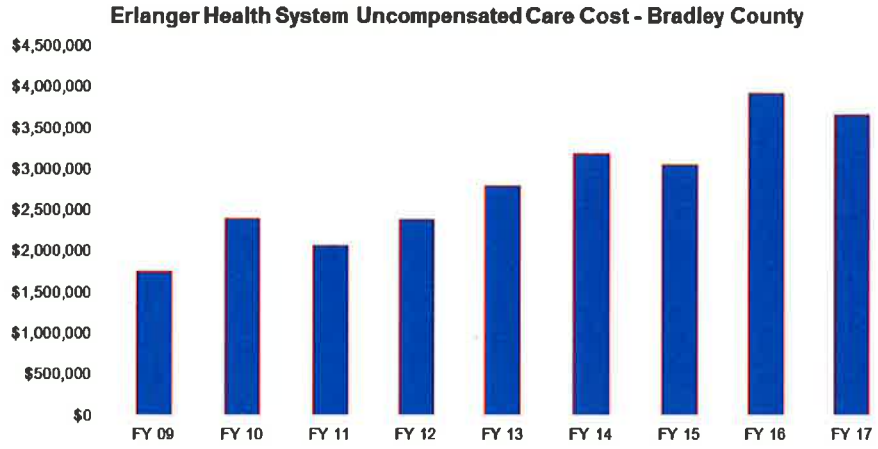
The amount of traffic on Interstate 75 effectively makes emergency services in Chattanooga, Tennessee, unavailable to the elderly and infirmed. See the table below, which illustrates the heavy volume of traffic on Interstate 75 between Cleveland, Tennessee, and Chattanooga, Tennessee.

Erlanger Bradley County -- Average Annual Daily Traffic ("AADT") Count
For Traffic Stations On Interstate 75 Between Cleveland, TN, And Chattanooga, TN

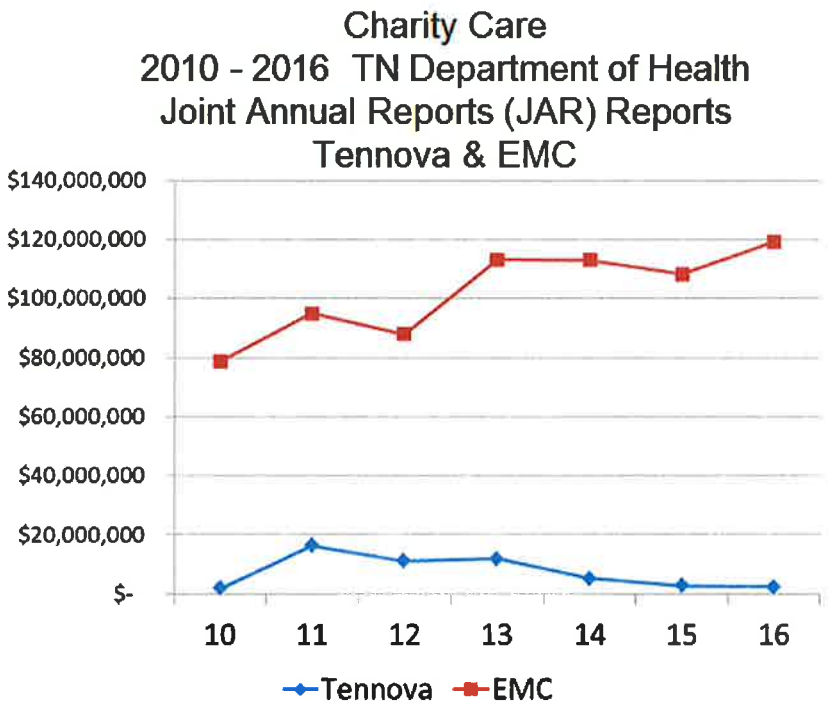
Tenn. DOT Station NO.	Route	Location	Year	AADT			
00616	I-75	South Of Volunteer Ordinance Road	2016	74,906			
			2015	76,990			
			2014	73,982			
			2013	69,426			
00074	I-75	West Ooltewah, TN	2016	70,784	*3 Year Average*	2016	73,556
			2015	73,977		2015	75,991
			2014	70,858		2014	72,930
			2013	66,335		2013	68,577
00166	I-75	South Of Junction SR-2 And I-75	2016	74,979			
			2015	77,005			
			2014	73,950			
			2013	69,970			

The average daily traffic count for 2016 was 73,556 vehicles, or an average of 51 vehicles per minute … or an average of 1 vehicle every 1.2 seconds. With this heavy traffic volume, the elderly and infirmed simply prefer not to drive in these types of conditions. They may simply forego seeking treatment for care.

The following chart illustrates how *Erlanger's* charity care burden from Bradley County has doubled over the last nine (9) years, from 2009 to 2017.



Erlanger's charity care burden has increased, relative to *Tennova Healthcare - Cleveland*,as shown in the following chart. While *Erlanger's* charity care burden has increased dramatically, *Tennova's* charity care burden has dramatically decreased. It should be noted that in an open letter to the community by Bradley County Mayor D. Gary Davis on September 27, 2005, *Tennova* assured Bradley County that it would carry it's share of responsibility for indigent care (copy attached). This does not appear to be supported by actual experience.



With the recent closure of *Copper Basin Medical Center*, in Polk County, Tennessee, more patients can be expected to travel to Chattanooga, Hamilton County, and *Erlanger Medical Center* specifically, for emergency medical care. *Erlanger Medical Center* is the region's safety net provider, serving all those in need regardless of ability to pay. In FY 2017, *Erlanger Medical Center* provided more than $110 million in uncompensated care to those in need. The new trauma center will be located immediately off Interstate 75 at Exit 20, with access to U.S. Highway 64, for efficient and convenient access from the service area, which consists of Bradley and Polk counties in Tennessee.

It should also be noted that *Erlanger Health System* is acquiring *Murphy Medical Center*, in Murphy, North Carolina, effective April 1, 2018. Placement of a provider based ED with trauma center in Bradley County, Tennessee, will provide more efficient access to this needed service for residents of western North Carolina, because Hwy. 64 is a direct route which allows for such access from Murphy, North Carolina. The allows for access to needed trauma services without having to come all the way to Erlanger Medical Center in Chattanooga, Tennessee, which reduces transport time by approximately 40 minutes for ground based EMS.

Erlanger Bradley County seeks approval to initiate a provider based emergency department with Level IV trauma center designation, and a full service cardiac catheterization laboratory. The need for this project has developed over several years for many reasons.

- The *Erlanger East Hospital* ED opened in 2013 and under the *American College Of Emergency Physicians* ("ACEP") standards should accommodate a capacity of 25,000 visits per year, in FY 2017 the total was 34,799. In FY 2018 the total will likely be 38,000 to 40,000 visits. *Erlanger* has a need to decompress the volume on the *East* campus. The high level of traffic also impedes access to *Erlanger East Hospital* going south.

- The ED's on *Erlanger's* main campus (EMC & Children's) are experiencing high volumes, and in FY 2018 will be between 88,000 to 90,000 visits. With two (2) trauma centers, and the only trauma center in Hamilton County, *Erlanger* has a need to decompress the volume on its' main campus to ensure access to needed services.

- *Copper Basin Medical Center* in Polk County was the latest rural hospital to close, resulting in it's ED closing as well. It should be noted that *Erlanger Health System* has tried to assist *Copper Basin Medical Center*, by offering advice and meeting with HSDA staff and attending a hearing with the Division of Licensure, to provide technical and regulatory assistance in an effort to preclude closure of the hospital, but without success.

- Outmigration from the service area (Bradley Polk counties) is significant. With a total of 61,911 ED visits in 2016, 16,869 patients (27.2%) outmigrated from the service area.

- *Erlanger Bradley County* will be a designated trauma center, bringing Level IV trauma care to Bradley County. Further, the trauma

center will be part of *Erlanger's Trauma Network*, which includes a base for a *LifeForce* air ambulance already located at the Cleveland regional airport. The provider based ED will have access to a land ambulance as well as a helipad for *LifeForce* air ambulance. There will be a dedicated space (24/7) for land ambulance at the facility. The EMS service in Bradley County transports an average of 600 patients per year to *Erlanger Medical Center*. With the establishment of *Erlanger Bradley County*, EMS in Bradley County will not be required to make so many transports, so the service area population will be better served as a result. *Erlanger* has significant experience collaborating with EMS services through it's four (4) state service area.

The objective for developing the Level IV trauma center and provider based ED in Bradley County is to foster access by placing an emergency department with trauma service, within a reasonable distance of the service area population, for which no trauma service is currently available. The service area for *Erlanger Bradley County* will be Bradley and Polk counties in Tennessee. Thus, patients will not need to travel to Chattanooga, Hamilton County, for needed emergency services.

2.) *Ownership Structure* - The provider based emergency department in Bradley County will be owned by *Erlanger Medical Center*.

3.) *Service Area* - *Erlanger Bradley County* will foster access to a centrally located emergency service. The service area for this provider based ED and trauma center will be Bradley and Polk counties in Tennessee.

4.) *Existing Similar Service Providers* - Within the defined service area, *Erlanger Bradley County* will be the only ED provider with a Level IV trauma center, readily accessible to residents of Bradley and Polk counties. *Tennova*

Healthcare - Cleveland operates an emergency department, but does not offer trauma services.

5.) *Project Cost* - The total project cost for *Erlanger Bradley County* is $ 11,297,935, with total construction cost of $ 4,086,390. This yields a construction cost per square foot of $330.00, which is above the median SF cost of $289.85, but well below the 3rd Quartile SF cost of $395.94, for new construction.

6.) *Funding* - Funding for *Erlanger Bradley County* will be provided by operating funds of *Erlanger Health System*.

7.) *Financial Feasibility (including when the proposal will realize a positive financial margin)* - The *Projected Data Chart* shows a positive margin years in years 1 and 2.

8.) *Staffing* - It is anticipated that there will be a total of 36.7 FTE's at *Erlanger Bradley County*.

B. Overview

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide healthcare that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in section B of this application. Please summarize in one page or less each of the criteria.

1.) *Need* - The *Erlanger Bradley County* provider based ED and trauma center will serve a need which has been developing over several years for many reasons.

- The *Erlanger East Hospital* ED opened in 2013 and under the *American College Of Emergency*

Physicians ("ACEP") standards should accommodate a capacity of 25,000 visits per year, in FY 2017 the total was 34,799. In FY 2018 the total will likely be 38,000 to 40,000 visits. *Erlanger* has a need to decompress the volume on the *East* campus.

- The ED's on *Erlanger's* main campus (EMC & Children's) are experiencing high volumes, and in FY 2018 will be between 88,000 to 90,000 visits. With a Level I trauma center for adults and children, and the only trauma center in Hamilton County, *Erlanger* has a need to decompress the volume on its' main campus to assure access to needed services.

- *Copper Basin Medical Center* in Polk County was the latest rural hospital to close, resulting in it's ED closing as well. It should be noted that *Erlanger Health System* has tried to assist *Copper Basin Medical Center*, by offering advice and meeting with HSDA staff and attending a hearing at the Division of Licensure, to provide technical and regulatory assistance in an effort to preclude closure of the hospital, but without success.

- Outmigration from the service area (Bradley Polk counties) is significant. With a total of 61,911 ED visits in 2016, 16,869 patients (27.2%) outmigrated from the service area.

- *Erlanger Bradley County* will be a designated trauma center, bringing Level IV trauma care to Bradley County. Further, the trauma center will be part of *Erlanger's Trauma Network*, which includes a base for a *LifeForce* air ambulance already located at the Cleveland regional airport. The provider based ED will have access to a land ambulance as well as a helipad for *LifeForce* air ambulance. There will be a designated space (24/7) for an EMS ambulance at the facility. Also, the Bradley County emergency service transports an average of 600 patients per year to *Erlanger Medical*

Center. With the establishment of *Erlanger Bradley County*, the emergency service in Bradley County will not be required to make so many transports, so the service area will be better served as a result.

EHS -- Analysis Of ED Visits By Patient Destination
For Service Area Of Erlanger Bradley County

		2014	2015	2016
Bradley County				
	Outmigration To EHS	5,809	6,421	6,682
	Outmigration To Memorial Hospital	2,619	2,642	2,667
	Outmigration To Parkridge Health System	1,159	1,540	1,391
	Tennova - Cleveland	39,204	39,266	38,056
	Other	1,687	2,085	2,108
	Total - Bradley County	50,478	51,954	50,904
Polk County				
	Outmigration To EHS	791	934	910
	Outmigration To Memorial Hospital	276	307	277
	Outmigration To Parkridge Health System	88	129	120
	Outmigration To Tennova - Cleveland	3,819	3,708	3,605
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	2,612	2,784	2,714
	Total - Polk County	11,331	11,647	11,007
Total				
	EHS	6,600	7,355	7,592
	Memorial Hospital	2,895	2,949	2,944
	Parkridge Health System	1,247	1,669	1,511
	Tennova - Cleveland	43,023	42,974	41,661
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	4,299	4,869	4,822
	Total	61,809	63,601	61,911
Notes >>	1.) ED visit data from THA market share database.			

As may be seen from the data, in 2016 there was a total of 12,047 emergency visits which outmigrated to Chattanooga hospitals. Further, 3,381 emergency patients went to the *Copper Basin* ED in 2016. All of this adds up to 15,428 ED visits, or 24.9%, where the patients have either chosen to outmigrate, or may now need to outmigrate from the service area for emergency care.

The objective for developing the Level IV trauma center and provider based ED in Bradley County is to foster access by placing an emergency department with trauma service, within a reasonable distance of the population of Bradley County and the surrounding area. The service area for *Erlanger Bradley County* will be Bradley and Polk counties in Tennessee.

2.) *Economic Feasibility* - The Projected Data Chart shows a positive margin years in years 1 and 2.

3.) *Appropriate Quality Standards* - *Erlanger Bradley County* will be accredited by *The Joint Commission.* It will also participate in the quality reporting and monitoring program through *Erlanger Health System*.

4.) *Orderly Development* - This project represents orderly development of the healthcare system. It seeks to initiate a provider based ED with Level IV trauma center, which is linked to performance of the broader healthcare delivery system in such a manner, as to place *Erlanger Bradley County* where maximum access can occur for the population which has the most need, while also ensuring financial sustainability.

It will also provide healthcare facilities which meet current spatial requirements for the services to be offered. Please keep in mind the ED capacity constraints for *Erlanger East Hospital* as well as *Erlanger's* main campus need to be decompressed.

C.) Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response

*** Not Applicable. ***

4. A. Owner of the Facility, Agency, or Institution.

Chattanooga-Hamilton County Hospital Authority
D / B / A
Erlanger Health System
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403

B. Type of Ownership or Control (*Check One*).

A.	Sole Proprietorship	
B.	Partnership	
C.	Limited Partnership	
D.	Corporation (For Profit)	
E.	Corporation (Not-for-Profit)	
F.	Governmental (State of TN or Political Subdivision)	X
G.	Joint Venture	
H.	Limited Liability Company	
I.	Other (Specify)	

ATTACH a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/Filingearch.aspx. **Attachment Section A-4A.**

***Describe** the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members with 5% ownership interest (direct or indirect).*

5. Name of Management / Operating Entity (if applicable).

*** Not Applicable. ***

***For new facilities or existing facilities** without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology*

and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract. **Attachment Section A-5.**

6. A. Legal Interest in the Site of the Institution
(Check One)

A.	Ownership	X
B.	Option to Purchase	
C.	Lease of _____ Years	
D.	Option to Lease	
E.	Other (Specify)	

Check appropriate line above: *For applicant or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicant or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option To Purchase Agreement, Option To Lease Agreement, or other appropriate documentation. Option To Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option To Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** *on the date of the Agency's consideration of the certificate of need application.*

B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 ½" x 11" sheet of white paper, single or double sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1.) Plot Plan **must include:**

a.) Size of site (**in acres**);

Response

The size of the site in Cleveland, Bradley County, is approximately 2.9 acres. It is noted that the option agreement specifies 15 acres, however, the remaining 12.1 acres may be for sale or designated for other uses.

A copy of the site plan for *Erlanger Bradley County* is attached to this CON application.

b.) Location of structure on the site;

Response

Erlanger Bradley County will be placed toward the eastern boundary of the site, toward Cherokee Gateway Blvd. The site will be addressed on Cherokee Gateway Blvd., however, it should be noted that the location is located contiguous to U.S. Interstate 75 off exit 20, with access to U.S. Highway 64, for efficient and convenient access from the Service area.

c.) Location of the proposed construction / renovation; and

Response

Located at an unaddressed site, otherwise described as 2.9 acres, at the southeast quadrant of Exit 20 northbound on U.S. Interstate 75, accessed vie Cherokee Gateway Blvd., Cleveland, Bradley County, Tennessee.

d.) Names of streets, roads or highway that cross or border the site.

Response

The provider based ED as described, will be located at an unaddressed site, otherwise described as 2.9 acres, at the southeast quadrant of Exit 20 northbound on U.S. Interstate 75, accessed via Cherokee Gateway Blvd., Cleveland, Bradley County, Tennessee. The site is

contiguous to U.S. Interstate 75 at Exit 20, with access to U.S. Highway 64 via Cherokee Gateway Blvd., for efficient and convenient access from the service area, accessible by exit number 20.

2.) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many necessary to illustrate the floor plan.

Response

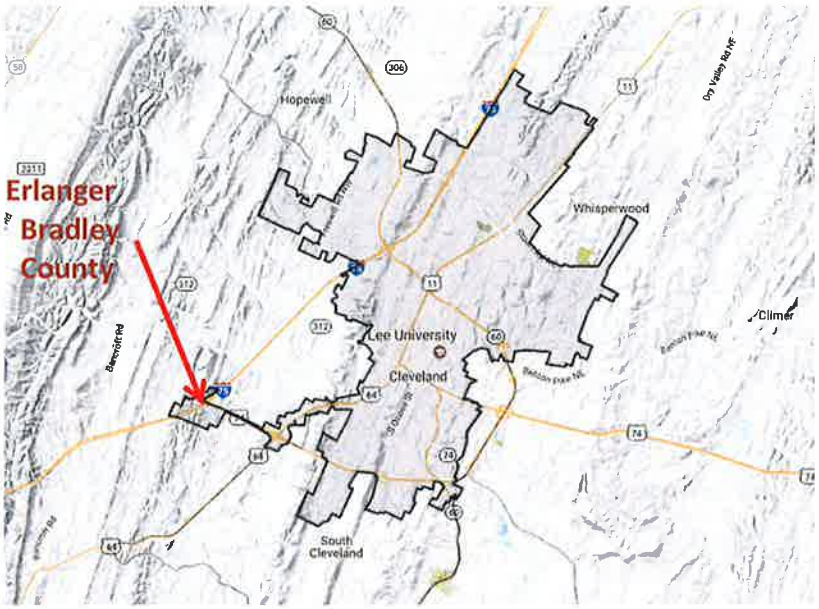
The floor plan for *Erlanger Bradley County* is attached to this CON application.

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

Response

Erlanger Bradley County will be located within the city limits of Cleveland, Tennessee. The City of Cleveland does have a limited public transportation system, however, it does not extend to the outer boundary of the city for the site of *Erlanger Bradley County*.

Accessibility to the provider based ED is through the use of publicly available roads, primarily U.S. Interstate 75 and U.S. Highway 64. A map of the Cleveland, Tennessee, geography appears below, and the location of *Erlanger Bradley County* is noted.



Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

7. **Type of Institution**

(Check as appropriate - more than one response may apply)

A.	Hospital (Specify) _____	____
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	____
C.	ASTC, Single Specialty	____
D.	Home Health Agency	____
E.	Hospice	____
F.	Mental Health Hospital	____
G.	Intellectual Disability / Institutional Habilitation Facility ICF / IID	____
H.	Nursing Home	____
I.	Outpatient Diagnostic Center	____
J.	Rehabilitation Facility	____
K.	Residential Hospice	____
L.	Non-Residential Substitution-Based Treatment Center For Opiate Addiction	____
M.	Other (Specify) Provider Based Emergency Dept. & Cardiac Cath. Lab.	X

8. **Purpose of Review**

(Check appropriate line(s) appropriate - more than one

response may apply)

A. New Institution _____
B. Modifying an ASTC With Limitation Still Required Per CON _____
C. Addition Of MRI Unit _____
D. Pediatric MRI _____
E. Initiation of Health Care Service As Defined In TCA § 68-11-1607(a)(4) (Specify) _____ _____
F. Change In Bed Complement _____
[*Please note the type of change by underlining the appropriate response:* Increase, Decrease, Designation, Distribution, Conversion, Relocation]
G. Satellite Emergency Dept. X
H. Change Of Location _____
I. Other (Specify) X
Cardiac Catheterization Laboratory

9. Medicaid / TennCare, Medicare Participation

MCO Contracts [Check all that apply]

X AmeriGroup X United Healthcare Community Plan
X BlueCare X TennCare Select

Medicare Provider Number 044-1306
Medicaid Provider Number 044-1306
Certification Type General Medical / Surgical

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare ?

Medicare ___ Yes ___ No X N/A
Medicaid / TennCare ___ Yes ___ No X N/A

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

		Current Licensed	*Beds Staffed*	*Beds Proposed*	*(*)Beds Approved*	*(**)Beds Exempted*	*TOTAL Beds at Completion*
1.)	Medical	313	313				313
2.)	Surgical	158	158				158
3.)	ICU / CCU	121	121				121
4.)	Obstetrical	31	31				31
5.)	NICU	64	64				64
6.)	Pediatric	49	49				49
7.)	Adult Psychiatric						
8.)	Geriatric Psychiatric	12	12				12
9.)	Child / Adolescent Psychiatric						
10.)	Rehabilitation						
11.)	Adult Chemical Dependency						
12.)	Child / Adolescent Chemical Depend.						
13.)	Long Term Care Hospital						
14.)	Swing Beds						
15.)	Nursing Home – SNF (Medicare only)						
16.)	Nursing Home – NF (Medicaid only)						
17.)	Nursing Home – SNF / NF (dually certified M'care/M'caid)						
18.)	Nursing Home – Licensed (non-certified)						
19.)	ICF / IID						
20.)	Residential Hospice						
	TOTAL	788	788				788

(*) Beds approved but not yet in service. (**) Beds exempted under 10% per 3 year provision.

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

Response

*** Not Applicable. ***

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number	CON Expiration Date	Total Licensed Beds Approved

CN1601-002A	July 1, 2019	10
CN1603-012A	Oct. 1, 2019	88

11. Home Healthcare Organizations - Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

	Existing Licensed County	Patient Office County	Proposed Licensed County		Existing Licensed County	Patient Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McNairy	☐	☐	☐
Campbell	☐	☐	☐	Macon	☐	☐	☐
Cannon	☐	☐	☐	Madison	☐	☐	☐
Carroll	☐	☐	☐	Marion	☐	☐	☐
Carter	☐	☐	☐	Marshall	☐	☐	☐
Cheatham	☐	☐	☐	Maury	☐	☐	☐
Chester	☐	☐	☐	Meigs	☐	☐	☐
Claiborne	☐	☐	☐	Monroe	☐	☐	☐
Clay	☐	☐	☐	Montgomery	☐	☐	☐
Cocke	☐	☐	☐	Moore	☐	☐	☐
Coffee	☐	☐	☐	Morgan	☐	☐	☐
Crockett	☐	☐	☐	Obion	☐	☐	☐
Cumberland	☐	☐	☐	Overton	☐	☐	☐
Davidson	☐	☐	☐	Perry	☐	☐	☐
Decatur	☐	☐	☐	Pickett	☐	☐	☐
DeKalb	☐	☐	☐	Polk	☐	☐	☐
Dickson	☐	☐	☐	Putnam	☐	☐	☐
Dyer	☐	☐	☐	Rhea	☐	☐	☐
Fayette	☐	☐	☐	Roane	☐	☐	☐
Fentress	☐	☐	☐	Robertson	☐	☐	☐
Franklin	☐	☐	☐	Rutherford	☐	☐	☐
Gibson	☐	☐	☐	Scott	☐	☐	☐
Giles	☐	☐	☐	Sequatchie	☐	☐	☐
Grainger	☐	☐	☐	Sevier	☐	☐	☐
Greene	☐	☐	☐	Shelby	☐	☐	☐
Grundy	☐	☐	☐	Smith	☐	☐	☐
Hamblen	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage And Cost Per Square Foot Chart

Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Emergency Dept.						9,883	9,883
Catheterization Lab.						2,500	2,500
Unit/Department GSF Sub-Total						12,383	12,383
Other GSF Total							
GSF Total						12,383	12,383
(*) Total Cost						$ 4,086,390	$ 4,086,390
(**) Cost Per Square Foot						$ 330.00	$ 330.00
Cost Per Square Foot Is Within Which Range (*For quartile ranges, please refer to the Applicant's Toolbox On www.tn.gov/hsda*)					☐ Below 1st Quartile ☐ Between 1st And 2nd Quartile ☐ Between 2nd And 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st And 2nd Quartile ☒ Between 2nd And 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st And 2nd Quartile ☒ Between 2nd And 3rd Quartile ☐ Above 3rd Quartile

(*) The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

(**) Cost Per Square foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET and/or Linear Accelerator

1.) Describe the acquisition of magnetic Resonance Imaging (MRI) scanner that is adding an MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000, and/or

Response

*** Not Applicable. ***

2.) Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

A.) Complete the chart below for acquired equipment.

☐	Linear Accelerator	MEV _____	Types:	☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____
				☐ By Purchase
		Total Cost(*): _____		☐ By Lease -- Expected Useful Life (Yrs) ____
		☐ New	☐ Refurbished	☐ If not new, how old ? (Yrs) ____
☐	MRI	Tesla _____	Magnet:	☐ Breast ☐ Extremity
				☐ Open ☐ Short Bore ☐ Other _____
				☐ By Purchase
		Total Cost(*): _____		☐ By Lease -- Expected Useful Life (Yrs) ____
		☐ New	☐ Refurbished	☐ If not new, how old ? (Yrs) _____
☐	PET	☐ PET Only	☐ PET / CT	☐ PET / MRI
				☐ By Purchase
		Total Cost(*): _____		☐ By Lease -- Expected Useful Life (Yrs) ____
		☐ New	☐ Refurbished	☐ If not new, how old ? (Yrs) ____

(*) As defined by Agency Rule 0720-9-.01(13)

Response

** Not Applicable. **

B.) In the case of equipment purchase, include a quote and/or proposal from an equipment

vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

Response

*** Not Applicable. ***

C.) Compare lease cost of the equipment to it's fair market value. Note: Per Agency rule, the higher cost must be identified in the project cost chart.

Response

*** Not Applicable. ***

D.) Schedule of Operations:

Location	Days Of Operation *(Sunday Through Saturday)*	Hours Of Operation *(Example: 8 am - 3 pm)*
Fixed Site (*Applicant*)		
Erlanger Bradley County ED	Sunday - Saturday	7 am – 6:59 am (24 Hours)
Erlanger Bradley County Cath. Lab.	Monday - Friday	8 am – 5 pm (on call as needed)
Mobile Locations		
(Applicant)	N / A	
(Name Of Other Location)		
(Name Of Other Location)		

E.) Identify the clinical applications to be provided that apply to the project.

Response

The provider based ED will offer all services consistent with a full service emergency department with a Level IV trauma center. The cardiac

catheterization laboratory will offer both diagnostic and therapeutic (i.e.-interventional) procedures as needed for treatment of patients from the provider based ED.

F.) If the equipment has been approved by the FDA within the last 5 years, provide documentation of the same.

Response

*** Not Applicable. ***

Section B

GENERAL CRITERIA FOR CERTIFICATE OF NEED

Section B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide healthcare that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the state health plan (Guidelines For Growth), developed pursuant to Tennessee Code Annotated § 68-11-1625.

The following questions are listed according to the four (4) criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Healthcare. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on 8 ½" x 11" white paper, single sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. **If a question does not apply to your project, indicate "Not Applicable (NA)".**

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

[Standards & Criteria, Effective - 2000, p. 23]

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under those specific activities.

Response

**** Not Applicable. ****

2. For relocation or replacement of an existing licensed health care institution:

a. The applicant should provide plans which include costs for both renovation and relocation,

demonstrating the strengths and weaknesses of each alternative.

Response

*** *Not Applicable.* ***

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Response

The *Erlanger Bradley County* provider based ED will serve a need which has been developing over several years for many reasons.

- The *Erlanger East Hospital* ED opened in 2013 and under the *American College Of Emergency Physicians* ("ACEP") standards should accommodate a capacity of 25,000 visits per year, in FY 2017 the total was 34,799. In FY 2018 the total will likely be 38,000 to 40,000 visits. *Erlanger* has a need to decompress the volume on the *East* campus.

- The ED's on *Erlanger's* main campus (EMC & Children's) are experiencing high volumes, and in FY 2018 will be between 88,000 to 90,000 visits. With a Level I trauma center, and the only trauma center in Hamilton County, *Erlanger* has a need to decompress the volume on its' main campus to ensure access to needed services.

- *Copper Basin Medical Center* in Polk County was the latest rural hospital to close, resulting in it's ED closing as well. It should be noted that *Erlanger Health System* has tried to assist *Copper Basin Medical Center*, by offering advice and meeting with HSDA staff and attending a hearing at the Division of Licensure, to provide technical and regulatory assistance in an effort to preclude closure of the hospital, but without success.

- Outmigration from the service area (Bradley Polk counties) is significant. With a total of 61,911 ED visits in 2016, 12,047 patients outmigrated from the service area.

- *Erlanger Bradley County* will be a designated trauma center, bringing Level IV trauma care to Bradley County. Further, the trauma center will be part of *Erlanger's Trauma Network*, which includes a base for a *LifeForce* air ambulance already located at the Cleveland regional airport. The provider based ED will have access to a land ambulance as well as a helipad for *LifeForce* air ambulance. There will be a dedicated space (24/7) for an EMS ambulance at the facility. Also, the Bradley County emergency service transports an average of 600 patients per year to *Erlanger Medical Center*. With the establishment of *Erlanger Bradley County*, the emergency service in Bradley County will not be required to make so many transports, so the service will be better served as a result.

EHS -- Analysis Of ED Visits By Patient Destination
For Service Area Of Erlanger Bradley County

		2014	2015	2016
Bradley County				
	Outmigration To EHS	5,809	6,421	6,682
	Outmigration To Memorial Hospital	2,619	2,642	2,667
	Outmigration To Parkridge Health System	1,159	1,540	1,391
	Tennova - Cleveland	39,204	39,266	38,056
	Other	1,687	2,085	2,108
	Total - Bradley County	50,478	51,954	50,904
Polk County				
	Outmigration To EHS	791	934	910
	Outmigration To Memorial Hospital	276	307	277
	Outmigration To Parkridge Health System	88	129	120
	Outmigration To Tennova - Cleveland	3,819	3,708	3,605
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	2,612	2,784	2,714
	Total - Polk County	11,331	11,647	11,007
Total				
	EHS	6,600	7,355	7,592
	Memorial Hospital	2,895	2,949	2,944
	Parkridge Health System	1,247	1,669	1,511
	Tennova - Cleveland	43,023	42,974	41,661
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	4,299	4,869	4,822
	Total	61,809	63,601	61,911
Notes >>	1.) ED visit data from THA market share database.			

As may be seen from the data, in 2016 there was a total of 12,047 emergency visits which outmigrated to Chattanooga hospitals. Further, 3,381 emergency patients went to the Copper Basin ED in 2016. All of this adds up to 15,428 ED visits, or 24.9%, where the patients have either chosen to outmigrate, or may now need to outmigrate from the service area for emergency care.

The objective for developing the Level IV trauma center and provider based ED in Bradley County is to foster access by placing an emergency department with trauma service, within a reasonable distance of the population of Bradley County and the surrounding area. The service area for *Erlanger Bradley County* will be Bradley and Polk counties in Tennessee.

3. **For renovation or expansions of an existing licensed health care institution:**

   a. **The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**

      Response

      *** Not Applicable. ***

   b. **The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

      Response

      *** Not Applicable. ***

[End Of Responses To Construction, Renovation, Expansion, And Replacement Of Health Care Institutions, 2000, page 23]

FREESTANDING EMERGENCY DEPARTMENTS

[Standards & Criteria, 2016 Update To Tennessee State Health Plan]

1. **Determination Of Need: The determination of need shall be based upon the existing access to emergency services in the proposed service area. The applicant should utilize the metrics below, as well as other relevant metrics, to demonstrate that the population in the proposed service area has inadequate access to emergency services due to geographic isolation, capacity challenges, or low-quality of care. The applicant shall provide information on the number of existing emergency department (ED) facilities in the service area, as well as the distance of the proposed FSED from these existing facilities. If the proposed service area is comprised of contiguous ZIP Codes, the applicant shall provide this information on all ED facilities located in the county or counties in which the service area ZIP Codes are located. The applicant**

should utilize Centers for Medicare and Medicaid Services (CMS) throughput measures, available from the CMS Hospital Compare website, to illustrate the wait times at existing emergency facilities in the proposed service area. Data provided on the CMS Hospital Compare website does have a three to six month lag. In order to account for the delay in this information, the applicant may supplement CMS data with other more timely data. The applicant should also provide data on the number of visits per treatment room per year for each of the existing emergency department facilities in the service area. Applicants should utilize applicable data in the Hospital Joint Annual Report to demonstrate the total annual ED volume and annual emergency room visits of the existing facilities within the proposed service area. All existing EDs in the service area should be operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition as capacity for EDs. The capacity levels set forth by this document should be utilized as a guideline for describing the potential of a respective functional program. The annual visits per treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing ED facility in order to better demonstrate the need for expansion.

ED-1 Median time from ED arrival to ED departure for ED admitted patients
ED-2 Median time from admit decision to departure for ED admitted patients
OP-18 Median time from ED arrival to ED departure for discharged ED patients
OP-20 Door to diagnostic evaluation by a qualified medical professional
OP-22 ED-patient left without being seen

Source:

https://www.medicare.gov/hospitalcompare/search.html
https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

If the applicant is demonstrating low-quality care provided by existing EDs in the service area, the applicant shall utilize the Joint Commission's "Hospital Outpatient Core Measure Set". These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's Specification Manual for National Hospital Outpatient Department Quality Measures. Existing emergency facilities should be in the bottom quartile of the state in the measures listed below in order to demonstrate low-quality of care.

OP-1 Median Time to Fibrinolysis
OP-2 Fibrinolytic Therapy Received Within 30 Minutes
OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4 Aspirin at Arrival OP-5 Median Time to ECG
OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients
OP-20 Door to Diagnostic Evaluation by a Qualified Medical Personnel
OP-21 ED-Median Time to Pain Management for Long Bone Fracture
OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival

Sources:

https://www.jointcommission.org/hospital outpatient department/
https://www.jointcommission.org/assets/1/6/HAP Outpatient Dept Core Measure Set.pdf
https://www.medicare.gov/hospitalcompare/search.html
https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

The HSDA should consider additional data provided by the applicant to support the need for the proposed FSED including, but not limited to, data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules. These data may provide the HSDA with additional information on the level of need for emergency services in the proposed service area. If providing additional data, applicants should utilize Hospital Discharge Data System data (HDDS) when applicable. The applicant may utilize other data sources to demonstrate the percentage of behavioral health patients but should explain why the alternative data source provides a more accurate indication of the percentage of behavioral health patients than the HDDS data.

See Standard 2, Expansion of Existing Emergency Department Facility, for more information on the establishment of a FSED for the purposes of decompressing volumes and reducing wait times at the host hospital's existing ED.

Note: Health Planning recognizes that limitations may exist for specific metrics listed above. When significant limitations exist (e.g. there are not adequate volumes to evaluate) applicants may omit these metrics from the application. However, the application should then discuss the limitations and reasoning for omission. Applicants are encouraged to supplement the listed metrics with additional metrics that may provide HSDA with a more complete representation of the need for emergency care services in the proposed service area.

Response

For the operating metrics within this criterion, data is presented below for the five (5) primary ED indicators which are identified, for *Erlanger Medical Center* and *Tennova Healthcare - Cleveland*. It should be noted that longer wait times are expected for a Level I trauma center such as *Erlanger Medical Center*, however, long wait times would not be expected for a general community hospital with no trauma center, as is the case with *Tennova Healthcare - Cleveland*.

EHS -- Analysis Of ED Indicators From CMS Hospital Compare
For The Service Area Of Erlanger Bradley County

Indicator	Description	Erlanger Med. Ctr.	State Of Tennessee
ED-1	Median Time From ED Arrival To ED Departure For Admitted Patients	346 min.	340 min.
ED-2	Median Time From Admit Decision To ED Departure For Admitted Patients	204 min.	147 min.
OP-18	Median Time From ED Arrival To ED Departure For Discharged ED Patients	131 min.	172 min.
OP-20	Door To Diagnostic Evaluation By A Qualified Medical Professional	30 min.	28 min.
OP-22	ED Patient Left Without Being Seen	3%	2%

		Tennova - Cleveland	State Of Tennessee
ED-1	Median Time From ED Arrival To ED Departure For Admitted Patients	373 min.	278 min.
ED-2	Median Time From Admit Decision To ED Departure For Admitted Patients	189 min.	104 min.
OP-18	Median Time From ED Arrival To ED Departure For Discharged ED Patients	199 min.	166 min.
OP-20	Door To Diagnostic Evaluation By A Qualified Medical Professional	23 min.	26 min.
OP-22	ED Patient Left Without Being Seen	5%	2%

Notes >> 1.) The State of Tennessee averages for each hospital are different due to the classification of each hospital, based on ED visit volume.
2.) Data obtained from the *Medicare* Hospital Compare website.

The only other ED in the service area is *Tennova Healthcare - Cleveland*, and it is approximately 6.7 miles from the proposed location of *Erlanger Bradley County*, however, it does not provide trauma services. Also, for illustrative purposes, *Erlanger East Hospital* in Hamilton County, is approximately 16.7 miles from the proposed location.

Pertaining to the visits per treatment room, appearing below is a table which shows the average number of ED visits per treatment room for *Tennova Healthcare - Cleveland* as well as *Erlanger East Hospital* and *Erlanger's* main campus ED's with Level I trauma centers. It should be noted that the average number of treatments for *Erlanger East* is approximately 55.7% higher than capacity*(1)*, as per the utilization guidelines promulgated by the *American College of Emergency Physicians* (ACEP), which stipulates 1,389 visits per year for an ED facility with 18 treatment rooms.

It is noted that the ED at *Tennova - Cleveland* is below it's assigned utilization of 1,596 visits per treatment room, however, the need for *Erlanger* to decompress it's volume at *Erlanger East Hospital*, along with the significant volume of outmigration from the

1 The guidelines specify 25,000 ED visits for a facility with 17 treatment rooms. *Erlanger East* average of 2,163 in FY 2018 is calculated as … ((2,163 - 1,389) / 1,389) = 55.7%.

service area … more than demonstrate the need for a provider based ED with trauma center at *Erlanger Bradley County*.

EHS -- Analysis Of Average ED Visits Per Treatment Room
For The Service Area Of Erlanger Bradley County

Hospital	No. Of Rooms	2014	2015	2016	2017	2018(est)
Total ED Visits						
Erlanger Medical Center		52,272	55,597	51,926	49,815	51,028
Children's Hospital @ Erlanger		37,895	41,502	40,759	40,993	37,636
Erlanger East Hospital		22,009	26,172	31,197	34,799	36,776
Tennova - Cleveland		49,791	50,533	48,501		
Average ED Visits Per Treatment Room						
Erlanger Medical Center	48	1,089	1,158	1,082	1,038	1,063
Children's Hospital @ Erlanger	31	1,222	1,339	1,315	1,322	1,214
Erlanger East Hospital	17	1,295	1,540	1,835	2,047	2,163
Tennova - Cleveland	42	1,186	1,203	1,155		

Notes >> 1.) Data is from the Joint Annual Reports for 2014, 2015 and 2016. For 2017 and 2018, data is from Erlanger internal records.

2. **Expansion of Existing Emergency Department Facility: Applicants seeking expansion of the existing host hospital ED through the establishment of a FSED in order to decompress patient volumes should demonstrate the existing ED of the host hospital is operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition as capacity for EDs. The capacity levels set forth by this document should be utilized as a guideline for describing the potential of a respective functional program. The applicant shall utilize the applicable data in the Hospital Joint Annual Report to demonstrate total annual ED volume and annual emergency room visits. The annual visits per treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of**

patients served within the existing ED facility in order to better demonstrate the need for expansion. See Standard 1, Demonstration of Need, for examples of additional evidence.

Additionally, the applicant should discuss why expansion of the existing ED is not a viable option. This discussion should include any barriers to expansion including, but not limited to, economic efficiencies, disruption of services, workforce duplication, restrictive covenants, and issues related to access. The applicant should also provide evidence that all practical efforts to improve efficiencies within the existing ED have been made, including, but not limited to, the review of and modifications to staffing levels.

Applicants seeking to decompress volumes of the existing host hospital ED should be able to demonstrate need for the additional facility in the proposed service area as defined in the application in accordance with Standard 1, Determination of Need.

Response

Pertaining to the visits per treatment room, appearing below is a table which shows the average number of ED visits per treatment room for *Tennova Healthcare - Cleveland* as well as *Erlanger East Hospital* and *Erlanger's* main campus ED's. It should be noted that the average number of treatments for *Erlanger East* is approximately 55.7% higher than capacity, as per the utilization guidelines promulgated by the *American College of Emergency Physicians* (ACEP), which stipulates 1,389 visits per year for an ED facility with 18 treatment rooms.

It is noted that the ED at *Tennova - Cleveland* is below it's assigned utilization of 1,596 visits per treatment room, however, the need for *Erlanger* to decompress it's volume at *Erlanger East Hospital*, along with the significant volume of outmigration from the service area … more than demonstrate the need for a provider based with trauma center at *Erlanger Bradley County*.

EHS -- Analysis Of Average ED Visits Per Treatment Room
For The Service Area Of Erlanger Bradley County

Hospital	No. Of Rooms	2014	2015	2016	2017	2018(est)
Total ED Visits						
Erlanger Medical Center		52,272	55,597	51,926	49,815	51,028
Children's Hospital @ Erlanger		37,895	41,502	40,759	40,993	37,636
Erlanger East Hospital		22,009	26,172	31,197	34,799	36,776
Tennova - Cleveland		49,791	50,533	48,501		
Average ED Visits Per Treatment Room						
Erlanger Medical Center	48	1,089	1,158	1,082	1,038	1,063
Children's Hospital @ Erlanger	31	1,222	1,339	1,315	1,322	1,214
Erlanger East Hospital	17	1,295	1,540	1,835	2,047	2,163
Tennova - Cleveland	42	1,186	1,203	1,155		

Notes >> 1.) Data is from the Joint Annual Reports for 2014, 2015 and 2016. For 2017 and 2018, data is from Erlanger internal records.

It is not feasible to expand the ED's on *Erlanger's* main campus at the present time due to spatial constraints within the existing physical plant, as well as the public roads which surround the campus. For the *Erlanger East Hospital* ED there is not sufficient available land remaining on the campus to expand the ED, and also expand the parking area which would be required to accommodate the increased ED volume.

3. Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed FSED on existing EDs in the service area and shall include how the applicant's services may differ from existing services. Approval of the proposed FSED should be contingent upon the applicant's demonstration that existing services in the applicant's proposed geographical service area are not adequate and/or there are special circumstances that require additional services.

Rural: The applicant should provide patient origin data by ZIP Code for each existing facility as well as the proposed FSED in order to verify the proposed facility will not negatively impact the patient base of the existing rural providers. The establishment of a FSED in a rural area should only be approved if the applicant can adequately demonstrate the proposed facility will not negatively impact any existing rural

facilities that draw patients from the proposed service area. Additionally, in an area designated as rural, the proposed facility should not be located within 10 miles of an existing facility. Finally, in rural proposed service areas, the location of the proposed FSED should not be closer to an existing ED facility than to the host hospital.

Critical Access Hospitals (CAH): In Tennessee, certain CAHs are not located in rural areas according to the definition of rural provided in these standards. The location of the proposed FSED should not be closer to an existing CAH than to the host hospital.

Response

The only other ED in the service area is *Tennova Healthcare - Cleveland*. Since it does not offer trauma care, the impact of *Erlanger Bradley County* is expected to be limited. There is no other provider of trauma care in the service area.

	EHS -- Analysis Of ED Visits By Patient Destination For Service Area Of Erlanger Bradley County			
		2014	2015	2016
Bradley County				
	Outmigration To EHS	5,809	6,421	6,682
	Outmigration To Memorial Hospital	2,619	2,642	2,667
	Outmigration To Parkridge Health System	1,159	1,540	1,391
	Tennova - Cleveland	39,204	39,266	38,056
	Other	1,687	2,085	2,108
	Total - Bradley County	50,478	51,954	50,904
Polk County				
	Outmigration To EHS	791	934	910
	Outmigration To Memorial Hospital	276	307	277
	Outmigration To Parkridge Health System	88	129	120
	Outmigration To Tennova - Cleveland	3,819	3,708	3,605
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	2,612	2,784	2,714
	Total - Polk County	11,331	11,647	11,007
Total				
	EHS	6,600	7,355	7,592
	Memorial Hospital	2,895	2,949	2,944
	Parkridge Health System	1,247	1,669	1,511
	Tennova - Cleveland	43,023	42,974	41,661
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	4,299	4,869	4,822
	Total	61,809	63,601	61,911
Notes >>	1.) ED visit data from THA market share database.			

As may be seen from the data, in 2016 there was a total of 12,047 emergency visits which outmigrated to Chattanooga hospitals. Further, 3,381 emergency patients went to the Copper Basin ED in 2016. All of this adds up to 15,428 ED visits, or 24.9%, where the patients have either chosen to outmigrate, or may now need to outmigrate from the service area for emergency care.

The objective for developing the Level IV trauma center and provider based ED in Bradley County is to foster access by placing an emergency department with trauma service, within a reasonable distance of the population of Bradley County and the surrounding area.

4. Host Hospital Emergency Department Quality of Care: Additionally, the applicant shall provide data to demonstrate the quality of care being provided at the ED of the host hospital. The quality metrics of the host hospital should be in the top quartile of the state in order to be approved for the establishment of a FSED. The applicant shall utilize the Joint Commission's hospital outpatient core measure set. These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's Specification Manual for National Hospital Outpatient Department Quality Measures.

OP-1 Median Time to Fibrinolysis
OP-2 Fibrinolytic Therapy Received Within 30 Minutes
OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4 Aspirin at Arrival
OP-5 Median Time to ECG
OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients
OP-20 Door to Diagnostic Evaluation by a Qualified Medical Personnel
OP-21 ED-Median Time to Pain Management for Long Bone Fracture
OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival

Sources:

https://www.jointcommission.org/hospital_outpatient_department/
https://www.jointcommission.org/assets/1/6/HAP_Outpatient_Dept_Core_Measure_Set.pdf
https://www.medicare.gov/hospitalcompare/search.html
https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

Note: Health Planning recognizes that limitations may exist for specific metrics listed above. When significant limitations exist (e.g. there are not adequate volumes to evaluate) applicants may omit these metrics from the application. However, the application should then discuss the limitations and reasoning for omission. Applicants are encouraged to supplement the listed metrics with additional metrics that may provide HSDA with a more complete

representation of the need for emergency care services in the proposed service area.

Response

For the operating metrics within this criterion, data is presented below for the five (5) primary ED indicators which are identified, for *Erlanger Medical Center* and *Tennova Healthcare - Cleveland.* It should be noted that longer wait times are expected for a Level I trauma center such as *Erlanger Medical Center*, however, long wait times would not be expected for a general community hospital with no trauma center.

EHS -- Analysis Of ED Indicators From CMS Hospital Compare For The Service Area Of Erlanger Bradley County

Indicator	Description	Erlanger Med. Ctr.	State Of Tennessee
ED-1	Median Time From ED Arrival To ED Departure For Admitted Patients	346 min.	340 min.
ED-2	Median Time From Admit Decision To ED Departure For Admitted Patients	204 min.	147 min.
OP-18	Median Time From ED Arrival To ED Departure For Discharged ED Patients	131 min.	172 min.
OP-20	Door To Diagnostic Evaluation By A Qualified Medical Professional	30 min.	28 min.
OP-22	ED Patient Left Without Being Seen	3%	2%
		Tennova - Cleveland	**State Of Tennessee**
ED-1	Median Time From ED Arrival To ED Departure For Admitted Patients	373 min.	278 min.
ED-2	Median Time From Admit Decision To ED Departure For Admitted Patients	189 min.	104 min.
OP-18	Median Time From ED Arrival To ED Departure For Discharged ED Patients	199 min.	166 min.
OP-20	Door To Diagnostic Evaluation By A Qualified Medical Professional	23 min.	26 min.
OP-22	ED Patient Left Without Being Seen	5%	2%

Notes >> 1.) The State of Tennessee averages for each hospital are different due to the classification of each hospital, based on ED visit volume.
2.) Data obtained from the *Medicare* Hospital Compare website.

5. Appropriate Model for Delivery of Care: The applicant should discuss why a FSED is the appropriate model for delivery of care in the proposed service area.

Response

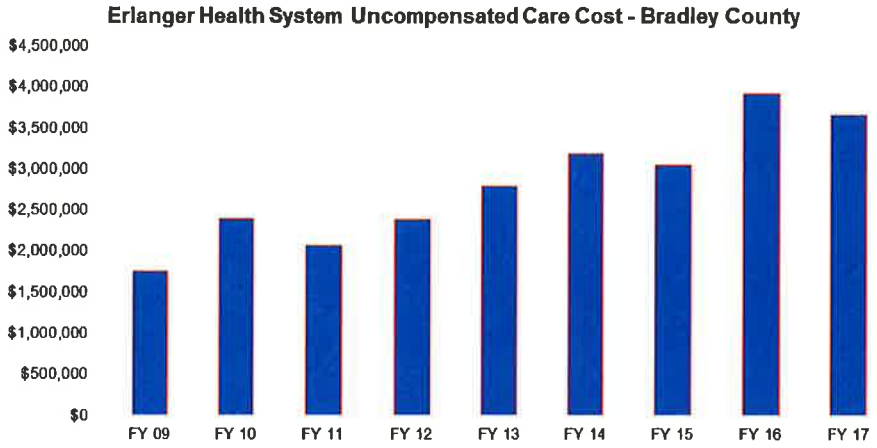
The outmigration from the service area clearly demonstrates the need for emergency services. *Erlanger Medical Center* has demonstrated that a provider based ED with Level IV trauma center is needed. It should be noted that patient from the service area who need emergency service with trauma care must currently travel over an hour to reach *Erlanger's* main campus, the location of *Erlanger*

Bradley County will decrease that by approximately 30-40 minutes.

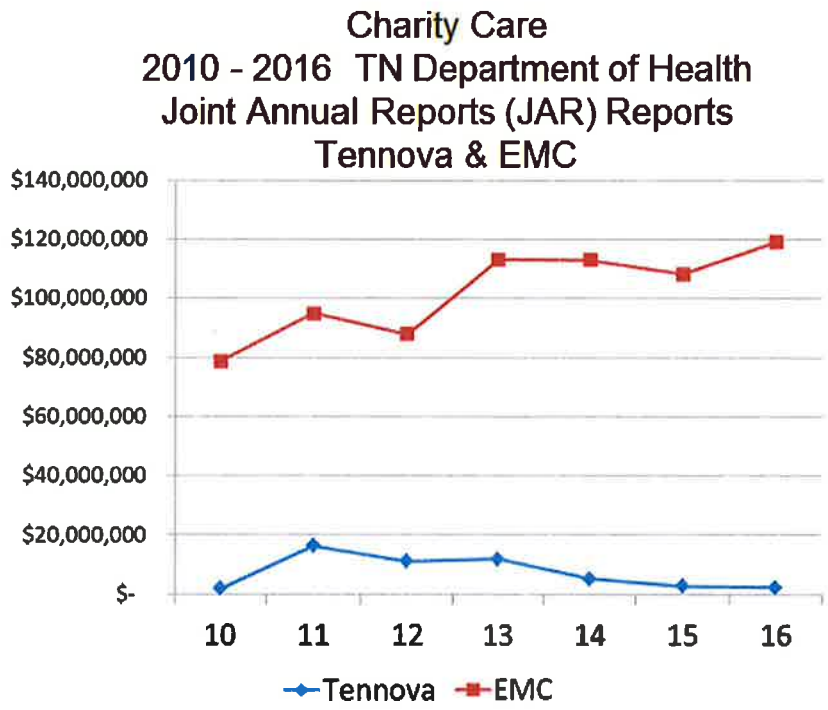
	EHS -- Analysis Of ED Visits By Patient Destination For Service Area Of Erlanger Bradley County			
		2014	2015	2016
Bradley County				
	Outmigration To EHS	5,809	6,421	6,682
	Outmigration To Memorial Hospital	2,619	2,642	2,667
	Outmigration To Parkridge Health System	1,159	1,540	1,391
	Tennova - Cleveland	39,204	39,266	38,056
	Other	1,687	2,085	2,108
	Total - Bradley County	50,478	51,954	50,904
Polk County				
	Outmigration To EHS	791	934	910
	Outmigration To Memorial Hospital	276	307	277
	Outmigration To Parkridge Health System	88	129	120
	Outmigration To Tennova - Cleveland	3,819	3,708	3,605
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	2,612	2,784	2,714
	Total - Polk County	11,331	11,647	11,007
Total				
	EHS	6,600	7,355	7,592
	Memorial Hospital	2,895	2,949	2,944
	Parkridge Health System	1,247	1,669	1,511
	Tennova - Cleveland	43,023	42,974	41,661
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	4,299	4,869	4,822
	Total	61,809	63,601	61,911
Notes >>	1.) ED visit data from THA market share database.			

As may be seen from the data, in 2016 there was a total of 12,047 emergency visits which outmigrated to Chattanooga hospitals. Further, 3,381 emergency patients went to the Copper Basin ED in 2016. All of this adds up to 15,428 ED visits, or 24.9%, where the patients have either chosen to outmigrate, or may now need to outmigrate from the service area for emergency care.

. The following chart illustrates how *Erlanger's* charity care burden from Bradley County has doubled over the last nine (9) years, from 2009 to 2017.



Further, the following chart shows how Erlanger's charity care burden has increased, relative to *Tennova Healthcare - Cleveland*. While Erlanger's charity care burden has increased dramatically, *Tennova's* charity care burden has dramatically decreased.



As a safety net provider with six (6) helicopters, *Erlanger Health System* provides essential services to those in need. As an integral part of *Erlanger Health System*, the new ED will have access to highly specialized resources in emergency medicine, Level I trauma care via *Erlanger's* main campus, a fleet of air ambulances and a graduate medical training program for Emergency physicians.

Erlanger's reputation in emergency medicine is national in scope, with *Erlanger Medical Center* hosting national trauma meetings and associated educational and credentialing meetings. *Erlanger* is one of only a few hospitals in the country that have the ability to raise the standard of care in the delivery of emergency medicine.

6. Geographic Location: The FSED should be located within a 35 mile radius of the hospital that is the main provider.

Response

The provider based emergency department with trauma center Cleveland, Bradley County, will be located approximately twenty seven (27) miles from *Erlanger Medical Center*, as shown below.

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

Response

The outmigration from the service area clearly demonstrates the need for emergency services. *Erlanger Medical Center* has demonstrated that a provider based ED with Level IV trauma center is needed. It should be noted that patient from the service area who need emergency service with trauma care must currently travel over an hour to reach *Erlanger's* main campus, the location of *Erlanger Bradley County* will decrease that by approximately 30-40 minutes.

EHS -- Analysis Of ED Visits By Patient Destination
For Service Area Of Erlanger Bradley County

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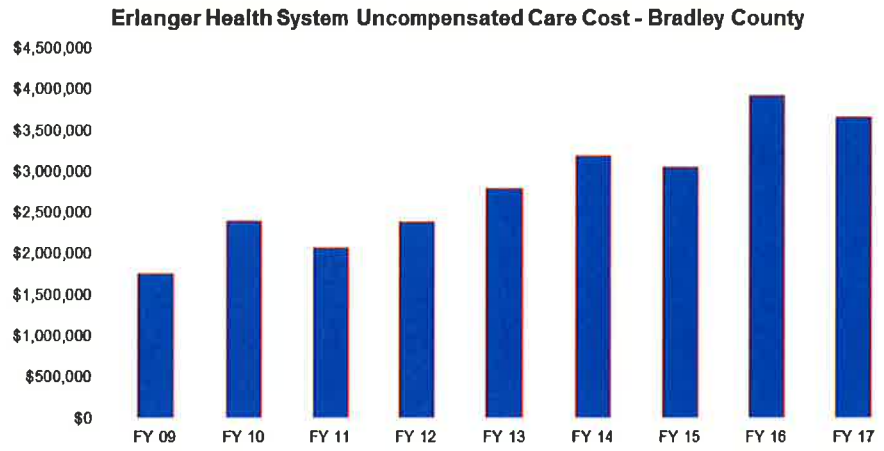

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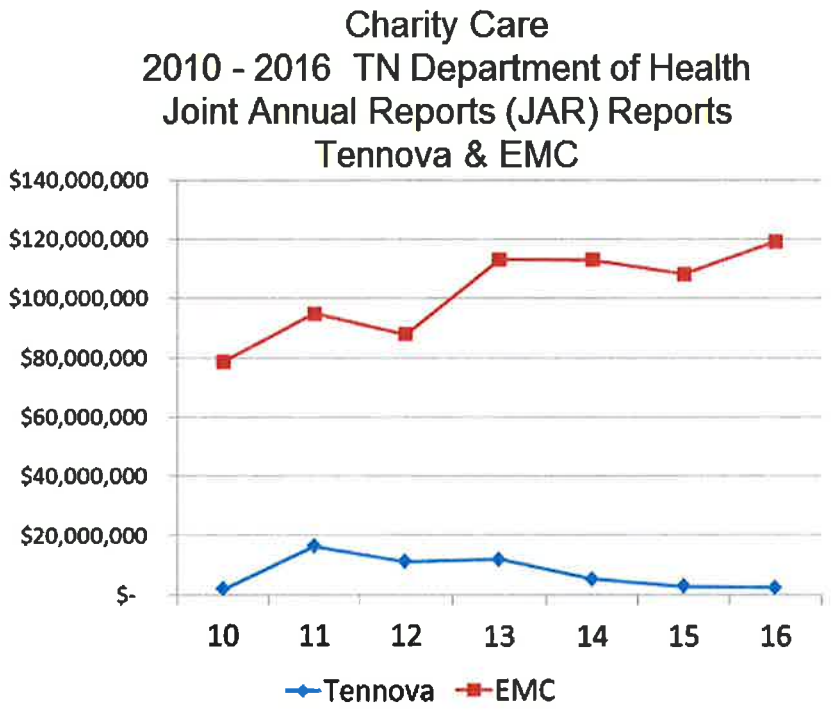

Erlanger Health System is a safety net provider for Tennessee and has a demonstrated track record of serving all patients regardless of ability to pay. *Erlanger Health System* annually provides more uncompensated care than all other hospitals in the region combined, the annual cost of this care typically exceeds $100 million. *Erlanger Medical Center* is where community hospitals send their most difficult cases. *Erlanger Health System* also operates a "system of care" that facilitates access to a broad range of tertiary services including Level I trauma services for adults and children. Additionally, a copy of *Erlanger's* charity care policy is attached to this CON application.

8. Services to High-Need Populations: Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are uninsured, low income, or patients with limited access to emergency care.

Response

Erlanger Health System is a safety net provider for Tennessee and has a demonstrated track record of serving all patients regardless of ability to pay, including indigent care from Bradley County, Tennessee. *Erlanger Health System* annually provides more uncompensated care than all other hospitals in the region combined, the annual cost of this care typically exceeds $100 million. *Erlanger Medical Center* is where community hospitals send their most difficult cases. *Erlanger Health System* also operates a "system of care" that facilitates access to a broad range of tertiary services including Level I trauma services for adults and children. Additionally, a copy of *Erlanger's* charity care policy is attached to this CON application.

9. Establishment of Non-Rural Service Area: The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The applicant shall demonstrate the orderly development of emergency services by providing information regarding current patient origin by ZIP

Code for the hospital's existing ED in relation to the proposed service area for the FSED.

Establishment of a Rural Service Area: Applicants seeking to establish a freestanding emergency department in a rural area with limited access to emergency medical care shall establish a service area based upon need. The applicant shall demonstrate the orderly development of emergency services by providing information regarding patient origin by ZIP Code for the proposed service area for the FSED.

Response

The table shows that in 2016, 82.2% (50,904) of ED visits in the service area originated in Bradley County, and 17.8% (11,007) originated in Polk County. Bradley County is considered to be "non-rural" and Polk County is considered to be "rural".

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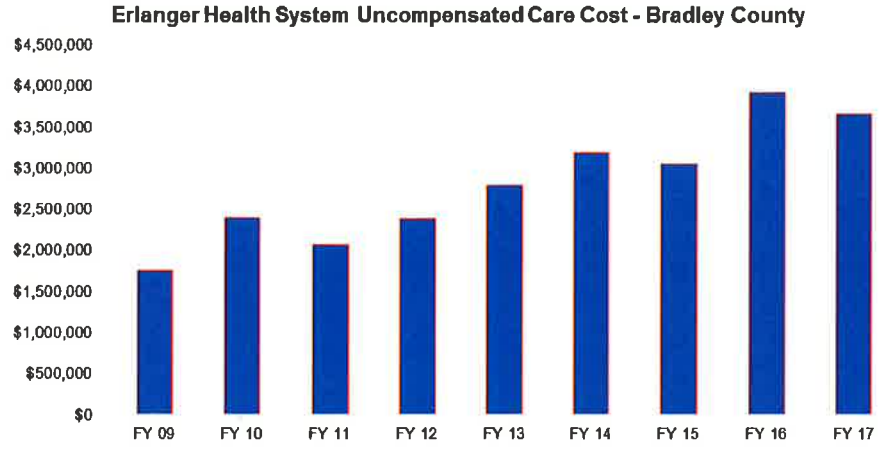
10. Relationship to Existing Applicable Plans; Underserved Area and Population: The proposal's relationship to underserved geographic areas and underserved population groups shall be a significant consideration.

Response

Erlanger Bradley County will be the only provider of trauma care in the service area. More specifically, *Erlanger* has "stepped up" to the task of providing charity for the service area. The following chart illustrates how *Erlanger's* charity care burden from Bradley County has doubled over the last nine (9) years, from 2009 to 2017.



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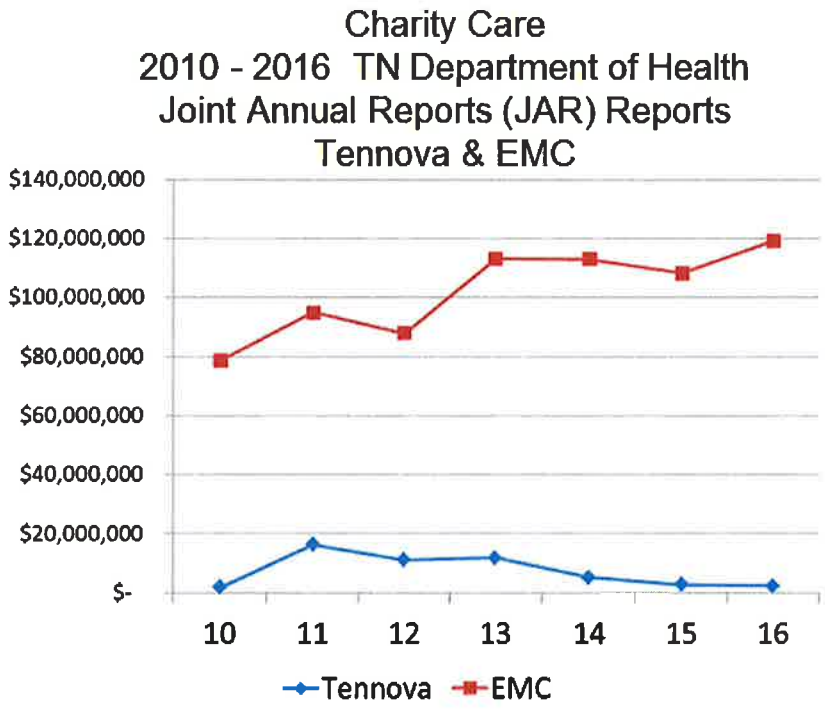

Erlanger Bradley County will have a helipad that provides access, via *LifeForce* helicopter, to Level I trauma services for adults and children. *Erlanger Medical Center* also provides emergency service oversight for the entire regional service area and is affiliated with the University of Tennessee - College of Medicine, to train emergency physicians, including a fellowship in advanced emergency medicine. *Erlanger Health System* continuously demonstrates its commitment to the underserved. It's efforts have had a direct impact in improving health status for rural underserved communities.

Finally, it should be noted that Polk County, Tennessee, which is part of the service area for *Erlanger Bradley County*, is a *Medically Underserved Area* ("MUA") as designated by the *Health Resources & Services Administration* ("HRSA").

11. Composition of Services: Laboratory and radiology services, including but not limited to XRAY and CT scanners, shall be available on-site during all hours of operation. The FSED should also have ready access to pharmacy services and respiratory services during all hours of operation.

Response

As with existing ED services provided by *Erlanger Medical Center*, the same services will be provided by *Erlanger Bradley County* and it's provider based ED in Cleveland, Bradley County. Services will be inclusive of on-site X-Ray, CT, Laboratory and Respiratory Therapy. Also, emergency medical professionals will staff the ED twenty-four (24) hours per day.

12. **Pediatric Care: Applicants should demonstrate a commitment to maintaining at least a Primary Level of pediatric care at the FSED as defined by CHAPTER 1200-08-30 Standards for Pediatric Emergency Care Facilities including staffing levels, pediatric equipment, staff training, and pediatric services. Applicants should include information detailing the expertise, capabilities, and/or training of staff to stabilize or serve pediatric patients. Additionally, applicants shall demonstrate a referral relationship, including a plan for the rapid transport, to at least a general level pediatric emergency care facility to allow for a specialized higher level of care for pediatric patients when required.**

Response

Erlanger Bradley County will provide emergency and trauma services to adults and children. *Children's Hospital @ Erlanger*, located in Chattanooga, Tennessee, is a state designated regional pediatric center. Access via *LifeForce* helicopter can be accomplished in a matter of minutes from Cleveland, Bradley County. Staff from *Children's Hospital @ Erlanger* provide education and training on appropriate protocol and treatment of pediatric emergencies. *Erlanger Bradley County* will have a helipad to foster patient transfer as needed.

13. **Assurance of Resources: The applicant shall document that it will provide the resources necessary to properly support the applicable level of emergency services.**

Included in such documentation shall be a letter of support from the applicant's governing board of directors or Chief Financial Officer documenting the

full commitment of the applicant to develop and maintain the facility resources, equipment, and staffing to provide the appropriate emergency services. The applicant shall also document the financial costs of maintaining these resources and its ability to sustain them to ensure quality treatment of patients in the ED continuum of care.

