Original Application

Cleveland TN Hospital Company, LLC d/b/a Tennova Healthcare-Cleveland

CN1803-015

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Tennova Healthcare - Cleveland

Certificate of Need Application
to
Establish a Freestanding Emergency Department

Name of Facility: Cleveland Tennessee Hospital Company, LLC d/b/a
Tennova Healthcare – Cleveland
2305 Chambliss Avenue, NW
Cleveland, Tennessee 37311

Contact Person: Lisa Childers, ACEO
Tennova Healthcare – Cleveland
2305 Chambliss Avenue, NW
Cleveland, Tennessee 37311

March 14, 2018

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare - Cleveland
Name

2305 Chambliss Avenue, NW — Bradley
Street or Route — County

Cleveland — TN — 37311
City — State — Zip Code

Website address: www.tennova.com

*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

Lisa Childers — ACEO
Name — Title

Cleveland Tennessee Hospital Company, LLC d/b/a
Tennova Healthcare – Cleveland — lisa.childers@mytennova.com
Company Name — Email address

2305 Chambliss Avenue — Cleveland — TN — 37311
Street or Route — City — State — Zip Code

ACEO — 423-559-6101 — 423-559-6653
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

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

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

RESPONSE: Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland ("Tennova Cleveland") is a 351-bed licensed general acute care hospital with two campuses in Cleveland, Bradley County, Tennessee: the main hospital campus with 251 licensed beds, and a satellite hospital campus (Tennova Cleveland – Westside) with 100 beds. Tennova Cleveland is part of Tennova Healthcare, a 16-hospital network that spans across the state of Tennessee and includes numerous outpatient facilities as well as the Tennova Medical Group, providing primary care and specialty care services in multiple locations across Tennessee.

Tennova Cleveland proposes to establish a Freestanding Emergency Department ("FSED") in its home county to reduce the current high capacity constraints at its main hospital campus ED, and simultaneously enhance access to emergency services for residents in the communities it has historically served. The proposed FSED will be hospital-based, operating as a satellite ED, thus utilizing the same proven high quality programs and services of Tennova Cleveland's main campus ED. The same physician group (TeamHealth) that currently cares for ED patients at Tennova Cleveland's main hospital campus ED will provide care for patients in the FSED.

Tennova Cleveland's ED serves nearly 50,000 patients each year, making the community hospital a high-volume facility. The vast majority of Tennova Cleveland's ED patients reside in Bradley and Polk Counties. Residents and businesses in these two counties rely on Tennova Cleveland for ED services, evidenced by the letters of support provided and by Tennova Cleveland's historical ED market share in the two counties.

In 2015, Tennova Cleveland cared for nearly 8 out of 10 Bradley County residents needing emergency services (77.6%), making the hospital by far the primary provider of ED services in its home county. That same year, Tennova Cleveland cared for almost one-third of Polk County ED residents seeking ED services (28.9%), making Tennova Cleveland the 2nd leading ED provider to Polk County residents (not far behind Copper Basin Medical Center).

Late last year (October 2017), Polk County's local hospital, Copper Basin Medical Center, closed. Now, residents from Polk County must travel outside of their home county for all hospital-based services, including emergency services. The historical reliance of Polk County residents on Tennova Cleveland to meet their healthcare needs, including emergency services as well as a comprehensive array of inpatient and outpatient services, means that Polk County residents will naturally turn to Tennova Cleveland to fill the void left by their home-county hospital closure. Thus, the already near-capacity ED on Tennova Cleveland's main hospital campus will be further strained as the hospital cares for the growing Bradley County population in addition to the Polk County ED patients in need of healthcare services close to home.

The capacity constraints of Tennova Cleveland's high-volume ED are exacerbated by the type of patients served. Tennova Cleveland's ED serves a disproportionately high percentage of uninsured (self-pay) patients and a low percentage of commercially-insured patients compared

to the total ED patient population in Bradley and Polk Counties. At the same time, Tennova Cleveland serves a relatively high percentage of Medicare (*i.e.*, generally population ages 65+) ED patients compared to all residents seeking emergency services in the 2-county area.

The uninsured and elderly population oftentimes require greater resources, time, and skills of staff members compared to insured, younger patients because the uninsured and elderly patients are likely to have comorbidities and/or complexity of needs beyond the immediate crisis resulting in the ED visit. The relatively resource-intensive patient population served by Tennova Cleveland, including for example the uninsured, elderly, and behavioral health patients, is illustrated by the disproportionately high percentage of highest-acuity patients (identified by CPT Code 99285) Tennova Cleveland serves compared to the total ED patient population in Bradley and Polk Counties. For example, in 2015, almost one-third (32.6%) of Tennova Cleveland's ED patients were of the highest acuity (CPT Code 99285) compared to the approximate 18% highest acuity (CPT Code 99285) of all ED patients from Bradley and Polk Counties that sought care anywhere.

The proposed FSED will provide needed additional capacity for Tennova Cleveland, enabling it to continue providing quality care to its current and future ED patients. Notably, an expansion 'in-place' of Tennova Cleveland's main hospital campus ED is not a viable alternative because of campus space limitations. Moreover, any expansion of the hospital's ED on its main campus would require temporary closure of portions of the ED for renovation and expansion, which would completely disrupt patient care and temporarily reduce access to emergency services. Thus, renovation and expansion in place for the main campus hospital ED is not an option.

The proposed FSED will be located in north Cleveland (Bradley County) near Interstate 75 ("I-75") Exit 27 along the Highway 11 corridor. The location is approximately 3 miles from the hospital's main campus ED, and is centrally-located in the service area. Public transportation, available for Bradley County residents through the Cleveland Urban Area Transit System ("CUATS"), has a route that passes along Stuart Road near the proposed FSED. The availability of public transportation is material in this instance because of the large uninsured and underinsured (TennCare) population Tennova Cleveland's ED serves.

The FSED will enhance access to emergency services for the fast-growing north Bradley County area. The ZIP Code in which the FSED will be located (37312) is the most populated and fastest growing in the 2-county service area, reflecting the significant residential, retail, and commercial/industrial growth along the Highway 11 corridor. Letters of support from businesses in this area specifically address the benefits of the proposed FSED's location in close proximity to industrial plants in north Bradley County. As stated by the local businesses, having a FSED located close to their plants will be extremely beneficial because the hospital's expertise will be even more readily available for any medical emergency that may arise.

Finally, the proposed expansion of Tennova Cleveland's ED will ensure that patients can receive needed health care services close to home, without the need to travel in to Chattanooga. Requiring residents to travel into the heavily-congested Chattanooga area for emergency services, or for any health care service that is available locally, is not only a major inconvenience that causes undue stress and hardship on the patient and family, but is also disruptive to the relationships that local residents have with their community providers.

2) Ownership structure;

RESPONSE: Cleveland Tennessee Hospital Company, LLC, d/b/a Tennova Healthcare – Cleveland is part of the Tennova Healthcare system. Tennova Healthcare system is part of Community Health Systems, Inc. ("CHS"), one of the nation's leading operators of general acute care hospitals with 127 hospitals in 20 states.

3) Service area;

RESPONSE: The service area for the proposed FSED encompasses all of Bradley and Polk Counties. The 2-county service area accounts for approximately 88% of all emergency patients at Tennova Cleveland. As a point of reference, residents from Bradley and Polk Counties similarly account for the vast majority of all inpatients (approximately 86%) admitted to Tennova Cleveland.

4) Existing similar service providers;

RESPONSE: Tennova Cleveland is the only provider of emergency services in the 2-county area. Moreover, with the closure of Polk County's Copper Basin Medical Center in October 2017, Tennova Cleveland is the closest provider for emergency services for most service area residents.

5) Project cost;

RESPONSE: The project cost for the proposed FSED is $12,081,195. This cost includes land acquisition, site work, construction of the facility and all fixed and moveable equipment.

6) Funding;

RESPONSE: The project will be funded through an interest-free cash transfer from the ultimate parent, CHS. (*See* the project funding letter provided in Attachment B-EconFeas-B.)

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

RESPONSE: The proposed project will realize a positive financial margin in Project Year 1.

8) Staffing.

RESPONSE: The proposed FSED will be staffed with 47.2 full time equivalents ("FTEs"). As the emergency service will be available 24 hours per day, 7 days a week, 365 days per year, around-the-clock staffing is included. The proposed staffing includes clinical positions such as Registered Nurses, Nursing Assistants/Techs, and Respiratory Therapists, as well as Radiology and CT Technologists to support the imaging services in the FSED. Additional positions include Laboratory staff along with other support functions such as patient registration and security.

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care 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;

RESPONSE: The proposed satellite ED is needed to reduce the current high capacity constraints at Tennova Cleveland's main hospital campus ED and enhance access to emergency services for residents in the heavily populated and fast-growing north Bradley County area.

Tennova Cleveland's busy ED is operating at virtual capacity, serving patients with complex medical needs who require significant time and resources. To optimally serve its patient population, Tennova Cleveland has several specialized treatment rooms within its total 41-treatment room complement, including for example two (2) isolation rooms and five (5) secure rooms (used primarily for patients with behavioral health and/or substance abuse issues). All of Tennova Cleveland's treatment rooms are private, enhancing quality of care and patient privacy and comfort. Tennova Cleveland's high volume of ED patients, coupled with the types of patients served and the need for specialized rooms within the ED, results in the hospital's main campus ED effectively operating at capacity much of the time.

The proposed FSED will provide needed additional capacity for the hospital to optimally care for its current and future patient population. Moreover, the closure of Copper Basin Medical Center in Polk County last year means that Tennova Cleveland's already-crowded and highly-utilized ED will become even more so as it cares for a growing number of Polk County ED patients.

The availability of an emergency facility in close proximity to the industrial and manufacturing plants in Bradley County is another benefit of the proposed project. Tennova Cleveland's FSED will of course provide services 24 hours/day, 7 days/week, 365 days/year, unlike the numerous 'convenient care' centers that have opened along the Highway 11 corridor in north Cleveland. The distinction between the proposed FSED and retail and urgent care clinics is important: Tennova Cleveland will provide a higher level of care than convenient care centers and will be available every hour, every day. The need for this distinct level of care in close proximity to the industrial and manufacturing plants in north Bradley County, many of which operate 24/7/365, is documented in the letters of support included in this application.

Moreover, Tennova Cleveland's FSED will provide a needed patient access point for uninsured and underinsured patients, two groups of patients that urgent care and retail clinics do not typically serve. To illustrate, approximately 16% of Tennova Cleveland's ED visits annually are for uninsured (self-pay) patients compared to the approximate 5% of Bradley and Polk County total ED patients who are uninsured. Tennova Cleveland's additional ED capacity is needed to ensure the needs of all emergency service patients are met in a timely and efficient manner, including those patients unable to pay for their care.

Expansion and renovation on Tennova Cleveland's main hospital campus is not a viable option; thus, the proposed FSED is needed to provide additional ED capacity and enhance access to services for residents in the 2-county service area.

2) Economic Feasibility;

RESPONSE: The needed expansion of Tennova Cleveland's emergency services cannot be accomplished on the main hospital campus; thus, an off-campus solution to expand the ED is needed. The proposed project accomplishes the needed expansion while concurrently enhancing access to emergency services for residents in the 2-county service area. The proximity to the growing residential, retail, and commercial/industrial area of the county is a benefit of the project, and one that will help ensure the economic feasibility of the FSED.

The proposed project will be funded from an interest-free cash transfer from the hospital's ultimate parent, CHS.

Tennova Cleveland projects to serve a portion of its current ED patient population at the FSED as well as a number of Polk County residents previously served by Copper Basin Medical Center (now closed). As demonstrated later in this application, the reasonable volume projections support the financial performance of the proposed FSED, which is expected to have a positive bottom line in Project Year 1.

3) Appropriate Quality Standards; and

RESPONSE: Tennova Cleveland is a Joint Commission-accredited hospital with a history of providing quality care to the communities it serves.

Specific to emergency services, Tennova Cleveland offers an accredited Chest Pain Center that meets the criteria of the American College of Cardiology ("ACC") and the American Heart Association ("AHA") for high quality care. Tennova Cleveland's Chest Pain Center provides highly specialized care devoted to treating patients with acute coronary syndrome, including the rapid identification of patients presenting with unstable angina (chest pain), decreased time to treatment for heart attack patients, and 24-hour care for chest pain treatment.

One of the many ways that the hospital provides quality care is to ensure that its medical staff members are board-certified. To that end, all of the physicians providing emergency services in the hospital's main ED, and who will provide emergency services in the proposed FSED, are board-certified or board-eligible.

Across all services, Tennova Cleveland is committed to providing safe, quality care for every patient. The hospital's physicians, nurses and all other clinicians actively work to continually improve care, utilizing measurement tools to monitor progress and identify opportunities to further development. The hospital's Quality and Safety Committee, along with its Leadership and Medical Staff committees, reviews results to continually enhance clinical procedures based on scientific evidence and best practices.

4) Orderly Development to adequate and effective health care.

RESPONSE: The proposed project will positively contribute to the orderly development of health care services in the service area by providing Tennova Cleveland with needed additional ED capacity and providing service area residents with a second, centrally-located and accessible emergency service close to their homes and work. With the population increasing and aging in the service area, and the residents of Polk County now relying even more on Tennova Cleveland for health care services, including emergency services, Tennova Cleveland's already highly-utilized and near capacity ED will serve even more patients. Thus, the proposed expansion of ED services is needed to optimally serve Tennova Cleveland's current and future patients.

The proposed FSED is the result of ongoing discussions and plans by Tennova Cleveland to meet its communities' needs for locally available and accessible services. At the same time, another healthcare provider, Erlanger Health System ("Erlanger"), is proposing to develop a satellite ED in Bradley County as part of its Hamilton County-based hospital. Notably, while Tennova Cleveland's project will ensure Bradley and Polk County patients remain close to home for care, Erlanger's project will not. Thus, in contrast to Tennova Cleveland's project, Erlanger's proposed project does not support the orderly development of health care services in the service area; rather, it undermines it.

It is important to note that while the majority of ED patients are treated and discharged home, a portion of ED visits result in an inpatient admission to a hospital. The majority of ED patients who must be admitted for inpatient care *remain at the hospital where they initially sought treatment*. For example, Tennova Cleveland annually admits approximately 13.5% of its ED patients to its hospital for inpatient care. This will continue to be the case with the satellite ED expansion.

The relevance of the ED admission rate to the orderly development of health care services is this: Tennova Cleveland has the ability to care for admitted ED patients in their local community, ensuring continuity of care for the patient. Erlanger does not. If approved, Erlanger will have to transport any ED patient treated in its Bradley County FSED to Chattanooga when inpatient care is needed, or, alternatively, admit its FSED patients to Tennova Cleveland for inpatient care.

For the small portion of ED patients who will need to be admitted to a specialized tertiary or quaternary care provider, they will still be transferred to a hospital outside of Bradley and Polk Counties, most oftentimes to Chattanooga for highly-specialized care. Neither the proposed Tennova Cleveland FSED nor the proposed Erlanger FSED in Bradley County will change the existing specialized tertiary and quaternary referral patterns. Those patterns will remain in place, supporting the existing health care delivery system and the orderly development of same.

Finally, it must be noted that Tennova Cleveland's proposed project will have no adverse impact on any existing provider because the project is needed to better serve existing Tennova Cleveland patients, and to care for the Polk County ED patients who have long relied on Tennova Cleveland for healthcare services, including emergency services, and now have no home-county hospital.

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.

Not applicable.

4. SECTION A: PROJECT DETAILS

A. Owner of the Facility, Agency or Institution

Cleveland Tennessee Hospital Company, LLC

d/b/a Tennova Healthcare – Cleveland
Name

423-559-6000
Phone Number

2305 Chambliss Avenue, NW
Street or Route

Bradley
County

Cleveland
City

TN
State

37311
Zip Code

B. Type of Ownership of Control (Check One)

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

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/FilingSearch.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 of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.*

5. Name of Management/Operating Entity (If Applicable)

Not Applicable
Name

Street or Route

County

City

State

Zip Code

Website address:

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5.**

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

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

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants 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.

*****Please see Attachment A-6A for the site entitlement.***

6B. 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 1/2" 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***);

   b. Location of structure on the site;

   c. Location of the proposed construction/renovation; and

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

RESPONSE: A copy of the plot plan for the proposed FSED on Stuart Road is included as Attachment A-6B.1.

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 as necessary to illustrate the floor plan.

RESPONSE: A copy of the floor plan for the proposed FSED is included as Attachment A-6B.2.

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: Tennova Cleveland's proposed FSED is located on Stuart Road in northern Cleveland. Stuart Road becomes Paul Huff Parkway as it moves northward, crossing both U.S. Highway 11 as well as I-75. The distance from the site of the proposed FSED to U.S. Highway 11 is less than 2 miles; the distance from the site to I-75 is approximately 3 miles.

Public transportation is available for Bradley County residents through the Cleveland Urban Area Transit System, which is operated by the Southeast Tennessee Human Resource Agency ("SETHRA"). CUATS operates 5 distinct routes throughout Cleveland which converge on the Transit Center located at the 'Old Railroad Depot' downtown. The Yellow Line passes along Stuart Road at the proposed freestanding emergency department site as it approaches the Cleveland YMCA, making the proposed FSED site accessible to public transportation.

Buses operate from 6 a.m. to 7 p.m. on weekdays. Fares are affordable and reduced fares are available for students, seniors and those with disabilities. Day and monthly passes are also available.

Please refer to Attachment A-6B.3 for additional information regarding local transit options available to patients of Tennova Cleveland's proposed FSED.

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) **Gen Med/Surg**	X	H.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		I.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		J.	Rehabilitation Facility	
D.	Home Health Agency		K.	Residential Hospice	
E.	Hospice		L.	Nonresidential Substitution-Based Treatment Center for Opiate Addiction	
F.	Mental Health Hospital		M.	Other (Specify)_____	
G.	Intellectual Disability Institutional Habilitation Facility ICF/IID				

Check appropriate lines(s).

8. Purpose of Review (Check appropriate lines(s) – more than one response may apply)

A.	New Institution		F.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
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 T.C.A. §68-11-1607(4) (Specify) ___		G.	Satellite Emergency Dept.	X
			H.	Change of Location	
			I.	Other (Specify)_____	

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 *44-0185*

Medicaid Provider Number *44-0185*

Certification Type *Hospital*

RESPONSE: Tennova Cleveland encompasses two hospital campuses, the main hospital campus and the Westside campus.

Tennova Healthcare currently contracts through master provider agreements with each of the TennCare Managed Care Organizations ("MCO"). Tennova Healthcare intends to continue participation in these plans; thus, Tennova Cleveland will continue participation in the plans as well.

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

Medicare __Yes __No __N/A Medicaid/TennCare __Yes __No __N/A

RESPONSE: *Not Applicable. Tennova Cleveland is an existing, licensed hospital.*

10. **Bed Complement Data**

A. **Please indicate current and proposed distribution and certification of facility beds. **Main Campus data is below.**

**** Please see the bed complement for Tennova Cleveland, including the Westside campus, in Attachment A-10A.**

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical *(combined med/surg)*	208	112				208
2) Surgical						
3) ICU/CCU	24	24				24
4) Obstetrical	12	12				12
5) NICU	3	3				3
6) Pediatric	4	4				13
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL	251	155				251

**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.

Not Applicable. No changes in bed capacity or allocation are proposed as part of this project.

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(s)	CON Expiration Date	Total Licensed Beds Approved
N/A		

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

Not Applicable

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	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 Footage Chart

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Satellite Emergency Department						11,000	11,000
Unit/Department GSF Sub-Total							
Other GSF Total							
Total GSF						11,000	11,000
*Total Cost						$4,998,300	$4,998,300
**Cost Per Square Foot						$454.39	$454.39
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 X Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile X 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 – ***Not Applicable***

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a 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
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 _____	
	Total Cost*: _____	☐ By Purchase ☐ By Lease	Expected Useful Life (yrs) ___
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs)	
☐ MRI	Tesla: ____ Magnet:	☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____	
	Total Cost*: _____	☐ By Purchase ☐ By Lease	Expected Useful Life (yrs) ___
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs)	
☐ PET	☐ PET only ☐ PET/CT	☐ PET/MRI	
	Total Cost*:	☐ By Purchase ☐ By Lease	Expected Useful Life (yrs)
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs)	

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

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.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*	_____	_____
Mobile Locations *(Applicant)*	_____	_____
(Name of Other Location)	_____	_____
(Name of Other Location)		

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

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

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care 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 developed pursuant to
T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" 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)."***

QUESTIONS

SECTION B: NEED

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

Standards and Criteria
Regarding Certificate of Need Applications for Freestanding Emergency Departments

1. Determination of Need in the Proposed Service Area

The applicant must demonstrate need for an emergency department in **at least one** of the following ways: *geographic isolation, capacity challenges, and/or low quality of care at existing emergency department (ED) facilities in the proposed service area*. Applicants are not required to address and provide data for all three categories. However, the applicant's ability to demonstrate need in multiple categories may strengthen the application.

A. Geographic Isolation[1]

Check the Box that Applies:

☐ **The applicant is demonstrating geographic isolation for the proposed service area. If this box is checked the applicant must provide the information below.**

☒ **The applicant is not demonstrating geographic isolation for the proposed service area.[1]**

Data:

Utilizing the following table, provide the number of existing ED facilities in the proposed service area, as well as the distance of the proposed FSED from these 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. Add as many rows and/or columns to the table as necessary to adequately address this portion of the Determination of Need Standard.

Table 1
Existing ED Facilities and Distance from the Proposed FSED

Emergency Department	Bradley County	Polk County	Distance from Proposed FSED Site
Tennova Cleveland	1	0	Approximately 3 miles

Source & Notes:
Driving miles range from 2.8 to 3.2 per Google Maps.
Tennova Cleveland operates the only Emergency Department in the 2-county service area. Copper Basin Medical Center, a Critical Access Hospital, closed in October 2017.