Response

A letter from the CFO for *Erlanger Health System* is attached to this CON application. The letter assures *Erlanger's* commitment to the provider based ED which will be part of *Erlanger Medical Center* and the *Erlanger Trauma Network*. This commitment will be to provide necessary resources, operate and staff the provider based ED sufficiently as to ensure high quality care, both within and along the ED continuum.

14. Adequate Staffing: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians and nurses. Each FSED is required to be staffed by at least one physician and at least one registered nurse at all times (24/7/365). Physicians staffing the FSED should be board certified or board eligible emergency physicians. If significant barriers exist that limit the applicant's ability to recruit a board certified or board eligible emergency physician, the applicant shall document these barriers for the HSDA to take into consideration. Applicants are encouraged to staff the FSED with registered nurses certified in emergency nursing care and/or advanced cardiac life support. The medical staff of the FSED shall be part of the hospital's single organized medical staff, governed by the same bylaws. The nursing staff of the FSED shall be part of the hospital's single organized nursing staff. The nursing services provided shall comply with the hospital's standards of care and written policies and procedures.

Adequate Staffing of a Rural FSED: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians. FSEDs proposed to be located in rural areas are required to be staffed in accordance with the Code of Federal Regulations Title 42, Chapter IV, Subchapter G, Part 485, Subpart F - Conditions of Participation: Critical Access Hospitals (CAHs). This standard requires a physician, nurse practitioner, clinical nurse specialist, or physician assistant be available at all times the CAH operates. The standard additionally requires a registered nurse, clinical nurse specialist, or licensed practical nurse to be on duty whenever the CAH has one or more inpatients. However, because FSEDs shall be in operation 24/7/365 and because they will not have inpatients, a registered nurse, clinical nurse specialist, or licensed practical nurse shall be on duty at all times (24/7/365). Additionally, due to the nature of the emergency services provided at an FSED and the hours of operation, a physician, nurse practitioner, clinical nurse specialist, or physician assistant shall be on site at all times.

Source:

http://www.ecfr.gov/cgi-bin/textidx?rgn=div6&node=42:5.0.1.1.4.4#se42.5.485_1631

Response

Erlanger Bradley County will be fully accredited by *The Joint Commission*. *Erlanger* does not anticipate difficulties in staffing the provider based ED with trauma center. The ED will be staffed as shown in the following table.

Erlanger Bradley County -- Satellite ED Position Listing			
	Projected FTE's	EHS Avg. Wage	Area Avg. Wage
Direct Patient Care Positions			
Nurse Practitioner (Non-Exempt)	4.4	53.88	46.70
Pharmacist, Staff	1.0	62.97	53.95
Rad. Tech., Spec. Proc.	1.3	23.10	23.30
RN, Staff	8.9	29.89	27.50
Total - Direct Patient Care Positions	15.6		
Non-Direct Patient Care Positions			
ED Director	1.0	57.19	51.74
Nurse Manager	3.0	45.36	41.83
Lab Coordinator	1.3	39.08	33.69
Med. Technologist	5.6	33.02	22.86
Pt. Service Rep.	5.2	13.77	13.74
Maint. Supervisor	0.7	33.77	25.90
Dist. Tech.	1.3	15.09	13.28
Total - Non-Patient Care Positions	18.1		
Total Employees	33.7		
Contractual Staff	0.0		
Total Employees	33.7		

15. Medical Records: The medical records of the FSED shall be integrated into a unified retrieval system with the host hospital.

Response

Erlanger Health System implemented a new EMR system on October 29, 2017. The new EMR system is fully integrated and will serve as a unified retrieval system across all hospitals and ambulatory care sites, including *Erlanger Bradley County* and it's provider based ED with trauma center. Upon approval of this project, the same EMR system will be installed in *Erlanger Bradley County* and it's provider based ED in Cleveland, Tennessee.

16. Stabilization and Transfer Availability for Emergent Cases: The applicant shall demonstrate the ability of the proposed FSED to perform stabilizing treatment within the FSED and demonstrate a plan for the rapid transport of patients from the FSED to the most appropriate facility with a higher level of emergency

care for further treatment. The applicant is encouraged to include air ambulance transport and an on-site helipad in its plan for rapid transport. The stabilization and transfer of emergent cases must be in accordance with the Emergency Medical Treatment and Labor Act.

Response

Erlanger Health System prides itself on the "system of care" that it has developed across a four state area, which includes *LifeForce* air ambulance & helicopter transfer, co-located EMS partnerships, emergency medical oversight and supervision, and physician training in emergency medicine. The depth and breadth of emergency medical services are unmatched elsewhere, while being fully integrated across the healthcare delivery system and the entire four (4) state regional service area. Transfer agreements are in place for many community hospitals in the regional service area. Please see the list attached to this CON application.

The provider based ED in Cleveland, Bradley County, will have a helipad to accommodate *LifeForce* air ambulance and helicopter transfer. As necessary, the stabilization and transfer of emergent cases will be in accordance with the *Emergency Medical Treatment & Labor Act*. *Erlanger's* established "system of care" serves to offset the longer EMS express times typically found in a rural market.

17. Education and Signage: Applicants must demonstrate how the organization will educate communities and Emergency medical services (EMS) on the capabilities of the proposed FSED and the ability for the rapid transport of patients from the FSED 13 to the most appropriate hospital for further treatment. It should also inform the community that inpatient services are not provided at the facility and patients requiring inpatient care will be transported by EMS to a full service hospital. The name, signage, and other forms of communication of the FSED shall clearly indicate that it provides care for emergency and/or urgent medical conditions without the requirement of a scheduled appointment. The applicant is encouraged to demonstrate a plan for educating the community on appropriate use of emergency services contrasted with

appropriate use of urgent or primary care.

Response

Erlanger Bradley County and the provider based ED with trauma center, will work extensively with communities to educate them on the provision of services. Signage and naming conventions will meet all CMS standards and guidelines. In addition, the public communication will include display advertisements in the local newspaper which provide a succinct explanation as to the nature and type of services available, which will contrast the difference between emergency care, with urgent care and primary care.

Further, a significant component of trauma services is to provide community education pertaining to the nature, methods of prevention, and appropriate methods of treatment for trauma wounds. *Erlanger* attributes its success in delivering services to the community, in part, to its efforts to engage and educate the community.

18. Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health and outpatient behavioral health care system, including mental health and substance use, providers/services, providers of psychiatric inpatient services, and working agreements with other related community services assuring continuity of care. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of ED usage. Rationale: The State Health Plan moved from a primary emphasis of health care to an emphasis on "health protection and promotion". The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

Response

Erlanger Health System has business development and physician liaison staff that have been collecting information about the need for emergency services within the service area. It's "system of care" is well known to provide access to a broad based continuum of services,

while ensuring continuity via an integrated EMR system. As a safety net provider, *Erlanger Bradley County* and it's provider based ED with trauma center assure access to all patients, regardless of their ability to pay. *Erlanger Bradley County* will work extensively with communities to educate them on the provision of services. *Erlanger* attributes its success in delivering services to the community, in part, to its efforts to engage and educate the community.

19. Data Requirements: Applicants shall agree to provide the Department of Health and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response

Erlanger Bradley County and the provider based ED with trauma center, will provide all reasonably requested information and statistical data related to the operation and provision of services. Also, to report such data as requested.

20. Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. The FSED shall be integrated into the host hospital's quality assessment and process improvement processes.

Response

Erlanger Bradley County with provider based ED and trauma center will be accredited by *The Joint Commission*. and the *American College of Surgeons* (for trauma care). They will also participate in quality reporting and monitoring, as evidenced by the quality information discussed previously and attached to this CON application. The quality reporting and monitoring will continue with *Erlanger Bradley County* and it's provider based ED.

21. Provider-Based Status: The applicant shall comply with regulations set forth by 42 CFR 413.65, Requirements for a determination that a facility or an organization has provider-based status, in order to obtain provider-based status. The applicant shall demonstrate eligibility to receive Medicare and Medicaid reimbursement, willingness to serve emergency uninsured patients, and plans to contract with commercial health insurers.

Response

Erlanger Bradley County and it's provider based ED with trauma center, will serve emergency uninsured patients regardless of ability to pay. *Erlanger Health System*, participates in both the Medicare and TennCare/Medicaid reimbursement programs. As a component unit, *Erlanger Bradley County* will also participate in these programs. Also, many commercial payors which have a contractual agreement with *Erlanger Health System* will be able to access all the services of *Erlanger Bradley County*. Further, *Erlanger Bradley County* will meet CM standards for provider based designation.

22. Licensure and Quality Considerations: Any applicant for this CON service category shall be in compliance with the appropriate rules of the TDH, the EMTALA, along with any other existing applicable federal guidance and regulation. The applicant shall also demonstrate its accreditation status with the Joint Commission or other applicable accrediting agency. The FSED shall be subject to the same accrediting standards as the licensed hospital with which it is associated.

Response

Erlanger Bradley County and it's provider based ED with trauma center will be accredited by *The Joint Commission* and the *American College of Surgeons* (for trauma care), and they will also comply with rules of TDH, EMTALA and other applicable Federal regulations, as do all other *Erlanger* ED's. Such accreditation will be maintained by *Erlanger Bradley County* and it's provider based ED with

trauma center, upon approval and implementation of this project.

[End Of Responses To Standards & Criteria For Freestanding Emergency Departments, 2016 Update To Tennessee State Health Plan]

CARDIAC CATHETERIZATION SERVICES -- REVISED & UPDATED STANDARDS AND CRITERIA

[Standard & Criteria Effective November 18, 2009]

Standards For All Cardiac Catheterization Services

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

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, will fully collaborate with the Division of Health Planning and other stakeholders to develop a framework for greater accountability to these *Standards and Criteria*.

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, will be licensed by the Department

of Health and will also be accredited by *The Joint Commission*. Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, has a formalized written protocol for immediate and efficient transfer of patients to *Erlanger Medical Center*. A copy of the policy is attached to this CON application.

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, has a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiency. A copy of the policy is attached to this CON application. Applicant will cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee. Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

5.) Data Requirements: Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested

information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, will provide to the *Department of Health* and/or the *Health Services & Development Agency* all reasonably requested information and statistical data. Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

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

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, will document ongoing compliance with the latest clinical guidelines of the American College of Cardiology / Society For Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards (ACC Guidelines).

Further, we intend to seek accreditation by *Accreditation For Cardiovascular Excellence* ("ACE").

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, will assign appropriate staff to the cardiac catheterization laboratory from the laboratory at *Erlanger Medical Center*. Since *Erlanger Bradley County*, will be licensed and operate as, a satellite facility of *Erlanger Medical Center*, the staff located at *Erlanger Bradley County* will possess the same skills as the staff at *Erlanger Medical Center*. The skills of these staff members are transferable between both cardiac catheterization laboratories and they may be rotated between both locations. Such rotation will provide synergy for the cardiac catheterization service line within *Erlanger Health System*.

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

Response

A copy of the report from the Tennessee Dept. of Health, CON Cardiac Cath Need is attached to this CON application. The report shows that the service area for *Erlanger Bradley County* only has one (1) catheterization laboratory at *Tennova - Cleveland*, and this unit performed a weighted total of 435.5 procedures, which is 21.8% of capacity. However, it should be noted that the catheterization laboratories on *Erlanger's* main campus are operating at 131.5% of capacity, with a weighted total of

10,520 procedures performed in four (4) catheterization laboratories (10,520 / 8,000 = 131.5%). As such, there is a need to decompress the volume on the main campus.

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

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

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

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

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

Response

*** Not Applicable. ***

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

a.) Who is offering the service in a medically

underserved area as designated by the United States Health Resources and Services Administration; or

Response

Bradley and Polk counties in Tennessee comprise the service area for *Erlanger Bradley County*. Both counties are designated as medically underserved by the United States Health Resources and Services Administration ("HRSA"). The index of medical underservice for Bradley County is 43.20, and for Polk County is 51.3. An index score below 62 indicates a medically underserved geographic area. A copy of the classification was obtained from the HRSA website, and is attached to this CON application.

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

Response

The mortality rate for heart disease in Tennessee is 207.3 per 100,000 in 2015, according to the U. S. *Centers For Disease Control* (copy attached). The mortality rate for heart disease in Bradley County is 219.3, and for Polk County is 225.6, according to the Tennessee Dept. of Health "Quick Facts" as of 2009, which is the most recent data available on the TDOH website (copies attached).

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

Response

Erlanger Bradley County, as a provider based unit of *Erlanger Medical Center*, is a component facility of the designated safety net hospital by the Bureau of Tenncare Essential Access Hospital payment program.

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, already has signed contracts with the Tenncare MCO's. Please see the list of contracts in attached to this CON application.

Specific Standards For Diagnostic Cardiac Catheterization Services Only

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

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

Response

Not Applicable. Please see *Standards For Therapeutic Cardiac Catheterization Services* below.

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

Response

Not Applicable. Please see *Standards For Therapeutic Cardiac Catheterization Services* below.

13.) Minimum Physician Requirement To Initiate A New Service: The initiation of a new diagnostic cardiac cathetereization program should require at least one cardiologist who performed an average of 75 diagnostic cardiac catheterization procedures over the most recent five year period. All participating cardiologists in the proposed program should be board certified or board eligible in cardiology and any relevant cardiac subspecialties.

Response

Not Applicable. Please see *Standards For Therapeutic Cardiac Catheterization Services* below.

Specific Standards For Therapeutic Cardiac Catheterization Services

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

14.) Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 400 diagnostic and/or therapeutic cardiac catheterization cases per year by its third year of operation. At least 75 of these cases per year should include a therapeutic cardiac catheterization procedure. Annual volume shall be measured based upon a two-year average which shall

begin at the conclusion of the applicant's first year of operation. Only cases including diagnostic and therapeutic cardiac catheterization procedures as defined by these Standards and Criteria shall count towards meeting this minimum volume standard.

Response

The need for the cardiac catheterization service at *Erlanger Bradley County* will meet the minimum volume standard. Following is the estimated volume of interventional and total catheterization patients.

	Interventional Patients	Total Patients
Year 1	65	260
Year 2	104	416
Year 3	107	428
Year 4	110	441
Year 5	113	454
Average - Years 1-2	85	338
Average - Years 2-3	106	422
Average - Years 3-4	109	435
Average - Years 4-5	112	448

The skills of the staff members at *Erlanger Bradley County* will be transferable between the other cardiac catheterization laboratories and constitute a core competency of *Erlanger*. While at *Erlanger Medical Center, Erlanger East Hospital* or *Erlanger Bradley County*, these staff members may be rotated between locations. Such rotation will provide synergy for the cardiac catheterization service line within *Erlanger Health System*.

15.) Open Heart Surgery Availability: Acute care facilities proposing to offer adult therapeutic cardiac catheterization services shall not be required to maintain an on-site open heart surgery program. Applicants without on-site open heart surgery should follow the most recent American College of Cardiology / American Heart Association / Society For Cardiac Angiography and Interventions Practice Guideline Update for Percutaneous Coronary Intervention (ACC/AHA/SCAI Guidelines). As of the adoption of

these Standards and Criteria, the latest version (2007) may be found online at: http://www.ahajournals.org/cgi/CIRCULATIONAHA.107.185159.

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, will follow the most recent American College of Cardiology / American Heart Association / Society For Cardiac Angiography and Interventions Practice Guideline Update for Percutaneous Coronary Intervention (ACC/AHA/SCAI Guidelines).

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

Response

Erlanger Bradley County, as a satellite facility of *Erlanger Medical Center*, will have a minimum of 2 cardiologists with at least 1 cardiologist who performed an average of 75 therapeutic procedures over the most recent five year period.

17.) Staff and Service Availability: Ideally, therapeutic

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

Response

We anticipate that the cardiac catheterization patients which are served at *Erlanger Bradley County* generally will not be high risk patients. High risk patients are generally served at *Erlanger Medical Center*. However, the need may arise for a high risk intervention given the totality of the patient status and clinical conditions. The cardiologists who serve patients at *Erlanger Bradley County* will be the same physicians that serve patients at *Erlanger Medical Center* and *Erlanger East Hospital*. These cardiologists have the necessary expertise and experience to serve higher acuity patients, including emergency patients at *Erlanger Bradley County* and would base the decision on which patients to serve on a clinical assessment, clinical judgment, patient safety, quality of care, and outcomes. We would not place the patient at unnecessary risk.

The skills of the staff members at *Erlanger Bradley* will be transferable between the other cardiac catheterization laboratories and constitute a core competency of *Erlanger Health System*. While at *Erlanger Medical Center, Erlanger East Hospital* or *Erlanger Bradley County*, these staff members may be rotated between locations. Such rotation will provide synergy for the cardiac catheterization service line within *Erlanger Health System*.

The cardiac catheterization laboratory at *Erlanger Medical Center* comports with the standards in this criterion.

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

Response

This criterion is not applicable because *Erlanger Bradley County* does not seek to "expand" a currently existing service. We seek approval to initiate a "new" cardiac catheterization service at this location.

Specific Standards For Pediatric Cardiac Catheterization Services

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

19.) Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 100 cases per year by its third year of operation. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. Only cases that include diagnostic and therapeutic cardiac catheterization procedures as defined by these Standards and Criteria shall count towards meeting this minimum volume standard.

Response

This criterion is not applicable because *Erlanger Bradley County* will not be performing pediatric cardiac catheterization procedures.

20.) Minimum Physician Requirements to Initiate a New Service: The initiation of a new pediatric cardiac catheterization program should require at least two cardiologists with at least one cardiologist having

performed an average of 50 pediatric cardiac catheterization procedures over the most recent five year period. Pediatric cardiac catheterization procedures should be performed only by board certified or board elgible physicians specializing in pediatric cardiac care.

Response

This criterion is not applicable because *Erlanger Bradley County* will not be performing pediatric cardiac catheterization procedures.

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

Response

This is criterion is not applicable because *Erlanger Bradley County* will not be performing pediatric cardiac catheterization procedures.

Specific Standards For Mobile Cardiac Catheterization Services

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

22.) Minimum Volume Standard: Such applicants should demonstrate that the proposed service utilization will be a minimum of 60 cardiac catheterization cases per day of operation per year by its third year of operation. Annual volume shall be measured based upon a two-year average which shall begin at the conclusion of the applicant's first year of operation. If the applicant is proposing services in a rural area where the HSDA determines that access to diagnostic cardiac catheterization services has been limited, and if the applicant is pursuing a partnership with a tertiary facility to share and train staff, the Agency may determine that a minimum volume of 40 cases per day of operation per year is acceptable. Only cases that include diagnostic cardiac catheterization

procedures may count towards meeting this minimum volume standard.

Response

This criterion is not applicable because *Erlanger Bradley County* will not be offering mobile cardiac catheterization procedures.

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

Response

This criterion is not applicable because *Erlanger Bradley County* will not be offering mobile cardiac catheterization procedures.

[End Of Responses To Standard & Criteria For Cardiac Catheterization Services, Effective November 18, 2009, pages 7 - 24]

GENERAL QUESTIONS CONCERNING NEED, ECONOMIC FEASIBILITY, APPLICABLE QUALITY STANDARDS & CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

(I.) *NEED*

1. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health services & Development

Agency, or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

Response

Responses to the *CON Criteria & Standards* applicable to this project have been addressed.

- Construction, Renovation, Expansion, And Replacement Of Healthcare Institutions
- Freestanding Emergency Departments
- Cardiac Catheterization Services -- Revised & Updated Standards & Criteria

2. **Describe the relationship of this project to the applicant facility's long range development plans, if any, and how it relates to related previously approved projects of the applicant.**

Response

Erlanger East Hospital initiated cardiac catheterization services along with the opening of the new patient tower in December, 2016. *Erlanger East Hospital* also holds a CON to initiate a satellite radiation therapy service along with the relocation of a Linear Accelerator from *Erlanger Medical Center* (no. CN1412-048); a CON (No. CN1601-002) to transfer ten (10) medical/surgical beds from *Erlanger Medical Center* to *Erlanger East Hospital* and convert them to NICU beds, for initiation of a Level III NICU service. Further, a CON is outstanding for *Erlanger Behavioral Health, LLC*, for a new eighty eight (88) bed behavioral health hospital (no. CN1603-012), which is currently under construction. Further, two (2) CON applications were approved in December, 2017, for *Erlanger Sequatchie Valley Regional Hospital* (no. CN1709-027) and *Erlanger Sequatchie Valley Regional Hospital - Freestanding Emergency Department* (no. CN1709-028).

Erlanger Health System prides itself on the "system of care" that it has developed across a four state area, which includes *LifeForce* air ambulance & helicopter transfer, co-located EMS partnerships, emergency medical oversight and supervision, and physician training in emergency medicine. The depth and breadth of emergency

medical services are unmatched elsewhere, while being fully integrated across the healthcare delivery system and the entire four (4) state regional service area. Transfer agreements are in place for many community hospitals in the regional service area. Please see the list attached to this CON application.

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. As such, *Erlanger Bradley County* and it's provider based ED with trauma service is part of a long term plan to make services more accessible.

3. Identify the proposed service and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable.
Attachment - Section - Need - 3.

Please complete the following tables, if applicable:

Service Area Counties	*Historical Utilization - County Residents*	*% Of Total Procedures*
County 1		
County 2		
Etc.		
Total		

Response

The service area for *Erlanger Bradley County* is Bradley and Polk counties in Tennessee. The county utilization for ED services appears below, for the most recent three (3) year period.

	ED Visits By County					
	========= ED Visits ========			===== % Of Total Visits ======		
	2014	2015	2016	2014	2015	2016
Bradley County, Tennessee	50,478	51,954	50,904	81.7%	81.7%	82.2%
Polk County, Tennessee	11,331	11,647	11,007	18.3%	18.3%	17.8%
Total	61,809	63,601	61,911	100.0%	100.0%	100.0%
Notes >>	1.) ED visit data from THA market share database.					

Additional pertinent information is relevant to establishment of the defined service area for *Erlanger Bradley County*. The *Erlanger Bradley County* provider based ED with trauma center will serve a need which has been developing over several years for many reasons.

- The *Erlanger East Hospital* ED opened in 2013 and under the *American College Of Emergency Physicians* ("ACEP") standards should accommodate a capacity of 25,000 visits per year, in FY 2017 the total was 34,799. In FY 2018 the total will likely be 38,000 to 40,000 visits. *Erlanger* has a need to decompress the volume on the *East* campus.

- The ED's on *Erlanger's* main campus (EMC & Children's) are experiencing high volumes, and in FY 2018 will be between 88,000 to 90,000 visits. With a Level I trauma center, and the only trauma center in Hamilton County, *Erlanger* has a need to decompress the volume on its' main campus.

- *Copper Basin Medical Center* in Polk County was the latest rural hospital to close, resulting in it's ED closing as well. It should be noted that *Erlanger Health System* has tried to assist *Copper Basin Medical Center*, by offering advice and meeting with HSDA staff and the Division of Licensure, to provide technical and regulatory assistance in an effort to preclude closure of the hospital, but without success.

- Outmigration from the service area (Bradley and Polk counties) is significant. With a total of 61,911 ED visits in 2016, 16,869

patients (27.2%) outmigrated from the service area.

- *Erlanger Bradley County* will be a designated trauma center, bringing Level IV trauma care to Bradley County. Further, the trauma center will be part of *Erlanger's Trauma Network*, which includes a base for a *LifeForce* air ambulance already located at the Cleveland regional airport. The provider based ED will have access to a land ambulance as well as a helipad for *LifeForce* air ambulance. There will be a reserved space (24/7) for land ambulance at the facility. Also, the Bradley County emergency service transports an average of 600 patients per year to *Erlanger Medical Center*. With the establishment of *Erlanger Bradley County*, the emergency service in Bradley County will not be required to make so many transports, so the general population will be better served as a result.

	EHS -- Analysis Of ED Visits By Patient Destination For Service Area Of Erlanger Bradley County			
		2014	2015	2016
Bradley County				
	Outmigration To EHS	5,809	6,421	6,682
	Outmigration To Memorial Hospital	2,619	2,642	2,667
	Outmigration To Parkridge Health System	1,159	1,540	1,391
	Tennova - Cleveland	39,204	39,266	38,056
	Other	1,687	2,085	2,108
	Total - Bradley County	50,478	51,954	50,904
Polk County				
	Outmigration To EHS	791	934	910
	Outmigration To Memorial Hospital	276	307	277
	Outmigration To Parkridge Health System	88	129	120
	Outmigration To Tennova - Cleveland	3,819	3,708	3,605
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	2,612	2,784	2,714
	Total - Polk County	11,331	11,647	11,007
Total				
	EHS	6,600	7,355	7,592
	Memorial Hospital	2,895	2,949	2,944
	Parkridge Health System	1,247	1,669	1,511
	Tennova - Cleveland	43,023	42,974	41,661
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	4,299	4,869	4,822
	Total	61,809	63,601	61,911
Notes >>	1.) ED visit data from THA market share database.			

As may be seen from the data, in 2016 there was a total of 12,047 emergency visits which outmigrated to Chattanooga hospitals. Further, 3,381 emergency patients went to the Copper Basin ED in 2016. All of this adds up to 15,428 ED visits, or 24.9%, where the patients have either chosen to outmigrate, or may now need to outmigrate from the service area for emergency care.

The objective for developing the Level IV trauma center and provider based ED in Bradley County is to foster access by placing an emergency department with trauma service, within a reasonable distance of the population of Bradley County and the surrounding area. The service area for *Erlanger Bradley County* will be Bradley and Polk counties in Tennessee.

The service area is reasonable and provides balance between population density and service proximity. A map showing the service area is attached to this CON application.

4-A 1) Describe the demographics of the population to be served by the proposal.

Response

For the defined service area, the general population is expected to grow 1.8% compared to 2.1% for Tennessee. Those enrolled in TennCare comprise 20.9% of the population compared to 21.0% for Tennessee. Those living below the poverty level is 17.7% compared to 15.3% for Tennessee. Those over age 25 with less than a high school diploma is 11.4% compared to 15.3% for Tennessee. The median household income is $40,520 compared to $45,219 for Tennessee. The minority population is 9.9% compared to 23.5% for Tennessee. The elderly (age 65+) comprise 17.9% compared to 17.5% for Tennessee.

2) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data:
http://www.tn.gov/health/article/statistics-population
TennCare Enrollment Data:
http://www.tn.gov/tenncare/topic/enrollment-data
Census Bureau Fact Finder:
http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

	Dept. Of Health / Health Statistics						Bureau Of The Census				TennCare	
Demographic Variable / Geographic Area	Total Population - Current Year	Total Population - Projected Year	Total Population - % Change	(*) Target Population - Current Year	(*) Target Population - % Change	(*) Target Population - Projected Year As % Of Total	Median Age	Median Household Income	Persons Below Poverty Level	Persons Below Level As % Of Total	TennCare Enrollees	TennCare Enrollees As % Of Total
County A												
County B, etc.												
Service Area Total												
State Of TN Total												

(*) Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child & adolescent psychiatric services will serve the population ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 202.

Response

As requested, the table has been completed.

	Dept. Of Health / Health Statistics						Bureau Of The Census				TennCare	
Demographic Variable / Geographic Area	Total Population - Current Year	Total Population - Projected Year	Total Population - % Change	(*) Target Population - Current Year	(*) Target Population - % Change	(*) Target Population - Projected Year As % Of Total	Median Age	Median Household Income	Persons Below Poverty Level	Persons Below Level As % Of Total	TennCare Enrollees	TennCare Enrollees As % Of Total
Bradley County	106,600	108,679	2.0%	106,600	2.0%	100.0%	39.1	$42,114	18,912	17.7%	22,330	20.9%
Polk County	17,538	17,726	1.1%	17,538	1.1%	100.0%	42.1	$38,925	3,086	17.6%	4,084	23.3%
Service Area Total	124,138	126,405	1.8%	124,138	1.8%	100.0%	39.5	$40,520	21,998	17.7%	26,414	21.3%
State Of TN Total	6,887,572	7,035,572	2.1%	6,887,572	2.1%	100.0%	38.7	$45,219	1,050,889	15.3%	1,446,810	21.0%

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

The special needs of the service area are significant. The *Erlanger Bradley County* provider based ED with trauma center will serve a need which has been developing over several years for many reasons.

- The *Erlanger East Hospital* ED opened in 2013 and under the *American College Of Emergency*

Physicians ("ACEP") standards should accommodate a capacity of 25,000 visits per year, in FY 2017 the total was 34,799. In FY 2018 the total will likely be 38,000 to 40,000 visits. *Erlanger* has a need to decompress the volume on the *East* campus.

- The ED's on *Erlanger's* main campus (EMC & Children's) are experiencing high volumes, and in FY 2018 will be between 88,000 to 90,000 visits. With a Level I trauma center, and the only trauma center in Hamilton County, *Erlanger* has a need to decompress the volume on its' main campus.

- *Copper Basin Medical Center* in Polk County was the latest rural hospital to close, resulting in it's ED closing as well. It should be noted that *Erlanger Health System* has tried to assist *Copper Basin Medical Center*, by offering advice and meeting with HSDA staff and the Division of Licensure, to provide technical and regulatory assistance in an effort to preclude closure of the hospital, but without success.

- Outmigration from the service area (Bradley and Polk counties) is significant. With a total of 61,911 ED visits in 2016, 16,869 patients (27.2%) outmigrated from the service area.

- *Erlanger Bradley County* will be a designated trauma center, bringing Level IV trauma care to Bradley County. Further, the trauma center will be part of *Erlanger's Trauma Network*, which includes a base for a *LifeForce* air ambulance already located at the Cleveland regional airport. The provider based ED will have access to a land ambulance as well as a helipad for *LifeForce* air ambulance. There will be a reserved space (24/7) for land ambulance at the facility. Also, the Bradley County emergency service transports an average of 600 patients per year to *Erlanger Medical Center*. With the establishment of *Erlanger*

Bradley County, the emergency service in Bradley County will not be required to make so many transports, so the general population will be better served as a result.

	EHS -- Analysis Of ED Visits By Patient Destination For Service Area Of Erlanger Bradley County			
		2014	**2015**	**2016**
Bradley County				
	Outmigration To EHS	5,809	6,421	6,682
	Outmigration To Memorial Hospital	2,619	2,642	2,667
	Outmigration To Parkridge Health System	1,159	1,540	1,391
	Tennova - Cleveland	39,204	39,266	38,056
	Other	1,687	2,085	2,108
	Total - Bradley County	50,478	51,954	50,904
Polk County				
	Outmigration To EHS	791	934	910
	Outmigration To Memorial Hospital	276	307	277
	Outmigration To Parkridge Health System	88	129	120
	Outmigration To Tennova - Cleveland	3,819	3,708	3,605
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	2,612	2,784	2,714
	Total - Polk County	11,331	11,647	11,007
Total				
	EHS	6,600	7,355	7,592
	Memorial Hospital	2,895	2,949	2,944
	Parkridge Health System	1,247	1,669	1,511
	Tennova - Cleveland	43,023	42,974	41,661
	Copper Basin Medical Center	3,745	3,785	3,381
	Other	4,299	4,869	4,822
	Total	61,809	63,601	61,911
Notes >>	1.) ED visit data from THA market share database.			

As may be seen from the data, in 2016 there was a total of 12,047 emergency visits which outmigrated to Chattanooga hospitals. Further, 3,381 emergency patients went to the Copper Basin ED in 2016. All of this adds up to 15,428 ED visits, or 24.9%, where the patients have either chosen to outmigrate, or may now need to outmigrate from the service area for emergency care.

The objective for developing the Level IV trauma center and provider based ED in Bradley County is to foster access by placing an emergency department with trauma service, within a reasonable distance of the population of Bradley County and the surrounding area. The service area for *Erlanger Bradley County* will be Bradley and Polk counties in Tennessee.

For the defined service area, the general population is expected to grow 1.8% compared to 2.1% for Tennessee. Those enrolled in TennCare comprise 20.9% of the population compared to 21.0% for Tennessee. Those living below the poverty level is 17.7% compared to 15.3% for Tennessee. Those over age 25 with less than a high school diploma is 11.4% compared to 15.3% for Tennessee. The median household income is $40,520 compared to $45,219 for Tennessee. The minority population is 9.9% compared to 23.5% for Tennessee. The elderly (age 65+) comprise 17.9% compared to 17.5% for Tennessee.

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

Response

There are not currently any outstanding CON projects of similar healthcare providers, in the service area.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or

documentation from referral sources, and identification of all assumptions.

Response

The historical ED utilization for *Erlanger Medical Center, Erlanger East Hospital, and Tennova - Cleveland* is as follows, along with the projected ED utilization for *Erlanger Bradley County.*

EHS -- Forecast Of ED Utilization

Hospital	No. Of Rooms	===== Historical Utilization ======= 2014	2015	2016	2017	===== Projected Utilization ======= 2018	2019	2020	2021
Total ED Visits									
Erlanger Medical Center		52,272	55,597	51,926	49,815	50,313	50,816	51,324	51,837
Children's Hospital @ Erlanger		37,895	41,502	40,759	40,993	41,403	41,817	42,235	42,657
Erlanger East Hospital		22,009	26,172	31,197	34,799	37,235	39,841	42,630	45,614
Tennova - Cleveland		49,791	50,533	48,501	49,608	50,104	50,605	51,111	51,622
Average ED Visits Per Treatment Room									
Erlanger Medical Center	48	1,089	1,158	1,082	1,038	1,048	1,059	1,069	1,080
Children's Hospital @ Erlanger	31	1,222	1,339	1,315	1,322	1,336	1,349	1,362	1,376
Erlanger East Hospital	17	1,295	1,540	1,835	2,047	2,190	2,344	2,508	2,683
Tennova - Cleveland	42	1,186	1,203	1,155	1,181	1,193	1,205	1,217	1,229

Notes >>
1.) Data is from the Joint Annual Reports for 2014, 2015 and 2016.
2.) Data for 2017 for Erlanger ED's is from internal records.
3.) Tennova data for 2017 is estimated.
4.) Tennova growth rate is assumed at 1% in projected years.
5.) Erlanger Medical Center Children's Hospital @ Erlanger growth rates are assumed at 1% in projected years.
6.) Erlanger East Hospital growth rate is assumed at 7% in projected years. It should be noted that this is a conservative estimate, as there was an 18.9% growth rate in 2015, 19.2% in 2016, and 11.5% in 2017.

As may be seen from the projected utilization, *Erlanger East Hospital* will be approximately 93% above it's standard threshold for utilization by 2021, if current trends remain the same [(2,683-1,389) / 1,389 = 93%].

(II.) *ECONOMIC FEASIBILITY*

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

A. All projects should have a project cost of at least $ 15,000 (the minimum CON filing fee). (See application instructions for filing fee.)

B. The cost of any lease (building, land and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total construction Cost on the Square Footage Chart.

E. For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs. Provide a letter that includes the following:

1.) A general description of the project;
2.) An estimate of the cost to construct the project;
3.) A description of the status of the site's suitability for the proposed project; and
4.) Attesting the physical environment will conform to applicable federal standards, Guidelines For Design & construction Of Hospital And Health Care Facilities in current use by the licensing authority.

Response

The *Project Cost Chart* has been completed and the architect letter is attached to this CON application.

It is noted that the option agreement specifies 15 acres, however, the remaining 12.1 acres may be for sale or designated for commercial, or other uses. For this reason, on the *Project Cost Chart*, only 2.9 acres of the site acquired are included in the acquisition cost.

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PROJECT COST CHART

A. Construction And Equipment Acquired By Purchase.

1.	Architecural And Engineering Fees	278,650
2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)	50,000
3.	Acquisition Of Site	831,317
4.	Preparation Of Site	200,000
5.	Total Construction Cost	4,086,390
6.	Contingency Fund	230,000
7.	Fixed Equipment (Not Included In Construction Contract)	3,559,902
8.	Moveable Equipment (List all equipment over $ 50,000 as separate attachments)	1,797,084
9.	Other (Specify) Signage, IT, etc.	200,000

B. Acquisition By Gift, Donation, Or Lease.

1.	Facility (inclusive of building and land)	0
2.	Building Only	0
3.	Land Only	0
4.	Equipment (Specify)	0
5.	Other (Specify)	0

C. Financing Costs And Fees.

1.	Interim Financing	0
2.	Underwriting Costs	0
3.	Reserve For One Year's Debt Service	0
4.	Other (Specify)	0

D.	Estimated Project Cost	(A + B + C)	11,233,343
E.	CON Filing Fee		64,592
F.	Total Estimated Project Cost	(D + E) **TOTAL**	11,297,935

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

___ A. Commercial Loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

X E. Cash Reserves - Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

___ F. Other - Identify and document funding from all other sources.

Response

Erlanger Bradley County in Cleveland, Tennessee, will be financed through cash reserves and general operating funds of *Erlanger Health System*.

3. Complete Historical Data Charts on the following two pages - *Do not modify the charts provided or submit Chart substitutions*!

Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being represented in the proposed project, if applicable. Only complete on chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliate" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Response

The *Historical Data Chart* for *Erlanger Health System* has been completed. *Erlanger Bradley County* does not have any historical financial data to report.

[X] Total Facility
[ ] Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year – 2015	Year – 2016	Year – 2017
A.	Utilization Data (Specify Unit Of Measure, e.g., 1,000 patient days, 500 visits) *Admissions*	33,340	35,414	38,626
B.	Revenue From Services To Patients			
	1. Inpatient Services	1,182,962,344	1,351,864,630	1,552,586,681
	2. Outpatient Services	830,030,436	1,051,720,167	1,179,346,530
	3. Emergency Services	171,845,957	174,619,483	153,831,309
	4. Other Operating Revenue (Specify) Cafeteria, POB Rent, etc.	32,126,111	34,832,638	39,199,172
	Gross Operating Revenue	2,216,964,848	2,613,036,918	2,924,963,692
C.	Deductions From Gross Operating Revenue			
	1. Contractual Adjustments	1,317,441,010	1,582,294,354	1,805,144,352
	2. Provision For Charity Care	92,392,901	120,162,010	143,776,063
	3. Provision For Bad Debt	93,878,274	86,281,667	89,674,488
	Total Deductions	1,503,712,185	1,788,738,031	2,038,594,903
	NET OPERATING REVENUE	713,252,663	824,298,887	886,368,789
D.	Operating Expenses			
	1. Salaries And Wages	270,118,412	343,380,137	328,114,115
	a. Direct Patient Care			
	b. Non-Patient Care			
	2. Physician's Salaries And Wages	76,375,201	76,810,637	130,206,238
	3. Supplies	93,104,628	115,383,067	127,781,133
	4. Rent			
	a. Paid To Affiliates			
	b. To Non-Affiliates	5,816,951	5,600,980	6,860,915
	5. Management Fees			
	a. Paid To Affiliates			
	b. To Non-Affiliates			
	6. Other Operating Exp. (Specify) Insurance, Purch. Svcs., etc.	193,745,905	227,661,689	256,109,721
	Total Operating Expenses	639,131,097	768,836,510	849,072,122
E.	**Earnings Before Interest, Taxes & Depr.**	74,589,035	56,345,580	37,296,667
F.	Non-Operating Expenses			
	1. Taxes	558,754	425,049	483,494
	2. Depreciation	25,647,102	25,494,192	26,942,042
	3. Interest			
	4. Other Non-Operating Expenses			
	Total Non-Oper. Exp.	26,205,856	25,494,192	27,425,536
	NET INCOME (LOSS)	47,885,710	29,543,136	9,871,131

G. Other Deductions			
1. Annual Principal Debt Repayment	7,300,000	5,197,931	4,455,000
2. Annual Capital Expenditure	19,110,605	69,608,123	63,658,569
Total Other Deductions	26,410,605	74,806,054	68,113,569
NET BALANCE	21,475,105	(45,262,918)	(58,242,438)
DEPRECIATION	25,647,102	25,494,192	26,942,042
FREE CASH FLOW (Net Balance + Depreciation)	47,122,207	(19,768,726)	(31,300,396)

☑ **Total Facility**
☐ **Project Only**

HISTORICAL DATA CHART -- OTHER EXPENSES

Other Expense Categories

		Year - 2014	Year – 2015	Year – 2016
1.)	Purchased Services	137,413,193	156,823,176	168,691,796
2.)	Utilities	9,572,575	9,809,510	10,609,759
3.)	Drugs	43,565,706	57,986,926	71,695,682
4.)	Insurance & Taxes	3,194,431	3,042,077	5,112,484
5.)				
6.)				
7.)				
	Total -- Other Expenses	193,745,905	227,661,689	256,109,721

[ ] Total Facility
[X] Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in ___July___ (Month).

		Year – 2015	Year – 2016	Year – 2017
A.	Utilization Data (Specify Unit Of Measure, e.g., 1,000 patient days, 500 visits) _____			
B.	Revenue From Services To Patients			
	1. Inpatient Services			
	2. Outpatient Services			
	3. Emergency Services			
	4. Other Operating Revenue (Specify) _____			
	Gross Operating Revenue			
C.	Deductions From Gross Operating Revenue			
	1. Contractual Adjustments			
	2. Provision For Charity Care			
	3. Provision For Bad Debt			
	Total Deductions			
	NET OPERATING REVENUE			
D.	Operating Expenses			
	1. Salaries And Wages			
	a. Direct Patient Care			
	b. Non-Patient Care			
	2. Physician's Salaries And Wages			
	3. Supplies			
	4. Rent			
	a. Paid To Affiliates			
	b. To Non-Affiliates			
	5. Management Fees			
	a. Paid To Affiliates			
	b. To Non-Affiliates			
	6. Other Operating Exp.			
	Total Operating Expenses			
E.	**Earnings Before Interest, Taxes & Depr.**			
F.	Non-Operating Expenses			
	1. Taxes			
	2. Depreciation			
	3. Interest			
	4. Other Non-Operating Expenses			
	Total Non-Oper. Exp.			
	NET INCOME (LOSS)			

G.	Other Deductions		
	1. Annual Principal Debt Repayment	_____	_____	_____
	2. Annual Capital Expenditure	_____	_____	_____
	Total Other Deductions	_____	_____	_____
	NET BALANCE	_____	_____	_____
	DEPRECIATION	_____	_____	_____
	FREE CASH FLOW (Net Balance + Depreciation)	_____	_____	_____

☐ **Total Facility**
☑ **Project Only**

HISTORICAL DATA CHART -- OTHER EXPENSES

Other Expense Categories

		Year – 2014	Year – 2015	Year – 2016
1.)	Purchased Services			
2.)	Utilities			
3.)	Drugs			
4.)	Insurance			
5.)	Corporate O/H Allocation			
6.)				
7.)				
	Total -- Other Expenses			

4. **Complete Projected Data Charts on the following two pages - *Do not modify the charts provided or submit Chart substitutions*!**

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense information for the *Proposal Only* (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. Only complete one chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliate" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Response

The *Projected Data Charts* for *Erlanger Health System* and *Erlanger Bradley County* have been completed.

[X] Total Facility Project Only

PROJECTED DATA CHART

Give information for the two years following the completion of this proposal. The fiscal year begins in July (Month).

		Year – 1	Year – 2
A.	Utilization Data (Specify Unit Of Measure, e.g., 1,000 patient days, 500 visits) *Admissions*	42,033	43,294
B.	Revenue From Services To Patients		
	1. Inpatient Services	1,717,846,834	1,769,382,239
	2. Outpatient Services	1,267,254,517	1,305,272,153
	3. Emergency Services	216,769,480	223,272,564
	4. Other Operating Revenue (Specify) Cafeteria, POB Rent, etc.	43,181,261	44,476,699
	Gross Operating Revenue	3,245,052,092	3,342,403,655
C.	Deductions From Gross Operating Revenue		
	1. Contractual Adjustments	2,006,457,128	2,066,650,841
	2. Provision For Charity Care	152,440,835	157,014,060
	3. Provision For Bad Debt	109,566,851	112,853,857
	Total Deductions	2,268,464,814	2,336,518,758
	NET OPERATING REVENUE	976,587,278	1,005,884,897
D.	Operating Expenses		
	1. Salaries And Wages	424,884,153	437,630,677
	a. Direct Patient Care		
	b. Non-Patient Care		
	2. Physician's Salaries And Wages	95,042,612	97,893,891
	3. Supplies	141,344,665	145,585,004
	4. Rent		
	a. Paid To Affiliates		
	b. To Non-Affiliates	7,902,248	7,902,248
	5. Management Fees		
	a. Paid To Affiliates		
	b. To Non-Affiliates		
	6. Other Operating Exp.	261,395,911	268,928,596
	Total Operating Expenses	930,569,589	957,940,416
E.	**Earnings Before Interest, Taxes & Depr.**	46,017,689	47,944,481
F.	Non-Operating Expenses		
	1. Taxes	525,000	525,000
	2. Depreciation	31,598,801	32,546,765
	3. Interest	9,439,529	9,722,715
	4. Other Non-Operating Expenses	(545,641)	
	Total Non-Oper. Exp.	41,017,689	42,794,480
	NET INCOME (LOSS)	5,000,000	5,150,001

G.	Other Deductions		
	1. Annual Principal Debt Repayment	5,300,000	5,300,000
	2. Annual Capital Expenditure	45,792,779	47,166,562
	Total Other Deductions	51,092,779	52,466,562
	NET BALANCE	(46,092,779)	(47,316,561)
	DEPRECIATION	31,598,801	32,546,765
	FREE CASH FLOW (Net Balance + Depreciation)	(14,493,978)	(14,769,796)

☑ **Total Facility**
☐ **Project Only**

PROJECTED DATA CHART -- OTHER EXPENSES

Other Expense Categories

		Year - 1	Year - 2
1.)	Purchased Services	175,888,546	180,879,508
2.)	Utilities	10,659,912	10,962,394
3.)	Drugs	71,040,342	73,171,553
4.)	Insurance	3,807,111	3,915,141
5.)	Other		
6.)	Corporate O/H Allocation		
7.)			
	Total -- Other Expenses	261,395,911	268,928,596

[ ] Total Facility
[X] Project Only

PROJECTED DATA CHART

Give information for the two years following the completion of this proposal. The fiscal year begins in July (Month).

		Year – 1	Year – 2
A.	Utilization Data (Specify Unit Of Measure, e.g., 1,000 patient days, 500 visits) *ED Visits*	14,000	15,500
B.	Revenue From Services To Patients		
	1. Inpatient Services		
	2. Outpatient Services	5,729,049	9,597,303
	3. Emergency Services	29,727,384	34,459,347
	4. Other Operating Revenue (Specify)		
	Gross Operating Revenue	35,456,433	44,056,650
C.	Deductions From Gross Operating Revenue		
	1. Contractual Adjustments	24,566,229	30,754,591
	2. Provision For Charity Care	2,015,232	2,522,880
	3. Provision For Bad Debt	2,248,757	2,815,231
	Total Deductions	28,830,218	36,092,702
	NET OPERATING REVENUE	6,626,216	7,963,948
D.	Operating Expenses		
	1. Salaries And Wages		
	a. Direct Patient Care	1,691,592	1,944,292
	b. Non-Patient Care	1,292,997	1,486,447
	2. Physician's Salaries And Wages		
	3. Supplies	147,083	233,830
	4. Rent		
	a. Paid To Affiliates		
	b. To Non-Affiliates		
	5. Management Fees		
	a. Paid To Affiliates		
	b. To Non-Affiliates		
	6. Other Operating Exp.	1,853,467	2,229,057
	Total Operating Expenses	4,985,139	5,893,626
E.	**Earnings Before Interest, Taxes & Depr.**	1,641,077	2,070,322
F.	Non-Operating Expenses		
	1. Taxes		
	2. Depreciation	502,410	502,410
	3. Interest		
	4. Other Non-Operating Expenses		
	Total Non-Oper. Exp.	502,410	502,410
	NET INCOME (LOSS)	1,138,667	1,567,912

G.	Other Deductions		
	1. Annual Principal Debt Repayment		
	2. Annual Capital Expenditure		
	Total Other Deductions		
	NET BALANCE	1,138,667	1,567,912
	DEPRECIATION	502,410	502,410
	FREE CASH FLOW (Net Balance + Depreciation)	1,641,077	2,070,322

☐ **Total Facility**
☑ **Project Only**

PROJECTED DATA CHART -- OTHER EXPENSES

Other Expense Categories

		Year - 1	Year - 2
1.)	Purchased Services	742,153	849,364
2.)	Implants	198,129	326,516
3.)	Drugs	121,750	167,946
4.)	Utilities	232,200	232,200
5.)	Other	559,235	653,031
6.)			
7.)			
	Total -- Other Expenses	1,853,467	2,229,057

5. **A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.**

	Previous Year	*Current Year*	*Year 1*	*Year 2*	*% Change -- Current Year To Year 2*
Gross Charge (Gross Operating Revenue / Utilization Data)					
Deduction From Revenue (Total Deductions / Utilization Data)					
Average Net Charge (Net Oper. Revenue / Utilization Data)					

Response

As requested, the table has been completed. However, please note that there is not any historical data to report for *Erlanger Bradley County*.

	Previous Year	*Current Year*	*Year 1*	*Year 2*	*% Change -- Year 1 To Year 2*
Gross Charge (Gross Operating Revenue / Utilization Data)			$2,533	$2,842	12.2%
Deduction From Revenue (Total Deductions / Utilization Data)			$2,059	$2,329	13.1%
Average Net Charge (Net Oper. Revenue / Utilization Data)			$473	$514	8.7%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response

The list of average patient charges appear below, by service line for *Erlanger Medical Center, Erlanger East Hospital* and *Tennova - Cleveland*. Applicant does revise it's patient charge structure on a periodic basis (i.e.- annually) during the budget cycle each fiscal year. However, applicant does not anticipate any changes to existing patient charges specifically as a result of this project.

Average ED Charge Per Visit -- For CY 2016			
	Erlanger Med. Ctr.	Erlanger East	Tennova - Cleveland
Blood and blood-forming organ dzs	$13,982	$3,775	$29,435
Circulatory system dzs	$24,012	$5,241	$23,710
Complic. pregnancy, childbirth, puerperium	$6,112	$2,166	$6,796
Condit originating in the perinatal period	$7,554	$851	$3,453
Congenital anomalies	$18,325	$878	$9,754
Digestive system dzs	$9,419	$3,393	$20,628
Endo/nutrit/metab dzs and immune disorder	$9,556	$3,913	$22,394
Genitourinary system dzs	$7,365	$4,287	$15,166
Infectious and parasitic dzs	$14,695	$2,017	$52,430
Injury and poisoning	$11,266	$2,050	$10,203
Mental disorders	$6,594	$2,107	$10,054
Musculoskel sys and connect tiss dzs	$5,388	$1,829	$7,602
Neoplasms	$51,572	$4,636	$62,140
Nerv system and sense organ dzs	$6,170	$2,652	$6,706
Other conditions	$3,195	$3,663	$8,859
Respiratory system dzs	$5,052	$2,147	$16,269
Skin and subcutaneous tissue dzs	$2,986	$1,634	$8,190
Unknown or No Diagnosis	$6,662	$1,739	$6,510
Grand Total	$9,322	$2,858	$14,855

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services & Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) codes(s).

Response

The list of average patient charges appear below, by service line for *Erlanger Medical Center, Erlanger East Hospital* and *Tennova - Cleveland*. It is of interest to note that Erlanger Medical Center's average charge per visit is noticeably lower than *Tennova - Cleveland*, for most service lines, with a few exceptions. Further, the average charge per visit for *Erlanger East Hospital* is lower than *Tennova - Cleveland* for every service line, without exception.

Average ED Charge Per Visit -- For CY 2016			
	Erlanger Med. Ctr.	Erlanger East	Tennova - Cleveland
Blood and blood-forming organ dzs	$13,982	$3,775	$29,435
Circulatory system dzs	$24,012	$5,241	$23,710
Complic. pregnancy, childbirth, puerperium	$6,112	$2,166	$6,796
Condit originating in the perinatal period	$7,554	$851	$3,453
Congenital anomalies	$18,325	$878	$9,754
Digestive system dzs	$9,419	$3,393	$20,628
Endo/nutrit/metab dzs and immune disorder	$9,556	$3,913	$22,394
Genitourinary system dzs	$7,365	$4,287	$15,166
Infectious and parasitic dzs	$14,695	$2,017	$52,430
Injury and poisoning	$11,266	$2,050	$10,203
Mental disorders	$6,594	$2,107	$10,054
Musculoskel sys and connect tiss dzs	$5,388	$1,829	$7,602
Neoplasms	$51,572	$4,636	$62,140
Nerv system and sense organ dzs	$6,170	$2,652	$6,706
Other conditions	$3,195	$3,663	$8,859
Respiratory system dzs	$5,052	$2,147	$16,269
Skin and subcutaneous tissue dzs	$2,986	$1,634	$8,190
Unknown or No Diagnosis	$6,662	$1,739	$6,510
Total	$9,322	$2,858	$14,855

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha numeric order and labeled as Attachment C, Economic Feasibility. Note: Publicly held entities only need to reference their SEC filings.

Response

As the *Projected Data Chart* for the project illustrates, it is expected to have a positive margin for

years 1 and 2. It is noted that *Erlanger Bradley County* has been conservative with revenue, and liberal with expenses.

Erlanger Bradley County in Cleveland, Tennessee, will be financed through continuing operations of *Erlanger Health System*.

B. Net Operating Margin Ratio - Demostrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings Before Interest, Taxes & Depreciation / Net operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table.

Year	*2nd Year Previous To Current Year*	*1st Year Previous To Current Year*	*Current Year*	*Projected Year 1*	*Projected Year 2*
Net Operating Margin Ratio					

Response

As requested, the table has been completed. However, it should be noted that there is no historical data to report for this project.

Year	*2nd Year Previous To Current Year*	*1st Year Previous To Current Year*	*Current Year*	*Projected Year 1*	*Projected Year 2*
Net Operating Margin Ratio	-	-	-	6.2%	6.3%

C. Capitalization Ratio (Long Term debt to capitalization) - Measures the proportion of debt financiang in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt /

(Long-term debt/Total Equity (Net Assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratio's are not expected from outside the company lenders that provide funding.

Response

Erlanger Health System does not maintain a separate balance sheet for each member facility. As such, the asset listing is maintained on the corporate schedules of *Erlanger Health System*. For this reason, the capitalization ratios pertaining to this question represent the financial status of *Erlanger Health System*.

Based on the audited financial statements for *Erlanger Health System* at June 30, 2017 (copy attached), the capitalization ratio is 50.3, calculated as follows.

1.)	Long Term Debt	$202,918,634
2.)	Total Equity (Net Assets)	$200,288,815
3.)	Long Term Debt + Total Equity	$403,207,449
	Ratio (Line 1 / Line 3) x 100	50.33

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1

	Projected Gross Operating Revenue	*As A % Of Total*
Medicare / Medicaid Managed Care		
TennCare / Medicaid		
Commercial / Other Managed Care		
Self - Pay		
Charity Care		
Other (Specify _____)		
Total		

Response

Erlanger Medical Center participates in Medicare, *TennCare*, Medicaid, and most other government sponsored programs designed for vulnerable segments of the population.

As requested, the table has been completed below.

	Projected Gross Operating Revenue	*As A % Of Total*
Medicare / Medicare Managed Care	8,850,457	24.2%
TennCare / Medicaid	5,566,660	15.7%
Commercial / Other Managed Care	16,193,611	45.7%
Self - Pay	4,432,054	12.5%
Charity Care	435,456	1.2%
Other (Specify _____)	248,195	0.7%
Total	35,456,433	100.0%

It should be noted that *Erlanger Health System* provides $ 100 million in uncompensated car per year.

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTE's) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources

Position Classification	*Existing FTE's*	*Projected FTE's*	*Average Wage (Contractual Rate)*	*Area Wide / State Wide Average Wage*
A. Direct Patient Care Positions				
Position 1				
Position 2				
Etc.				
Total - Direct Patient Care Positions				
B. Non-Patient Care Positions				
Position 1				
Position 2				
Etc.				
Total - Non-Patient Care Positions				
Total Employees *(A + B)*				
C. Contractual Staff				
Total Staff *(A + B + C)*				

Response

As requested, the table has been completed. However, *Erlanger Bradley County* does not have any historical data to report.

Erlanger Bradley County -- Satellite ED
Position Listing

	Projected FTE's	EHS Avg. Wage	Area Avg. Wage
Direct Patient Care Positions			
Nurse Practitioner (Non-Exempt)	4.4	53.88	46.70
Pharmacist, Staff	1.0	62.97	53.95
Rad. Tech., Spec. Proc.	1.3	23.10	23.30
RN, Staff	8.9	29.89	27.50
Cardiac Specialist	2.0	30.58	32.31
Total - Direct Patient Care Positions	17.6		
Non-Direct Patient Care Positions			
ED Director	1.0	57.19	51.74
Manager - Cath. Lab.	1.0	45.62	46.41
Nurse Manager	3.0	45.36	41.83
Lab Coordinator	1.3	39.08	33.69
Med. Technologist	5.6	33.02	22.86
Pt. Service Rep.	5.2	13.77	13.74
Maint. Supervisor	0.7	33.77	25.90
Dist. Tech.	1.3	15.09	13.28
Total - Non-Patient Care Positions	19.1		
Total Employees	36.7		
Contractual Staff	0.0		
Total Employees	36.7		

9. **Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:**

   A. **Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.**

   B. **Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.**

   Response

Expansion of the ED at *Erlanger East Hospital* is not feasible because the land available on the campus is not sufficient to accommodate additional parking that would be required. Expansion of the ED's at *Erlanger Medical Center* and *Children's Hospital @ Erlanger* is not feasible because the facility is limited by the available spatial constraints. Also, the ED's have no additional room to expand as the campus is literally surrounded by public roads. There simply is not room to accommodate larger ED's on *Erlanger's* main campus. As such, this is the only option available to ensure access to needed services.

(III.) *CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE*

1. **List all health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

   Response

The most significant relationship between this proposal and the existing healthcare system is that it will be part of an existing health system and enhance *Erlanger Health System's* ability to integrate its services within the regional service area as the safety net provider, trauma center and region's only academic medical center. A list of the patient transfer agreements, along with a list of the currently contracted payor organizations, is attached to this CON application.

By providing these services regardless of a patient's ability to pay, the regional healthcare delivery system of care is positively impacted by the services envisioned in this application.

The applicant will have transfer arrangements with the following hospitals which are owned by *Erlanger Health System*.

-- Erlanger Medical Center
-- Erlanger East Hospital
-- Erlanger North Hospital
-- T. C. Thompson Children's Hospital
-- Erlanger Bledsoe Hospital

Further, Erlanger currently has patient transfer agreements in place with more than 70 hospitals and other providers in the four (4) state area. These providers refer patients to *Erlanger* because of the depth and breadth of its programs and services.

2. Describe the effects of competition and/or duplication of the proposal on the healthcare system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

Response

The effects of this proposal will be positive for the healthcare system because it will deliver the most

appropriate level of care for those who are in need of emergency medical service regardless of ability to pay, and thereby, will also serve to foster improved access to care. The regional healthcare delivery system is positively impacted by serving those who are otherwise in need of these necessary services, regardless of their ability to pay.

As demonstrated herein, *Erlanger Bradley County* seeks approval to initiate a provider based emergency department with a Level IV trauma service and a full service cardiac catheterization laboratory, to make these services available to Bradley and Polk counties in Tennessee. The need for this project has developed over several years for many reasons, as follows.

- The *Erlanger East Hospital* ED opened in 2013 and under the *American College Of Emergency Physicians* ("ACEP") standards should accommodate a capacity of 25,000 visits per year, in FY 2017 the total was 34,799. In FY 2018 the total will likely be 38,000 to 40,000 visits. *Erlanger* has a need to decompress the volume on the *East* campus.

- The ED's on *Erlanger's* main campus (EMC & Children's) are experiencing high volumes, and in FY 2018 will be between 88,000 to 90,000 visits. With a Level I trauma center, and the only trauma center in Hamilton County, *Erlanger* has a need to decompress the volume on its' main campus.

- *Copper Basin Medical Center* in Polk County was the latest rural hospital to close, resulting in it's ED closing as well. It should be noted that *Erlanger Health System* has tried to assist *Copper Basin Medical Center*, by offering advice and meeting with HSDA staff and the Division of Licensure, to provide technical and regulatory assistance in an effort to preclude closure of the hospital, but without success.

- Outmigration from the service area (Bradley Polk counties) is significant. With a total

of 61,911 ED visits in 2016, 16,869 patients (27.2%) outmigrated from the service area.

- *Erlanger Bradley County* will be a designated trauma center, bringing Level IV trauma care to Bradley County. Further, the trauma center will be part of *Erlanger's Trauma Network*, which includes a base for a *LifeForce* air ambulance already located at the Cleveland regional airport. The provider based ED will have access to a land ambulance as well as a helipad for *LifeForce* air ambulance. There will be a reserved space (24/7) for land ambulance at the facility. Also, the Bradley County emergency service transports an average of 600 patients per year to *Erlanger Medical Center*. With the establishment of *Erlanger Bradley County*, the emergency service in Bradley County will not be required to make so many transports, so the general population will be better served as a result.

The objective for developing the Level IV trauma center and provider based ED in Bradley County is to foster access by placing an emergency department with trauma service, within a reasonable distance of the population of Bradley County and the surrounding area. The service area for *Erlanger Bradley County* will be Bradley and Polk counties in Tennessee. Thus, patients will not need to travel to Chattanooga, Hamilton County, for needed emergency services.

B. Negative Effects

Response

Applicant does not envision adverse effects of this proposal on the healthcare system. While a small portion of patients who currently utilize providers in the service area may seek an alternative, it is anticipated that this effect will be minimal. That being said, it should not be overlooked that there are no trauma services available in the service area.

3. **A. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State Of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission On Accreditation Of Rehabilitation Facilities.**

Response

Professional staff for the proposal is expected to be available and accessible, including clinical leadership. All clinical staff will be licensed as required by the respective *Health Professional Boards* of the *Tennessee Dept. of Health*.

Erlanger Bradley County and it's provider based ED with trauma center will be accredited by *The Joint Commission*, and will also be in compliance with rules of the *Tennessee Dept. of Health*, and other applicable Federal regulations. Such accreditation will be maintained upon approval and implementation of this project.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes, regulations, and accreditation standards.

C. Discuss the applicant's participation in the training of students in the areas of medicine,

nursing, social work, etc. (e.g.-internships, residencies, etc.).

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few. It is also expected that *Erlanger Behavioral Health* will do so as well.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the *University of Tennessee at Chattanooga* to assist nurses transitioning from RN to BSN. *Erlanger* provides a teaching environment for staff as well with various on-the-job training opportunities (i.e.-CT for Radiologic Technologist, Certification for LPN's, etc.). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography. Also, *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health. *Erlanger* has established strong long term relationships with the region's colleges, universities and clinical programs. A list of the many schools, colleges and universities with which Erlanger maintains collaborative relationships ("Clinical Affiliation Agreements") is attached to this CON application.

The *University of Tennessee - College of Medicine* is co-located at *Erlanger* and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

Emergency Medicine
Family Medicine

Internal Medicine
Obstetrics & Gynecology
Orthopedic Surgery
Pediatrics
Plastic Surgery
Surgery
Urology
Transitional Year

Fellowship Programs
Cardiovascular Disease
Colon & Rectal Surgery
Emergency Medicine
Gastroenterology
Gynecologic Surgery - Minimally Invasive
Neuro-Interventional Surgery
Orthopedic Trauma Surgery
Surgical Critical Care
Vascular Surgery
Ultrasound
Transitional Year

Erlanger Health System is also a member of the *Vanderbilt University Medical Center - Health Network*. This affiliation will further enhance our ability to provide state of the art research, education and training programs. *Erlanger Health System* has also affiliated with *Technion Institute Of Technology*, in Haifa, Israel, for training of medical students, as well as graduate medical education, residency training and research. Increased opportunity exists in various medical specialties to potentially add to *Erlanger's* growing portfolio of medical research and training programs.

4. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: State of Tennessee, Dept. of Health

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.):

** Not applicable to this project. **

Accreditation: Joint Commission on Accreditation of Healthcare Organizations

A. If an existing institution, please describe the Current standing with any licensing, certifying, or accrediting agency or commission. Provide a copy of the current license of the facility.

Response

Erlanger Bradley County and it's provider based ED with trauma center will be accredited by *The Joint Commission*, and will also be licensed by the Tennessee Dept. of Health, and compliant with current Federal and State regulations. Such accreditation and licensure will be maintained by *Erlanger Bradley County* and it's provider based ED with trauma service, upon approval and implementation of this project.

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response

As requested, a copy of the most recent *Statement Of Deficiencies & Plan Of Correction*, is attached to this CON application.

C. Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

Response

Erlanger Medical Center, in the last three (3) survey cycles, has not had any results leading to suspension of admissions, civil monetary penalties, or notice of termination proceedings.

1.) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response

** *Not applicable.* **

5. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

A. Has any of the following:

1.) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

Response

Erlanger Bradley County, if approved, will be a member of *Erlanger Health System*, which is a governmental unit authorized by an act of the *Tennessee General Assembly* in formation of the *Chattanooga-Hamilton County Hospital Authority*. As a governmental unit, with "public ownership" by the people of the State of Tennessee, no person or entity owns more than 5%, either directly or indirectly.

2.) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for the applicant) has an ownership interest of more than 5%; and/or

Response

Erlanger Bradley County, if approved, will be a member of *Erlanger Health System*, which is a governmental unit authorized by an act of the *Tennessee General Assembly* in formation of the *Chattanooga-Hamilton County Hospital Authority*. As a governmental unit, with "public ownership" by the people of the State of Tennessee, no person or entity owns more than 5%, either directly or indirectly.

3.) Any physician or other provider of healthcare, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

Response

Erlanger Bradley County will be a member of *Erlanger Health System*, which is a governmental unit authorized by an act of the *Tennessee General Assembly* in formation of the *Chattanooga-Hamilton County Hospital Authority*. As a governmental unit, with "public ownership" by the people of the State of Tennessee, no person or entity owns more than 5%, either directly or indirectly.

B. Been subjected to any of the following:

1.) Final Order or Judgment in a state licensure action;

Response

Erlanger Medical Center has not been subject to a final order or judgment in any licensure action.

2.) Criminal fines in cases involving a Federal or State health care offense;

Response

Erlanger Medical Center has not been the subject of any criminal fines involving a Federal or State healthcare offense.

3.) Civil monetary penalties in cases involving a Federal or State health care offense;

Response

Erlanger Medical Center has not been the subject of any civil monetary penalties involving a Federal or State healthcare offense.

4.) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response

Erlanger Medical Center has not been the subject of any administrative monetary penalties involving a Federal or State healthcare offense.