Data Source:

Licensure facility search, Joint Annual Reports (JAR), MapQuest, Other GPS searching

https://apps.health.tn.gov/facilityListings/

https://apps.health.tn.gov/PublicJARS/Default.aspx

RESPONSE: As shown in the table above, there is only one (1) Emergency Department in the 2-county service area: Tennova Cleveland. However, for ease of review, the following chart shows the distances and ideal driving times from the proposed Tennova Cleveland FSED to hospitals located in the area, including all hospitals located in Hamilton County.

[1] ***Please note:*** Though the project is not being proposed to specifically address geographic isolation in the service area, the FSED in north Cleveland will enhance geographic accessibility for residents in the 2-county service area, as demonstrated below.

Table 2 Driving Distance and Minimum Drive Time from Proposed FSED to Area Hospitals				
Hospital	**City**	**County**	**Miles** ***One-Way***	**Free Flow Driving Time** ***One-Way***
Tennova Healthcare - Cleveland	Cleveland	Bradley	2.9	7 min
Erlanger East Hospital	Chattanooga	Hamilton	25.2	29 min
Starr Regional Med Ctr - Athens	Athens	McMinn	25.7	30 min
Starr Regional Med Ctr - Etowah	Etowah	McMinn	27.2	38 min
Rhea Medical Center	Dayton	Rhea	29.7	40 min
Parkridge East Hospital	Chattanooga	Hamilton	30.0	31 min
Parkridge Medical Center	Chattanooga	Hamilton	32.2	36 min
CHI Memorial Hospital	Chattanooga	Hamilton	32.8	37 min
CHI Memorial Hospital Hixson	Hixson	Hamilton	32.8	33 min
Erlanger Medical Center	Chattanooga	Hamilton	35.2	40 min
Erlanger North Hospital	Chattanooga	Hamilton	36.6	41 min
Sweetwater Hospital Association	Sweetwater	Monroe	39.2	40 min

Source: Google Maps.
Note: Driving times and free-flow distances based on the proposed FSED site address of 600 Stuart Road NE, Cleveland, TN, 37312.

The free flow (or "low estimate") travel times presented in the table above represent the "ideal" scenario. The reality is that patients' and families' travel times will oftentimes be much higher than the free flow times shown above because congestion increases dramatically the closer one travels into the highly-congested Chattanooga area.

The proposed service area definition for Tennova Cleveland's FSED is based on the hospital's historical ED patient origin, as shown below. For reference, the ranking of counties based on the number of ED patients served at Tennova Cleveland is included.

Table 3
Tennova Cleveland ED Visits by County, CY17

Rank	County	ED Visits	% of Total	Cum. %
Proposed FSED Service Area:				
1	Bradley	37,982	80.3%	80.3%
2	Polk	3,566	7.5%	**87.8%**
All Other ED Patients' Home Counties:				
3	McMinn	1,804	3.8%	91.6%
4	Unknown	1,541	3.3%	94.9%
5	Hamilton	1,135	2.4%	97.3%
6	Meigs	529	1.1%	98.4%
7	Rhea	235	0.5%	98.9%
8	Monroe	132	0.3%	99.2%
--	All Others	402	0.8%	100.0%
Total ED Visits		**47,326**	**100.0%**	N/A

Source: Tennova Cleveland internal documents.

The reasonableness of the service area for the proposed FSED is further evidenced by Tennova Cleveland's ED market share in Bradley and Polk Counties compared to its ED market share in surrounding counties. Information in the following table is the most recent data available from the Tennessee Department of Health ("TDOH"), Division of Policy, Planning and Assessment.

Table 4
Total ED Visits by County, 2015

County	Total ED Visits for County Residents	Tennova Cleveland ED Visits	Tennova Cleveland % Market Share	Tennova Cleveland Market Share Ranking
Proposed FSED Service Area:				
Bradley	45,255	35,108	77.6%	1
Polk	9,990	2,886	28.9%	2
Other ED Patients' Home Counties:				
McMinn	40,801	1,486	3.6%	4
Hamilton	163,584	895	0.5%	9
Meigs	7,740	944	12.2%	2
Rhea	20,927	170	0.8%	9

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment; Hospital Discharge Data System.

As shown in the previous table, Bradley and Polk County residents rely on Tennova Cleveland for emergency services. Of interest is a comparison of Tennova Cleveland's #2 market share ranking in Polk and Meigs Counties. Notably, though Tennova Cleveland has the 2nd highest market share of ED patients in Meigs County, the majority of those residents (53%) rely on Starr Regional Medical Center in Athens ("Starr Regional"), McMinn County, for emergency services. That market dominance by Starr Regional in Meigs County contrasts with Tennova Cleveland's #2 market share of approximately 12% there. Thus, there is a significant gap between the market leader (Starr Regional) and Tennova Cleveland's #2 market position in Meigs County.

Conversely, Tennova Cleveland's #2 market share ranking in Polk County is much closer to the market leader (the now-closed Copper Basin Medical Center). Copper Basin Medical Center served approximately 38% of the ED patients from Polk County in 2015, compared to Tennova Cleveland's #2 market share ranking of 29% in Polk County. The hospital with the next highest percentage of ED market share in Polk County served only 17% of patients. Thus, Polk County residents relied on Tennova Cleveland (and the now closed Copper Basin Medical Center) for emergency services.

For ease of review, the following table provides ZIP Code-level patient origin data for Tennova Cleveland, with the ranking of the number of ED patients from each ZIP shown. (In total, Tennova Cleveland serves ED patients from more than 900 ZIP Codes.) The ZIP Codes included in the table below comprise the entire geographic area of Bradley and Polk Counties, including geographic ZIP Codes and P.O. Boxes, so that all of Bradley and Polk County ED patients are included in the table.

Table 5
Tennova Cleveland ED Visits by ZIP Code, CY17

Rank	ZIP Code	County	ED Visits	% of Total	Cum. %
1	37311	Bradley	14,084	29.8%	29.8%
2	37323	Bradley	10,480	22.1%	51.9%
3	37312	Bradley	10,036	21.2%	73.1%
4	37307	Polk	1,313	2.8%	75.9%
5	37362	Polk	1,227	2.6%	78.5%
6	37310	Bradley	1,195	2.5%	81.0%
7	37336	Bradley	958	2.0%	83.0%
8	37353	Bradley	741	1.6%	84.6%
11	37361	Polk	458	1.0%	85.6%
14	37320	Bradley	377	0.8%	86.4%
18	37325	Polk	193	0.4%	86.8%
19	37369	Polk	177	0.4%	87.1%
22	37364	Bradley	111	0.2%	87.4%
24	37317	Polk	94	0.2%	87.6%
31	37391	Polk	56	0.1%	87.7%
51	37326	Polk	21	0.0%	87.7%
52	37333	Polk	21	0.0%	87.8%
87	37316	Polk	6	0.0%	**87.8%**
All Other ZIP Codes			5,778	12.2%	100.0%
Total All ED Visits			**47,326**	**100.0%**	N/A

Source: Tennova Cleveland internal documents.

The importance of locally accessible and available emergency services that *can be supported by locally available and accessible inpatient care* is demonstrated by the letters of support included in Attachment B-Need-A.1. As stated in these letters, continuity of care and family support is enhanced and undue stress and difficulty of travel in to Chattanooga is eliminated when health care services are available locally in outlying communities such as Cleveland.

Requiring residents to travel into Chattanooga for health care services that are available locally disrupts the patients' relationships with local community providers, removes the patient from his/her support system (family and friends), and causes unnecessary stress and difficulty on the patient and family as they navigate the congested roadways into and around Chattanooga.

The difficulty and stress that travel into Chattanooga causes patients and families is illustrated by Chattanooga's ranking as having the 11th worst interchange in the nation. (*See* Attachment B-Need-A.2.) According to American Transportation Research Institute, the Chattanooga interchange of I-24/US 27 is the 11th worst truck bottleneck in the country. This interchange and the I-24/I-75 interchange are recognized traffic bottlenecks that service area residents must endure when traveling from their homes to Chattanooga hospitals. The proposed FSED will ensure that needed emergency services, supported by local inpatient services, are available to Bradley and Polk County residents so that they do not routinely have to travel into – or be transported via ambulance – into the Chattanooga area for care.

Moreover, the location of the FSED will also provide the commercial, industrial, and manufacturing plants in north Bradley County with enhanced accessible to emergency services that will be available 24/7/365. As stated in letters of support included in Attachment B-Need-A.1, Tennova Cleveland serves the community's day-to-day injuries and illnesses, including those that occur at local employers, as well as providing a critically important resource when a significant emergency occurs.

For example, last year Tennova Cleveland was the receiving facility for a group of injured workers when the local community experienced a significant on-site incident at a Bradley County industrial plant. The availability and accessibility of Tennova Cleveland's emergency services meant that injured workers who live and work in the service area were cared for locally rather than requiring transport to a distant facility, which would have resulted in a significant delay in initial treatment for the injury. Moreover, when emergency patients such as these industrial plant workers need inpatient care, they are able to receive that care in their home community at Tennova Cleveland rather than being transported out of the area.

Thus, for all of the reasons stated above, the proposed project will enhance accessibility to emergency services for residents in the defined service area, which consists of Bradley and Polk Counties.

B. Capacity Challenges: Wait Times and Visits Per Treatment Room

Check the Box that Applies:

[X] **The applicant is demonstrating capacity challenges in the proposed service area. If this box is checked the applicant must provide the information below.**

[ ] **The applicant is not demonstrating capacity challenges in the proposed service area.**

Data:

1. Wait Times

To demonstrate wait times in the proposed service area and demonstrate need, complete the below table for each existing ED facility in the proposed service area.

RESPONSE: As documented previously, there is only 1 Emergency Department in the 2-county service area: Tennova Cleveland. Information for the existing ED provider in the service area is shown below and includes quality reporting measurements across various categories.

When reviewing the following chart it is important to note that Tennova Cleveland's ED is designated as a "high volume" hospital by Medicare, with annual ED visits volume in the 40,000 to 59,999 range. Additionally, please note that a range of quality indicators are included in the table below, reflecting that while there are some wait times that are high at Tennova Cleveland due to a number of factors, including its high volume of high-acuity and complex patients, other measurements show that the time to initiate care in the hospital's ED is quicker than the state and/or national averages.

Table 6
Sole Community Hospital Provider in Defined Service Area (Bradley & Polk Counties)
Information for time period: 4/1/2016 to 3/31/2017

Measure		Tennova Healthcare - Cleveland	Tennessee Average	National Average
Tennova Cleveland Emergency Department Volume Designation**		**High**	**N/A**	**N/A**
ED-1	Median Time from ED Arrival to ED Departure for ED Admitted Patients	401 Minutes	272 Minutes	297 Minutes
ED-2	Median Time from Admit Decision to Departure for ED Admitted Patients	206 Minutes	95 Minutes	121 Minutes
OP-1	Median Time to Fibrinolysis	N/A	22 Minutes	28 Minutes
OP-2	Fibrinolytic Therapy Received Within 30 Minutes	N/A	71%	57%
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	42 Minutes	53 Minutes	58 Minutes
OP-4	Aspirin at Arrival	100%	96%	95%
OP-5	Median Time to ECG	4 Minutes	6 Minutes	7 Minutes

Table 6 Sole Community Hospital Provider in Defined Service Area (Bradley & Polk Counties) Information for time period: 4/1/2016 to 3/31/2017				
Measure		**Tennova Healthcare - Cleveland**	**Tennessee Average**	**National Average**
Tennova Cleveland Emergency Department Volume Designation**		**High**	**N/A**	**N/A**
OP-18	Median Time from ED arrival to ED Departure for Discharged ED Patients	207 Minutes	170 Minutes	163 Minutes
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Professional	19 Minutes	19 Minutes	25 Minutes
OP-21	ED-Median Time to Pain Management for Long Bone Fracture	94 Minutes	47 Minutes	49 Minutes
OP-22	ED-Patient Left Without Being Seen	5%	2%	2%
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 Within 45 Minutes of ED Arrival	88%	74%	72%
Source: Medicare.gov Hospital Compare website; March 2018. **Note: High-volume Emergency Department providers serve 40,000 - 59,999 patients annually.				

Data Source:
Centers for Medicare and Medicaid Services (CMS)
https://data.medicare.gov/data/hospital-compare

2. Visits Per Treatment Room

Complete the following table to provide data on the number of visits per treatment room per year for each of the existing ED facilities in the service area. For this analysis, service area is defined as including all of any county included in the ZIP Code area.

RESPONSE: Tennova Cleveland is the only Emergency Department in the 2-county service area; however, for ease of review, the following table provides visits per room for all hospitals in surrounding counties.

Table 7
Visits Per Treatment Room in Existing ED Facilities in the Surrounding Service Area Counties
Ranked from Highest to Lowest Total ED Visits, 2016

Emergency Department (Hospital)	County	Total Visits	# of ED Rooms	# of Visits per Room	ACEP-Low to High Range*
Erlanger Medical Center	Hamilton	66,006	79	836	1,585-1,250
Parkridge East Hospital	Hamilton	50,430	19	2,654	1,613-1,250
CHI Memorial Hospital	Hamilton	49,445	31	1,595	1,613-1,250
Tennova Healthcare - Cleveland	**Bradley**	**48,501**	**41**	**1,183**	**1,613-1,250**
Starr Regional Medical Center - Athens	McMinn	39,297	N/A	N/A	1,600-1,212
Parkridge Medical Center	Hamilton	38,394	23	1,669	1,600-1,212
CHI Memorial Hixson	Hamilton	32,674	21	1,556	1,429-1,200
Erlanger East Hospital	Hamilton	31,197	17	1,835	1,429-1,200
Sweetwater Hospital Association	Monroe	25,528	15	1,702	1,389-1,250
Rhea Medical Center	Rhea	23,039	14	1,646	1,389-1,250
Erlanger North Hospital	Hamilton	14,857	8	1,857	1,364-1,154
Starr Regional Medical Ctr - Etowah	McMinn	11,000	9	1,222	1,250-909
Copper Basin Medical Ctr *(now closed)*	**Polk**	**6,750**	**3**	**2,250**	**1,250-909**

Source & Notes:
2016 Joint Annual Report of Hospitals (JARs). N/A = data not available in the 2016 JAR.
*ACEP information provides low to high visits per treatment space ranges from *American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future*, Second Edition, pages 116-117, Figure 5.1.

As shown in the table above, Tennova Cleveland's ED is operating near the high range guideline of 1,250 "capacity" when evaluated on an annual, average basis. It is important to note that on a daily basis, Tennova Cleveland's high-volume ED serves a *disproportionately high percentage* of high-acuity, uninsured, and Medicare (generally those individuals ages 65 and over) patients, resulting in the ED operating at or very near optimal "capacity" much of the time. The proposed expansion of Tennova Cleveland's ED services, via the satellite ED, will enhance the operational efficiency and patient flow of the hospital's high-volume ED, ultimately enhancing quality of care for service area residents.

Data Source:

Hospital Joint Annual Report, Search site

American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 116-117

C. Low Quality of Care at Existing Emergency Departments in the Service Area

Note: The host hospital ED should NOT be demonstrating low quality of care. This applies to other operators in the proposed service area. ***NOT APPLICABLE.***

Check the Box that Applies:

☐ **The applicant is demonstrating low quality of emergency care in the proposed service area. If this box is checked the applicant must provide the information below.**

☒ **The applicant is *not* demonstrating low quality of emergency care in the proposed service area.**

Data:

If the applicant is demonstrating low quality of care, complete the following table for each existing ED facility in the proposed service area. The Joint Commission's "Hospital Outpatient Core Measure Set" is utilized to demonstrate the quality of care provided by EDs. 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. It is the responsibility of the applicant to provide data on the existing facilities in the proposed service area what quartile is applicable for each measure. For this analysis, service area is defined as including all of any county included in a ZIP Code area.

Quality of Care Provided at Existing ED Facilities in the Proposed Service Area

Measure	ED	Year(s)	ED Time	Check (X) Applicable Quartile			
				Below 1st Quartile	Between 1st Quartile and Median	Between Median and 3rd Quartile	Above 3rd Quartile
OP-1: Median Time to Fibrinolysis							
OP-2: Fibrinolytic Therapy Received Within 30 Minutes							
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							

D. Other Applicable Data Related to Need and Capacity

Check the Box that Applies:

[X] **The applicant is providing additional data related to need and capacity. If this box is checked the applicant must provide the information below.**

[ ] **The applicant is not providing additional data related to need and capacity.**

Data:

The applicant may provide data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules at existing EDs in the proposed service area to demonstrate capacity challenges. If the applicant is providing additional data, at a minimum, complete the following table for all ED facilities in the proposed service area. Other relevant categories may be added to the table by the applicant.

RESPONSE: As documented in the tables below, Tennova Cleveland serves a disproportionately high percentage of high-acuity, uninsured, and Medicare patients compared to the total ED patient population in the service area. Notably, these patient populations oftentimes utilize greater resources and take significantly more time and skills of clinical staff members compared to lower acuity, insured, and younger patients because they are likely to have comorbidities and/or complexity of needs beyond the immediate crisis resulting in the ED visit. Tennova Cleveland requests additional ED space to optimally serve its current and future emergency patients.

Please note that for reference and completeness, Tennova Cleveland is providing both county and ZIP Code-level information obtained from TDOH in this section of the application. In the following analyses, the county and ZIP Code-level data is virtually identical (as expected) because the ZIP Codes included in the analyses comprise the entirety of the 2-county geographic area.

The most recent data available from the TDOH is 2015. For comparison purposes, Tennova Cleveland has provided information for 2015 – 2017 (most recent data available).

The following table documents that Tennova Cleveland serves a disproportionately high percentage of high-acuity patients compared to total service area ED patients.

Table 8 Tennova Cleveland serves a Disproportionately High Percentage of High-Acuity Patients Compared to Total Service Area ED Patients *Acuity Levels are Ranked Lowest (Level 1) to Highest (Level 5)*						
Acuity Level *(Lowest to Highest)*	**CPT Code**	**Tennova Cleveland Total ED Visits**			**Total ED Visits for Defined Service Area, 2015**	
		CY15	**CY16**	**CY17**	**Bradley & Polk Counties**	**ZIP Codes in 2-Counties**
Level 1	99281	4.1%	3.4%	3.1%	4.3%	4.3%
Level 2	99282	7.5%	6.4%	6.9%	12.0%	12.2%
Level 3	99283	28.3%	26.2%	26.5%	33.6%	33.7%
Level 4	99284	30.8%	31.8%	30.9%	32.1%	32.1%
Level 5	**99285**	**29.3%**	**32.2%**	**32.6%**	**17.9%**	**17.8%**
Total		100.0%	100.0%	100.0%	100.0%	100.0%

Sources & Notes:
TDOH, Division of Policy, Planning and Assessment; and Tennova Cleveland internal data.
Please refer to Table 5 for the complete listing of ZIP Codes in the 2-county service area.

Please note: The acuity levels indicated in the table above and throughout the application are based on the above-indicated CPT evaluation and management ("E&M") billing codes, with Level 4 and 5 codes indicating patients with more complex, resource-intensive conditions.

Notably, Tennova Cleveland's use of CPT billing codes to categorize ED patient acuity is consistent with prior applications of Blount Memorial Hospital (CN1603-011) and Gateway Medical Center at Sango (CN1507-027). In both of those previously-approved applications, Level 1 corresponded to CPT Code 99281 (lowest acuity patient) and Level 5 corresponded to CPT Code 99285, highest acuity patient. Moreover, the use of CPT Codes to indicate patient severity/acuity is also consistent with data provided by TDOH.

The use of CPT Codes to categorize the severity of ED patients differs, however, from the Emergency Severity Index ("ESI") ranking of acuity which categorizes ED patients at the time of triage. The ESI ranking is *reverse* of the use of CPT Codes in categorizing patient acuity, with the ESI Level 1 representing the highest acuity and Level 5 representing the lowest. Specifically, ESI ranking at the time of patient triage ranges from Level 1-resuscitation, 2-emergent, 3-urgent, 4-less urgent to Level 5-non-urgent (or lowest acuity).

The information regarding acuity ranking based on CPT billing codes versus ESI is provided for clarity as the application is reviewed, and in anticipation of the HSDA Meeting presentation on this application.

Tennova Cleveland also serves a disproportionately high percentage of uninsured (self-pay) and Medicare patients compared to the total ED patient population in its defined 2-county service area, as shown below. Consequently, Tennova Cleveland serves a disproportionately low percentage of commercial (insured) ED patients compared to the total ED patient population in Bradley and Polk Counties.

Table 9
Tennova Cleveland serves a Disproportionately High Percentage of Uninsured Patients Compared to Total Service Area ED Patients

	Tennova Cleveland Total ED Visits			Total ED Visits for Defined Service Area, 2015	
Payer Mix	**CY15**	**CY16**	**CY17**	**Bradley & Polk Counties**	**ZIP Codes in 2-Counties**
Commercial	21.9%	22.4%	22.4%	35.1%	35.0%
TennCare	32.0%	31.2%	30.2%	30.8%	30.8%
Medicare	28.7%	29.5%	29.9%	23.0%	23.0%
Other Govt.	1.0%	1.2%	1.2%	0.0%	0.0%
Self-Pay (Uninsured)	**16.3%**	**15.6%**	**16.3%**	**4.5%**	**4.6%**
Unknown	0.0%	0.0%	0.0%	6.6%	6.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Sources & Notes:
TDOH, Division of Policy, Planning and Assessment; and Tennova Cleveland internal data.
Please refer to Table 5 for the complete listing of ZIP Codes in the 2-county service area.
TDOH payer mix categories include the following: Self-Pay includes free care; Medicaid includes TennCare plus CoverTN, Cover Kids, and Access TN.
Tennova Cleveland Medicare payer mix includes dual-eligible patients, thus includes patients ages 65+ as well as some patients under 65.

The following table has been completed to the extent possible by Tennova Cleveland. Statewide average information has been requested from TDOH. (Please note that the Applicant does not have access to the Tennessee Hospital Association Hospital Discharge Data System.) In lieu of statewide average data, Tennova Cleveland has provided service area information for the percentage of high-acuity patients.

As demonstrated below, Tennova Cleveland serves a significantly greater percentage of high-acuity ED patients than total service area ED patients. The high percentage and volume of high-acuity patients served by Tennova Cleveland documents the need for the proposed expansion of the hospital's main campus ED.

Table 10 Additional Data to Demonstrate Need in the Proposed Service Area						
Emergency Department	**% of Behavioral Health Patients**	**Statewide Average**	**% of High Acuity Patients***	**Service Area Average****	**% of Patients Ages 65+**	**Statewide Average**
Tennova Cleveland	4.5%	N/A	63.5%	50.0%	20.4%	N/A

Sources & Notes:
Tennova Cleveland internal data. Data is for CY2017.
*Includes high acuity Levels 4 and 5 (*see* Table 8).
**Service area average information (2015) provided for reference; data from TDOH.

The need for the proposed FSED is further documented by the number of patients who are admitted directly from Tennova Cleveland's ED to the hospital for inpatient care. As shown below, Tennova Cleveland admits a significant number of patients from its Emergency Department to its hospital.

Table 11 Tennova Cleveland Admits a Large Number of ED Patients to its Hospital, CY17		
Patient Type	**ED Visits**	**% of Total**
Inpatient	6,371	13.5%
Outpatient	40,955	86.5%
Total	**47,326**	**100.0%**

Source: Tennova Cleveland internal data.

The expansion of Tennova Cleveland's ED will ensure the hospital can continue to provide high quality, efficient care to the large number of patients it serves, while offering the ED patient that needs to be admitted for inpatient care the choice of remaining in the local community rather than being transported to Chattanooga for the inpatient stay.

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 or above capacity. This applies to any hospital that the applicant has indicated the proposed project will assist in decompressing ED patient volumes.

Check the Box that Applies:

[X] **The applicant is demonstrating the need to decompress volumes at the host hospital ED. If this box is checked the applicant must provide the information below.**

[ ] **The applicant is not demonstrating the need to decompress volumes at the host hospital ED.**

A. Visits Per Treatment Room

Data:

The applicant should provide data on the number of visits per treatment room per year at the relevant existing ED facility. This number should be compared to the ACEP guidelines found in Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, Table 5.2, pages 109-112. Complete the following two tables in order to demonstrate host hospital ED capacity. In order to determine if the host hospital is a low, medium, or high range hospital, utilize Table 5.2, pages 109-112 in the ACEP Guidelines. The results for the majority of the factors in the second table determine the range selected for the first table.

RESPONSE: Please see the tables below.

Table 12 Tennova Cleveland (Host Hospital) ED Visits Per Treatment Room				
Emergency Department Design: A Practical Guide to Planning, American College of Emergency Physicians – Estimates for Emergency Department Areas and Beds				
Most Recent Year Annual Visits (2017)	**Dept. Gross Area**	**Bed Quantities**		
	Low, Medium, or High Range	**Low, Medium, or High Range Bed Qty.**	**Low, Medium, or High Range Visits/Beds**	**Estimated Area/Bed**
47,326	High	40	1,250	850

Table 13 Tennova Cleveland CY17 Factors Supporting Appropriateness of ACEP *High Range Guideline*	
Factor	**Result**
% Emergency Department Patients Admitted as Inpatients	13.5%
Length of Stay (Hours) in ED	4.46
% of ED Patients seen in Private Rooms	100%
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	15%
% of observation and extended stay patient remaining in ED	4.7%
# Average Minutes an ED patient admitted as an inpatient remains in ED	131
Average turnaround time (minutes) for results for lab and imaging studies	115: lab 208: imaging
% of behavioral health ED patients	4.5%
% of ED patients either ESI 4 or 5	10.0%
% of ED patients Age 65+	20.4%
% of imaging studies performed in ED	55.3%
Provisions in ED for family consult/grieving rooms	Yes
Availability of geriatric specialty area	No
Availability of pediatric specialty area	Yes
Availability of prisoner/detention patient specialty area	No
Availability of administrative/teaching specialty area	No

For ease of review, the following table is a visual presentation of Tennova Cleveland's position among the various ACEP guidelines relating to ED processes, design, and patients served set forth in of the ACEP ED Design guideline presented in *Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition*. As documented in the following table, **Tennova Cleveland fits squarely within the high range of numerous guidelines set forth by the ACEP, including those related directly to patient care.**

Table 14
Tennova Cleveland's "Relative" Position along the
Benchmark Factors for Emergency Department Design Impacting Patient Care Spaces and Square Footage Needs
Highlighted Range is 'best fit' for Tennova Cleveland in the Guidelines

Factors	Low Range	Mid-Range	High Range
Percentage of Admitted Patients	< 8%	8% - 25%	> 25%
Length of Stay	< 2.25 Hours	2.25 Hours - 4.0 Hours	> 4.0 Hours
Patient Care Spaces	Few Private Rooms w/ Mostly Flex Space	Mix of Private Rooms and Flex Spaces	All Private Rooms
Inner Waiting and Results Waiting Areas	Significant Use of Inner Waiting or Results Waiting	Limited Use of Inner Waiting or Results Waiting	No Inner Waiting or Results Waiting Areas
Location of Clinical Decision Unit or Observation Space	CDU/Observation Outside Emergency Department	Mix of CDU/Observation Inside and Outside Department	CDU/Observation within Emergency Department
Boarding of Admitted Patients	Admissions Transported Out of Department in 60 Minutes or Less	Admissions Transported Out of Department From 61 Minutes to 150 Minutes	Admissions Remain in Department for Over 150 Minutes After Order to Admit
Turnaround Times for Diagnostic Tests	Average Turnaround Time for Lab and Imaging Results 45 Minutes or Less	Average Turnaround Time for Lab and Imaging Results 46 Minutes to 90 Minutes	Average Turnaround Time for Lab and Imaging Results More Than 90 Minutes
Percentage of Behavioral Health Patients	Under 3%	3% to 6.99%	7% or Greater
Percentage of Non-urgent Patients	Over 45% of Patients Classified as ESI 4 and 5 Combined	25% to 45% of Patients Classified as ESI 4 and 5 Combined	Less Than 25% of Patients Classified as ESI 4 and 5 Combined
Age of Patients	Less Than 10% Older Than 65 Years	10% to 20% of Patients Older Than 65 Years	More Than 20% of Patients Older Than 65 Years

Table 14
Tennova Cleveland's "Relative" Position along the
Benchmark Factors for Emergency Department Design Impacting Patient Care Spaces and Square Footage Needs
Highlighted Range is 'best fit' for Tennova Cleveland in the Guidelines

Factors	Low Range	Mid-Range	High Range
Imaging Facilities Included within the Emergency Department	No Imaging Studies in the Department	Limited General Radiology and CT in the Department	Multiple Imaging Rooms in the Department
Family Amenities	No Family Consult or Nourishment Areas	Limited Consult Rooms	Multiple Family and Consult Rooms
Specialty Components: Geriatrics	No Specialty Area for Geriatrics	Limited Area within Department Designated for Geriatric Care	Specialized Geriatric Module in Department with Multiple Rooms
Specialty Components: Pediatrics	No Specialty Area for Pediatrics	Limited Area within Department Designated for Pediatric Care	Specialized Pediatric Module in Department with Additional Support Space
Specialty Components: Detention	Limited Jail/Prisoner Patients	Limited Area within Department Designated for Detention Patients	Large Detention Population with Separate Unit and Access
Need for Administrative or Teaching Spaces	Minimal Administrative Space, No Support for Teaching Programs	Offices for Department Administration and Moderate Amount of Teaching/ Conference Space	Extensive Needs for Teaching Space and Offices

Source: ACEP Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition.

B. Additional Data

Check the Box that Applies:

[X] **The applicant is providing additional data related to capacity, efficiencies, and demographics. If this box is checked the applicant must provide the information below.**

[ ] **The applicant is not providing additional data related to capacity, efficiencies, and demographics.**

Data:

The applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing host hospital ED facility in order to better demonstrate the need for expansion. The applicant may provide data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules. If the applicant is providing additional data, at a minimum, complete the following table for the host hospital ED. Other relevant categories may be added to the table by the applicant.

RESPONSE: The following information was previously provided, but is provided again for ease of review and in direct response to Tennova Cleveland's request to expand its existing Emergency Department facility through establishment of a satellite ED in the most populated and fastest-growing area of its home county. (*See* the response to "1. D. Determination of Need in the Proposed Service Area, Additional Information".)

As documented previously and shown below, Tennova Cleveland serves a disproportionately high percentage of high-acuity, uninsured, and Medicare patients compared to the total ED patient population in the service area. Notably, these patient populations oftentimes utilize greater resources and take significantly more time and skills of clinical staff members compared to lower acuity, insured, and younger patients because they are likely to have comorbidities and/or complexity of needs beyond the immediate crisis resulting in the ED visit. Tennova Cleveland requests additional ED space to optimally serve its existing and future emergency patients.

Please note that for reference and completeness, Tennova Cleveland is providing both county and ZIP Code-level information obtained from TDOH in this section of the application. In the following analyses, the county and ZIP Code-level data is virtually identical (as expected) because the ZIP Codes included in the analyses comprise the entirety of the 2-county geographic area.

The most recent data available from the TDOH is 2015. For comparison purposes, Tennova Cleveland has provided information for 2015 – 2017 (most recent data available).

The following table documents that Tennova Cleveland serves a disproportionately high percentage of high-acuity patients compared to total service area ED patients.

Table 15 Tennova Cleveland serves a Disproportionately High Percentage of High-Acuity Patients Compared to Total Service Area ED Patients *Acuity Levels are Ranked Lowest (Level 1) to Highest (Level 5)*						
Acuity Level (Lowest to Highest)	**CPT Code**	**Tennova Cleveland Total ED Visits**			**Total ED Visits for Defined Service Area, 2015**	
		CY15	**CY16**	**CY17**	**Bradley & Polk Counties**	**ZIP Codes in 2-Counties**
Level 1	99281	4.1%	3.4%	3.1%	4.3%	4.3%
Level 2	99282	7.5%	6.4%	6.9%	12.0%	12.2%
Level 3	99283	28.3%	26.2%	26.5%	33.6%	33.7%
Level 4	99284	30.8%	31.8%	30.9%	32.1%	32.1%
Level 5	**99285**	**29.3%**	**32.2%**	**32.6%**	**17.9%**	**17.8%**
Total		100.0%	100.0%	100.0%	100.0%	100.0%

Sources & Notes:
TDOH, Division of Policy, Planning and Assessment; and Tennova Cleveland internal data.
Please refer to Table 5 for the complete listing of ZIP Codes in the 2-county service area.

Tennova Cleveland also serves a disproportionately high percentage of uninsured (self-pay) and Medicare patients compared to the total ED patient population in its defined 2-county service area, as shown below. Consequently, Tennova Cleveland serves a disproportionately low percentage of commercial (insured) ED patients compared to the total ED patient population in Bradley and Polk Counties.

Table 16 Tennova Cleveland serves a Disproportionately High Percentage of Uninsured Patients Compared to Total Service Area ED Patients					
	Tennova Cleveland Total ED Visits			**Total ED Visits for Defined Service Area, 2015**	
Payer Mix	**CY15**	**CY16**	**CY17**	**Bradley & Polk Counties**	**ZIP Codes in 2-Counties**
Commercial	21.9%	22.4%	22.4%	35.1%	35.0%
TennCare	32.0%	31.2%	30.2%	30.8%	30.8%
Medicare	28.7%	29.5%	29.9%	23.0%	23.0%
Other Govt.	1.0%	1.2%	1.2%	0.0%	0.0%
Self-Pay (Uninsured)	**16.3%**	**15.6%**	**16.3%**	**4.5%**	**4.6%**
Unknown	0.0%	0.0%	0.0%	6.6%	6.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Sources & Notes:
TDOH, Division of Policy, Planning and Assessment; and Tennova Cleveland internal data.
Please refer to Table 5 for the complete listing of ZIP Codes in the 2-county service area.
TDOH payer mix categories include the following: Self-Pay includes free care; TennCare includes CoverTN, Cover Kids, and Access TN.
Tennova Cleveland Medicare payer mix includes dual-eligible patients, thus includes patients ages 65+ as well as some patients under 65. [Hospital: please confirm]

The following table has been completed to the extent possible by Tennova Cleveland. Statewide average information has been requested from TDOH. (Please note that the Applicant does not have access to the Tennessee Hospital Association Hospital Discharge Data System.)

In lieu of statewide average data, Tennova Cleveland has provided service area information for the percentage of high-acuity patients. As demonstrated below, Tennova Cleveland serves a significantly greater percentage of high-acuity ED patients than total service area ED patients. The high percentage and volume of high-acuity patients served by Tennova Cleveland documents the need for the proposed expansion of the hospital's main campus ED.

Table 17
Additional Data to Demonstrate Need in the Proposed Service Area

Emergency Department	% of Behavioral Health Patients	Statewide Average	% of High Acuity Patients*	Service Area Average**	% of Patients Ages 65+	Statewide Average
Tennova Cleveland	4.5%	N/A	63.5%	50.0%	20.4%	N/A

Sources & Notes:
Tennova Cleveland internal data. Data is for CY2017.
*Includes high acuity Levels 4 and 5 (see Table 15).
**Service area average information (2015) provided for reference; data from TDOH.

The need for the proposed FSED is further documented by the number of patients who are admitted directly from Tennova Cleveland's ED to the hospital for inpatient care. As shown below, Tennova Cleveland admits a significant number of patients from its Emergency Department to its hospital.

Table 18
Tennova Cleveland Admits a Large Number of ED Patients to its Hospital, CY17

Patient Type	ED Visits	% of Total
Inpatient	6,371	13.5%
Outpatient	40,955	86.5%
Total	**47,326**	**100.0%**

Source: Tennova Cleveland internal data.

The expansion of Tennova Cleveland's ED will ensure the hospital can continue to provide high quality, efficient care to the large number of patients it serves while offering the ED patient that needs to be admitted for inpatient care the choice of remaining in the local community rather than being transported to Chattanooga for the inpatient stay.

3. Relationship to Existing Similar Services in the Area

A. All Applicants

Data:

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. Utilize the below tables to address this portion of the standards.

RESPONSE: Tennova Cleveland is the only ED provider in the service area. Nonetheless, the following analyses include utilization information for hospitals in the surrounding area, including Hamilton County. As demonstrated below, service area residents rely on Tennova Cleveland for emergency services. The community's reliance on its local hospital supports the proposed project. As the sole community provider in the service area, Tennova Cleveland seeks permission to expand its existing ED through establishment of a FSED in the most populated and fastest-growing area of the county.

The proposed project is needed to enhance quality of care and access to emergency services for Tennova Cleveland's current and projected ED patients, including Polk County ED patients who must now travel outside of their home county for care since Copper Basin Medical Center closed. Tennova Cleveland's proposed ED expansion project, to be accomplished through the development of a satellite ED facility, will have no adverse impact on any existing provider.

Table 19
Hospital ED Utilization in the Proposed Service Area (PSA) and all Hamilton County EDs
Ranked Highest to Lowest for Bradley County ED Visits, 2015

Hospital	Bradley Co. ED Visits	% of Bradley Visits	Polk Co. ED Visits	% of Polk Visits	Total PSA ED Visits	Total Market Share
Tennova Healthcare - Cleveland	**35,108**	**77.6%**	**2,886**	**28.9%**	**37,994**	**68.8%**
Erlanger Medical Center	3,647	8.1%	483	4.8%	4,130	7.5%
CHI Memorial Hospital	1,608	3.6%	164	1.6%	1,772	3.2%
Erlanger East Hospital	1,337	3.0%	72	0.7%	1,409	2.6%
Starr Regional Med Ctr - Athens	957	2.1%	626	6.3%	1,583	2.9%
Parkridge Medical Center	664	1.5%	52	0.5%	716	1.3%
Parkridge East Hospital	631	1.4%	0	0.0%	631	1.1%
Other Hospitals*	524	1.2%	238	2.4%	762	1.4%
Starr Regional Med Ctr - Etowah	278	0.6%	1,713	17.1%	1,991	3.6%
CHI Memorial Hixson	202	0.4%	0	0.0%	202	0.4%
Rhea Medical Center	110	0.2%	0	0.0%	110	0.2%
Erlanger North Hospital	65	0.1%	0	0.0%	65	0.1%
Copper Basin Medical Ctr *(closed)*	**64**	**0.1%**	**3,756**	**37.6%**	**3,820**	**6.9%**
Sweetwater Hospital Association	60	0.1%	0	0.0%	60	0.1%
Total	**45,255**	**100.0%**	**9,990**	**100.0%**	**55,245**	**100.0%**

Source: TDOH, Division of Policy, Planning and Assessment.
*Note: Other Hospitals include all hospitals with 50 or less ED visits from the PSA counties.

Tennova Cleveland is the fourth (4th) busiest ED of all hospitals serving patients in the 2-county service area in terms of total ED visits seen in 2016, regardless of the hospital's location (*i.e.*, home county). Notably, though Erlanger Medical Center in Chattanooga (Hamilton County) is the busiest ED in the area, Erlanger's average annual ED visits per room is by far the lowest in the area, with an annual average of 836 visits per room.

Table 20
Visits Per Treatment Room in Existing ED Facilities in the Surrounding Area
Ranked from Highest to Lowest Total ED Visits, 2016

Emergency Department (Hospital)	County	Total Visits	# of ED Rooms	# of Visits per Room
Erlanger Medical Center	Hamilton	66,006	79	836
Parkridge East Hospital	Hamilton	50,430	19	2,654
CHI Memorial Hospital	Hamilton	49,445	31	1,595
Tennova Healthcare - Cleveland	**Bradley**	**48,501**	**41**	**1,183**
Starr Regional Medical Center - Athens	McMinn	39,297	N/A	N/A
Parkridge Medical Center	Hamilton	38,394	23	1,669
CHI Memorial Hixson	Hamilton	32,674	21	1,556
Erlanger East Hospital	Hamilton	31,197	17	1,835
Sweetwater Hospital Association	Monroe	25,528	15	1,702
Rhea Medical Center	Rhea	23,039	14	1,646
Erlanger North Hospital	Hamilton	14,857	8	1,857
Starr Regional Medical Ctr - Etowah	McMinn	11,000	9	1,222
Copper Basin Med Ctr *(now closed)*	**Polk**	**6,750**	**3**	**2,250**

Source & Notes:
2016 Joint Annual Report of Hospitals (JARs).
N/A = data not available in the 2016 JAR.

The following table ranks the hospitals that serve ED patients from the service area based on the hospital's market share of ED visits in 2015 (the most recent data available). Hamilton County is included in the table for reference. As shown, Tennova Cleveland is the market leader in the 2-county service area, illustrating the community's support of, and reliance on, its local hospital for emergency and inpatient services.

Table 21
Market Shares of ED Facilities in the Proposed Service Area + Hamilton County, 2015

County	% Highest Market Share ED	% 2nd Highest Market Share ED	% 3rd Highest Market Share ED	% Applicant Host ED (if not top 3)
Bradley County	Tennova Cleveland (77.6%)	Erlanger Medical Center (8.1%)	CHI Memorial Hospital (3.6%)	N/A
Polk County	Copper Basin Med Ctr (37.6%)	Tennova Cleveland (28.9%)	Starr Regional – Etowah (17.1%)	N/A
Hamilton County	Erlanger Medical Center (25.8%)	Parkridge Medical Center (15.0%)	CHI Memorial Hixson (14.5%)	9th Highest: 0.5%

Data Source:
Hospital Discharge Data System (HDDS) – FSED Template

4. Host Hospital Emergency Department Quality of Care

The quality of the host hospital should be in the top quartile of the state in order to be approved for the establishment of a FSED. It is the responsibility of the applicant to provide data on the host hospital ED and what quartile is applicable for each measure.

Data:
The Joint Commission's "Hospital Outpatient Core Measure Set" is utilized to demonstrate the quality of care provided by EDs.

Please complete the following table.

Table 22
Quality of Care Provided at the Host Hospital ED
4/1/2016 to 3/31/2017

Measure		Tennova Healthcare - Cleveland	Tennessee Average	National Average	Comparison to National Average
Tennova Cleveland Emergency Department Volume Designation**		**High**	**N/A**	**N/A**	
OP-1	Median Time to Fibrinolysis	N/A	22 Minutes	28 Minutes	N/A
OP-2	Fibrinolytic Therapy Received Within 30 Minutes	N/A	71%	57%	N/A
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	42 Minutes	53 Minutes	58 Minutes	Exceeded Benchmarks
OP-4	Aspirin at Arrival	100%	96%	95%	Top 10%
OP-5	Median Time to ECG	4 Minutes	6 Minutes	7 Minutes	Top 10%
OP-18	Median Time from ED arrival to ED Departure for Discharged ED Patients	207 Minutes	170 Minutes	163 Minutes	Did Not Meet Benchmarks
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Professional	19 Minutes	19 Minutes	25 Minutes	Met or Exceeded Benchmarks
OP-21	ED-Median Time to Pain Management for Long Bone Fracture	94 Minutes	47 Minutes	49 Minutes	Did Not Meet Benchmarks
OP-22	ED-Patient Left Without Being Seen	5%	2%	2%	Did Not Meet Benchmarks
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 Within 45 Minutes of ED Arrival	88%	74%	72%	Exceeded Benchmarks

Source: Medicare.gov Hospital Compare website; March 2018.
**Note: High-volume Emergency Department providers serve 40,000 - 59,999 patients annually.