5.) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response

Erlanger Health System was the subject of an investigation by both Federal and Tennessee law enforcement agencies. In 2005, the investigation resulted in *Erlanger* entering into a *Corporate Integrity Agreement* and agreed to pay an administrative monetary penalty. The *Corporate Integrity Agreement* has now expired.

6.) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response

Erlanger Medical Center has not been the subject of any suspension or termination of participation in Medicare or Medicaid/TennCare programs.

7.) Is presently the subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response

Erlanger Medical Center has not been the subject of/to an investigation, regulatory action, or party in any civil or criminal action.

8.) Is presently subject to a corporate integrity agreement.

Response

Erlanger Medical Center is not presently subject to a corporate integrity agreement.

6. Outstanding Projects

A. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
			(*) Annual Progress Report(s)		
CON Number	*Project Name*	*Date Approved*	*Due Date*	*Date Filed*	*Expiration Date*

(*) Annual Progress Reports - HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 days of the completion date and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

Response

As requested, the table has been completed.

Outstanding Projects					
CON Number	Project Name	Date Approved	(*) Annual Progress Report(s) Due Date	Date Filed	Expiration Date
CN1601-002	Erlanger East Hospital – Level III NICU	04/27/2016	04/27/2017	04/24/2017	07/01/2019
CN1412-048	Erlanger East Hospital – Cancer Center & Linear Accelerator	03/25/2015	03/25/2017	04/17/2017	05/01/2019
CN1603-012	Erlanger Behavioral Health, LLC	08/24/2016	10/01/2017	07/03/2017	10/01/2019

B. Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response

CN1601-002 Erlanger East Hospital is in process of implementation, providing education to staff and medical professionals, as well as evaluating minimum cost options to complete the project.

CN1412-048 A request for extension has been approved by the HSDA. Site clearing is in process.

CN1603-012 Construction has begun and is currently on schedule.

7. Equipment Registry - For the applicant and all entities in common ownership with the applicant.

A. Do you own, lease, operate and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET) ?

Response

Erlanger Health System, through it's member hospitals, owns and operates several pieces of major medical equipment, including Computed Tomography, Linear

Accelerator, Magnetic Resonance Imaging, and Positron Emission Tomography.

B. If yes, have you submitted their registration to HSDA ? If you have, what was the date of submission?

Response

Registration was submitted on January 24, 2017.

C. If yes, have you submitted your utilization to Health Services & Development Agency ? If you have, what was the date of submission ?

Response

Utilization data was submitted on February 9, 2017.

(IV.) *QUALITY MEASURES*

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response

Erlanger Bradley County will report annually using forms prescribed by the *Agency* concerning continued need and appropriate quality measures, if approved. The Applicant's commitment to meeting appropriate quality standards, is addressed by the following items.

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

Response

The applicant commits to maintaining a payor mix consistent with that detailed in the application, as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent.

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

Response

The applicant commits to maintaining staffing comparable to the staffing chart presented in the CON application.

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

Response

The applicant will obtain and maintain all applicable state licenses in good standing.

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

Response

The applicant will obtain and maintain TennCare and Medicare certifications.

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulations for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

Response

The applicant has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application.

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

Response

The applicant has not been decertified within the prior three years.

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

a. This may include accreditation by any organization approved by Center for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor would be acceptable if applicable. Other acceptable organizations may include, but are not limited to, the following:

American College of Radiology for Positron Emission Tomography, Magnetic Resonance Imaging and Outpatient Diagnostic Center projects.

Response

The applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess its level of performance in relation to established standards and to implement ways to continuously improve.

(V.) *STATE HEALTH PLAN QUESTIONS*

T.C.A. § 68-11-1625 requires the Tennessee Department of Health's, Division of Health Planning, to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of need program. The 5 Principles For Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles For Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

Response

The effects of this proposal will be positive for the healthcare system because it will deliver the most appropriate level of care for those who are in need of emergency medical service regardless of ability to pay, and thereby, will also serve to foster improved access to care. The regional healthcare delivery system is positively impacted by serving those who are otherwise in need of these necessary services, regardless of their ability to pay.

As demonstrated herein, *Erlanger Bradley County* seeks approval to initiate a provider based emergency department with a Level IV trauma service and a full service cardiac catheterization laboratory, to make these services available to Bradley and Polk counties in Tennessee. The need for this project has developed over several years for many reaons, as follows.

- The *Erlanger East Hospital* ED opened in 2013 and under the *American College Of Emergency Physicians* ("ACEP") standards should accommodate a capacity of 25,000 visits per

year, in FY 2017 the total was 34,799. In FY 2018 the total will likely be 38,000 to 40,000 visits. *Erlanger* has a need to decompress the volume on the *East* campus.

- The ED's on *Erlanger's* main campus (EMC & Children's) are experiencing high volumes, and in FY 2018 will be between 88,000 to 90,000 visits. With a Level I trauma center, and the only trauma center in Hamilton County, *Erlanger* has a need to decompress the volume on its' main campus.

- *Copper Basin Medical Center* in Polk County was the latest rural hospital to close, resulting in it's ED closing as well. It should be noted that *Erlanger Health System* has tried to assist *Copper Basin Medical Center*, by offering advice and meeting with HSDA staff and the Division of Licensure, to provide technical and regulatory assistance in an effort to preclude closure of the hospital, but without success.

- Outmigration from the service area (Bradley Polk counties) is significant. With a total of 61,911 ED visits in 2016, 16,869 patients (27.2%) outmigrated from the service area.

- *Erlanger Bradley County* will be a designated trauma center, bringing Level IV trauma care to Bradley County. Further, the trauma center will be part of *Erlanger's Trauma Network*, which includes a base for a *LifeForce* air ambulance already located at the Cleveland regional airport. The provider based ED will have access to a land ambulance as well as a helipad for *LifeForce* air ambulance. There will be a reserved space (24/7) for land ambulance at the facility. Also, the Bradley County emergency service transports an average of 600 patients per year to *Erlanger Medical Center*. With the establishment of *Erlanger Bradley County*, the emergency service in Bradley County will not be required to make so many transports, so the general

population will be better served as a result.

The objective for developing the Level IV trauma enter and provider based ED in Bradley County is to foster access by placing an emergency department with trauma service, within a reasonable distance of the population of Bradley County and the surrounding area. The service area for *Erlanger Bradley County* will be Bradley and Polk counties in Tennessee. Thus, patients will not need to travel to Chattanooga, Hamilton County, for needed emergency services.

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. As such, *Erlanger Bradley County* is part of a long term plan to make services more accessible, and to ultimately improve the health of Tennesseans.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Response

Erlanger Bradley County will provide access to emergency medical care with trauma service for Bradley and Polk counties in Tennessee, as part of the *Erlanger Trauma Network*. The goal of this project is to locate a provider based ED where it will be most accessible to the service area. Also, it will be part of the "system of care" which *Erlanger Health System* has developed.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

Response

Pertaining to the visits per treatment room, appearing below is a table which shows the average number of ED visits per treatment room for *Tennova Healthcare – Cleveland* as well as *Erlanger East Hospital* and *Erlanger's*

main campus ED's. It should be noted that the average number of treatments for *Erlanger East* is approximately 55.7% higher than capacity, as per the utilization guidelines promulgated by the *American College of Emergency Physicians* (ACEP), which stipulates 1,389 visits per year for an ED facility with 18 treatment rooms.

It is noted that the ED at *Tennova – Cleveland* is below it's assigned utilization of 1,596 visits per treatment room, however, the need for *Erlanger* to decompress it's volume at *Erlanger East Hospital*, along with the significant volume of outmigration from the service area … more than demonstrate the need for a provider based ED with trauma center at *Erlanger Bradley County*.

EHS -- Analysis Of Average ED Visits Per Treatment Room
For The Service Area Of Erlanger Bradley County

	Hospital	No. Of Rooms	2014	2015	2016	2017	2018(est)
Total ED Visits							
	Erlanger Medical Center		52,272	55,597	51,926	49,815	51,028
	Children's Hospital @ Erlanger		37,895	41,502	40,759	40,993	37,636
	Erlanger East Hospital		22,009	26,172	31,197	34,799	36,776
	Tennova - Cleveland		49,791	50,533	48,501		
Average ED Visits Per Treatment Room							
	Erlanger Medical Center	48	1,089	1,158	1,082	1,038	1,063
	Children's Hospital @ Erlanger	31	1,222	1,339	1,315	1,322	1,214
	Erlanger East Hospital	17	1,295	1,540	1,835	2,047	2,163
	Tennova - Cleveland	42	1,186	1,203	1,155		
Notes >>	1.) Data is from the Joint Annual Reports for 2014, 2015 and 2016. For 2017 and 2018, data is from Erlanger internal records.						

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Response

Erlanger Bradley County, as a member facility of *Erlanger Health System*, will have access to quality monitoring activities which many facilities do not. The applicant is accredited by *The Joint Commission* and is licensed by the *Tennessee Dept. of Health*. This monitoring consists of periodic review of quality indicators which are part of a robust program of quality improvement.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few. It is also expected that *Erlanger Behavioral Health* will do so as well.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the *University of Tennessee at Chattanooga* to assist nurses transitioning from RN to BSN. *Erlanger* provides a teaching environment for staff as well with various on-the-job training opportunities (i.e.-CT for Radiologic Technologist, Certification for LPN's, etc.). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography. Also, *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health. *Erlanger* has established strong long term relationships with the region's colleges, universities and clinical programs. A list of the many schools, colleges and universities with which Erlanger maintains collaborative relationships (Clinical Affiliation Agreements) is attached to this CON application.

The *University of Tennessee - College of Medicine* is co-located at *Erlanger* and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

Emergency Medicine
Family Medicine
Internal Medicine
Obstetrics & Gynecology
Orthopedic Surgery
Pediatrics
Plastic Surgery
Surgery
Urology
Transitional Year

Fellowship Programs
Cardiovascular Disease
Colon & Rectal Surgery
Emergency Medicine
Gastroenterology
Gynecologic Surgery - Minimally Invasive
Neuro-Interventional Surgery
Orthopedic Trauma Surgery
Surgical Critical Care
Vascular Surgery
Ultrasound
Transitional Year

Erlanger Health System is also a member of the *Vanderbilt University Medical Center - Health Network*. This affiliation will further enhance our ability to provide state of the art research, education and training programs. *Erlanger Health System* has also affiliated with *Technion Institute Of Technology*, in Haifa, Israel, for training of medical students, as well as graduate medical education, residency training and research. Increased opportunity exists in various medical specialties to potentially add to *Erlanger's* growing portfolio of medical research and training programs.

PROOF OF PUBLICATION

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 publication of the letter of intent.

Response

Attached is a copy of the *Letter Of Intent* which was filed with the *Tennessee Health Services & Development Agency*. The original publication affidavit is also attached to this CON application.

NOTIFICATION REQUIREMENTS

(Applies only to Non-Residential Substitution-Based Treatment Centers For Opiate Addiction)

Note that T.C.A. § 68-11-1607(c)(9)(A) states that "… Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

Response

*** Not applicable. ***

DEVELOPMENT SCHEDULE

T.C.A. § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for cause shown. Subsequent to granting a Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   Response

   The *Project Completion Forecast Chart* has been completed and appears on the following page.

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Response

   *** Not Applicable. ***

PROJECT COMPLETION FORECAST CHART

Assuming the CON approval becomes the final Agency action on the date listed in item 1 below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

PHASE		Days Required	Anticipated Date (MONTH / YEAR)
1.	Initial HSDA decision date.		06 / 18
2.	Architectural and engineering contract signed.	15	06 / 18
3.	Construction documents approved by the *Tennessee Dept. Of Health.*	180	12 / 18
4.	Construction contract signed.	30	01 / 19
5.	Building permit secured.	30	02 / 19
6.	Site preparation completed.	60	04 / 19
7.	Building construction commenced.	-	04 / 19
8.	Construction 40 % complete.	150	09/ 19
9.	Construction 80 % complete.	150	01 / 20
10.	Construction 100 % complete (approved for occupancy.	90	04 / 20
11.	*Issuance of license.	30	05 / 20
12.	*Initiation of service.	-	05 / 20
13.	Final Architectural Certification Of Payment.	30	06 / 20
14.	Final Project Report Form (HR0055).	60	08 / 20

(*) For projects that do NOT involve construction or renovation, please complete items 11 and 12 only.

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

FEB 14 '18 AM 11:12

A F F I D A V I T

STATE OF TENNESSEE

COUNTY OF HAMILTON

Joseph M. Winick, being first duly sworn, says that he / she is the applicant named in this application or his / her / it's lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services & Development Agency, and and T.C.A. § 68-11-1601, *et seq*, and that the responses to this application or any other questions deemed appropriate by the Tennessee Health Services & Development Agency are true and complete.

SIGNATURE

SWORN to and subscribed before me this 12 of February (Month), 2018 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

SHELIA HALL STATE OF TENNESSEE NOTARY PUBLIC HAMILTON COUNTY

Shelia Hall

NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

TABLE OF ATTACHMENTS

Proof Of Publication

HSDA - Letter Of Intent
HSDA - Publication Of Intent
Affidavit Of Publication

Description	Section / Item
Letter - Bradley County Mayor	A-3
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Articles Of Organization	A-4
Purchase Agreement	A-6-A
Erlanger Bradley County - Site Plan	A-6-B(1)
Erlanger Bradley County - Floor Plan	A-6-B(2)
List Of Managed Care Payor Contracts	A-9
Medicare Indicators	B-ED
CFO Letter For ED	B-ED
Letter - TDOH Approval Of Erlanger Trauma Center	B-ED
Report - Survey Of Erlanger Trauma Center	B-ED
Erlanger Charity Care Policy	B-ED
Cardiac Cath. Calculations - Certificate Of Need	B-CCS
HRSA Medically Underserved Index	B-CCS-10
Mortality Data For Service Area	B-CCS-10
CDC - Heart Disease Mortality By State	B-CCS-10
Policy For Cardiac Catheterization	B-CCS
Policy For Transferring Cardiac Catheterization Patients	B-CCS
Quality Control & Monitoring For Cardiac Catheterization	B-CCS
Policy Pertaining To Emergencies	B-CCS
Policy On Outpatient Orders And	B-CCS
Service Area	B-I-3
Architect Letter - Construction Cost	B-II-1
Siemens Quote For CT Unit	B-II-1
Siemens Quote For Equipment Maintenance	B-II-1
Siemens Quote For Bi-Plane Unit	B-II-1
Siemens Quote For Equipment Maintenance	B-II-1
Funding - CFO Letter	B-II-2
Erlanger Interim Financial Statements	B-II-3
Erlanger Audited Financial Statements	B-II-3
List Of EHS Patient Transfer Agreements	B-III-1
List Of EH Clinical Affiliation Agreements	B-III
Erlanger Medical Center License	B-III-4
Statement Of Deficiencies & Plan Of Correction	B-III-4

ATTACHMENTS

PUBLICATION OF INTENT

TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

==========

Instructions To Newspaper

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than four (4) inches.

==========

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Medical Center, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new provider based (satellite) emergency department, to include a cardiac catheterization laboratory for outpatient services. The ED will be designated as a Level IV trauma center, which will be part of the Erlanger Trauma Network. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Bradley County – Provider Based Emergency Department, located at an unaddressed site, otherwise described as 2.9 acres, at the southeast quadrant of Exit 20 northbound on U.S. Interstate 75, accessed via Cherokee Gateway Blvd., Cleveland, Bradley County, Tennessee, 37353. The total project cost is estimated to be $ 11,297,935.00.

The anticipated date of filing the application is February 14, 2018.

The contact person for this project is Joseph M. Winick, Lead Executive – Innovation Center, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

==========

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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Cleveland Daily Banner

1505 25th St., NW, P.O. Box 3600, Cleveland, TN 37320

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"Moulin Rouge" (1952) Jose Ferrer.
Death Do Us Part" (2017) Taye Diggs. Premiere.
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Fútbol Mexicano Primera División (N) (Live)
ER "Man vs. Pigeon" | Bizarre ER (N)

STATE OF TENNESSEE, COUNTY OF BRADLEY

Susan Steckley having first duly sworn, makes oath that she is Legal Clerk of the Cleveland Daily Banner, a daily newspaper published in Bradley County and of general circulation therein, and that the following is a true copy of the legal notice which has been published 1 time in said newspaper and online at www.clevelandbanner.com and www.tnpublicnotice.com on the following dates, to wit:
Certificate Need, ad #217196
February 9, 2018

and that there X is due _____ has been paid the said Cleveland Daily Banner for such publication the sum of

One hundred and forty-one dollars and 40/100

$141.40

This publication fully complies with Tennessee Code Annotated 1-3-120.

Susan Steckley
Legal Clerk

Sworn to and subscribed before me this 9th day of February 2018.

Vicky Guy
Notary Public

VICKY GUY
STATE OF TENNESSEE NOTARY PUBLIC
BRADLEY COUNTY

My Commission expires:

12/21/2021

Cleveland Daily Banner

1505 25th St., NW, P.O. Box 3600, Cleveland, TN 37320

LEGAL PUBLICATION
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Legal ad runs on February 9, 2018

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Notary Public

VICKY GUY
STATE OF TENNESSEE NOTARY PUBLIC
BRADLEY COUNTY

My Commission expires:

12/21/2021

Cleveland Daily Banner
20 PAGES • 50¢
163rd YEAR • No. 244
THE CITY WITH SPIRIT
FRIDAY, FEBRUARY 9, 2018
CLEVELAND, TN 37311

LEGAL PUBLICATION
NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

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Legal ad runs on February 9, 2018

Description	Section / Item
Letter - Bradley County Mayor	A-3

BRADLEY COUNTY COMMISSION
LOUIE ALFORD, CHAIRMAN
Post Office Box 1167
Cleveland, TN 37364-1167
Phone (423) 728-7105
Fax (423) 728-7161

November 17, 2017

Mr. Kevin Spiegel, FACHE
Erlanger President & CEO
975 East Third Street
Chattanooga, TN 37403

Dear Mr. Spiegel:

Thank you for taking the time to meet with me to discuss Erlanger expanding into Bradley County. For many years, Erlanger has been a hallmark in Chattanooga and our regional area. I know the residents of Bradley County would sincerely appreciate local access to Erlanger care without having to travel to Hamilton County. It's also reassuring to know a Level 1 Trauma center would be available in life threatening situations.

Mr. Spiegel, I offer whatever assistance you may need to make the Erlanger Bradley County project a long term success. I believe a Bradley County Erlanger campus could be a lifeblood for our community.

Sincerely,

Louie Alford

Louie Alford

September 27, 2005

OUR COUNTY
D. GARY DAVIS
BRADLEY COUNTY MAYOR

As you have probably read in the news, the Bradley County Commission voted last Monday to sell Bradley Memorial Hospital to Community Health Systems. This was a very difficult issue for me personally because I view the hospital as one of the county's greatest assets and an institution in which we can all be proud. Unfortunately, because of the environment in the healthcare field today and as a result of the current financial status of BMH, the sale was inevitable.

Several months ago the Hospital Board of Trustees voted to approach area hospitals to gauge their interest in purchasing Bradley Memorial. Community Health Systems (CHS), the parent company of Cleveland Community Hospital, presented a proposal to the Hospital Board to purchase the hospital for $76.5 million dollars with an additional guarantee to invest $36.8 million in capital improvements.

The closing of the sale with CHS ends a long era in Bradley County. For more than 52 years, our county has enjoyed the good fortune of having its own locally controlled and operated hospital. That era, however, now ends.

A concern of many people was whether or not CHS's offer was a fair and accurate reflection of the value of BMH. Outside consultants, hired at the insistence of myself and other Commissioners, placed the business value of Bradley Memorial Hospital at zero, $11 million for equipment, and $42 million for real estate for a total appraisal value of $53 million. Appraisals were conducted from various angles and all showed that the $76.5 million offer exceeded the current value of BMH.

After all liabilities have been resolved, the Hospital's CEO has estimated that some $20 million will be available. The money will be placed in an interest-bearing account from the outset until its use can be determined. How the $20 million will be used is still to be determined by a joint committee of eight people, four appointed by the Hospital Board and four appointed by the Bradley County Commission.

Another concern involved indigent care and the ability to guarantee the level of care provided by our county hospital. This concern was addressed in the contract with Community Health Systems agreeing to continue to provide indigent care at the level now provided by BMH.

In terms of the agreement itself, the citizens of Bradley County will get a good deal. Along with the sale price of $76.5 million, net working capital of the Hospital has been estimated at around $4 million, which should bring the total to over $80 million. Also, as I mentioned earlier, CHS will invest $36.8 million dollars in capital improvements.

Additionally, Community Health has pledged to seek approval from the State of Tennessee to spend $10 million to develop an open heart program. CHS will also make additional annual capital improvements in the hospital averaging three percent of the annual net revenues.

CHS Vice President of Operations Bill Hussey has said Bradley Memorial will become the acute care campus with the creation of new services and the expansion of existing ones to curb the out-migration of patients to the Chattanooga market.

Cleveland Community Hospital will be converted to an outpatient center with expansion of the existing behavioral line of care.

Community Health will offer employment to substantially all employees of BMH, who will retain their seniority with regard to employee benefits. CHS will also honor prior accrued sick and vacation pay.

I was not overjoyed by the news about BMH. However, after careful review, I came to the conclusion that we needed to consider CHS's proposal. I have been a longtime supporter of Bradley Memorial Hospital. I think it has really been great for our community, and we have really built Cleveland and Bradley County around Bradley Memorial Hospital in the past. However, we must now realize that there will be another way of providing health care in the future.

I would like to take this opportunity to thank all the employees of Bradley Memorial Hospital for their understanding and patience during the ongoing discussions and contract negotiations over the past few months. I realize that many Bradley County citizens have spent their entire careers working to make Bradley Memorial the wonderful healthcare facility it is today. I would also like to apologize to the employees for the threats of layoffs from hospital administration during the final week before the sale. I believe these threats were unnecessary and a scare tactic to force a vote on the sale of the Hospital when it was going to occur anyway.

It was not my intention to delay the sale of the Hospital. However, it is my job and the job of the County Commission to make sure tax dollars, as well as any additional revenues the county receives, is spent in a fiscally responsible manner that will benefit as many citizens as possible.

All angles must be looked at and examined to determine the best use of the net proceeds from the sale of the Hospital. It is my concern, as well as the concern of some Commissioners, that this decision is made jointly by representatives elected by Bradley County citizens along with the appointed Hospital Board.

The sale of BMH is expected to be completed on October 1. It is my hope that the joint committee appointed to determine the use of the remaining funds from the sale will work cooperatively for the benefit of all the citizens of Bradley County.

Description	Section / Item
Secretary Of State Acknowledgement	A-4
Articles Of Organization	A-4

State of Tennessee

EHS Enabling Legislation

Department of State

To all to whom these Presents shall come, Greeting:

I Gentry Crowell, Secretary of State of the State of Tennessee do hereby certify that the annexed is a true copy of

PRIVATE CHAPTER NO. 125

SENATE BILL NO. 1499

PRIVATE ACTS OF 1977

the original of which is now on file and a matter of record in this office.

In Testimony Whereof, I have hereunto subscribed my Official Signature and by order of the Governor affixed the Great Seal of the State of Tennessee at the Department in the City of Nashville, this 13th day of June A.D. 19 77

Gentry Crowell

Secretary of State

PRIVATE CHAPTER NO. 125

SENATE BILL NO. 1499

By Albright, Ortwein

Substituted for: House Bill No. 1514

By Robinson (Hamilton)

AN ACT To amend Chapter 297 of the 1976 Private Acts of Tennessee entitled "AN ACT To create a Governmental Hospital Authority to own and operate Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and other related facilities and provide for the establishment and organization of a Board of Trustees for the operation thereof," relative to the Board of Trustees of said Hospital Authority and the powers and duties thereof, to the issuance of bonds and other obligations by the authority and the securing thereof, to the Financial Review Committee with respect to the authority and the duties and powers thereof, and to other provisions with respect to the duties and obligations of the authority, and validating and reenacting said Chapter No. 297 and ratifying all acts of the Board of Trustees of the authority.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Chapter 297 of the Private Acts of 1976 is amended by amending Section 1 thereof to read as follows:

"SECTION 1. A governmental Hospital Authority to be known as the Chattanooga-Hamilton County Hospital Authority, is hereby created and established for and on behalf of Hamilton County, Tennessee, for the purpose of performing a governmental function by operating Baroness Erlanger Hospital and T. C. Thompson Children's Hospital and such other similar or associated hospitals and existing health centers deemed appropriate to be operated by said authority as sole operator for the purpose of providing health care facilities and programs for the residents of Hamilton County, Tennessee."

SECTION 2. Chapter 297 of the Private Acts of 1976 is amended by deleting the first paragraph of Section 2 thereof and by substituting for such paragraph two new paragraphs to read as follows:

"SECTION 2. The Hospital Authority shall be operated upon the tracts and parcels of real property owned jointly by Hamilton County and the City of Chattanooga, Tennessee, and on which are situated the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital or upon any other real property acquired by the authority through gift and purchase. The city and the county are authorized and directed to convey and assign all real property constituting the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital to the authority. The city and the county are also authorized to convey and assign all personal property constituting the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital to the authority.

"In the event the authority shall at any time cease to exist as the operator of Baroness Erlanger Hospital, T. C. Thompson Children's Hospital and such other similar or associated hospitals and existing health centers deemed appropriate to be operated by the authority as sole operator, the real estate which was owned on August 5, 1976, by the county and the city and conveyed to the authority by the county and the city, shall revert in fee simple to the county, subject to such encumbrances as may be on said property at the time of reversion; provided, however, that the city shall have an option to require transfer to it of the title to the same proportion of such real estate as was owned by the city on such date, subject to such encumbrances on that portion of the real estate.

"If the authority shall at any time cease to use any such parcel or parcels of said real estate for hospital or related purposes for a period of two (2) years, then the county and the city shall have the option to require transfer to them of title to such parcel or parcels in fee simple, subject to such encumbrances as may be on said property at the time of such transfer of title, in the same proportion as such parcel or parcels were previously owned by the county and the city. In the event that either the county or the city shall elect not to exercise its option with respect to any such parcel or parcels of real estate, then the other of them shall have the option to require transfer to it of the entire parcel or parcels of real estate in question. In the event that neither the county nor the city decides that they wish to exercise said option, then the authority shall have the right to dispose of such property in whatever manner it deems appropriate."

SECTION 3. Chapter 297 of the Private Acts of 1976 is amended by amending Section 3 thereof to read as follows:

"SECTION 3. Said Hospital Authority shall be operated and controlled by a Board of Trustees consisting of eleven (11) members who shall serve without compensation but who shall be indemnified by the authority for any liability they might incur while acting in such capacity other than from culpable negligence. The original members of the Board of Trustees and their respective terms of office are declared to be those

individuals whose names are set out below, and upon expiration of such terms the members of the Board of Trustees shall be appointed by the county judge of the county, the mayor of the city, the chancellors of the chancery courts, and the legislative delegation for four (4) year terms as provided in the next succeeding paragraph hereof. The following are confirmed as the original members of the Board of Trustees and shall hold office for terms ending as follows (or until their successors are appointed):

Name of Trustee	Successor to be Appointed by	Term of Office Expires
David P. McCallie, M.D.	Mayor	11-1-80
Mrs. Vi Ketchersid	County Judge	11-1-80
Stan Guthrie	Chancellors	11-1-80
Harry W. McKeldin, Jr.	Mayor	11-1-79
Robert Brewer, Jr.	County Judge	11-1-79
Don J. Russell, M.D.	Mayor and County Judge (with approval of medical society)	11-1-79
J. E. Lawrence	Mayor	11-1-78
John C. Cantrell	County Judge	11-1-78
Claude Ramsey	Legislative Delegation	11-1-78
Charles Griffin	Mayor	11-1-77
Forrest Cate	County Judge	11-1-77

"The method of appointment of the members of the Board of Trustees after the expiration of the terms of the original members of such board shall be as follows: The mayor of the city shall appoint four (4) trustees, with the approval of a majority of the members of the Board of Commissioners. The county judge of the county shall appoint four (4) trustees, with the approval of a majority of the members of the county council. Said mayor and county judge shall jointly appoint one (1) trustee with the approval of the president of the Chattanooga-Hamilton County Medical Society, Inc., acting with the approval of a majority of the House of Delegates of said society, and with the approval of a majority of the members, respectively, of the Board of Commissioners and of the county council. The chancellors of chancery court shall jointly appoint one (1) trustee. The legislative delegation shall by a majority vote appoint one (1) trustee.

"Upon the expiration of the term of office of any trustee, his successor shall be appointed for a term of four (4) years by the authority appointing the trustee whose term has expired. The original trustees, for all purposes of this section, shall be considered to have been appointed by the mayor, the county judge, the chancellors and/or the legislative delegation as indicated in the above tabulation.

"All such appointments to the Board of Trustees as provided herein shall be made without regard to religious preference, race, sex or national origin, and in the making of appointments due consideration shall be given to making said Board of Trustees representative, as nearly as may be practicable, of all residents of the city and county, including the various racial groups therein.

"Any member so appointed to the Board of Trustees may, for reasonable cause, be removed from his or her office in the same manner and by the same authority as such member was appointed to the office; provided that such removal shall be preceded by a full hearing and adequate notice of such hearing. 'Reasonable cause' shall include, but shall not be limited to, misconduct in office, failure to perform duties prescribed by this act or other applicable law, or failure to diligently pursue the objectives for which the authority was created.

"Vacancies on the Board of Trustees caused by any reason whatsoever, shall be filled by appointment of the authority who appointed the trustee vacating the office, but without the necessity of approval otherwise herein required. A trustee so appointed shall hold office for the remainder of the term of the trustee vacating the office.

"A member of the Board of Trustees may serve as such trustee for not more than eight (8) consecutive years, excluding any previous service as a member of the Board of Trustees of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital."

The occupancy of their respective offices by the present members of the Board of Trustees (being those individuals enumerated in amended Section 3 above) is hereby ratified and confirmed.

SECTION 4. Chapter 297 of the Private Acts of 1976 is amended by repealing Section 4 thereof and substituting therefor a new Section 4 to read as follows:

"SECTION 4. Whenever used in this act, unless a different meaning clearly appears from the context, the following terms whether used in the singular or the plural shall be given the following respective interpretations:

'Authority' or 'Hospital Authority' means the Chattanooga-Hamilton County Hospital Authority as created by this act.

'Board of Commissioners' means the Board of Commissioners of the city.

'Board of Trustees' means the Board of Trustees of the authority as provided for in this act.

'Bonds' means bonds of the authority authorized to be issued by this act. 'Advance refunding bonds' means bonds issued for the purpose of refunding outstanding bonds which will neither mature by their terms nor be subject to and called for redemption within a period of 30 days following the date of issuance of said advance refunding bonds.

'Chancellors' means the Chancellors of the Chancery Courts of Hamilton County, Tennessee.

'Chief Executive Officer' means, as the context requires, the president of the authority, the mayor of the city, and the county judge of the county.

'City' means the City of Chattanooga, Tennessee.

'County' or 'Hamilton County' means Hamilton County, Tennessee.

'County Council' means the county council of the county.

'County Judge' means the county judge or such other chief executive officer of the county as may be created by subsequent law.

'Financial Review Committee' means the Financial Review Committee provided for in this act.

'Hamilton County Sales Tax Agreement' means the agreement between the city and the county, dated March 23, 1966.

'Legislative Delegation' means the Hamilton County delegation to the Legislature of Tennessee, being the Senators and Representatives elected from those districts lying in whole or in part in the county.

'Mayor' means the mayor of the city or such other chief executive officer of the city as may be created by subsequent law.

'Notes' means notes of the authority authorized to be issued by this act. 'Short-Term Notes' means nonrenewable notes having a term no longer than three (3) years. 'Long-Term Notes' means renewable short-term notes and notes having a term longer than three (3) years.

'Project' or 'Facility' shall mean any one or combination of buildings, structures or facilities owned by the authority, including the site therefor and all machinery and equipment therein or necessary to the operation thereof, and shall include expressly the Baroness Erlanger Hospital and the T. C. Thompson Children's Hospital."

SECTION 5. Chapter 297 of the Private Acts of 1976 is amended by repealing Section 5 thereof and by renumbering Section 6 thereof as Section 5.

SECTION 6. Chapter 297 of the Private Acts of 1976 is amended by renumbering Section 7 thereof as Section 6 and by amending said renumbered Section 6 to read as follows:

"SECTION 6. The Board of Trustees shall be vested with the full, absolute and complete authority and responsibility for the complete operation, management, conduct and control of the business and affairs of the Hospital Authority herein created. This authority and responsibility shall include, but shall not be limited to, the establishment, promulgation and enforcement of the rules, regulations and policies of the authority, the granting of or the refusal of medical staff privileges, the upkeep and maintenance of all property, the administration of all financial affairs of the authority, including pledging of assets for expansion and improvement of facilities and any other necessary financial needs of the authority. The authority shall have, but shall not be limited to, the following powers together with all powers incidental thereto or necessary for the performance of those hereinafter stated: (1) to sue and be sued and to prosecute and defend, at law or in equity, in any court having jurisdiction of the subject matter and of the parties; (2) to have and use an official seal and to alter the same at pleasure; (3) to acquire, whether by purchase, construction, exchange, gift, lease, or otherwise, and to improve, maintain, extend, equip and furnish hospital and related facilities within the corporate limits of Hamilton County, including expressly, but without limitation, professional office buildings, ancillary residence facilities and data processing facilities, and including all real and personal properties which the Board of Trustees may deem necessary in connection therewith and regardless of whether or not any such facilities shall then be in existence; (4) to execute all contracts, agreements and other instruments with any person, partnership, corporation, federal, state, county or municipal government, including but not limited to the issuance of bonds, mortgages, notes and other forms of indebtedness, and contracts for the

management of hospital and clinic facilities (but no such management contract shall exceed two (2) years in length); (5) subject to the provisions of Section 2 hereof, to sell, lease, exchange, donate, and convey any or all of its properties whenever its Board of Trustees shall find any such action to be in furtherance of the purposes for which the authority was created; (6) to borrow money and issue its bonds and notes for the purpose of carrying out any of its powers; (7) as security for the payment of the principal of and interest on any bonds and notes so issued and any agreements made in connection therewith, to mortgage and pledge any or all of its facilities or any part or parts thereof, whether then owned or thereafter acquired, and to pledge all or any portion of the revenues and receipts therefrom or from any thereof; (8) to employ and pay compensation to such employees, and agents, including attorneys, accountants, engineers, architects and financial consultants, as the Board of Trustees shall deem necessary for the business of the authority; and (9) to establish bylaws and make all rules and regulations not inconsistent with the provisions of this act, deemed expedient for the management of the authority's affairs.

"No contract, except for personal services or lease obligations, involving an expenditure exceeding one thousand dollars ($1,000.00), nor several proposed contracts aggregating more than one thousand dollars ($1,000.00), for the same general work or kind of work, supplies or equipment, shall be awarded until after at least one advertisement in some newspaper of general circulation published in the county at least ten (10) days before such contract is awarded or supplies purchased, and then only to the lowest and best bidder. Said bids shall be sealed and filed with the president or his designee, who shall publicly open them on the date specified and not prior thereto. No entire project or purchase involving the same type of work, equipment or supplies shall be split into small contracts. Nothing in this paragraph shall be construed to apply to the issuance of bonds or notes by the authority.

"Purchases and contracts involving an expenditure of not more than one thousand dollars ($1,000.00) shall be made in conformity with the rules and regulations adopted by the Board of Trustees.

"The authority shall prescribe reasonable rates, fees and charges for the services and facilities furnished by the authority and shall revise such rates, fees and charges from time to time so as to produce revenue at least sufficient to pay the principal of and interest on all bonds and other obligations issued by the authority, including reserves therefor, and to pay the cost of maintaining and operating its facilities."

SECTION 7. Chapter 297 of the Private Acts of 1976 is amended by the addition of a new Section 7 thereto to read as follows:

"SECTION 7. Except as herein otherwise expressly provided, all bonds issued by the authority shall be payable solely out of and secured by a pledge of all or any portion of the revenues and receipts derived from the authority's projects or of any thereof as may be designated in the proceedings of the Board of Trustees under which such obligations shall be authorized to be issued and may be secured by a mortgage or deed of trust covering all or any part of the projects from which the revenues and receipts so pledged may be derived, as such projects may thereafter be extended or enlarged; provided, that notes issued in anticipation of the issuance of bonds may be retired out of the proceeds of such bonds. The proceedings under which the bonds are authorized and any such mortgage or deed of trust may contain agreements and provisions respecting the maintenance of the facilities covered thereby, the establishment of rates, fees and charges for the services and facilities furnished by the authority, the creation and maintenance of special funds from the revenues of the authority and the rights and remedies available in the event of default, all as the Board of Trustees shall determine advisable and not in conflict with the provisions of this act. Each pledge, mortgage and deed of trust made for the benefit or security of any bonds of the authority shall continue in effect until the principal of and interest on the bonds for the benefit of which the same were made shall have been fully paid. In the event of default in such payment or in any agreement of the authority made as a part of the contract under which the bonds were issued, whether contained in the proceedings authorizing the bonds or in any mortgage or deed of trust executed as security therefor, such payment or agreement may be enforced by suit, mandamus, the appointing of a receiver in equity or by foreclosure of any such mortgage or deed of trust, or any one or more of such remedies.

"Such bonds may be executed and delivered by the authority at any time and from time to time, may be in such form and denominations and of such terms and maturities, may be subject to redemption prior to maturity either with or without premium, may be in fully registered form or in bearer form registrable either as to principal or interest or both, may bear such conversion privileges and be payable in such installments and at such time or times not exceeding forty (40) years from the date thereof, may be payable at such place or places whether within or without the State of Tennessee, may bear interest at such rate or rates payable at such time or times and at such place or places and evidenced in such manner, may be executed by such officers of the authority, and may contain such provisions not inconsistent herewith, all as shall be provided in the proceedings of the Board of Trustees whereunder the bonds shall be authorized to be issued. Any bonds of the authority may be sold at public or private sale for such price and in such manner and from time to time as may be determined by the Board of Trustees to be most advantageous, and the authority may pay all expenses, premiums and commissions which its Board of Trustees may deem necessary or advantageous in connection with the issuance thereof.

"Proceeds of bonds and notes issued by the authority may be used for the purpose of constructing, acquiring, reconstructing, improving, equipping, furnishing, bettering, or extending any project or projects, including the payment of interest on the bonds during construction of any such project and for six (6) months after the estimated date of completion, the payment of engineering, fiscal, architectural, bond insurance and legal expenses incurred in connection with such project and the issuance of the bonds, and the establishment of a reasonable reserve fund for the payment of principal of and interest on such bonds in the event of a deficiency in the revenues and receipts available for such payment. Any bonds and long-term notes shall, except as herein otherwise expressly provided, be issued for capital expenditures and none of the proceeds shall be used for operational expenditures or routine maintenance needs.

"Except as hereinafter in this paragraph provided, the amount of bonds and notes of the authority which may be issued at any time, together with any bonds and notes of the authority then outstanding, shall not exceed an amount equal to ninety percent (90%) of the sum of the value of the existing plant, property and equipment of the authority at the time of issuance of such bonds plus the contract price of the improvements to be constructed, acquired and installed from the proceeds of such bonds, less (1) the principal amount outstanding, if any, of such bonds as may have been issued by the county for the expansion, remodeling, repairing, equipping, and/or construction of all or any part of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital, and (2) the amount, if any, of any unfunded portion of the employees' pension fund of Baroness Erlanger Hospital and/or T. C. Thompson Children's Hospital. Plant, property and equipment for the purpose of the preceding sentence shall be stated at market value as determined by a professional appraiser to be selected by the Financial Review Committee. A certificate of such professional appraiser with respect to the value of such plant, property and equipment, a certificate of the county judge of the county with respect to the amount of outstanding bonds of the county for such hospital purposes, and a certificate of the chief executive officer of the authority with respect to the unfunded portion of such employees' pension fund shall each be conclusive for the purposes of determining the amount of bonds and notes which may be issued pursuant to this paragraph. The limitations expressed in this paragraph shall not apply to the issuance of advance refunding bonds.

"The Board of Trustees shall direct in the proceedings authorizing the issuance of any bonds of the authority that there shall be set aside and appropriated as a reserve for the payment of principal and interest on said bonds an amount not less than the required amount of principal and interest on the bonds falling due during the 12 month period next succeeding the date of issuance of the bonds.

"Any bonds or notes of the authority at any time outstanding may at any time and from time to time be refunded by the authority by the issuance of its refunding bonds in such amount as the Board of Trustees may deem necessary, but not exceeding the sum of the following: (a) the principal amount of the obligations being refinanced; (b) applicable redemption premiums thereon; (c) unpaid interest on such obligations to the date of delivery or exchange of the refunding bonds; (d) in the event the proceeds from the sale of the refunding bonds are to be deposited in trust

as hereinafter provided, interest to accrue on such obligations from the date of delivery to the first or any subsequent available redemption date or dates selected, in its discretion, by the Board of Trustees, or to the date or dates of maturity, whichever shall be determined by the Board of Trustees to be most advantageous or necessary to the authority; and (e) expenses, premiums and commissions of the authority, including bond discount, deemed by the Board of Trustees to be necessary for the issuance of the refunding bonds. A determination by the Board of Trustees that any refinancing is advantageous or necessary to the authority, or that any of the amounts provided in the preceding sentence should be included in such refinancing, or that any of the obligations to be refinanced should be called for redemption on the first or any subsequent available redemption date or permitted to remain outstanding until their respective dates of maturity, shall be conclusive.

"Any such refunding may be effected either by the exchange of the refunding bonds for the obligations to be refunded thereby with the consent of the holders of the obligations so to be refunded, or by sale of the refunding bonds and the application of the proceeds thereof to the payment of the obligations to be refunded thereby, in the manner herein provided.

"Prior to the issuance of the refunding bonds, the Board of Trustees shall cause notice of its intention to issue the refunding bonds, identifying the obligations proposed to be refunded and setting forth the estimated date of delivery of the refunding bonds, to be given to the holders of the outstanding obligations by publication of an appropriate notice one (1) time each in a newspaper having general circulation in Hamilton County and in a financial newspaper published in New York, New York, and having national circulation. As soon as practicable after the delivery of the refunding bonds, and whether or not any of the obligations to be refunded are to be called for redemption, the Board of Trustees shall cause notice of the issuance of the refunding bonds to be given in the manner provided in the preceding sentence.

"If any of the obligations to be refunded are to be called for redemption, the Board of Trustees shall cause notice of redemption to be given in the manner required by the proceedings authorizing such outstanding obligations.

"The principal proceeds from the sale of any refunding bonds shall be applied only as follows: either,

(a) to the immediate payment and retirement of the obligations being refunded; or

(b) to the extent not required for the immediate payment of the obligations being refunded then such proceeds shall be deposited in trust to provide for the payment and retirement of the obligations being refunded and to pay any expenses incurred in connection with such refunding, but provision may be made for the pledging and disposition of any surplus, including, without limitation, provision for the pledging of any such surplus to the payment of the principal of and interest on any issue or series of refunding bonds. Money in any such trust fund may be invested in direct obligations of, or obligations the timely payment of principal of and interest on which are fully guaranteed by the United States government, or obligations of any agency or instrumentality of the United States government, or in certificates of deposit issued by a bank or trust company located in the State of Tennessee if such certificates shall be secured by a pledge of any of said obligations having an aggregate market value, exclusive of accrued interest, equal at least to the principal amount of the certificates so secured. Nothing herein shall be construed as a limitation on the duration of any deposit in trust for the retirement of obligations being refunded but which shall not have matured and which shall not be presently redeemable or, if presently redeemable, shall not have been called for redemption."

SECTION 8. Chapter 297 of the Private Acts of 1976 is amended by adding at the end of the third paragraph of Section 9 thereof a new sentence to read as follows:

"A certificate by such actuary with respect to the currency of such required pension fund contributions shall be conclusive for the purpose of determining compliance by the authority with the provisions of this section."

SECTION 9. Chapter 297 of the Private Acts of 1976 is amended by adding a new sentence to the end of Section 10 thereof, said new sentence to read as follows:

"Notwithstanding the foregoing provisions of this section, nothing herein contained shall be construed as limiting any expenditures made by the authority for the payment of principal of and in-

terest on bonds or other obligations issued by the authority."

SECTION 10. Chapter 297 of the Private Acts of 1976 is amended by amending Section 11 thereof to read as follows:

"SECTION 11. A Financial Review Committee shall be created consisting of seven (7) members, one (1) of whom shall be Black. The membership shall be composed of the auditor of the city, the auditor of the county, and five (5) other persons who are residents of Hamilton County, three (3) of whom shall be appointed by the county judge with the approval of a majority vote of the county council and two (2) of whom shall be appointed by the mayor with the approval of a majority vote of the Board of Commissioners; provided, that if any members of such committee shall not have been so appointed within 90 days from the date of approval of this act by the county council of the county, such members shall thereupon be appointed by a majority vote of the members of the legislative delegation.

"The members of the committee shall serve without compensation. They shall be indemnified by the authority for any liability they might incur while acting in such capacity other than for culpable negligence. With the exception of the city auditor and the county auditor, the remaining members shall be initially appointed to staggered terms as follows: two (2) for terms of three (3) years; one (1) to be so appointed by the county judge and one (1) to be so appointed by the mayor; two (2) for terms of two (2) years; one (1) to be so appointed by the county judge and one (1) to be so appointed by the mayor; and one (1) to be so appointed by the county judge for a term of one (1) year. Thereafter, each appointee shall serve for a period of three (3) years and such appointee's successor shall be appointed in the same manner and by the same official who appointed the person whose term has expired. Any person appointed to fill a vacancy for any reason other than expiration of term of office shall be appointed to hold office for the remainder of the term of the member vacating the office. Said vacancy shall be filled in the same manner as the original appointment.

"The Financial Review Committee shall review the proposed issuance of bonds or long-term notes, to consider if the issuance of said obligations is within the fiscal ability of the authority based upon the appropriate preceding annual audits, monthly operating statements subsequent to the closing date of the most recent audit period included in the most recent annual audit, additional revenue projections reasonably anticipated as a result of the proposed capital expenditure (taking into account any probable revenue loss during replacement, if any), and any other data reasonably bearing upon the fiscal soundness of the issuance of such bonds or long-term notes. At such time or times as the Board of Trustees of the authority shall desire to authorize the issuance of bonds or long-term notes it shall first submit the proposal to issue such obligations to the Financial Review Committee, which committee shall file its advisory report thereon with the Board of Trustees within sixty (60) days after the receipt of such proposal. Upon the filing of such report with the Board of Trustees, or after sixty (60) days following the date of submission of such proposal to such committee, whichever is earlier, the Board of Trustees may proceed with the issuance of such bonds or long-term notes; provided, that the submission to the Financial Review Committee herein required shall not be necessary at any time if such committee has not then been validly appointed and is not in existence.

"The Financial Review Committee shall annually review the proposed budget prepared by the Board of Trustees and shall file its report thereon with the Board of Trustees and the County Council.

"All reports of the Financial Review Committee shall be made to the County Council of the county, the Board of Commissioners of the city and the Board of Trustees of the authority, and shall be considered by the respective governing bodies with which such reports are filed."

SECTION 11. Chapter 297 of the Private Acts of 1976 is amended by adding six new sections thereto to be numbered 17 to 22, inclusive, and to read as follows:

SECTION 17. Notwithstanding any other provision of this act the county shall have the option to purchase all real and personal property of the authority if either of the following shall have occurred:

(a) The authority shall have defaulted in the payment when due of principal or interest on any of its bonds or long-term notes then outstanding; or

(b) The authority shall have filed written notice with the county judge that it is the expectation of the Board of Trustees of the authority that the authority will so default in the payment of principal of or interest on any of its bonds or long-term notes then outstanding on the next succeeding date on which such principal or interest shall fall due.

"The purchase price in the event that the county shall elect to exercise any such option shall be an amount equal to the principal of and interest to maturity or the first call date, if any, whichever shall be earlier, together with any applicable premiums, on all bonds and long-term notes of the authority then outstanding, and the amount so received by the authority from the county shall be impressed with a trust in favor of the holders of such bonds and long-term notes and shall be used for the payment of principal of and interest and redemption premiums thereon and for no other purpose.

"Such purchase option of the county shall be superior to any right of foreclosure herein permitted, and any mortgage hereinafter granted by the authority shall recognize and be subject to such option to purchase.

"SECTION 18. The authority is hereby declared to be a public instrumentality acting on behalf of the county, but without the power of eminent domain, and in that connection to be fulfilling a public function, and the authority and all properties at any time owned by it and the income therefrom and all bonds or notes issued by the authority and the income therefrom shall be exempt from all taxation in the State of Tennessee. Also, for purposes of the Securities Law of 1955, compiled as Sections 48-1601 through 48-1648, Tennessee Code Annotated, and any amendment thereto or substitution therefor, bonds or notes issued by the authority shall be deemed to be securites issued by a public subdivision of the State of Tennessee.

"SECTION 19. The authority shall be a public nonprofit corporation and no part of its net earnings remaining after payment of its expenses shall inure to the benefit of any individual, firm or corporation.

"SECTION 20. Neither the county nor the city shall in any event be liable for the payment of the principal of or interest on any bonds or notes of the authority or for the performance of any pledge, mortgage, obligation or agreement of any kind whatsoever which may be undertaken by the authority, and none of the bonds or notes of the authority or any of its agreements or obligations shall be construed to constitute an indebtedness of either the county or the city within the meaning of any constitutional or statutory provision whatsoever.

"SECTION 21. Nothing contained in this act shall be construed to impair any contract rights which may have vested prior to the enactment of this act.

"SECTION 22. It is hereby declared that the purpose of this act is to facilitate adequate hospital facilities for the residents of the county. Bonds may be issued under this act without regard to the requirements, restrictions or procedural provisions contained in any other law."

SECTION 12. Chapter 297 of the Private Acts of 1976 is hereby in all respects ratified and confirmed and said act as herein amended is hereby reenacted by this General Assembly.

SECTION 13. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect any other provisions or application of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 14. This act shall have no effect unless it is approved by a two-thirds vote of the County Council of Hamilton County. Its approval or nonapproval shall be proclaimed by the presiding officer of the county council and certified by such officer to the Secretary of State.

SECTION 15. For the purpose of approving this act as provided in Section 14 it shall take effect on becoming law, the public welfare requiring it, but for all other purposes it shall be effective only upon being approved as provided in Section 14.

SENATE BILL NO. 1499

PASSED: May 19, 1977

SPEAKER OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

APPROVED this 28th day of May 19 77

GOVERNOR

Description	Section / Item
Purchase Agreement	A-6-A

C. Larry Armour
2127 Ooltewah Ringgold Road
Chattanooga, TN 37363

RE: Letter of Intent to Purchase approximately 15 acres located at _____, Cleveland, TN (the "Property")

Dear Mr. Armour:

We are pleased to submit this Letter of Intent ("LOI") expressing the interest of Erlanger Health System ("Buyer"), a Tennessee non-profit governmental entity, in entering into an arrangement with Cleveland Exit 20 GP ("Seller"), a Tennessee General Partnership. The purpose of this Letter of Intent is to set forth the general terms upon which Seller would sell to Buyer the Property and all improvements, buildings and structures located thereon.

Purchase Price: The Purchase Price shall not exceed $286,661 per acre, which may be subject to further negotiation after verification from an independent third party of the fair market value, for approximately 15 Acres. The Purchase Price shall include all costs associated with the excavation and mass grading only of the Property by Buyer with additional costs for excavation and mass grading to be paid by Seller; provided, however, that Seller have the right to review and approve Buyer's grading plans and grading contractor, such approval not to be unreasonably withheld. The Buyer's final election of acreage will be determined by the Buyer's engineer during the preliminary site design phase and confirmed by Survey, as prepared by a State of Tennessee licensed Professional Land Surveyor, prior to the end of the Inspection Period (the "Final Acreage Calculation"). The purchase price would be payable in immediately available funds at closing. At closing, Seller shall by warranty deed convey to Buyer marketable fee simple title to the Property, free and clear of any and all title defects and exceptions including, but not limited to, liens, claims, charges and other material encumbrances, subject only to taxes not yet due and payable and such other non-monetary exceptions agreed to by Buyer in writing during the Inspection Period (as defined below).

Real Property Agreement: The parties agree to negotiate in good faith the specific terms of a formal real property purchase agreement (the "Agreement") incorporating the provisions of this LOI and containing such representations and warranties and other terms as are customary in transactions of this type in the general location of the Property. Counsel to Buyer shall draft the Agreement and any other applicable ancillary agreements for Seller's review and approval following final execution of a copy of this LOI by all parties.

Intended Use:

Seller will be provided an opportunity to review and approve plans, such approval not to be unreasonably withheld for the proposed use and agrees to collaborate with Buyer before and during the development process. Any property owned by Seller within 1 mile of the Property shall not be utilized for any services or purpose that is substantially similar to the services which are or may be provided by a general acute care hospital, medical hospital or specialty hospital, without Buyer's prior written consent, to be defined in the Agreement. Seller agrees that approximately 2.9 acres of the Property will be utilized by Buyer for development and operation of a provider-based emergency department, and the remainder of the Property will be utilized for health-related purposes.

Inspection Period:

Buyer shall have, and the Agreement shall provide for, an inspection period (the "Inspection Period") which shall commence as provided in the Agreement. Seller shall provide Buyer with any Property documentation in Seller's possession for Buyer to conduct its due diligence during the Inspection Period. Buyer and its agents or representatives shall be entitled to go upon the Property during the Inspection Period at reasonable times to inspect, perform investigations, determine the status of utilities and access, conduct zoning investigations, feasibility studies and other studies or tests that Buyer deems necessary or appropriate to determine, in Buyer's sole discretion, whether the Property is suitable and zoned for Buyer's intended use of the Property. Buyer agrees to provide Seller with reasonable advanced notice of all inspection activities and shall indemnify Seller for any damage to the Property that is incurred as a direct result of such inspection activities. If Buyer determines that the Property is not suitable for any reason for Buyer's intended use or purpose, or the Property is not in suitable condition, then the Buyer may, upon written notice to the Seller prior to the expiration of the Inspection Period, terminate the Agreement or LOI and neither party shall have any other or future obligation to the other, except for those obligations that expressly survive the termination of the Agreement of this LOI.

Environmental Review:

During the Inspection Period, Buyer also shall have the right at its sole expense to commission and conduct such environmental evaluations of the Property as Buyer determines necessary in Buyer's sole discretion, including without limitation a Phase I environmental evaluation. If the results of the Phase I environmental evaluation indicate that a Phase II environmental evaluation is appropriate, a Phase II environmental evaluation shall be conducted in accordance with reasonable standards and procedures but only with the prior written approval of Seller, in Seller's sole discretion.

Condition of Property:

The Agreement shall contain certain Seller representations concerning the Property as are customary in similar transactions as the parties shall agree, including without limitation (i) compliance with law and (ii) environmental compliance which representations shall be to the best of Seller's knowledge without due inquiry.

All utilities, including but not limited to sanitary and storm water sewers, public water facilities, telephone lines, electric power and natural gas connections (collectively, "Utilities") shall be available to the Property. If utilities are not suitable for Buyer's intended use, Buyer may elect to terminate the LOI or Agreement upon written notice to Seller prior to the expiration of the Inspection Period.

Ingress, egress and regress for the benefit of the Property shall be (a) sufficient and acceptable to Buyer and Seller, (b) in compliance with all applicable laws and ordinances, and (c) sufficient, including but not limited to scope and size, to enable Buyer to obtain all necessary building permit(s) and certificate(s) of occupancy in connection with the construction, maintenance and repair of existing or proposed improvements to the Property and operate the Property for Buyer's intended use.

Closing Conditions:

Buyer's obligation to consummate the transaction contemplated hereby is expressly subject to each of the following conditions having been fulfilled prior to the Closing Date (as defined below):

A. The Title Insurer shall be irrevocably committed to issue an extended or standard (at Buyer's election) form of ALTA owner's title insurance, and such extensions and endorsements thereto as Buyer shall determine appropriate, subject only to the payment of its regular premium and receipt of an ALTA survey (if extended coverage is requested) (all such costs for title premiums and search shall be borne by Buyer;

B. No default by Seller and/or Buyer shall exist under the Agreement, and Buyer shall have approved the condition of the Property prior to expiration of the Inspection Period;

C. Buyer shall have obtained zoning approval and any other specific permitted use requirements for use of the property for Buyer's intended use along with any other required federal, state or local certificates or approvals, including but not limited to approval from the State of Tennessee, Health Services & Development Agency (HSDA) as well as the Board of Trustees for the Buyer;

D. Seller shall have terminated any existing Lease on the Property; and

E. Such other conditions as are agreed to by the parties and set forth in the Agreement.

Closing Date: The "Closing Date" of the transaction, contemplated hereby shall occur not later than 90 days after receipt by Buyer of final, unappealable certificate of need from HSDA and approval of the transaction by the Board of Trustees of Buyer. In any event, the Closing Date shall occur by August 1, 2019, or either party may terminate this LOI or the Closing Date may be extended by mutual agreement.

Assignment: Buyer shall have the right to assign and transfer its interests hereunder to any corporation, partnership, limited liability company, or other business entity affiliated with and controlled by Buyer. Upon any assignment, Buyer's obligations under the Agreement shall terminate.

Brokers: Except as provided for herein above, the parties hereto warrant to one another that neither has had dealings with any other broker or agent in connection with the Property. Each party will indemnify and hold the other harmless from the claims of any other brokers or finders based upon the action of such party.

Tax-Deferred Exchange: In the event Buyer or Seller desires to effect a tax-deferred exchange in connection with the conveyance of the Property, Buyer and Seller agree to cooperate in effecting such exchange; provided, however, that the exchanging party shall be responsible for all additional costs associated with such exchange, and provided further, that the non-exchanging party shall not assume any additional liability with respect to such tax- deferred exchange. Seller and Buyer shall execute such additional documents, at no cost to the non-exchanging party, as shall be required to give effect to this provision.

Expiration of Offer: The LOI shall constitute an open offer until Buyer receives approval from both HSDA and its Board of Trustees, after which time either party may terminate this LOI if an Agreement has not been executed within (90) days from receipt of approval from HSDA and the Board of Trustees.

Entire Agreement: This letter agreement embodies all agreements between the parties and supersedes all prior oral or written agreements and offers.

Except with respect to the undertakings of the parties set forth below, which are intended to be legally binding agreements, the parties agree that this letter is intended to serve only as an expression of the parties' mutual intent concerning the transaction contemplated hereby and none of the parties shall have any obligation hereunder unless and until a formal purchase agreement has been executed and delivered by Buyer and Seller,

Neither party shall disclose the existence of this letter or its contents, nor the transaction proposed hereby, to third parties (other than its representatives, accountants, counsel, state agency and/or applicable financing institutions, who will all be bound by this paragraph and have a need to know) unless required to do so by applicable law or regulation.

Buyer shall deliver to Seller a first draft of the Agreement, incorporating the provisions of this LOI and containing representations, warranties and other terms and conditions customary in transactions of this type, to Seller within sixty (60) business days after receipt by Buyer of final, unappealable certificate of need from HSDA and approval of the transaction by the Board of Trustees of Buyer. Upon receipt by Seller of the first draft of the Agreement, Buyer and Seller shall negotiate in good faith to agree upon the final form and substance of the Agreement, and execute the Agreement, as soon as reasonably possible thereafter.

In consideration of the considerable expenses incurred and to be incurred by Buyer in pursuing the transaction contemplated by this LOI, Seller agrees to negotiate exclusively with Buyer with respect to the purchase and sale of the Property, as defined herein, for as long as this executed LOI is in effect. Further, Seller agrees not to solicit or consider other proposals concerning the Property or provide information to other entities expressing interest in the Property whether for themselves or others, or to divulge or otherwise disclose information to any such entity regarding any aspects of the transaction described in this LOI including without limitation price, terms, or status of negotiations and discussions between Buyer and Seller or their authorized representatives so long as this LOI is in effect.

If Seller is in agreement with the foregoing, please so indicate by having the enclosed copy of this LOI executed in the space provided below and return the same to me upon which time a fully executed copy will be returned to you

Yours truly,

Joseph M. Winick
Lead Executive, Erlanger Innovation Center

Agreed and Accepted as of Feb. 12, 2018:

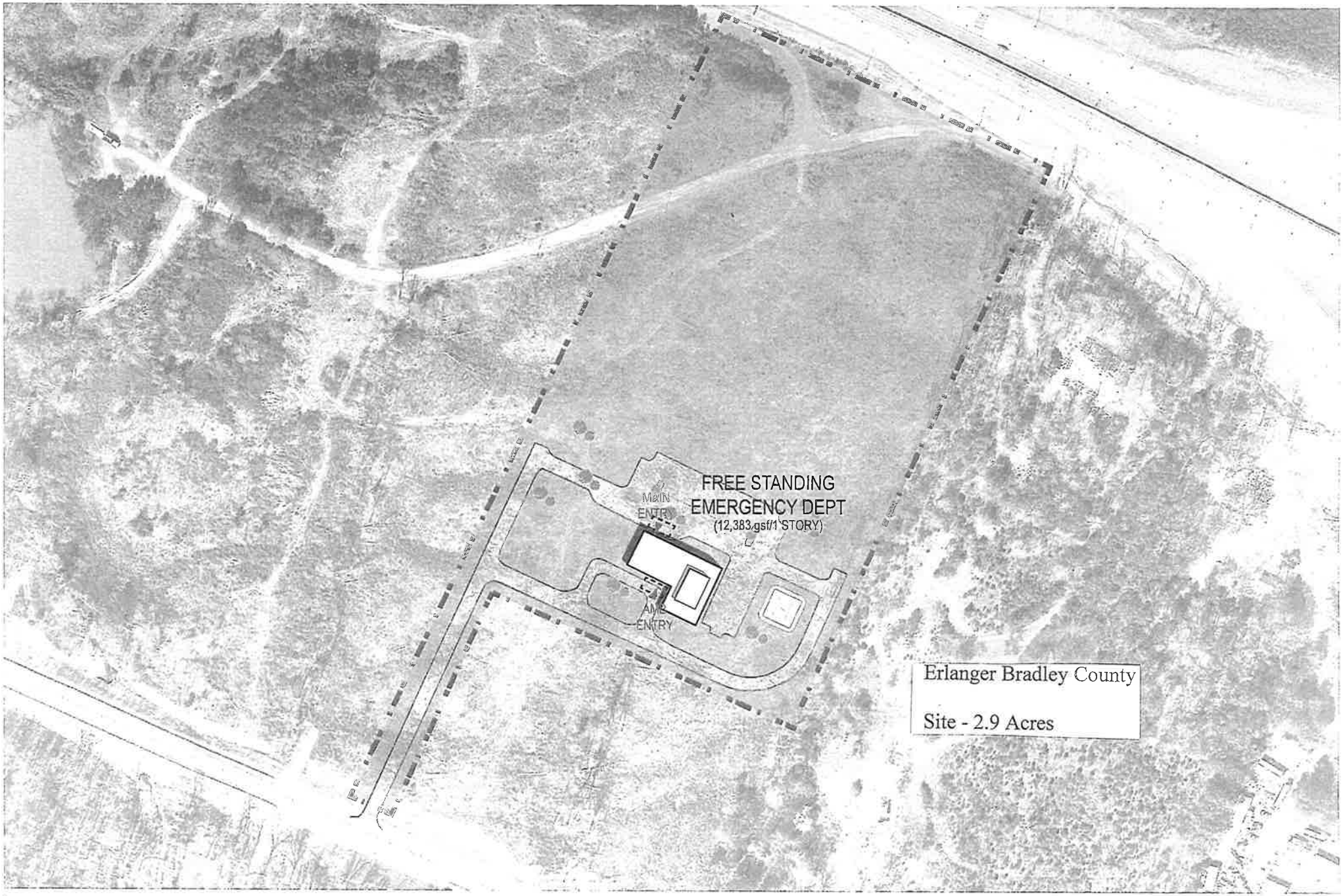
Cleveland Exit 20, GP

By: _____

Name: C. Larry Armour

Its: Managing Partner

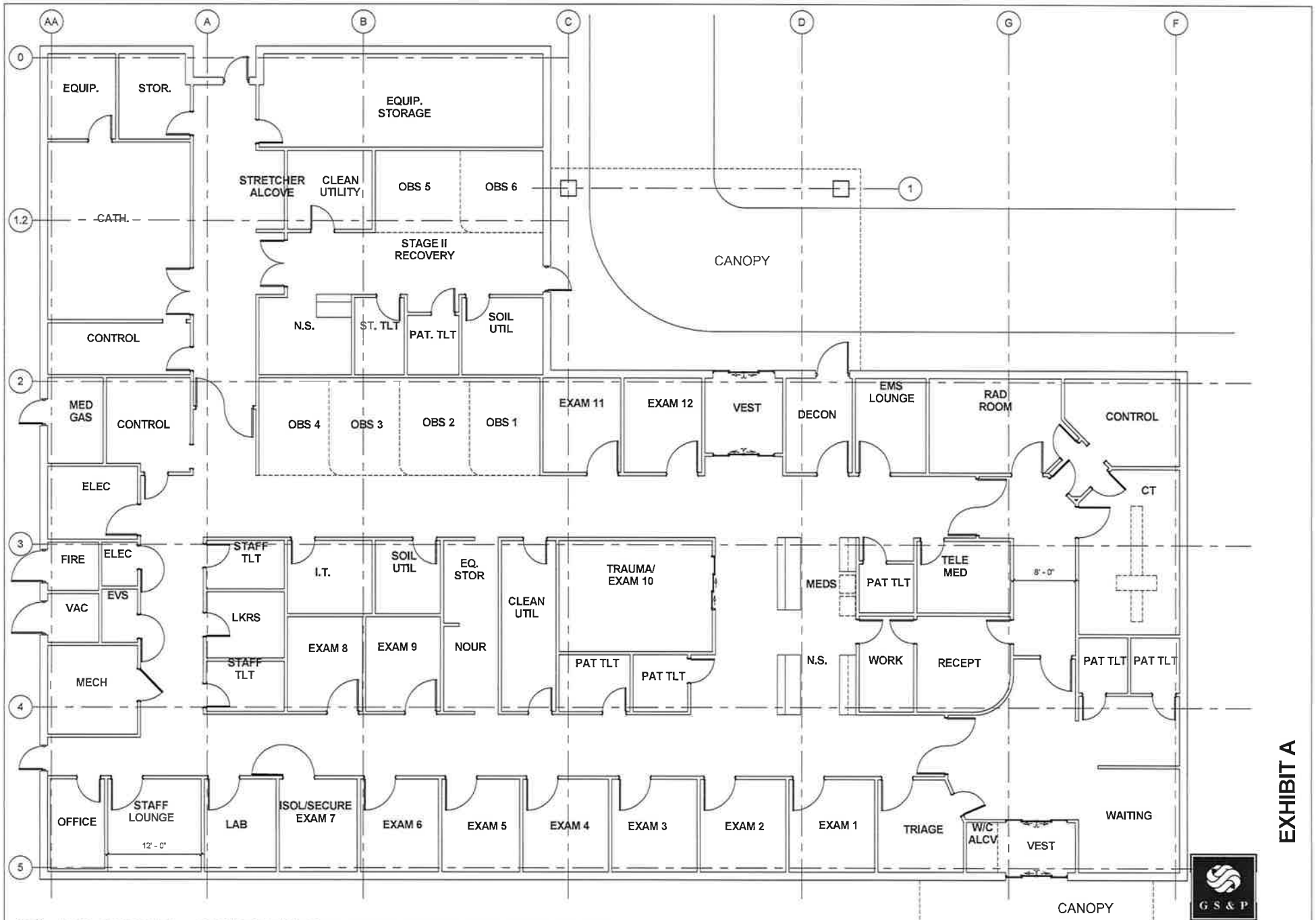
Description	Section / Item
Erlanger Bradley County - Site Plan	A-6-B
Erlanger Bradley County - Floor Plan	A-6-B



erlanger
Health System

ERLANGER BRADLEY COUNTY FREESTANDING ED
FEBRUARY 7, 2018

GRESHAM SMITH AND PARTNERS



1 **ERLANGER - BRADLEY COUNTY FREE-STANDING ED**

October 30, 2017

12,383 GROSS SF

GS&P

GRESHAM SMITH AND PARTNERS

EXHIBIT A

Description	Section / Item
List Of Managed Care Payor Contracts	A-9

Erlanger Health System
List Of Managed Care Payor Contracts

A. TennCare Managed Care Organizations
- -- BlueCare
- -- TennCare *Select*
- -- AmeriGroup Community Care
- -- United Healthcare Community Plan

B. Georgia Medicaid Managed Care Organizations
- -- AmeriGroup Community Care
- -- CareSource
- -- Peach State Health Plan
- -- WellCare Of Georgia

C. Commercial Managed Care Organizations
- -- Blue Cross / Blue Shield of Tennessee
  - - Blue Network P
  - - Blue Network S
  - - Cover Kids
  - - Blue Advantage
- -- Blue Cross of Georgia (HMO & Indemnity)
- -- Baptist Health Plan
- -- CIGNA Healthcare of Tennessee, Inc. (includes LocalPlus)
- -- CIGNA Lifesource (Transplant Network)
- -- UNITED Healthcare of Tennessee, Inc. (Commercial & Medicare Advantage)
- -- Aetna Health
- -- Health Value Management D/B/A Choice Care Network (Commercial & Medicare Advantage)
- -- HUMANA (Choicecare Network, HMO, PPO, POS & Medicare Advantage)
- -- HUMANA Military
- -- Cigna-HealthSpring (Commercial & Medicare Advantage)
- -- WellCare Medicare
- -- Olympus Managed Health Care, Inc.
- -- TriWest (VAPC3)

D. Alliances
- -- Health One Alliance

E. Networks
- -- Multi-Plan (includes Beech Street & PHCS)
- -- MCS Patient Centered Healthcare
- -- National Provider Network
- -- NovaNet (group health)
- -- USA Managed Care Corp.
- -- MedCost
- -- Alliant Health Plan
- -- Crescent Preferred Provider Organization
- -- Evolutions Healthcare System
- -- Prime Health Resources
- -- Three Rivers Provider Network
- -- Galaxy Health Network
- -- First Health Network
- -- Integrated Health Plan
- -- Logicomp Business Solutions, Inc.
- -- HealthSCOPE Benefits, Inc.
- -- HealthCHOICE (Oklahoma State & Education Employees Group Insurance Board)

F. Other
- -- Alexian Brothers Community Services

Description	Section / Item
Medicare Indicators	B-ED
CFO Letter For ED	B-ED
Erlanger Charity Care Policy	B-ED
Letter - TDOH Approval Of Erlanger Trauma Center	B-ED
Report - Survey Of Erlanger Trauma Center	B-ED

Medicare.gov | Hospital Compare

The Official U.S. Government Site for Medicare

Select to print all information

Hospital profile

Timely & effective care

ERLANGER MEDICAL CENTER

975 E 3RD ST
CHATTANOOGA, TN 37403
(423) 778-7000

Overall rating:
2 out of 5 stars
Learn more about the overall ratings

Distance: 30.6 miles

Add to My Favorites
Map and directions for

Hospital type: Acute Care Hospitals
Provides emergency services: Yes

Timely & effective care

These measures show how often hospitals provide care that research shows gets the best results for patients with certain conditions. This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

Cataract surgery outcome

Cataracts affect your vision and are very common in older people. Cataracts can make your vision blurry and can impact your ability to see at night. The purpose of cataract surgery is to improve visual function and the quality of life for people with cataracts.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	ERLANGER MEDICAL	TENNESSEE AVERAGE	NATIONAL AVERAGE

	MEDICAL CENTER	AVERAGE	AVERAGE
Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery *Higher percentages are better*	Not Available[5]	93%[20]	87%[20]

Colonoscopy follow-up

A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal cancer. Scientific evidence shows that the following measures represent best practices for follow-up colonoscopies.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	ERLANGER MEDICAL CENTER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy *Higher percentages are better*	42%	81%[20]	81%[20]
Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe *Higher percentages are better*	92%	89%[20]	87%[20]

Heart attack care

An acute myocardial infarction (AMI) or heart attack happens when one of the heart's arteries becomes blocked and the supply of blood and oxygen to part of the heart muscle is slowed or stopped. When the heart muscle doesn't get the oxygen and nutrients it needs, the affected heart tissue may die. These measures assess the extent to which some of the recommended treatments are provided, if appropriate, for most adults who have had a heart attack.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely heart attack care

	ERLANGER MEDICAL CENTER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital *A **lower** number of minutes is better*	Not Available[1]	54 Minutes[20]	58 Minutes[20]
Average (median) number of minutes before outpatients with chest pain or possible heart attack got an ECG *A **lower** number of minutes is better*	7 Minutes	6 Minutes[20]	7 Minutes[20]
Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival	Not Available[7]	72%[20]	58%[20]

Higher *percentages are better*			
Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department ***Higher*** *percentages are better*	90%	96%[20]	95%[20]

Hospital Compare data are reported using the median only. However, the median is often referred to as the 'average' on the Hospital Compare website to allow for ease of understanding.