5. Appropriate Model for Delivery of Care

The applicant should discuss why a FSED is the appropriate model for the delivery of care in the proposed service area.

RESPONSE: Tennova Cleveland's proposed FSED offers several distinct advantages over convenient care centers (*e.g.*, urgent care and retail clinics):

(1) **Willingness and ability to care for high-acuity patients**.
The FSED will care for patients with all acuity levels and illnesses, providing the necessary staff (*e.g.*, physicians), resources (*e.g.*, laboratory), and equipment (*e.g.*, CT) to provide care to all patients in need of emergency services. This is in direct contrast to retail clinics and urgent care centers that primarily, if not entirely, offer low-acuity and wellness (*e.g.*, immunizations) services.

(2) **Willingness and ability to care for uninsured patients**.
Tennova Cleveland's FSED will provide a needed patient access point for uninsured and underinsured patients, two groups of patients that urgent care and retail clinics do not typically serve. To illustrate, approximately 16% of Tennova Cleveland's ED visits annually are for uninsured (self-pay) patients compared to the approximate 5% of Bradley and Polk County total ED patients who are uninsured. Though data is not available on the payer mix of patients seeking care at convenient care centers, convenient care centers typically serve insured patients.

Moreover, Tennova Cleveland's proposed FSED will offer all emergency patients, including uninsured and underinsured (*e.g.*, TennCare) patients, the ability to access a smaller, dedicated outpatient campus that is easier to navigate than the hospital's larger, more complex main hospital campus.

(3) **Willingness and ability to provide care to patients 24 hours per day, 7 days per week, 365 days per year**.
Retail clinics and urgent care centers are typically open limited hours, usually from 7am until late evening (almost always no later than midnight), with even more limited hours on the weekend (Saturday and Sunday). Conversely, Tennova Cleveland's FSED will be open 24/7/365, just as its main campus ED is always open and ready to serve patients anytime they need emergency care.

(4) **Provision of care by board-certified and/or board-eligible physicians**.
The FSED will be staffed by physicians, which directly contrasts with retail and urgent care clinics that almost always, if not always, are staffed by physician extenders ("mid-levels"), *i.e.*, Nurse Practitioners and Physicians Assistants.

Specifically, Tennova Cleveland will staff the proposed FSED with board-certified and/or board-eligible TeamHealth physicians, which is the emergency physician group that currently cares for patients at Tennova Cleveland's main hospital campus ED.

Tennova Cleveland's proposed FSED will be located in north Bradley County, the most populated and fastest-growing area of the county that is also home to multiple commercial and industrial plants. For reference, below is a list identifying some of the large manufacturing and distribution companies located throughout Bradley County, illustrating the type of companies that will benefit from the proposed FSED.

Table 23
Select Bradley County Manufacturing & Commercial Plants, March 2018

Company	City	ZIP Code	Employment
Whirlpool Corporation	Cleveland	37323	1,417
Amazon - Fulfillment Center	Charleston	37310	1,143
Peyton's Southeastern	Cleveland	37323	950
Jackson Furniture	Cleveland	37311	800
Wacker Polysilicon	Charleston	37310	600
Mars Chocolate North America	Cleveland	37312	575
Bayer	Cleveland	37323	462
Renfro	Cleveland	37323	400
Olin Corporation	Charleston	37310	384
Duracell	Cleveland	37312	210

Sources: Cleveland/Bradley Chamber of Commerce and Corporate Websites.

6. Geographic Location

Data:

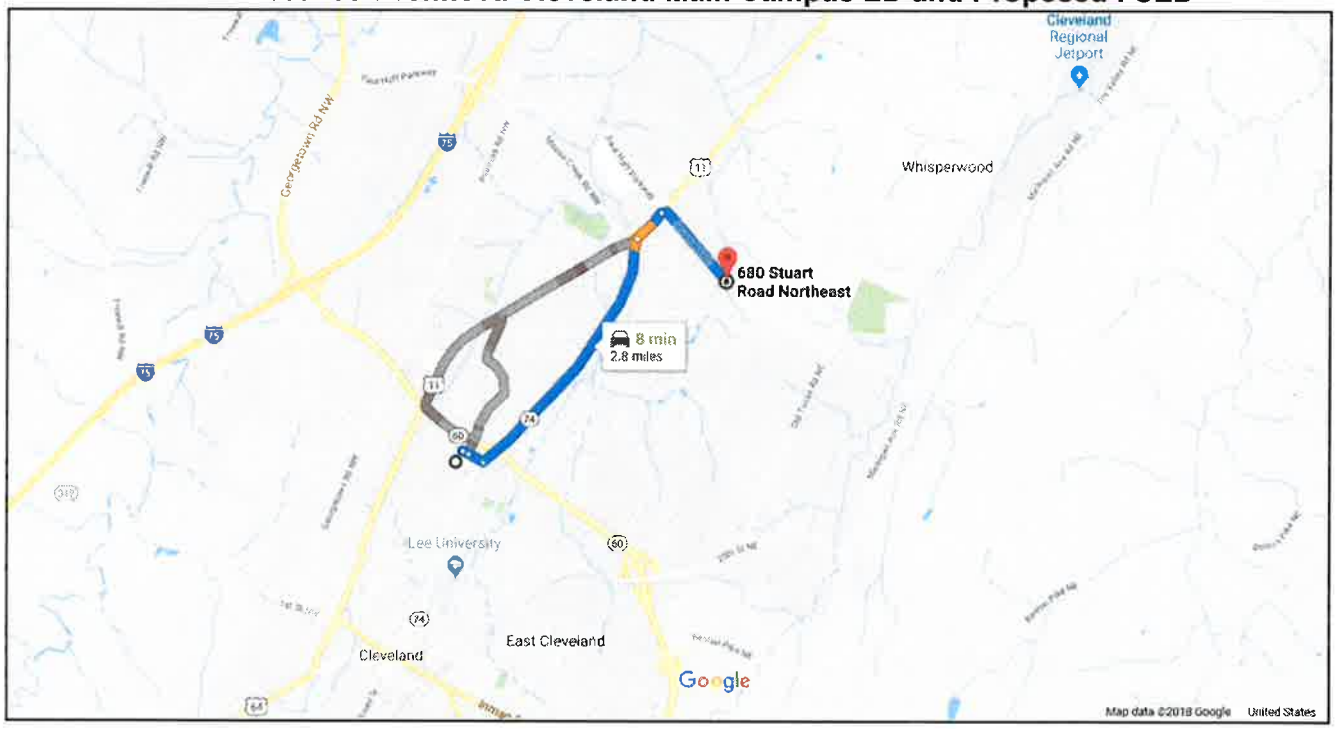
The FSED should be located within a 35 mile radius of the hospital that is the main provider. A map can also be provided as evidence. Please complete the following table.

Table 24 Distance from Host Hospital
Approximately 3 miles
Source: Google Maps.

RESPONSE: As documented in the table above, the proposed FSED is located approximately 3 driving miles from Tennova Cleveland's main hospital campus (located at 2305 Chambliss Ave NW, Cleveland, TN 37311).

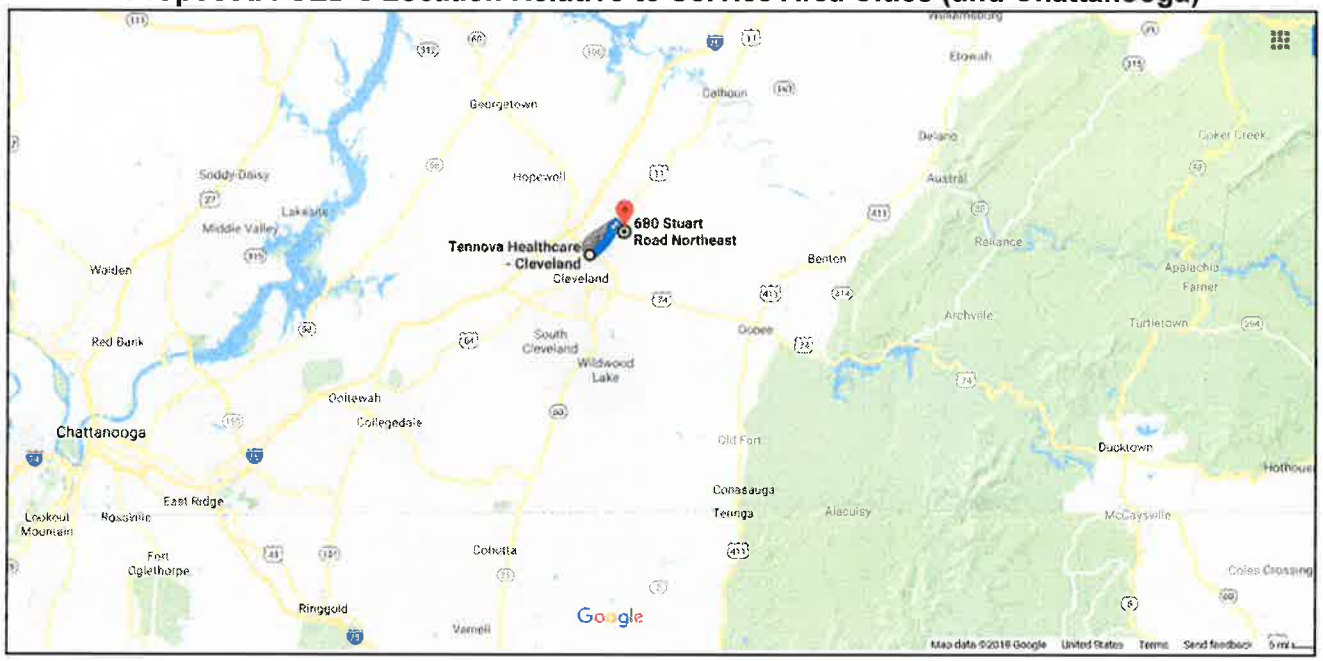
The following map shows the relative distance and driving routes from the main hospital campus ED location to the proposed FSED.

Figure 1
Distance between Tennova Cleveland Main Campus ED and Proposed FSED



An additional map is provided to show the locations of the existing and proposed EDs of Tennova Cleveland relative to the 2-county service area. As shown below, the proposed FSED will be located in northeast Bradley County, easily accessible to residents of Bradley and Polk Counties, and in close proximity to the fast-growing north Bradley County area.

Figure 2
Proposed FSED's Location Relative to Service Area Cities (and Chattanooga)



7. Access

The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification.

RESPONSE: Tennova Cleveland will continue serving equally all of the service area in which it seeks certification, *i.e.*., Bradley and Polk Counties. As demonstrated throughout this application, Tennova Cleveland serves all residents within the service area equally, illustrated by the hospital ED's disproportionate levels of uninsured, high-acuity, and Medicare patients. Moreover, Tennova Cleveland will provided a needed patient access point for emergency services for residents from Polk County (who have historically relied rely on Tennova Cleveland for emergency services) now that Copper Basin Medical Center has closed.

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.

Data:

Use the following table to compare the payor mix of the host hospital to payor mix of the total service area. Applicants may also present evidence demonstrating limited access to emergency care in the proposed service area when applicable.

Data Source:

Hospital Discharge Data System (HDDS)

RESPONSE: As demonstrated below and discussed throughout this application, Tennova Cleveland serves a disproportionately high share of the uninsured (self-pay and free care) ED patient population in the service area. Consequently, Tennova Cleveland serves a disproportionately small share of the commercially-insured ED patient population, as demonstrated below.

Table 25
Services to High Need Populations by Payor: ED Visits*
Comparison of Service Area Counties' Total ED Visits by Payer to Tennova Cleveland

Payer	Bradley County	% of Total	Polk County	% of Total	Tennova Cleveland	% of Total
TennCare	13,110	29.0%	3,899	39.0%	14,292	30.2%
Medicare	10,356	22.9%	2,361	23.6%	14,146	29.9%
Self-Pay & Free Care	**1,469**	**3.2%**	**998**	**10.0%**	**7,695**	**16.3%**
Commercial	17,013	37.6%	2,400	24.0%	10,610	22.4%
Other/Unknown	3,307	7.3%	332	3.3%	583	1.2%
Total	**45,255**	**100.0%**	**9,990**	**100.0%**	**47,326**	**100.0%**

Sources: TDOH, Division of Policy, Planning and Assessment; and Tennova Cleveland internal data.
*Most recent data available provided: county-level data (Bradley and Polk total ED visits) is 2015 data; Tennova Cleveland data is 2017.
Note: TennCare includes CoverTN, Cover Kids, and Access TN.

9. Establishment of Service Area

A. Establishment of Non-Rural Service Area

[X] **The proposed service area is non-rural. If this box is checked the applicant must provide the information below.**

[ ] **The proposed service area is rural.**

B. Establishment of Rural Service Area

[X] **The proposed service area is rural. If this box is checked the applicant must provide the information below.**

[ ] **The proposed service area is non-rural.**

Applicants seeking to establish a FSED in a rural service area with limited access to emergency medical care shall establish a service area based upon need.

Data:
Applicants should provide the number of existing ED facilities in the proposed service area.

Data Source:
Licensure facility search, Joint Annual Reports (JAR), MapQuest, Other GPS searching

https://apps.health.tn.gov/facilityListings/

https://apps.health.tn.gov/PublicJARS/Default.aspx

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

Data:
Socio- demographics of the service area

Projected populations to receive services

Complete the following tables to demonstrate:

a. Patient origin for the hospital's existing ED in relation to the proposed service area for the FSED
b. Patient Origin of the service area residents (i.e. market share).

The applicant may add or remove as many ZIP Code/County and Hospital ED lines as is necessary.

RESPONSE: Tennova Cleveland's proposed FSED will serve residents primarily from two counties, one of which is a non-rural county (Bradley) and the other of which is rural county (Polk). Notably, Tennova Cleveland is the only hospital provider in the 2-county area because the Polk County Critical Access Hospital (Copper Basin Medical Center) closed in October 2017.

The following tables are provided to document the reasonableness of the service area for the proposed project.

The proposed service area definition for Tennova Cleveland's FSED is based on the hospital's historical ED patient origin, as shown below. For reference, the ranking of counties based on the number of ED patients served at Tennova Cleveland is included.

Table 26
Patient Origin, Ranked Highest to Lowest
Tennova Cleveland, CY17

Rank	County	ED Visits	% of Total	Cum. %
Proposed FSED Service Area:				
1	Bradley	37,982	80.3%	80.3%
2	Polk	3,566	7.5%	**87.8%**
All Other ED Patients' Home Counties:				
3	McMinn	1,804	3.8%	91.6%
4	Unknown	1,541	3.3%	94.9%
5	Hamilton	1,135	2.4%	97.3%
6	Meigs	529	1.1%	98.4%
7	Rhea	235	0.5%	98.9%
8	Monroe	132	0.3%	99.2%
--	All Others	402	0.8%	100.0%
Total ED Visits		**47,326**	**100.0%**	N/A

Source: Tennova Cleveland internal documents.

Tennova Cleveland is the only ED provider in the service area. As demonstrated below, service area residents rely on Tennova Cleveland for emergency services.

Table 27 ED Patient Destination by Hospital for Service Area Counties (Includes all EDs with 50 or More Patients from a County) *Ranked Highest to Lowest for Bradley County ED Visits, 2015*						
Hospital	**Bradley Co. ED Visits**	**% of Bradley Visits**	**Polk Co. ED Visits**	**% of Polk Visits**	**Total PSA ED Visits**	**Total Market Share**
Tennova Healthcare - Cleveland	**35,108**	**77.6%**	**2,886**	**28.9%**	**37,994**	**68.8%**
Erlanger Medical Center	3,647	8.1%	483	4.8%	4,130	7.5%
CHI Memorial Hospital	1,608	3.6%	164	1.6%	1,772	3.2%
Erlanger East Hospital	1,337	3.0%	72	0.7%	1,409	2.6%
Starr Regional Med Ctr - Athens	957	2.1%	626	6.3%	1,583	2.9%
Parkridge Medical Center	664	1.5%	52	0.5%	716	1.3%
Parkridge East Hospital	631	1.4%	0	0.0%	631	1.1%
Other Hospitals*	524	1.2%	238	2.4%	762	1.4%
Starr Regional Med Ctr - Etowah	278	0.6%	1,713	17.1%	1,991	3.6%
CHI Memorial Hixson	202	0.4%	0	0.0%	202	0.4%
Rhea Medical Center	110	0.2%	0	0.0%	110	0.2%
Erlanger North Hospital	65	0.1%	0	0.0%	65	0.1%
Copper Basin Medical Ctr *(closed)*	**64**	**0.1%**	**3,756**	**37.6%**	**3,820**	**6.9%**
Sweetwater Hospital Association	60	0.1%	0	0.0%	60	0.1%
Total	**45,255**	**100.0%**	**9,990**	**100.0%**	**55,245**	**100.0%**

Source: TDOH, Division of Policy, Planning and Assessment.
*Note: Other Hospitals include all hospitals with 50 or less ED visits from the PSA counties.

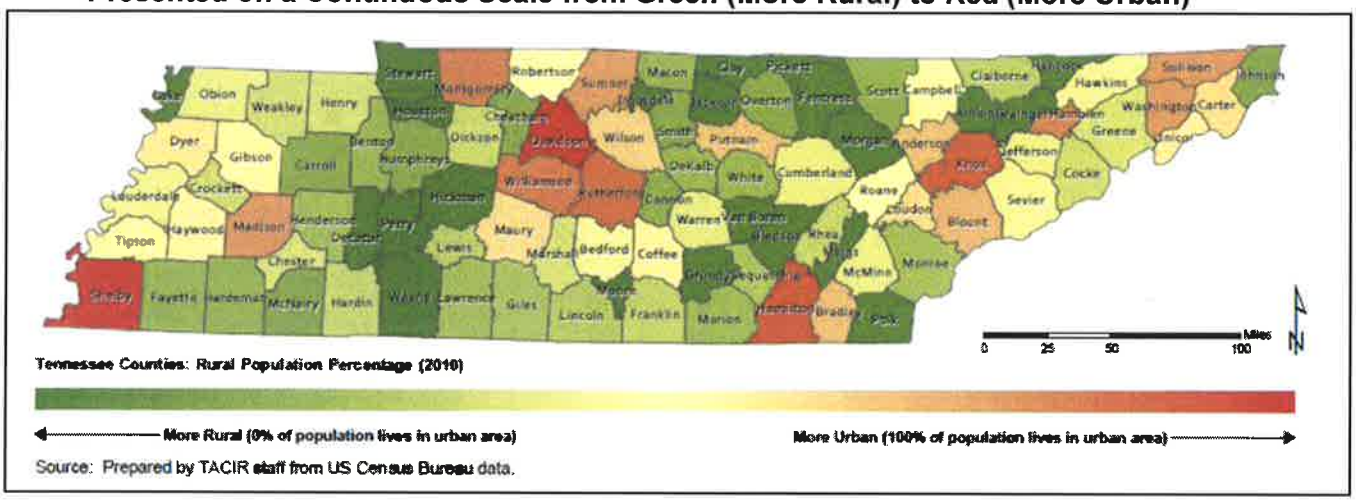
The following information is provided regarding the rural and non-rural nature of the service area counties.

According to the Tennessee Advisory Commission on Intergovernmental Relations August 2016 staff report, Tennessee's 95 counties can be graded based on an Index of Relative Rurality which was developed by Purdue University. Using this index, a 0 denotes an urban county while an index approaching 1 denotes a rural county.

According to the Index, Bradley County's Index of Relative Rurality is .283 based on 2010 data, ranking it 84th of 95 counties in the State of Tennessee. Thus, Bradley County is one of the top 15 urban counties in Tennessee.

The opposite is true for Polk County. Polk's index is .546, ranking at 21st in the State, one of the top 25 rural counties in Tennessee. Therefore, Tennova Cleveland's proposed freestanding emergency department will serve both urban and rural populations.

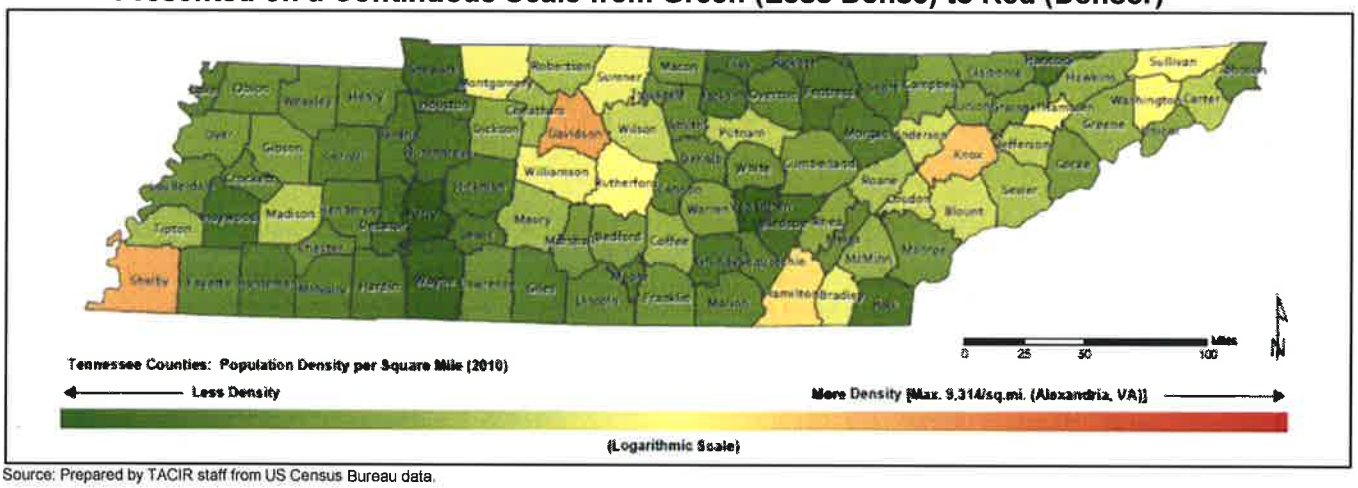
Figure 3
Percent Rural Population of Tennessee Counties (2010)
Presented on a Continuous Scale from Green (More Rural) to Red (More Urban)



Source: Prepared by TACIR staff from US Census Bureau data.

Given the counties' relative population bases, it is no surprise that Bradley County, the location of the proposed FSED, is the more densely populated county. Polk County, as noted earlier, is more rural in nature with a significantly lower population density. The following map illustrates the relative density and rural/non-rural nature of the two service area counties.

Figure 4
Population Density of Tennessee Counties (2010)
Presented on a Continuous Scale from Green (Less Dense) to Red (Denser)



Source: Prepared by TACIR staff from US Census Bureau data.

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.

Data:

Complete the following table of federally designated areas in the proposed service area to address this portion of the standards.

RESPONSE: The following chart has been completed, documenting that the service area is comprised of underserved population groups as defined by select federal designations.

Table 28
Underserved Geographic Areas and Underserved Population Groups

Proposed Service Area ZIP Code and/or County	Medically Underserved Area Check (X) if Applicable	Medically Underserved Populations Check (X) if Applicable	Health Professional Shortage Area Check (X) if Applicable	Shortage Area for Mental Health Services Check (X) if Applicable
Bradley	X	X	X	X
Polk	X	X	X	X

As documented above, Bradley and Polk Counties are currently designated in whole or in part as Medically Underserved Areas ("MUA"), which is based in part on a lack of access to primary care health services.

The following table provides the index score for service area MUAs. The index is based on four criteria: population-to-provider ratio, percent of the population below the federal poverty level, percent of the population over age 65, and the infant mortality rate. Areas with an *index of 62.0 or less qualify for a MUA designation.* As shown below, many communities in service area have HRSA index scores well below the 62.0 threshold.

Moreover, the 4 districts in Bradley County have been designated as MUAs for over two decades, confirming that enhancing access to timely care is the best approach to increase the health status of the residents in these communities. Tennova Cleveland currently serves the residents of these communities. The proposed FSED will enhance access to emergency services for residents throughout the 2-county service area.

Table 29 Medically Underserved Areas By County and HRSA Service Area			
County	**HRSA Service Area Name**	**Index Score**	**Year Designated**
Bradley County:			
Bradley	Cleveland Division Service Area – District 3	43.20	1994
Bradley	Cleveland Division Service Area – District 5	43.20	1994
Bradley	Cleveland Division Service Area – District 6	43.20	1994
Bradley	Cleveland Division Service Area – District 7	43.20	1994
Polk County:			
Polk	Polk County Service Area	51.30	2016

Source: Health Resources & Services Administration Data Warehouse.
Notes:
Index score applies to the entire Medically Underserved Area, on a scale from 0 (highest need) to 100 (lowest need).
Year designated is when the MUA was originally designated as a needy area.

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 repository services during all hours of operation.

Complete the following table to demonstrate the intent to provide the required services.

RESPONSE: The following chart confirms that Tennova Cleveland's proposed FSED will provide imaging (CT, X-Ray, and Ultrasound) services on-site and that those services will be available 24 hours per day, 7 days per week, 365 days per year. Laboratory, pharmacy, and respiratory services will be similarly available on-site. All listed services will be provided in-house by Tennova Cleveland.

Table 30 Composition of Services			
Service	**Hours Available**	**On-Site**	**Contracted or In-House**
Laboratory	24/7	Yes	In-house
X Ray	24/7	Yes	In-House
CT Scanner	24/7	Yes	In-House
Ultrasound	24/7	Yes	In-House
Pharmacy	24/7	Yes	In-house
Respiratory	24/7	Yes	In-House

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: Tennova Cleveland commits to maintaining at least a Primary Level of pediatric care at the proposed FSED. Currently, Tennova Cleveland cares for children of all ages on its main hospital campus ED. The same proven quality of services, including staffing levels and pediatric equipment, will be provided at the FSED.

Tennova Cleveland's ability to care for patients of all ages is illustrated by the 6,770 pediatric ED patients (14.3%) served in 2017, as shown below.

Table 31
Tennova Cleveland ED Visits, CY17

Age Cohort	Total	% of Total
<1	686	1.4%
1-17	6,084	12.9%
18-64	30,921	65.3%
65-74	4,501	9.5%
75-84	3,486	7.4%
85+	1,648	3.5%
Total	**47,326**	**100.0%**

Source: Tennova Cleveland internal data.

Tennova Cleveland has in place referral relationships and transfer protocols for children in need of emergency transport to a specialized children's facility (*e.g.*, Erlanger Children's Hospital). These same referral relationships and plans for rapid transport will be utilized at the FSED. Illustrative of Tennova Cleveland's relationship and ability to rapidly transport pediatric patients for a specialized higher level of care when needed is the approximate 50 pediatric patients transported in 2017 to a Children's Hospital.

13. Assurance of Resources

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

RESPONSE: Tennova Cleveland is committed to developing, maintaining, and staffing the proposed FSED in order to provide the appropriate level of emergency services at the facility, as evidenced by the financial projections included in this application that account for necessary staffing and resources. A project funding letter from CHS, the applicant's ultimate parent, confirming that the project will have the necessary resources is provided in Attachment B-EconFeas-B.

14. Adequate Staffing

A. All Applicants

The 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. If the applicant plans to contract with an emergency physician group, the applicant should provide information on the physician group's ability to meet the staffing requirements.

Utilize the following table to demonstrate planned staffing.

RESPONSE: Tennova Cleveland has the proven ability to recruit, hire and train the appropriate numbers of qualified personnel to staff the proposed FSED. As an existing provider of emergency services, Tennova Cleveland has experience and a proven record of appropriately staffing emergency care services with qualified personnel.

Additionally, Tennova Cleveland has the demonstrated ability to supervise the appropriate personnel, assess competencies and skills, and retain staff in relation to emergency services as well as overall hospital-wide services that are available at the hospital's two campuses. Tennova Cleveland will utilize these capabilities to properly staff the proposed FSED with qualified, well-trained personnel. For example, the proposed facility will be staffed by Registered Nurses certified in emergency nursing care and/or advanced cardiac life support.

Related to physician resources, Tennova Cleveland has an existing relationship with TeamHealth, a leading clinician services organization with over 20,000 affiliated physicians and advanced practice clinicians across over 3,200 facilities and physician groups nationwide. The Medical Director for the new FSED, Anthony G. Steele, MD, FACEP, is Board-Certified in Emergency Medicine and has been with TeamHealth since 2014. Additional physicians staffing the facility will also be either board-certified or board-eligible.

B. Non-Rural Staffing Requirements

[X] **The proposed service area is non-rural. If this box is checked the applicant must provide the information below.**

[ ] **The proposed service area is rural.**

The 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.

RESPONSE: Please see the information provided above and staffing by position provided in response to Section B-Economic Feasibility-H. The proposed FSED will be located in Bradley County, a non-rural county, though the service area includes a rural county (Polk).

C. Rural Staffing Requirements

[ ] **The proposed service area is rural. If this box is checked the applicant must provide the information below.**

[X] **The proposed service area is non-rural.****

The 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.

RESPONSE: Not applicable.

**Though the service area includes a rural county (Polk), the proposed FSED will be located in Bradley County, a non-rural county, and the rural staffing requirements appear to relate to the location of the FSED itself.

15. Medical Records

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

RESPONSE: Tennova Cleveland's proposed FSED will have an integrated medical record system between its existing main hospital campus ED and the proposed FSED, ensuring continuity of care in all instances, including for example when the ED patient from the FSED must be admitted to Tennova Cleveland for inpatient care.

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: Tennova Cleveland currently maintains transfer agreements with Bradley County EMS as well as hospitals in Chattanooga that offer advanced tertiary and/or quaternary-level services that Tennova Cleveland does not provide. Copies of those transfer agreements are included in Attachment B-Need-A.3. These transfer agreements include all services and locations of Tennova Cleveland, thus will include the proposed FSED as well.

Tennova Cleveland maintains an agreement with air ambulance transport. The main hospital campus has a helipad located near the existing emergency department. In the event of an emergency, the proposed FSED's southeastern parking lot can be utilized for helicopter landings. As security staff is onsite at all hours, security would be available to assist with preparation of the site (relocating cars) and landing and takeoff procedures at the FSED.

All stabilization and transfer procedures of emergent cases will be in accordance with the Emergency Medical Treatment and Labor Act, as is the case with the hospital's main campus ED.

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 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: Tennova Healthcare successfully opened a freestanding emergency department in Clarksville, Tennessee in December of 2017. Signage and external communications clearly identified the facility as an emergency department. Tennova Cleveland will utilize a similar signage and communications approach at its proposed freestanding emergency department in Clarksville. Specific examples of the communication plan to be implemented in Bradley County follows.

The communication plan will consist of all channels of outreach, with the hospital and its staff members working closely to educate law enforcement, EMS and other first responders in the to the community, as well as the general resident population.

Channels of communication will include, for example:

1) Media – Traditional (Newspaper, Radio, Billboard and Television), Social (Facebook Campaign) and Digital.
2) Direct Mail to Direct Mail Campaign to a 10 mile radius from the address with a patient mix of ages 18-84 Male and Female.
3) "Text Blast" through a local radio station that is estimated to reach 12,000+ subscribers
4) Internal Communication – EMAIL blast, CEO chats, Newsletters, Email to Board Members, Medical Staff and Employees.
5) External Communication – Direct mail to consumers, Ground Breaking Events, Grand Opening Events/Ribbon Cutting
    a. Invitees will include: Political, Medical, Hospital Board of Trustees, First Responder Agencies, Chamber of Commerce Members and Members of the community surrounding the location, to give a few examples.
6) Civic Group Presentations and Community Outreach.

Signage Plan:
The hospital's signage plan will reflect clear concise messaging to the services provided at the FSED. Signage will be in place during construction as well as during groundbreaking and once the facility is opened.

18. Community Linkage Plan

Please discuss the applicant community linkage plan that includes the following elements as described below.

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.

RESPONSE: Tennova Cleveland understands the necessity of actively engaging in a Community Linkage Plan to address the mental health, substance abuse, and importance of behavioral health crisis intervention in the Cleveland area. Tennova Cleveland has a dedicated Behavioral Health Liaison who maintains ongoing communication with community resources such as outpatient and inpatient behavioral health providers, primary care physicians, other EDs in the surrounding area, local therapists, mobile crisis response teams, and chemical dependency residential treatment facilities.

These relationships are maintained for the purpose of addressing local behavioral health concerns and to strategize on how to raise awareness to these issues. These outreach efforts also provide education on resources available in the local community, including intensive outpatient and inpatient services with an emphasis on alternative options to ED referrals.

Tennova behavioral health offers 24-7 assessments, and is able to assess the level of care for those seeking treatment for mental health and/or substance use. It is the Community Liaison's goal to educate the community on this resource, encourage them to use our 24-7 access to care at our facility as a primary contact while in a behavioral health crisis and not have to solely rely on area EDs for this need.

Tennova Cleveland's Behavioral Health Community Liaison is also actively involved with the Region III Provider Partnership Meetings which are held at Moccasin Bend Mental Health Institute in Chattanooga, TN. A primary purpose of these meeting is to clarify and address system issues of patient care for individuals in need of emergency mental health services. Those at the table are representatives from local inpatient and outpatient behavioral health facilities, chemical dependency treatment facilities, local law enforcement, and suicide prevention groups. A benefit of participation in this group is the knowledge the Community Liaison continues to build regarding the community-based resources available to individuals (and their families) in crisis. The participation also ensures that Tennova Cleveland Behavioral Health understands its community's needs so that it may be responsive to those needs.

The Community Liaison also participates in County Health Council Meetings in the region. The Councils are primarily made up of individuals from local community assistance programs and outpatient treatment agencies. Among the topics that are discussed are the needs of those in the lower income population, including Medicaid/TennCare and uninsured patients, and resources available to meet those needs.

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: Tennova Cleveland agrees to provide the Department of Health and the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services at the proposed FSED. Tennova Cleveland also agrees to report this data in the time and format 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: Tennova Cleveland has in place a well-established and proven Quality Assurance Plan that will be implemented at the proposed FSED. (*See* Attachment B-Need-A.4.)

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: Tennova Cleveland currently receives Medicare and TennCare/Medicaid reimbursement, serves uninsured patients (including a disproportionately high percentage of uninsured emergency patients), and contracts with commercial health insurers. As a satellite ED of the hospital, the proposed FSED will operate and serve the same patient populations. The proposed FSED will have provider-bases status, thus complying with regulations set forth by 42 CFR 413.65.

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: Tennova Cleveland is in good standing with all licensing, certifying and accrediting agencies. A copy of the hospital license, Joint Commission accreditation, and Tennova Healthcare's CMS Letter of Compliance are included in Attachment B-Need-A.5.

B. 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: The expansion of emergency services, through the establishment of a FSED, is a key component of the hospital's and Tennova Healthcare's long-range development plans to ensure that services are offered in the hospital's local community to meet the needs of all service area residents. The proposed FSED will provide the local community with an additional patient access point for emergency services on a smaller, more manageable outpatient-only campus, and provide more accessible emergency services for the growing north Bradley County residents and businesses.

C. Identify the proposed service area 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 B - Need-C.

Please complete the following tables, if applicable:

RESPONSE: The proposed service area for the project is comprised of two counties: Bradley and Polk, which combined represent approximately 88% of Tennova Cleveland's ED patients. The proposed service area definition for Tennova Cleveland's FSED is based on the hospital's historical ED patient origin, as shown below. For reference, the ranking of counties based on the number of ED patients served at Tennova Cleveland is included.

Table 32
Tennova Cleveland ED Visits by County, CY17

Rank	County	ED Visits	% of Total	Cum. %
Proposed FSED Service Area:				
1	Bradley	37,982	80.3%	80.3%
2	Polk	3,566	7.5%	**87.8%**
All Other ED Patients' Home Counties:				
3	McMinn	1,804	3.8%	91.6%
4	Unknown	1,541	3.3%	94.9%
5	Hamilton	1,135	2.4%	97.3%
6	Meigs	529	1.1%	98.4%
7	Rhea	235	0.5%	98.9%
8	Monroe	132	0.3%	99.2%
--	All Others	402	0.8%	100.0%
Total ED Visits		**47,326**	**100.0%**	N/A

Source: Tennova Cleveland internal documents.

The reasonableness of the service area for the proposed FSED is further evidenced by Tennova Cleveland's ED market share in Bradley and Polk Counties compared to its ED market share in surrounding counties. Information in the following table is the most recent data available from the TDOH, Division of Policy, Planning and Assessment, and is based on information from the Tennessee Hospital Discharge Data System.

Table 33
Total ED Visits by County, 2015

County	Total ED Visits for County Residents	Tennova Cleveland ED Visits	Tennova Cleveland % Market Share	Tennova Cleveland Market Share Ranking
Proposed FSED Service Area:				
Bradley	45,255	35,108	77.6%	1
Polk	9,990	2,886	28.9%	2
Other ED Patients' Home Counties:				
McMinn	40,801	1,486	3.6%	4
Hamilton	163,584	895	0.5%	9
Meigs	7,740	944	12.2%	2
Rhea	20,927	170	0.8%	9

Source: Tennessee Department of Health, Division of Policy, Planning and Assessment; Hospital Discharge Data System.

As shown in the previous table, Bradley and Polk County residents rely on Tennova Cleveland for emergency services. Of interest is a comparison of Tennova Cleveland's #2 market share ranking in Polk and Meigs Counties. Notably, though Tennova Cleveland has the 2nd highest market share of ED patients in Meigs County, the majority of those residents (53%) rely on Starr Regional Medical Center in Athens ("Starr Regional"), McMinn County, for emergency services. That market dominance by Starr Regional in Meigs County contrasts with Tennova Cleveland's #2 market share of approximately 12% there. Thus, there is a significant gap between the market leader (Starr Regional) and Tennova Cleveland's #2 market position in Meigs County.

Conversely, Tennova Cleveland's #2 market share ranking in Polk County is much closer to the market leader (the now-closed Copper Basin Medical Center). Copper Basin Medical Center served approximately 38% of the ED patients from Polk County in 2015, compared to Tennova Cleveland's #2 market share ranking of 29% in Polk County. The hospital with the next highest percentage of ED market share in Polk County served only 17% of patients. Thus, Polk County residents relied on Tennova Cleveland (and the now closed Copper Basin Medical Center) for emergency services.

The reliance of service area residents on Tennova Cleveland is driving the need for the proposed project. As the service area population increases and ages, and the residents in Polk County rely even more on surrounding hospitals, primarily including Tennova Cleveland, for locally available and accessible healthcare services, the current capacity constraints at the hospitals' main campus ED are expected to worsen.

The proposed FSED will enable Tennova Cleveland to optimally serve its current and future patient population, which are reflected in the following tables.

Table 34 Tennova Cleveland Projected Total ED Visits, Project Years 1 & 2			
Service Area County	**Projected Year 1 (2020) ED Visits**	**Projected Year 2 (2021) ED Visits**	**Projected Patient Origin, 2021**
Bradley	36,865	37,209	77.7%
Polk	4,894	4,918	10.3%
Total Svc Area	**41,759**	**42,127**	**88.0%**
All Other Counties	5,694	5,745	12.0%
Total Projected ED Visits	**47,453**	**47,872**	**100.0%**

As shown above, the projected patient origin by county mirrors the current patient origin by county, with approximately 88% of ED visits forecasted to come from the 2-county service area in Project Years 1 and 2 (with Project Year 2 calculation shown). Tennova Cleveland's remaining 12% of projected ED patients are expect to continue coming from surrounding areas outside of the defined service area.

Tennova Cleveland expects to serve patients with all acuity levels at both hospital campuses, which will increase access to emergency services for all patients, including high-acuity patients, as documented below.

Table 35 Tennova Cleveland Projected Total ED Visits by Acuity Level and Campus							
Acuity Level ***(Lowest to Highest)***	**CPT Code**	**Project Year 1 (2020)**			**Project Year 2 (2021)**		
		FSED Visits	**Main Campus Visits**	**Total Visits**	**FSED Visits**	**Main Campus Visits**	**Total Visits**
Level 1	99281	368	1,103	1,471	445	1,039	1,484
Level 2	99282	819	2,456	3,274	991	2,312	3,303
Level 3	99283	3,144	9,431	12,575	3,172	9,515	12,686
Level 4	99284	1,466	13,197	14,663	1,479	13,313	14,792
Level 5	99285	1,547	13,923	15,470	1,561	14,046	15,606
Total		**7,343**	**40,110**	**47,453**	**7,648**	**40,224**	**47,872**

Tennova Cleveland proposes to utilize the following ED treatment room complement at its two EDs (main campus and proposed FSED) in order to optimally serve its projected patient population.

Table 36
Tennova Cleveland Current and Proposed ED Treatment Rooms

Room Type	Main Campus (Existing)	Freestanding (Proposed)	Total
General Exam Room	26	6	32
Major Exam Room	4	1	5
Secure Holding Room	5	0	5
Isolation Exam Room	2	1	3
OB/GYN Exam Room	2	0	2
ENT Exam Room	1	0	1
Cast Room	1	0	1
Total ED Rooms	**41**	**8**	**49**

TENNESSEE COUNTY MAP

D. 1). a) Describe the demographics of the population to be served by the proposal.

RESPONSE: The 2-county service area (Bradley and Polk Counties) currently accounts for approximately 88% of the emergency patients receiving care at Tennova Cleveland. While Bradley County is a non-rural county, Polk County is generally considered rural. The 2-county area total population currently exceeds 125,000 residents, and is projected to grow to almost 130,000 total residents.

The median household income for both counties is lower than the state as a whole. Polk County has a higher percentage of persons below the poverty level than the state as a whole and a higher percentage of the population that is enrolled in TennCare that the state overall. Thus, the need for locally accessible and available services close to Polk County residents' homes, including inpatient services resulting from ED visits, is illustrated by the socioeconomic and demographic data of this rural, relatively poor county.

Bradley County represents the greatest concentration of residents with approximately 86% of the population of the two-county service area.

b) 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

RESPONSE: For the proposed FSED project, the Current Year is 2018 and the Projected Year is 2022. The Target Population is the entire population, *i.e.*, all ages.

Please note that immediately following the county-level chart, Tennova Cleveland has provided ZIP Code information to document the population growth in ZIP Code 37312 relative to ZIP Codes in the entire 2-county service area.

Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population- Current Year (2018)	Total Population- Projected Year (2022)	Total Population- % Change	*Target Population- Current Year (2018)	*Target Population- Projected Year (2022)	*Target Population- % Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total Population
Bradley County	107,651	111,750	3.8%	107,651	111,750	3.8%	100.0%	38.2	$43,721	14,838	14.2%	22,874	21.2%
Polk County	17,627	17,977	2.0%	17,627	17,977	2.0%	100.0%	42.5	$41,520	2,717	16.2%	4,170	23.7%
Service Area Total	125,278	129,727	3.6%	125,278	129,727	3.6%	100.0%	N/A	N/A	17,555	14.5%	27,044	21.6%
State of TN Total	6,960,524	7,263,893	4.4%	6,960,524	7,263,893	4.4%	100.0%	38.5	$46,574	1,050,889	15.8%	1,476,375	21.2%

** 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 and 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 2020.*

*Target population is the total population (i.e., all ages). Population estimates are provided for 2018 and 2022.