Emergency department care

Timely and effective care in hospital emergency departments is essential for good patient outcomes. Delays before getting care in the emergency department can reduce the quality of care and increase risks and discomfort for patients with serious illnesses or injuries. Waiting times at different hospitals can vary widely, depending on the number of patients seen, staffing levels, efficiency, admitting procedures, or the availability of inpatient beds.

The information below shows how quickly the hospitals you selected treat patients who come to the hospital emergency department, compared to the average for all hospitals in the U. S.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely emergency department care

	ERLANGER MEDICAL CENTER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Average (median) time patients who came to the emergency department with broken bones had to wait before getting pain medication	46 Minutes	47 Minutes[20]	50 Minutes[20]

*A **lower** number of minutes is better*			
OP-22 **Percentage of patients who left the emergency department before being seen** *Lower percentages are better*	3%	2%[20]	2%[20]
Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival *Higher percentages are better*	Not Available[1]	73%[20]	71%[20]

Volume legend (patients annually): Low: 0 - 19,999 Medium: 20,000 - 39,999 High: 40,000 - 59,999 Very High: 60,000+	ERLANGER MEDICAL CENTER
Emergency department volume	Very High
Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient *A **lower** number of minutes is better* ED-1	346 Minutes[2] Other Very High volume hospitals Nation: 334 Minutes[20] Tennessee: 340 Minutes[20]
Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room *A **lower** number of minutes is better* ED-2	204 Minutes[2] Other Very High volume hospitals Nation: 136 Minutes[20] Tennessee: 147 Minutes[20]
Average (median) time patients spent in the emergency department	131 Minutes

before leaving from the visit *A **lower** number of minutes is better* OP-18	Other Very High volume hospitals Nation: 172 Minutes[20] Tennessee: 165 Minutes[20]
Average (median) time patients spent in the emergency department before they were seen by a healthcare professional *A **lower** number of minutes is better* OP-20	30 Minutes Other Very High volume hospitals Nation: 28 Minutes[20] Tennessee: 27 Minutes[20]

Hospital Compare data are reported using the median only. However, the median is often referred to as the 'average' on the Hospital Compare website to allow for ease of understanding.

Preventive care

Hospitals and healthcare providers play a crucial role in promoting, providing and educating patients about preventive services and screenings and maintaining the health of their communities. Many diseases are preventable through immunizations, screenings, treatment, and lifestyle changes. The information below shows how well the hospitals you selected are providing preventive services.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	ERLANGER MEDICAL CENTER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Patients assessed and given influenza vaccination ***Higher** percentages are better*	98%[2]	96%[20]	94%[20]
Healthcare workers given influenza vaccination ***Higher** percentages are better*	95%	89%[20]	88%[20]

Stroke care

Stroke care

A stroke, sometimes called a "brain attack," occurs when blood flow to the brain is interrupted. When a stroke occurs, brain cells in the immediate area begin to die because they stop getting the oxygen and nutrients they need to function. There are 2 major kinds of stroke:

An ischemic stroke is caused by fatty build-up or a blood clot that blocks or plugs a blood vessel or artery in the brain.

A hemorrhagic stroke is caused by a blood vessel in the brain that breaks and bleeds into the brain.

Strokes can cause a loss of the ability to speak, memory problems, or paralysis on one side of the body. Getting the right care at the right time can help reduce the risk of complications and another stroke. These measures show some of the standards of stroke care that hospitals should follow, for adults who have had a stroke.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely stroke care

	ERLANGER MEDICAL CENTER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started ***Higher*** *percentages are better*	95%[2]	88%[20]	88%[20]

Blood clot prevention & treatment

Because hospital patients often have to stay in bed for long periods of time, any patient who is admitted to the hospital is at increased risk of developing a blood clot in the veins (known as venous thromboembolism). Blood clots can break off and travel to other parts of the body and cause serious problems, even death. Fortunately, there are safe, effective, and proven procedures to prevent blood clots or to treat them when they occur.

The measures listed below show how well hospitals are providing recommended care known to prevent or treat blood clots and how often blood clots occur that could have been prevented.

Find out why these measures are important

Find out why those measures are important.

Get more information about the data.

Get the current data collection period.

Blood clot prevention

	ERLANGER MEDICAL CENTER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Patients who developed a blood clot while in the hospital who *did not* get treatment that could have prevented it ***Lower*** *percentages are better*	4%[2]	2%[20]	2%[20]

Blood clot treatment

	ERLANGER MEDICAL CENTER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Patients with blood clots who were discharged on a blood thinner medicine and received written instructions about that medicine ***Higher*** *percentages are better*	92%[2]	93%[20]	93%[20]

Pregnancy & delivery care

By providing care to pregnant women that follows best practices, hospitals and doctors can improve chances for a safe delivery and a healthy baby.

This measure shows the percentage of pregnant women who had elective deliveries 1-3 weeks early (either vaginally or by C-section) whose early deliveries weren't medically necessary. Higher numbers may indicate

that hospitals aren't doing enough to discourage this unsafe practice.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	ERLANGER MEDICAL CENTER	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary ***Lower*** *percentages are better*	3%[2]	2%[20]	2%[20]

If footnotes appear in the table, hover over the number to get more details. View more footnote details.

Medicare.gov | Hospital Compare

The Official U.S. Government Site for Medicare

Select to print all information

Hospital profile

Timely & effective care

TENNOVA HEALTHCARE-CLEVELAND

2305 CHAMBLISS AVE NW
CLEVELAND, TN 37311
(423) 339-4132

Overall rating:
2 out of 5 stars
Learn more about the overall ratings

Distance: 1.6 miles

Add to My Favorites
Map and directions for

Hospital type: Acute Care Hospitals
Provides emergency services: Yes

Timely & effective care

These measures show how often hospitals provide care that research shows gets the best results for patients with certain conditions. This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

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Get more information about the data.

Get the current data collection period.

	TENNOVA	TENNESSEE	NATIONAL

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery *Higher percentages are better*	Not Available[5]	93%[20]	87%[20]

Colonoscopy follow-up

A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal cancer. Scientific evidence shows that the following measures represent best practices for follow-up colonoscopies.

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Get more information about the data.

Get the current data collection period.

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy *Higher percentages are better*	100%	81%[20]	81%[20]
Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe *Higher percentages are better*	100%	89%[20]	87%[20]

Heart attack care

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Get the current data collection period.

Timely heart attack care

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital *A **lower** number of minutes is better*	42 Minutes	54 Minutes[20]	58 Minutes[20]
Average (median) number of minutes before outpatients with chest pain or possible heart attack got an ECG *A **lower** number of minutes is better*	4 Minutes	6 Minutes[20]	7 Minutes[20]
Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of	Not Available[7]	72%[20]	58%[20]

arrival ***Higher*** *percentages are better*			
Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department ***Higher*** *percentages are better*	100%	96%[20]	95%[20]

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The information below shows how quickly the hospitals you selected treat patients who come to the hospital emergency department, compared to the average for all hospitals in the U. S.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely emergency department care

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Average (median) time patients who came to the emergency department with broken bones had to wait before getting	92 Minutes	47 Minutes[20]	50 Minutes[20]

wait before getting pain medication *A **lower** number of minutes is better*			
OP-23 **Percentage of patients who left the emergency department before being seen** ***Lower** percentages are better*	5%	2%[20]	2%[20]
Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival ***Higher** percentages are better*	89%	73%[20]	71%[20]

Volume legend (patients annually): Low: 0 - 19,999 Medium: 20,000 - 39,999 High: 40,000 - 59,999 Very High: 60,000+	TENNOVA HEALTHCARE-CLEVELAND
Emergency department volume	High
Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient *A **lower** number of minutes is better* ED-1	373 Minutes[2] Other High volume hospitals Nation: 296 Minutes[20] Tennessee: 278.5 Minutes[20]
Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room *A **lower** number of minutes is better* ED-2	189 Minutes[2] Other High volume hospitals Nation: 119 Minutes[20] Tennessee: 104 Minutes[20]

Average (median) time patients spent in the emergency department before leaving from the visit *A **lower** number of minutes is better* OP-18	199 Minutes Other High volume hospitals Nation: 162 Minutes[20] Tennessee: 166.5 Minutes[20]
Average (median) time patients spent in the emergency department before they were seen by a healthcare professional *A **lower** number of minutes is better* OP-30	23 Minutes Other High volume hospitals Nation: 26 Minutes[20] Tennessee: 23 Minutes[20]

Hospital Compare data are reported using the median only. However, the median is often referred to as the 'average' on the Hospital Compare website to allow for ease of understanding.

Preventive care

Hospitals and healthcare providers play a crucial role in promoting, providing and educating patients about preventive services and screenings and maintaining the health of their communities. Many diseases are preventable through immunizations, screenings, treatment, and lifestyle changes. The information below shows how well the hospitals you selected are providing preventive services.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Patients assessed and given influenza vaccination ***Higher** percentages are better*	93%[2]	96%[20]	94%[20]
Healthcare workers given influenza vaccination	72%	89%[20]	88%[20]

***Higher** percentages are better*			

Stroke care

A stroke, sometimes called a "brain attack," occurs when blood flow to the brain is interrupted. When a stroke occurs, brain cells in the immediate area begin to die because they stop getting the oxygen and nutrients they need to function. There are 2 major kinds of stroke:

An ischemic stroke is caused by fatty build-up or a blood clot that blocks or plugs a blood vessel or artery in the brain.

A hemorrhagic stroke is caused by a blood vessel in the brain that breaks and bleeds into the brain.

Strokes can cause a loss of the ability to speak, memory problems, or paralysis on one side of the body. Getting the right care at the right time can help reduce the risk of complications and another stroke. These measures show some of the standards of stroke care that hospitals should follow, for adults who have had a stroke.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Timely stroke care

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started ***Higher** percentages are better*	Not Available[7]	88%[20]	88%[20]

Blood clot prevention & treatment

Because hospital patients often have to stay in bed for long periods of time, any patient who is admitted to the hospital is at increased risk of developing a blood clot in the veins (known as venous thromboembolism). Blood clots can break off and travel to other parts of the body and cause serious problems, even death. Fortunately, there are safe, effective, and proven procedures to prevent blood clots or to treat them when they occur.

The measures listed below show how well hospitals are providing recommended care known to prevent or treat blood clots and how often blood clots occur that could have been prevented.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

Blood clot prevention

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Patients who developed a blood clot while in the hospital who *did not* get treatment that could have prevented it *Lower percentages are better*	Not Available[1]	2%[20]	2%[20]

Blood clot treatment

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Patients with blood clots who were discharged on a blood thinner medicine and received written instructions about that medicine *Higher percentages are better*	98%	93%[20]	93%[20]

Pregnancy & delivery care

By providing care to pregnant women that follows best practices, hospitals and doctors can improve chances for a safe delivery and a healthy baby.

This measure shows the percentage of pregnant women who had elective deliveries 1-3 weeks early (either vaginally or by C-section) whose early deliveries weren't medically necessary. Higher numbers may indicate that hospitals aren't doing enough to discourage this unsafe practice.

Find out why these measures are important.

Get more information about the data.

Get the current data collection period.

	TENNOVA HEALTHCARE-CLEVELAND	TENNESSEE AVERAGE	NATIONAL AVERAGE
Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary *Lower percentages are better*	0%[2]	2%[20]	2%[20]

If footnotes appear in the table, hover over the number to get more details. View more footnote details.

erlanger

February 9, 2017

Ms. Melanie Hill, Executive Director
Tennessee Health Services Agency
State of Tennessee
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application, Bradley County Emergency Department/ Level IV Trauma Center

Dear Ms. Hill:

This letter serves to confirm our intent to utilize funds from operations and cash reserves to develop and implement the provider based, satellite Emergency Department/Level IV Trauma Center in Bradley County having a capital cost of $ 11,297,935, subject to CON approval as well as approval of the Chattanooga-Hamilton County Hospital Authority. A copy of our audited financial statements are enclosed with the CON application.

Please let us know if you have any questions or if additional information is needed. Thank you.

Sincerely,

J. Britton Tabor, CPA, FACHE
Executive Vice President & CFO

GOVERNOR

CHAPTER NO. 80

SENATE BILL NO. 276

By Albright, Crutchfield

Substituted for: House Bill No. 762

By Starnes, Wood, Robinson (Hamilton), McAfee

AN ACT Relative to the Chattanooga-Hamilton County Hospital Authority and to amend Chapter 297 of the Private Acts of 1976.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Chapter 297 of the Private Acts of 1976, is amended by deleting the first sentence of Section 12 and substituting the following:

Chattanooga-Hamilton County Hospital Authority shall be obligated to make available without regard to race, religion or national origin, its facilities and patient care programs to the indigent (as defined from time to time by the County Auditor) residents (as defined from time to time by the County Auditor with the approval of the county legislative body) of Hamilton County, City of Chattanooga, and all other incorporated municipalities within Hamilton County to the extent that funds are appropriated from time to time by the County Council and adjusted profits (profits minus principal payments on Hospital building bonds and long-term notes) derived from operation of the Hospital are utilized.

SECTION 2. This act shall have no effect unless it is approved by a two-thirds (2/3) vote of the Hamilton County legislative body. Its approval or nonapproval shall be proclaimed by the presiding officer of the Hamilton County legislative body and certified by him to the Secretary of State.

SECTION 3. For the purpose of approving or rejecting the provisions of this act, it shall be effective upon becoming a law, the public welfare requiring it.

PASSED: May 16, 1985

SPEAKER OF THE SENATE

Origination Date: 10/03/2017 Approval: _Britt Tabor_____		
Reviewed/ Revised Date:	Effective Date:	Approval:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Erlanger Health System Policy

Index Title: Financial Assistance Policy

Originating Department: Patient Financial Services

Number: 8227.038

Policy statement:
In accordance with the long-standing Hamilton County Assistance Program, it is the policy of Erlanger Health System (EHS) to grant our patients access to essential or non-elective care, regardless of their ability to pay.

Scope: Erlanger Health System

Definitions:

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Non-cash benefits (such as food stamps and housing subsidies) do <u>not</u> count;
- Determined on a before-tax basis;

- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Uninsured: The patient has no insurance or third party liability or assistance to assist with meeting his/her payment obligations.

Gross Charges: The total charges at Erlanger Health System's full established rates for the provision of patient care services before deductions from revenue are applied.

Emergency Medical Conditions: Defined within the meaning of section 1867 of the Social Security Act 942.U.S.C. 1395dd).

Medically Necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

Health Insurance Market Place: Organizations set up to facilitate the purchase of health insurance in every state of the United States in accordance with Patient Protection and Affordable Care Act. Marketplaces provide a set of government-regulated and standardized health care plans from which individuals may purchase health insurance eligible for federal subsidies.

Procedure:

Charity assistance is available to all patients who qualify after providing the necessary documentation and completing the application process. If a patient qualifies for Charity assistance, the charges for qualifying medical services will be appropriately adjusted by Erlanger Heath System. Financial Advocates are available to assist patients in making applications for charity care, which may be available for those who earn up to 200% of the Federal Poverty Guidelines. Applications for assistance are available at Erlanger Health System between 8:30 a.m. and 4:30 p.m. (Monday through Friday) and are available on-line at www.erlanger.org. Services eligible for Charity Care are medically necessary inpatient and outpatient services.

In addition to assisting with charity, Erlanger Health System staff is available to patients in determining eligibility for programs such as TennCare, Medicaid or the Affordable Health Care Act coverage. When patients qualify for TennCare, Medicaid or any other health insurance, those coverages will first be billed with payment pursued and collected prior to Charity Assistance being considered. Once those program eligibility/benefits are exhausted and resolved, then Charity consideration would be pursued for any remaining qualifying balance. The Financial Advocates are available to assist uninsured patients in determining a source of payment. For those patients not eligible for financial assistance, it is the policy of the Erlanger Health System to permit patients when eligible to make regular payments on a monthly basis. Erlanger Health System utilizes external

collection firms on debt collection as needed. When appropriate, Erlanger Health System will refer past due accounts to collection attorneys for the purposes of collecting from those who have the ability to pay. In appropriate circumstances, attorney fees will be sought in addition to unpaid balances.

It is the policy of Erlanger to:

- Treat all patients equally, with dignity, respect, and compassion.
- Serve the emergency health needs of everyone, regardless of ability to pay.
- Assist patients who cannot pay for part or all of the care they receive at Erlanger Health System.
- Balance the needed financial assistance for some patients with broader fiscal responsibilities in order to keep the Health System viable financially.
- Respond promptly to patient's questions regarding their bills and request for financial assistance.
- Make available information regarding our charity care policy.
- Have clear understanding of written policies to help patients determine if they are eligible for public or hospital-sponsored financial assistance programs.
- Ensure outside collection agencies follow hospital billing and collection guidelines.

The intent of the Erlanger Health System Financial Assistance Policy is to establish a fair and equitable system for determining hospital charity. General guidelines are established, allowing for evaluation of unique financial circumstances.

A patient is potentially eligible for financial assistance by income standards when the annual individual or family income does not exceed 200% of the Federal Poverty Guidelines as published annually in the Federal Register. Current income will be a factor in assessing hospital charity but will not be the sole determining factor. Among other elements to be considered are temporary factors such as short term layoff, unemployment, disability or other demonstrated hardship.

An evaluation of available assets will be necessary to determine eligibility for charity. If assets exist to pay the debt, charity could be denied. The State of Tennessee is a member of the Federal Healthcare Exchange Program. Therefore,

applicants are required to apply for insurance through the Health Insurance Marketplace. If applicant fails to enroll during open enrollment, or qualifies for health insurance coverage through the Marketplace and chooses not to enroll, or allows insurance premiums to lapse, charity care may be denied.

PROGRAM GUIDELINES:

1. Charity is evaluated on the basis of assets as well as gross family income.

2. For Hamilton County residents, Charity is approved for up to six (6) months. Hamilton County residents must reapply for charity care if the six (6) month time period has expired.

   For all other applicants (who are not from Hamilton County, Tennessee), Charity may be approved for up to three (3) months. Non-Hamilton County residents must reapply for Charity if the three (3) month (or other approved time period) has expired.

3. Charity applies only after all other resources have been exhausted.

4. If a complete Financial Assistance Application has been timely filed by a patient, the Application will be processed even if there is available pending liability, litigation or other payer sources potentially available. However, the determination of whether the patient qualifies for Charity will be pending based on the payment outcome of the other payment sources.

5. A determination of the applicant's eligibility is made as soon as practical after the application is completed.

6. In order to be considered for Charity the following financial information must be submitted with the Financial Assistance Application:

   a. Latest bank statement.
   b. Latest Federal income tax return ***(For self-employed applicants, all decisions will be based on gross income found on line 1, box 1 on the applicant's Schedule C.)*** or most recent paycheck stub.

c. List of lawsuits and potential claims/lawsuits you have that may lead to you receiving additional money.

Note:

(a) A hardship letter can be included to justify your inability to

pay.

(b) Failure to provide the financial information after receiving written notice outlining the additional information needed and a reasonable opportunity to provide the information may result in Charity Care being denied.

7. Income Guidelines: To be eligible for charity care, gross family income must be at or below 200% of the current HH Poverty guidelines found on the U. S. Department of Health and Human Services website: **http://aspe.hhs.gov/poverty/figures-fed-reg.cfm**

8. Asset and credit investigations may be conducted on all charity cases. If it is determined that assets exist or the patient has the ability to pay the debt, charity may be denied.

9. Eligibility for Charity means the charges for qualifying medical services will be written off.

   As the qualifying charges are written off, no patient eligible for financial assistance will be charged more for emergency or medically necessary services than the Amounts Generally Billed (AGB). Thus, the calculation of AGB as defined by IRS 26 CFR Section 501(r) is not necessary, as the policy meets both AGB calculation methods.

10. Anyone who applies for financial assistance, but does not provide the required documents for review:
    - will receive notice outlining the additional information needed, and
    - will be given a reasonable opportunity to provide the information.

    However,
    - if the patient does not provide the required documents,
    - refuses to apply for insurance in the Health Insurance Marketplace, or
    - allows insurance to lapse due to lack of payment

    the patient may not be considered for Charity and may be fully liable for payment of their bill.

11. Any applicant fraudulently misrepresenting his or her income level will be immediately disqualified for consideration for charity care. In the event the applicant makes fraudulent misrepresentations, the patient's account balance will be billed to the responsible party.

12. Applicant must apply for charity within two hundred and forty (240) days after the date the Applicant receives their first post-discharge billing statement. This deadline may be extended in certain circumstances covered in 26 CFR § 1.501(r)(3). When an applicant applies for Charity, Erlanger Health System will review and consider all

accounts within ninety (90) days from receipt of the completed application.

13. Charity approval on cases that fall outside the established guidelines must be approved by the Assistant Vice President, Revenue Cycle or designee and are purely discretionary.

Uninsured, Self-Pay Patients:

A Managed Care type discount will be applied to all self-pay accounts in accordance with Tennessee Code Annotated § 68-11-262. The self-pay discount is computed by the Tennessee Hospital Association, which sets a maximum collection rate for uninsured patients.

These discounts do not apply to programs or services that are elective in nature.

Examples of elective programs or services include (but are not limited to) wellness programs, cosmetic procedures, etc. Elective programs and services have specific pricing and are exempt from qualifying for charity care.

Hamilton County Assistance Program

The Hamilton County Assistance Program applies to all Hamilton County residents who qualify for charity care under the above-referenced federal poverty guidelines. Hamilton County residents who meet Erlanger's charity care criteria are qualified for both in-patient and out-patient Erlanger services for a six-month period of time.

340B:

We utilize 340B medications for qualified patients of the hospital as that term is defined and applied within the Federal 340 B Drug Discount Program, see policy PC 220 340B Drug Purchasing and Compliance Policy.

Prompt Pay Discount for Patients with Health Insurance

For Erlanger hospital billed services, patients with health insurance (government, commercial or managed care insurance) will be eligible for a 10% prompt pay discount on balances that are the patient's responsibility. Payment must be received and posted within fifteen (15) days from the date of the first statement sent to the patient. This prompt pay discount does not apply to Erlanger physician services billing.

Use of Outside Collection Agencies Or Attorneys:

When the patient has not responded to our request for payment and failed to pay their debt owed, the account will be referred to an outside collection agency or collection attorney. In appropriate circumstances, attorney fees will be sought in addition to unpaid balances.

Litigation:

When appropriate, hospital reserves the right to seek judgments and ultimately garnishments and levies on non-exempt wages and/or assets from those patients who have not paid the outstanding debt. Hospital will not take any action to have patient removed from their property, but where appropriate will seek judgment for the amount owed and place judgment liens against patient's real property. Before pursuing litigation, the hospital will review the patient's financial condition via credit reporting to ensure litigation is appropriate according to Erlanger's guidelines.

Credit Reporting:

Erlanger routinely uses data provided by outside agencies to verify information such as credit scores, assets, etc. This information is often used in deciding whether the patient is eligible for charity, determining medical indigency, and assessing the viability of collection on the patient's account.

Monthly Payment Arrangements:

Efforts will be made by Erlanger to collect balances in full either by cash, check or credit card, prior to establishing monthly payment arrangements. Payment arrangements may be granted only after all other payment options have been exhausted. In lieu of payment arrangements, Erlanger reserves the right to refer eligible patients for bank loans to pay off their hospital account. Erlanger does not charge interest on monthly payment plans, therefore long term arrangements are discouraged wherever possible. The minimum monthly payment is dependent on the balance of the account. Please see the following:

ACCOUNT BALANCE	PAYMENT SCHEDULE
$25.00 - $600.00	**Minimum payment of $25.00 per month**
$601.00-$1200.00	**Minimum payment of $50.00 per month**
$1201.00-$1800.00	**Minimum payment of $75.00 per month**
$1801.00-$2400.00	**Minimum payment of $100.00 per month**

$2401.00-$3000.00 Minimum payment of $125.00 per month

$3001.00-$3600.00 Minimum payment of $150.00 per month

$3601.00-$4200.00 Minimum payment of $175.00 per month

$4201.00-$4800.00 Minimum payment of $200.00 per month

Approval must be obtained from the AVP, Revenue Cycle or designee to accept a payment plan that is less than what is described in the schedule. Likewise, payment arrangements may be declined if the term of the payments does not meet a reasonable period of time to settle or liquidate the debt owed. Payment arrangements exceeding 24 months must have the approval of a PFS Manager or AVP, Revenue Cycle, and it is within their discretion to approve.

Committee	Approval/Date

Medical Director	Approval/Date

References:

Department of Health and Human Services Poverty Guidelines.
http://aspe.hhs.gov/poverty/figures-fed-reg.cfm
Federal Register, Vol. 77, No. 17 January 26, 2012
Safety Net Hospitals for Pharmaceutical Access

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
TELEPHONE: 615-741-2584
WEBSITE: http://health.tn.gov/ems/

May 26, 2015

Kevin M. Spiegel
President, Chief Executive Officer
Erlanger Medical Center
975 East Third Street
Chattanooga, TN 37403

Dear Mr. Spiegel:

On May 1, 2015 the Tennessee Department of Health, Office of Emergency Medical Services conducted a verification site visit of Erlanger Medical Centers Level I Trauma Center. After review of the findings from the site visit the following recommendations will be presented to the Board for Licensing Health Care Facilities (BLHCF), on September 9, 2015.

The site team finds that Erlanger Medical Center continues to meet all requirements and standards of a Level I Trauma Center and recommends continued designation as a Level I Trauma Center. Areas for improvement that were identified will be reviewed at the next site visit.

The BLHCF meeting will be held at 665 Mainstream Drive, 1st Floor Iris Board Room, Nashville, TN. 37243. The meeting will begin at 0900 AM CST.

Thank you for your dedication to trauma care in Tennessee. Please contact me at 615-741-7208 with any questions.

Sincerely,

Rob Seesholtz, BSN, RN, EMT-P
Trauma System Manager

Cc: Michelle Long, Assistant Commissioner, BHL&R
Vincent Davis, Director, HCF
Donna Tidwell, Director, EMS
Ann Rutherford Reed, Director of Licensure HCF

ERLANGER MEDICAL CENTER
CHATTANOOGA, TENNESSEE
TRAUMA CENTER VERIFICATION SITE VISIT REPORT
MAY 1, 2015

Introduction

Erlanger Medical Center was site visited on May 1, 2015. This hospital was designated a Level I Trauma Center in August 1988. The site visit was conducted as required by the Board of Licensing Health Care Facilities as a performance based review using the Trauma Center rules 1200-08-12 (revised March 2013). Generation of this report was accomplished by: Interviews with key personnel (hospital administrators, the Trauma Medical Director, the Trauma Program Manager and other involved personnel), direct evaluation of care via review of individual medical records, analysis of trauma registry data and reports, review of the quality assurance program, and other supporting documents. There is a comprehensive regional pediatric center, but that is housed in a separate hospital with a separate emergency department and the management of pediatric trauma cases is not included in this report.

Improvements and Accomplishments

Numerous improvements and accomplishments have been implemented since the last site visit:

1. A 6th trauma surgeon has been added to the service
2. A dedicated trauma clinic has been reinstituted
3. The regional operational center has been upgraded and expanded with state-of-the-art technology. The center serves as the nucleus for pre-hospital access and covers all transfers, Flight Ops, MedComm, control room for patient care, Bed Desk, Transport within the facility, Case Management, and Registration activities
4. There has been an overhaul of the trauma intake process, including revision of the Trauma Activation Criteria, team member Roles/Responsibilities, and a new EMS survey. This has resulted in reorganization of the trauma bay, a formalized EMS Report format, a station for EMS to stand upon intake, and Visual Aids/Floor Decals
5. An Injury Prevention/Outreach Coordinator has been hired
6. There is now a 3rd Trauma NP
7. Community interaction with Hixson High School resulted in as award as Tennessee State Winner of Battle of the Belt
8. SBIRT Program has been implemented
9. Erlanger continues to offer its annual Trauma Symposium now in its 8th season
10. Erlanger's Trauma Services Department won the "Spirit of 911" Award for injury prevention efforts in the community
11. There are now 4 funded full-time registrars, a 5th is being added in July
12. Trauma On-Call Privileges are now overseen by Trauma Medical Director and Chief of Surgery
13. There is a new Trauma Organ Donation/Procurement scorecard

14. Dr. Barker regularly attends the Trauma Care Advisory Council for the state
15. Development of an ECMO program under the direction of Trauma Service Physicians

Trauma Injury and Payor Data

Trauma service admissions are stable at 2667 patients admitted during the index calendar year. Review of the ISS range revealed:

	Total Admits	ISS 0-15	ISS 16-25	ISS 26-40	ISS 41+	Ave ISS	Ave RTS	RTS <10
2009	2671	1666 62.4%	608 22.8%	318 11.9%	79 2.9%	15	7.1	341 12.8%
2012	2702	1812 67.1%	625 23.1%	228 8.4%	37 1.4%	12.4	7.23	314 11.6%
2014	2667	1783 67%	618 23%	221 8.2%	45 1.7%	12.3	11.15	281 10.5%

The severity mix noted by these ISS scores falls within the normal range expected of a Level I Trauma Center in the State of Tennessee and has changed little since 2012.

Financial summary of patients over the past year:

Site Visit Year	Self Pay	Comm. Insur.	Medicare	Medicaid	TennCare	Work. Comp.	Other
2009	14%	39%	19%	5%	11%	4%	6%
2012	19.5%	38.1%	24.2%	3.8%	8.9%	4.8%	---
2014	20.4%	45.5%	21.7%	2.6%	7.8%	2%	---

Hospital Organization

Primary Trauma Service Personnel

Position	Name	% Time Committed to Trauma Program
Chief of Trauma	Phillip Burns, M. D.	20%
Trauma Medical Director	Donald Barker, M. D.	75%
Trauma Service Line Admin.	Beth Jordan, BSN, RN	25%
Trauma Program Manager	Angela Basham-Saif, BSN, RN	100%
Surgical Critical Care Director	Robert Maxwell, M. D.	50%
Hosp. Admin Responsible for Trauma	Ranae Thompson, MSN, RN	15%
Trauma Registrar	Christie Ware, RHIA	100%
Trauma Registrar	Heather Kelly	100%
Trauma Registrars	2 funded vacancies	100%
Trauma Administrative Asst	Candy Royer	20%
PIPS Coordinator	Sandy Wolfe, BSN, RN	100%
Injury Prevention/Outreach Coordinator	Regena Young, BSN, RN	100%
Acute Care Nurse Practitioners	Jammie Dill, MSN, ACNP Lori Neal, MSN, ACNP Jennifer O'Neal, FNP	100% 100% 100%
Trauma Research Coordinator	Patricia Lewis, RN, CCRC	75%
Critical Care Nurse Clinicians	Jenny Dillard, RN Jill Hale, RN Jana Jackson, RN Laura Kirk, RN David Wolfkill, RN Renee Mills, RN Cathy Cornett, RN Vaness Korter, RN Jared Weber, RN Heather Wilson, RN	50% 50% 50% 50% 50% 50% 50% 50% 50% 50%

Trauma Surgeons	Donald Barker, M. D. Benjamin Dart, MD Robert Maxwell, MD Phillip Smith, MD Vincent Mejia, MD Darren Hunt, MD	75% 100% 100% 100% 100% 100%

Trauma Service/Activation Criteria/Response Times. There are currently six surgeons responsible for trauma call. All have added certification in surgical critical care. All trauma and acute care surgery cases/call are staffed by these fellowship trained trauma surgeons who take in-house call. All participants have current ATLS certification, appropriate continuing education credits in trauma annually, and appropriate participation in trauma service conferences and committees. Trauma Service organization includes three mid-level providers and ten registered nurses (red/gray shirts) who are involved in the ongoing clinical care of trauma patients throughout their hospital stay. The Red/Grey Shirt team is an innovative approach to trauma care. They alternate between providing trauma care and as part of the rapid response team. They provide continuity for patients from the ED bay to the floor and ICU, assist with massive transfusion protocols and other resuscitative activities. All mid-level providers participate in the quality improvement program and trauma case reviews.

Written graded activation criteria have been updated and divided into Level I and II activations. These were presented to the site survey team and are also posted in the Emergency Department. The intake process has also been improved. An EMS survey was undertaken to improve field to ED hand-offs, a script for the radio report and bedside report created, and a specified area for EMS outlined within the trauma bay.

The organizational chart for the institution was reviewed and interviews with administration, as well as other documentation, demonstrate support for the Trauma Program. An annual budget was presented and clear documentation of application of Tennessee Trauma Fund Monies (Tennessee Trauma Fund Law of 2007) for Trauma Program needs was verified.

Trauma response times were reviewed. Chief resident response times to trauma activations was appropriate, however, response times for Attending Surgeons fell below the "on-time" allocations (15 minutes for Level I traumas and 30 minutes for Level II traumas. Upon further enquiry, this was felt to be a documentation issue. The current trauma flow sheet does not capture this appropriately. Considerable work has been done on a new paper trauma flow sheet which includes this metric. Documentation of this metric needs to be improved upon.

Surgical Specialty Availability. Surgical specialty call schedules were reviewed and 24/7 coverage of all required specialties was documented. Review of Trauma Performance documents did not reveal any problems with Surgical Specialty coverage or availability. Of particular note, the trauma attendings place intracerebral monitoring devices, thus providing prompt emergent care to the injured patient.

Non-Surgical Specialty Availability. Non-Surgical specialty call schedules were reviewed and documented 24/7 coverage of all required specialties. Review of Trauma

Performance Documents did not reveal any problems with Surgical Specialty coverage or availability. Of note, all the trauma surgeons are capable of instituting and directing Continuous Renal Replacement Therapy to their patients in the ICU.

Facility Resources and Capabilities

- **Emergency Department: Personnel/Qualifications/Equipment.** The Emergency Department has a designated Physician Director, Robert Hamilton MD, and is entirely staffed by physicians Board Certified in Emergency Medicine. Adequate nursing staff is available 24/7. Tour of the Emergency Department verifies that all essential equipment is available.

- **Intensive Care Unit for Trauma Patients: Personnel/Qualifications/Equipment.** Dr. Robert Maxwell is the Medical Director of the Trauma/Surgical Intensive Care Unit. All Attending Trauma Surgeons take in-house call. Additionally, there is senior surgical house staff available in-house on a 24/7 basis. Nurse ratios are appropriate, there is immediate access to laboratory services and Point-of-Care (POC) testing is available. All essential equipment is present on the unit. A new ECMO program has been instituted and is currently overseen by the Trauma Service Physicians

- **Post-anesthetic Recovery Room.** No deficiencies were documented.

- **Acute Hemodialysis.** Hemodialysis is available 24/7. Continuous renal replacement therapy (CRRT) is also available and directed by the Attending Trauma Surgeons.

- **Organized Burn Care.** Erlanger does not have a burn center. Transfer Agreements with regional Burn Centers were provided to the site review team.

- **Radiological Special Capabilities.** The site team reviewers toured the Radiology Department. All required capabilities were noted to be present. Additionally, there is 24/7 Radiologic Attending Staff in-house.

- **Organ Donation Protocols.** Organ donor protocols were reviewed and appropriate levels of notification were met for the Trauma ICU. A scorecard for donation has been developed and implemented house-wide.

Operating Suite Special Requirements/Availability

There is an operating room available for the trauma service 24/7. Three operating rooms are staffed throughout the night, and if in use, a call team is activated. All required equipment is available.

Clinical Laboratory Services

All essential Clinical Laboratory Services are available. Additionally, point-of-care (POC) testing is available in key areas: the operating room, emergency department,

and Trauma ICU. Of note, the Blood Bank has worked closely with Trauma Services to provide innovative solutions to the exsanguinating patient: These initiatives include:

1. Use of liquid plasma
2. Ability of Life Force Air Medical to recommend initiation of the massive transfusion protocol
3. Life Force now carries liquid plasma
4. Clear guidelines and order sets for use of blood products
5. Monthly evaluation of blood product and massive transfusion protocol use
6. Availability of thawed plasma - extending life of product from 24 hours to 5 days

Trauma Medical Director

Donald Barker continues to be the Trauma Director. He maintains appropriate certification, participates fully in call, and has the authority to manage all aspects of trauma care. He coordinates performance improvement and the peer review process, and with assistance of the hospital administrator, is involved in the budgetary process. He is current in ATLS and provides other trauma-related education within and without the institution. He is actively involved in research and the development of treatment protocols. He attends state trauma meetings regularly. A process has now been put into place to allow him to authorize trauma service privileges for providers on the on-call panel.

Attending General Surgeons on the Trauma Service

One hundred percent of the call for trauma is done by the Trauma Medical Director and Trauma Service physicians (Dr. Dart, Dr. Maxwell, Dr. Mejia, Dr. Smith, and Dr. Hunt). All are Board Certified in General Surgery with added qualifications in Surgical Critical Care. All have current ATLS certification, appropriate trauma specific CME, and are actively involved in research.

Trauma Nurse Coordinator (TNC)/Trauma Program Manager (TPM)

The full-time Trauma Program Manager is Angela Basham-Saif, BSN, RN. She brings a wealth of knowledge and energy to her position. The Trauma Service Line Director is Beth Jordan, BSN, RN, who has served in multiple capacities with the trauma service. Both possess experience in Emergency/Critical Care Nursing. A defined job description was presented to the site surveyors and is appropriate. Administrative and budgetary support for the trauma program was evident.

Trauma Registry

The trauma registry in this hospital is maintained by several registrars. Christie Ware, RHIA, and Heather Kelly are currently the only two registrars listed. There has been some turnover in these positions, but the facility is funded for 4 FTE's, and has agreed to fund a 5th position beginning July 2015. The FTE issue has been corrected since the last site visit, but given position turnover, there has been delayed reporting to the state. All patients with an ICD-9 discharge codes of 800-959 are placed in the registry with the

following exclusions: 905-909.9 (late effects of injury), 910-924.9 (superficial injuries), and 930-939.0 (foreign bodies). Data is obtained from retrospective chart review for registry entry.

Programs for Quality Assurance: Medical Care Education/Trauma Process Improvement/Operational Process Improvement (System Issues)

1. **Department M & M Conference** is held weekly and attended by all Trauma Service faculty and residents. It is a quality assurance conference where all Trauma Service complications and deaths are reviewed. Most issues involving clinical care are resolved at this conference. Where necessary, issues can be referred to the Trauma Committee, individual department or division QA committees, or the Multi-Disciplinary Trauma Peer Review Committee. Operational issues that arise during the reviews at this conference are sent to the Trauma Committee.
2. **The Trauma Committee** is a multi-disciplinary committee that meets bi-monthly. It is an administrative committee that deals primarily with systems operations and Trauma Service function. QI issues are discussed in relation to systems operations and no peer review occurs. Most issues involving systems operations are resolved at this committee or by direct communication of the Trauma Director with department or division heads. Issues that cannot be resolved are sent to the Hospital Quality Improvement Committee for further action.
3. **Multi-disciplinary Trauma Peer Review Committee (MDC**) is a multi-disciplinary committee which now meets monthly and is comprised of Trauma Service Physicians, Neurosurgeons, Plastic Surgeons, Orthopedic Surgeons, Anesthesiologists, Emergency Medicine Physicians, the Critical Care Fellow, and the Hospital CQI Director. Residents and other personnel do not attend this committee. It is primarily an attending physician peer review of trauma care committee. The attendings discuss the care issues among those attending physicians providing trauma care. Most issues reviewed at this committee are resolved through discussion at the committee meeting and documented on the MDC log sheet. Other issues of concern are referred to the Trauma Committee. This committee allows a more focused review on senior level decision making processes in trauma care and interaction between sub-specialty surgical services is improved through the function of this committee. Case discussion summaries are dictated, items requiring further action are clearly documented, and were available for review.
4. **Discharge Planning Committee** is held weekly and is a multi-disciplinary committee attended by the primary trauma physician plus Rehabilitation Services, Occupational Therapists, Physical Therapists, and others. Review of all current Trauma Service patients and discussion of care issues occurs. This multi-disciplinary approach enhances general service efficiency and throughput.
5. **Hospital Medical Quality Improvement Committee (MQIC)** meets bimonthly and is made up of the physician and administrative leadership of the hospital. It reviews all hospital QI efforts. Problems not solved through other mechanisms can go through this committee to the hospital administration or the Board.

6. **Trauma Attending Staff Meeting** is attended by the trauma surgeons and the trauma program manager. This occurs weekly or as needed. It is an administrative meeting and focuses on Trauma Service Line function. Issues that are discussed include pre-hospital concerns, guidelines, performance improvements, and research. Any issues that require further resolution are sent to the appropriate committees.
7. **Blood Utilization Committee** is a new committee that meets monthly. Dr. Maxwell serves as chair. A scorecard is maintained and all massive transfusion protocols evaluated.

Chart Reviews of Medical Care

All charts for review were available on computer and assistance for access obtained from Trauma Service personnel as per the request letter. Multiple TRISS plots were available for review. The data was divided based on blunt and penetrating trauma. Evaluation of the TRISS plots revealed that the overall mortality occurred in patients with more severe injuries and those with co-morbidities that placed patients into a higher risk category.

Thirty-five to forty charts were reviewed for clinical care and all team members participated in the chart review. Although charts from all categories were reviewed, there was a concentration on the more severely injured patients. Overall the clinical care was deemed acceptable.

The program has developed a Confidential MQIC Review Worksheet. All complications and deaths are reviewed. A list of complications is generated by the Nurse Practitioners with input from the trauma surgeons and residents. Medical care complications are initially reviewed by the Trauma Coordinator/Trauma Director and all significant issues noted are discussed at the MDC or MQIC. Complications are also determined by resident records maintained through routine care as mandated by the Residency Review Committee (RRC). The forms provide a synopsis of the care and patient hospital course. All deaths and adverse events are summarized on this form, including a brief hospital course description and a judgment regarding appropriateness of treatment, outcome, contributing causes and whether further action was warranted. Clear follow up of issues was also documented on the MQIC Case Review Worksheet. Loop closure was evident. Administrative and system issues that arise are routinely sent to surgery MQIC or other department MQIC and actions are clearly outlined in the Peer Review Worksheet.

Trauma Bypass Log

A bypass memo was available and documents 0% diversion since 2001. Since this is the only Trauma Center in the area, there is administrative and medical care commitment to not go on trauma bypass. This has clearly been effective.

Outreach/Training/Public Education/Research

There is public service and outreach effort demonstrated by this Trauma Center. The Trauma Service at Erlanger is involved in continuing trauma education at the professional level. Programs for physicians, nurses, and EMT's exist, and strong support for ATLS and ATCN is documented. Additional programs include PHTLS, TNCC, and PALS. There are community continuing education programs, and numerous school programs, including bicycle safety, seat belt awareness, teenage driver safety, Helmet use, and other such programs. The Trauma Coordinator and other personnel have spent a great deal of time in a myriad of outreach efforts. There is a new injury prevention and outreach coordinator. LifeForce personnel and Pediatric Trauma Services do additional outreach.

As a Level I Trauma Center, there is a requirement for research. Erlanger Medical Center actively participates in a variety of research activities and has an adequate number of trauma research publications. This publication and presentation list was available to site reviewers.

Trauma System Development

The Regional Medical Communication Center (RMCC) is located at Erlanger Medical Center. Dr. Barker is on the Trauma Care Advisory Council and the Tennessee Committee on Trauma and has regularly attended meetings since the last site visit.

CONCLUSIONS

This hospital has demonstrated a continuing commitment to excellence in trauma care, quality improvement assessment of care, and regional involvement in trauma outreach education and injury prevention. It is obvious that specific support from hospital administration and medical staff for the trauma program is present. The trauma division staff and other hospital personnel are highly motivated and have demonstrated an allegiance to support the trauma program. Efforts on behalf of Trauma by the Trauma Director, the Trauma Surgeons, the Hospital Administration, the professional staff, and especially the Trauma Service Line Administrator are to be specifically commended.

The site team finds that Erlanger Medical Center in Chattanooga, Tennessee is continuing to meet all requirements and standards of a Level I Trauma Center. No deficiencies were found. The site team recommends continued designation as a Level I Trauma Center.

AREAS OF IMPROVEMENT

1. The current electronic emergency department flow sheets are difficult to follow and obtain critical information regarding patient care. This institution plans to transition to EPIC for its electronic health record. Nevertheless, a paper flow sheet for trauma must be maintained in order to record data accurately and completely during these fast-paced events. There are no electronic methods available at this time to gather this time-sensitive data quickly and efficiently. In

order to be compliant with state and national reviews, a paper flow sheet remains the gold standard for data collection during trauma resuscitations.

2. Trauma response times did not meet defined criteria for trauma attendings (15 minutes for Level I traumas and 30 minutes for Level II traumas). This was determined to be a documentation problem. The new paper flow sheet has included this metric and should solve this issue.
3. There is a prolonged dwell time in the emergency department due to throughput issues. The institution needs to consider developing a trauma overflow or receiving unit.
4. The institution remains months behind in trauma registry submission. The addition of the two FTE's for the registry is noted and should help rectify this situation. These positions also need to be supported with funding for education and certification to ensure accurate and complete data acquisition.
5. The current trauma bays in the ED fashioned such that consistent temperature control and privacy cannot be maintained.
6. One of the CT scanners supporting the ED and trauma service is a 16 slice scanner. Evidence has accumulated that this does not provide the diagnostic capability to diagnose certain trauma injuries and an upgrade must be considered.

EXIT INTERVIEW

Following the site visit, the team held a meeting to evaluate the findings and make conclusions. An exit interview was then held and the conclusions and recommendations as stated in this report were presented to the hospital administrative, medical and nursing staff present.

Description	Section / Item
Cardiac Cath Calculations - Certificate Of Need	B-CCS
HRSA Medically Underserved Index	B-CCS-10
Mortality Data For Service Area	B-CCS-10
Policy For Cardiac Catheterization	B-CCS
Policy For Transferring Cardiac Catheterization Patients	B-CCS
Quality Control & Monitoring For Cardiac Catheterization	B-CCS
Policy Pertaining To Emergencies	B-CCS
Policy On Outpatient Orders And	B-CCS

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Data Sources: TDH Hospital Discharge Data System (HDDS)
Data Years: 2013-2015 (most recent years of finalized HDDS data)

Methodology: Determine the three year Cardiac Cath weighted volume (diagnostic and therapeutic) performed by each Tennessee hospital in the service area by 13 age groups calculating a single year average. Include all patients seen, both Tennessee resident and non-resident. Include all occurrences of Cardiac Cath ICD-9 and ICD-10 Procedure Codes or CPT HCPCS codes with a Revenue Code 0481, Cardiology - Cardiac Cath Lab. Summarize cases based on the highest weighted code.

Cardiac Cath ICD-9, ICD-10 and CPT codes and categorizations determined by the Bureau of TennCare and the Tennessee Hospital Association. Notes: there was a major shift in CPT coding beginning in 2011; ICD-10 coding began the fourth quarter of 2015.

The service area for the current application includes Bradley, Hamilton and Polk counties. Acute care hospitals found in this area (during the years 2013-2015) are Skyridge Medical Center, Skyridge Medical Center Westside, Erlanger Medical Center, Erlanger North, Erlanger East, Memorial North Park, Memorial Healthcare System, Parkridge Medical Center, Parkridge East Hospital and Copper Basin Medical Center.

Skyridge Medical Center Westside (State ID 06233) and Copper Basin Medical Center (State ID 70223) did not record any claims in the time period with Revenue Code 0481, Cardiology - Cardiac Cath Lab.

Skyridge Medical Center (State ID 06223)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2013-2015

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	311.5	310.0	1.5	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	15.0	15.0	0.0	0.0
40 - 44	26.5	25.0	1.5	0.0
45 - 49	37.0	37.0	0.0	0.0
50 - 54	39.0	39.0	0.0	0.0
55 - 59	46.0	46.0	0.0	0.0
60 - 64	52.0	52.0	0.0	0.0
65 - 69	43.0	43.0	0.0	0.0
70 - 74	33.0	33.0	0.0	0.0
75 - 79	6.0	6.0	0.0	0.0
80 - 84	12.0	12.0	0.0	0.0
85 +	2.0	2.0	0.0	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	124.0	8.0	108.0	8.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	7.0	0.0	3.0	4.0
40 - 44	16.0	4.0	12.0	0.0
45 - 49	15.0	0.0	15.0	0.0
50 - 54	11.0	2.0	9.0	0.0
55 - 59	21.0	0.0	21.0	0.0
60 - 64	18.0	0.0	18.0	0.0
65 - 69	18.0	2.0	12.0	4.0
70 - 74	6.0	0.0	6.0	0.0
75 - 79	3.0	0.0	3.0	0.0
80 - 84	9.0	0.0	9.0	0.0
85 +	0.0	0.0	0.0	0.0

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

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

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Hospital Discharge Data System, 2013-2015. Nashville, TN.

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Erlanger Medical Center (State ID 33203)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2013-2015

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	5,187.0	4,772.0	93.0	322.0
0 - 17	98.0	86.0	0.0	12.0
18 - 29	53.0	25.0	0.0	28.0
30 - 39	182.5	149.0	1.5	32.0
40 - 44	270.5	255.0	1.5	14.0
45 - 49	438.0	407.0	3.0	28.0
50 - 54	686.0	637.0	15.0	34.0
55 - 59	773.5	721.0	10.5	42.0
60 - 64	755.5	701.0	22.5	32.0
65 - 69	752.5	688.0	22.5	42.0
70 - 74	529.0	493.0	6.0	30.0
75 - 79	374.5	349.0	7.5	18.0
80 - 84	200.0	192.0	0.0	8.0
85 +	74.0	69.0	3.0	2.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	5,333.0	1,062.0	3,507.0	764.0
0 - 17	96.0	76.0	12.0	8.0
18 - 29	56.0	6.0	6.0	44.0
30 - 39	197.0	12.0	129.0	56.0
40 - 44	293.0	20.0	237.0	36.0
45 - 49	414.0	48.0	294.0	72.0
50 - 54	702.0	136.0	486.0	80.0
55 - 59	849.0	142.0	603.0	104.0
60 - 64	813.0	138.0	579.0	96.0
65 - 69	703.0	200.0	411.0	92.0
70 - 74	533.0	128.0	333.0	72.0
75 - 79	360.0	94.0	198.0	68.0
80 - 84	226.0	52.0	150.0	24.0
85 +	91.0	10.0	69.0	12.0

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

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

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Hospital Discharge Data System, 2013-2015. Nashville, TN.

Erlanger North (State ID 33213)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2013-2015

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	3.0	3.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	1.0	1.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	1.0	1.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	1.0	1.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	6.0	0.0	6.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	3.0	0.0	3.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	3.0	0.0	3.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	0.0	0.0	0.0	0.0
70 - 74	0.0	0.0	0.0	0.0
75 - 79	0.0	0.0	0.0	0.0
80 - 84	0.0	0.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

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

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

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Hospital Discharge Data System, 2013-2015. Nashville, TN.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Erlanger East (State ID 33233)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2013-2015

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

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

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

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

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Hospital Discharge Data System, 2013-2015. Nashville, TN.

Memorial North Park (State ID 33223)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2013-2015

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	77.0	73.0	0.0	4.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	1.0	1.0	0.0	0.0
30 - 39	3.0	3.0	0.0	0.0
40 - 44	2.0	2.0	0.0	0.0
45 - 49	5.0	5.0	0.0	0.0
50 - 54	5.0	5.0	0.0	0.0
55 - 59	8.0	8.0	0.0	0.0
60 - 64	7.0	7.0	0.0	0.0
65 - 69	11.0	9.0	0.0	2.0
70 - 74	12.0	12.0	0.0	0.0
75 - 79	7.0	7.0	0.0	0.0
80 - 84	12.0	10.0	0.0	2.0
85 +	4.0	4.0	0.0	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	115.0	4.0	111.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	3.0	0.0	3.0	0.0
30 - 39	9.0	0.0	9.0	0.0
40 - 44	3.0	0.0	3.0	0.0
45 - 49	3.0	0.0	3.0	0.0
50 - 54	9.0	0.0	9.0	0.0
55 - 59	6.0	0.0	6.0	0.0
60 - 64	9.0	0.0	9.0	0.0
65 - 69	14.0	2.0	12.0	0.0
70 - 74	23.0	2.0	21.0	0.0
75 - 79	6.0	0.0	6.0	0.0
80 - 84	18.0	0.0	18.0	0.0
85 +	12.0	0.0	12.0	0.0

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

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

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Hospital Discharge Data System, 2013-2015. Nashville, TN.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Memorial Healthcare System (State ID 33323)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2013-2015

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	11,475.5	10,010.0	211.5	1,254.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	46.0	34.0	0.0	12.0
30 - 39	214.0	199.0	3.0	12.0
40 - 44	380.0	347.0	3.0	30.0
45 - 49	649.5	597.0	4.5	48.0
50 - 54	1,045.5	947.0	16.5	82.0
55 - 59	1,285.5	1,169.0	22.5	94.0
60 - 64	1,589.0	1,386.0	27.0	176.0
65 - 69	1,952.0	1,674.0	42.0	236.0
70 - 74	1,704.5	1,436.0	40.5	228.0
75 - 79	1,329.5	1,137.0	28.5	164.0
80 - 84	849.5	734.0	19.5	96.0
85 +	430.5	350.0	4.5	76.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	11,149.0	1,720.0	6,717.0	2,712.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	33.0	4.0	9.0	20.0
30 - 39	143.0	20.0	99.0	24.0
40 - 44	338.0	28.0	234.0	76.0
45 - 49	603.0	86.0	417.0	100.0
50 - 54	967.0	140.0	651.0	176.0
55 - 59	1,229.0	180.0	813.0	236.0
60 - 64	1,411.0	210.0	873.0	328.0
65 - 69	1,823.0	324.0	1,035.0	464.0
70 - 74	1,686.0	300.0	930.0	456.0
75 - 79	1,391.0	218.0	813.0	360.0
80 - 84	947.0	126.0	513.0	308.0
85 +	578.0	84.0	330.0	164.0

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

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

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Hospital Discharge Data System, 2013-2015. Nashville, TN.

Parkridge Medical Center (State ID 33383)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2013-2015

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	5,032.5	4,445.0	49.5	538.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	36.0	16.0	0.0	20.0
30 - 39	117.0	89.0	0.0	28.0
40 - 44	171.5	162.0	1.5	8.0
45 - 49	334.5	316.0	4.5	14.0
50 - 54	519.0	469.0	6.0	44.0
55 - 59	628.5	575.0	1.5	52.0
60 - 64	653.5	588.0	7.5	58.0
65 - 69	857.0	770.0	15.0	72.0
70 - 74	707.0	619.0	0.0	88.0
75 - 79	547.0	472.0	9.0	66.0
80 - 84	318.5	262.0	4.5	52.0
85 +	143.0	107.0	0.0	36.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	5,159.0	846.0	3,153.0	1,160.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	58.0	2.0	0.0	56.0
30 - 39	125.0	10.0	63.0	52.0
40 - 44	176.0	10.0	138.0	28.0
45 - 49	308.0	32.0	252.0	24.0
50 - 54	488.0	46.0	342.0	100.0
55 - 59	593.0	86.0	399.0	108.0
60 - 64	676.0	112.0	444.0	120.0
65 - 69	814.0	176.0	546.0	92.0
70 - 74	746.0	154.0	420.0	172.0
75 - 79	564.0	114.0	270.0	180.0
80 - 84	366.0	76.0	174.0	116.0
85 +	245.0	28.0	105.0	112.0

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

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

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Hospital Discharge Data System, 2013-2015. Nashville, TN.

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment

Certificate of Need Cardiac Cath Calculations based on 2009 State Health Plan Standards

Parkridge East Hospital (State ID 33393)

Highest Weighted* Cardiac Cath Services Provided - Hospital Discharge Recorded Data - 2013-2015

Diagnostic Cardiac Caths				
	Diagnostic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	14.0	14.0	0.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	1.0	1.0	0.0	0.0
30 - 39	1.0	1.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	1.0	1.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	5.0	5.0	0.0	0.0
70 - 74	2.0	2.0	0.0	0.0
75 - 79	3.0	3.0	0.0	0.0
80 - 84	1.0	1.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

Therapeutic Cardiac Caths				
	Therapeutic	Service Categories		
Age Grp	Total	CC	PV	EP
Total	20.0	2.0	18.0	0.0
0 - 17	0.0	0.0	0.0	0.0
18 - 29	0.0	0.0	0.0	0.0
30 - 39	0.0	0.0	0.0	0.0
40 - 44	0.0	0.0	0.0	0.0
45 - 49	0.0	0.0	0.0	0.0
50 - 54	0.0	0.0	0.0	0.0
55 - 59	0.0	0.0	0.0	0.0
60 - 64	0.0	0.0	0.0	0.0
65 - 69	9.0	0.0	9.0	0.0
70 - 74	3.0	0.0	3.0	0.0
75 - 79	6.0	0.0	6.0	0.0
80 - 84	2.0	2.0	0.0	0.0
85 +	0.0	0.0	0.0	0.0

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

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

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Healthcare Facility Statistics. Hospital Discharge Data System, 2013-2015. Nashville, TN.

From the 2015 Joint Annual Reports (JAR) of Hospitals there are 16 Cardiac Cath labs in operation in the service area:

Skyridge Medical Center State (ID 06223) – 1 lab
Erlanger Medical Center (State ID 33203) – 4 labs
Memorial Healthcare System (State ID 33323) – 7 labs
Parkridge Medical Center (State ID 33383) – 4 labs

Service Area Hospital	Diagnostic Cardiac Caths	Therapeutic Cardiac Caths	Total Cardiac Caths
Skyridge Medical Center (State ID 06223)	311.5	124.0	435.5
Erlanger Medical Center (State ID 33203)	5,187.0	5,333.0	10,520.0
Erlanger North (State ID 33213)	3.0	6.0	9.0
Erlanger East (State ID 33233)	2.0	0.0	2.0
Memorial North Park (State ID 33223)	77.0	115.0	192.0
Memorial Healthcare System (State ID 33323)	11,475.5	11,149.0	22,624.5
Parkridge Medical Center (State ID 33383)	5,032.5	5,159.0	10,191.5
Parkridge East Hospital (State ID 33393)	14.0	20.0	34.0
Totals	22,102.5	21,906.0	44,008.5

# of Caridac Cath Labs in Service Area (JAR)	16
Capacity per Lab (defined by standards)	2,000
Total Capacity in Service Area	32,000
Percent of Existing Services to Capacity	137.5%

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment

MUA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 11/10/2017

State: Tennessee
County: Bradley County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pages

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Date
Bradley County	011	Cleveland Division Service Area	03253	Medically Underserved Area	Medically Underserved Area	43.20	05/12/1994	05/12/1994

MCD (91152) District 7
MCD (90772) District 5
MCD (90392) District 3
MCD (90962) District 6

1 Page Size: 20 01 items in 01 pages

MUA Find Results

Search Criteria

Click on a column heading to sort the results in ascending or descending order.

Start Over | Modify Search Criteria | Map View

Data as of 11/10/2017

State: Tennessee
County: Polk County
MUA ID: All

Collapse All

1 Page Size: 20 01 items in 01 pa

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Da
Polk County	139	Polk County Service Area	1479461357	Medically Underserved Area	Medically Underserved Area	51.30	10/03/2016	10/03/2016

1 Page Size: 20 01 items in 01 pa

Medically Underserved Area/Population (MUA/P) Application Process

State Primary Care Offices (PCOs) use the Shortage Designation Management System (SDMS) to submit MUA and MUP applications to us for review.

Eligibility for MUA/P designation depends on the Index of Medical Underservice (IMU) calculated for the area or population proposed for designation. Under the established criteria, an area or population with an IMU of 62.0 or below qualifies for designation as an MUA/P.

What is the Index of Medical Underservice (IMU)?

The IMU scale is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved.

We calculate the IMU by assigning a weighted value to an area or population's performance on four demographic and health indicators, then adding the weighted values together.

We use the following indicators:

- Provider per 1,000 population ratio
- % Population at 100% of the Federal Poverty Level (FPL)
- % Population age 65 and over
- Infant Mortality Rate

What is the Application Process for Exceptional Medical Underserved Populations (MUPs)?

A state governor can recommend, and a PCO can then request, an exceptional MUP for a population that demonstrates need but does not meet the regular criteria for designation.

Applications for these designation requests should describe in detail the unusual local conditions, access barriers, and other demonstrated needs which led to the recommendation for exceptional designation.

Such requests must also include a written recommendation for designation from the governor or other chief executive officer of the state (or state-equivalent) and local health official, as well as any supporting data.

Date Last Reviewed: October 2016

Contact Us

Shortage designation questions?