Table 37
Service Area (Bradley & Polk Counties) ZIP Code Socioeconomic and Demographic Information

ZIP Code	Primary City	County	% of Tennova Cleveland ED Visits, 2017	Patient Origin Rank 2017	Total Population 2018	Projected Population 2022	Population Change %	Median Age	Median Household Income	Individuals Below Poverty Level %
37311	Cleveland	Bradley	29.8%	1	28,962	29,727	2.6%	31.9	$31,305	31.3%
37323	Cleveland	Bradley	22.1%	2	31,385	32,390	3.2%	40.2	$44,881	16.3%
37312	**Cleveland**	**Bradley**	**21.2%**	**3**	**33,989**	**35,484**	**4.4%**	**41.4**	**$52,843**	**12.4%**
37307	Benton	Polk	2.8%	4	4,849	4,933	1.7%	39.8	$41,419	11.6%
37362	Old Fort	Polk	2.6%	5	3,699	3,784	2.3%	39.7	$40,476	19.9%
37310	Charleston	Bradley	2.5%	6	4,687	4,886	4.2%	43.2	$58,556	14.5%
37336	Georgetown	Bradley	2.0%	7	4,412	4,555	3.2%	45.2	$51,066	10.6%
37353	Mc Donald	Bradley	1.6%	8	4,954	5,077	2.5%	44.2	$44,067	13.9%
37361	Ocoee	Polk	1.0%	11	1,505	1,535	2.0%	55.8	$58,448	11.3%
37320*	Cleveland	Bradley	0.8%	14						
37325	Delano	Polk	0.4%	18	1,771	1,792	1.2%	38.2	$40,323	28.2%
37369	Reliance	Polk	0.4%	19	1,091	1,097	0.5%	55.5	$45,028	9.5%
37364*	Cleveland	Bradley	0.2%	22						
37317	Copperhill	Polk	0.2%	24	2,683	2,680	-0.1%	47.5	$41,831	18.0%
37391	Turtletown	Polk	0.1%	31	1,604	1,619	0.9%	49.6	$31,523	14.7%
37326*	Ducktown	Polk	0.0%	51						
37333	Farner	Polk	0.0%	52	518	519	0.2%	40.6	$22,407	51.0%
37316*	Conasauga	Polk	0.0%	87						
Service Area					**126,109**	**130,076**	3.1%			

*Note: P.O. Box for which only patient origin data is available; no population-based information is available.
Sources:
Patient Origin - Tennova Healthcare Cleveland Internal Records.
Total and Projected Population - Claritas - Pop-Facts Premier 2018
Age, Income and Poverty Level - 2012-2016 American Community Survey 5-Year Estimates, U.S. Census Bureau.

ZIP Code 37312, the location of the proposed FSED, is highlighted for ease of review. As shown above, the proposed ZIP Code location of the FSED is the most populated and fastest-growing ZIP Code in the service area.

Data in the table above has been collected from the following sources:

- Median Age is sourced from The United State Census Bureau's ACS Demographic and Housing Estimates, 2012-2016 American Community Survey 5-Year Estimates.
- Median Household Income, in 2016 dollars, sourced from U.S. Census Bureau, American Community Survey (ACS), 5-Year Estimates.
- Persons Below Poverty Level, % of Total Population, sourced from U.S. Census Bureau 2016 American Community Survey (ACS), 1 Year Estimates. Persons in Poverty calculated utilizing U.S. Census Bureau July 1, 2016 population estimates.
- TennCare Enrollee totals are sourced from the TennCare Enrollment Report for January 2018 and the TennCare Enrollees as a % of Total Population is calculated using the Current Year population from the Tennessee Department of Health (Population Projections, Tennessee Counties and the State, The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, 2017 Revised UTCBER Population Projection Series.

2) 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 demographic data in the tables above provide evidence that the residents of the service area have a number of unique needs based on their age and general economic status. Tennova Cleveland's proposed ED expansion, through establishment of a FSED, will continue to serve all patients in the service area, including the elderly, women, racial and ethnic minorities, and low-income groups.

The following table provides additional detail regarding the population ages 65+ in the service area counties. As documented, the service area population is older than the state as a whole, with almost one-quarter of Polk County's populated forecast to be ages 65+ in 2022.

Table 38
Service Area Population Ages 65+

			Growth 2018-2022		% of Total Pop	
County	**2018**	**2022**	**Number**	**Percent**	**2018**	**2022**
Bradley	19,073	21,665	2,592	13.6%	17.7%	19.4%
Polk	3,882	4,375	493	12.7%	22.0%	24.3%
Total	**22,955**	**26,040**	**3,085**	**13.4%**	**18.3%**	**20.1%**
Tennessee	1,175,938	1,362,320	186,382	15.8%	16.9%	18.8%

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment. 2017 Revised UTCBER Population Projection Series.

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

RESPONSE: Tennova Cleveland is the only provider of emergency services in the 2-county service area. There are currently no approved but unimplemented emergency services in the service area.

Nonetheless, the following table is provided showing hospitals in surrounding counties, including all facilities in Hamilton County. As shown below, Tennova Cleveland is the fourth (4th) busiest ED of all hospitals serving patients in the 2-county service area in terms of total ED visits seen in 2016, regardless of the hospital's location (*i.e.*, home county).

Notably, though Erlanger Medical Center in Chattanooga (Hamilton County) is the busiest ED in the area, Erlanger's average annual ED visits per room is by far the lowest in the area, with an average annual 836 visits per room.

Table 39
Visits Per Treatment Room in Existing ED Facilities in the Surrounding Area
Ranked from Highest to Lowest Total ED Visits, 2016

Emergency Department (Hospital)	County	Total Visits	# of ED Rooms	# of Visits per Room
Erlanger Medical Center	Hamilton	66,006	79	836
Parkridge East Hospital	Hamilton	50,430	19	2,654
CHI Memorial Hospital	Hamilton	49,445	31	1,595
Tennova Healthcare - Cleveland	**Bradley**	**48,501**	**41**	**1,183**
Starr Regional Medical Center - Athens	McMinn	39,297	N/A	N/A
Parkridge Medical Center	Hamilton	38,394	23	1,669
CHI Memorial Hixson	Hamilton	32,674	21	1,556
Erlanger East Hospital	Hamilton	31,197	17	1,835
Sweetwater Hospital Association	Monroe	25,528	15	1,702
Rhea Medical Center	Rhea	23,039	14	1,646
Erlanger North Hospital	Hamilton	14,857	8	1,857
Starr Regional Medical Ctr - Etowah	McMinn	11,000	9	1,222
Copper Basin Med Ctr *(now closed)*	**Polk**	**6,750**	**3**	**2,250**

Source & Notes:
2016 Joint Annual Report of Hospitals (JARs).
N/A = data not available in the 2016 JAR.

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

RESPONSE: For details regarding the projected utilization by campus, please refer to Tables 34 – 35 presented above.

Table 40
Tennova Cleveland Historical & Projected ED Visits

	Historical Volume			Projected Volume	
Facility	**CY15**	**CY16**	**CY17**	**Year 1**	**Year 2**
Main Hospital Campus	50,533	48,501	47,326	40,110	40,224
Freestanding	0	0	0	7,343	7,648
Total Cases	**50,533**	**48,501**	**47,326**	**47,453**	**47,872**

Sources: Tennova Cleveland Joint Annual Reports, and internal documents.
Note: 2015 data shown reflects internal data because the reported JAR data was incorrect.

SECTION B: ECONOMIC FEASIBILITY

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

1) All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee)

RESPONSE: The total cost of the proposed Project, $12,081,195, includes a CON Filing Fee of $69,070. The CON Filing Fee is attached to the application and a copy of the submitted check is included in Attachment B-EconFeas-A.1.

2) 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.

RESPONSE: Not applicable. The Project does not encompass the leasing of any buildings, land or equipment. The proposed FSED will be constructed on land purchased by Tennova Cleveland and the facility will be owned by the hospital.

3) 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.

RESPONSE: The cost for the moveable equipment that is part of the proposed Project includes maintenance agreements, taxes and installation charges. See Attachment B-EconFeas-A.3 for equipment quotes for a CT unit, two X-ray units (one mobile, one fixed), and an ultrasound unit.

4) 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 reported on the Square Footage Chart.

RESPONSE: The construction cost for the proposed project is above the third quartile of construction costs per square foot for new facilities. The project cost are reasonable given the nature of the proposed project, including for example, the architectural requirements for a FSED that includes medical gases throughout the facility as well as electrical and mechanical systems required to support an isolation room, and laboratory and imaging services.

As Tennova Healthcare recently completed construction of a new FSED in Clarksville, Tennessee, the construction cost estimates for the proposed freestanding emergency department in Cleveland are reasonable based on recent experiences by Tennova Healthcare.

5) For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

   a) A general description of the project;

   b) An estimate of the cost to construct the project;

   c) A description of the status of the site's suitability for the proposed project; and

   d) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

RESPONSE: Please refer to Attachment B-EconFeas-A.5 for a letter from HFR Design providing a general description of the proposed project as well as the estimated construction cost. The letter also addresses the site's suitability for the proposed project and confirms that the design of the proposed freestanding emergency department conforms to applicable standards, specifications and requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

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PROJECT COST CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$460,000
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$120,000
	3.	Acquisition of Site	$905,000
	4.	Preparation of Site	$495,000
	5.	Total Construction Costs	$4,998,300
	6.	Contingency Fund	$1,592,557
	7.	Fixed Equipment (Not included in Construction Contract)	
	8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)*	$2,242,643
	9.	Other (Specify) IT/Furnishings/Signage	$1,198,625
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify)	
	5.	Other (Specify)	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify)	
D.	Estimated Project Cost (A+B+C)		**$12,012,125**
E.	CON Filing Fee		$69,070**
F.	Total Estimated Project Cost (D+E)	**TOTAL**	**$12,081,195**

*See Attachment B-EconFeas-A.3 for equipment quotes for a CT unit, X-ray machines, and an ultrasound unit.

**The exact amount of the filing fee check submitted to HSDA was $69,069.72, so that the total estimated project cost is exactly $12,081,194.72. The project cost amount shown above is rounded up to the nearest whole dollar for ease of review.

B. Identify the funding sources for this project.

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 Section B-Economic Feasibility-B.)***

__ 1) 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;

__ 2) 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;

__ 3) General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ 4) Grants – Notification of intent form for grant application or notice of grant award;

XX 5) 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

__ 6) Other – Identify and document funding from all other sources.

C. 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 presented in the proposed project, if applicable. **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-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

HISTORICAL DATA CHART:
TENNOVA CLEVELAND

x Total Facility
□ Project Only

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

		2015	2016	2017
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) – **Patient Days**	36,194	38,304	38,552
B.	Revenue from Services to Patients			
1.	Inpatient Services	460,978,957	501,560,602	536,008,357
2.	Outpatient Services	527,604,524	609,052,683	604,362,365
3.	Emergency Services	115,279,199	126,189,186	132,694,500
4.	Other Operating Revenue (Specify): Rental, Cafeteria, Misc	649,300	459,450	1,026,070
	Gross Operating Revenue	**$1,104,511,980**	**$ 1,237,261,921**	**$1,274,091,292**
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	889,229,241	997,865,293	1,037,492,174
2.	Provision for Charity Care	51,194,298	60,178,835	62,489,080
3.	Provisions for Bad Debt	23,457,132	23,517,338	21,141,477
	Total Deductions	**$963,880,671**	**$1,081,561,466**	**$1,121,122,731**
NET OPERATING REVENUE		**$140,631,309**	**$155,700,455**	**$152,968,561**
D.	Operating Expenses			
1.	Salaries and Wages			
	a. Direct Patient Care	45,290,205	46,462,803	47,214,640
	b. Non-Patient Care	11,871,659	12,607,935	11,826,586
2.	Physician's Salaries and Wages	6,195,270	6,724,677	7,569,221
3.	Supplies	22,821,732	24,475,560	24,228,537
4.	Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates	2,416,910	3,059,060	3,336,452
5.	Management Fees:			
	a. Paid to Affiliates	3,941,135	3,747,105	4,051,834
	b. Paid to Non-Affiliates			
6.	Other Operating Expenses	25,148,679	25,548,955	27,966,810
	Total Operating Expenses	**$ 117,685,590**	**$122,626,095**	**$126,194,080**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$22,945,719**	**$33,074,360**	**$26,774,481**
F.	Non-Operating Expenses			
1.	Taxes	2,609,851	3,041,257	3,045,992
2.	Depreciation	9,311,996	9,062,767	8,696,012
3.	Interest	10,763,466	9,225,395	6,194,736
4.	Other Non-Operating Expenses			
	Total Non-Operating Expenses	**$ 22,685,313**	**$ 21,329,419**	**$ 17,936,740**
NET INCOME (LOSS)		**$ 260,406**	**$ 11,744,941**	**$ 8,837,741**

Chart Continues Onto Next Page

NET INCOME (LOSS)	**$ 260,406**	**$ 11,744,941**	**$ 8,837,741**
G. Other Deductions			
1. Annual Principal Debt Repayment			
2. Annual Capital Expenditure	3,621,276	6,240,666	4,608,101
Total Other Deductions	**$ 3,621,276**	**$ 6,240,666**	**$ 4,608,101**
NET BALANCE	**$ 3,360,870**	**$ 5,504,275**	**$ 4,229,640**
DEPRECIATION	**$ 9,311,996**	**$ 9,062,767**	**$ 8,696,012**
FREE CASH FLOW (Net Balance + Depreciation)	**$ 5,951,126**	**$ 14,567,042**	**$ 12,925,652**

X Total Facility

☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	2015	2016	2017
1. Purchased Services	$ 8,896,848	$ 8,451,371	$ 9,500,981
2. Provider Tax	5,267,461	5,267,461	5,267,461
3. Med Spec Fees	4,359,852	4,478,655	4,664,465
4. Repairs and Maintenance	3,117,482	2,991,792	2,970,916
5. Utilities	2,220,966	2,121,453	2,099,762
6. All Other (Marketing, Insurance, etc.)	1,286,070	2,238,223	3,463,225
Total Other Expenses	**$ 25,148,679**	**$ 25,548,955**	**$ 27,966,810**

HISTORICAL DATA CHART:
EXISTING EMERGENCY DEPARTMENT

□ Total Facility
X Project Only

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

		2015	2016	2017
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) – **ED Visits**	50,533	48,501	47,326
B.	Revenue from Services to Patients			
	1. Inpatient Services			
	2. Outpatient Services			
	3. Emergency Services	145,088,190	160,257,186	136,594,307
	4. Other Operating Revenue (Specify)_____			
	Gross Operating Revenue	**$145,088,190**	**$160,257,186**	**$136,594,307**
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	130,494,482	145,172,288	122,990,72
	2. Provision for Charity Care			
	3. Provisions for Bad Debt	2,189,056	2,262,735	2,040,541
	Total Deductions	**$132,683,539**	**$147,435,023**	**$125,031,243**
NET OPERATING REVENUE		**$12,404,651**	**$12,822,163**	**$11,563,064**
D.	Operating Expenses			
	1. Salaries and Wages (*includes Benefits*)			
	c. Direct Patient Care	4,488,030	4,533,364	4,625,882
	d. Non-Patient Care	766,706	774,450	790,255
	2. Physician's Salaries and Wages			
	3. Supplies	824,714	865,885	819,436
	4. Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates	13,416	13,416	13,416
	5. Management Fees:			
	c. Paid to Affiliates			
	d. Paid to Non-Affiliates			
	6. Other Operating Expenses	2,161,477	2,423,601	2,769,508
	Total Operating Expenses	**$8,254,343**	**$8,610,716**	**$9,018,497**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$4,150,308**	**$4,211,447**	**$2,544,567**
F.	Non-Operating Expenses			
	1. Taxes			
	2. Depreciation			
	3. Interest			
	4. Other Non-Operating Expenses			
	Total Non-Operating Expenses			
NET INCOME (LOSS)		**$4,150,308**	**$4,211,447**	**$2,544,567**

Chart Continues Onto Next Page

NET INCOME (LOSS)	**$4,150,308**	**$4,211,447**	**$2,544,567**
G. Other Deductions			
1. Annual Principal Debt Repayment			
2. Annual Capital Expenditure			
Total Other Deductions			
NET BALANCE	**$4,150,308**	**$4,211,447**	**$2,544,567**
DEPRECIATION			
FREE CASH FLOW (Net Balance + Depreciation)	**$4,150,308**	**$4,211,447**	**$2,544,567**

☐ Total Facility
X Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	2015	2016	2017
1. Med Spec Fees	2,099,876	2,375,180	2,283,030
2. Purchased Services	30,035	21,786	14,629
3. Repairs and Maintenance	29,401	19,163	13,178
4. Other	2,165	1,058	4,351
5. Contract Labor		6,414	454,320
Total Other Expenses	**$2,161,477**	**$2,423,601**	**$2,769,508**

D. 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 projections 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-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

PROJECTED DATA CHART;
TENNOVA CLEVELAND

X Total Facility
□ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **January** (Month).

		2020	2021
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **Patient Days**	39,635	40,428
B.	Revenue from Services to Patients		
	1. Inpatient Services	568,816,357	580,192,684
	2. Outpatient Services	641,354,177	654,181,260
	3. Emergency Services	140,816,465	143,632,794
	4. Other Operating Revenue (Specify)_Rent, Cafeteria, Misc	1,088,874	1,110,651
	Gross Operating Revenue	**$1,352,075,872**	**$1,379,117,389**
C	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	1,100,994,995	1,123,014,895
	2. Provision for Charity Care	66,313,912	67,640,190
	3. Provisions for Bad Debt	22,435,505	22,884,215
	Total Deductions	**$1,189,744,411**	**$1,213,539,299**
NET OPERATING REVENUE			
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	50,104,554	51,106,645
	b. Non-Patient Care	12,550,468	12,801,477
	2. Physician's Salaries and Wages	8,032,518	8,193,168
	3. Supplies	25,711,517	26,225,748
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	3,540,670	3,611,483
	5. Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	4,299,839	4,385,835
	6. Other Operating Expenses	29,678,602	30,272,174
	Total Operating Expenses	**$133,918,167**	**$136,596,530**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$28,413,294**	**$28,981,560**
F.	Non-Operating Expenses		
	1. Taxes	3,232,431	3,297,080
	2. Depreciation	9,228,278	9,412,843
	3. Interest	6,573,903	6,708,381
	4. Other Non-Operating Expenses		
	Total Non-Operating Expenses	**$19,034,612**	**$19,415,305**
NET INCOME (LOSS)		**$9,378,681**	**$9,566,255**

Chart Continues Onto Next Page

NET INCOME (LOSS)	**$9,378,681**	**$9,566,255**
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment		
2. Annual Capital Expenditure	5,000,000	5,000,000
Total Other Deductions	**$5,000,000**	**$5,000,000**
NET BALANCE	**$4,378,681**	**$4,566,255**
DEPRECIATION	**$9,228,278**	**$9,412,843**
FREE CASH FLOW (Net Balance + Depreciation)	**$13,606,959**	**$13,979,098**

X Total Facility

☐ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	2020	2021
1. Purchased Services	10,082,517	10,284,167
2. Provider Tax	5,589,872	5,701,669
3. Med Spec Fees	4,949,968	5,048,967
4. Repairs and Maintenance	3,152,760	3,215,815
5. Utilities	1,565,878	1,597,196
6. All Other (Marketing, Insurance, etc.)	4,337,607	4,424,360
Total Other Expenses	**$29,678,602**	**$30,272,174**

PROJECTED DATA CHART:
PROPOSED FSED

□ Total Facility
X Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **January** (Month).

		2020	2021
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) – **ED Visits**	7,343	7,648
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services		
	3. Emergency Services	23,826,566	25,808,880
	4. Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$23,826,566**	**$25,808,880**
C	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	20,121,719	21,879,941
	2. Provision for Charity Care	76,245	82,588
	3. Provisions for Bad Debt	190,613	206,471
	Total Deductions	**$20,388,577**	**$22,169,001**
NET OPERATING REVENUE		**$3,437,989**	**$3,639,879**
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	2,292,002	2,337,842
	b. Non-Patient Care	261,063	266,285
	2. Physician's Salaries and Wages		
	3. Supplies	146,860	157,549
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	9,600	9,600
	5. Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses	75,221	164,864
	Total Operating Expenses	**$2,784,787**	**$2,936,140**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$653,242**	**$703,739**
F.	Non-Operating Expenses		
	1. Taxes		
	2. Depreciation	621,941	621,941
	3. Interest		
	4. Other Non-Operating Expenses	5,000	7,500
	Total Non-Operating Expenses	**$626,941**	**$629,441**
NET INCOME (LOSS)		**$26,301**	**$74,298**

Chart Continues Onto Next Page

NET INCOME (LOSS)	**$26,301**	**$74,298**
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment		
2. Annual Capital Expenditure		
Total Other Deductions		
NET BALANCE	**$26,301**	**$74,298**
DEPRECIATION	**$621,941**	**$621,941**
FREE CASH FLOW (Net Balance + Depreciation)	**$648,242**	**$696,239**

☐ Total Facility
X Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	2020	2021
1. Purchased Services	35,821	37,254
2. Marketing	20,000	20,000
3. Repairs and Maintenance	14,400	14,400
4. Utilities	5,000	5,000
5. Service Contracts	0	88,210
Total Other Expenses	**$75,221**	**$164,864**

PROJECTED DATA CHART:
ED COMBINED (FSED & MAIN CAMPUS)

□ Total Facility
X Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **January** (Month).