Email us, or call 301-594-5168

Additional Contacts

State Primary Care Offices

Centers for Medicare and Medicaid Services (CMS)

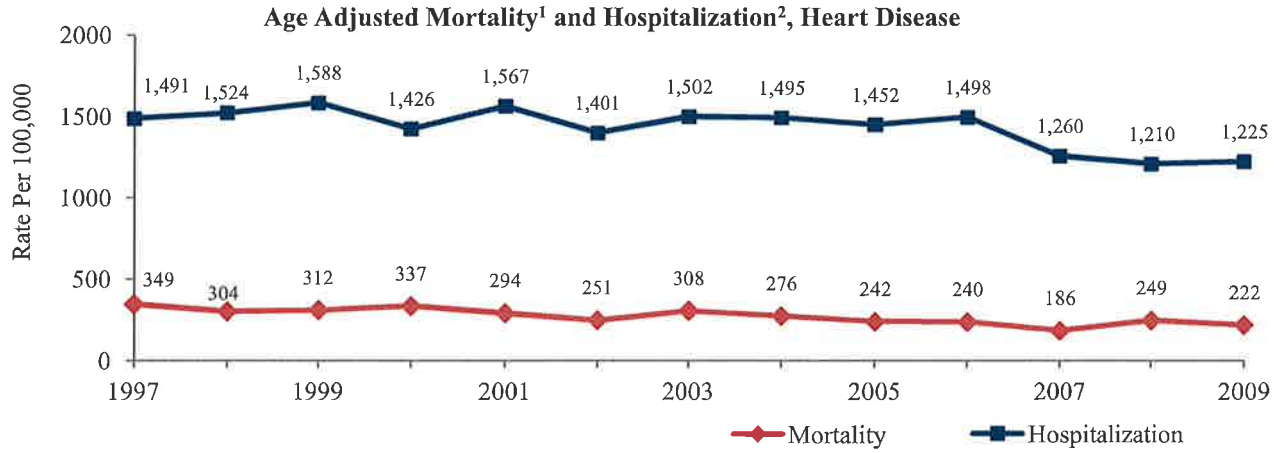
Resources & Tools

HRSA Data Warehouse

HPSA Find / MUA/P Find

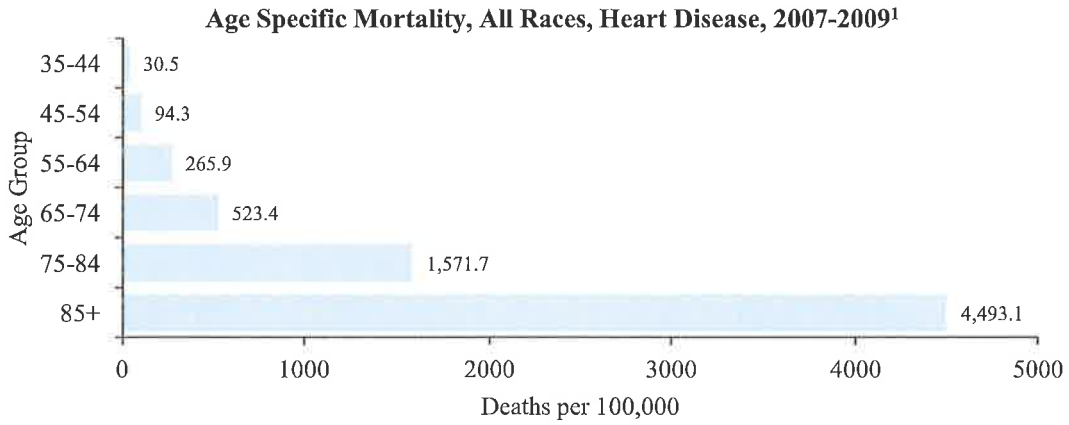
Bradley

Heart Disease



Heart Disease Mortality[1] and Hospitialization[2], 2007-2009

	Total	White	Black	Female	Male
Mortality (per 100,000)	219.3	218.2	245.9	165.6	303.0
Hospitalization (per 100,000)	1,231.6	1,219.6	1,183.0	988.0	1,524.9



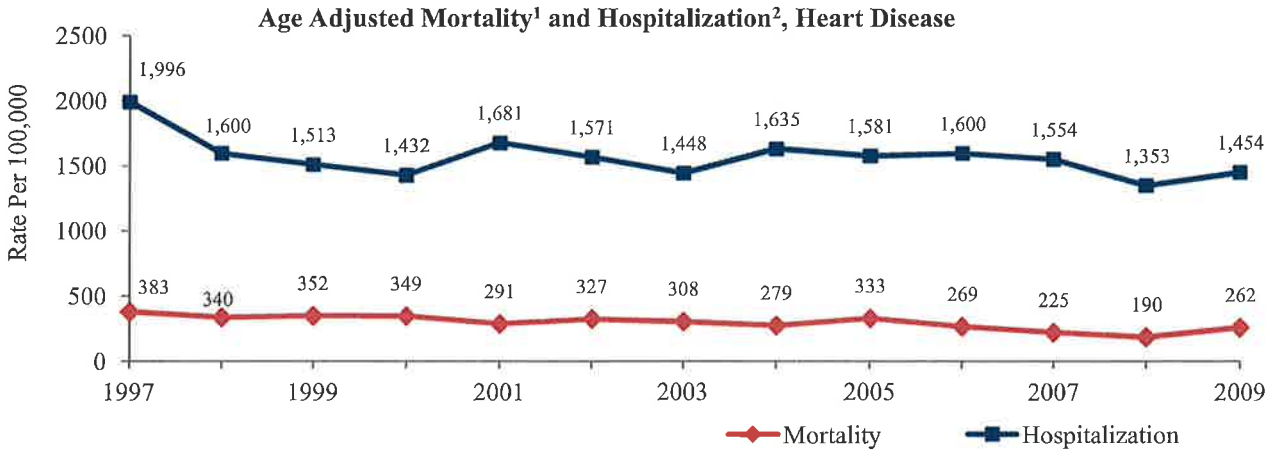
[1]Data Source: Death Statistical System, Tennessee Department of Health, Division of Health Statistics. Age adjustment based on the 2000 standard US population.

[2]Data Source: Hospital Discharge Data System, Tennessee Department of Health, Division of Health Statistics, 2007-2009. Data are for discharges, not necessarily for unique patients and are calculated for all ages. Age adjusted to the 2000 standard US population.

^ Indicates data has been suppressed due to small numbers.

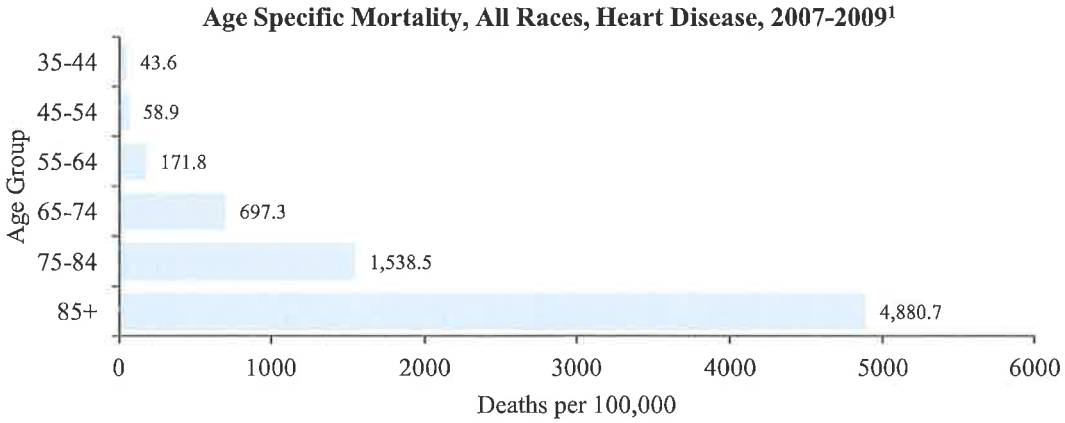
Polk

Heart Disease



Heart Disease Mortality[1] and Hospitialization[2], 2007-2009

	Total	White	Black	Female	Male
Mortality (per 100,000)	225.6	225.0	0.0	204.6	228.6
Hospitalization (per 100,000)	1,453.1	1,429.9	0.0	1,159.4	1,743.4



[1]Data Source: Death Statistical System, Tennessee Department of Health, Division of Health Statistics. Age adjustment based on the 2000 standard US population.

[2]Data Source: Hospital Discharge Data System, Tennessee Department of Health, Division of Health Statistics, 2007-2009. Data are for discharges, not necessarily for unique patients and are calculated for all ages. Age adjusted to the 2000 standard US population.

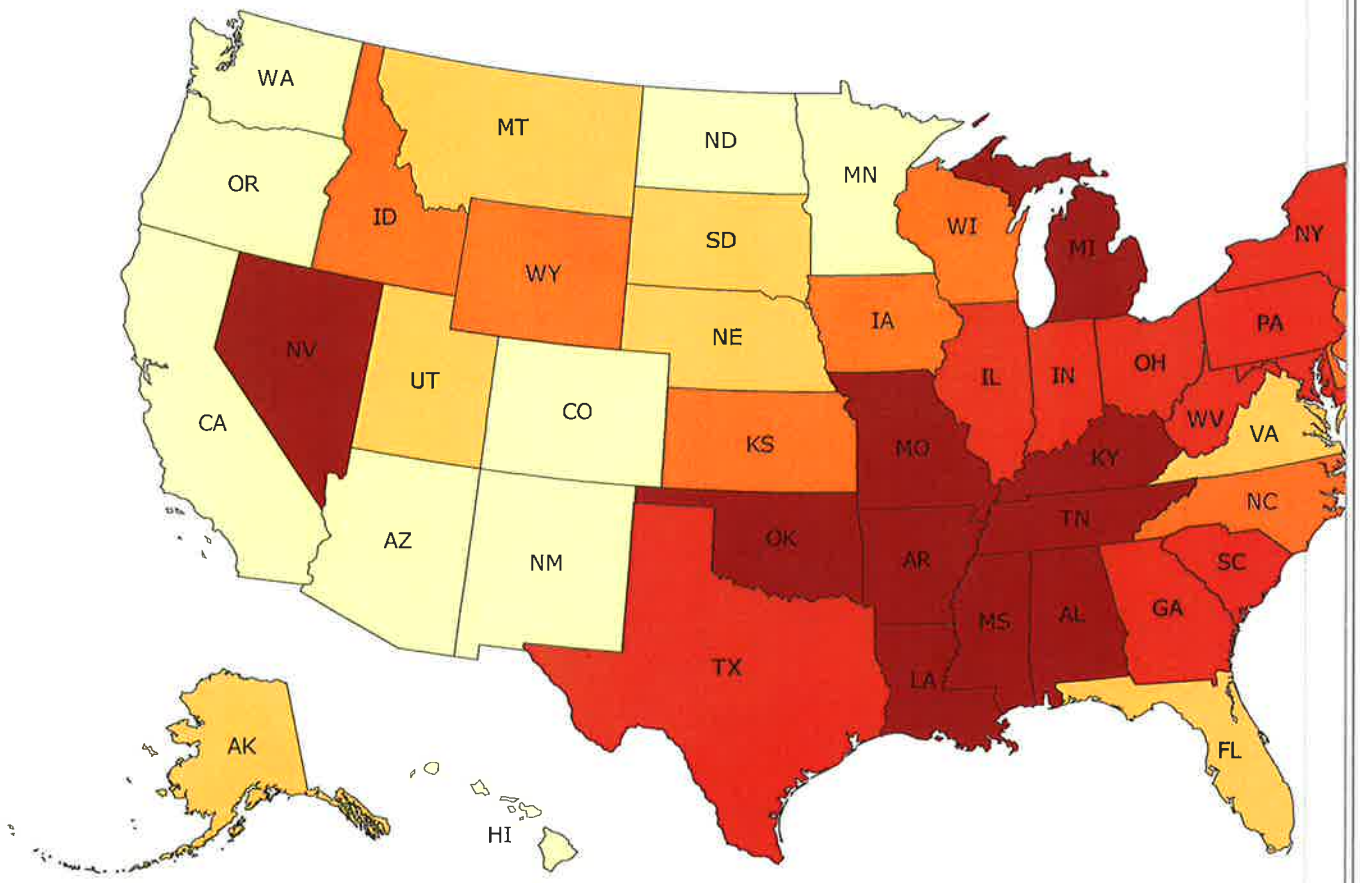
^ Indicates data has been suppressed due to small numbers.

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Heart Disease Mortality by State

2015 2014 2005

Heart Disease Mortality by State: 2015



Age-Adjusted Death Rates[1]

United States 168.5

- 116.6 - 145.6
- 147.8 - 155.8
- 156 - 166.7
- 169.3 - 191.7

197.8 - 240.5

Data Table

Location	Heart Disease Death Rates (Click for Rankings)	Death
Alabama	229.7	
Alaska	154.1	
Arizona	138.8	
Arkansas	223.2	
California	145.6	
Colorado	128.4	
Connecticut	147.8	
Delaware	165.2	
Florida	149.8	
Georgia	180.2	
Hawaii	135.6	
Idaho	156.4	
Illinois	171.5	
Indiana	182.3	
Iowa	160.9	
Kansas	158.5	
Kentucky	197.8	
Louisiana	212.1	
Maine	157.3	
Maryland	169.3	
Massachusetts	138.5	
Michigan	198.9	
Minnesota	116.6	
Mississippi	240.5	
Missouri	197.9	
Montana	155.8	
Nebraska	154.5	
Nevada	200.9	
New Hampshire	149.0	
New Jersey	166.7	

New Mexico	142.4
New York	181.6
North Carolina	162.4
North Dakota	142.4
Ohio	191.7
Oklahoma	234.0
Oregon	136.1
Pennsylvania	177.8
Rhode Island	160.4
South Carolina	177.8
South Dakota	150.9
Tennessee	207.3
Texas	171.6
Utah	152.9
Vermont	152.5
Virginia	154.2
Washington	137.6
West Virginia	191.3
Wisconsin	156.0
Wyoming	159.4

Download Data (csv) >

[1]The number of deaths per 100,000 total population.

Source: http://wonder.cdc.gov (http://wonder.cdc.gov)

States are categorized from highest rate to lowest rate. Although adjusted for differences in age-distribution and population size, rankings by state do not take into account other state specific population characteristics that may affect the level of mortality. When the number of deaths is small, rankings by state may be unreliable due to instability in death rates.

Related Sites

Origination Date: ____ Approval: _____		
Reviewed/ Revised Date:	Effective Date:	Approval:
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____

Erlanger Health System
Policy and Procedure

Index Title: Guidelines for Cardiac Procedures Scheduled at Erlanger East Cath Lab
Originating Department: Cardiac Cath Lab/Cardiovascular Services
Number: PC-

Policy statement: Recommendations outlining the protocol and steps, based on ACC guidelines, that will be taken to ensure high risk or unstable patients are not catheterized at Erlanger East.

Scope: Interventional and Non Interventional Cardiologists, Cardiac Cath Lab Staff, Cardiovascular Services

Definitions:
PCI- Percutaneous Coronary Intervention
CHF- Congestive Heart Failure
LVEF- Left Ventricular Ejection Fraction

Procedure Protocol:

I. Pre Procedure

- Only patients that are considered "low risk" or that have minimal likelihood of coronary artery disease are to be scheduled for cardiac catheterization procedures at Erlanger East.
- A Cardiologist will determine the appropriateness/risk of the procedure prior to scheduling at Erlanger East.
- Procedures will be performed based on ACC guidelines for off-site surgical backup facilities.

II. High-Risk Patients Unsuitable for PCI at Facilities without on-site Cardiac Surgery

- Decompensated CHF without evidence for active ischemia
- Recent (<8 weeks) cerebrovascular accident
- Advanced malignancy
- Known Clotting Disorders
- LVEF< 30%

- Chronic Kidney Disease (Creatinine >2.0 mg/dl)
- Ongoing Ventricular Arrhythmias
- Known >50% Left Main Stenosis or three-vessel disease unprotected by bypass surgery
- Patients with single target lesion that jeopardizes a large area of the myocardium

III. PCI Case Selection/ACC Recommendations

PCI will avoided in patients with:

- >50% diameter stenosis of left main
- Long, calcified lesions at high risk for PCI failure
- Lesions in multiple vessels
- Lesions with TIMI 3 flow in patients with left main or three-vessel disease where bypass surgery would be of more benefit to the patient
- Culprit lesions in distal branches that by performing a PCI may cause or worsen more proximal lesions
- Chronic total occlusions
- Moderate to severely calcified lesions
- Older vein grafts
- Substantial thrombus in the vessel or lesion site
- Probable need for rotational or other atherectomy device

Committee	Approval/Date

Medical Director	Approval/Date

References:

Dehmer GJ, Blankenship JC, Cilingiroglu M, Dwyer JG, Feldman DN, Gardner TJ, Grines CL, Singh M. SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup. Catheterization and Cardiovascular Interventions, February 2014

Origination Date: 01/02/2015		
Approval: _____		
Reviewed/ Revised Date:	Effective Date:	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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Erlanger Health System
Policy and Procedure

Index Title: Transfer Plan for patients having an elective Cardiac Catherization with possible PCI procedure at the EHS East facility without on-site surgical backup

Originating Department: Cardiovascular Services

Number: PC-

Policy statement: Transfer protocol in the event of a procedural complication which would warrant emergent or surgical intervention requiring transport to EHS main campus to provide cardiac surgical support. This also includes the transfer of non-emergent patients to EHS main campus requiring complex or PCI interventional procedures not available at the EHS East facility.

Scope: Cardiovascular Services, Interventional cardiologist, Cardiac Cath Lab staff (CCL), Emergency Department (ED), Emergency Medical Services (EMS), and Patient Logistics

Definitions:
EHS- Erlanger Health System
EMS- Emergency Medical Services
CCL- Cardiac Catheterization Laboratory
ED- Emergency Department
PCI- Percutaneous Coronary Intervention
IABP- Intra-aortic balloon pump
ACLS- Advanced Cardiac Life Support
TC- Transfer Center
RN- Registered Nurse
RRT- Registered Respiratory Therapist
RT- Radiology Technician

Procedure Protocol:

I. Pre-Procedure

- Prior to an elective outpatient cardiac procedure that will be performed at the EHS East facility the patient, family members and/or appropriate consenting party will be made aware that they made need to be transferred to the EHS main campus for further evaluation and treatment in the event that their condition warrants cardiac surgical support or a PCI procedure not available at the EHS East facility.

II. Transfer

- The patient requiring an emergent or PCI procedure not available at the EHS East facility will be accepted to the EHS main campus regardless of facility availability and/or staff resources.

- Patient Logistics/Transfer Center (Ext 8100) will be notified by the CCL staff of all patients that are being transferred from the EHS East facility and begin the process of bed assignment for the patient according to patient status.

- In the event of a patient condition requiring emergent/immediate transfer or a stable non-emergent transfer to EHS main campus, Puckett EMS will be contacted for patient transport per the CCL staff by calling (423-894-1800). Every effort will be made to ensure arrival of the patient to EHS main campus within 60 minutes of decision to transfer the patient. If Puckett EMS is not able to be available on-site in 6 minutes, they will then as per Puckett EMS policy and agreement with EHS contact another EMS service for mutual aid transport.

- The transporting EMS service will have available and/or be able to accommodate the following: portable cardiac ECG and pressure monitoring, sufficient O2 supply, suction, multiple drips, ACLS drugs, resuscitation equipment, defibrillator and IABP.

- The transport team will include paramedics, RN, RRT and CCL personnel with IABP expertise as needed. All members of the team should be ACLS certified.

- In the patient requiring emergent surgical intervention, the interventional cardiologist will contact the cardiovascular surgeon with the appropriate patient information and the need for surgical intervention.

Committee	Approval/Date

Medical Director	Approval/Date

References:

1. Dehmer GJ, Blankenship JC, Cilingiroglu M, Dwyer JG, Feldman DN, Gardner TJ, Grines CL, Singh M. SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup. Catheterization and Cardiovascular Interventions, February 2014

Quality Control and Monitoring for Erlanger East Cath Lab

These steps will be taken and documented to ensure quality control and procedure/patient monitoring is carefully followed:

- Comprehensive Documentation of Indications for PCI
- Appropriate Indication for Elective PCI
- Assessment of Candidacy for Dual-Antiplatlet Therapy
- Use of Embolic Protections Devices in the Treatment of Saphenous Vein Bypass Graft Disease
- Documentation of Preprocedural Glomerular Filtration Rate and Contrast Dose Used During the Procedure
- Radiation Dose Documentation
- Postprocedural Optimal Medical Therapy Composite (percentage of patients $\geq$18 for whom PCI is performed who are prescribed optimal medical therapy at discharge)
- Cardiac Rehabilitation Patient Referral Documentation and Tracking
- Regional/National PCI Registry Participant (NCDR Cath/PCI and ACTION)
- Annual Operator PCI Volume
- Annual Hospital PCI Volume
- Monthly Cath Lab Quality meetings, including Interventional Cardiologist, Cardiac Service Line and the Chief of Cardiology, will be held to discuss concerns and/or complications with cardiac cath lab procedures and patient outcomes.

References:

ACC indicates American College of Cardiology; AHA, American Heart Association; AMA-PCPI, American Medical Association–Physician Consortium for Performance Improvement; NCQA, National Committee for Quality Assurance; PCI,
percutaneous coronary intervention; and SCAI, Society for Cardiovascular Angiography and Interventions.
*For comprehensive information on these measures, including measure exceptions, please refer to the complete ACC/AHA/AMA-PCPI/NCQA/SCAI performance measurement specifications through the PCPI Web site (http://www.amaassn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI).

Origination Date:		
Approval:		
Reviewed Date:	Revised Date:	Ap
12/05		
	1/09	
5/11		
	6/12	
	1/13	

Erlanger Health System
Policy and Procedure

Index Title: Emergency Response on Erlanger Baroness Campus
Originating Department: Administration
Number: 8316.951
Description for EHS Intranet: Emergency; Emergency Response; Off campus emergencies;

Policy statement: Erlanger Health System (EHS) provides this policy and process to determine who should respond when an emergency situation occurs on the Baroness Campus, and designated adjacent areas.

Scope: EHS employees within Baroness Campus.

Procedure:

When an emergency situation occurs within Baroness Campus / Miller Eye Center or any location on the ground or first floor of the Medical Mall, a Code Blue, Code 5 or Rapid Response call should be made.

Emergency situations that occur on adjacent grounds, e.g. driveways, parking lots, Whitehall Building, Fillauer Building, UT Family Practice, E kids, Lincoln Park Building and any area not described above should contact 911. For additional medical expertise, the House Supervisor (HS) may be contacted.

Independent Physician Practices are not part of the Hospital and should be considered as adjacent grounds. For these areas, contact 911 in emergency situations.

The HS can be immediately contacted by dialing 778-6911. After assessing the nature of the emergency, while waiting for a response, the appropriate first aid care, CPR (Cardiopulmonary Resuscitation), containment of bleeding and/or comfort measures are to be offered. This care must be consistent with good medical practice (which may mean, "doing no harm" and not moving the person). The HS will determine the level of response required for emergency/medical situations after considering the following:

- Personal safety of the responding personnel.
- Availability of medically trained staff who could be dispatched to the location.
- Status/need of current and waiting patients, in that the medical care of these individuals will not be delayed or impaired by having emergency personnel dispatched to another location.

- Availability of portable medical equipment and supplies to be transported by emergency medical personnel to the location.

The Rapid Response Nurse (7789) may be called on to serve as the back up for the HS, should the HS be unavailable.

The HS will put the Emergency Department on stand-by for additional stabilizing and packaging equipment, including transport needs via stretcher.

See CPR Adult Code Blue Process, PC.120.
See CPR Pediatric Code 5 Process, 6012.08

Committee	Approval/Date
Legal	6/12
Code Committee	6/12

Medical Director	Approval/Date

References:

Erlanger Health System
Policy and Procedure

Origination Date: 02/11/09		
Approval:		
Reviewed Date:	Revised Date:	Approval:
4/18/112/2013		
		7/2014

Index Title: Non-EmergentHospitalOutpatient Order Policy
Originating Department: Patient Access
Number: 8316.1035
Description for EHS Intranet: Outpatient Orders

Policy Statement: Erlanger Health System (EHS) requires a complete and valid physician outpatient order prior to non-emergent hospital services being rendered.

Purpose: To establish guidelines outlining the documentation required for all non-emergent outpatient services orders submitted in accordance with payer guidelines. This policy should be used in conjunction with the Non-Covered Services Policy and the Medical Necessity Policy.

Scope: All non-emergent outpatient services provided by an outpatient department of Erlanger Health System.

Exceptions: Exceptions to this policy applicable to Medicare patients include the following services for which Medicare does not require a documented order:

- Screening mammography;
- Pneumococcal pneumonia vaccine (PPV) and its administration;
- Influenza vaccine and its administration.

Definitions:

Authentication: The requirement of a written signature or a computer-secure entry by a unique identifier of a primary author who has approved the entry.

Advance Beneficiary Notice (ABN): An ABN is a written notice given to a Medicare Beneficiary before Part B services are furnished when Erlanger Health System believes that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary (i.e., under §1862(a)(1) of the Act) and Erlanger Health System (EHS) wishes to bill the patient for the provided services. The information in the ABN will assist the beneficiary in making an informed decision whether or not to receive the service and be financially responsible for the payment.

Deferral of Hospital Outpatient Services: The deferral or re-scheduling of services until the receipt of a complete and valid physician order and the financial requirements being met.

Medical Necessity: Items or services which may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.

Modification of Orders: Existing orders may not be changed by EHS personnel. Any change or addition to a service or test embodied in an existing order requires that the procedures noted in the "Modification of Outpatient Orders" section of this policy be followed.

Non-Physician Practitioner ("NPP"): An NPP can be a physician assistant, clinical psychologist, nurse practitioner, clinical nurse specialists, licensed clinical social worker, or certified nurse midwife acting within his/her state scope of practice laws and hospital-granted privileges.

Outpatient Laboratory Requisition: A computer generated document listing outpatient tests that are available for a Physician to order. It can serve as evidence of the services the Physician intended to order if it is also adequately documented in the medical record and authenticated.

Order Sets: An order that outlines a treatment regime or standard of care required for a patient having a specifically-defined type of care / treatment (i.e., AHCPR protocol for treatment of pressure ulcers). Special Note: Orders for outpatient services may be supported by a valid, approved hospital order set that has been initiated by a physician or NPP and approved by the hospital's Medical Staff. A copy of the order set must be maintained in the patient's medical records.

Recurring Orders: A physician may submit an order for tests, injections, lab, infusions, etc., to be performed on a recurring basis. The recurring order must include all elements as outlined in theoutpatient order elements noted below in this policy, including:

- Frequency of the test, etc. to be performed (such as monthly, weekly,bi-weekly, etc.)
- The length of time that the order is to re-occur and is valid(such as 6 weeks, 2 weeks, 3 months, etc.) Most will be updated every six months – however, a Recurring Order may be valid beyond 6 months or less / more than this time period based on time specifications of the physician as the duration of the patient's specific treatment period, not to exceed twelve months.
- Number of treatments to be provided (such as 10 HBO TX, etc.)
- Must be medically necessary

Treating physician: A physician, as defined in §1861 (r) of the Social Security Act (the Act), who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary's specific medical problem.

PROCEDURES:

The following are the required data elements for Non-Emergent Hospital Outpatient Orders:

1. Patient Legal Name;
2. Patient date of birth;
3. Reason for ordering the test or service (i.e., diagnosis description signs or symptoms);

4. Physician or qualified health professional authentication "signature";
5. Name of ordering practitioner;
6. Date of order (Date provider signed the order).

A complete and valid physician order contains the above elements. When the above elements are present and all other coverage guidelines are met, the hospital may provide and subsequently bill for the services ordered once performed.

Special Note: An acceptable order should not include such diagnosis language as:

- Rule/Out (R/O)
- Possible
- Suspicious
- Probable

A complete and valid physician order should be secured for all non-emergent outpatient services at least 48 hours prior to the patient's date of serviceby responsible registration and scheduling personnel.

All non-emergent outpatient services scheduled without a complete and valid order 48 hours prior to the patient's date of service will be escalated by Patient Access. The physician or physician's office personnel will be contacted via telephone and email notifying them that the service will be deferred due to the lack of a valid order. Once notified, the physician's office must supply a valid order that contains all of the required elements no later than 24 hours prior to scheduled appointment to prevent the service from being deferred and rescheduled.

Unscheduled or walk-in patients must arrive at registration with a complete and valid physician order. Patient Access, Registration or other responsible personnel receiving an incomplete order must call the physician office and request the required information. The physician office must furnish a new order for any unscheduled or walk-in patients arriving at registration without a complete and valid order prior to the services being provided. Unscheduled or walk-in patients may experience extended wait times pending receipt of a complete and valid order, verification of patient insurance policy requirements related to pre-certification or pre-authorization of services prior to services being rendered.

Every effort should be made to obtain all required information prior to services being rendered. For Medicare and Medicaid patients, the Center for Medicare & Medicaid Services guidelines state that if patient care or the integrity of a specimen is at risk, you should continue processing the test (s) or performing service (s) and subsequently obtain the required elements. This requires clinical judgment and should be discussed with appropriate supervisor(s).

All Patient Access registration departments are responsible for scanning the complete and valid physician order into HPF in order for the order to become a part of the patient's medical record.

If any of the required outpatient order data elements noted above are missing, a new order will be **REQUIRED** directly from the physician prior to the services being performed.

Verbal orders will notbe accepted for non-emergent hospital outpatient services.

Modification of Order:

As noted above, every effort should be made to obtain all required information prior to non-emergent outpatient services being provided. Patient Access, Registration or other personnel receiving an incomplete order must call the physician office and request that the physician office furnish a new and valid order prior to the services being provided.

If patient services were rendered with an incomplete order (i.e. missing or incorrect Dx),the physician can make an entry to clarify/correct this by amending the patient's medical record, documenting the missing data element and / or reason for the correction and providing us with a copy of the amended patient record. If an order for a clinical diagnostic service is missing the provider's authentication, you may rely on a copy of the patient's medical record if it already has documentation of the provider's intent to order the services and the medical record had beenpreviously authenticated. Please note that this should be the exception not the rule.

Implementation:

1. EHS must ensure all outpatient orders, whether paper-based or generated through web-based physician portals, meet the requirements of this policy.
2. EHS must have a process in place to ensure staff and Physicians are notified of the requirements of this policy.

Annual Review:

This policy and related supporting documents are subject to annual review by the Patient Access Department and members of the Revenue Cycle Committee, including the Office of Compliance.

Enforcement:

All EHS personnel whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Those employees who fail to comply with this policy will be subject to appropriate disciplinary action pursuant to EHS' applicable policy and procedure, up to and including termination.

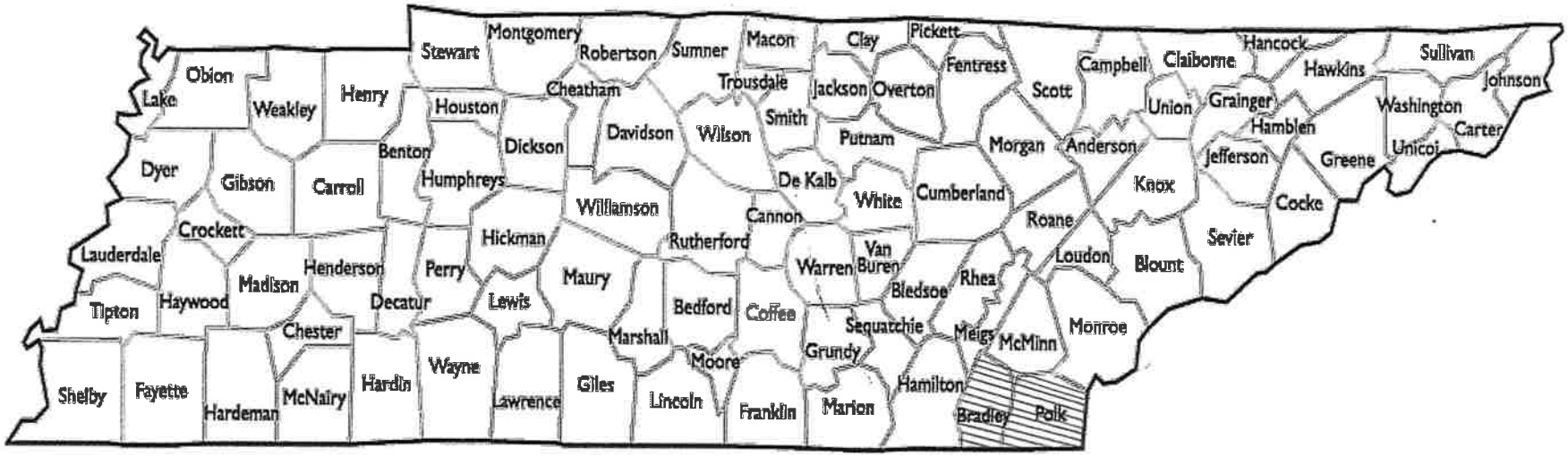
Committee	Approval/Date

References:

Medicare Conditions of Participation
42 C.F.R §482.23; §428.24; §428.26b.4
42 C.F.R §410.32
TJC (The Joint Commission) RC standards
TJC (The Joint Commission) MS 2.5
http://www.cms.gov/Medicare/Coding/ICD10/index.html
CMS Benefit Policy Manual (Pub 100.02) Transmittal 80
CMS "Medicare Program Integrity Manual" (Publication [Pub.] (100-08), Chapter 3, Section 3.4.11. D
CMS, State Operations Manual Appendix A-Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals, Interpretive Guidelines §482.24(c) (1) (i) and (ii)
EHS Rules and Regulations of the Medical Staff (January 18, 2011)
EHS Bylaws of the Medical Staff (May 2010)
The ABN manual instructions and ABN Form CMS -R-131 are available at
http://www.cms.gov/ BNI/02_ABN.asp

Description	Section / Item
Service Area	B-I-3

TENNESSEE COUNTY MAP



Description	Section / Item
Architect Letter - Construction Cost	B-II-1
Siemens Quote For CT Unit	B-II-1
Siemens Quote For Equipment Maintenance	B-II-1
Siemens Quote For Bi-Plane Unit	B-II-1
Siemens Quote For Equipment Maintenance	B-II-1

October 27, 2017

Mr. Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, Tennessee 37403

Subject: **Bradley County Free-Standing Emergency Department**
Erlanger Health System
Chattanooga, Tennessee
GS&P Project No. 19252.23

Dear Joe:

Thank you for engaging Gresham, Smith and Partners on the design and development of the above-referenced project. We are excited to be working with Erlanger on the new free-standing emergency department to serve residents of Bradley County.

Based on plans developed to date and our review of the site and building conditions, we estimate construction costs of the project, net of contingencies, equipment and related expenses at $330.00 per square foot for the emergency department with 12,383 SF for a total construction cost of is $4,086,390. The site for the emergency department is suitable for its intended use and will provide convenient access from adjacent roadways.

Plans for design of the building will comply with the latest AIA standards and guidelines for design and construction of hospitals as prescribed by the Tennessee Department of Health.

Please let us know if you need additional information.

Sincerely,

Jeffery Morris, AIA, LEED AP, LEAN, EDAC
Principal

JEFFERY E. MORRIS
REGISTERED ARCHITECT
STATE OF TENNESSEE
NO. 100200

27 Oct. 2017

GRESHAM, SMITH AND PARTNERS
ARCHITECTURE ENGINEERING INTERIORS PLANNING
222 Second Avenue South / Suite 1400 / Nashville, Tennessee 37201-2308 / Phone 615.770.8100 / www.greshamsmith.com

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40 Liberty Boulevard, Malvern, PA 19355

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PRELIMINARY PROPOSAL

Customer Number: 0000006071

Date: 7/25/2017

ERLANGER HEALTH SYSTEM
975 EAST THIRD STREET
CHATTANOOGA, TN 37403

Quote Nr: **1-L5B1FJ Rev. 0**

SOMATOM Definition AS (64-slice Configuration)

All items listed below are included for this system: *(See Detailed Technical Specifications at end of Proposal.)*

Qty	Part No.	Item Description
1	14444263	**SOMATOM Definition AS (64slice)** The SOMATOM Definition AS (64-slice configuration) is Siemens' state-of-the-art single source CT that provides the possibility to maximize clinical outcome and to minimize radiation dose. The unique STRATON X-ray source utilizes an electron beam that is accurately and rapidly deflected, creating two precise focal spots alternating 4,608 times per second. This doubles the X-ray projections reaching each detector element. The two overlapping projections result in an oversampling in z-direction. The resulting measurements interleave half a detector slice width, doubling the scan information without a corresponding increase in dose. Siemens' proprietary UFC (Ultra Fast Ceramic) detectors and the corresponding 64-slice detector electronics enable a virtually simultaneous readout of two projections for each detector element - resulting in a full 64-slice acquisition. This sampling scheme is identical to that of a 64 x 0.3 mm allowing for reconstruction of 192 slices using 0.1 mm reconstruction interval increment The fast rotation time of 0.33 seconds (0.3 s optional) delivers excellent temporal resolution. The SOMATOM Definition AS is set to raise the standard of patient-centric productivity with FAST CARE Technology. With Siemens' FAST - Fully Assisting Scanner Technologies - the SOMATOM Definition AS can simplify typically time consuming and complex procedures during a CT examination: the scanning process gets more intuitive and the results become more reproducible. The CARE technology includes many unique features like CARE kV that sets the ideal voltage for every examination and adjusts the respective scan parameters or industry's first Adaptive Dose Shield that prevents clinically irrelevant over radiation in spiral scanning.
1	14420766	**SAFIRE #AWP** The Sinogram Affirmed Iterative Reconstruction (SAFIRE) enhances spatial resolution, reduces image noise and increases sharpness by introducing multiple iteration steps in the reconstruction process. The resulting image quality enables to reduce dose by up to 60%*. *In clinical practice, the use of SAFIRE may reduce CT patient dose depending on the clinical task, patient size, anatomical location, and clinical practice. A consultation with a radiologist and a physicist should be made to determine the appropriate dose to obtain diagnostic image quality for the particular clinical task. The following test method was used to determine a 54 to 60% dose reduction when using the SAFIRE reconstruction software. Noise, CT numbers, homogeneity, low contrast resolution and high contrast resolution were assessed in a Gammex 438 phantom. Low dose data reconstructed with SAFIRE showed the same image quality compared to full dose data based on this test. Data on file.
1	14444243	**iMAR #AWP** The iMAR metal artifact reduction algorithm combines three successful approaches (beam hardening correction, normalized sinogram inpainting and frequency split). This allows to reduce metal artifacts caused by metal implants such as coils, metal screws and plates, dental fillings or implants. iMAR is compatible with extended FoV, the extended CT scale as well as the newest dose reduction feature. Along with the new algorithm comes the simple user interface of iMAR enabling easy reconstruction of clinical images with reduced metal artifacts.

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Qty	Part No.	Item Description
1	14433993	**FAST Planning #AWP** Direct, organ-based setting of scan and recon ranges for a faster and more standardized workflow
1	14449409	**FAST Adjust** FAST Adjust: assists the user to handle system settings in a fast and easy way by automatically solving of conflicts within user defined limits by one single click on the FAST Adjust button. The limits for scan time and tube current per scan are defined via the Scan Protocol Assistant. FAST Adjust offers an undo functionality to return to previously set values.
1	14449412	**CARE kV** CARE kV automatically proposes the best tube voltage based on the patient's size, the system capabilities, and the type of examination. Once the kV setting has been chosen, CARE kV also automatically adjusts other scan parameters, including the tube current. This reduces dose, maintains a constant image quality, and simplifies processes for technicians.
1	14420771	**CARE Child** Dedicated pediatric CT imaging, including 70 kV scan modes and specific CARE Dose4D curves and protocols.
1	14449411	**CARE Dashboard** Visualization of activated dose reduction features and technologies for each scan range of an examination to analyze and manage the dose to be applied in the scan.
1	14449410	**CARE Profile** CARE Profile: Visualization of the dose distribution of the scan range along the topogram prior to the scan.
1	14408111	**Extended Field of View #AWP** Software program with special reconstruction algorithms that allow for visualization of objects using a FOV up to 78 cm (non-diagnostic image quality). License to use software on a single unit.
1	14419142	**Workstream 4D #AWP** WorkStream 4D further enhances the already superb workflow of the SOMATOM CT system by offering direct generation of sagittal, coronal, oblique or double-oblique reconstructed images directly from CT raw data as part of the CT protocol.
1	14419144	**DICOM SR Viewer #AWP** The DICOM SR (structured report) Viewer allows to read reports created with specific applications (e.g. Circulation, Lung Care, Calcium Scoring and Onco) without the application itself being on the respective computer.
1	14420824	**Standard IRS** Reconstruction computer for the preprocessing and reconstruction of the CT raw data. The reconstruction computer contains a cluster of 2 high-performance GPU boards performing the preprocessing and reconstruction of the CT data. The raw data memory is 900 GByte. The peak recon performance is 40 frames/sec.
1	14408152	**UHR** UHR mode delivers Ultra High resolution in plane of up to 24lp/cm for high defined imaging of small structures such as inner ear, joints or fractures of the bone
1	14408032	**Rear cover incl. gantry panels** Rear Cover including gantry control panels with control functionality from the backside.
1	14420777	**Patient Table 2000 mm** Patient table to support up to 200cm scan range. Motor-driven table height adjustment from min. 49 cm to max. 92 cm, longitudinal movement of the tabletop 200 cm in increments of 0.5 mm, positioning accuracy +/- 0.25 mm from any direction. Horizontal scan range 200 cm. Table height can be controlled alternatively by means of foot switch (2 each on both sides of the patient table). In the case of emergency stop or power failure, the tabletop can also be moved manually in horizontal direction. Max. table load: 227 kg/500 lbs, Table feed speed: 2-200 mm/s, Distance between gantry front and table base 40 cm. Positioning aids: Mattress protector, head-arm support (inclusive cushion), and non-tiltable head holders with positioning cushion set, patient restraining system for head fixation, restraining-strap set with body fixation strap that

PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
		can be directly connected to the patient table top, headrest, table extension, knee-leg support.
1	14420929	**Mattress for Patient Table** For the comfortable positioning of the patient on the CT table.
1	14408022	**Cooling System Air** Air cooling for the dissipation of heat generated in the gantry.
1	14408101	**Computer Desk #AWP** New CT desk to accommodate the control components and color monitor. Width: 1200 mm, Depth: 800 mm, Height: 720 mm.
1	14408102	**Computer Cabinet #AWP** New cabinet to accommodate the computer system and UPS. Matched to the design of the control console table. Width: 800 mm, Depth: 800 mm, Height: 720 mm
1	CT_RECON_192	**AS-64 slice configuration z-Sharp Tech.** The unique STRATON X-ray source utilizes an electron beam that is accurately and rapidly deflected, creating two precise focal spots alternating 4,608 times per second. This doubles the X-ray projections reaching each detector element. The two overlapping projections result in an oversampling in z-direction. The resulting measurements interleave half a detector slice width, doubling the scan information without a corresponding increase in dose. Siemens' proprietary UFC (Ultra Fast Ceramic) detectors and the corresponding 64-slice detector electronics enable a virtually simultaneous readout of two projections for each detector element - resulting in a full 64-slice acquisition. This sampling scheme is identical to that of a 64 x 0.3 mm allowing for reconstruction of 192 slices using 0.1 mm reconstruction interval increment. z-Sharp Technology, utilizing the STRATON X-ray sources and the UFC detectors, provides scan speed independent visualization of 0.33 mm isotropic voxels and a corresponding elimination of spiral artifacts in the daily clinical routine at any position within the scan field.
1	SURE_VIEW	**SureView** Provides exceptional image quality at any pitch setting, enabling you to scan faster because you can scan at any pitch without degrading image quality
1	UFC_DETECTOR	**UFC Detector** Ultra Fast Ceramics (UFC) technology is a unique type of scintillation technology material that quickly and efficiently transforms radiation from the X-ray tube into light signals. Its superb overall quantum efficiency and unique short afterglow enable time-critical X-ray detection at low doses and extremely fast data collection.
1	FAST_SCAN_ASSIST	**FAST Scan Assistant** FAST Scan Assistant: An intuitive user interface for solving conflicts by changing the scan time, resp. the pitch and/or the maximum tube current manually.
1	ADAPT_DOSE_SHIELD	**Adaptive Dose Shield** Adaptive Dose Shield for spiral acquisition to eliminate pre- and post-spiral over-radiation.
1	CT_LUNGIMAGINGAS64	**Lung Imaging** For well over a decade, CT has been recognized and used as the standard of care for lung nodule detection and sizing. This is due to CT's spatial resolution, geometric accuracy, and ability to create various reconstructions and 3D views. The high contrast environment in the chest between the lungs and the nodules makes for a relatively easy detection task for clinicians using CT images. Recent advances in CT technology have allowed these scans to be effectively performed at lower doses, higher resolutions, and faster scan times. The SOMATOM Definition AS64 CT is indicated for use in low dose lung cancer screening for high risk populations*. The AS64 is delivered with two specific scan protocols to provide low dose lung cancer screening exams at approximately 1.5 mGy CTDI for a standard size adult. These default protocols utilize Siemens proprietary dose reducing features such as CARE Dose4D(tm), automatic exposure control technology that

PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
		modulates and adapts dose for every patient, for high image quality at low dose. *As defined by professional medical societies.
1	CARE_DOSE4D	**CARE Dose4D** CARE Dose4D delivers the highest possible image quality at the lowest possible dose for patients - maximum detail, minimum dose. Adaptive dose modulation for up to 60% dose reduction
1	DICOM_SR	**DICOM SR Dose Reports** DICOM structured file allows for the extraction of dose values (CDTIvol, DLP)
1	DOSE_ALERT	**Dose Alert** Dose Alert: As requested by the new release of the standard IEC 60601 3rd edition, the SOMATOM Definition automatically adds up CTDIvol and DLP depending on z-position (scan axis). The Dose Alert window appears, if either of these cumulative values exceeds a user-defined threshold.
1	DOSE_NOTIFICATION	**Dose Notification** Dose Notification: As requested by the new release of the standard IEC 60601 3rd edition, the SOMATOM Definition AS provides the ability to set dose reference values (CTDIvol, DLP) for each scan range. If these reference values are exceeded the Dose Notification window informs the user.
1	CT_TILTED_SPIRAL	**Gantry tilt incl. tilted spiral** Allows for sequential scanning with a tilted gantry between +/- 30°, depending on the vertical position of the table. Using the gantry tilt sensitive organs (like eye lenses) can be moved out of the scan range or it eases access during interventional procedures. The tilted spiral allows to utilize the gantry tilt for spiral scan modes.
1	NEURO_BEST CONTRAST	**Neuro BestContrast** The Neuro BestContrast algorithm can provide enhanced tissue contrast, resulting in improved contrast between gray and white matter without increasing image noise. This post processing step is rapid and can be easily incorporated into clinical workflow where it can be used with other dose reduction approaches such as iterative reconstruction.
1	ACCESS_PROTECT	**Access Protection** Scan Protocols are password protected allowing only authorized staff members to access and permanently change protocols
1	NEMA_XR-29	**NEMA_XR-29 Standard** This system is in compliance with NEMA XR-29 Standard Attributes on CT Equipment Related to Dose Optimization and Management, also known as Smart Dose.
1	CT_UPS_DEF_AS	**Standard UPS for Definition AS** The standard partial system uninterruptible power system (UPS) is built directly into the power distribution cabinet (PDC) and supports the critical circuits for table and gantry electronics, console computer, image reconstruction system, and the internal Ethernet switch (to ensure connectivity). This enables safe removal of patient if outage occurs during scanning. The UPS allows for a safe shutdown of the CT scanner in the event of power interruption. The UPS provides 5-7 minutes of power, during which the user is prompted and guided through the process to perform a safe shutdown of the system. This safe shutdown ensures that no data is lost.
1	CT_PM	**CT Project Management** A Siemens Project Manager (PM) will be the single point of contact for the implementation of your Siemen's equipment. The assigned PM will work with the customer's facilities management, architect or building contractor to assist you in ensuring that your site is ready for installation. Your PM will provide initial and final drawings and will coordinate the scheduling of the equipment, installation, and rigging, as well as the initiation of on-site clinical education.
1	CT_BUDG_ADDL_RIG	**Budgetary Add'l/Out of Scope Rigging @ $5,000**

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Qty	Part No.	Item Description
1	CT_STD_RIG_INST	**CT Standard Rigging and Installation** This quotation includes standard rigging and installation of your CT new system. Standard rigging into a room with reasonable access, as determined by Siemens Project Management, during standard working hours (Mon. - Fri./ 8 a.m. to 5 p.m.) It remains the responsibility of the Customer to prepare the room in accordance with the SIEMENS planning documents. Any special rigging requirements (Crane, stairs, etc.) and/or special site requirements (e.g. removal of existing systems, etc.) is an incremental cost and the responsibility of the Customer. All other "out of scope" charges (not covered by the standard rigging and installation) will be identified during the site assessment and remain the responsibility of the Customer.
1	4SPAS014	**Low Contrast CT Phantom & Holder**
1	PSPD250480Y3K	**Surge Protective Device (SPD)**
1	CTSDEF01	**CT Slicker** Thermoseal seams and flaps deflect fluids, reducing contaminant penetration into the cushion and table. Contaminants are retained on the tabletop or shunted to the floor. Cleanup is faster, more thorough, and contaminant build-up is reduced. Built using heavy, clear, micro matte vinyl, and top grade hook and loop fastening strips (Velcro) to better fit the specified table. Custom vinyl resists tears and minimizes radiologic interference. Latex free. Set includes CT Skirts. Shipped with main cover, a catheter bag holder, and 3 restraining belts unless otherwise noted. Includes warranty from RADSCAN Medical.
1	EZ9900C	**Dual EmpowerCTA w/EDA (ceiling)**
1	CT_EDUOPTION5	**Clinical Education & Training: Option 5** Siemens offers multiple options for clinical education and training on your new system. These options enable a more personalized approach to the introduction to system operation, features, and benefits and will help ensure that your technologists and physicians have the opportunity to engage in the level of training that best meets your current clinical needs and business objectives. The following items are the education and training modules are highly recommended for the operation of your new Siemens system and are most effective for sites where technologists and/or physicians have limited experience on Siemens' systems. In addition to covering routine procedures, this option also provides additional opportunities to learn more specialized procedures and further increase efficiencies.
1	CT_CONVERPKG	**Education Pkg for Conversion Customers** This educational package is designed to assist customers in the transition to Siemens CT scanning systems. The package offering consists of two 4 hour customized workshop sessions at the customer's facility-both sessions must be scheduled for and subsequently completed within a 24 hour window, access to Siemens Learning Center for 12 months and up to a total of 100 CE's. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	CT_INITIAL_32	**Initial onsite training 32 hrs** Up to (32) hours of on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Training will cover agenda items on the ASRT approved checklist. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	CT_FOLLOWUP_16	**Follow-up training 16 hrs** Up to (16) hours of follow-up on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.

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Qty	Part No.	Item Description
1	CT_FOLLOWUP_24	**Follow-up training 24 hrs** Up to (24) hours of follow-up on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	SY_PR_TEAMPLAY	**teamplay Welcome & Registration Package** teamplay is a cloud-based network that brings together your imaging modality users, the systems' dose and utilization data, and the users' expertise to help you improve the delivery of care to your patients. Basic features are provided free of charge. Premium features (benchmarking, non-Siemens devices) are provided on a trial basis for three months at no charge, and may be used thereafter on a subscription fee basis. To register: http://teamplay.siemens.com/#/institutionRegistration/1

System Total: $720,113

Siemens Medical Solutions USA, Inc.
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PRELIMINARY PROPOSAL

OPTIONS on Quote Nr: **1-L5B1FJ Rev. 0**

OPTIONS for SOMATOM Definition AS (64-slice Configuration)

All items listed below are OPTIONS:

Qty	Part No.	Item Description	Extended Price
1	14408037	**HeartView CT** Scanning technique and program for ECG controlled data acquisition and image reconstruction with SOMATOM. The package comprises: HeartView CT option on the syngo Acquisition Workplace console for the ECG-controlled acquisition and reconstruction of artifact free images of the heart. The ECG signal is supplied by an ECG device integrated in the gantry. The use of the software of this option is restricted to a single system unit.	+ $41,250
1	14408038	**Cardio BestPhase Plus #AWP** Cardio BestPhase, is a software dedicated to automatically detect the optimal phase for motion-less coronary visualization. The phase is defined in either end-systole, end-diastole or both time points and automatically reconstructed.	+ $15,400
1	14449414	**Physiological Measurement Module** The Physiological Measurement Module allows connection of a 3 Channel ECG cable for ECG controlled cardiac acquisition. Item includes ECG cable	+ $2,200
1	14420778	**Multi Purpose Table** Patient table to support up to 200 cm scan range. Motor-driven table height adjustment from min. 55 cm to max. 92 cm, longitudinal movement of the tabletop 200 cm in increments of 0.5 mm, positioning accuracy (horizontal) is +/- 0.5 mm. The accuracy of the repositioning (horizontal) is specified as +/- 0.25 mm. Table height can be controlled alternatively by means of foot switch (2 each on both sides of the patient table). In the case of emergency stop or power failure, the tabletop can also be moved manually in horizontal direction. Max. table load: 227 kg/500 lbs (with bariatric table top up to 307 kg/676 lbs); table feed speed: 1-200 mm/s; distance between gantry front and table base 40 cm. Positioning aids: Mattress protector, head-arm support (inclusive cushion), and non-tiltable head holders with positioning cushion set, patient restraining system for head fixation, restraining-strap set with body fixation strap that can be directly connected to the patient table top, headrest, table extension, knee-leg support	+ $33,000
1	14408217	**High Cap. Patient & Trauma Tab.Top** The high capacity and trauma table top offers the capability to support up to 307 kg/676 lbs of patient weight. It allows easy positioning and transfer from and to the table; due to its flat surface. Special accessories and an extended table top width of 530 mm ensure a safe and comfortable positioning for obese patients.	+ $27,500
1	14408218	**High Cap. Patient & Trauma Acc Kit** The High capacity and Trauma accessory kit contains additional Patient restraint set with a width of 400mm and additional table extensions for feet and head.	+ $2,200

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Qty	Part No.	Item Description	Extended Price
1	14414734	**Mattress for Bariatric Table Top** This mat is used for scanning non-bariatric patients on the flat, bariatric table top. Placing this mat on the bariatric table top eliminates the need to exchange the table top when non-bariatric patients are scanned. This mat has a curved profile and enables comfortable positioning of non-bariatric patients.	+ $1,650
1	14410232	**Mat for MPT Standard Table Top** Replacement for the positioning mattress for Standard Multi-purpose tabletop.	+ $440

FINANCING: The equipment listed above may be financed through Siemens. Ask us about our full range of financial products that can be tailored to meet your business and cash flow requirements. For further information, please contact your local Sales Representative.

Siemens Healthcare is pleased to submit this Preliminary Pricing Proposal. A Preliminary Pricing Proposal is provided for planning purposes only; it is not contractually binding. To receive a contractually binding proposal for the Products listed above, inclusive of Terms, Conditions, and Warranty coverage, please contact your Siemens Healthcare Sales Representative.

Siemens Healthcare

Brad Fox
(615) 585-2104
brad.fox@siemens-healthineers.com

SIEMENS Healthineers

Proposal # 1-L7CH4W

THIS QUOTATION REPRESENTS A PRELIMINARY PROPOSAL AND DOES NOT CONSTITUTE AN OFFER OR A CONTRACT. A BINDING CONTRACT THAT INCLUDES THE TERMS SET FORTH HEREIN SHALL ONLY BECOME EFFECTIVE UPON EXECUTION BY THE PARTIES OF A COMPLETE AGREEMENT.

District / Sales Office

SIEMENS MEDICAL SOLUTIONS USA,INC.
4800 North Point Pkwy
Alpharetta, GA 30022
Attn: Craig McKissack
Phone: (615) 943-2657
Fax: (615) 691-7474
Email: stephen.mckissack@siemens-healthineers.com

Sold To

ERLANGER HEALTH SYSTEM
975 EAST THIRD STREET
CHATTANOOGA, TN 37403

Bill To

ERLANGER HEALTH SYSTEM
975 EAST THIRD STREET
CHATTANOOGA, TN 37403

Payer

ERLANGER HEALTH SYSTEM
975 EAST THIRD STREET
CHATTANOOGA, TN 37403

Item #	System Name	Functional Location	Service Agreement	Contract Duration	Warranty Period Price	Partial Year Price	Annual Price
1	SOMATOM Definition AS64		Gold contract	Warranty + 7 Years	$0	$0	$116,584
2	Magnetom Skyra		Select contract	Warranty + 7 Years	$0	$0	$137,843
3	Chiller		OEM contract	Warranty + 7 Years	$0	$0	$11,500

Proactive Service Plans: (Pinnacle, Select, Essential) Notwithstanding anything to the contrary contained in this Agreement, remote access to the Equipment identified above will be established through a broadband internet based connection to either a Customer-owned or Siemens-provided secure end-point. The method of connection will be a Peer-to -Peer VPN IPsec tunnel (non-client based) with specific inbound and outbound port requirements.

Includes:
Parts and/or Labor to the extent shown in Exhibit A.
Principal Coverage Period (PCP) as stated in Exhibit A for each system.
System Updates.
Access to Siemens Customer Care Center for technical telephone support (remote diagnostics, if available to the site and the equipment).

Excludes:
Parts defective due to "acts of God", abuse, misuse, neglect, thermal and shock. Specialty components, including, but not limited to: Glassware, Flat Detectors, Consumables, Transducers, MRI coils, SPECT and PET sources (unless purchased as an option). Non-Siemens components and accessories (such as VCR, injector, laser printer, MR surface coils, tables/table tops, chiller, UPS, etc.) unless specifically identified in Exhibit A.

Notes:
The chilled water supply is an integral part of the MR Equipment covered by this Agreement and is critical for the proper operation of the Equipment and for minimizing the loss of cryogens and preventing damage to the MR and its components. Servicing of the chiller by vendors contracted and certified by Siemens is the recommended path for reducing downtime, potential cryogen losses and damage to the MR and its components. Cryogens lost on the associated MR Equipment and any other damages caused to the MR and any of its components due to issues with chillers not serviced by Siemens under a Siemens service contract or due to other excluded causes (e.g., interruption of power, force majeure occurrences, Customer misuse or negligence, etc.) are not covered under this Agreement and will be replaced and/or repaired at the Customer's sole cost and expense at the current negotiated rate for Siemens "Service By Request" (Time and Materials) customers.

Exhibit A

Item #1:

Equipment:	**SOMATOM Definition AS64**		
Equipment Location:	ERLANGER HEALTH SYSTEM		
Address:	975 EAST THIRD STREET, CHATTANOOGA, TN 37403		
Functional Location:	**Service Quote Nr:** 1-L7BXJ1 Rev 0	**Equipment Quote Nr:** 1-L5B1FJ	**Payment Frequency:** Monthly
Standard Warranty: Extended Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: Gold contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 7 Year Duration	**Annual Price:** $116,584

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	06:00am - 04:00pm M-F	06:00am - 04:00pm M-F
Uptime Guarantee	97%	97%
Phone Response	30 min	30 min
On-Site Response	4 hours	4 hours
Parts Order Requirement	noon	noon
Parts Delivery	Same Day	Same Day
Application Hotline Phone Support	✓	✓
CT Detector Coverage	✓	✓
General Spare Parts Coverage	✓	✓
Labor	✓	✓
LifeNet Access	✓	✓
No Consumable Coverage	✓	✓
Planned Maintenance	✓	✓
Quality Assurance	✓	✓
Safety Checks	✓	✓
Siemens Remote Services	✓	✓
Siemens Virus Protection SELECT	✓	✓
Technical Phone Support	✓	✓
Travel	✓	✓
UM Basic Report CT	✓	✓
Updates	✓	✓
Water/Air Cooling System	✓	✓
X-Ray Tube Coverage Unlimited	✓	✓
syngo Remote Assist Hotline Support	✓	✓
Accredited Self Study Program	N/A	Qty 1
EVOLVE Definition AS (without IRS)	N/A	✓
Enhanced Virtual Learning Sub	N/A	Qty 1

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

Item #2:

Equipment:	**Magnetom Skyra**		
Equipment Location:	ERLANGER HEALTH SYSTEM		
Address:	975 EAST THIRD STREET, CHATTANOOGA, TN 37403		
Functional Location:	**Service Quote Nr:** 1-L7BXJ1 Rev 0	**Equipment Quote Nr:** 1-L6CDWA	**Payment Frequency:** Monthly
Standard Warranty: Extended Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: Select contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 7 Year Duration	**Annual Price:** $137,843

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	08:00am - 10:00pm M-F	08:00am - 10:00pm M-F
Annual Exam Allowance	Unlimited	Unlimited
Uptime Guarantee	98%	98%
Phone Response	30 min	30 min
On-Site Response	4 hours	4 hours
Parts Order Requirement	noon	noon
Parts Delivery	Same Day	Same Day
ACR Support Package MR	✓	✓
Application Hotline Phone Support	✓	✓
Coil Coverage	✓	✓
Continuous Effort	✓	✓
General Spare Parts Coverage	✓	✓
Guardian Pro MR	✓	✓
Labor	✓	✓
LifeNet Access	✓	✓
MMA and Helium	✓	✓
No Consumable Coverage	✓	✓
PM's performed outside PCP weekdays	✓	✓
Planned Maintenance	✓	✓
Quality Assurance	✓	✓
Real Time Monitoring M-F 7am-10pm ET	✓	✓
Safety Checks	✓	✓
Siemens Remote Services	✓	✓
Siemens Virus Protection SELECT	✓	✓
Technical Phone Support	✓	✓
Travel	✓	✓
UM Advanced Report MR	✓	✓
Updates	✓	✓
syngo Remote Assist Hotline Support	✓	✓
Accredited Self Study Program	N/A	Qty 1
EVOLVE HW Skyra, Skyra fit	N/A	✓
EVOLVE SW Skyra, Skyra fit	N/A	✓
Enhanced Virtual Learning Sub	N/A	Qty 1

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

Item #3:

Equipment:	**Chiller**		
Equipment Location:	ERLANGER HEALTH SYSTEM		
Address:	975 EAST THIRD STREET, CHATTANOOGA, TN 37403		
Functional Location:	**Service Quote Nr:** 1-L7BXJ1 Rev 0	**Equipment Quote Nr:** 1-L6CDWA	**Payment Frequency:** Monthly
Standard Warranty: OEM Basic Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: OEM contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 7 Year Duration	**Annual Price:** $11,500

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	**Warranty Period**	**Contract Period**
Principal Coverage Period	08:00am - 10:00pm M-F	08:00am - 10:00pm M-F
On-Site Response	4 hours	4 hours
Chiller Coverage Exclusions	✓	✓
Chiller Life Expectancy	✓	✓
General Spare Parts Coverage	✓	✓
Labor	✓	✓
Planned Maintenance	✓	✓
Technical Phone Support	✓	✓
Travel	✓	✓
Updates	✓	✓

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

Glossary

Deliverables	Description
Accredited Self Study Program	This accredited self-study program provides the latest trends in imaging. These hot topic review articles will be mailed directly to your institution and will provide up to 24 Category A Continuing Education Credits fully recognized by ARRT and NMTCB. A comprehensive study guide accompanies each article to help ensure focus on technologist-relevant information.
ACR Support Package MR	This ACR accreditation assistance package includes a remotely executed pre-submission system quality check to evaluate the readiness of one applicable Siemens system to acquire images for ACR accreditation. Supporting deliverables include one printed accreditation guidebook (additional copies available electronically) aligned to the applicable Siemens system and Siemens operating system nomenclature, workflow templates and/or phantom acquisition protocols and available web based user training containing imaging acquisition tips relative to the ACR accreditation process. Additionally, unlimited technical and clinical applications phone support pertaining to the system readiness and deliverables described above , performed by the Uptime Service Center during normal hours of operation M-F 8-8PM EST during the term of this engagement agreement. Customer is responsible for applying for accreditation, and all tasks and costs related to the application and acquiring the ACR phantom, collecting images, working with and communicating with the ACR. Numerous factors determine whether a site receives ACR accreditation. Therefore, Siemens does not guarantee a site will receive ACR accreditation.
Application Hotline Phone Support	Siemens Customer Care Center Clinical Applications Phone Support is provided with this contract during modality specified hours, call 1-800-888-7436 with your questions and to receive direct access to a Clinical Education Specialist
Chiller Coverage Exclusions	Glycol is a consumable and the customer's responsibility to maintain glycol onsite after installation. If the service vendor is not able to identify the specific supplier of glycol in the system, it may become necessary to flush and refill the system to specifications.Flush and refills under these circumstances are considered an exclusion to the service agreement.
Chiller Life Expectancy	Note: Chiller systems. The OEM suppliers have implemented a 10 year life expectancy on chiller systems. Siemens Healthineers will provide you an End of Service (EOS) notification no less than twelve (12) months prior to the EOS date. Full-service contracts cannot be approved beyond the 10th year; however, there is an annual, renewable Preventative Maintenance PM option. Replacement of chiller is recommended subsequent to EOS notification.
Coil Coverage	Covers the repair and replacement of Siemens coils (Third Party coils are not covered, i.e. Invivo 4 Channel wrist array, lower extremity, knee array, 7-channel Breast, 4 ch. Small Extremity coil, 8-channel Shoulder) If your service contract has a parts allowance, the coils will be deducted from the parts allowance. If you do not have parts coverage, repair or replacement of a coil will be a billable charge.
Continuous Effort	In room-down/system-down situations, on-site work will continue past the contract PCP, 7 days a week, at no additional charge until the system is repaired, by not later than 1:00 a.m. local time. Continuous Effort applies only when a CSE has been on-site for at least one (1) hour prior to the end of the PCP. In such a case, Continuous Effort shall begin at the end of the PCP and end at 1 a.m. the following calendar day. Continuous Effort shall resume no sooner than seven (7) hours later, and may resume at a later time with the consent of the Customer.
CT Detector Coverage	Repair and maintenance coverage of UFC (Ultra Fast Ceramic) multislice spiral CT Detector.
Enhanced Virtual Learning Sub	This (12) month multi-modality subscription will provide access for imaging professionals at the customer site to e.learnings, tuition for one-hour virtual monthly webinars, step-by-step videos, and up to (24 CEUs). Imaging professionals must be logged into PEPconnect (Siemens online learning platform) to be eligible to receive CEUs. PEPconnect provides access to all online and virtual training documentation with a wide variety of product-specific, clinical and job-relevant courses, as well as performance support activities for customers with Siemens medical equipment. This educational offering must be completed (12) months from purchase date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
EVOLVE Definition AS (without IRS)	At least 1 software upgrade to the next syngo level; also, 1 hardware upgrade to the main system and, if existent, the connected syngo CT Workplace. Contract including syngo Evolve for connected syngo CT Workplace must be purchased if purchased on the main system to ensure compatibility. syngo MultiModality Workplace and refurbished systems excluded in all cases.
EVOLVE HW Skyra, Skyra fit	Customer receives at least one hardware upgrade to the main system as they become available providing a service contract is in place covering Evolve. Syngo MultiModality Workplace excluded in all cases.
EVOLVE SW Skyra, Skyra fit	Customer Receives all software upgrades and updates to the main system as they become available providing a service contract is in place covering Evolve. Syngo MultiModality Workplace excluded in all cases.
General Spare Parts Coverage	Replacement of standard spare parts. Excludes high-vacuum components, consumables, Shock wave components, Transducers, TEE's and Specialty Probes, Flat Panel Detectors, MMLC, and Waveguides. Excludes non-Siemens parts unless specifically identified in Exhibit A.

Deliverables	Description
Guardian Pro MR	The Siemens Guardian Program™ offers you proactive online monitoring of your system's performance on an ongoing real-time basis. By continuously monitoring your system for possible deviations from current norms, the Guardian Program provides for a high level of system availability, making it possible to detect and resolve system errors before malfunctions occur. In the event of a system error message, one of our certified support engineers will immediately evaluate and initiate appropriate actions.. An expert opinion on the exact status of your system is also offered within the first 15 minutes.
Labor	Unlimited coverage of on-site labor during the Principal Coverage Period indicated. Preferred labor rates for billable service outside of Principal Coverage Period (at current prevailing tiered rates).
LifeNet Access	The LifeNet portal provides access to customer service information related to diagnostic imaging equipment. Access includes service and PM management tools, equipment performance reports, service documentation, asset management and service contract management tools and much more.
MMA and Helium	Maintenance of magnet ancillary components and magnet performance. Covers parts and labor associated with maintaining the magnet and refrigeration components (CryoCare). Covers burst disc, vent kit, valves, MSUP, ERDU, helium compressor, high pressure gas lines and cold head. Supply of liquid helium and labor to fill magnet. - If the magnet refrigeration system shut down due to facility services failure, then cryogen usage will increase and additional charges may apply - Helium fills to recover from a customer caused quench will be chargeable.
No Consumable Coverage	Upon selection to not have consumable coverage, customer agrees to supply at his/her own expense consumables, such as but not limited to, batteries, leads, padding, storage media, cassettes, etc. Full list of consumables covered can be found on Lifenet customer portal: www.usa.siemens.com/lifenet.
On-Site Response	Siemens guarantees on-site CSE arrival within a specific time period (see Exhibit A) after a call for service has been placed with the Siemens Customer Care Center. This on-site response applies in system/room down situations only. (See Response Time Guarantee in General Terms and Conditions for additional information)
Parts Delivery	Spare parts arrival for on-site repair of room-down/system-down is typically the Same Day following the time the parts order is submitted.
Parts Order Requirement	Parts order must be placed with Siemens by noon (Customer's local time) in order to receive Parts Delivery commitment as specified.
Phone Response	The response time indicated on Exhibit A provides preferred call-handling of a service event. This call-back response is the telephone response to the customer by the Siemens Customer Care Center personnel or the CSE to provide the status of the service call.
Planned Maintenance	Preventive services carried out in accordance with the equipment's specific maintenance plan. This includes: tracking and scheduling of required maintenance tasks; exchange of wear and tear parts according to maintenance plan; care measures; adjustments to factory specifications; verification of specified performance and functionality; documentation and detailed protocol of system condition.
PM's performed outside PCP weekdays	Planned maintenance optimizes system reliability through standardized measures and procedures. Siemens will coordinate planned maintenance in accordance with the manufacturer's recommendations outside the PCP hours designated on Exhibit A on Weekdays only.
Principal Coverage Period	Hours defined in Exhibit A during which agreed-upon services are provided.
Principle Coverage Period 14 HRS. 8AM-10PM	Specific 14-hour period during which agreed-upon services are provided, as noted above.
Quality Assurance	Regular quality assurance tasks and image quality inspections to achieve consistent, high-quality images, are performed to keep the system within the quality specifications as issued by the factory.
Real Time Monitoring M-F 7am-10pm ET	Real time event monitoring of a system by a Siemens engineer. Customers will be notified of critical events and action for resolution within 15 minutes of event occurring. Events of non-critical nature will be stored for trending purposes enabling predictive analysis for potential future failures. Siemens will respond to trends and schedule service accordingly.
Safety Checks	Safety Checks are performed to insure compliance with all local and federal guidelines and regulations. This service consists of Tracking and scheduling of required tests Mechanical Safety Checks (e.g. mechanical movements etc.) Electrical Safety Checks (e.g. leakage currents, insulation etc.) Reporting of findings and results

Deliverables	Description
Siemens Remote Services	Siemens Remote Services – the efficient and comprehensive infrastructure for medical equipment-related remote services – combines high-tech medical engineering with state-of-the-art information technology. Services, which formerly required on-site visits, are now available via data transfer. SRS enables both Core Services (which are included as part of our standard service agreements), as well as optional services (called Enhanced Productivity Services - EPS) which customers can purchase as an enhancement to their agreement. **Core Services include:** remote diagnosis and repair via dial-in modem, event monitoring (performance screening of customer system where CSE evaluates status messages at periodic intervals and initiates appropriate service action within the scope of customers service agreement), software updates, LifeNet web site access. **Enhanced Productivity Services (EPS) include:** Guardian Program, Virus Protection Program, Utilization Management, Application training and on-site support.
Siemens Virus Protection SELECT	Siemens Virus Protection SELECT consists of the following service features: Virus scanner installation: Expert installation of the certified and tested virus scanner Trend Micro OfficeScan Ongoing remote virus scanner updates: Constant automatic remote updates of the latest validated virus pattern and scan engine Security Hotline: The local Uptime Service Center is our customer's contact for up-to-date virus information and rapid response support. Siemens Virus Protection is available for all *syngo*-based systems which are - connected to our SRS infrastructure by a VPN broadband connection - covered by one of our service agreements - equipped with the required software version, which includes the Virus Scanner as well as the necessary CA-based Managed Node Package (MNP). Siemens will not be liable for system failures and loss of patient data, caused by a virus.
syngo Remote Assist Hotline Support	Allows Siemens to connect to your Siemens Imaging Console and provides you with direct real time support. Available for Tim Class MRI Systems with software version VB17 or VC13, AND Definition Class CT Systems. Requires a Siemens remote service connection.
Technical Phone Support	Direct access to specialists at the Siemens Customer Care Center for fast diagnosis and technical support. Technical Phone Support is available to Siemens customers over the telephone, 24 hours a day, 7 days a week.
Travel	Includes travel time for Customer Service Engineer to and from Customer's site. Subject to change to reflect currently prevailing rates, if occurring outside of the Principal Coverage Period indicated.
UM Advanced Report MR	Siemens Utilization Management Advanced provides system-specific usage data, which is collected from the system itself. This detailed data allows Siemens' customers the ability to leverage their system's full potential. Advanced Reporting includes reports on system usage and performance as well as detailed reports on body region studies and provides anonymous benchmark information about comparable systems at other facilities operating in similar environments. These reports are easily accessible through Siemens' customer portal LifeNet.
UM Basic Report CT	Utilization Management Basic provides periodic evaluation updates of your system's capacity performance, including, for example, information on patient examinations per day, or the number of studies conducted on individual body parts. UM Basic provides an overview about the system usage and therefore serve as initial indicators of how system utilization can be optimized. It contains general information such as: total number of patients, average/total number of patient exams per hour, total number of protocols, total number of patient exams, mean time between patient exams, average duration per patient exam. In addition, the report shows system-specific information such as: average number of scan seconds per patient exam, average duration per study, total number of reconstructed images, total number of selected body regions, total number of archiving operations, or percentage number of studies per coil.
Unlimited Exams	Coverage includes an unlimited number of Patient Exams per year.
Updates	Modifications or reliability enhancements to equipment. Includes two types: Mandatory (safety and performance-related update instructions) and Non-mandatory (reliability-related service instructions). Does not include enhancements to the operating system or additional functionality.
Uptime Guarantee	Guarantee that the Equipment will function at the minimum Uptime Performance level set forth in Exhibit A of this Agreement. A SRS connection via VPN broadband is mandatory.
Water/Air Cooling System	Coverage of the split heat exchanger, also known as a remote cooling system, active cooling system or split chiller. (This is a Siemens unit, manufactured by Riedel.) Maintenance for this unit is included in the system service price of the service agreement and does not require the purchase of separate chiller coverage.

Deliverables	Description
X-Ray Tube Coverage Unlimited	Warranty - Unlimited tube coverage provided on all CT x-ray tubes. After warranty - Annual x-ray tube coverage is unlimited scan seconds.

Siemens Medical Solutions USA, Inc. General Terms and Conditions

1. Scope

For the term set forth on the first page hereof under the heading "Contract Duration", Siemens will provide (i) remedial maintenance service on the equipment described on the preceding pages hereof (the "Equipment") when requested by the Customer, as well as planned maintenance inspections, when scheduled, as further described in the Glossary section attached hereto, in order to keep the Equipment operating in accordance with the manufacturer's specifications, and (ii) any training courses and/or other educational offerings described in Exhibit A and the Glossary. Siemens will make every effort to respond to service calls at a mutually agreed upon arrival time consistent with the provisions cited in Section 2. In connection with the provision of Equipment maintenance services, Siemens may take photographs or other images of the Equipment or components thereof in order to expedite the completion of repairs, provided that any such photographs shall not include any patients, employees or agents of the Customer and further provided that such photographs and images will only be used in order for Siemens to carry out its duties and responsibilities hereunder.

In the event that (i) the term of this Agreement does not include the Equipment warranty period (as indicated on the first page hereof under the heading "Contract Duration"), or (ii) the term of this Agreement does not commence immediately upon the expiration of the Siemens warranty, or (iii) the Equipment was serviced prior to commencement of the term by anyone other than Siemens or an authorized Siemens dealer or service provider, or (iv) the Equipment was moved from its original location or is not connected to its original power supply (other than portable or mobile Equipment), then the Equipment is subject to inspection by Siemens to determine if it is in good operating condition prior to the commencement of services under this Agreement. Any inspection as well as any repairs or adjustments deemed necessary by Siemens during such inspection shall be made at Siemens' per-call rates and terms then in effect and shall include charges for parts, with all such repairs or adjustments to be completed prior to the commencement of service under this Agreement.

If this Agreement includes any training courses or other educational offerings, such training courses or other offerings may consist of on-site training or consultation at the Customer site, a Siemens training facility or via conference call or net meeting, self-study or computer based training, or other arrangements, as further described in Exhibit A and the Glossary. In some cases, tuition charges will cover travel and lodging for off-site training, and in other cases Customer will be responsible for all travel and lodging costs. Details of the training are provided on Exhibit A and the Glossary.

2. Principal Coverage Period (PCP)

Service and maintenance will be provided during the principal coverage period ("PCP") as defined on Exhibit A, excluding the following holidays: New Years Day, Memorial Day (observed), Independence Day, Labor Day, Thanksgiving Day, Christmas Day. If one of the foregoing holidays falls on a Saturday, then the holiday will be observed on the previous Friday, and if the holiday falls on a Sunday, the holiday will be observed on the following Monday. Unless an extended hours coverage option has been selected, labor and travel required outside the PCP will be charged at Siemens' per-call rates and terms then in effect.

3. Replacement Parts

Siemens will supply at its own expense, necessary parts, except as indicated in the Glossary section, provided replacement of the parts is required because of normal wear and tear or otherwise deemed necessary by Siemens and further provided that the Siemens-manufactured parts are available from the factory. All Parts will be new, standard parts, or used, reworked or refurbished parts that comply with applicable performance and reliability specifications. Exchange parts removed from the Equipment shall become the property of Siemens unless such exchange parts constitute "hazardous wastes", "hazardous substances", "special wastes" or other similar materials, as such terms are defined by any federal, state or local laws, rules or regulations, in which case, at the option of Siemens, the exchange parts shall remain the property of the Customer and shall be disposed of by the Customer in strict compliance with all applicable laws, rules and regulations.

4. Planned Maintenance (PM)

Planned maintenance will be carried out according to the manufacturer's recommended schedule. Planned maintenance generally includes checking mechanical and electrical safety, lubrication, functional testing and adjusting for optimum performance as specified in the detailed planned maintenance work plan.

5. Software Maintenance

Whenever the Equipment covered by this Agreement utilizes Siemens' operating system software, Siemens will provide all maintenance and commercially available updates for such operating system software as part of this Agreement. Such updates will solely enhance previously purchased capacities of the Equipment. Operating system software upgrades that provide new features or capabilities or that require hardware changes will be offered to Customer when commercially available and at purchase prices established by Siemens. In addition, some upgrades may require applications training performed by Siemens' personnel that will be offered at Siemens' rates and terms then in effect. Siemens retains the sole right to determine whether an upgrade requires such training.

Nothing in this Agreement shall in any way grant to Customer any right to or license in any diagnostic service software utilized by Siemens in servicing the Equipment. Such service software is and remains the property of Siemens and is available to Customer pursuant to the terms and conditions of a separate diagnostic materials license agreement, which may require payment of a license fee. This service software shall be disabled by Siemens upon cancellation or termination of this Agreement.

6. Equipment; Location; Remote Access

The Equipment covered under this Agreement is limited to the Siemens furnished Equipment described on the face sheet(s). The Equipment shall not be moved to another location unless Customer obtains the prior written consent of Siemens, subject to the following exceptions (i) portable Equipment (e.g., Ultrasound equipment, but not including any equipment that is housed in a mobile vehicle, van or trailer) may be moved to other locations within the same facility, so long as the Customer informs Siemens of the location of the Equipment when Siemens is scheduled to provide on-site service; (ii) if Equipment is located in a trailer, van or other form of mobile vehicle, the Equipment may be moved from the Equipment Location identified on Exhibit A, provided, however, that Siemens shall not be required to service such Equipment, and the Response Time and Uptime Performance Guarantees (if any) shall not apply, if either (a) the Customer does not notify Siemens at least one (1) month in advance of the Equipment's mobile route, or (b) the Equipment is moved more than 25 miles from the original Equipment Location; and (iii) if fixed Equipment is moved to any other location within the Customer's facility, then either (a) the Customer will engage Siemens to relocate the Equipment, at Siemens' then current rates and charges, or (b) if Siemens does not perform the services necessary to relocate the Equipment, then Siemens may suspend services with respect to such Equipment until Siemens performs an inspection of the Equipment, at the Customer's cost, to determine if any repairs are necessitated as a result of any such relocation (in which case the Customer shall be separately charged for such repairs, including parts and labor, at Siemens' rates and charges then in effect).

Siemens service personnel will be given full and free access to the Equipment to perform inspections and service/maintenance on the Customer's premises, and will make specific appointments for such maintenance. If the Equipment is not made available at the appointed time, waiting time beyond a reasonable allowance will be charged at Siemens' per-call rates and terms then in effect.

Customer shall provide Siemens with both on-site and remote access to the Equipment. The remote access shall be provided through the Customer network as is reasonably necessary for Siemens to provide services under this Agreement. Remote access will be established through a broadband internet based connection to either a Customer owned or Siemens provided secure end-point. The method of connection will be a Peer-to-Peer VPN IPsec tunnel (non-client based) with specific inbound and outbound port requirements.

In the event the Customer fails to provide or maintain the remote access connection for any Proactive Service Agreement (e.g., Pinnacle, Select, Essential, as identified in Exhibit A), then Siemens shall have the option to terminate this Agreement. In addition, in accordance with the terms of Section 22 hereof, any Uptime Performance Guarantee shall be void if the remote access connection is not provided and available 24 hours per day, 7 days a week.

7. Agreement Term; Price; Payment Terms

This Agreement shall be in effect for the period stated on the first page of this Agreement.

For the basic services to be provided by Siemens under the terms of this Agreement, Siemens shall send invoices to the Customer and payments shall be made in advance based on the payment frequency shown in Exhibit A under "Payment Frequency".

Invoices for all amounts due under this Agreement shall be sent to the Customer by regular U.S. mail, postage prepaid, at the address set forth on the first page hereof under "Bill To".

All payments to be made by Customer under this Agreement are due net thirty (30) days from the invoice date. Past due payments shall bear interest at the rate of 1½% per month.

8. Causes for Exclusion/Separate Charges

This Agreement specifically excludes labor, parts and expenses necessary to repair Equipment:

- damaged by fire, accident, misuse, abuse, negligence, improper application or alteration or by a force majeure occurrence as described in Section 17 hereof, or by the Customer's failure to operate the Equipment in accordance with the manufacturer's instructions or to maintain the recommended operating environment and line conditions;

• defective due to unauthorized attempts to repair, relocate, maintain, service, add to or modify the Equipment by the Customer or any third party or due to the attachment and/or use of non-Siemens supplied parts, equipment or software without Siemens' prior written approval (and if the Customer or a third party modifies the Equipment, then Siemens may remove such Equipment from coverage under this Agreement unless the Customer restores the Equipment to the manufacturer's published specifications);

• defective due to any repair or service of the Equipment by the Customer or any third party prior to the commencement of the term of this Agreement;

• which failed due to causes from within non-Siemens supplied equipment, parts or software including, but not limited to, problems with the Customer's network;

• which is worn out and cannot be reasonably repaired due to the unavailability of spare parts from the original equipment manufacturer; or

• which is a transducer or probe and which is damaged or defective, or which failed, due to any of the foregoing causes or due to improper cleaning, disinfecting or TEE bite marks.

If Siemens is called upon to service or repair Equipment which falls under this Section 8, a separate invoice will be issued for labor, parts and expenses at Siemens' rates and terms then in effect.

This Agreement does not entitle the Customer to services related to information technology, patient and imaging workflow design and analysis, or problem diagnosis. Siemens' responsibility under this Agreement does not extend beyond the outbound or inbound sockets of the Equipment. In addition, changes, adjustments, additions or repairs required to or with respect to the Equipment resulting from issues, matters, items or concerns that are the responsibility of the Customer, such as changes related to Customer's network infrastructure, are not covered by this Agreement. This may include, but is not limited to, network IP address changes. Although the Equipment may have limited short term storage capacity, the storage of images, both patient and QA images, is the responsibility of the Customer.

If Siemens offers a Network Assistance option for the Equipment and the Customer purchases this option as indicated on Exhibit A, then Siemens shall assist the Customer in its efforts to identify the cause of any network or connectivity problems which may affect the operation of the Equipment; provided, however, that the price for this option does not include the cost of any repairs (labor, parts, etc.) to remedy such problems, which shall be the sole responsibility of the Customer. If the Customer does not purchase this option, or if this option is not offered by Siemens, then any assistance provided by Siemens to the Customer with respect to any network or connectivity issues shall require a P.O. from the Customer and shall be separately billed to the Customer at Siemens' then current rates and charges.

9. Default

Customer shall be in default under this Agreement upon: (i) a failure by Customer to make any payment due Siemens within ten (10) days of receipt of notice from Siemens that the payment was not made within the applicable payment period; (ii) a failure by Customer to perform any other obligation under this Agreement within thirty (30) days of receipt of notice from Siemens; (iii) a failure to grant Siemens access to the Equipment as set forth in Section 6 of this Agreement; (iv) a default by Customer or any affiliate of the Customer under any other obligation to or agreement with Siemens, Siemens Financial Services, Inc. or Siemens Medical Solutions Health Services Corporation, or any assignee of the foregoing (including but not limited to, a promissory note, lease, rental agreement, license agreement or purchase contract); or (v) the commencement of any insolvency, bankruptcy or similar proceedings by or against the Customer (including any assignment by Customer for the benefit of creditors). Upon the occurrence of any event of default hereunder, Siemens may, in addition to any and all other remedies available under law, elect to: (i) immediately cease providing services under this Agreement and any and all other agreements between the parties, or suspend any training courses or educational offerings provided under this Agreement, until the default is cured or corrected, (ii) terminate this Agreement, in which case Customer shall pay to Siemens (a) all amounts due under this Agreement through the effective date of termination, (b) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement from the date of termination through the scheduled expiration of the term of this Agreement, and (c) all costs and expenses of collection, including without limitation reasonable attorneys' fees and court costs incurred by Siemens as a result of the Customer's default, and/or (iii) commence collection actions (including court actions) for all sums due under this Agreement. All rights and remedies available to Siemens hereunder, by law or equity, shall be cumulative and there shall be no obligation for Siemens to exercise a particular remedy.

In the event that Customer cures all defaults hereunder, then prior to resumption of the Equipment maintenance services under this Agreement, Siemens may inspect the Equipment to determine if it is in good operating condition. Such inspection shall be charged to the Customer at Siemens' per-call rates and terms then in effect. Any repairs or adjustments which Siemens determines are required due to (i) the use of any non-Siemens parts, (ii) the repair or service of the Equipment by the Customer or any third party during the suspension of services by Siemens, or (iii) any of the exclusions from coverage set forth in Section 8 of this Agreement, shall be charged to the Customer at Siemens' rates and terms then in effect and shall include charges for parts, with all such repairs or adjustments to be completed prior to the resumption of service under this Agreement.

10. Limitation of Liability

Siemens' entire liability and Customer's exclusive remedy for any direct damages incurred by the Customer from any cause whatsoever, and regardless of the form of action, whether liability in contract or in tort, arising under this Agreement or related hereto, shall not exceed, as applicable: (i) an amount equal to the Annual Agreement Price (in effect when the cause of action arose) for the specific item of Equipment under this Agreement that caused the damage or is the subject matter of, or is directly related to, the cause of action, or (ii) the amount paid by Customer to Siemens under this Agreement for the particular training course or educational offering that is the subject matter of the claim. The foregoing limitation of liability shall not apply to claims by Customer or third parties for bodily injury or damage to real property or tangible personal property (including damage to the Equipment covered by this Agreement) caused solely and directly by the gross negligence or willful misconduct of Siemens. In addition, Siemens shall have no liability hereunder to Customer to the extent that Customer's or any third party's acts or omissions contributed in any way to any loss it sustained or to the extent that the loss or damage is due to a force majeure occurrence as described in Section 17 hereof or any other cause beyond the reasonable control of Siemens.

THIS IS A SERVICE AGREEMENT. WITHOUT LIMITING THE LIMITATION OF LIABILITY SET FORTH IN THE PRECEDING PARAGRAPH, SIEMENS EXPRESSLY DISCLAIMS ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING BUT NOT LIMITED TO, ANY IMPLIED WARRANTIES OF MERCHANTABILITY AND WARRANTIES OF FITNESS FOR A PARTICULAR PURPOSE. IN NO EVENT WILL SIEMENS BE LIABLE FOR ANY LOST PROFITS, LOST SAVINGS, LOST REVENUES, LOSS OF USE OR DOWNTIME (EXCEPT AS OTHERWISE PROVIDED HEREIN), LOST DATA, OR FOR ANY INDIRECT, INCIDENTAL, UNFORESEEN, SPECIAL, PUNITIVE OR CONSEQUENTIAL DAMAGES WHETHER BASED ON CONTRACT, TORT (INCLUDING NEGLIGENCE), STRICT LIABILITY OR ANY OTHER THEORY OR FORM OF ACTION, EVEN IF SIEMENS HAS BEEN ADVISED OF THE POSSIBILITY THEREOF, ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE USE OR PERFORMANCE OF THE EQUIPMENT.

11. Notices

Except for the issuance of invoices as set forth in Section 7 hereof, all notices required to be provided hereunder shall be in writing and shall be sent by overnight delivery via a nationally recognized delivery service or by certified or registered mail, postage prepaid, to Siemens at the address set forth on the first page of this Agreement and to the Customer at the address set forth under "Bill To" on the first page of this Agreement. Notice given in compliance with this Section 11 shall be sufficient for all purposes under this Agreement, and such notice shall be effective when sent. Either party may change its notice address only if notification is sent in writing pursuant to this Section 11.

12. Governing Law; Waiver of Jury Trial

This Agreement shall be governed by the laws of the Commonwealth of PA. TO THE EXTENT NOT PROHIBITED BY LAW, THE PARTIES WAIVE ALL RIGHTS TO A JURY TRIAL IN ANY LITIGATION ARISING FROM OR RELATED IN ANY WAY TO THIS AGREEMENT OR THE TRANSACTION CONTEMPLATED HEREBY.

13. Government Access Clause

Until the expiration of four (4) years after the furnishing of any services under this Agreement, Siemens shall make available upon written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, this Agreement and the books, documents and records of Siemens which are necessary to certify the nature and extent of costs incurred under this Agreement. If Siemens carries out any of the duties of this Agreement through a subcontract with a value of $10,000 or more over a 12 month period with a related organization, such subcontract shall include a clause to the effect that until the expiration of four (4) years after the furnishing of any services under the subcontract, the related organization shall make available upon written request of the Secretary of the Department of Health and Human Services, the Comptroller General, or any of their duly authorized representatives, the subcontract and the books, documents and records of the related organization that are necessary to certify the nature and extent of costs incurred under that subcontract.

This provision shall apply if and solely to the extent that Section 1861 (v) (1) (I) of the Social Security Act applies to this Agreement.

14. Damages, Costs, And Fees

In the event that any dispute or difference is brought arising from or relating to this Agreement or the breach, termination, or validity thereof, the prevailing party shall not be entitled to recover from the other party punitive damages. The prevailing party shall be entitled to recover from the other party all reasonable attorneys' fees and collection agency fees incurred, together with such other expenses, costs and disbursements as may be allowed by law.

15. Severability; Headings

No provision of this Agreement which may be deemed invalid, illegal or unenforceable will in any way invalidate any other portion or provision of this Agreement. Paragraph headings are for convenience only and will have no substantive effect.

16. Waiver

No failure, and no delay in exercising, on the part of any party, any right under this

Agreement will operate as a waiver thereof, nor will any single or partial exercise of any right preclude the further exercise of any other right.

17. Force Majeure

Siemens will not be liable to Customer for any failure to fulfill its obligations under this Agreement due to causes beyond its reasonable control and without its fault or negligence including, but not limited to, governmental laws and regulations, acts of God or the public, war or other violence, civil commotion, blockades, embargoes, calamities, floods, fires, earthquakes, explosions, accidents, storms, strikes, lockouts, work stoppages, labor disputes, or unavailability of labor, raw materials, power or supplies. In addition, in the event of any determination pursuant to the provisions of a collective bargaining agreement between the Customer and any labor union representing any employees of the Customer preventing or hindering the performance of any of the obligations of Siemens under this Agreement, or determining that the performance of any such obligations violates provisions of that collective bargaining agreement, or in the event a trade union, or unions, representing any of the employees of the Customer otherwise prevents Siemens from performing any such obligations, then Siemens shall be excused from the performance of such obligations unless the Customer makes all required arrangements with the trade union, or unions, to permit Siemens to perform the work. The Customer shall pay any additional costs incurred by Siemens that are related to any labor dispute(s) that involve the Customer.

18. Confidentiality

Siemens and the Customer shall maintain the confidentiality of any information provided or disclosed to the other party, its employees or agents (a "receiving party") relating to the business, customers and/or patients of the disclosing party, including but not limited to know-how, technical data, processes, software, techniques, developments, inventions, research products and plans for future developments, proprietary matters of a business or technical nature, as well as this Agreement and its terms (including the pricing and other financial terms under which the Customer will be obtaining the services hereunder). Confidential Information shall also include all written materials (including correspondence, memoranda, manuals, training materials, notes and notebooks) and all computer software, models, mechanisms, devices, drawings or plans which may be disclosed or made available embodying Confidential Information. All Confidential Information shall be and remain the sole and exclusive property of the disclosing party. Each party shall use reasonable care to protect the confidentiality of the information disclosed, but no less than the degree of care it would use to protect its own confidential information, and shall only disclose the other party's confidential information to its employees and agents having a need to know this information. Confidential Information shall not include any information or data which (i) is or becomes public knowledge (through no fault of the receiving party or any of its employees or agents), (ii) is made available to the receiving party by an independent third party without any obligation of confidentiality, (iii) is already in the receiving party's possession at the time of receipt from the disclosing party (as such prior possession can be properly demonstrated by it), or (iv) is required by law to be disclosed, provided that the receiving party gives the disclosing party advance notice of the requirement for disclosure so that the disclosing party can take whatever action it deems necessary to protect the disclosure of its Confidential Information. In addition, this confidentiality provision shall not apply to any action brought by either party to enforce the terms of this Agreement against the other party.

Any unauthorized use, disclosure or misappropriation of any Confidential Information by the receiving party in violation the foregoing may result in irreparable and continuing damage to the disclosing party; in the event of such breach, the disclosing party shall be entitled to obtain immediate injunctive relief and any other relief or remedies to which it may be entitled. The receiving party waives any requirement that the disclosing party post a bond or other security in connection with any petition filed by the disclosing party for injunctive relief. In the event that a court of competent jurisdiction determines that the receiving party has breached this provision, then the receiving party shall reimburse the disclosing party for the costs of any court proceedings and all reasonable attorneys' fees.

19. End of Support Announcement

Notwithstanding anything to the contrary contained herein, in the event that Siemens makes a general announcement that it will no longer offer service agreements for an item of Equipment or components thereof, or provide a particular service agreement option or feature, whether due to the unavailability of spare parts or otherwise (an "EOS Announcement"), then upon no less than twelve (12) months prior written notice to the Customer, Siemens may remove any affected Equipment, components, options or features from coverage under this Agreement, with a corresponding adjustment of the Annual Agreement Price. In addition, at the end of this twelve (12) month period, the Customer may either remove the affected Equipment components, options or features from coverage under this Agreement or request that Siemens provide service or parts on a time and materials basis only, at Siemens' rates and terms then in effect, for any Equipment, components, options or features subject to an EOS Announcement.

20. Removal of Equipment from Coverage

The Customer may remove Equipment from coverage under this Agreement at any time upon no less than thirty (30) days prior written notice to Siemens if the use of the Equipment is permanently discontinued and the Equipment is removed from service. There is no fee for this cancellation. Prorated credit will be issued for any advance payments made by the Customer for the period after the effective date of removal (based on the notice requirement). In addition, if the Customer sells or otherwise transfers any of the Equipment to a third party and the Equipment remains installed and in use at the same location, but such third party does not assume the obligations of the Customer under this Agreement or enter into a new service agreement with Siemens with a term at least equal to the unexpired term of this Agreement, then the Customer may terminate this Agreement with respect to such Equipment upon no less than thirty (30) days prior written notice to Siemens, in which case the Customer shall pay to Siemens (i) all amounts due under this Agreement through the effective date of termination (based on the notice requirement) and (ii) as liquidated damages and not as a penalty, an amount equal to 25% of the remaining payments due under this Agreement for such Equipment from the date of termination through the scheduled expiration of the term of this Agreement.

21. HIPAA

To the extent required by the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and any regulations promulgated thereunder, Siemens does hereby assure Customer that it will appropriately safeguard Protected Health Information (as defined under HIPAA) made available to or obtained by Siemens pursuant to this Agreement or any Service Schedule ("PHI"). Without limiting the obligations of Siemens otherwise set forth in this Agreement or imposed by applicable law, Siemens agrees to comply with applicable requirements of law relating to PHI and with respect to any task or other activity Siemens performs on behalf of Customer. Specifically, Siemens shall:

(a) not use or disclose PHI other than as permitted or required by this Agreement or as required by law, and limit any use or disclosure of PHI to a limited data set or the minimum necessary to accomplish the intended purpose of such use or disclosure;

(b) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains or transmits on behalf of the Customer, and comply, where applicable, with the HIPAA Security Rule with respect to such electronic PHI, and otherwise use appropriate safeguards to prevent use or disclosure of PHI, other than as provided for by this Agreement;

(c) report to Customer any use or disclosure of PHI not provided for by this Agreement, and report any security incident, of which Siemens becomes aware;

(d) in accordance with applicable HIPAA and HITECH requirements, ensure that any subcontractors or agents to whom Siemens provides PHI received from, or created or received by Siemens on behalf of, Customer agree to essentially the same restrictions and conditions that apply to Siemens with respect to PHI and implement reasonable and appropriate safeguards with respect to PHI;

(e) upon Customer's written request, make PHI available to the Customer as necessary for Customer to respond to individuals' requests for access to PHI about them, provided that the PHI in Siemens' possession constitutes a Designated Record Set and Siemens has been specifically engaged by Customer to so maintain and service such PHI on behalf of Customer;

(f) upon Customer's written request, make PHI available to Customer for amendment and incorporate any amendments to the PHI in accordance with applicable law, provided that the PHI in Siemens' possession constitutes a Designated Record Set and Siemens has been specifically engaged by Customer to so maintain and service such PHI on behalf of Customer;

(g) make available to Customer the information in its possession required to provide an accounting of disclosures of PHI as required by applicable law;

(h) mitigate, to the extent practicable, any harmful effect that is known to Siemens of a use or disclosure of PHI by Siemens in violation of the requirements of this Agreement or of law;

(i) provide notice of a breach of unsecured PHI to Customer without unreasonable delay, and in no case later than thirty (30) days after discovery of a breach. The notification shall include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by Siemens to have been, accessed, acquired, used, or disclosed. Siemens shall provide Customer with any other available information that Customer is required to include in notification to the individual under applicable law;

(j) make Siemens' internal practices, books, and records relating to the use and disclosure of PHI received from Customer available to the Secretary of the United States Health & Human Services for purposes of determining Customer's compliance with applicable law; and

(k) upon expiration or termination of this Agreement, return to Customer or destroy all PHI in its possession as a result of this Agreement and retain no copies of PHI, if it is feasible to do so. If return or destruction is not feasible, Siemens agrees to extend all protections contained in this Agreement to Siemens' use and/or disclosure of any retained PHI, and to limit further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.

Siemens may use and disclose PHI as necessary for Siemens to perform its obligations hereunder, and may (i) use the PHI for its proper management and administration and to carry out its legal responsibilities, (ii) disclose the PHI to a third party for Siemens' proper management and administration or to carry out Siemens' legal responsibilities, provided that the disclosures are required by law or Siemens obtains reasonable assurances from the third party regarding the confidential handling of such PHI as required under HIPAA and/or HITECH, and the third party agrees to notify Siemens of any instances in which the confidentiality of the information has been breached, (iii) provide data aggregation services related to the healthcare operations of Customer, and (iv) de-identify the PHI, and use such de-identified data, in accordance with the de-identification requirements under HIPAA.

Siemens agrees that it will negotiate in good faith an amendment to this Agreement if, and to the extent required by, the provisions of HIPAA and regulations promulgated thereunder, in order to assure that this Agreement is consistent therewith.

22. Uptime Performance Guarantee [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

For any Equipment that includes an Uptime Guarantee as specified in Exhibit A, Siemens guarantees that the Equipment will function at the minimum Uptime Performance (defined below) level set forth in Exhibit A (computed as described below).

"Uptime Performance" is defined as the capability of the Equipment to be utilized to treat or diagnose patients. The Equipment will be considered to be operational (i.e., it will not be considered to be "down"): (a) unless it cannot be utilized to treat or diagnose patients (room down); (b) if Siemens is prepared to perform maintenance services to make the Equipment operational but such service is refused by the Customer or is deferred by the Customer until a later time or date; (c) if the Equipment is not otherwise made available to Siemens' service engineers; (d) if the Equipment is down is due to, associated with, or caused by (i) misuse, negligence, or operator error, (ii) inadequate environmental conditions (not conforming with the environmental specifications provided by Siemens), including temperature and humidity, line power exceeding Siemens' requirements of voltage, frequency, impulses or transients, (iii) any of the exclusions set forth in Section 8 hereof, or (iv) acts of God or other force majeure events described in Section 17 hereof; or (e) during periods in which Siemens is performing scheduled or planned maintenance, changing high-vacuum components, and installing updates and/or upgrades. If the Equipment is not operational, then the Customer must immediately notify the Siemens Customer Care Center (24-hour Service Call Dispatch Center). Downtime will not commence until such notification is given to Siemens.

For purposes of calculating the Uptime Performance level percentage, such computation shall be made over the PCP, to include any extended coverage hours as indicated on Exhibit A. The Equipment's Uptime Performance shall be calculated to comply with the above guidelines on an annual basis. If the Equipment's Uptime Performance level is found to be less than the guaranteed percentage, as computed in accordance with the above guidelines, Siemens will extend the term of this Agreement by seven (7) calendar days (30 calendar days for Oncology Care Systems) for every percentage point (rounded to the nearest percent) below the guaranteed percentage. These days will be added at the end of the term of this Agreement. For example, if the guaranteed percentage is 97%, then 96% Uptime Performance would result in an extension of seven (7) calendar days and 95% Uptime Performance would result in an extension of fourteen (14) calendar days. The foregoing states Siemens' entire obligation and liability, and the Customer's sole remedy, for Siemens' failure to meet the Uptime Performance Guarantee.

In order for the Uptime Performance Guarantee to be effective, the Customer must place all calls for service through the Siemens Customer Care Center and must accept all Technical Assistance that is offered by Siemens, including, but not limited to, telephone support and remote diagnostics. For any period of time that the Customer does not seek and accept Technical Assistance from Siemens, then the Equipment shall be considered to be operational.

The Customer agrees to allow connection to Siemens' Remote Service diagnostic equipment, where available, for the Equipment covered by this Agreement. Siemens Remote Service (SRS) is required for SRS-capable systems. The Uptime Performance Guarantee shall be void if the SRS connection is not provided and available 24 hours per day, 7 days a week.

23. Response Time Guarantee [DOES NOT APPLY TO EVERY SERVICE AGREEMENT]

Siemens guarantees that it shall meet any on-site response time as specified in Exhibit A for system "down" situations. Response time is measured from the time that the Customer notifies the Siemens Customer Care Center that a system is down. The response time only applies during the PCP, to include any extended coverage hours (if selected by the Customer), as indicated on Exhibit A. For example, a request for on-site service made at noon on a Monday (where the PCP is 8:00 a.m. through 5:00 p.m., Mondays through Fridays) will have a guaranteed arrival time of 4:00 p.m. on the same day for customers with a four (4) hour response time and a guaranteed arrival time of 11:00 a.m. on the next day for customers with an eight (8) hour response time guarantee. A request for on-site service made at 9:00 a.m. on a Saturday will have a guaranteed arrival time of noon on the next Monday for customers with a four (4) hour response time and 4:00 p.m. on that Monday for customers with an eight (8) hour response time guarantee. If a request for on-site service is made outside the PCP (to include extended coverage hours, if selected by the Customer), Siemens will use its best efforts to have a CSE on-site as soon as possible.

If Siemens responds to a request for on-site service during the PCP but its work to repair or service the Equipment continues after the expiration of the PCP (to include any extended coverage hours, if applicable), then any work outside the PCP will be billed to the Customer, unless any optional Continuous Effort coverage that is available for the Equipment has been purchased as part of this Agreement. Continuous Effort coverage ensures that in room/system down situations, work will continue past the contracted PCP (including any extended coverage hours, if applicable, and/or core modality specific hours, as defined in the Glossary, if applicable) at no additional charge until the system is repaired or 1:00 a.m., whichever comes first, as long as the CSE has been on-site for one hour or more before the end of the contracted PCP (including any extended coverage hours and/or core modality specific hours, if applicable).

The remedy provided by Siemens for its failure to meet the on-site response time guarantee is as follows: for each one (1) hour or portion thereof that Siemens fails to meet the on-site response time guarantee, the Customer will receive one (1) free hour of overtime after the PCP for that service event. The foregoing states Siemens' entire obligation and liability, and the Customer's sole remedy, for Siemens' failure to meet the Response Time Guarantee.

24. Non-Assignment

Customer may not assign this Agreement unless it obtains the prior written consent of Siemens, which consent shall not be unreasonably withheld or delayed. Siemens may not assign this Agreement unless it obtains the prior written consent of the Customer, which consent shall not be unreasonably withheld or delayed, except that Siemens may assign without Customer approval to any subsidiary or affiliated company or any of its authorized dealers.

25. Reimbursement for Training Courses/Education Services Upon Early Termination; Cancellation Policy

If this Agreement includes any training courses or other educational offerings and this Agreement is terminated or Equipment is removed from coverage as provided hereunder prior to the expiration of the term, then Siemens may bill the Customer for any balance due and owing with respect to those training courses or other educational offerings that have been completed by the Customer, and Customer agrees to pay the same.

Customer shall notify the Siemens training and education coordinator, in advance, of the cancellation, in whole or in part, of any training or other educational offering, or any request to reschedule the same. The cancellation or rescheduling of any training courses and other educational offerings may be subject to the payment of a cancellation fee. A copy of Siemens' cancellation policy is available upon request or can be found at:
www.usa.siemens.com/clinicaleducation-cancellation-policy

26. Execution; Counterparts

If the Customer is a corporation or partnership, the person signing this Agreement on its behalf certifies that such person is an officer or partner thereof, that his or her action was duly authorized by appropriate corporate or partnership action, that such action does not conflict with the corporate charter or bylaws or the partnership agreement, as the case may be, or any contractual provision binding on such corporation or partnership, and that no consent of any stockholders to his or her action is required.

This Agreement may be executed in two (2) or more counterparts, each of which shall constitute an original document but all of which together shall constitute one and the same agreement.

27. Entire Agreement

This Agreement, including all exhibits and addenda attached hereto, constitutes the entire agreement between the parties relating to the subject matter hereof, and supersedes all prior and contemporaneous oral or written representations or communications between the parties. This Agreement may not be modified or amended, except in writing executed by the appropriate designated officers of the parties hereto. Any variation in the terms and conditions contained in this Agreement (including, but not limited to, the inclusion of Customer's own terms and conditions in any purchase order or other document issued by Customer in response to and/or referencing Siemens' quotation for service or this Agreement) shall not be deemed to be a part of this Agreement and shall not be binding upon Siemens unless set forth in writing and executed by the appropriate designated officer of Siemens. Subject to the limitations expressed herein, this Agreement will be binding upon and inure to the benefit of the parties hereto, their successors, legal representatives, and permitted assigns. Notwithstanding anything to the contrary contained herein, the provisions of Sections 9, 10, 12, 13, 14, 15, 16, 18, 21 and 25 shall survive the expiration or termination of this Agreement.

Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard, Malvern, PA 19355

SIEMENS REPRESENTATIVE
Brad Fox - (615) 585-2104

PRELIMINARY PROPOSAL

Customer Number: 0000006071

Date: 10/30/2017

ERLANGER HEALTH SYSTEM
975 E THIRD ST
CHATTANOOGA, TN 37403-2147

Budgetary quote for Cath lab

Quote Nr: **1-LZ960D Rev. 0**

Artis Q biplane

All items listed below are included for this system:

Qty	Part No.	Item Description
1	14434116	**Artis Q biplane Interv. Card.** The Artis Q product line is setting new standards in interventional imaging. The Artis Q biplane for interventional cardiology now features PURE(r). PURE adds smooth interaction to Siemens' smart technologies. It is designed to boost productivity and enhance outcomes for certain clinical applications while increasing image quality and reducing dose. The GIGALIX X-ray tube concentrates high pulse power on small, square-shaped focal spots (flat emitter technology for all focal spots). This provides unprecedented image quality for confidence in challenging situations. Imaging two projections simultaneously saves time and contrast. With the floor or ceiling-mounted stand full patient coverage is achievable. The patient table is fitted with a freely movable patient positioning tabletop. The two as20 flat detectors are optimized for cardiology and allow for steep angulations. Frame rates up to 30 f/s and functions for displaying and storing ECG curves are included. The complete CARE+CLEAR package offers optimal image quality at the lowest reasonable dose. Live and reference images are displayed on four 19" flat screens in the exam room. In the control room live images are displayed on two additional screens.
1	14434138	**FPD as40HDR (A) Card inst. of as20** Enlarging your field of view When ordering this flat detector, the following components of the basic configuration - as20 flat detector - Cardiac collimator

PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
		in plane A are replaced by - as40HDR flat detector - Angio collimator In addition, the components - GIGALIX 125/40/90 - G (2 foci) X-ray tube assembly with CLEARpulse in both planes has been replaced by - GIGALIX 125/30/40/90 - G (3 foci) X-ray tube assembly with CLEARpulse
1	14432949	**MULTISPACE.F** Manual stand rotation for additional work positions.
1	14432948	**Automap** Automatic stand positioning depending on the selected reference image and automatic reference image selection depending on the stand positioning.
1	14434153	**8P wireless footswitch ins. of cbl** For release of fluoroscopy, exposure and table brake, roadmap selection and mask reset as well as a configurable additional function. Note: This 8-pedal wireless footswitch replaces the 4-pedal or 8-pedal wired footswitch described in the basic configuration.
1	14432897	**Head-end table tilting** Motorized tilt and stepping of the patient table in longitudinal direction for electrophysiological or peripheral examinations, for example, as well as for stabilizing a patient. Includes a power-assisted tabletop control module. Notes: Table tilting reduces the maximum patient weight to 200 kg. As before however, it is possible to install up to 40 kg of additional accessories. Note: It is mandatory to provide UPS back up with this table option in order to comply with IEC 60601-2-43 CL. 201.15.101. Reason: In the event of power failure a neutral table position suitable for CPR must be reachable within 15 seconds. Please include a suitable UPS from Siemens as required or make sure any existing / planned UPS provision for your installation site will satisfy the requirement
1	14434160	**Fluoro Loop** Storage and display of dynamic fluoroscopic sequences (Fluoro Loop), for both planes. This saves an additional acquisition and reduces dose. The maximum storable fluoroscopic time depends on the selected pulse rate, e.g. 34 s at 30 p/s, 68 s at 15 p/s.
1	14434169	**CLEARstent Live** CLEARstent Live is a real-time stent enhancement tool and provides a stabilized view of the moving stent which is displayed on the Assist/Reference Monitor. CLEARstent Live allows real-time verification of stent positioning while moving the device. This enables the physician to precisely position the stent in relation to the anatomy of the heart and stents that already have been implanted. Contains both CLEARstent Live license and CLEARstent license. The CLEARstent imaging function allows an improved display of fine stent structures, i.e. the grid of inflated stents. CLEARstent is a post-processed stent enhancement and may be used also on previously acquired images.

Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard, Malvern, PA 19355

SIEMENS REPRESENTATIVE
Brad Fox - (615) 585-2104

PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
		Using the CLEARstent function special reference images from any scene or fluoroscopy scene acquired natively will be generated. Composite images are created by averaging several frames of a scene and by considering the alignment of balloon markers. If an ECG signal is available, the heart phase will also be taken into account.
1	14432918	**Low dose subtraction mode** Digital low-dose subtraction angiography with frame rates of 7.5, 10, 15, and 30 f/s (monoplane and biplane), acquisition, display, and storage in 1k² matrix. Preferably used for applications requiring low dose at higher frame rates, e.g. in pediatrics.
1	14432839	**syngo 2D Processing Engine** syngo X Workplace high-end workstation for 2D viewing and post-processing, with syngo-based user software and network modules.
1	14432853	**syngo Scene Compare w/biplane** Dual monitor support with biplane review functionality for the postprocessing of DSA scans. Both the evaluation of bi-planar scenes in synchronized mode and the comparison of scenes to single images are supported. The dynamic comparison of two scenes is also possible.
1	14432974	**syngo QCA coronary vessel analysis** Scientific analysis of the coronary vessels with determination of degree of stenosis, distance measurement and calibration.
1	14432978	**syngo LVA Quantification** Analysis of the left ventricle with distance measurement and calibration.
1	14432852	**syngo LVA Biplane Analysis** Biplane analysis of the left ventricle with distance measurement and calibration.
2	14432953	**Lower body radiation protection** This radiation shield protects the user from scattered radiation when standing at the table side. It can be attached to the accessory rails either on the right or on the left side of the patient positioning table. It provides the user an additional accessory rail. It includes a basic unit (71.5 cm x 75 cm / 28.2" x 29.5" (l x w); 7.7 kg / 16.98 lb), one lower body radiation protection pivot swivel element (77 cm x 48 cm / 30.3" x 18.9" (l x w); 3.8 kg / 8.4 lb) and three clip-on units (57 cm / 22.4" x 33 cm / 12.99" (l x h), 2.2 kg / 4.85 lb; 27 cm / 10.6" x 33cm / 12.99", 0.9 kg / 1.98 lb and 27 cm / 10.6" x 25cm / 9.8", 1 kg / 2.2 lb) with a lead of 0.5 mm / 0.02" Pb. The maximum weight of the accessory rails is 40 kg (88.2 lb). Intended only for use with Artis / ARTIS tables.
1	14434157	**Moveable upper body rad. protection** This radiation shield protects the user from scattered radiation. For room heights up to 290 cm / 114.2". It includes a ceiling rail (4 m / 157.5"), a ceiling mounted and movable stand (80 cm or 57 cm / 31.5" or 22,4"), a support arm (75 cm x 90 cm / 29.5" x 35.4") and an acrylic glass. The shield is made of acrylic glass with lead equivalent of 0.5 mm (w x h: 61 cm x 76 cm / 24" x 29.9"), which can pivot and rotate around a fixed point with a range of 360 degrees. The operation range is limited when used with Artis floor/biplane MN. Max. weight: 18 kg / 39.68 lb.
1	14440512	**LED Exam Light** Ceiling-mounted, flexible positionable examination light with focusable light system. It is fully integrated into the

PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
		ceiling-installed radiation protection mounting unit. - Luminance: 60,000 Lux for 100 cm / 39.4" distance - Working distance: 70 to 140 cm / 27.6" to 55.1" - Color rendering index Ra at 4500 Kelvin: 95 - Color temperature: 4,300 Kelvin - Focusable light field: 14 to 25 cm / 5.5" to 9.8" - Diameter of light head: 33 cm / 13" - Number of LEDs: 19 - Total input power: 20 VA
1	14443011	**Large Display diagn. Protection** The high quality laminated glass protective screen protects the panel of the monitor against mechanical damage and fluid ingress on the front. It is suited for clinical image evaluation. Features: The laminated glass enforces high mechanical strenght and resistivity against mechanical impact, the special coating reduces reflections for a continuous image quality, excellent spectral transmisison of at least 98%, can be added to existing Artis Large Display installations. Weight: approx. 12kg (55") up to 16kg (60") Note: Observe the maximum permissible load of the display suspension, a combination with other options mounted to the display suspension might be restricted.
1	14432950	**DICOM RIS-Modality Worklist** Import of patient/examination data from an external RIS/HIS patient management system with DICOM MWL (Modality Worklist).
1	14434172	**Large Display** Preparation for the large color flat screen display on a ceiling-mounted, longitudinally mobile, swiveling, rotating, and height-adjustable display holder in the examination room. Note: If a Large Display is selected, the Artis basic configuration includes a connection kit for the Large Display instead of the displays for the examination room. The type of large display can be chosen with a separate position.
1	14434176	**Large Display video controller 18** Large Display Video Controller 18 is the middle of three different video controller sizes. A maximum of 18 video signals can be connected and displayed simultaneously on the Large Display. The Large Display video controller 18 receives various internal and external video signals for presentation to scale on the Large Display. Up to 18 external and internal video sources can be connected (max. 14 DVI-D and 4 analog (VGA) channels).
1	14443012	**LD High Contrast panel size 55"** Large color flat screen display (including cables) for the examination room, with a panel diagonal of 55". This large display version provides an excelling clinical image quality due to it's new IPS panel technology.
1	14455598	**Artis Freestyle Access cable kit** Preparation for mounting, connection and display of the wireless "ACUSON Freestyle Elite with Artis Access" ultrasound system on the Large Display of the Artis system. Artis Freestyle Access optimizes the workflow when using ultrasound guidance in the interventional suite. It provides a zero-cables, zero footprint, fully connected solution for ultrasound guidance in the interventional suite.
1	AXA_INITIAL_32	**Initial onsite training 32 hrs** Up to (32) hours of on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Training will cover agenda items on the ASRT approved checklist. Uptime Clinical Education phone support is provided during the warranty period for specified

PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
		posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	AXA_FOLLOW UP_24	**Follow-up training 24 hrs** Up to (24) hours of follow-up on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	AXA_FOLLOW UP_12	**Follow-up training 12 hrs** Up to (12) hours of follow-up on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Uptime Clinical Education phone support is provided during the warranty period for specified posted hours. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	AXA_PURE_E SSCL	**AX Artis PURE Essential Class** Tuition for (1) imaging professional to attend Siemens class at Siemens Training Center. The Artis PURE Essentials Course is a 3.5-day classroom course beginning on Tuesday at 8:30 a.m. and ending on Friday at 12:00 p.m. It is designed to provide the participant with an in-depth knowledge of the essential functions of the Artis system as well as the skills needed to perform these functions. Through the use of demonstrations, lectures, and hands-on lab experience using an Artis system, participants will learn Artis system principles and workflows of patient examinations. Additionally, participants have the opportunity to meet other users and share their experiences and solutions to various challenges of the IR, cath lab, and the Hybrid OR environment. This class includes lunch, economy airfare, and lodging for (1) imaging professional. All arrangements must be arranged through Siemens designated travel agency. This educational offering must be completed by the later of (12) months from purchase or install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	AXA_ECLASS	**e.class-Virtual Instructor Led Training** AXA_ECLASS Tuition for up to (4) imaging professionals to participate in a Siemens instructor led virtual class. The virtual setting allows the participant to benefit from classroom training without the need to travel to a Siemens training center. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
3	AXA_ADD_32	**Additional onsite training 32 hours** Up to (32) hours of on-site clinical education training, scheduled consecutively (Monday - Friday) during standard business hours for a maximum of (4) imaging professionals. Training will cover agenda items on the ASRT approved checklist if applicable. This educational offering must be completed (12) months from install end date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
1	BART700PEDL	**Mark 7 Arterion, Pedestal System** The Arterion Mark 7 Pedestal contrast medium injector can be positioned anywhere at the patient positioning table on a mobile unit, for direct operation of all functions in the examination room. The injector system includes: A mobile pedestal stand with electronics unit, a contrast medium heater and a connection cable to the manual release. A support arm with injector head and a control lever for moving the injector head. A user control console with large touch screen and corresponding additional monitoring display on the injector head. Functions Pressure limitation: for 150 ml syringes 689 to 8273 kPa, corresponds to 100 to 1200 psi. . Flow rates for 150 ml syringes:

PRELIMINARY PROPOSAL

Qty	Part No.	Item Description
		0.1 to 45 ml/s in increments of 0.1 ml/s 0.1 to 59.9 ml/min in increments of 0.1 ml/min rise/fall: 0 to 9.9 s in increments of 0.1 seconds Release delay for injection or radiation: 0 to 99.9 s in increments of 0.1 s. Adjustable volume for 150 ml syringes: 1 ml to the max. syringe capacity in increments of 1 ml. Fill rate: Variable syringe filling speed 1-20ml/s. Injection protocols: Up to 40 injection protocols possible. Parameters currently displayed on the touch screen display and on the head display: Injection speed Injection volume Remaining volume Injection duration Applied pressure Contrast medium heating: Nominal 35°C (95°F)+-5°C (9°F) Injection data memory Up to 50 injection data items stored Included in the scope of delivery Injector standard configuration 150 ml SIEMENS interface cable Operator Manual Service manual (English). Power supply 200 V to 250 V; 50/60 Hz.
1	BINSART700P	**Arterion Pedestal Install**
1	E93PM150UAX	**Eaton 93PM-150 kW UPS** Complete system backup without interruption. One UPS per lab. Includes the following: Eaton 93PM UPS Electronics Cabinet w/integrated maintenance bypass sidecar Eaton 93PM Single Battery Cabinet System (Full load back-up time @ 150kW of 7.1 minutes.) Eaton 93PM Remote Monitoring Panel Network Card Eaton 24x7 start-up One year (24x7) warranty through Eaton Corp.

Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard, Malvern, PA 19355

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Brad Fox - (615) 585-2104

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Qty	Part No.	Item Description
		Not approved for sites that require OSHPD.
		Shipment is to customer's dock. Customer is responsible for logistics from the dock to inside location.
2	NT60010635	**Blue anti-fatigue floor mat for hospital**
1	AXA_RIG_QBP_STD	**Standard Rigging Q Q.Zen BP**
1	AXA_BUDG_ADDL_RIG	**Budgetary Add'l/Out of Scope Rigging $25,000**

System Total: $1,825,573

Siemens Medical Solutions USA, Inc.
40 Liberty Boulevard, Malvern, PA 19355

SIEMENS REPRESENTATIVE
Brad Fox - (615) 585-2104

PRELIMINARY PROPOSAL

FINANCING: The equipment listed above may be financed through Siemens. Ask us about our full range of financial products that can be tailored to meet your business and cash flow requirements. For further information, please contact your local Sales Representative.

Siemens Healthcare is pleased to submit this Preliminary Pricing Proposal. A Preliminary Pricing Proposal is provided for planning purposes only; it is not contractually binding. To receive a contractually binding proposal for the Products listed above, inclusive of Terms, Conditions, and Warranty coverage, please contact your Siemens Healthcare Sales Representative.

Siemens Healthcare

Brad Fox
(615) 585-2104
brad.fox@siemens-healthineers.com

SIEMENS Healthineers

THIS SERVICE SCHEDULE REPRESENTS A PRELIMINARY PROPOSAL AND DOES NOT CONSTITUTE AN OFFER OR A BINDING AGREEMENT. A BINDING AGREEMENT THAT INCLUDES THE TERMS SET FORTH HEREIN SHALL ONLY BECOME EFFECTIVE UPON EXECUTION BY THE PARTIES OF A FINAL AND COMPLETE SERVICE SCHEDULE.

Service Schedule No. 1-LZLFMO to Master Service Agreement between Siemens Medical Solutions USA, Inc. and ERLANGER HEALTH SYSTEM ("Customer")

Customer
ERLANGER HEALTH SYSTEM
975 E THIRD ST
CHATTANOOGA, TN 37403-2147

Bill To
ERLANGER HEALTH SYSTEM
ATTN ACCOUNTS PAYABLE
975 EAST THIRD STREET
CHATTANOOGA, TN 37403

Payer
ERLANGER HEALTH SYSTEM
ATTN ACCOUNTS PAYABLE
975 E THIRD ST
CHATTANOOGA, TN 37403

This Service Schedule is subject to all of the terms and conditions set forth in that certain Master Service Agreement dated (the "Agreement") between Siemens Medical Solutions USA, Inc. ("Siemens") and ERLANGER HEALTH SYSTEM ("Customer"). If there are any conflicts between the terms of this Service Schedule and the terms of the Agreement, the terms of this Service Schedule shall control. Capitalized terms used herein and not otherwise defined herein, unless the context otherwise requires, shall have the same meanings set forth in the Agreement.

1. The Equipment listed below is included in this Service Schedule. A detail of service coverage level is listed on the attached Exhibit A.

Item #	Description (Equipment)	Functional Location	Service Agreement	Contract Duration	Partial Year Price	Annual Price
1	Artis Q Biplane		Select contract	Warranty + 7 Years	$0	$136,970
2	syngo X Workplace		Select contract	Warranty + 7 Years	$0	$7,328
3	Mark 7 Arterion Injector		OEM contract	Warranty + 7 Years	$0	$5,250
4	Powerware 93PM 150 kW UPS		OEM contract	Warranty + 7 Years	$0	$9,275

The following are alternate/optional systems for this contract:

Opt/ Alt	Item #	Description (Equipment)	Functional Location	Service Agreement	Contract Duration	Partial Year Price	Annual Price	Initialed
Alt	1	Powerware 93PM 40kW UPS		OEM contract	Warranty + 7 Years	$0	$5,044	

2. This Service Schedule is subject to all the terms and conditions of the Agreement. Additional terms and conditions with respect to any other coverage purchased by the Customer, as indicated under "Contract Deliverable" and/or "Options/Alternatives" on Exhibit A, are attached in the hereto as Exhibit B.

3. This Service Schedule may be executed in two (2) or more counterparts, each of which shall constitute an original document but all of which together shall constitute one and the same agreement.

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Exhibit A to Service Schedule No. 1-LZLFMO

Customer Name: ERLANGER HEALTH SYSTEM

Item #1:

Equipment:	**Artis Q Biplane**		
Equipment Location:	ERLANGER HEALTH SYSTEM		
Address:	975 E THIRD ST, CHATTANOOGA, TN 37403-2147		
Functional Location:	**Service Quote Nr:** 1-LZOFOT Rev 0	**Equipment Quote Nr:** 1-LZ960D	**Payment Frequency:** Monthly
Standard Warranty: Extended Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: Select contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 7 Year Duration	**Annual Price:** $136,970

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	08:00am - 10:00pm M-F	08:00am - 10:00pm M-F
Annual Exam Allowance	Unlimited	Unlimited
Uptime Guarantee	98%	98%
Phone Response	30 min	30 min
On-Site Response	4 hours	4 hours
Parts Order Requirement	noon	noon
Parts Delivery	Same Day	Same Day
Application Hotline Phone Support	✓	✓
Continuous Effort	✓	✓
General Spare Parts Coverage	✓	✓
Gigalix Tube and Twin HDR FD Bundle	✓	✓
Guardian Pro AX	✓	✓
Labor	✓	✓
Large Display Monitor	Qty 1	Qty 1
LifeNet Access	✓	✓
No Consumable Coverage	✓	✓
PM's performed outside PCP weekdays	✓	✓
Planned Maintenance	✓	✓
Quality Assurance	✓	✓
Real Time Monitoring M-F 7am-10pm ET	✓	✓
Safety Checks	✓	✓
Siemens Remote Services	✓	✓
Siemens Remote Services	✓	✓
Siemens Virus Protection SELECT	✓	✓
Technical Phone Support	✓	✓
Travel	✓	✓
UM Advanced Report AX	✓	✓
Updates	✓	✓
Accredited Self Study Program	N/A	Qty 1
Enhanced Virtual Learning Sub	N/A	Qty 1
syngo Evolve AXA	N/A	✓

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

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No further Options or Alternatives are included in the above listed equipment.

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Item #2:

Equipment:	**syngo X Workplace**		
Equipment Location:	ERLANGER HEALTH SYSTEM		
Address:	975 E THIRD ST, CHATTANOOGA, TN 37403-2147		
Functional Location:	**Service Quote Nr:** 1-LZOFOT Rev 0	**Equipment Quote Nr:** 1-LZ960D	**Payment Frequency:** Monthly
Standard Warranty: Extended Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: Select contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 7 Year Duration	**Annual Price:** $7,328

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	08:00am - 10:00pm M-F	08:00am - 10:00pm M-F
Uptime Guarantee	98%	98%
Phone Response	30 min	30 min
On-Site Response	4 hours	4 hours
Parts Order Requirement	noon	noon
Parts Delivery	Same Day	Same Day
Safety Checks	✓	✓
Planned Maintenance	✓	✓
Quality Assurance	✓	✓
Updates	✓	✓
Technical Phone Support	✓	✓
Labor	✓	✓
Travel	✓	✓
LifeNet Access	✓	✓
Application Hotline Phone Support	✓	✓
Continuous Effort	✓	✓
General Spare Parts Coverage	✓	✓
PM's performed outside PCP weekdays	✓	✓
Siemens Virus Protection SELECT	✓	✓

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

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Item #3:

Equipment:	**Mark 7 Arterion Injector**		
Equipment Location:	ERLANGER HEALTH SYSTEM		
Address:	975 E THIRD ST, CHATTANOOGA, TN 37403-2147		
Functional Location:	**Service Quote Nr:** 1-LZOFOT Rev 0	**Equipment Quote Nr:** 1-LZ960D	**Payment Frequency:** Monthly
Standard Warranty: OEM Basic Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: OEM contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 7 Year Duration	**Annual Price:** $5,250

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	08:00am - 05:00pm M-F	08:00am - 05:00pm M-F
On-Site Response	1 Business Day	1 Business Day
Planned Maintenance	✓	✓
Labor	✓	✓
General Spare Parts Coverage	✓	✓
Travel	✓	✓
Hardware Updates/Upgrades	✓	✓

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

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Item #4:

Equipment:	**Powerware 93PM 150 kW UPS**		
Equipment Location:	ERLANGER HEALTH SYSTEM		
Address:	975 E THIRD ST, CHATTANOOGA, TN 37403-2147		
Functional Location:	**Service Quote Nr:** 1-LZOFOT Rev 0	**Equipment Quote Nr:** 1-LZ960D	**Payment Frequency:** Monthly
Standard Warranty: OEM Basic Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: OEM contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 7 Year Duration	**Annual Price:** $9,275

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	08:00am - 05:00pm M-F	08:00am - 05:00pm M-F
On-Site Response	1 Business Day	1 Business Day
Parts Delivery	Next Business Day	Next Business Day
Technical Phone Support (24X7)	✓	✓
Labor	✓	✓
General Spare Parts Coverage	✓	✓
Travel	✓	✓
Site Visits During PCP	✓	✓
Preventative Maintenance (UPS and Battery Only)	✓	✓

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

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Optional/Alternative System #1:

Equipment:	**Powerware 93PM 40kW UPS**		
Equipment Location:	ERLANGER HEALTH SYSTEM		
Address:	975 E THIRD ST, CHATTANOOGA, TN 37403-2147		
Functional Location:	**Service Quote Nr:** 1-LZOFOT Rev 0	**Equipment Quote Nr:** 1-LZ960D	**Payment Frequency:** Monthly
Standard Warranty: OEM Basic Warranty	**Warranty Start:** Upon Warranty Commencement	**Warranty End:** 1 Year Duration	**Warranty Price:** $0
Service Agreement: OEM contract	**Contract Start:** Upon Warranty Expiration	**Contract End:** 7 Year Duration	**Annual Price:** $5,044

(See Glossary pages for detailed description of items listed below.)

Coverage applies during the Warranty or Contract Period as indicated:	Warranty Period	Contract Period
Principal Coverage Period	08:00am - 05:00pm M-F	08:00am - 05:00pm M-F
On-Site Response	1 Business Day	1 Business Day
Parts Delivery	Next Business Day	Next Business Day
Technical Phone Support (24X7)	✓	✓
Labor	✓	✓
General Spare Parts Coverage	✓	✓
Travel	✓	✓
Site Visits During PCP	✓	✓
Preventative Maintenance (UPS and Battery Only)	✓	✓

This pricing is only valid for new service contracts that are signed with the equipment purchase or prior to warranty commencement.

No further Options or Alternatives are included in the above listed equipment.