		2020	2021
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) – **ED Visits**	47,453	47,872
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services		
	3. Emergency Services	183,487,793	216,636,184
	4. Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$183,487,793**	**$216,636,184**
C	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	165,667,644	194,796,960
	2. Provision for Charity Care	76,245	161,883
	3. Provisions for Bad Debt	2,330,334	2,630,019
	Total Deductions	**$168,274,223**	**$197,588,882**
NET OPERATING REVENUE		**$15,213,570**	**$19,047,322**
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	7,129,187	9,573,967
	b. Non-Patient Care	1,087,416	1,370,012
	2. Physician's Salaries and Wages		
	3. Supplies	1,031,656	1,220,154
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	13,890	14,167
	5. Management Fees:		
	a. Paid to Affiliates	9,600	9,600
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses	2,679,385	2,820,164
	Total Operating Expenses	**$11,951,133**	**$15,008,064**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$3,262,437**	**$4,039,258**
F.	Non-Operating Expenses		
	1. Taxes		
	2. Depreciation	1,250,941	1,250,101
	3. Interest		
	4. Other Non-Operating Expenses	5,000	7,500
	Total Non-Operating Expenses	**$1,255,941**	**$1,257,601**
NET INCOME (LOSS)		**$2,006,496**	**$2,781,657**

Chart Continues Onto Next Page

NET INCOME (LOSS)	**$2,006,496**	**$2,781,657**
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment		
2. Annual Capital Expenditure	500,000	500,000
Total Other Deductions	**$500,000**	**$500,000**
NET BALANCE	**$1,506,496**	**$2,281,657**
DEPRECIATION	**1,250,941**	**1,250,101**
FREE CASH FLOW (Net Balance + Depreciation)	**$2,757,437**	**$3,531,758**

☐ Total Facility
X Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	2020	2021
1. Med Spec Fees	2,472,291	2,521,737
2. Purchased Services	51,855	53,608
3. Repairs and Maintenance	29,610	29,914
4. Contract Labor	94,649	95,595
5. Service Contracts	0	88,210
6. Other	30,979	31,100
Total Other Expenses	2,679,384	2,820,164

E. 1) 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.

RESPONSE: The average charge per ED visit at Tennova Cleveland for the current (2017) and previous (2016) years are provided in the chart below. FSED proposed charges for Year 1 and Year 2 are also shown.

	Previous Year (2016)	Current Year (2017)	Year One (2020)	Year Two (2021)	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	$3,304	$2,886	$3,245	$3,375	16.9%
Deduction from Revenue *(Total Deductions/Utilization Data)*	$3,040	$2,642	$2,777	$2,899	9.7%
Average Net Charge *(Net Operating Revenue/Utilization Data)*	$ 264	$ 244	$ 468	$ 476	95.1%

2) 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 proposed FSED will be hospital-based, operating as a satellite ED, thus utilizing the same charge structure as Tennova Cleveland's main campus ED. As explained earlier, Tennova Cleveland serves a disproportionately high percentage of uninsured (self-pay) and Medicare patients compared to the total ED patient population in its defined 2-county service area. The uninsured and elderly population oftentimes require greater resources, time, and skills of staff members compared to insured, younger patients because the uninsured and elderly patients are likely to have comorbidities and/or complexity of needs beyond the immediate crisis resulting in the ED visit. The relatively resource-intensive patient population served by Tennova Cleveland is illustrated by the disproportionately high percentage of highest-acuity patients (identified by CPT Code 99285) and this high-acuity resource intensity is reflected in the project proposed charges.

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

RESPONSE: The proposed project charges and net revenue per FSED visit are reasonable when compared to other FSED projects recently reviewed by the Health Services and Development Agency:

	Average Charge per Visit	
Application	**Project Year 1**	**Project Year 2**
CN1507-027	$ 3,307	$ 3,439
Proposed FSED Project	$ 3,245	$ 3,375
CN1802-011	$ 2,533	$ 2,842
CN1603-011	$ 1,944	$ 2,003

Moreover, proposed average payment per FSED visit are commensurate with Tennova Cleveland's payor payment rates for CPT Codes 99281 – 99285, as summarized below:

Payor	Project Year 1	Project Year 2
Commercial/Other Mged	$ 1,253	$ 1,275
TennCare	$ 239	$ 244
Medicare	$ 291	$ 297
Other	$ 1,061	$ 1,085
Self-Pay/Free Care	$ 64	$ 60
Total	**$ 468**	**$ 476**

F. 1) 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 financial 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 Section B-Economic Feasibility-F1**. **NOTE: Publicly held entities only need to reference their SEC filings.**

RESPONSE: Tennova Cleveland's reasonable volume projections support the financial performance of the FSED, which is expected to have a positive bottom line in Project Year 1.

The applicant has cash available to implement the proposed project and support operations until financial breakeven, if needed. Please refer to Attachment B-EconFeas-B for a project funding letter from CHS.

As part of Tennova Healthcare, which has as its ultimate parent Community Health Systems, Inc. ("CHS"), the Applicant entity does not have audited financial statements. The most recent SEC filing of CHS (2017 Annual Report) reflects the ability of CHS to fund the project, if needed.

2) Net Operating Margin Ratio – Demonstrates 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, and 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* (2017)	Projected Year 1**	Projected Year 2**
Net Operating Margin Ratio	33.4%	32.8%	22.0%	13.2%	14.6%

* *Margin ratios represent existing Tennova ED services.*
** *Margin ratios represent the combined Tennova ED services (existing plus proposed FSED).*

3) Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing 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 year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

RESPONSE: CHS' FY17 capitalization ratio is 105.8, demonstrated by the financial statements provided in Attachment B-EconFeas-F1 and summarized in the following calculation:

Formula: (Long Term Debt /(Long Term Debt + Total Equity)) * 100

Data: (13,880/(13,880+(692))*100) = 105.8.

G. 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, Project Year 1:

Payor Source	Projected Gross Operating Revenue	As a % of total
Medicare/Medicare Managed Care	$7,147,970	30%
TennCare/Medicaid	$7,147,970	30%
Commercial/Other Managed Care	$5,480,110	23%
Self-Pay/Free Care	$4,050,517	17%
Total	$23,826,567	100.0%

H. 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 (FTEs) 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 FTEs 2017	Projected FSED FTEs Year 1	Average Wage (Contractual Rate)	Area Wide/Statewide Average Wage*
a) Direct Patient Care Positions				
Department Director	1.0	0.0	$56.12	n/a
Department Manager	1.0	1.0	$35.09	n/a

RNs	41.0	12.6	$35.67	$25.80
LPNs	4.0	0.0	$17.88	$17.71
Nursing Aide	4.0	4.2	$14.89	$11.91
Nursing Tech	12.0	6.3	$11.08	$11.46
Radiology Tech	2.0	2.1	$21.79	$24.51
CT Tech	1.5	4.2	$27.59	$27.75
Laboratory Tech	4.2	4.2	$24.51	$17.89
Respiratory Tech	4.2	4.2	$28.65	$23.82
Total Direct Patient Care Positions	**74.9**	**38.8**		

b) Non-Patient Care Positions				
Registrar	9.0	4.2	$13.08	$10.80
Security	4.2	4.2	$14.08	$13.88
Total Non-Patient Care Positions	13.2	8.4		
Total Employees *(A+B)*	88.1	47.2		
c) Contractual Staff	0.0	0.0		
Total Staff *(a+b+c)*	**88.1**	**47.2**		
*Source: TN Dept. of Labor and Workforce Development, May 2016 OES data – Cleveland, if position surveyed, and Statewide.				

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

1) 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.

RESPONSE: There are simply no cost-effective alternatives to the proposed FSED. The existing ED on Tennova Cleveland's main hospital campus cannot be expanded or redesigned without significant disruption to the existing emergency services offered and costly relocation of existing infrastructure, including for example mechanical systems, loading docks, and patient and family parking.

As noted earlier, the acuity of the patients presenting to the existing ED means that convenient care centers (*e.g.*, urgent care and retail clinics) are not viable options for the high-acuity, uninsured patient population Tennova Cleveland serves.

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

RESPONSE: New construction is the optimal alternative to expand the capacity of Tennova Cleveland's emergency services, which is needed to care for the high volume of patients served, including high-acuity patients.

SECTION B: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

A. List all existing health care providers (i.e., 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, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

RESPONSE: Tennova Cleveland has contractual and working relationships with a number of providers that represent a variety of segments of the healthcare industry, including general acute care hospitals, tertiary care medical centers, nursing homes, and home care organizations. Examples of Tennova Cleveland's many contractual and/or working relationships with area providers include:

Erlanger Medical Center
East Tennessee Children's Hospital
Starr Regional Medical Center
UT Medical Center – Knoxville
Vanderbilt University
Kindred Hospital (Chattanooga)
HealthSouth Chattanooga Rehabilitation Hospital
Sisken Hospital for Physical Rehabilitation

B. Describe the effects of competition and/or duplication of the proposal on the health care 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.

1) Positive Effects

RESPONSE: Tennova Cleveland's proposed FSED in north Cleveland will provide a significant benefit to the residents of the service area. Tennova Cleveland is the leading provider of emergency services in the service area; the expansion of its emergency care services through the addition of a FSED will allow the hospital to continue to meet its mission of serving its local community's needs, including the disproportionally high percentage of uninsured and high-acuity patients it serves in its ED.

2) Negative Effects

RESPONSE: The proposed FSED at Tennova Cleveland will have no adverse impact on any existing provider, or any service area resident. Instead, the proposed project will enhance access to locally available and accessible emergency services that are supported by a local community hospital.

C. 1) 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: Specific to physicians who will support the proposed FSED, Tennova Cleveland currently works with TeamHealth to provide physician staffing for its existing ED on the hospital's main campus. Tennova Cleveland will work with TeamHealth to include coverage in the expanded ED (FSED) to provide around-the-clock staffing for the proposed FSED. TeamHealth's network of providers includes over 20,000 affiliated physicians and advanced practice clinicians representing

multiple specialties including emergency services. Tennova Cleveland is confident that TeamHealth will provide the necessary physician coverage for the proposed freestanding emergency department.

Additionally, Tennova Cleveland already has a clinical management team for emergency services in place at the main hospital. This leadership will enable the hospital to immediately adopt the expanded service at the proposed FSED. Existing emergency department clinical and support staff will also be available to select shifts at either the main emergency department or the proposed freestanding facility.

For additional staffing that is needed, Tennova Cleveland will utilize its proven methods of staff recruitment and retention to ensure adequate staff for the FSED is in place. For example, Tennova has a robust and long-standing recruiting process with a demonstrated track record of hiring staff, including use of healthcare program affiliations and national online recruitment, among other means. As a statewide healthcare network, Tennova also has the ability to recruit across a wide geographic region and offer relocation opportunities for staff interested in moving to the Cleveland area.

Tennova Healthcare's retention tools include a comprehensive array of benefits that include medical, dental and vision insurance coverage, life and disability insurance benefits, tuition reimbursement and a 401K retirement plan. As a provider with multiple hospitals in the eastern Tennessee area, Tennova also has the ability to provide career growth opportunities that might not exist at a smaller, single-site institution. Thus, as demonstrated, staffing recruitment and retention for the proposed service expansion will not be a problem for Tennova Cleveland.

2) Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission 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 understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff.

3) 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: Tennova Healthcare, including the applicant entity Tennova Healthcare - Cleveland, has educational affiliations with numerous schools and organizations, including:

- AT Still University (Arizona School of Health Sciences)
- Carson Newman College
- Creighton University
- East Tennessee State University
- Grace Academy
- Independence University
- Iowa College Acquisition Co (Kaplan University)
- Knox County Schools
- Lincoln Memorial University
- Pellissippi State Community College
- Roane State Community College
- South College

- Tennessee Technical College at Jacksboro
- Tennessee Technical College at Knoxville
- Tennessee Technical College of Oneida
- Union County Schools
- University of New England
- University of Miami
- University of North Carolina at Chapel Hill
- University of Tennessee, Knoxville
- University of Tennessee, Memphis
- Vanderbilt University
- Walden University
- Walters State University

D. 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: **Tennessee Department of Health, Board for Licensing Health Care Facilities**

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

Accreditation (i.e., Joint Commission, CARF, etc.): **Joint Commission**

1) If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

RESPONSE: Tennova Cleveland is in good standing with all licensing, certifying and accrediting agencies. A copy of the hospital license, Joint Commission accreditation, and Tennova Healthcare's CMS Letter of Compliance are included in Attachment B-Need-A.2.

2) 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: Tennova Cleveland is in good standing with all licensing agencies. Please refer to Attachment B-Need-A.2 for the hospital license, Joint Commission accreditation, and Tennova Healthcare's CMS Letter of Compliance.

3) 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.

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

RESPONSE: Not applicable. Tennova Healthcare is in good standing with all licensing, certifying, and accrediting agencies.

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

1) Has any of the following:

a) 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);

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

c) Any physician or other provider of health care, 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%.

2) Been subjected to any of the following:

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

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

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

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

e) 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

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

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

h) Is presently subject to a corporate integrity agreement.

RESPONSE: Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland is subject to Community Health Systems, Inc.'s – their ultimate parent company – Corporate Integrity Agreement ("CIA"), dated July 28, 2014, with the Office of Inspector General ("OIG"). Tennova Cleveland is not aware of any of the other identified actions against it.

F. Outstanding Projects: ***Not applicable. The applicant has no outstanding projects.***

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

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

* 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 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

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

Not applicable.

G. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

1) 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)? Yes

2) If yes, have you submitted their registration to HSDA? If you have, what was the date of submission? Registration complete for all equipment as acquired.

3) If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? 2016 JAR completed with relevant volume data.

SECTION B: 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: Tennova Cleveland commits to reporting annually utilizing 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. Tennova Cleveland currently provides the Agency required data in a timely manner, such as the Joint Annual Report.

SECTION C: 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.

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

RESPONSE: The proposed addition of emergency services capacity, through the establishment of a FSED in the most populated and fastest-growing ZIP Code in the county, will improve the health of the people of Tennessee (including those in the proposed service area) by providing them with enhanced access to the full array of emergency services needed to care for patients of all acuity levels and regardless of payor source.

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

RESPONSE: The proposed Project will enhance access to care, both geographically and economically. Geographically, residents of the service area will have enhanced access to emergency services at Tennova Cleveland, which for many is the closest hospital available when one is in need of emergency care. Economically, Tennova Cleveland provides care to all patients, regardless of ability to pay. Tennova Cleveland provides care to the economically disadvantaged through full participation in the TennCare program, as well as the elderly, many with fixed incomes, through full participation in the Medicare program.

Moreover, Tennova Cleveland is the primary access point for emergency services to residents of the 2-county service area. By providing this important service to patients experiencing cardiac events, injuries, severe illness or an acute behavioral health condition, residents of the service area are able to access timely care in order to enable them to maintain and improve their health status and enhance their quality of life. The key role that Tennova Cleveland plays in the overall positive health of the community is evidenced in the annual County Health Rankings & Roadmaps rating that consistently lists Bradley County in the top one-third of counties in Tennessee both in Health Outcomes and Health Factors.

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

RESPONSE: The proposed FSED is specifically developed to address the health of the residents of Bradley and Polk Counties. The continuing need for emergency services for the residents of the service area is evidenced by the annual ED visit volume at Tennova Cleveland, which has trended near 50,000 visits annually for the past decade.

The proposed project will offer the community an additional access point and needed additional capacity, which will be offered on a smaller, outpatient-only campus that is easily accessible to all service area residents. The proposed project will allow Tennova Healthcare to continue providing emergency service locally for residents so that they do not have to travel outside their own community for care, or routinely have to be admitted to a distant hospital when acute care services are needed following an ED visit.

The proposed Project encourages economic efficiencies by allowing Tennova Cleveland to expand and simultaneously decompress its existing emergency services without disrupting patient care on its main hospital campus.

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

RESPONSE: Tennova Cleveland will continue to instill a level of confidence in service area residents that they are receiving care from a high-quality health care provider. Tennova Cleveland has been providing care to the community for over six decades. Quality health care and accessible services have allowed Bradley County to remain in the top one-third of all counties in both Health Outcomes and Health Factors as recognized by County Health Rankings & Roadmaps, a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Tennova's experienced team of nurses, physicians and additional clinicians and support staff provide emergency care to tens of thousands of patients each year. Tennova's network of hospitals across the state of Tennessee in total provide care to nearly half a million emergency patients each year. With the physician resources of TeamHealth, which represents more than 20,000 affiliated physicians and advance practice nurses nationwide, staffing the FSED, patients will be receiving care from an experienced team of clinicians and a network of hospitals that spans across the state of Tennessee.

Tennova Cleveland, as well as all of Tennova Healthcare, regularly monitor and measure clinical processes and outcomes in order to provide the best care possible to its patients. Tennova Cleveland will continue to focus on quality and improve the care provided by adhering to industry standards of care established by leading organizations as evidenced by hospital's current Chest Pain Center Accreditation from the American College of Cardiology, which it has held since 2014.

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

RESPONSE: The proposed Project supports workforce development by allowing qualified health care personnel to remain within the state to develop or maintain their skills and abilities by providing an additional site for emergency care services. Additionally, Tennova Healthcare and the applicant entity have educational affiliations with numerous schools and organizations, which supports the development, recruitment, and retention of a sufficient and quality health workforce for the service are and the state as a whole. For areas of the state in which communities do not have a local hospital, *e.g.*, adjacent Meigs County and more recently Polk County with the closure of Copper Basin Medical Center, it is critical that health care providers such as Tennova Cleveland are allowed to continue expanding to meet the needs of its communities.

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 the publication of the letter of intent.

See Proof of Publication included in the attachments.*

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential 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. ***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 good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need 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.**
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.**

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA 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		**June 27, 2018**
2. Architectural and engineering contract signed	60	Aug. 26, 2018
3. Construction documents approved by the Tennessee Department of Health	150	Nov. 24, 2018
4. Construction contract signed	180	Dec. 24, 2018
5. Building permit secured	201	Jan. 14, 2019
6. Site preparation completed	222	Feb. 4, 2019
7. Building construction commenced	252	March 6, 2019
8. Construction 40% complete	352	June 14, 2019
9. Construction 80% complete	412	Aug. 13, 2019
10. Construction 100% complete (approved for occupancy	472	Oct. 12, 2109
11. *Issuance of License	532	Dec. 11, 2019
12. *Issuance of Service	553	Jan. 1, 2020
13. Final Architectural Certification of Payment	613	March 1, 2020
14. Final Project Report Form submitted (Form HR0055)	673	April 30, 2020

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 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

MAR 14 '18 pm 7:59

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Williamson

Martin G. Schweinhart, being first duly sworn, says that he/she is the applicant named in this application or his/her/its 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 and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

SIGNATURE/TITLE
President, Cleveland Tennessee Hospital Company, LLC

Sworn to and subscribed before me this 12th day of March (Month), 2018 (Year) a Notary

Public in and for the County/State of Williamson/Tennessee.

NOTARY PUBLIC

My commission expires 9/16 (Month/Day), 2019 (Year).

MARY ANN ECKMAN
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY
My Commission Expires 09-16-2019

Appendix
Tennova Cleveland Proposal to Establish a FSED in its Home County

List of Attachments	
Attachment	**Information Included**
A-4A	Tennova Healthcare Organizational Documents
A-6A	Site Entitlement
A-6B.1	Site Plan
A-6B.2	Floor Plan
A-6B.3	Public Transportation Information
A-10A	Licensed Bed Complement
B-Need-A.1	Letters of Support
B-Need-A.2	Traffic Congestion Information: Chattanooga
B-Need-A.3	Hospital Transfer Agreements & FSED Policy
B-Need-A.4	Quality Assurance Program
B-Need-A.5	Licensure and Accreditation Documents
B-EconFeas-A.1	Filing Fee Check Copy
B-EconFeas-A.3	Equipment Quotes
B-EconFeas-A.5	Architect's Letter
B-EconFeas-B	Project Funding Letter
B-EconFeas-F1	CHS Audited Financial Information
Proof of Publication	Proof of Publication

Attachment A-4A

Tennova Healthcare Organizational Documents

Delaware

The First State

I, HARRIET SMITH WINDSOR, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "MARTIN HOME CARE SERVICES, LLC", FILED IN THIS OFFICE ON THE NINETEENTH DAY OF AUGUST, A.D. 2008, AT 5:37 O'CLOCK P.M.

Harriet Smith Windsor

Harriet Smith Windsor, Secretary of State

4589625 8100

080885207

AUTHENTICATION: 6802439

DATE: 08-20-08

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

STATE *of* DELAWARE
LIMITED LIABILITY COMPANY
CERTIFICATE *of* FORMATION

- **First:** The name of the limited liability company is Martin Home Care Services, LLC _____.
- **Second:** The address of its registered office in the State of Delaware is _____ 2711 Centerville Road, Suite 400 in the City of Wilmington (New Castle County). The name of its Registered agent at such address is Corporation Service Company _____.
- **Third:** *(Use this paragraph only if the company is to have a specific effective date of dissolution.)* "The latest date on which the limited liability company is to dissolve is _____."
- **Fourth:** *(Insert any other matters the members determine to include herein.)*

_____

In Witness Whereof, the undersigned have executed this Certificate of Formation of Martin Home Care Services, LLC this 19 day of August, 20 08.

BY: Robin Keck
Authorized Person(s)

NAME: Robin J. Keck, Organizer
Type or Print

State of Delaware
Secretary of State
Division of Corporations
Delivered 05:54 PM 08/19/2008
FILED 05:37 PM 08/19/2008
SRV 080885207 - 4589625 FILE

Delaware

The First State

I, HARRIET SMITH WINDSOR, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF AMENDMENT OF "MARTIN HOME CARE SERVICES, LLC", CHANGING ITS NAME FROM "MARTIN HOME CARE SERVICES, LLC" TO "CLEVELAND TENNESSEE HOSPITAL COMPANY, LLC", FILED IN THIS OFFICE ON THE SIXTEENTH DAY OF OCTOBER, A.D. 2008, AT 6:13 O'CLOCK P.M.