SIEMENS Healthineers

Glossary

Deliverables	Description
Accredited Self Study Program	This accredited self-study program provides the latest trends in imaging. These hot topic review articles will be mailed directly to your institution and will provide up to 24 Category A Continuing Education Credits fully recognized by ARRT and NMTCB. A comprehensive study guide accompanies each article to help ensure focus on technologist-relevant information.
Application Hotline Phone Support	Siemens Customer Care Center Clinical Applications Phone Support is provided with this contract during modality specified hours, call 1-800-888-7436 with your questions and to receive direct access to a Clinical Education Specialist
Continuous Effort	In room-down/system-down situations, on-site work will continue past the contract PCP, 7 days a week, at no additional charge until the system is repaired, by not later than 1:00 a.m. local time. Continuous Effort applies only when a CSE has been on-site for at least one (1) hour prior to the end of the PCP. In such a case, Continuous Effort shall begin at the end of the PCP and end at 1 a.m. the following calendar day. Continuous Effort shall resume no sooner than seven (7) hours later, and may resume at a later time with the consent of the Customer.
Enhanced Virtual Learning Sub	This (12) month multi-modality subscription will provide access for imaging professionals at the customer site to e.learnings, tuition for one-hour virtual monthly webinars, step-by-step videos, and up to (24 CEUs). Imaging professionals must be logged into PEPconnect (Siemens online learning platform) to be eligible to receive CEUs. PEPconnect provides access to all online and virtual training documentation with a wide variety of product-specific, clinical and job-relevant courses, as well as performance support activities for customers with Siemens medical equipment. This educational offering must be completed (12) months from purchase date. If training is not completed within the applicable time period, Siemens obligation to provide the training will expire without refund.
General Spare Parts Coverage	Replacement of standard spare parts. Excludes high-vacuum components, consumables, Shock wave components, Transducers, TEE's and Specialty Probes, Flat Panel Detectors, MMLC, and Waveguides. Excludes non-Siemens parts unless specifically identified in Exhibit A.
Gigalix Tube and Twin HDR FD Bundle	X-ray tube and Detector are covered for the full value of replacement for Wear and Failure. Coverage of the detector and tube is bundled and is provided at a discounted rate.
Guardian Pro AX	The Siemens Guardian Program™ offers you proactive online monitoring of your system's performance on an ongoing real-time basis. By continuously monitoring your system for possible deviations from current norms, the Guardian Program provides for a high level of system availability, making it possible to detect and resolve system errors before malfunctions occur. In the event of a system error message, one of our certified support engineers will immediately evaluate and initiate appropriate actions.. An expert opinion on the exact status of your system is also offered within the first 15 minutes.
Hardware Updates/Upgrades	Covers hardware updates and technical support.
Labor	Unlimited coverage of on-site labor during the Principal Coverage Period indicated. Preferred labor rates for billable service outside of Principal Coverage Period (at current prevailing tiered rates).
Large Display Monitor	Covers parts and labor to repair Large Monitor Display and all directly associated components from wear/failure (excludes damage), if required.
LifeNet Access	The LifeNet portal provides access to customer service information related to diagnostic imaging equipment. Access includes service and PM management tools, equipment performance reports, service documentation, asset management and service contract management tools and much more.
No Consumable Coverage	Upon selection to not have consumable coverage, customer agrees to supply at his/her own expense consumables, such as but not limited to, batteries, leads, padding, storage media, cassettes, etc. Full list of consumables covered can be found on Lifenet customer portal: www.usa.siemens.com/lifenet.
On-Site Response	Siemens guarantees on-site CSE arrival within a specific time period (see Exhibit A) after a call for service has been placed with the Siemens Customer Care Center. This on-site response applies in system/room down situations only. (See Response Time Guarantee in General Terms and Conditions for additional information)
Parts Delivery	Spare parts arrival for on-site repair of room-down/system-down is typically the Same Day following the time the parts order is submitted.
Parts Order Requirement	Parts order must be placed with Siemens by noon (Customer's local time) in order to receive Parts Delivery commitment as specified.
Phone Response	The response time indicated on Exhibit A provides preferred call-handling of a service event. This call-back response is the telephone response to the customer by the Siemens Customer Care Center personnel or the CSE to provide the status of the service call.
Planned Maintenance	Preventive services carried out in accordance with the equipment's specific maintenance plan. This includes: tracking and scheduling of required maintenance tasks; exchange of wear and tear parts according to maintenance plan; care measures; adjustments to factory specifications; verification of specified performance and functionality; documentation and detailed protocol of system condition.

SIEMENS Healthineers

Deliverables	Description
PM's performed outside PCP weekdays	Siemens will coordinate planned maintenance in accordance with the manufacturer's recommendations outside the PCP hours indicated in Exhibit A, on Weekdays only, between the hours of 6AM to 2AM Local Time.
Preventative Maintenance (UPS and Battery Only)	Siemens will coordinate planned maintenance in accordance with the manufacturer's recommendations within the PCP hours as indicated above.
Principal Coverage Period	Hours defined in Exhibit A during which agreed-upon services are provided.
Quality Assurance	Regular quality assurance tasks and image quality inspections to achieve consistent, high-quality images, are performed to keep the system within the quality specifications as issued by the factory.
Real Time Monitoring M-F 7am-10pm ET	Real time event monitoring of a system by a Siemens engineer. Customers will be notified of critical events and action for resolution within 15 minutes of event occurring. Events of non-critical nature will be stored for trending purposes enabling predictive analysis for potential future failures. Siemens will respond to trends and schedule service accordingly.
Safety Checks	Safety Checks are performed to insure compliance with all local and federal guidelines and regulations. This service consists of Tracking and scheduling of required tests Mechanical Safety Checks (e.g. mechanical movements etc.) Electrical Safety Checks (e.g. leakage currents, insulation etc.) Reporting of findings and results
Siemens Remote Services	Siemens Remote Services – the efficient and comprehensive infrastructure for medical equipment-related remote services – combines high-tech medical engineering with state-of-the-art information technology. Services, which formerly required on-site visits, are now available via data transfer. SRS enables both Core Services (which are included as part of our standard service agreements), as well as optional services (called Enhanced Productivity Services - EPS) which customers can purchase as an enhancement to their agreement. **Core Services include**: remote diagnosis and repair via dial-in modem, event monitoring (performance screening of customer system where CSE evaluates status messages at periodic intervals and initiates appropriate service action within the scope of customers service agreement), software updates, LifeNet web site access. **Enhanced Productivity Services (EPS) include**: Guardian Program, Virus Protection Program, Utilization Management, Application training and on-site support.
Siemens Virus Protection SELECT	Siemens Virus Protection SELECT consists of the following service features: Virus scanner installation: Expert installation of the certified and tested virus scanner Trend Micro OfficeScan Ongoing remote virus scanner updates: Constant automatic remote updates of the latest validated virus pattern and scan engine Security Hotline: The local Uptime Service Center is our customer's contact for up-to-date virus information and rapid response support. Siemens Virus Protection is available for all *syngo*-based systems which are - connected to our SRS infrastructure by a VPN broadband connection - covered by one of our service agreements - equipped with the required software version, which includes the Virus Scanner as well as the necessary CA-based Managed Node Package (MNP). Siemens will not be liable for system failures and loss of patient data, caused by a virus.
Site Visits During PCP	Unlimited site visits during the Principal Coverage Period indicated.
syngo Evolve AXA	At least 1 software upgrade. 1 hardware upgrade to the main system (IVS). syngo MultiModality Workplace and refurbished systems excluded in all cases.
Technical Phone Support	Direct access to specialists at the Siemens Customer Care Center for fast diagnosis and technical support. Technical Phone Support is available to Siemens customers over the telephone, 24 hours a day, 7 days a week.
Technical Phone Support (24X7)	Direct access to specialists at the Siemens Customer Care Center for fast diagnosis and technical support 24 hours a day, 7 days a week.
Travel	Includes travel time for Customer Service Engineer to and from Customer's site. Subject to change to reflect currently prevailing rates, if occurring outside of the Principal Coverage Period indicated.

SIEMENS Healthineers

Deliverables	Description
UM Advanced Report AX	Siemens Utilization Management Advanced provides system-specific usage data, which is collected from the system itself. This detailed data allows Siemens' customers the ability to leverage their system's full potential. Advanced Reporting includes reports on system usage and performance as well as detailed reports on body region studies and provides anonymous benchmark information about comparable systems at other facilities operating in similar environments. These reports are easily accessible through Siemens' customer portal LifeNet.
Unlimited Exams	Coverage includes an unlimited number of Patient Exams per year.
Updates	Modifications or reliability enhancements to equipment includes two types: Mandatory (safety and performance-related update instructions) and Non-mandatory (reliability-related service instructions). Labor is included during the hours of PCP. Does not include enhancements to the operating systems or additional functionality.
Uptime Guarantee	Siemens guarantees that the Equipment will function at the minimum Uptime Performance level as specified on Exhibit A. System availability is calculated over a 12-month period, calculated over the Principal Coverage Period. Siemens Remote Services (SRS) connection via VPN broadband is required. (See Uptime Guarantee of General Terms and Conditions for further details.)

Description	Section / Item
Funding - CFO Letter	B-II-2

erlanger

November 12, 2017

Ms. Melanie M. Hill
Executive Director
State of Tennessee
Health Services & Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application, Bradley County Emergency Department/Level IV Trauma Center

Dear Ms. Hill:

This letter serves to confirm our intent to utilize funds from operations and cash reserves to develop and implement the provider based, satellite Emergency Department/Level IV Trauma Center in Bradley County having a capital coast of $10,783,486, subject to CON approval as well as approval of the Chattanooga-Hamilton County Hospital Authority. A copy of our audited financial statements are enclosed with the CON application.

Please let us know if you have questions or if additional information is needed. Thank you.

Sincerely,

J. Britton Tabor, CPA, FACHE
Executive Vice President & CFO

Description	Section / Item
Erlanger Interim Financial Statements	B-II-3
Erlanger Audited Financial Statements	B-II-3

Quarterly Disclosure

First Quarter Fiscal 2017/2018

This financial report is confidential and proprietary information. This document is not a public record until finalized and released by the chief financial officer. The embargo date for the information contained herein is October 16, 2017 at 5P.M. EST. No part of the information contained herein may be released or discussed publicly until this date.

ERLANGER HEALTH SYSTEM
Unaudited Consolidated Balance Sheets as of: September 30, 2017

ASSETS	2018	2017
UNRESTRICTED FUND		
CURRENT:		
Cash and temporary investments	$ 60,952,066	$ 87,128,089
Funds held by trustee - current portion	2,526	-
Patient accounts receivable	652,205,745	490,304,223
Less allowances for patient A/R	(497,084,050)	(365,095,969)
Net patient accounts receivable	155,121,694	125,208,253
Other receivables	14,721,319	5,448,783
Due from third party payors	6,195,030	5,921,447
Inventories	16,884,056	17,354,858
Prepaid expenses	12,361,045	6,692,235
Total current assets	266,237,736	247,753,666
PROPERTY, PLANT, AND EQUIPMENT		
Net property, plant and equipment	247,117,121	198,154,405
LONG-TERM INVESTMENTS	398,678	1,199,920
OTHER ASSETS:		
Assets whose use is limited	127,531,229	148,520,873
Deferred debt issue cost	508,984	678,645
Other assets	6,783,164	1,169,938
Total other assets	134,823,377	150,369,456
DEFERRED OUTFLOWS OF RESOURCES		
Deferred pension adjustments	12,029,558	13,312,022
Deferred amounts from debt refunding	1,437,134	529,952
TOTAL	**$ 662,043,604**	**$ 611,319,420**

LIABILITIES	2018	2017
UNRESTRICTED FUND		
CURRENT:		
Current maturities of long term debt	$ 4,689,621	$ 4,640,630
Accounts payable/unearned income	69,177,666	41,621,506
Accrued salaries & related liabilities	35,130,628	19,454,095
Construction fund payable	323,505	1,516,306
Accrued Interest payable	4,517,074	4,468,377
Total current liabilities	113,838,495	71,700,915
POST RETIREMENT BENEFITS (GASB 67/68 & FAS 112)	70,210,900	68,138,360
RESERVE FOR OTHER LIABILITIES	26,885,549	24,323,934
DEFERRED INFLOWS OF RESOURCES		
Deferred pension adjustments	-	511,392
Deferred gain from sale-leaseback	2,718,298	3,006,213
LONG - TERM DEBT	202,999,356	206,883,343
FUND BALANCE:		
Unrestricted	186,856,136	209,562,062
Invested in capital assets, net of related debt	52,314,693	21,527,185
Restricted	6,220,178	5,666,016
	245,391,007	236,755,262
TOTAL	**$ 662,043,604**	**$ 611,319,420**

Erlanger Health System

Unaudited Consolidated Statement of Operations

For the quarter ended September 30, 2017 and 2016

	Current Quarter		
	Actual	Budget	Prior Year
Net patient service revenue	$ 225,681,183	$ 232,988,258	$ 203,105,767
Other revenue(expense)	4,425,075	5,141,398	9,830,174
Net operating revenue	230,106,258	238,129,656	212,935,942
Expenses			
Salaries and employee benefits	122,518,507	135,526,363	108,105,919
Supplies	34,997,527	34,379,685	29,824,438
Purchased services	47,625,371	46,974,369	42,602,850
Utilities	2,950,186	2,680,595	2,804,017
Drugs	15,243,789	13,557,542	16,844,012
Depreciation	7,930,225	7,960,075	9,031,413
Insurance & taxes	1,108,086	1,214,667	1,189,921
Total operating expense	232,373,691	242,293,295	210,402,570
Excess rev. over/(under) exp. from operations	(2,267,432)	(4,163,639)	2,533,372
NONOPERATING INCOME:			
Gain (Losses) on disposal of assets	(43,360)	(65,651)	(3,580)
Interest Income/Gains (Losses) on Investments	411,761	288,999	(204,455)
Interest expense	(2,206,361)	(2,379,278)	(1,593,762)
Provisions for income tax	161,268	280,390	(121,723)
Excess rev. over/(under) expenses	$ (3,944,125)	$ (6,039,179)	$ 609,852
Operating Margin	5,666,946	3,859,499	11,668,054
Operating Margin	-0.99%	-1.75%	1.19%
Total Margin	-1.71%	-2.54%	0.29%

PYA
Certified Public Accountants

Audited Combined Financial Statements

Chattanooga-Hamilton County Hospital Authority (d/b/a Erlanger Health System and Discretely Presented Component Units)

Year Ended June 30, 2017

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Audited Combined Financial Statements

Year Ended June 30, 2017

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Audited Combined Financial Statements

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PYA
Certified Public Accountants

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INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
Chattanooga-Hamilton County Hospital Authority
(d/b/a Erlanger Health System):

Report on the Combined Financial Statements

We have audited the accompanying combined financial statements of the business-type activities of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) and its discretely presented component units (collectively, Erlanger), as of and for the year ended June 30, 2017, and the related notes to the combined financial statements, which collectively comprise the Primary Health System's basic combined financial statements as listed in the table of contents.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these combined financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to Erlanger's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Erlanger's internal control. Accordingly, we express no such opinion. An audit also includes

evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component units of the Primary Health System as of June 30, 2017, and the respective changes in financial position and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information: Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis (shown on pages 3 through 10), the Schedule of Changes in Net Pension Liability and Related Ratios (shown on page 48) and the Schedule of Actuarial Contributions (shown on page 49) be presented to supplement the basic combined financial statements. Such information, although not a part of the basic combined financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic combined financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic combined financial statements, and other knowledge we obtained during our audit of the basic combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
September 20, 2017

Management's Discussion and Analysis

MANAGEMENT'S DISCUSSION AND ANALYSIS

The discussion and analysis of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System's financial performance provides an overview of financial activities for the fiscal year ended June 30, 2017.

Erlanger Health System (the Primary Health System) is the largest healthcare provider in Southeast Tennessee and the seventh largest public hospital nationwide. The Primary Health System maintains a number of very specialized clinical services such as Level I trauma, Level IV neonatal, kidney transplantation, a Regional Cancer Unit, a full-service children's hospital, and open-heart surgery, all of which are primarily serviced by six "Life Force" helicopters and supported by subspecialty physicians (residents, faculty and private attending physicians) located on its campuses.

OVERVIEW OF THE COMBINED FINANCIAL STATEMENTS

The combined financial statements consist of two parts: Management's Discussion and Analysis and the combined financial statements. The combined financial statements also include notes that explain in more detail some of the information in the combined financial statements.

The combined financial statements of the Primary Health System offer short-term and long-term financial information about its activities. The combined statements of net position include all of the Primary Health System's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to the Primary Health System's creditors (liabilities). The assets and liabilities are presented in a classified format, which distinguishes between current and long-term assets and liabilities. It also provides the basis for computing rate of return, evaluating the capital structure of the Primary Health System and assessing the liquidity and financial flexibility of the Primary Health System.

All of the fiscal year's revenues and expenses are accounted for in the combined statements of changes in net position. These statements measure the success of the Primary Health System's operations and can be used to determine whether the Primary Health System has successfully recovered all of its costs through the services provided, as well as its profitability and credit worthiness.

The final required financial statement is the combined statement of cash flows. The primary purpose of this statement is to provide information about the Primary Health System's cash receipts, cash payments and net changes in cash resulting from operating, investing, non-capital financing and financing activities. The statement also provides answers to such questions as where did cash come from, what was cash used for, and what was the change in the cash balance during the reporting period.

The analysis of the combined financial statements of the Primary Health System begins on the next page. One of the most important questions asked about the Primary Health System's finances is "Is the financial condition of the Primary Health System as a whole better or worse as a result of the fiscal year's activities?" The combined statements of net position and the combined statements of changes in net position report information about the Primary Health System's activities in a way that will help answer this question. These two statements report the net position of the Primary Health System and changes in the net position. One can think of the Primary Health System's net position – the difference between assets and liabilities – as one way to measure financial health or financial position. Over time, increases or decreases in the Primary Health System's net position is one indicator of whether its financial health is improving or deteriorating. However, one will need to consider other non-financial factors such as changes in economic conditions, regulations and new or changed government legislation.

REPORTING ENTITY

The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by generally accepted accounting principles, these financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational, financial or other relationships with the Primary Health System.

ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC (Cyberknife), UT-Erlanger Medical Group, Inc. (the Medical Group) and Erlanger Health Plan Trust are legally separate organizations for which the Primary Health System is either financially accountable or owns a majority interest. Accordingly, these organizations represent component units of the Primary Health System. The financial statements of Erlanger Health Plan Trust are blended with the financial statements of the Primary Health System, as the Board of Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

During fiscal year 2011, Cyberknife was capitalized by contributions from the Primary Health System and certain other minority partners. Cyberknife provides radiation therapy services, specifically robotic stereotactic radiosurgical services through the use of a Cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2017, the Primary Health System owned 51% of Cyberknife's outstanding membership units.

The Medical Group was formed on June 30, 2011 and will provide professional healthcare and related services to the public through its employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Medical Group is currently not active.

During fiscal year 2017, ContinuCare Health Services, Inc. sold Erlanger Pharmacies to CVS Pharmacy.

KEY FINANCIAL INDICATORS

The following key financial indicators are for Erlanger Health System as a whole. They are inclusive of the Primary Health System, ContinuCare HealthServices, Inc., and the 51% controlling share of Cyberknife of Chattanooga, LLC.

- Total income before contributions for Erlanger Health System for fiscal year 2017 is $9 million compared to $25 million for fiscal year 2016.

- Total cash and investment reserves at June 30, 2017 are $104 million (excluding $108 million in capital investment funds and $50 million of funds held by Trustees or restricted by donors or others).

- Net days in accounts receivable for Erlanger Health System (utilizing a three-month rolling average of net revenue) is 57 days at June 30, 2017 compared to 56 days at June 30, 2016.

- For fiscal year 2017, Erlanger Health System recognized $20.6 million in public hospital supplemental payments from the State of Tennessee compared to $18.2 million in fiscal year 2016.

- For fiscal year 2017, Erlanger Health System recognized $10.5 million in essential access payments from the State of Tennessee compared to $10.4 million in fiscal year 2016.

- For fiscal year 2017, Erlanger Health System recognized $8.6 million in disproportionate share payments from the State of Tennessee compared to $15.1 million in fiscal year 2016.

- For fiscal year 2017, Erlanger Health System recognized $1.2 million in trauma fund payments from the State of Tennessee compared to $1.1 million in fiscal year 2016.

The required bond covenant ratios for fiscal year 2017 compared to bond requirements are as follows:

	June 30, 2017	*Master Trust Indenture*	*Bond Insurer Requirements 04 Series*
Debt service coverage ratio	3.07	1.10	1.35
Current ratio	2.27	N/A	1.50
Days cash on hand	80	N/A	65 days
Indebtedness ratio	51%	N/A	65%

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. For fiscal year 2017, Erlanger Health System met all required debt covenants.

NET POSITION

Erlanger Health System's net position for the combined Primary Health System and Aggregate Discretely Presented Component Units increased by approximately $14 million in fiscal year 2017. Our analysis focuses on the net position (Table 1) and changes in net position (Table 2) of the Primary Health System's operating activities. Discussion focuses on the Primary Health System and its blended component units.

Net position for the Primary Health System increased from $236 million as of June 30, 2016 to $247 million as of June 30, 2017. The current ratio (current assets divided by current liabilities) decreased from 2.56 in 2016 to 2.25 in 2017 for the Primary Health System.

Table 1 - Net Position (in Millions)

	June 30, 2017		*June 30, 2016*	
	Primary Health System	*Discretely Presented Component Units*	*Primary Health System*	*Discretely Presented Component Units*
Current and other assets	**$ 423**	**$ 22**	$ 444	$ 14
Capital assets	**232**	**7**	186	8
Total Assets	**655**	**29**	630	22
Deferred ouflows of resources	**13**	**-**	15	-
	$ 668	**$ 29**	$ 645	$ 22

	June 30, 2017		*June 30, 2016*	
	Primary Health System	***Discretely Presented Component Units***	***Primary Health System***	***Discretely Presented Component Units***
Long-term debt outstanding	**$ 203**	**$ 1**	$ 208	$ -
Other liabilities	**215**	**9**	197	6
Total Liabilities	**418**	**10**	405	6
Deferred inflows of resources	**3**	**-**	4	-
	$ 421	**$ 10**	$ 409	$ 6
Net position				
Net investment in capital assets	**$ 43**	**$ 6**	$ 17	$ 5
Restricted expendable	**4**	**-**	3	-
Unrestricted	**200**	**13**	216	11
Total Net Position	**$ 247**	**$ 19**	$ 236	$ 16

Days in cash decreased from 90 days as of June 30, 2016 to 80 days as of June 30, 2017 for the Primary Health System resulting from increased investment in capital.

Days in net accounts receivable for the Primary Health System were 58 days as of June 30, 2016 and 59 days at June 30, 2017, with the increase being attributed to increased volumes.

Capital assets for the Primary Health System were $232 million as of June 30, 2017. Additions for fiscal year 2017 totaled $70 million while $19 million of assets were retired or sold. Depreciation expense was $26 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $20 million in fiscal year 2017. Construction in progress was $43 million as of June 30, 2017. Included in construction in progress is the EPIC project totaling $22 million.

Long-term debt outstanding amounted to $203 million as of June 30, 2017 compared to $208 million as of June 30, 2016.

Other liabilities for the Primary Health System were $215 million as of June 30, 2017 compared to $197 million as of June 30, 2016, due in part to increased net pension liability.

CHANGES IN NET POSITION

The focus for Erlanger Health System's management team during fiscal year 2017 was to increase the Primary Health System's volumes in a number of key product lines in a flat market,

improve relationships with stakeholders, strategic capital investment, EPIC installation and improve operating efficiencies.

Table 2 - Changes in Net Position (in Millions)

	June 30, 2017		*June 30, 2016*	
	Primary Health System	***Discretely Presented Component Units***	***Primary Health System***	***Discretely Presented Component Units***
Net patient service revenue	**$ 836**	**$ 12**	$ 778	$ 11
Other revenue	**18**	**22**	15	22
Total Revenue	**854**	**34**	793	33
Operating Expenses:				
Salaries, wages and benefits	**444**	**15**	406	14
Supplies and other expenses	**197**	**19**	174	13
Purchased services	**173**	**3**	160	3
Depreciation and amortization	**26**	**1**	25	1
Total Expenses	**840**	**38**	765	31
Operating income revenues in excess of (less than) expenses	**14**	**(4)**	28	2
Nonoperating gains	**2**	8	4	(1)
Interest expense and other	**(7)**	**(1)**	(7)	-
Operating/capital contributions	**2**	**-**	-	-
Change in Net Position	**$ 11**	**$ 3**	$ 25	$ 1

Net patient service revenue for the Primary Health System increased from $778 million in fiscal year 2016 to $836 million in fiscal year 2017. Admissions for fiscal year 2017 were 38,999 compared to 35,758 for fiscal year 2016, a 9.1% increase. Observation days increased from 7,637 for fiscal year 2016 to 8,082 for fiscal year 2017, or by 5.8%. Air ambulance flights increased from 2,190 flights for fiscal 2016 to 2,272 flights for fiscal year 2017, or by 3.7%. Medicare case mix index increased from 1.87 for fiscal year 2016 to 1.91 for fiscal year 2017. Total surgical inpatients increased from 10,143 for fiscal year 2016 to 11,277 for fiscal 2017, or by 11.2%. Total surgical outpatients for fiscal year 2017 increased by 3.7% over the prior year. Total emergency room visits were 157,038 for fiscal year 2017, a 1.4% increase over fiscal year 2016. Physician practice outpatient visits have increased from 351,875 in fiscal 2016 to 428,608 in fiscal 2017, or by 21.8%.

Salaries for the Primary Health System increased from $406 million in fiscal year 2016 to $444 million in fiscal year 2017. Staffing was in concert with the increased volumes. Paid FTE's per

adjusted occupied bed decreased from 4.7 in fiscal year 2016 to 4.6 in fiscal year 2017, however, salary cost for fiscal year 2017 per hour increased by 2.9% over the prior year. Efficient productivity of operations continue to be evident even though staff is working toward the inpatient "go live" of e-chart. A 3% raise for all other eligible employees was implemented in January 2016.

Supplies and other expenses increased from $174 million for fiscal year 2016 to $197 million in fiscal year 2017. Supplies and drugs per adjusted admission for the Primary Health System decreased from $1,815 in fiscal year 2016 to $1,754 in fiscal year 2017. Increased 340B savings have reduced drug costs for fiscal year 2017.

Purchased services increased from $160 million in fiscal year 2016 to $173 million in fiscal year 2017 due in part to an increase in contracted hospitalist fees resulting from increased volumes and increased computer services costs associated with implementation of the EPIC system project.

Depreciation and amortization expense increased from $25 million in fiscal year 2016 to $26 million in fiscal 2017 due in part to opening Erlanger East in December 2016.

Interest expense of $7 million in fiscal year 2017 is comparable to the prior year.

OUTLOOK

The State of Tennessee continues to review the TennCare program (the State's Medicaid program). For fiscal years 2012 and 2013, the State passed a Hospital Coverage Fee to offset shortfalls in the State's budget for TennCare. The fee has remained intact and TennCare rates were stable in fiscal years 2014 - 2017. CMS has notified the State of their intention to change the methodology of the supplemental pools. The TennCare waiver received final approval in December 2016. This is a five-year waiver that must remain in compliance with federal law. The biggest change in the new waiver is related to supplemental pool payments to hospitals. Out-of-state Medicaid and TennCare changes would affect the Primary Health System's bottom line with TennCare and Medicaid patients representing approximately 23% of the payer mix. Self-pay patients represent approximately 7% of the charge utilization. Healthcare reform and future changes in Medicare regulations could also have an adverse effect on the Primary Health System's future operations since Medicare represents approximately 33% of the payer mix.

During fiscal year 2014, the Primary Health System was added as a participant to the Public Hospital Supplemental Payment Pool for public hospitals in Tennessee through a collaborative effort with local Mayors, State Senators and Representatives, Hamilton County Medical Society, Board members, physicians and hospital leadership. The inclusion of the Primary Health System

in the pool netted $20.6 million of additional federal funding for fiscal year 2017 and $18.2 million for fiscal year 2016. The Public Hospital Supplemental Payment Pool is part of the current CMS pool methodology discussions. Funding of $23.3 million for fiscal year 2018 was received in August 2017.

The Primary Health System recognized Essential Access payments totaling $10.4 million from the State of Tennessee for fiscal year 2017, and $10.4 million in 2016. Disproportionate share payments were not approved by the Federal government for fiscal year 2014 and funds received during 2015 were deferred until 2016 based on management's evaluation. Disproportionate share payments of $15.1 million were recorded in fiscal year 2016 compared to $8.6 million in 2017. Additionally, the Primary Health System recognized trauma funding of $1.2 million and $1.1 million in fiscal years 2017 and 2016. Payments from the State of Tennessee for the fiscal year 2017 are expected to be consistent with the fiscal year 2016. Due to the 1966 Hamilton County Sales Tax Agreement expiring in May 2011, the Hamilton County appropriations to the Primary Health System have been reduced from $3 million to $1.5 million for 2017 and 2016.

The focus of Erlanger Health System's CEO and leadership team for fiscal year 2017 has been top-line, sustainable growth, strategic capital investment, EPIC implementation, cost containment and strengthened physician relations. The strategic plans put in place this fiscal year have yielded strong positive results and enabled investment in Erlanger and the community. The health system has infused $71 million from bond sales into major growth initiatives.

Fiscal year 2017 reflected continued growth based on strategic plan and initiatives completed to date and others in the process of being completed. The surgery expansion at the main campus is a strong contributor to health system performance as is the $50 million expansion at Erlanger East, where a full-service hospital was made available for the first time to residents of East Hamilton County. During fiscal 2017, the Primary Health System implemented the ambulatory module of EPIC. The inpatient module of EPIC will be implemented in fiscal 2018. A strong team and support cast are in place; however, the complexities of the challenge are magnified as an array of programs and services and providers need to coordinate efforts to execute successfully. Competition and related market place additional challenges and risks to the mix. An effective team is in place to accelerate effective execution of this endeavor.

For FY 2018, it is anticipated that the Primary Health System will continue to realize further progress all on fronts, the opening of the Erlanger Heart and Lung Institute, the opening of the Erlanger Behavioral Health Hospital, with growth fostered by effective execution on key strategic initiatives, by new bed and surgical capacity and by physician engagement and clinical leadership. The Erlanger brand will continue to attract the attention of other providers and physician alike. We expect to see continued growth from within the service area and from outlying areas particularly as small hospitals in the region seek to align to gain access to Erlanger's "system of care."

Audited Combined Financial Statements

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position

	June 30, 2017	
	Primary Health System	***Discretely Presented Component Units***
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 82,900,927	$ 11,859,367
Temporary investments	3,108,980	6,048,721
Patient accounts receivable, net	134,468,077	2,161,233
Estimated amounts due from third party payers	5,801,710	-
Due from other governments	1,199,599	424,619
Inventories	16,509,567	359,637
Receivable from Walker County, Georgia	2,901,667	-
Other current assets	19,408,061	699,076
TOTAL CURRENT ASSETS	266,298,588	21,552,653
NET PROPERTY, PLANT AND EQUIPMENT	231,517,390	7,032,749
LONG-TERM INVESTMENTS, for working capital	498,014	-
ASSETS LIMITED AS TO USE	132,018,368	-
OTHER ASSETS:		
Prepaid bond insurance	551,399	-
Equity in discretely presented component units	18,339,497	-
Receivable from Walker County, Georgia, net of current portion	5,803,334	-
Other assets	12,820	508,597
TOTAL OTHER ASSETS	24,707,050	508,597
TOTAL ASSETS	655,039,410	29,093,999
DEFERRED OUTFLOWS OF RESOURCES		
Deferred pension adjustments	12,029,558	-
Deferred amounts from debt refunding	1,458,618	-
TOTAL DEFERRED OUTFLOWS OF RESOURCES	13,488,176	-
COMBINED ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 668,527,586	$ 29,093,999

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position - Continued

	June 30, 2017	
	Primary Health System	***Discretely Presented Component Units***
LIABILITIES		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 79,142,994	$ 2,131,557
Accrued salaries and related liabilities	31,561,325	1,269,287
Due to other governments	424,619	1,199,599
Current portion of long-term debt and capital leases	4,686,080	377,820
Other current liabilities	2,401,304	3,425,676
TOTAL CURRENT LIABILITIES	118,216,322	8,403,939
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	202,918,634	937,500
NET PENSION LIABILITY	70,000,930	-
OTHER LONG-TERM LIABILITIES	27,615,029	718,454
TOTAL LIABILITIES	418,750,915	10,059,893
DEFERRED INFLOWS OF RESOURCES		
Deferred gain from sale-leaseback	2,718,298	-
TOTAL DEFERRED INFLOWS OF RESOURCES	2,718,298	-
NET POSITION:		
Unrestricted	200,288,815	13,275,257
Net investment in capital assets	43,266,364	5,758,849
Restricted expendable:		
Health plan trust	1,637,342	-
Donor restricted	1,865,852	-
TOTAL NET POSITION	247,058,373	19,034,106
COMBINED LIABILITES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION	$ 668,527,586	$ 29,093,999

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Changes in Net Position

	Year Ended June 30, 2017	
	Primary Health System	*Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 835,521,971	$ 11,647,646
Other revenue	18,368,318	22,555,419
TOTAL OPERATING REVENUE	853,890,289	34,203,065
OPERATING EXPENSES:		
Salaries, wages and benefits	443,623,327	14,955,615
Supplies and other expenses	192,063,265	18,523,552
Purchased services	173,279,391	2,839,792
Insurance and taxes	4,798,860	377,367
Depreciation and amortization	26,332,521	1,238,109
TOTAL OPERATING EXPENSES	840,097,364	37,934,435
OPERATING INCOME (LOSS)	13,792,925	(3,731,370)
NONOPERATING REVENUE (EXPENSES):		
Gain (loss) on disposal of assets	(60,460)	7,941,643
Investment income (loss), net of fees	(1,300,948)	430,423
Net gain from discretely presented component units	2,874,758	-
Interest expense	(6,308,956)	(95,948)
Provision for income taxes	-	(1,561,325)
NET NONOPERATING REVENUE (EXPENSES)	(4,795,606)	6,714,793
INCOME BEFORE CONTRIBUTIONS	8,997,319	2,983,423
Operating contributions (distributions), net	(747,667)	(250,000)
Capital contributions	2,901,378	-
CHANGE IN NET POSITION	11,151,030	2,733,423
NET POSITION AT BEGINNING OF YEAR	235,907,343	16,300,683
NET POSITION AT END OF YEAR	$ 247,058,373	$ 19,034,106

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statement of Cash Flows

Primary Health System	*Year Ended June 30, 2017*
CASH FLOWS FROM OPERATING ACTIVITIES:	
Receipts from third-party payers and patients	$ 825,621,635
Payments to vendors and others for supplies, purchased services, and other expenses	(364,142,335)
Payments to and on behalf of employees	(436,498,550)
Other receipts	18,959,273
NET CASH PROVIDED BY OPERATING ACTIVITIES	43,940,023
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:	
Contributions to other organizations, net	(747,667)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:	
Acquisition and construction of capital assets, net	(63,658,569)
Principal paid on bonds, capital lease obligations and other	(4,813,051)
Interest payments on long-term debt	(9,417,657)
Capital contributions	2,901,378
NET CASH USED IN CAPITAL AND RELATED FINANCING ACTIVITIES	(74,987,899)
CASH FLOWS FROM INVESTING ACTIVITIES:	
Interest, dividends, and net realized gains/losses on investments	1,658,606
Change in temporary and long-term investments for working capital	(12,468)
Net cash transferred from assets limited as to use	22,663,306
NET CASH PROVIDED BY INVESTING ACTIVITIES	24,309,444
DECREASE IN CASH AND CASH EQUIVALENTS	(7,486,099)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	90,387,026
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 82,900,927
SUPPLEMENTAL SCHEDULE OF NON-CASH ACTIVITIES	
Capital assets accrued in payables	$ 9,176,970
Unrealized investment losses	$ (2,959,554)

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statement of Cash Flows - Continued

Primary Health System	***Year Ended June 30, 2017***
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES:	
Operating income	**$ 13,792,925**
Adjustments to reconcile operating income to net cash provided by operating activities:	
Depreciation and amortization	**26,332,521**
Pension adjustments, net	**3,933,617**
Amortization of deferred gain	**(287,915)**
Changes in assets and liabilities:	
Patient accounts receivable, net	**(11,393,234)**
Estimated amounts due from third party payers, net	**2,198,409**
Inventories and other assets	**(950,676)**
Accounts payable and accrued expenses	**6,396,357**
Accrued salaries and related liabilities	**3,191,160**
Other current and long-term liabilities	**726,859**
NET CASH PROVIDED BY OPERATING ACTIVITIES	**$ 43,940,023**

NOTE A--SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity: The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Chattanooga-Hamilton County Hospital Authority consists of the Primary Health System and its aggregate discretely presented component units as disclosed below.

The Primary Health System provides comprehensive healthcare services throughout Hamilton and Bledsoe counties, as well as outlying areas in southeastern Tennessee and north Georgia. These services are provided primarily through the hospitals and other facilities located on the Baroness and East campuses of Erlanger Medical Center. The Primary Health System also operates other hospitals and clinics throughout the area. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by accounting principles generally accepted in the United States of America, these combined financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational or financial relationships with the Primary Health System.

The primary mission of the Primary Health System and its component units is to provide healthcare services to the citizens of Chattanooga, Hamilton County and the surrounding area. Only those activities directly associated with this purpose are considered to be operating activities. Other activities that result in gains or losses unrelated to the Primary Health System's primary mission are considered to be nonoperating.

Erlanger Health Plan Trust, ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC, and UT-Erlanger Medical Group, Inc. are legally separate organizations which the Primary Health System has determined are component units of the Primary Health System.

Blended Component Unit: The financial statements of Erlanger Health Plan Trust include assets limited as to use totaling $1,637,342 as of June 30, 2017 and net investment gain totaling $6,003 for the year ended June 30, 2017 that are blended in the combined financial statements of the Primary Health System. The board of the Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

Discretely Presented Component Units: The discretely presented component units' column in the combined financial statements includes the financial data of the Primary Health System's other component units. They are reported in a separate column to emphasize that they are legally separate from the Primary Health System. See the combined, condensed financial information in Note O.

1. ContinuCare HealthServices, Inc. and subsidiary (ContinuCare) provide health and supportive services to individuals in their homes in the Hamilton County and north Georgia areas. ContinuCare also provides retail pharmacy goods and services at four locations in Hamilton County. The Primary Health System owns 100% of the stock of ContinuCare. Separately audited financial statements for ContinuCare HealthServices, Inc. may be obtained by mailing a request to 1501 Riverside Drive, Suite 140, Chattanooga, Tennessee 37406.

2. Cyberknife of Chattanooga, LLC (Cyberknife) provides radiation therapy services, specifically robotic stereotactic radiosurgical services, through the use of a Cyberknife stereotactic radiosurgery system on the Primary Health System's campus. The Primary Health System owns 51% of Cyberknife's outstanding membership units and Cyberknife is fiscally dependent on the Primary Health System.

   A condition of admission as a Member of Cyberknife, is to deliver limited guaranties, guaranteeing pro-rata repayment of indebtedness of Cyberknife incurred to finance its equipment costs and its working capital needs. As of June 30, 2017, total debt outstanding was $1,312,500 with payments due through December 2018. Management believes that the Primary Health System will not be required to make any payments related to the guarantee of this indebtedness.

   Separate financial statements for Cyberknife of Chattanooga, LLC may be obtained by mailing a request to 975 East Third Street, Chattanooga, Tennessee 37403.

3. UT-Erlanger Medical Group, Inc. (the Medical Group) was formed on June 30, 2011 and will provide professional healthcare and related services to the public through employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Primary Health System is not entitled to any potential earnings of the Medical Group except for compensation for services rendered to the Medical group on its behalf. However, based upon the significance of the Medical Group's potential operation to the Primary Health System, management believes its exclusion would be misleading and as such, includes the Medical Group as a component unit. The Medical Group is currently not active.

Erlanger Health System Foundations (the Foundation): The Foundation assists the Primary Health System to promote and develop charitable and educational opportunities as they relate to healthcare services provided by the Primary Health System. The Primary Health System is not financially accountable for the Foundation and as a result, the Foundation has not been included in the combined financial statements.

Contribution revenue from the Foundation totaling approximately $246,000 was recognized by the Primary Health System for the year ended June 30, 2017. The Primary Health System provided support to the Foundation of $987,000 in 2017.

Use of Estimates: The preparation of the combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the combined financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise Fund Accounting: The Primary Health System and its blended component units utilize the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Recently Issued Accounting Pronouncements: In June 2017, the GASB issued Statement No. 87, *Leases*, which requires balance sheet recognition of a liability and right-to-use asset for substantially all leases with a maximum possible term exceeding 12 months. The lease liability is measured at the present value of payments made during the lease term. In later periods, the lessee should amortize the discount of the lease liability and report it as an outflow of resources (interest expense) for the period. The lease asset is measured as the sum of the amount of the initial measurement of the lease liability, lease payments made to the lessor at/before the beginning of the lease term, and any initial direct costs. A lease asset is amortized over the shorter of the lease term or the useful life of the underlying asset and reported as an amortization expense. The requirements of this Statement are effective for reporting periods beginning after December 15, 2019; early adoption is permitted. Management is currently evaluating the impact of the adoption of the Statement on the combined financial statements.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at rates which reflect the amount expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by third-party payer programs under payment formulas in effect. Net patient revenue also includes an estimated provision for bad debts based upon management's evaluation of collectability based upon the age of the receivables and other criteria, such as payer classification and management's assumptions about conditions it expects to exist and courses of action it expects to take. The Primary Health System's policies do not require collateral or other security for accounts receivable, although the Primary Health System routinely accepts assignment or is otherwise entitled to receive patient benefits payable under health insurance programs, plans or policies. Supplemental payments from the State of Tennessee are recognized when determinable over the period to which they pertain (see Note B).

Charity Care: The Primary Health System accepts patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain policies established by the County Auditor with regard to the Hamilton County indigent program or by the Primary Health System for other patients. Essentially, these policies define charity services as those services for which minimal payment is anticipated. In assessing a patient's inability to pay, the County and the Primary Health System utilize the generally recognized poverty income levels, but also include certain cases where incurred charges are significant when compared to the income of the patient. These charges are not included in net patient service revenue.

Cash Equivalents: The Primary Health System considers all highly liquid investments with maturities of three months or less when purchased, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be cash equivalents.

Inventories: Inventories consist principally of medical and surgical supplies, general store supplies, and pharmacy items and are stated at lower of cost (first-in, first-out) or fair market value.

Investments: The Primary Health System's investments (including assets limited as to use) are reported at fair market value. Assets limited as to use include funds designated by the Board, funds held by trustees under trust indentures, and funds restricted by donors or grantors for specific purposes. The Primary Health System considers those investments with maturities of more than three months when purchased, maturing in more than one year and whose use is not limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be long-term investments.

Temporary Investments: The Primary Health System considers all highly liquid investments with maturities of more than three months when purchased and maturing in less than one year, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be temporary investments.

Net Property, Plant and Equipment: Property, plant and equipment is recorded on the basis of cost. Donated assets are recorded at their fair market value at the date of donation. Leases that are substantially installment purchases of property are recorded as assets and amortized over the lesser of their estimated useful lives or the lease term which range from three to twenty years; related amortization is included in depreciation expense. Depreciation expense is computed over estimated service lives of the respective classes of assets using the straight-line method. The Primary Health System has established a capitalization threshold for property, plant and equipment of $2,500 except for computer equipment, which has a threshold of $1,000. Interest expense and interest income on borrowed funds related to construction projects are capitalized

during the construction period, if material. Costs of maintenance and repairs are charged to expense as incurred.

The Primary Health System reviews the carrying value of capital assets if facts and circumstances indicate that recoverability may be impaired. A capital asset is considered impaired when its service utility has declined significantly and unexpectedly. The Primary Health System did not experience any prominent events or changes in circumstances affecting capital assets which would require determination as to whether impairment of a capital asset has occurred during the year ended June 30, 2017.

Prepaid Bond Insurance: Costs related to insurance associated with bond issues are being amortized over the terms of the respective debt issues by the effective interest method.

Compensated Absences: The Primary Health System recognizes an expense and accrues a liability for employees' paid annual leave and short-term disability in the period in which the employees' right to such compensated absences is earned. Liabilities expected to be paid within one year are included as accrued salaries and related liabilities in the accompanying combined statements of net position.

Pensions: Pension amounts (net pension liability, deferred outflows of resources and deferred inflows of resources related to the pension, and pension expense, fiduciary net position of the Primary Health System's pension plan (the Plan) and additions to or deductions from the Plan's fiduciary net position) have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value

Income Taxes: The Primary Health System is exempt from income taxes as it qualifies for exemption from federal income taxes pursuant to IRC Section 115 as an instrumentality of the State of Tennessee. Therefore, no provision for income taxes has been recognized in the accompanying combined financial statements for the Primary Health System.

As a for-profit entity, ContinuCare is subject to state and federal income taxes. ContinuCare HealthServices, Inc. and its subsidiary file consolidated federal income tax returns separately from the Primary Health System. At June 30, 2017, ContinuCare had no significant uncertain tax positions. Tax returns for the years ended June 30, 2014 through 2017 are subject to examination by taxing authorities.

As a limited liability corporation, Cyberknife, is subject to State of Tennessee income taxes. At June 30, 2017 Cyberknife had no significant uncertain tax positions. Tax returns for the years ended June 30, 2014 through 2017 are subject to examination by taxing authorities.

Contributed Resources: Resources restricted by donors for specific purposes are held as restricted funds and are recognized as operating or capital contributions in the accompanying combined financial statements. When an expense is incurred for purposes for which both restricted and unrestricted resources are available, restricted resources are used first. Fundraising expenses are netted against contributions recognized.

Net Position: The net position of the Primary Health System is classified into three components. *Net investment in capital assets* consists of capital and other assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. The *restricted expendable* net position consists of assets that must be used for a particular purpose that are either externally imposed by creditors, grantors, contributors or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation. *The unrestricted net position* consists of remaining assets that do not meet the definition of *net investment in capital assets* or *restricted expendable.*

Fair Value of Financial Instruments: The carrying amounts reported in the combined statements of net position approximate fair value, except as described below.

The carrying value of long-term debt and capital lease obligations (including the current portion) was $207,604,714 as of June 30, 2017. The estimated fair value of long-term debt and capital lease obligations (including current portion) was $213,110,000 at June 30, 2017. The fair value of long-term debt related to fixed interest long-term debt and capital lease obligations was estimated using discounted cash flows, based on the Primary Health System's incremental borrowing rates or from quotes obtained from investment advisors. The fair value of long-term debt related to variable rate debt approximates its carrying value.

NOTE B--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates by the Primary Health System to net patient service revenue as presented in the combined statements of revenue, expenses and changes in net position for the year ended June 30, 2017 is as follows:

	Primary Health System
Inpatient service charges	$ 1,552,586,681
Outpatient service charges	1,307,574,226
Gross patient service charges	2,860,160,907
Less: Contractual adjustments and other discounts	1,792,010,245
Charity care	143,507,342
Provision for bad debts	89,121,349
	2,024,638,936
Net patient service revenue	$ 835,521,971

Charity Care and Community Benefit: The Private Act of the State of Tennessee establishing the Primary Health System obligates the Primary Health System to make its facilities and patient care programs available to the indigent residents of Hamilton County to the extent of funds appropriated by Hamilton County and adjusted operating profits, as defined. The annual appropriation from Hamilton County totaled $1,500,000 for fiscal year 2017. Total charity care charges for services provided to the certified indigent residents of Hamilton County (net of the appropriation) were approximately $16,554,000 for the year ended June 30, 2017 for the Primary Health System.

In addition to charity care provided to specific patients within the hospital setting, the Primary Health System also provides unreimbursed services to the community which includes free and low-cost health screenings. The Primary Health System also hosts health fairs and helps sponsor many other events that are free to the public and are spread throughout the year in various community locations.

The Primary Health System's Community Relations department includes HealthLink Plus, a free adult membership program with over 8,000 members in the Chattanooga Statistical Metropolitan Service Area. The Community Relations department hosts several free community events throughout the year utilizing the services of physicians, nurses, volunteers, educators, registered dietitians, social workers, secretaries and management personnel of the Primary Health System.

The Primary Health System's consumer call center, Erlanger HealthLink (423-778-LINK) is a free call center staffed by RN's to answer health questions, offer free physician referrals and to register participants in the programs offered by Community Relations, Women's & Infant Services and other departments and divisions of the Primary Health System.

Uncompensated Care Costs: The following table summarizes the estimated total uncompensated care costs (based on the ratio of total operating revenue and expenses) provided by Erlanger Medical Center as defined by the State of Tennessee for the year ended June 30, 2017:

Uncompensated cost of TennCare/Medicaid	$ 43,676,286
Traditional charity uncompensated costs	41,271,009
Bad debt cost	25,293,491
Total estimated uncompensated care costs	$ 110,240,786

The uncompensated cost of TennCare/Medicaid is estimated by taking the estimated cost of providing care to the TennCare/Medicaid patients less payments from the TennCare and Medicaid programs. The payments exclude revenues from essential access and other supplemental payments from TennCare of approximately $10,481,000 for the year ended June 30, 2017 and such payments are not guaranteed for future periods.

Revenue from Significant Payers: Gross patient service charges related to the Medicare program accounted for approximately 34.6% of the Primary Health System's patient service charges for the year ended June 30, 2017. Gross patient service charges related to the TennCare/Medicaid programs accounted for approximately 22.8% of the Primary Health System's patient service charges for the year ending June 30, 2017. TennCare typically reimburses providers at an amount less than their cost of providing services to TennCare patients. At June 30, 2017, the Primary Health System has a credit concentration related to receivables from the Medicare and TennCare programs.

During 2017, the Primary Health System recognized revenue related to trauma fund payments of approximately $1,170,000. Further, during 2017, the Primary Health System recognized disproportionate share payments (DSH) of approximately $8,620,000. Disproportionate share payments recognized in 2017 and prior years are subject to audit and potential recoupments although management believes it has meritorious defenses against any such recoupments. The U.S. District Court for the Middle District of Tennessee permanently enjoined the federal government from enforcing policies related to the calculation of the DSH payment limit against the Tennessee Hospital Association. The federal government has appealed this decision. Future distributions under these programs are not guaranteed. In 2017 the Primary Health System also received and recognized a net payment of $20,598,837 from the Public Hospital Supplemental Payment Pool. The Public Hospital Supplemental Payment Pool is part of the current Centers for Medicare and Medicaid Series pool methodology discussions.

Laws and regulations governing the Medicare and TennCare/Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates, as they relate to revenue recognized from these programs, will change by a material amount in the near term. The estimated reimbursement amounts are adjusted in subsequent

periods as cost reports are prepared and filed and as final settlements are determined. Final determination of amounts earned under prospective payment and cost reimbursement activities is subject to review by appropriate governmental authorities or their agents. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under Medicare and Medicaid programs. The effect of prior year cost report settlements, or changes in estimates, had no significant impact on net patient service revenue in 2017.

The Primary Health System has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates, per diems and discounts from established charges.

NOTE C--CASH AND CASH EQUIVALENTS

Cash and cash equivalents reported on the combined statements of net position include cash on hand and deposits with financial institutions including demand deposits, which meet the definition of a cash equivalent.

Cash and cash equivalents consist of the following:

	Primary Health System
Demand deposits	$ 82,886,473
Cash on hand	14,454
	$ 82,900,927

Bank balances consist of the following:

	Primary Health System
Insured (FDIC)	$ 522,522
Collateralized under the State of Tennessee Bank Collateral Pool	86,154,815
	$ 86,677,337

In accordance with Tennessee Code Annotated Section 9-1-118, the full amount of principal and any accrued interest of each such deposit is insured by the FDIC up to statutory limits. For deposits above and beyond the amount covered by federal deposit insurance, the Primary Health

System follows the requirements as set forth in the Tennessee Code Annotated Title 9 Chapter 4, Part 5, "Collateral Pool for Public Deposits Act of 1990," whereby "Local governments with bank deposits that are in excess of the amount covered by FDIC insurance must either maintain the deposit with a bank that is a member of the bank collateral pool or collateralize the deposit in accordance with State statues."

The Primary Health System's deposits are exposed to custodial credit risk if they are not covered by depository insurance and the deposits are uncollateralized or are collateralized with securities held by the pledging financial institution's trust department or agent but not in the Primary Health System's name. The deposit risk is that, in the event of the failure of a depository financial institution, the Primary Health System will not be able to recover deposits or will not be able to recover collateral securities that are in the possession of an outside party. At June 30, 2017, the Primary Health System's bank balances were not exposed to custodial credit risk since the full amount was covered by FDIC insurance or by the State of Tennessee Collateral Pool.

NOTE D--DISAGGREGATION OF RECEIVABLE AND PAYABLE BALANCES

Patient Accounts Receivable, Net: Patient accounts receivable and related allowances are as follows:

	Primary Health System
Gross patient accounts receivable	$ 577,513,785
Estimated allowances for contractual adjustments and uncollectible accounts	(443,045,708)
Net patient accounts receivable	$ 134,468,077

Other Current Assets: Other current assets consist of the following:

	Primary Health System
Prepaid expenses	$ 6,920,287
Supplemental payments receivable (see Note B)	6,030,531
Other receivables	6,457,243
Total other current assets	$ 19,408,061

Accounts Payable and Accrued Expenses: Accounts payable and accrued expenses consist of the following:

	Primary Health System
Due to vendors	$ 72,812,098
Other	6,330,896
Total accounts payable and accrued expenses	$ 79,142,994

Other Long-Term Liabilities: Other long-term liabilities, and the related activity, consist of the following:

	Balance at June 30, 2016	***Unearned Revenue Recognized***	***Payments/ Other***	***Balance at June 30, 2017***
Compensated absences	$ 17,030,625	$ -	$ 2,872,242	$ 19,902,867
Medical malpractice	4,972,400	-	545,090	5,517,490
Job injury program	1,253,139	-	(1,096,798)	156,341
Unearned revenue	2,186,429	(237,858)		1,948,571
Other	89,760	-	-	89,760
Total other long-term liabilities	$ 25,532,353	$ (237,858)	$ 2,320,534	$ 27,615,029

NOTE E--NET PROPERTY, PLANT AND EQUIPMENT

Net property, plant and equipment activity for the Primary Health System consisted of the following:

	Balance at June 30, 2016	***Additions***	***Reductions/ Transfers***	***Balance at June 30, 2017***
Capital assets:				
Land and improvements	$ 21,569,286	$ 212,602	$ 1,965,112	$ 23,747,000
Buildings	233,712,632	629,412	32,727,123	267,069,167
Equipment	410,134,839	3,785,940	19,061,122	432,981,901
	665,416,757	4,627,954	53,753,357	723,798,068

	Balance at June 30, 2016	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2017*
Accumulated depreciation:				
Land and improvements	(8,825,770)	(559,962)	3,380	(9,382,352)
Buildings	(185,262,223)	(6,749,741)	40,518	(191,971,446)
Equipment	(334,925,533)	(19,022,818)	20,303,173	(333,645,178)
	(529,013,526)	(26,332,521)	20,347,071	(534,998,976)
Capital assets net of accumulated depreciation	136,403,231	(21,704,567)	74,100,428	188,799,092
Construction in progress	49,662,761	67,521,905	(74,466,368)	42,718,298
	$ 186,065,992	$ 45,817,338	$ (365,940)	$ 231,517,390

Construction in progress at June 30, 2017 consists of various projects for additions and renovations to the Primary Health System's facilities and computer systems. The estimated cost to complete construction projects is approximately $59,700,000. During 2017, the Primary Health System capitalized interest expense of approximately $3,300,000 on construction projects, net of interest income of approximately $300,000 earned on construction funds.

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE

The Primary Health System invests primarily in United States government and agency obligations, municipal and other bonds and short-term money market investments that are in accordance with the Primary Health System's investment policy. The carrying and estimated fair values for long-term investments, and assets limited as to use, by type are as follows:

	Primary Health System
U.S. Treasury notes	$ 38,870,890
U.S. Government agency obligations	69,298,329
Municipal bonds	9,799,690
Corporate bonds and others	4,151,705
Cash equivalents	10,395,768
Total investments and assets limited as to use	$ 132,516,382

Assets limited as to use are designated for the following purposes:

	Primary Health System
Capital investment funds	$ 107,521,078
Under bond indentures - held by trustees	
Debt service reserve fund	6,197,145
Construction fund	12,605,144
Self-insurance trust	4,057,659
Health plan trust	1,637,342
	$ 132,018,368

Assets limited as to use for capital investment are to be used for the replacement of property and equipment or for any other purposes so designated by the Board of Trustees. The debt service reserve fund is to be used only to make up any deficiencies in other funds related to the Hospital Revenue and Refunding Bonds Series 2004. The construction fund may be used for various construction and renovation projects related to the Series 2014 bonds.

The Primary Health System's investment policy specifies the types of investments which can be included in board-designated assets limited as to use, as well as collateral or other security requirements. The investment policy also specifies the maximum maturity of the portfolio of board-designated assets. Assets limited as to use and held by trustees are invested as permitted by the bond indenture.

Custodial Credit Risk: The Primary Health System's investment securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of the Primary Health System, and are held by either the counterparty or the counterparty's trust department or agent but not in the Primary Health System's name. The risk is that, in the event of the failure of the counterparty to a transaction, the Primary Health System will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party. Substantially all of the Primary Health System's investments, including assets limited as to use, are uninsured or unregistered. Securities are held by the counterparty, or by its trust department or agent, in the Primary Health System's name.

Concentration of Credit Risk: This is the risk associated with the amount of investments the Primary Health System has with any one issuer that exceeds 5% or more of its total investments. Investments issued or explicitly guaranteed by the U.S. Government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement. The Primary Health System's investment policy does not restrict the amount that may be held for any single issuer. At June 30, 2017, none of the Primary Health System's

investments with any one issuer exceed 5% of its total investments except certain U.S. Government agency obligations.

Credit Risk: This is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The Primary Health System's investment policy provides guidelines for its fund managers and lists specific allowable investments. The credit risk profile of the Primary Health System's investments, including assets limited as to use (excluding U.S. Government securities), as of June 30, 2017, is as follows:

		Rating				
Investment Type	*Total*	*AAA*	*AA*	*A*	*BBB*	*N/A*
U.S. Government agency obligations	$ 69,298,329	$ 67,699,344	$ 1,598,985	$ -	$ -	$ -
Municipal bonds	9,799,690	5,407,178	4,172,437	220,075	-	-
Corporate bonds and others	4,151,705	2,949,881	-	1,201,824	-	-
Cash equivalents	10,395,768	-	-	-	-	10,395,768
Total investments	$ 93,645,492	$ 76,056,403	$ 5,771,422	$ 1,421,899	$ -	$ 10,395,768

Interest Rate Risk: This is the risk that changes in interest rates will adversely affect the fair value of an investment. The Primary Health System's investment policy authorizes a strategic asset allocation that is designed to provide an optimal return over the Primary Health System's investment horizon and within specified risk tolerance and cash requirements. The distribution of the Primary Health System's investments, including assets limited as to use, by maturity as of June 30, 2017, is as follows:

		Remaining Maturity				
Investment Type	*Total*	*12 months or less*	*13-24 Months*	*25-60 Months*	*Over 60 Months*	*N/A*
U.S. Treasury notes	$ 38,870,890	$ 1,235,437	$ 3,889,252	$ 33,746,201	$ -	$ -
U.S. Government agency obligations	69,298,329	14,033,987	7,260,921	1,694,965	46,308,456	-
Municipal bonds	9,799,690	7,565,872	2,019,310	214,508	-	-
Corporate bonds and others	4,151,705	1,217,071	-	2,934,634	-	-
Cash equivalents	10,395,768	10,395,768	-	-	-	-
Total investments	$ 132,516,382	$ 34,448,135	$ 13,169,483	$ 38,590,308	$ 46,308,456	$ -

NOTE G--LONG-TERM DEBT

Long-term debt at June 30, 2017 consists of the following:

	Primary Health System
Revenue and Refunding Bonds, Series 2014A, including bond premium of $7,929,184	$ 157,849,184
Revenue and Refunding Bonds, Series 2004, net of bond discount of $237,283 and including bond issue premium of $560,111	31,707,828
Total bonds payable	189,557,012
2014B Note payable	12,000,000
Capital leases - Note L	6,047,702
	207,604,714
Less: current portion	(4,686,080)
	$ 202,918,634

On December 1, 2014, the Primary Health System issued $149,920,000 Series 2014A bonds for the purpose of advance refunding $20,615,000 of the outstanding Series 2004 bonds (described below), $30,300,000 of the outstanding Series 2000 bonds, $17,375,000 of the Series 1998A bonds, and $27,465,000 of the outstanding Series 1997A bonds. The Primary Health System also utilized the proceeds to pay certain issuance costs and deposited a portion of the bond proceeds in the amount of $71,000,000 into a construction fund. The advance refunding of the Series 2004 bonds, Series 1998A bonds, and 1997A bonds resulted in a loss of $1,116,755 that is reported as a deferred outflow of resources and will be amortized over the term of the Series 2014A bonds.

The Series 2014A bonds consist of series bonds maturing annually beginning October 1, 2018 through 2034 and term bonds maturing on October 1, 2039 and 2044. The term bonds are subject to mandatory sinking fund redemption beginning October 1, 2035. The Series 2014A bonds are also subject to redemption by the Primary Health System at any interest payment date at a redemption price equal to the principal amount plus accrued interest.

Interest rates for the Series 2014A bonds are as follows:

Series bonds	3.0% to 5.0%
Term bonds	4.125% to 5.0%

In conjunction with the issuance of the Series 2014A bonds, the Primary Health Systems issued a $12,000,000 note payable (2014B note) through a financial institution to advance refund the remaining $11,775,000 of outstanding Series 1997A bonds and pay issuance costs. Principal payments of $100,000 are due annually beginning October 1, 2018 until the maturity date of October 1, 2021. The 2014B note bears interest, payable monthly, at a variable rate equal to the 1-month London Interbank Offered Rate plus a margin ranging from .73% to 2.25% based on the debt rating of the Primary Health System. The applicable interest rate at June 30, 2017 was 1.74%.

On January 1, 2004, the Primary Health System issued $85,000,000 insured Series 2004 bonds for the purpose of refunding $80,925,000 of the total outstanding Series 1993 bonds. The Primary Health System also utilized the proceeds to pay certain issuance costs and establish a debt service fund. The outstanding Series 2004 bonds mature annually on October 1 through 2022 in varying amounts. The Series 2004 bonds maturing after October 1, 2019 may be redeemed by the Primary Health System after October 1, 2019 at a redemption price equal to the principal amount plus accrued interest. Interest rates for the outstanding Series 2004 bonds range from 4.125% to 5.0%.

During 2015, a portion of the Series 2004 bonds totaling $20,615,000 were defeased with the issuance of the Series 2014A bonds proceeds through the deposit of funds into an irrevocable escrow account in amounts sufficient to pay the principal and interest when due. A portion of the defeased Series 2004 bonds totaling $10,840,000 has been redeemed. The escrow balance for payment of the remaining principal and interest totaled $10,440,718 at June 30, 2017.

The Series 2014A bonds, Series 2004 bonds and 2014B note were issued on parity, with respect to collateral, and are also secured by a mortgage on a portion of the Primary Health System's main campus. The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. As of June 30, 2017, management believes the Primary Health System is in compliance with all such covenants.

Long-term debt activity for the Primary Health System for the year ended June 30, 2017 consisted of the following:

	Balance at June 30, 2016	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2017*
Bonds Payable				
Series 2014	$ 158,140,163	$ -	$ 290,979	$ 157,849,184
Series 2004	36,183,687	68,759	4,544,618	31,707,828
Total bonds payable	194,323,850	68,759	4,835,597	189,557,012

	Balance at June 30, 2016	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2017*
2014B Note payable	12,000,000	-	-	12,000,000
Other loans	188,397	-	188,397	-
Capital leases	6,217,356	-	169,654	6,047,702
Total long-term debt	$ 212,729,603	$ 68,759	$ 5,193,648	$ 207,604,714

The Primary Health System's scheduled principal and interest payments (estimated for variable rate debt based on rates at June 30, 2017) on bonds payable and other long-term debt (excluding capital leases) are as follows:

Year Ending June 30,	*Principal*	*Interest*	*Total*
2018	$ 4,575,000	$ 8,924,366	$ 13,499,366
2019	5,060,000	8,704,428	13,764,428
2020	5,295,000	8,463,545	13,758,545
2021	5,540,000	8,211,334	13,751,334
2022	5,815,000	7,933,911	13,748,911
2023-2027	24,780,000	36,362,243	61,142,243
2028-2032	28,265,000	31,217,008	59,482,008
2033-2037	35,985,000	23,331,484	59,316,484
2038-2042	45,225,000	13,877,425	59,102,425
2043-2045	32,765,000	2,511,125	35,276,125
TOTAL	$ 193,305,000	$ 149,536,869	$ 342,841,869

NOTE H--PENSION PLAN

Plan Description: The Primary Health System sponsors and administers the Chattanooga-Hamilton County Hospital Authority Pension Retirement Plan & Trust (the Plan), a single-employer, non-contributory defined benefit pension plan covering employees meeting certain age and service requirements. The Plan issues a publicly available financial report that can be obtained from 975 East Third Street, Chattanooga, Tennessee 37403.

The Primary Health System has the right to amend, in whole or in part, any or all of the provisions of the Plan. Effective July 1, 2009, the Plan was amended to be closed to new employees or rehires, and to further clarify the maximum years of service to be 30. During June 2014, the Plan was amended to freeze the accrual of additional benefits.

Benefits Provided: In addition to normal retirement benefits, the Plan also provides for early retirement, disability and death benefits. Retirement benefits are calculated as a percent of the employee's average monthly salary for the last 10 calendar years (prior to June 2014) times the employee's years of service. Employees earn full retirement benefits after 30 years of service. Early retirement benefits are available once an employee has reached age 55 and 10 years of service at a reduced rate based on age. Disability retirement benefits are available after 3 years of credited service, determined in the same manner as retirement benefits and are payable at the normal retirement date. Death benefits equal the actuarial equivalent value of the employee's vested accrued benefit as of the date of death. An employee who terminates service for other reasons after three years of credited service will receive retirement benefits at the normal retirement date.

Employees Covered: At July 1, 2017, the following employees were included in the Plan:

Active employees	1,814
Inactive employees with deferred benefits	1,294
Inactive employees currently receiving benefits	173
	3,281

Contributions: The Primary Health System has no legal or Plan requirements to fund the Plan and funds the Plan as contributions are approved by the Board of Trustees based on an actuarially determined rate recommended by an independent actuary. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned during the year with an additional amount to finance any unfunded accrued liability.

Net Pension Liability: The Primary Health System's net pension liability was measured as of June 30 2017, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of July 1, 2017. The total pension liability in the actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	N/A
Salary increases	N/A
Investment rate of return	7.5%
Discount rate	7.5%

The mortality assumption is based on the RP 2014 (adjusted to 2006) Total Data Set with Scale MP 2016.

The long-term expected rate of return on the Plan's investments was determined by applying the most recent capital market assumptions, as developed by the investment manager, using a building block approach. The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized as follows:

Asset Class	*Target Allocation*	*Long-term Expected Real Rate of Return*
Large cap equity	15.00%	8.00%
Alternative investments	35.00%	7.00%
Mid/Small cap equity	10.00%	8.75%
International equity	20.00%	7.50%
Fixed income	15.00%	6.70%
Real estate	5.00%	7.00%

The Plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees assuming the actuarially determined contributions are made each year, although not required by the funding policy. Therefore, the discount rate for determining the total pension liability is equal to the long-term expected rate of return on pension plan investments.

Changes in the Net Pension Liability: Changes in the Primary Health System's net pension liability are as follows for the year ended June 30, 2017:

	Total Pension Liability	*Plan Fiduciary Net Position*	*Net Pension Liability*
Balance, June 30, 2016	$ 125,397,044	$ 58,558,658	$ 66,838,386
Interest	8,889,938	-	8,889,938
Liability gains or losses	4,595,946	-	4,595,946
Assumptions changes	1,015,446	-	1,015,446
Benefit payments	(13,981,845)	(13,981,845)	-
Administrative expenses	-	(518,260)	518,260
Investment income	-	4,052,889	(4,052,889)
Investment gains or losses	-	2,253,669	(2,253,669)
Employer contributions	-	5,550,488	(5,550,488)
Balance, June 30, 2017	$ 125,916,529	$ 55,915,599	$ 70,000,930

The following presents the net pension liability of the Primary Health System calculated using the current discount rate of 7.5 percent, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1-percentage-point higher (8.5%) than the current rate:

	1% Decrease 6.5%	*Current Rate 7.5%*	*1% Increase 8.5%*
Net pension liability	$ 77,097,756	$ 70,000,930	$ 63,765,750

Pension Expense and Deferred Outflows of Resources: For the year ended June 30, 2017, the Primary Health System recognized pension expense totaling $9,484,103. At June 30, 2017, the Primary Health System reported deferred outflows of resources from the following sources:

	Deferred Outflows	*Deferred Inflows*
Differences between expected and actual experience	$ 5,543,929	$ -
Changes of assumptions	1,682,893	-
Differences between projected and actual earnings	4,802,736	-
	$ 12,029,558	$ -

Amounts reported as deferred outflows of resources related to pensions will be recognized in pension expense as follows:

Year Ending June 30,	
2018	$ 4,128,799
2019	4,128,799
2020	3,376,827
2021	395,133

NOTE I--OTHER RETIREMENT PLANS

The Primary Health System maintains and administers defined contribution plans under Section 403(b) and 401(a) of the IRC which provides for voluntary contributions by employees. The Plans are for the benefit of all employees 25 years of age or older with at least 12 months of employment.

The Primary Health System matches 50% of each participant's contribution up to 2% of the participant's earnings. For eligible employees hired on or after July 1, 2009, the Primary Health System will make profit sharing contributions equal to 3% of their earnings, regardless if the

employee is making contributions. Additionally, active employees in the frozen pension plan will receive an additional 2.5% contribution through fiscal year 2019. Employer and employee contributions to the plans were approximately $1,870,000 and $9,724,000, respectively, for the year ended June 30, 2017.

NOTE J--MEDICAL MALPRACTICE AND GENERAL LIABILITY CLAIMS

As of January 1, 1976, the Primary Health System adopted a self-insurance plan to provide for malpractice and general liability claims and expenses arising from services rendered subsequent to that date. In 1980, the Primary Health System's Self-Insurance Trust Agreement (the Agreement) was amended to include all coverages that a general public liability insurance policy would cover. In 1988, the Agreement was amended and restated to comply with amendments to the Tennessee Governmental Tort Liability Act and to formally include any claims and expenses related to acts of employees of the Primary Health System. The Primary Health System is funding actuarial estimated liabilities through a revocable trust fund with a bank. The trust assets are included as a part of assets limited as to use in the accompanying combined statements of net position. Such amounts in the trust can be withdrawn by the Primary Health System only to the extent there is an actuarially determined excess. The annual deposit to the self-insurance trust fund is determined by management based on known and threatened claims, consultation with legal counsel, and a report of an independent actuary. Losses against the Primary Health System are generally limited by the Tennessee Governmental Tort Liability Act to $300,000 for injury or death to any one person in any one occurrence or $700,000 in the aggregate. However, claims against healthcare practitioners are not subject to the foregoing limits applicable to the Primary Health System. Any such individuals employed by the Primary Health System, excluding employed physicians for which the Primary Health System has purchased insurance coverage, are covered by the Trust to the limits set forth therein.

In the opinion of management, the revocable trust fund assets are adequate at June 30, 2017 to cover potential liability and malpractice claims and expenses that may have been incurred to that date.

The Primary Health System provides for claims and expenses in the period in which the incidence related to such claims occur based on historical experience and consultation with legal counsel. It is the opinion of management that the reserve for estimated losses and loss adjustment expense at June 30, 2017 is adequate to cover potential liability and malpractice claims which may have been incurred but not reported (IBNR) to the Primary Health System. Such reserve for IBNR claims reflects a discount rate of 5.5% based on the Primary Health System's expected investment return during the payout period.

NOTE K--COMMITMENTS AND CONTINGENCIES

Litigation: The Primary Health System is subject to claims and suits which arise in the ordinary course of business. In the opinion of management, the ultimate resolution of such pending legal proceedings has been adequately provided for in its combined financial statements, and will not have a material effect on the Primary Health System's results of operations or financial position.

Workers Compensation: The Primary Health System has a job injury program to provide benefits to workers injured in employment-related accidents. This program provides medical and indemnity benefits to employees injured in the course of employment for a period up to 24 months from the date of injury. The Primary Health System has recorded a projected liability for known claims that is included in other long-term liabilities in the combined statements of net position.

Healthcare Benefits: The Primary Health System maintains a self-insured healthcare plan to provide reimbursement for healthcare expenses for covered employees. The Primary Health System has estimated and recorded a liability for claims incurred but not reported in the combined financial statements.

Service Agreements: The Primary Health System has entered into various long-term service agreements. Early termination of the agreements could result in fees, penalties and reimbursement of various renovation expenses.

Electronic Health Records: The American Recovery and Reinvestment Act of 2009 and the Health Information Technology for Economic and Clinical Health (HITECH) Act established incentive payments under the Medicare and Medicaid programs for healthcare providers that use certified Electronic Health Record (EHR) technology. To qualify for incentive payments, healthcare providers must meet designated EHR meaningful use criteria as defined by the Centers for Medicare & Medicaid Services (CMS). Incentive payments are awarded to healthcare providers who have attested to CMS that applicable meaningful use criteria have been met. Compliance with meaningful use criteria related to amounts received and recognized in prior years is subject to audit by the federal government or its designee. Management believes the Primary Health System is in compliance with applicable rules and no accrual for repayment has been established.

Regulatory Compliance: The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, Medicare fraud and abuse, and most recently under the Provision of Health Insurance Portability and Accountability Act of 1996, matters related to patient records, privacy and security. Recently, government activity has increased with

respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers, such as the Medicare Recovery Audit Contractor Program. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

In the normal course of business, the Primary Health System continuously monitors and investigates potential issues through its compliance program. Management believes that the Primary Health System is in compliance with applicable laws and regulations or has reported any amounts payable related to known violations, including amounts identified through the Medicare Recovery Audit Contractor program, or similar initiatives, and any settlements will not have a significant impact on the combined financial statements. However, due to the uncertainties involved and the status of ongoing investigations, management's estimate could change in the near future and the amount of the change could be significant.

Health Care Reform: In March 2010, Congress adopted comprehensive healthcare insurance legislation, Patient Care Protection and Affordable Care Act and Health Care and Education Reconciliation Act. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

Construction Grant: During 2017, the Primary Health System entered into an agreement with the Tennessee Valley Authority (TVA). Under the terms of the agreement, TVA will fund a portion of the cost of the construction of a new combined heat and power system (CHP), which will meet the technical requirements outlined in the agreement. The Primary Health System has committed to fund the remainder of the construction of the CHP (to be completed by June 2020) and to fund the operating costs of the CHP for a minimum of 12 years. The CHP is required to generate a specified level of output for 12 years subsequent to completion.

Payments to the Primary Health System are made by TVA based upon achieving certain milestones related to the construction of the CHP. During 2017, payments received totaled approximately $2,100,000 and have been recognized as part of capital contributions in the accompanying statements of changes in net position as management has determined this to be a nonexchange transaction and recognized the payments as milestones are achieved.

In the event the CHP is not completed and functional by June 30, 2020, the Primary Health System will be required to return all funds received. Further, in the event output over the 12-year period is less than specified in the agreement, the Primary Health System would be required to return a portion of the funds. Management believes the likelihood of any of the grant monies being repaid is remote based upon the progress to date and the heating and cooling requirements of the Primary Health System.

Letter of Intent: On June 23, 2017, the Primary Health System entered into a Letter of Intent ("LOI") with the current member/operator of Murphy Medical Center ("Hospital"), Town of Murphy Hospital, Southwestern Health System, Inc., and Murphy Medical Center, Inc., for the purpose of exploring partnership opportunities between Primary Health System and the Hospital in Murphy, NC. Currently, the Primary Health System, through a due diligence process, is considering a member substitution scenario versus a lease arrangement. In the member substitution scenario, the Primary Health System would assume the assets and liabilities. In the lease scenario, the Primary Health System would lease the Hospital for an amount certain. Under both scenarios, the Primary Health System would be responsible for the ongoing operations of the Hospital on a go forward basis. Per the LOI, the parties expect to complete the due diligence process and, if to the Primary Health System's satisfaction, execute a definitive agreement prior to January 1, 2018.

Behavioral Health Joint Venture: Through a joint venture with Acadia Chattanooga Holdings, LLC, via articles of organization filed with the Secretary of State's office on March 7, 2016, the Health System became a minority owner in Erlanger Behavioral Health, LLC, a Tennessee, limited liability company, formed for the purpose of constructing and operating an inpatient and outpatient behavioral health hospital in Chattanooga, Tennessee. In exchange for a 20% ownership in the venture, the Health System contributed the costs for obtaining and the associated value of the appropriate certificate of need, twelve existing geri-psych beds previously housed at its North facility, its trade name and mark, and a contribution toward the option for the purchase of real property upon which the project will be housed. The project is currently under construction and expected to be accepting patients in the spring of 2018. The Health System does not guarantee any indebtedness or have any other financial obligations related to the entity.

NOTE L--LEASES

Capital: During 2012, the Primary Health System entered into an agreement to sell certain professional office buildings (POBs) and concurrently entered into agreements to lease space from the purchaser. The sales price of the POBs was approximately $13,333,000, and a gain of approximately $6,695,000 was realized. Since the Primary Health System is leasing back certain space, a portion of the gain has been deferred and is being recognized over the terms of the

leases. Amortization of the deferred gain is included in non-operating revenue (expenses) for the year ended June 30, 2017. The leases entered into under this sale/leaseback agreement include certain leases which meet the criteria for capitalization. Interest on these leases has been estimated at 7% per annum.

During 2011, the Primary Health System acquired a parcel of land from the Industrial Development Board of the City of Chattanooga, Tennessee for a nominal amount. The Primary Health System also entered into a project development agreement with a developer to facilitate final design, financing and construction of a medical office building for the benefit of Volkswagen Group of America Chattanooga Operations, LLC (Volkswagen) on this land. The Primary Health System has entered into a forty-year ground lease, with the option of two ten-year renewal terms, of the parcel to the developer. Additionally, in 2012, the Primary Health System has entered into a twenty-year lease with the developer for certain space in the medical office building for a wellness center and other operations under a capital lease agreement.

The following is a summary of the net book value of property under capital leases by major classes at June 30, 2017:

	Primary Health System
Buildings	$ 6,599,976
Equipment	79,333
	6,679,309
Less: accumulated amortization	(2,432,777)
	$ 4,246,532

The following is a schedule of future minimum lease payments under capital leases:

Year Ending June 30,	
2018	$ 744,453
2019	759,311
2020	774,587
2021	790,291
2022	806,435
2023-2027	3,622,896

Year Ending June 30,	
2028-2032	3,527,970
2033-2034	160,498
Total minimum lease payments	11,186,441
Less: amount representing interest	(5,138,739)
Present value of minimum lease payments	$ 6,047,702

Operating: The Primary Health System rents office space and office equipment under non-cancelable operating leases through 2033, containing various lease terms. The leases have other various provisions, including sharing of certain executory costs. Rent expense under operating leases was approximately $16,770,000 in 2017.

Future minimum lease commitments for all non-cancelable leases with terms in excess of one year are as follows:

Year Ending June 30,	
2018	$ 12,735,282
2019	9,470,716
2020	7,658,897
2021	4,625,853
2022	1,628,423
Thereafter	17,402,053
	$ 53,521,224

Rental Revenues: The Primary Health System leases office space to physicians and others under various lease agreements with terms in excess of one year. Rental revenue recognized for the year ended June 30, 2017 totaled approximately $2,901,000. The following is a schedule of future minimum lease payments to be received:

Year Ending June 30,	
2018	$ 1,050,500
2019	372,645
2020	224,978
2021	86,118
2022	60,451
Thereafter	226,836
	$ 2,021,528

NOTE M--FAIR VALUE MEASUREMENTS

The Primary Health System categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. The hierarchy is based on the valuation inputs used to measure the fair value of the asset. Level 1 inputs are quoted prices in active markets for identical assets or liabilities; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant unobservable inputs.

The Primary Health System has the following recurring fair value measurements as of June 30, 2017:

	Carrying Value	*Level 1*	*Level 2*	*Level 3*
U.S. Treasury obligations	$ 38,870,890	$ 38,870,890	$ -	$ -
U.S. government agency obligations	69,298,329	-	69,298,329	-
Municipal bonds	9,799,690	-	9,799,690	-
Corporate bonds and others	4,151,705	-	4,151,705	-
Cash and cash equivalents	10,395,768	10,395,768	-	-
	$132,516,382	$ 49,266,658	$ 83,249,724	$ -

The fair value of investments in U.S. government agency bonds, municipal bonds and corporate bonds is estimated based on matrix pricing of similar assets or market corroborated pricing.

NOTE N--MANAGEMENT AGREEMENT

On April 13, 2011, the Primary Health System's Board of Trustees approved a resolution authorizing a management agreement (the Agreement) between the Primary Health System, Hutcheson Medical Center, Inc. and affiliates (collectively, Hutcheson) and the Hospital Authority of Walker, Dade and Catoosa Counties in Georgia (the Hospital Authority).

Under the terms of the Agreement, the Primary Health System proposed general operating policies and directives for Hutcheson; was responsible for the day-to-day management of Hutcheson and provided oversight of ancillary aspects of Hutcheson, such as physician practices, education, research, and clinical services. The Agreement's initial term was to be through March 31, 2021 with the Primary Health System to have the option to extend the agreement for two additional five-year terms. The Primary Health System was authorized to terminate the Agreement, without cause, upon written notice at any point subsequent to May 25, 2013. Upon such termination, Hutcheson was to be obligated to make a Termination Payment to the Primary Health System consisting of all expenses then owed by Hutcheson and any outstanding advances under a Line of Credit Agreement, discussed below. Hutcheson could also terminate the agreement without cause at any point subsequent to May 25, 2013 by paying the Termination

Payment, as well as the lesser of a) $1,000,000 per year for each year the Agreement has been in place, or b) $1,000,000 less any management fees paid in each Agreement year.

In addition to the Agreement, the Primary Health System agreed to extend a Line of Credit (the Line) to the Hospital Authority. The maximum amount available under the Line was $20,000,000 and at June 30, 2017, the draws on the Line totaled $20,000,000. The Line called for interest only payments each month on the outstanding balance, based on the London InterBank Offered Rate plus 4% or a rate of 5%, whichever is greater. However, any unpaid interest through March 31, 2013 was deferred and to be paid over a twelve-month period commencing on that date. All outstanding draws were due at the maturity date, which is consistent with the Agreement termination dates, discussed above.

The Line was secured by a Security Agreement on the primary Hutcheson medical campus. Further, the Counties of Walker and Catoosa, Georgia (collectively, the Counties) provided additional security in the form of guarantees under an Intergovernmental Agreement. Under the Intergovernmental Agreement, the Counties each agreed to a maximum liability of $10,000,000 to secure the line. The form of such guarantee was at the option of the Counties and was to become enforceable upon a notice of default delivered by the Primary Health System. The form of the guarantee selected by the Counties can include a) a payment of 50% by each County of the amounts owing under the Line, b) payments as they become due up to the respective $10,000,000 limits or c) after non-Judicial foreclosure under the Security Agreement, each County could elect to pay 50% of any deficiency between the amount outstanding under the Line and the then fair market value. Both Counties previously agreed to levy annual property taxes, if needed to honor these guarantees.

In June 2013, the Agreement was modified to allow Hutcheson to issue requests for proposals for the lease or sale of Hutcheson properties without creating a breach of the Agreement. As part of the Agreement, Hutcheson committed to obtain alternative financing and repay the line of credit upon the earlier of the replacement financing being obtained by Hutcheson, or June 1, 2014. In August of 2013, however, Hutcheson terminated the Agreement. In response thereto, the Primary Health System declared Hutcheson to be in default under the Agreement and made formal demand of Hutcheson as to all amounts then due and payable. In February 2014, the Primary Health System filed suit against Hutcheson in order to collect the moneys, including principal, interest and penalties, then due. In response to such filing, Hutcheson has asserted multiple counter claims against the Primary Health System alleging mismanagement and other failures under the Agreement. Additionally, another senior creditor has filed a separate lawsuit against the Primary Health System alleging priority over the Primary Health System's security interest and, presumably, the County guarantees relating to Hutcheson. The litigation was filed in the United States District Court in the Northern District of Georgia, Rome Division.

During the pendency of the litigation, Hutcheson's operating entities (Hutcheson Medical Center, Inc. and Hutcheson Medical Division, Inc., but not the Hospital Authority) filed for Chapter 11 bankruptcy protection in the Northern District of Georgia. Such filing automatically stayed the pending litigation to the extent it pertained to Hutcheson's operating entities. On September 15, 2015, the Bankruptcy Court did appoint a Chapter 11 Trustee in order to facilitate a sale of Hutcheson's interests and to consider conversion to a Chapter 7 under the Bankruptcy Code. Following the filing of adverse proceedings by the Primary Health System against the Hutcheson entities with the Bankruptcy Court, the parties reached an agreement as to the sale and disposition of the entities' primary assets, including its skilled nursing facility and acute care hospital. As a result of the same, the Primary Health System was paid a total of $2,590,000 from such sale and, further, the Bankruptcy Court made various findings of fact to enable the Primary Health System to pursue its guarantees against Walker and Catoosa County. Per the Agreement and the Line, the Counties were entitled to and did receive a credit against their guarantees. The Primary Health System remains tangentially involved in the bankruptcy action to ensure that any of its interests remain adequately protected. That portion of the litigation relating to the Hospital Authority, which is unable to seek bankruptcy protection under Georgia law, did continue for a period of time parallel to the bankruptcy proceeding and ultimately resulted in judgment in the Primary Health System's favor in the amount of $36,500,000. The Hospital Authority is apparently judgment-proof and has no material assets at this point. The Primary Health System remains a judgment creditor against the Hospital Authority.

Regions Bank (Regions) is also a creditor of Hutcheson and initiated related litigation in the U.S. District Court for the Northern District of Georgia in Rome (Case No. 4:14-cv-00191) against the Primary Health System in its effort to protect its interest, if any, in the litigation. Specifically, Regions claims the Primary Health System's interest is subordinate to its interest and seeks a declaration of such priority. Regions claims that Hutcheson owes Regions in excess of $22.3 million that is allegedly a senior debt to the debt Hutcheson owes to the Primary Health System. Regions further claims that the Primary Health System's attempted foreclosure constitutes a breach of the Management Agreement to which Regions is allegedly a third-party beneficiary and related contracts. Regions filed a Motion for a temporary restraining order on July 28, 2014, seeking to enjoin the foreclosure proceedings. The Court denied Regions Motion for a temporary restraining order as moot in light of the injunctive relief it granted to Hutcheson in the related litigation. Regions filed a second Motion for a temporary restraining order on October 15, 2014, which was heard on October 24, 2014. The Court again denied the Motion for a temporary restraining order as moot due to the injunctive relief granted to Hutcheson in the related litigation. The Primary Health System filed a Motion to Dismiss in the Regions suit, which was granted on October 29, 2014 and dismissed all claims against the Primary Health System in their entirety. Regions appealed the dismissal to the 11th Circuit. As part of the agreement reached in the adverse action filed by the Primary Health System in the Bankruptcy Court (as referenced above), Regions agreed to dismiss its appeal with prejudice.

On or about December 28, 2015, Erlanger filed suit against Walker County in the United States District Court for the Northern District of Georgia in Rome (Case No. 4:15-cv-00250) to enforce its guarantee on the remaining amount of approximately $8,705,000 (in consideration of the credit referenced above), plus interest. On August 23, 2016, the Court granted the Primary Health System's motion for summary judgment for such amount. Shortly thereafter, Walker County appealed that order to the 11th Circuit Court of Appeals, which court affirmed on all counts July 17, 2017. The Court of Appeals thereafter remanded the case back to the Court for trial on the issue of attorneys' fees owed to the Primary Health System relating to the litigation. The pre-trial scheduling order is currently due on September 28, 2017. The Primary Health System intends to seek enforcement of the Court's judgment as to principal, interest and attorneys' fees immediately. At June 30, 2017, amounts due from Walker County are reflected as current or long-term assets based on management's evaluation of the timing of payments.

As to Catoosa County, rather than file suit directly against it, the Primary Health System worked with and negotiated a settlement agreement resolving all claims under the guarantee as to Catoosa County for the lump-sum payment of $6,250,000. Such amounts were paid in full in 2016.

NOTE O--CONDENSED FINANCIAL INFORMATION

The following is condensed, financial information related to the discretely presented component units as of and for the year ended June 30, 2017:

	ContinuCare	*Cyberknife*
Due from other governments	$ 247,615	$ 177,004
Other current assets	20,757,822	370,212
Total Current Assets	21,005,437	547,216
Net property, plant and equipment	4,573,500	2,459,249
Other assets	467,177	41,420
Total Assets	$ 26,046,114	$ 3,047,885
Due to other governments	$ 1,199,599	$ -
Other current liabilities	6,724,038	480,302
Total Current Liabilities	7,923,637	480,302
Long-term debt and capital lease obligations	718,454	937,500
Total Liabilities	8,642,091	1,417,802

	ContinuCare	*Cyberknife*
Net position		
Unrestricted	12,833,343	441,914
Net investment in capital assets	4,570,680	1,188,169
Total Net Position	17,404,023	1,630,083
Total Liabilities and Net Position	$ 26,046,114	$ 3,047,885
Year Ended June 30, 2017		
Net patient and operating revenue	$ 32,364,798	$ 1,838,267
Operating expenses:		
Salaries, wages and benefits	14,697,033	258,582
Supplies and other expenses	21,093,742	646,969
Depreciation	609,519	628,590
Total Operating Expenses	36,400,294	1,534,141
Operating Income (Loss)	(4,035,496)	304,126
Nonoperating revenue (expense)	6,796,216	(81,423)
Operating distributions	-	(250,000)
Change in Net Position	2,760,720	(27,297)
Net Position at Beginning of Period	14,643,303	1,657,380
Net Position at End of Period	$ 17,404,023	$ 1,630,083

ContinuCare owes the Primary Health System for various services, supplies, and rents provided, or expenses paid on its behalf. Actual expenses incurred related to these services (including 340(b) pharmacy discounts remitted to the Primary Health System) were approximately $7,612,000 in 2017. In addition, ContinuCare provides staffing, contract nurse visits, and administrative services to the Primary Health System. Revenues from such services were approximately $584,000 for the year ended June 30, 2017. Amounts due at June 30, 2017 are included in amounts due to/from other governments in the accompanying combined financial statements. During 2017, ContinuCare sold substantially all of its pharmacy operations to an unrelated third party. A gain of approximately $8,000,000 was recognized on the sale of the operations and assets.

The Primary Health System owes Cyberknife for radiation services provided by Cyberknife to the Primary Health System's patients. Revenues related to those services provided to the Primary Health System were approximately $1,840,000 in 2017. Amounts due at June 30, 2017 are included in amounts due to/from other governments in the accompanying combined financial statements.

NOTE P--SUBSEQUENT EVENTS

Subsequent events have been evaluated through the date of the Independent Auditor's Report, which is the date the financial statements were available to be issued. During this period, management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2017 financial statements.

Required Supplementary Information

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Schedule of Changes in Net Pension Liability and Related Ratios

Year Ended June 30, 2017

	2016	2017
Total pension liability		
Interest	$ 9,054,674	$ 8,889,938
Differences between expected and actual experience	3,599,202	4,595,946
Changes of assumptions or inputs	(329,629)	1,015,446
Benefit payments	(15,040,450)	(13,981,845)
Net change in total pension liability	(2,716,203)	519,485
Total pension liability, beginning of year	128,113,247	125,397,044
Total pension liability, end of year	$ 125,397,044	$ 125,916,529
Plan fiduciary net position		
Contributions - employer	$ 2,000,004	$ 5,550,488
Net investment income, net	(4,064,193)	6,306,558
Benefit payments	(15,040,450)	(13,981,845)
Administrative expense	(592,487)	(518,260)
Net change in plan fiduciary net position	(17,697,126)	(2,643,059)
Plan fiduciary net position, beginning of year	76,255,784	58,558,658
Plan fiduciary net position, end of year	$ 58,558,658	$ 55,915,599
Net pension liability, end of year	$ 66,838,386	$ 70,000,930
Fiduciary net position as a percentage of the total pension liability	46.70%	44.41%
Covered-employee payroll	$ 117,027,000	$ 106,620,000
Net pension liability as a percentage of covered-employee payroll	57.11%	65.65%

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Schedule of Actuarial Contributions

Year Ended June 30, 2017

	2017	*2016*	*2015*	*2014*	*2013*	*2012*	*2011*	*2010*	*2009*	*2008*
Actuarially determined contributions	$ 5,943,258	$ 4,957,642	$ 4,364,255	$ 12,832,292	$ 11,165,101	$ 10,367,973	$ 8,833,977	$ 7,501,004	$ 7,192,948	$ 6,731,386
Actual employer contributions	5,550,488	2,000,004	1,000,000	-	11,165,101	10,367,970	8,833,977	7,501,004	7,192,000	6,172,593
Contribution deficiency	$ 392,770	$ 2,957,638	$ 3,364,255	$ 12,832,292	$ -	$ 3	$ -	$ -	$ 948	$ 558,793
Covered-employee payroll	$106,619,652	$117,026,565	$115,717,311	$121,093,695	$138,807,819	$147,947,134	$144,176,724	$139,291,860	$138,478,848	$127,662,977
Contributions as a percentage of covered-employee payroll	5.21%	1.71%	0.86%	0.00%	8.04%	7.01%	6.13%	5.39%	5.19%	4.84%

Notes to Schedule:

Valuation date:	Actuarially determined contribution rates are calculated as of June 30, one year prior to the end of the fiscal year in which contributions are reported.
Actuarial cost method:	Entry age normal
Amortization method:	Level dollar, closed
Amortization period:	18 years
Asset valuation method:	4-year smoothed market
Inflation:	N/A
Lump sum interest rate:	4.0%
Salary increases:	N/A
Investment rate of return:	7.25%
Retirement age:	Normal retirement at 65 years, early retirement at 55 years with 10 years of service
Mortality:	RP 2014 (adjusted to 2006) Total Data Set with Scale MP 2016 in 2017 RP-2014 Mortality for Employees, Health Annuitants, and Disabled Annuitants with general projection per MP-2015 in 2016 RP-2014 Mortality for Employees, Health Annuitants, and Disabled Annuitants with general projection per MP-2014 in 2015 RP-2000 Mortality for Employees, Health Annuitants, and Disabled Annuitants projected to 2018 per Scale AA in 2014

Description	Section / Item
List Of Erlanger Patient Transfer Agreements	B-III-1

MediTract

Current Patient Transfer Agreements

Contract Number	Contract Type	Vendor Other	Department	Status	Effective Date	Expiration Date	Description
2002.6977C	Patient Transfer	Chattanooga Kidney Center North, LLC	8028 - Patient Logistics	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
2002.6976C	Patient Transfer	Chattanooga Kidney Center, LLC	8028 - Patient Logistics	Current	04/20/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
2002.6387C	Patient Transfer	East Tennessee Regional Hospitals	8413 - Disaster Management & EOC	Current	10/10/2014	Evergreen	Disaster Aid Agreement (Memorial Health Care; Parkridge Medical Center, Inc; Southern Tennessee Medical Center (Winchester & Sewanee); Copper Basin Medical Center; Star Regional Medical Center-(Athens & Etowah); Rhea Medical Center; Chattanooga Medical
2002.4833C	Patient Transfer	Eye Surgery Center of Chattanooga	8028 - Patient Logistics	Current	10/23/2014	Evergreen	Patient Transfer
2002.6973C	Patient Transfer	Kidney Center of Cleveland, LLC	8028 - Patient Logistics	Current	05/18/2015	Evergreen	Patient Transfer Agreement
2002.6975C	Patient Transfer	Kidney Center of Highway 58	8028 - Patient Logistics	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
2002.6974C	Patient Transfer	Kidney Center of Missionary Ridge	8028 - Patient Logistics	Current	05/18/2015	Evergreen	Patient Transfer Agreement (Prior Agreements 2002.4023A)
2002.6972C	Patient Transfer	Kidney Center of North Georgia	8028 - Patient Logistics	Current	05/18/2015	Evergreen	Patient Transfer Agreement
2002.5425C	Patient Transfer	Renaissance Surgery Center	8028 - Patient Logistics	Current	02/16/2012	Evergreen	Patient Transfer Agreement
2002.8098C	Patient Transfer	The Center for Oral and Facial	8028 - Patient Logistics	Current	07/31/2017	Evergreen	Patient Transfer Agreement
2002.7238C	Patient Transfer	Vascular Institute of Chattanooga	8028 - Patient Logistics	Current	01/21/2016	Evergreen	Patient Transfer Agreement
2002.1292C	Patient Transfer	Life Care Center of Collegedale	8028 - Patient Logistics	Current	01/01/1995	Evergreen	Patient Transfer Agreement
2002.1293C	Patient Transfer	Marshall Medical Center North	8028 - Patient Logistics	Current	02/01/2000	Evergreen	Pediatric Patient Transfer
2002.1294C	Patient Transfer	Life Care Center of Red Bank	8028 - Patient Logistics	Current	01/01/1995	Evergreen	Patient Transfer Agreement

2002.1306C	Patient Transfer	Tender Loving Care	8028 - Patient Logistics	Current	01/01/1995	Evergreen	Hospice Transfer
2002.1317C	Patient Transfer	LaFayette Health Care	8028 - Patient Logistics	Current	01/31/1995	Evergreen	Patient Transfer Agreement
2002.1321C	Patient Transfer	Jefferson Memorial Hospital	8028 - Patient Logistics	Current	10/22/2004	Evergreen	Patient Transfer Agreement
2002.1336C	Patient Transfer	Mountain Creek Manor	8028 - Patient Logistics	Current	01/20/1995	Evergreen	Patient Transfer Agreement
2002.1337C	Patient Transfer	Murphy Medical Center	8028 - Patient Logistics	Current	04/01/2000	Evergreen	Pediatric Patient Transfer Agreement
2002.1342C	Patient Transfer	Northside Hospital	8028 - Patient Logistics	Current	04/10/1992	Evergreen	Patient Transfer Agreement
2002.1363C	Patient Transfer	Renaissance Rehabilitation	8028 - Patient Logistics	Current	04/26/1990	Evergreen	Patient Transfer Agreement
2002.1372C	Patient Transfer	Rivermont Convalescent Center	8028 - Patient Logistics	Current	01/25/1995	Evergreen	Patient Transfer
2002.1384C	Patient Transfer	The Health Center at Standifer Place	8028 - Patient Logistics	Current	06/18/2012	Evergreen	Patient Transfer
2002.1385C	Patient Transfer	Shepherd Hills Health Care Center	8028 - Patient Logistics	Current	01/25/1995	Evergreen	Patient Transfer Agreement
2002.1388C	Patient Transfer	Methodist Medical Center	8028 - Patient Logistics	Current	02/06/2002	Evergreen	Patient Transfer Agreement
2002.1389C	Patient Transfer	Brookewood Medical Center	8028 - Patient Logistics	Current	06/27/2012	Evergreen	Patient Transfer Agreement
2002.1390C	Patient Transfer	Continuum Care Corporation d/b/a	8028 - Patient Logistics	Current	02/01/1999	Evergreen	Patient Transfer Agreement
2002.1430C	Patient Transfer	Bledsoe Community Medical Center	8028 - Patient Logistics	Current	06/27/2012	Evergreen	Patient Transfer
2002.1446C	Patient Transfer	The University of Tennessee Medical	8028 - Patient Logistics	Current	05/29/2002	Evergreen	Patient Transfer Agreement
2002.1461C	Patient Transfer	Erlanger Bledsoe	8028 - Patient Logistics	Current	10/01/2001	Evergreen	Patient Transfer Agreement
2002.1483C	Patient Transfer	Cookeville Regional Medical Center	8028 - Patient Logistics	Current	02/10/2010	Evergreen	Patient Transfer Agreement
2002.1498C	Patient Transfer	Scott County Hospital	8028 - Patient Logistics	Current	01/11/2001	Evergreen	Patient Transfer Agreement
2002.1499C	Patient Transfer	Wellmont Health Systems	8028 - Patient Logistics	Current	06/30/2001	Evergreen	Patient Transfer Agreement
2002.1502C	Patient Transfer	Laughlin Memorial Hospital, Inc	8028 - Patient Logistics	Current	11/23/2011	Evergreen	Patient Transfer Agreement
2002.1508C	Patient Transfer	Dialysis Clinic, Inc	7158 - Renal Transplant Administration	Current	03/23/1998	Evergreen	DCI Patient Transfer Agreements (all facilities -- see attachments)
2002.1539C	Patient Transfer	Fort Sanders Park West Medical Center	8028 - Patient Logistics	Current	10/22/1999	Evergreen	Patient Transfer Agreement
2002.1550C	Patient Transfer	Johnson City Medical Center	8028 - Patient Logistics	Current	05/29/2002	Evergreen	Patient Transfer Agreement
2002.1594C	Patient Transfer	St Barnabas Nursing Home	8028 - Patient Logistics	Current	01/25/1995	Evergreen	Patient Transfer Agreement
2002.1599C	Patient Transfer	North Jackson Hospital	8028 - Patient Logistics	Current	02/01/2000	Evergreen	Pediatric Patient Transfer Agreement
2002.1605C	Patient Transfer	National Health Care of Rossville	8028 - Patient Logistics	Current	05/17/2012	Evergreen	Patient Transfer Agreement
2002.1606C	Patient Transfer	National Health Care of Fort Oglethorpe	8028 - Patient Logistics	Current	05/22/2012	Evergreen	Patient Transfer Agreement

2002.1607C	Patient Transfer	National Healthcare of Dunlap	8028 - Patient Logistics	Current	06/20/2012	06/19/2018	Patient Transfer Agreement
2002.1608C	Patient Transfer	National Health Care of Athens	8028 - Patient Logistics	Current	05/15/2012	Evergreen	Patient Transfer Agreement
2002.1623C	Patient Transfer	Shriners Hospitals for Children	8028 - Patient Logistics	Current	07/01/2000	Evergreen	Pediatric Patient Transfer Agreement
2002.1634C	Patient Transfer	Rhea Medical Center	8028 - Patient Logistics	Current	02/06/2002	Evergreen	Patient Transfer Agreement
2002.1636C	Patient Transfer	Rhea County Medical Center	7158 - Renal Transplant Administration	Current	09/01/1989	Evergreen	Renal Transplant Services (Transfer)
2002.1650C	Patient Transfer	Siskin Hospital for Physical	8028 - Patient Logistics	Current	02/09/1990	Evergreen	Shared Services
2002.1670C	Patient Transfer	Alexian Village of Chattanooga	8028 - Patient Logistics	Current	01/01/1995	Evergreen	Patient Transfer Agreement
2002.1685C	Patient Transfer	Blount Memorial Hospital	8028 - Patient Logistics	Current	02/07/2001	Evergreen	Pediatric Patient Transfer Agreement
2002.1714C	Patient Transfer	Columbia Indian Path Medical Center	8028 - Patient Logistics	Current	01/13/1997	Evergreen	Patient Transfer Agreement
2002.1715C	Patient Transfer	Columbia East Ridge Hospital	8028 - Patient Logistics	Current	03/31/1998	Evergreen	Pediatric Patient Transfer Agreement
2002.1716C	Patient Transfer	East Ridge Hospital	8028 - Patient Logistics	Current	10/22/1996	Evergreen	Patient Transfer Agreement
2002.1717C	Patient Transfer	NovaMed Eye and Laser Surgery,	8028 - Patient Logistics	Current	06/27/2002	Evergreen	Patient Transfer Agreement
2002.1750C	Patient Transfer	Jamestown Regional Medical Center, f/k/a	8028 - Patient Logistics	Current	05/14/2012	Evergreen	Patient Transfer Agreement
2002.1753C	Patient Transfer	Cartersville Medical Center, LLC d/b/a	8028 - Patient Logistics	Current	05/21/2012	Evergreen	Patient Transfer Agreement
2002.1766C	Patient Transfer	Healthsouth Chattanooga Surgery	8028 - Patient Logistics	Current	04/13/1999	Evergreen	Patient Transfer Agreement
2002.2377C	Patient Transfer	St Mary's Health System, Inc	8028 - Patient Logistics	Current	04/01/2003	Evergreen	Patient Transfer Agreement
2002.2531C	Patient Transfer	Memorial Healthcare System d/b/a	8028 - Patient Logistics	Current	02/01/2015	Evergreen	Patient Transfer Agreement
2002.2697C	Patient Transfer	Redmond Regional Medical Center	8028 - Patient Logistics	Current	01/17/2012	Evergreen	Patient Transfer Agreement
2002.2699C	Patient Transfer	Murray Medical Center	8028 - Patient Logistics	Current	12/05/2011	Evergreen	Patient Transfer Agreement
2002.2700C	Patient Transfer	Medical Center of Manchester	8028 - Patient Logistics	Current	04/17/2015	Evergreen	Patient Transfer Agreement
2002.2702C	Patient Transfer	Lincoln County Health System	8028 - Patient Logistics	Current	11/30/2011	Evergreen	Patient Transfer Agreement
2002.2703C	Patient Transfer	Hamilton Medical Center	8028 - Patient Logistics	Current	11/22/2011	Evergreen	Patient Transfer
2002.2704C	Patient Transfer	Fannin Regional Hospital	8028 - Patient Logistics	Current	06/18/2012	Evergreen	Patient Transfer
2002.2706C	Patient Transfer	Cumberland Medical Center, Inc	8028 - Patient Logistics	Current	12/02/2011	Evergreen	Patient Transfer
2002.2707C	Patient Transfer	Copper Basin Medical Center	8028 - Patient Logistics	Current	12/01/2011	Evergreen	Patient Transfer Agreement
2002.2830C	Patient Transfer	Gordon Hospital	8028 - Patient Logistics	Current	07/01/2012	Evergreen	Patient Transfer Agreement
2002.2854C	Patient Transfer	Chattanooga Rehabilitation	8028 - Patient Logistics	Current	07/25/2012	Evergreen	Patient Transfer Agreement
2002.2891C	Patient Transfer	DeKalb Regional Medical Center, f/k/a	8028 - Patient Logistics	Current	09/28/2008	09/27/2018	Patient Transfer Agreement

2002.3545C	Patient Transfer	Cleveland Tennessee Hospital Company,	8028 - Patient Logistics	Current	11/15/2016	11/14/2019	Patient Transfer Agreement
2002.4049C	Patient Transfer	Vanderbilt University Medical Center	8028 - Patient Logistics	Current	07/01/2008	Evergreen	Burn Patient Transfer
2002.4234C	Patient Transfer	Physicians Surgery Center of	8028 - Patient Logistics	Current	04/13/2015	04/12/2059	Patient Transfer
2002.4267C	Patient Transfer	Parkridge Medical Center	8028 - Patient Logistics	Current	05/18/2012	Evergreen	Patient Transfer
2002.4290C	Patient Transfer	Sweetwater Dialysis Center	7157 - Renal Transplant Donor	Current	06/19/2009	Evergreen	Provide Renal Transplantation and other services to Clinic patients
2002.707C	Patient Transfer	Kindred Hospital	8028 - Patient Logistics	Current	10/01/2001	Evergreen	Patient Transfer Agreement
						No. Of Contract:	**75**

[redacted]

Description	Section / Item
List Of Erlanger Clinical Affiliation Agreements	B-III-1

MediTract

Current Clinical Affiliation Agreements

Contract Number	Contract Type	Vendor Other	Department	Status	Effective Date	Expiration Date	Description
2002.4828C	Clinical Affiliation	Andrews University	8384-Nursing Orientation & Education	Current	10/12/2010	Evergreen	Physical Therapy Program
2002.6500C	Clinical Affiliation	Baylor University	8384-Nursing Orientation & Education	Current	05/19/2014	Evergreen	Health, Human Performance & Recreation Program
2002.5536C	Clinical Affiliation	Bledsoe County Vocational Center	8384-Nursing Orientation & Education	Current	05/02/2012	Evergreen	Health Science Program
2002.4742C	Clinical Affiliation	Brenau University	8384-Nursing Orientation & Education	Current	08/02/2010	Evergreen	Nursing Program and Occupational Therapy Program
2002.4535C	Clinical Affiliation	Carson-Newman College	8384-Nursing Orientation & Education	Current	02/01/2010	Evergreen	School of Nursing
2002.4555C	Clinical Affiliation	Chattanooga Fire Department	8384 - Nursing Orientation & Education	Current	03/01/2010	Evergreen	Emergency Medical Services (EMS) Program
2002.7704C	Clinical Affiliation	Chattanooga State Community College	8022 - Executive Office - VP, Patient Care Services	Current	01/01/2017	06/30/2019	MOU, LPN Nurse Extender to A.A.S. Nursing (RN)
2002.4578C	Clinical Affiliation	College of St. Scholastica	8384-Nursing Orientation & Education	Current	03/12/2010	Evergreen	Healthcare Informatics and Information Management
2002.4856C	Clinical Affiliation	DeVry University, Inc.	8384-Nursing Orientation & Education	Current	06/25/2010	Evergreen	College of Health Sciences
2002.8215C	Clinical Affiliation	Drexel University, College of Nursing and Health	8384 - Nursing Orientation & Education	Current	10/06/2017	10/05/2020	Clinical Affiliation Agreement for Nursing Program
2002.6336C	Clinical Affiliation	East Tennessee State University	8384-Nursing Orientation & Education	Current	01/02/2014	01/01/2019	ETSU Intern Affilate Agreement
2002.5444C	Clinical Affiliation	Everest Institute	8384-Nursing Orientation & Education	Current	07/10/2009	Evergreen	Surgical Technology Program
2002.4958C	Clinical Affiliation	Georgia Department of Community Health	8384-Nursing Orientation & Education	Current	10/29/2010	Evergreen	Nutrition and WIC Program
2002.7131C	Clinical Affiliation	Indiana State University	8384 - Nursing Orientation & Education	Current	09/28/2015	Evergreen	Applied Medicine & Rehabilitation
2002.5734C	Clinical Affiliation	Iowa State University	8384-Nursing Orientation & Education	Current	09/04/2012	Evergreen	Dietetics Program

2002.4543C	Clinical Affiliation	Lee University	8384-Nursing Orientation & Education	Current	02/10/2010	Evergreen	Sociology (Social Work) Program, Athletic Training Education Program(s), and
2002.6204C	Clinical Affiliation	Lenoir Community College	8384-Nursing Orientation & Education	Current	10/28/2013	Evergreen	Public Safety Education Program
2002.5733C	Clinical Affiliation	Lenoir-Rhyne University	8384-Nursing Orientation & Education	Current	09/04/2012	Evergreen	Dietetic Internship Program
2002.4533C	Clinical Affiliation	Lincoln Memorial University	8384-Nursing Orientation & Education	Current	12/09/2009	Evergreen	Physician Assistance Program
2002.4831C	Clinical Affiliation	Lipscomb University	8384-Nursing Orientation & Education	Current	10/19/2010	Evergreen	Dietetic Internship
2002.6675C	Clinical Affiliation	Maryville University	8384-Nursing Orientation & Education	Current	09/26/2014	Evergreen	NEW CCA to provide clinical experience for Maryville University students
2002.4517C	Clinical Affiliation	Medical College of Georgia	8384-Nursing Orientation & Education	Current	02/04/2010	Evergreen	Allied Health Programs
2002.5429C	Clinical Affiliation	Mercer University College of Pharmacy and Health Sciences	8384-Nursing Orientation & Education	Current	02/28/2012	12/27/2017	Pharmacy Practice Program
2002.6057C	Clinical Affiliation	Meridian Institute of Surgical Assisting	8374 - Nurse Recruitment	Current	06/17/2013	Evergreen	Surgical Assisting Program
2002.7883C	Clinical Affiliation	National Institute of First Assisting	8384 - Nursing Orientation & Education	Current	03/13/2017	Evergreen	First Assistant In Surgery Program
2002.5247C	Clinical Affiliation	Nova Southeastern University	8384-Nursing Orientation & Education	Current	09/26/2011	Evergreen	Speach Language and Communciation Disorders Programs
2002.7628C	Clinical Affiliation	Royal Academy of Surgical Assisting, Inc	8384 - Nursing Orientation & Education	Current	10/04/2016	Evergreen	Surgical Assistant Program
2002.7849C	Clinical Affiliation	Samford University	8384 - Nursing Orientation & Education	Current	02/22/2017	Evergreen	Family Nurse Practitioner Program
2002.6058C	Clinical Affiliation	St. Louis College of Pharmacy	8384-Nursing Orientation & Education	Current	06/13/2013	Evergreen	Doctor of Pharmacy Program
2002.8203C	Clinical Affiliation	Tennessee State University	8384 - Nursing Orientation & Education	Current	09/28/2017	09/27/2022	Physical Therapy, Occupational Therapy & Speech Therapy Programs
2002.4502C	Clinical Affiliation	The University of Tennessee	8327 - Executive Office - Human Resources	Current	07/30/2013	Evergreen	Non-Clinical Master Academic Affiliation Agreement
2002.7212C	Clinical Affiliation	The Univsersity of Tennessee, Martin	8384-Nursing Orientation & Education	Current	12/09/2015	Evergreen	Dietetics Internship Program

2002.5709C	Clinical Affiliation	University of Arkansas for Medical Sciences	8384-Nursing Orientation & Education	Current	08/24/2012	Evergreen	Radiologist Assistant Program
2002.5428C	Clinical Affiliation	University of St. Augustine for Health Sciences	8384-Nursing Orientation & Education	Current	02/24/2012	Evergreen	Orthopaedic Physician Assistant Program
2002.4776C	Clinical Affiliation	University of St. Francis	8384-Nursing Orientation & Education	Current	09/18/2007	Evergreen	College of Nursing and Allied Health and Wellness Programs
2002.6810C	Clinical Affiliation	University of Tennessee at	8025 - CRNA School	Current	02/26/2015	Evergreen	Nurse Anesthesia Concentration
2002.7337C	Clinical Affiliation	University of Tennessee at Chattanooga	8384 - Nursing Orientation & Education	Current	03/19/2016	Evergreen	Occupational Therapy
2002.7441C	Clinical Affiliation	University of Tennessee through its College of Health	7091 - Children's Therapy Services	Current	06/06/2016	04/30/2018	Provide Fieldwork to Speech & Audiology Students
2002.5976C	Clinical Affiliation	University of the Cumberlands	8384-Nursing Orientation & Education	Current	04/19/2013	Evergreen	Physician Assistant Program
2002.4536C	Clinical Affiliation	University of West Georgia	8384 - Nursing Orientation & Education	Current	02/12/2010	Evergreen	Nursing
2002.8064C	Clinical Affiliation	Volunteer State Community College	7316 - CH Sleep Lab	Current	07/07/2017	07/06/2020	Physical Therapist Assistant and Sleep Diagnostics Program
2002.5086C	Clinical Affiliation	Walker County Emergency Services	8384 - Nursing Orientation & Education	Current	06/17/2011	Evergreen	Walker County Emergency Services Training Division
2002.8125C	Clinical Affiliation	Western Governors University	8384 - Nursing Orientation & Education	Current	08/18/2017	Evergreen	Bachelor of Science in Health Informatics Program
2002.7729C	Clinical Affiliation	Western Kentucky University	8384-Nursing Orientation & Education	Current	11/26/2016	11/25/2019	Speech-Language Pathology Program
2002.1522C	Clinical Affiliation	Emory University	8384 - Nursing Orientation & Education	Current	01/03/2012	Evergreen	Nursing Program
2002.1659C	Clinical Affiliation	State University of New York	8384-Nursing Orientation & Education	Current	11/05/2010	Evergreen	Dietetics Program
2002.169C	Clinical Affiliation	University of Tennessee - Memphis	8384 - Nursing Orientation & Education	Current	09/24/2014	Evergreen	Pharmacy
2002.1806C	Clinical Affiliation	Miller-Motte Technical College	8384-Nursing Orientation & Education	Current	03/01/2008	Evergreen	Medical Assisting, Dental Assisting, Sterile Processin and Surgical Technology Programs
2002.1895C	Clinical Affiliation	Trevecca Nazarene University	8384-Nursing Orientation & Education	Current	02/16/2010	Evergreen	Physician Assistant Program
2002.1896C	Clinical Affiliation	Tri-County Community College	8384-Nursing Orientation & Education	Current	10/17/2007	Evergreen	Clinical Affiliation Agreement - Emergency Medical Science Program

2002.1902C	Clinical Affiliation	Tyner Academy	8384-Nursing Orientation & Education	Current	11/23/2009	Evergreen	Educational Program CAA
2002.1933C	Clinical Affiliation	University of Tennessee at Chattanooga	8384-Nursing Orientation & Education	Current	07/02/2009	Evergreen	Biological and Environmental Science, Graduate Athletic Training, Nursing, Non-Profit Management, OB/GYN, Physical Therapy and Pre-Med
2002.1934C	Clinical Affiliation	Oakwood College	8384-Nursing Orientation & Education	Current	09/15/2008	Evergreen	Clinical Affiliation Agreement
2002.1995C	Clinical Affiliation	Northeast Alabama Community College	8384-Nursing Orientation & Education	Current	01/14/2009	Evergreen	Paramedic Program
2002.2105C	Clinical Affiliation	Dalton State College	8384-Nursing Orientation & Education	Current	05/01/2008	Evergreen	LPN, Surgical Tech, Emergency Medical Tech, Paramedic, Respiratory, OR Nursing, Allied Health
2002.2123C	Clinical Affiliation	Chattanooga College Medical, Dental & Technical Careers f/k/a ECPC Career College	8384-Nursing Orientation & Education	Current	03/06/2008	Evergreen	Medical Assistant, Medical Office, Office Technology, Dental Assistant and Pharmacy Technician
2002.2149C	Clinical Affiliation	Frontier Nursing University, Inc. f/k/a Frontier School of Midwifery and Family	8384-Nursing Orientation & Education	Current	09/28/2011	09/27/2018	Master of Science in Nursing & Doctorate of Nursing Practice Programs
2002.2171C	Clinical Affiliation	Wallace State Community College	8384-Nursing Orientation & Education	Current	11/01/2009	10/31/2018	Respiratory, Occupational & Physical Therapy Clinical Affiliation
2002.2186C	Clinical Affiliation	University of Tennessee at Knoxville	8384-Nursing Orientation & Education	Current	03/18/2010	Evergreen	Nursing & Nutrition Programs
2002.2190C	Clinical Affiliation	University of Tennessee at Memphis	8384-Nursing Orientation & Education	Current	06/04/2009	Evergreen	Nursing and Allied Health Programs
2002.2230C	Clinical Affiliation	Auburn University College of Human Sciences	8384-Nursing Orientation & Education	Current	06/16/2008	Evergreen	Child Life Internship
2002.2326C	Clinical Affiliation	Vanderbilt University School of Nursing	8384-Nursing Orientation & Education	Current	06/10/2011	Evergreen	Advanced Practice Nursing Program
2002.2360C	Clinical Affiliation	Southern Adventist University	8384-Nursing Orientation & Education	Current	05/01/2007	Evergreen	Nursing Program
2002.2361C	Clinical Affiliation	Southern Tennessee Medical Center	8384-Nursing Orientation & Education	Current	07/25/2008	Evergreen	Women and Infant RN
2002.2410C	Clinical Affiliation	Northwestern State Technical College	8384-Nursing Orientation & Education	Current	08/04/2008	Evergreen	Nursing and Allied Health

2002.2487C	Clinical Affiliation	Middle Tennessee State University	8384 - Nursing Orientation & Education	Current	09/18/2015	09/18/2018	BS Nursing Program
2002.2530C	Clinical Affiliation	Chattanooga Association for	8314 - Pastoral Care	Current	02/04/2012	02/03/2018	Clinical Pastoral Education Program
2002.2576C	Clinical Affiliation	University of South Alabama	8384-Nursing Orientation & Education	Current	05/26/2009	Evergreen	Children's Therapy & Nursing Programs
2002.2745C	Clinical Affiliation	Chattanooga State Technical Community College	8384 - Nursing Orientation & Education	Current	05/18/2009	Evergreen	CAA Programs listed on Assets tab
2002.2780C	Clinical Affiliation	Bethel University, f/k/a Bethel College	8384-Nursing Orientation & Education	Current	05/26/2009	Evergreen	Physician Assistant Program
2002.3028C	Clinical Affiliation	Jacksonville State University	8384-Nursing Orientation & Education	Current	08/07/2009	Evergreen	Nursing Program
2002.3230C	Clinical Affiliation	Auburn University	8384-Nursing Orientation & Education	Current	09/10/2010	Evergreen	Nursing & Speech and Hearing Programs
2002.3273C	Clinical Affiliation	Auburn University Montgomery, School of Nursing	8384-Nursing Orientation & Education	Current	12/04/2009	Evergreen	Nursing Program
2002.3274C	Clinical Affiliation	Red Bank High School	8384-Nursing Orientation & Education	Current	11/19/2009	Evergreen	Educational Program CAA
2002.3322C	Clinical Affiliation	Belmont University	8384-Nursing Orientation & Education	Current	05/01/2007	Evergreen	Occupational & Physical Therapy CAA
2002.3422C	Clinical Affiliation	Schoolcraft College	8384-Nursing Orientation & Education	Current	05/14/2007	Evergreen	Biomedical Internship CAA
2002.3442C	Clinical Affiliation	University of Alabama - Birmingham	8384-Nursing Orientation & Education	Current	06/05/2009	Evergreen	Acute Care Adult, Pediatric & Neonatal Respiratory Programs, Child Life Program, and Occupational and Physical Therapy
2002.3536C	Clinical Affiliation	Academy of Allied Health	8384-Nursing Orientation & Education	Current	07/30/2007	Evergreen	Allied Health
2002.3537C	Clinical Affiliation	Appalachian College of Pharmacy	8384-Nursing Orientation & Education	Current	11/19/2013	Evergreen	Pharmacy Program
2002.3540C	Clinical Affiliation	Walden University	8384-Nursing Orientation & Education	Current	05/30/2007	Evergreen	Nursing
2002.3541C	Clinical Affiliation	South College	8384-Nursing Orientation & Education	Current	08/16/2010	Evergreen	Physician Assistant & Pharmacy Programs
2002.3553C	Clinical Affiliation	Madisonville Community College	8384-Nursing Orientation & Education	Current	10/20/2010	Evergreen	Surgical Assistant Program

2002.3681C	Clinical Affiliation	Medical University of South Carolina	8384-Nursing Orientation & Education	Current	09/19/2017	Evergreen	Health Professions Rehabilitiation Sciences Program
2002.3819C	Clinical Affiliation	Virginia College, LLC	8384-Nursing Orientation & Education	Current	03/20/2008	Evergreen	Allied Health and Administrative Office Management Programs
2002.3874C	Clinical Affiliation	Chattanooga Hamilton County Medical Society and Medical Foundation of Chattanooga	8384 - Nursing Orientation & Education	Current	05/30/2008	Evergreen	Youth Leadership Program (Job Shadowing for High School Juniors and Seniors to shadow physicians and participate in roundtable
2002.3880C	Clinical Affiliation	Lifeguard Ambulance Service of Tennessee, LLC	8384 - Nursing Orientation & Education	Current	05/06/2008	Evergreen	Respiratory Care Credentialing Program
2002.3941C	Clinical Affiliation	Kennesaw State University	8384-Nursing Orientation & Education	Current	08/01/2008	Evergreen	WellStar Primary Care Nurse Practitioner Program
2002.3944C	Clinical Affiliation	Utah State University	8374 - Nurse Recruitment	Current	06/24/2008	Evergreen	Dietetic Internship Program
2002.3968C	Clinical Affiliation	Southwest Florida College	8384 - Nursing Orientation & Education	Current	08/07/2008	Evergreen	Professional Assistants PRN Program
2002.3972C	Clinical Affiliation	Tennessee Board of Regents	8384-Nursing Orientation & Education	Current	05/16/2017	05/15/2022	Nursing, Allied Health Programs & Health Information Technology Programs (See Exhibit A for
2002.4029C	Clinical Affiliation	Eastern Virginia Medical School	8384-Nursing Orientation & Education	Current	10/17/2008	Evergreen	Master Physician Assistant
2002.4030C	Clinical Affiliation	Tennessee Academy of Sleep Medicine	8384 - Nursing Orientation & Education	Current	10/17/2008	10/16/2018	Sleep Technology
2002.4064C	Clinical Affiliation	Signal Centers, Inc.	8384 - Nursing Orientation & Education	Current	10/22/2008	Evergreen	Young Adult Enrichment Program
2002.4116C	Clinical Affiliation	Gordon Hospital	8384 - Nursing Orientation & Education	Current	01/05/2009	Evergreen	Job Shadowing Agreement, Pediatric ICU
2002.4118C	Clinical Affiliation	University of Mississippi	8384-Nursing Orientation & Education	Current	01/15/2009	Evergreen	Speech Pathology Program
2002.4242C	Clinical Affiliation	South University	8384-Nursing Orientation & Education	Current	05/07/2009	Evergreen	Physician Assistant Program
						No. Of Contract:	**96**

[redacted]

Description	Section / Item
Erlanger Medical Center License	B-III-4
Statement Of Deficiencies & Plan Of Correction	B-III-4

Board for Licensing Health Care Facilities

State of Tennessee

0000000140

No. of Beds 0788

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

CHATTANOOGA HAMILTON COUNTY HOSPITAL AUTHORITY *to conduct and maintain a*

Hospital ERLANGER MEDICAL CENTER

Located at 975 EAST THIRD STREET, CHATTANOOGA

County of HAMILTON *, Tennessee.*

This license shall expire JUNE 04 *,* 2018 *, and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 1ST *day of* JUNE *,* 2017 *.*

In the Distinct Category(ies) of: PEDIATRIC CPRC HOSPITAL
TRAUMA CENTER LEVEL 1
GENERAL HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner, MD
COMMISSIONER

CF011

TN Department of Health

September 14, 2016

Mr. Kevin Spiegel, Administrator
Erlanger Medical Center
975 E 3rd St
Chattanooga TN 37403

RE: 44-0104

Dear Mr. Spiegel:

The East Tennessee Region of Health Care Facilities conducted a complaint investigation on July 19, 2016. An on-site revisit was conducted on September 07, 2016. Based on the on-site revisit and review of your plan of correction, we are accepting your plan of correction and your facility is in compliance with all participation requirements as of September 07, 2016

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-594-9396 or by fax: 865-594-5739.

Sincerely.

Tamra Turberville/cw

Tamra Turberville, RN
Regional Administrator
East TN Health Care Facilities

TT: cw

TN00039251

erlanger

August 3, 2016

Tamra Turberville, RN
Regional Administrator
State of Tennessee Department of Health
East TN Health Care Facilities
Division of Health Licensure and Regulation
7175 Strawberry Plains Pike, Ste 103
Knoxville, TN 37914

Erlanger Health System
975 East Third Street
Chattanooga, TN 37403
Provider Number: 44-0104

Ms. Turberville,

Enclosed you will find the plan of correction for the finding during the complaint investigation conducted at Erlanger East Campus on July 19, 2016. You will receive a faxed copy today and a hard copy delivered tomorrow by FedEx. If you have any questions or need additional information please contact me at 423-778-3341.

Thank you,

Debbie Shepherd

Debbie Shepherd, BSN, RN
Erlanger Health System
Corporate Preparedness Officer/Corporate Safety Officer

PRINTED: 07/21/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - EAST WOMENS PAVILION B. WING	(X3) DATE SURVEY COMPLETED C
	TNP531140		07/19/2016

NAME OF PROVIDER OR SUPPLIER: ERLANGER MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 975 E 3RD ST, CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 887	1200-8-1-.08 (17) Building Standards (17) The licensed contractor shall not install a system of water supply, plumbing, sewage, garbage or refuse disposal nor materially alter or extend any existing system until the architect or engineer submits complete plans and specifications for the installation, alteration or extension, to the department demonstrating that all applicable codes have been met and the department has granted necessary approval. (a) Before the hospital is used, Tennessee Department of Environment and Conservation shall approve the water supply system. (b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction. (c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F and 115°F. This Rule is not met as evidenced by: Based on testing and interview the facility failed to provide hot water at each hot water outlet at all times. Finds include;	H 887	H 887 1200-8-1-08 (17) Building Standards **The findings included:** (C) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105 degrees F and 115 degrees F. The rule was not met as evidenced by: Based on testing and interview the facility failed to provide hot water at each hot water outlet at all times. **Plan of Correction Responsibility:** The Chief Operating Officer and the Vice President of Facilities, and Construction Services has the responsibility for the corrective action and ongoing compliance. **When/How Corrected:** The hot water temperature was temporarily corrected on July 19 by opening the hot water loop to the area affected and eliminating a mixing valve in the environmental services closet that had a significant crossover issue. This temporary correction provided a continuous hot water flow to the area. The affected area was the Medical/Surgical Unit on the Erlanger Women's East Campus, ground level.	July 19, 2016

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JAMES
TITLE: Executive Vice President + Chief Medical Officer
(X6) DATE: 8/3/2016

EVP/CMO 3 Aug 16

PRINTED: 07/21/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - EAST WOMENS PAVILION B. WING	(X3) DATE SURVEY COMPLETED
	TNP531140		C 07/19/2016

NAME OF PROVIDER OR SUPPLIER: ERLANGER MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 975 E 3RD ST CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 887	Continued From page 1 Testing and interview with maintenance, on 7/19/16 between 11:00 AM and 12:35 PM revealed the facility failed to maintain hot water in the surgical services area of the facility. The following hot water temperatures were identified; Kitchen of surgical services- 89.3 degrees at 12:31 PM Breakroom of surgical services- 100 degrees at 12:20 PM Patient room 8715- 79 degrees at 12:35 PM Patient room 8716- 80.3 at 12:27 PM Patient room 8718- 74.8 at 12:32 PM These findings were verified by maintenance and acknowledged by the executive assistant administrator via phone during the exit conference on 7/19/16.	H 887	The permanent corrective action plan is as follows: 1. A site visit by a local engineering company was conducted on July 25, 2016; 2. After review of the plans by the engineer, the recommendation of correction was to install a hot water recirculation line in the Medical/Surgical Unit on the Erlanger Women's East Campus, ground level. 3. The hot water recirculation line was installed on July 27, 2016. The hot water loop to the area will continue to remain open providing hot water until the recirculation line is balanced by the plumbing contractor onsite – to be completed by August 30, 2016. 4. A high and low alarm for the hot water system will be added to the building management system for Erlanger Women's East by August 30, 2016. The installation of these alarms will notify engineering personnel of any out of range water temperature 24 hours per day/7 days/week. **Monitoring of the Corrective Action(s)** Monitoring will be ongoing (24 hours/day/7 days/week) by the energy management system for Erlanger Health System after the installation of the high and low alarm for the hot water system for the Erlanger Women's East building. Completion date August 30, 2016. In addition, the Erlanger building engineers will perform temperature checks on the hot water system as part of the daily building mechanical systems rounds.	July 25, 2016 July 27, 2016 August 30, 2016 August 30, 2016 Ongoing August 30, 2016 Ongoing

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

April 1, 2018

Mr. Joseph Winick, Sr Vice President
Erlanger Health System-Innovation Center
975 East 3rd Street
Chattanooga, TN 37403

RE: Certificate of Need Application – Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Medical Center - CN1802-011
The establishment of a satellite emergency department facility with seven treatment rooms and the initiation of cardiac catheterization services at an unaddressed site, otherwise described as 2.9 acres, at the southeast quadrant of Exit 20 northbound on U.S. Interstate 75, accessed via Cherokee Gateway Boulevard, Cleveland (Bradley County),TN. The applicant is owned by Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System. It will be under the administrative control of Erlanger Medical Center and will operate as an outpatient department of the hospital. The estimated project cost is $11,297,935.

Dear Mr. Winick:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1607, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project began on April 1, 2018. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on June 27, 2018.

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(8) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(9) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff is not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill/NF

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: April 1, 2018

RE: Certificate of Need Application
Chattanooga-Hamilton County Hospital Authority
d/b/a Erlanger Medical Center - CN1802-011

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a sixty (60) day review period to begin on April 1, 2018 and end on June 1, 2018.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Joseph Winick

FEB 9 '18 AM 11:01

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Cleveland Daily Banner, which is a newspaper of general circulation in Bradley County, Tennessee, on or before February 9, 2018, for one day.

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This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Medical Center, owned by the Chattanooga-Hamilton County Hospital Authority D/B/A Erlanger Health System, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a new provider based (satellite) emergency department, to include a cardiac catheterization laboratory for outpatient services. The ED will be designated as a Level IV trauma center, which will be part of the Erlanger Trauma Network. No other health care services will be initiated or discontinued.

The facility and equipment will be located at Erlanger Bradley County – Provider Based Emergency Department, located at an unaddressed site, otherwise described as 2.9 acres, at the southeast quadrant of Exit 20 northbound on U.S. Interstate 75, accessed via Cherokee Gateway Blvd., Cleveland, Bradley County, Tennessee, 37353. The total project cost is estimated to be $ 11,297,935.00.

The anticipated date of filing the application is February 14, 2018.

The contact person for this project is Joseph M. Winick, Lead Executive – Innovation Center, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	February 7, 2018 Date:	Joseph.Winick@erlanger.org E-Mail:

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The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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