Harriet Smith Windsor

Harriet Smith Windsor, Secretary of State

4589625 8100

081044997

AUTHENTICATION: 6918171

DATE: 10-17-08

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

State of Delaware
Secretary of State
Division of Corporations
Delivered 06:42 PM 10/16/2008
FILED 06:13 PM 10/16/2008
SRV 081044997 - 4589625 FILE

STATE OF DELAWARE
CERTIFICATE OF AMENDMENT

1. Name of Limited Liability Company: Martin Home Care Services, LLC

2. The Certificate of Formation of the limited liability company is hereby amended as follows:

First: The name of the limited liability company is Cleveland Tennessee Hospital Company, LLC

IN WITNESS WHEREOF, the undersigned have executed this Certificate on the 16 day of October, A.D. 2008.

By: [signature]
Authorized Person(s)

Name: Robin J. Keck
Print or Type

Secretary of State
Division of Business Services
312 Rosa L. Parks Avenue
6th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

DATE: 02/02/09
REQUEST NUMBER: 6433-1826
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 01/30/09 1202
EFFECTIVE DATE/TIME: 01/30/09 1202
CONTROL NUMBER: 0595287

TO:
CFS, INC.
8161 HWY. 100, 172

NASHVILLE, TN 37221

RE:
CLEVELAND TENNESSEE HOSPITAL COMPANY, LLC
APPLICATION FOR CERTIFICATE OF AUTHORITY -
LIMITED LIABILITY COMPANY

WELCOME TO THE STATE OF TENNESSEE. THE ATTACHED LIMITED LIABILITY COMPANY CERTIFICATE OF AUTHORITY HAS BEEN FILED WITH AN EFFECTIVE DATE AS INDICATED ABOVE.

A LIMITED LIABILITY COMPANY ANNUAL REPORT MUST BE FILED WITH THE SECRETARY OF STATE ON OR BEFORE THE FIRST DAY OF THE FOURTH MONTH FOLLOWING THE CLOSE OF THE LIMITED LIABILITY COMPANY'S FISCAL YEAR. ONCE THE FISCAL YEAR HAS BEEN ESTABLISHED, PLEASE PROVIDE THIS OFFICE WITH WRITTEN NOTIFICATION. THIS OFFICE WILL MAIL THE REPORT DURING THE LAST MONTH OF SAID FISCAL YEAR TO THE LIMITED LIABILITY COMPANY AT THE ADDRESS OF ITS PRINCIPAL OFFICE OR TO A MAILING ADDRESS PROVIDED TO THIS OFFICE IN WRITING. FAILURE TO FILE THIS REPORT OR TO MAINTAIN A REGISTERED AGENT AND OFFICE WILL SUBJECT THE LIMITED LIABILITY COMPANY TO ADMINISTRATIVE REVOCATION OF ITS CERTIFICATE OF AUTHORITY.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE LIMITED LIABILITY COMPANY CONTROL NUMBER GIVEN ABOVE.

FOR: APPLICATION FOR CERTIFICATE OF AUTHORITY - LIMITED LIABILITY COMPANY

ON DATE: 02/02/09

FROM:
CAPITAL FILING SERVICE (CFS)
8161 HIGHWAY 100
#172
NASHVILLE, TN 37221-0000

	FEES	
RECEIVED:	$300.00	$0.00
TOTAL PAYMENT RECEIVED:		$300.00

RECEIPT NUMBER: 00004522486
ACCOUNT NUMBER: 00101230

TRE HARGETT
SECRETARY OF STATE

SS-4458

FILED

RECEIVED
STATE OF TENNESSEE
For Office Use Only
2009 JAN 30 PM 12: 02
Hargett
Secretary of State

67

State of Tennessee

Department of State
Corporate Filings
312 Eighth Avenue North
6th Floor, William R. Snodgrass Tower
Nashville, TN 37243

APPLICATION FOR CERTIFICATE OF AUTHORITY
(Limited Liability Company)
(For use on and after 1/1/2006)

To the Secretary of State of the State of Tennessee:

Pursuant to the provisions of §48-249-904 of the Tennessee Revised Limited Liability Company Act, the undersigned hereby applies for a certificate of authority to transact business in the State of Tennessee, and for that purpose sets forth:

1. The name of the Limited Liability Company is: Cleveland Tennessee Hospital Company, LLC

If different, the name under which the certificate of authority is to be obtained is: _____

NOTE: ***The Secretary of State of the State of Tennessee may not issue a certificate of authority to a foreign Limited Liability Company if its name does not comply with the requirements of § 48-249-106 of the Tennessee Revised Limited Liability Company Act. If obtaining a certificate of authority under an assumed Limited Liability Company name, an application must be filed pursuant to § 48-249-106(d).***

2. The state or country under whose law it is formed is: Delaware

and its date of its formation is: August 19, 2008 *(must be month, day and year)*

3. The complete street address (including zip code) of its principal executive office is:

4000 Meridian Blvd. Franklin, TN 37067
Street *City/State* *Zip Code*

4. The complete street address (including the county and the zip code) of its registered office in Tennessee:

4000 Meridian Blvd. Franklin, TN Williamson 37067
Street *City/State* *County* *Zip Code*

The name of its registered agent at that office is: Ben Fordham

5. If the provisions of TCA §48-249-309(l) (relating to foreign series LLCs) apply, then the information required by that section should be attached as part of this document.

6. The number of members at the date of filing if more that six (6): N/A

7. If the limited liability company commenced doing business in Tennessee prior to the approval of this application, the date of commencement (month, day and year) N/A

NOTE: ***This application must be accompanied by a certificate of existence (or a document of similar import) duly authenticated by the Secretary of State or other official having custody of the Limited Liability Company records in the state or country under whose law it is organized. The certificate shall not bear a date of more than two (2) months prior to the date the application is filed in this state.***

January 29, 2009
Signature Date

Cleveland Tennessee Hospital Company, LLC
Name of Limited Liability Company

Authorized Representative
Signer's Capacity

Robin J. Keck
Signature

Robin J. Keck
Name (typed or printed)

SS-4233 (Rev. 01/06)

Filing Fee: $60 per member / minimum fee=$300, maximum fee=$3,000

RDA 2458

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "CLEVELAND TENNESSEE HOSPITAL COMPANY, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-NINTH DAY OF JANUARY, A.D. 2009.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "CLEVELAND TENNESSEE HOSPITAL COMPANY, LLC" WAS FORMED ON THE NINETEENTH DAY OF AUGUST, A.D. 2008.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE NOT BEEN ASSESSED TO DATE.

5433.1827

RECEIVED
STATE OF TENNESSEE
2009 JAN 30 PM 12:02
Tre Hargett
Secretary of State

SECRETARY'S OFFICE
1793 DELAWARE 1855

Jeffrey W. Bullock, Secretary of State

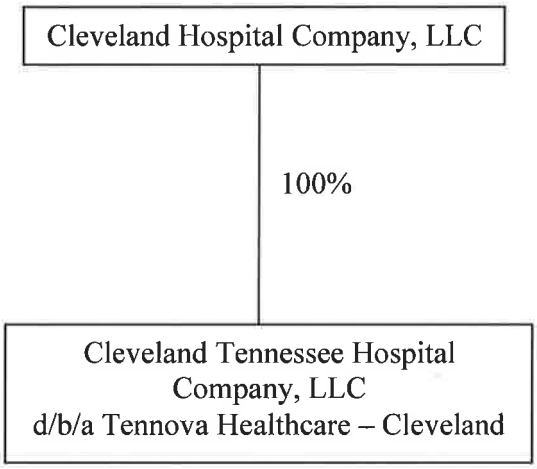
4589625 8300

AUTHENTICATION: 7108788

090084406

DATE: 01-29-09

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


Cleveland Hospital Company, LLC
100%
Cleveland Tennessee Hospital Company, LLC
d/b/a Tennova Healthcare – Cleveland

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

CHAFIN CONSULTING GROUP, INC.
MARTY CHAFIN
SUITE 104-150
2566 SHALLOWFORD ROAD NE
ATLANTA, GA 30345

March 9, 2018

Request Type: Certificate of Existence/Authorization
Request #: 0269413

Issuance Date: 03/09/2018
Copies Requested: 1

Document Receipt

Receipt # : 003888738 Filing Fee: $20.00

Payment-Credit Card - State Payment Center - CC #: 3723800218 $20.00

Regarding: CLEVELAND TENNESSEE HOSPITAL COMPANY, LLC

Filing Type:	Limited Liability Company - Foreign	Control # :	595287
Formation/Qualification Date:	01/30/2009	Date Formed:	08/19/2008
Status:	Active	Formation Locale:	DELAWARE
Duration Term:	Perpetual	Inactive Date:	

CERTIFICATE OF AUTHORIZATION

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

CLEVELAND TENNESSEE HOSPITAL COMPANY, LLC

* is a Limited Liability Company formed in the jurisdiction set forth above and is authorized to transact business in this State;

* has paid all fees, interest, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed an Application for Certificate of Withdrawal.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 026818732

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH CARE FACILITIES
665 Mainstream Drive, Second Floor
Metro Center
Nashville, TN 37243
www.tennessee.gov/health
6157417221 or 1-800-778-4504

RECEIVED
OCT 02 2015
Administration

September 29, 2015

COLEMAN FOSS
TENNOVA HEALTHCARE-CLEVELAND
2305 CHAMBLISS AVENUE NW
Cleveland, TN 37311

Facility Type: Hospital
License Number: 31

Dear Administrator:

Your letter of September 3, 2015 regarding the doing business as (d/b/a) name change of your hospital facility from Skyridge Medical Center to Tennova Healthcare – Cleveland and satellite location d/b/a name change from Skyridge Medical Center Westside to Tennova Healthcare – Cleveland effective September 28, 2015 is acknowledged.

An updated license will be forwarded to your facility within the next seven to ten business days.

Please contact me if I can be of further assistance.

Sincerely,

Eddie J. Stewart, Health Facilities Program Manager
Office of Health Care Facilities
Licensure Section

cc: East Tennessee Regional Administrator
Medicaid Provider Enrollment
Health Services and Developmental Agency
Nerissa Harvey, Policy Planning and Assessment
Lonnie Matthews, Division of Health Statistics
Nora Sewell, Tennessee Hospital Association
Alyssa Chase, HMA, HCQIP, Director, Q Source
Bill Harmon, Plans Review
Will Oden, CHEP, Emergency Preparedness Assistant Finance Director
Madeline Coleman, Quality Improvement Section
Dolores Willis, Information Technology Services Division

Tennova Healthcare

PATIENT

Coleman Foss
Chief Executive Officer

Wes Griffith
Chief Financial Officer

- P. Allan Gayler ACFO
  - Controller
    - Decision Support
    - Accounting
    - Payroll
- Business Office
- Patient Access
- Health Information Management
- Privacy
- Information Systems
- Case Management
- Materials Management

Ann Marie Brewer
Community Relations

- Senior Circle
- Volunteers/ Chaplains

Stephanie Austin
Assistant Administrator, Westside Campus

- Marketing
- Strategic Development
- Nutritional Services
- Housekeeping

Lisa Childers

- Practice Management
- Rehabilitation
- Wound Center
- Strategic Development
- Lab
- Occupational Medicine
- Imaging Services
- Physician Recruitment
- Pine Ridge Behavioral Health
- Pharmacy

Andrea Lockerby
DPO

- Hospitalists/ ED Physicians
- Facilities
  - BioMed
  - Security

Jeanette Fetter
CQO

- Quality
- Med Staff Coordinator
- Risk Management
- Compliance
- Infection Control

Kris Godfrey
Human Resources

- Employee Health
- Recruitment
- Education

CNO
Kristina Cherry

- Cardio Pulmonary
- Interventional Labs Cath – Angio
- Chest Pain Center
- Women's Services Pediatrics
- Surgical Services
- GI
- Behavioral Health Nursing
- Wound Care Nursing
- Emergency Department
- Patient Experience

Laura Franklin
ACNO

- Telemetry 4th
- Medical 3rd
- Surgical 2 N
- MICU
- 5th Floor M/S
- Infusion/ Transporters
- SICU
- Ortho 2 S
- Administrative House Supervisors
- Clinical Informaticist

Coleman Foss, CEO
December 21, 2017

Attachment A-6A

Site Entitlement

DocuSign Envelope ID: D6D93140-5D62-44A6-BDD2-361ADCD847CC

February 26, 2018

VIA EMAIL

Estate of Joe Corn Stuart &
Rodgers C/O Mr. Wes Rodgers
400 Stuart Road, Suite 2
Cleveland, Tennessee 37312

RE: Acquisition of +- 2.44 Acres, at 680 Stuart Road NE 37312, Cleveland, TN (the "Asset"), described as Parcel 042G J 003.02 in Bradley County, TN

Wes and Elizabeth,

As discussed we would like to submit a letter of intent (LOI) on behalf of **Cleveland Tennessee Hospital Company, LLC** (DE) and its affiliates or its assignee(s) (collectively "**Buyer**") regarding the sale of the Asset. The purpose of this LOI is to facilitate negotiation of a mutually satisfactory purchase agreement (the "**Purchase Agreement**") by and between buyer and **The Estate of Joe Corn Stuart** (the holder of all property interest previously held by The Stuart Family Partnership) & Rodgers (collectively "**Sellers**"). This LOI sets forth the general terms and conditions pursuant to which Buyer will purchase the Asset:

1. Effective Date. The "**Effective Date**" of the LOI shall be the date upon which Buyer receives a counterpart hereof signed on behalf of Seller.

2. Transaction. Buyer shall acquire 100% fee simple interests in the Asset with Seller's rights, title and interest in and to all land, improvements, fixtures, easement, permits and licenses, whether tangible or intangible (to the extent the same is transferable) owned by Seller and associated with the Asset.

3. Purchase Price. $905,000.00 (the "**Purchase Price**"). Buyer shall have no financing contingency for this purchase.

4. Deposit. Within three (3) business days after executing the Purchase Agreement Buyer shall deliver to an escrow agent selected by Buyer (the "**Escrow Agent**") an initial deposit in an amount equal to $25,000 in cash, to be held in an escrow account in accordance with the terms of the Purchase Agreement and to serve as an initial earnest money deposit under the Purchase Agreement (the "**Initial Deposit**"). The Initial Deposit, including any interest earned thereon, shall remain refundable if:

(a) Buyer has given notice to the Seller, prior to the expiration of the Inspection Period and any extensions thereof (as defined below), that it does not wish to proceed with the purchase; or

(b) Seller fails to perform any of its material obligations under the Purchase Agreement; or

(c) A condition precedent to closing fails to be satisfied and is not waived by the beneficiary of such condition precedent.

If Buyer does not give notice to terminate prior to the expiration of the Inspection Period, Buyer shall then post a second earnest money deposit in the amount of $25,000 (the "**Second Deposit**") and both

deposit amounts shall become nonrefundable (except in the event of Seller default) and shall be credited toward the Purchase Price or retained by Seller as liquidated damages, as the sole and exclusive remedy against the Buyer regarding the proposed purchase of the Asset and all agreements related thereto.

5. Inspection Period. The Purchase Agreement shall include a 270-day inspection period which will commence after Seller's delivery of all due diligence items in Seller's possession listed on Exhibit A (the "**Inspection Period**"). During the Inspection Period, Seller shall allow Buyer to conduct its inspection and review of the Asset (including, without limitation, obtaining environmental studies (provided that any Phase II environmental site inspection shall be made with Seller's prior written permission), surveys and property condition assessments and provide Buyer access to the site at a time reasonably convenient to the Seller and with prior, written notification to same, subject to customary terms and conditions including, without limitation, the following:

(a) Buyer will utilize commercially reasonable efforts not to interfere with Seller's operation of the Asset, and to exercise such efforts in the least intrusive manner. Buyer will indemnify and hold Seller harmless for any and all costs incurred by Seller related to Buyer's due diligence and inspection of the Assets, including but not limited to Seller's attorneys' fees. Buyer shall not discuss the proposed purchase with any tenants, their agents or invitees, unless Seller provides prior permission and then only with such parties as are designated tenant representatives.

(b) To the extent damaged, Buyer covenants to repair and restore the Asset promptly to a substantially similar condition that existed prior to said inspection.

(c) Buyer shall immediately pay or cause to be removed any liens filed against any property as a result of any actions taken above by or on behalf of Buyer. The Escrow Agent will be authorized to satisfy said liens from the Deposit prior to its return to Buyer.

(d) Prior to closing, Buyer shall have the right to update third party diligence reports in order to satisfy necessary requirements.

6. Due Diligence. Buyer shall draft the proposed Purchase Agreement and provide the same to Seller. Due diligence materials are listed in Exhibit A to the extent in Seller's possession. Upon Seller's request and in the event Buyer terminates the Purchase Agreement, Buyer will immediately provide to Seller all due diligence reports, survey and such other due diligence.

7. Closing. The Purchase Agreement shall provide that Buyer must notify Seller of its election to terminate the Purchase Agreement by or before 5:00 p.m. on the date which the Inspection Period expires. If Buyer does not provide such notice by such time, then Buyer shall be deemed to have elected to proceed to closing. If Buyer elects to proceed with closing the purchase, the closing date shall occur on the earlier to occur of (i) thirty (30) days after the expiration of the Inspection Period or (ii) satisfaction of all conditions precedent to closing (the "**Closing Period**").

Buyer shall have a one-time option to extend the Closing Period for an additional sixty (60) days (the "**Closing Extension Option**"). If Buyer elects to exercise its Closing Extension Option, Buyer will notify Seller of its election, in writing, not less than two (2) business days before the expiration of the Closing Period. Upon exercising its Closing Extension Option, Buyer will post an additional $25,000 (the "**Extension Deposit**") with the Escrow Agent, and the Extension Deposit will be non-refundable to the Buyer and shall be credited, along with all previous deposits, toward the Purchase Price or retained by Seller as liquidated damages, as the sole and exclusive remedy against the Buyer regarding the proposed purchase of the Asset and all agreements related thereto.

Closing Contingency: Buyer and Seller acknowledge that as a part of the transaction that Buyer is required to obtain certain approvals from governmental authorities for the intended use of the Asset. Buyer's obligation to close on the property shall be contingent upon receipt of all required governmental approvals, including but not limited to a Certificate of Need from the State of Tennessee for its intended use.

8. Transaction Costs. Seller and Buyer shall each be responsible for the payment of the costs of their respective legal counsel, brokers (if any), tax advisors and other professionals. Buyer shall be responsible for all costs and expenses associated with its due diligence and financing, inspections, and the costs of any endorsements to the owner's title insurance policy. Any applicable deed transfer tax shall be the responsibility of Buyer. Seller shall be responsible for the standard owner's title insurance premium. Any additional transaction costs shall be borne by Seller and Buyer in such manner as is customary in the jurisdiction where the property is located.

9. Title and Survey. Buyer shall order a title commitment after execution of the Purchase Agreement and must provide any objections prior to the expiration of the Inspection Period. Seller shall have the right, in its sole discretion, to elect whether to resolve any such objections and the Inspection Period shall be extended for the period during which Seller attempts to resolve such objectives. Upon closing the purchase, Seller shall convey the Asset free and clear of all monetary liens, ad valorem real property taxes and encumbrances created by, through, or under Seller, except for any permitted exceptions (which shall be defined in the Purchase Agreement, as amended if necessary). Upon execution of the Purchase Agreement, Seller will provide to Buyer the most recent survey of the Asset in Seller's possession. Buyer shall be responsible, at its sole cost, for obtaining surveys of the Asset.

10. Prorations. Real estate and personal property taxes shall be prorated as of Closing date on a "due date" basis, with such taxes deemed paid in advance. All reserves in escrow with Lender (e.g., taxes, insurance, repairs, replacement and rollovers) shall be refunded or credited to Seller at Closing.

11. Broker. By acceptance hereof, Buyer and Seller acknowledge that Seller's Representative will be Garry Rodgers of Rodgers Group and Elizabeth Foss of The Estate of Joe Corn Stuart. Mr. Rodgers has disclosed that he owns a minority interest in this property, therefore he will consult and assist in this transaction without a fee. Seller will pay Jim Eaton with Geis Realty (whom represents the Buyer) a real estate brokerage commission, which will be agreed to in a separate commission agreement.

12. Casualty. If, prior to closing, any or all of the Asset shall be partially or totally destroyed (such that the cost of repairing damage to the Asset will exceed five percent (5%) of the Purchase Price, such damage is not substantially repaired by the closing elate, and thereby the Asset is rendered unsuitable for its permitted use, Buyer shall have the option, at its sole discretion, to (i) carve out impacted asset(s), (ii) terminate the Purchase Agreement and receive an amount equal to its Deposit from Seller or (iii) proceed to closing, in which event Seller shall assign the insurance proceeds pertaining to the damage and credit Buyer any insurance deductibles (less any amounts Seller expends on repairing such damage).

13. Public Announcements: Each party hereto agrees that it shall not make a public announcement or disclosure regarding the transactions described in, or the parties to, this LOI without the prior, written approval of the Buyer. Buyer shall approve the timing, form and substance of any such public announcement or disclosure made by the other or the other's representative or affiliate, which approval shall not be unreasonably withheld, conditioned or delayed, except if a party is required to make a public announcement or disclosure under applicable law, in which case no such approval by the other party shall be required.

14. Exclusivity. Each party hereto agrees that until the earlier of (i) sixty (60) days after the execution hereof, or (ii) the execution of the Purchase Agreement, (the "**Exclusivity Period**"), neither party to this LOI, nor their officers, directors, employees, agents, consultants and representatives, shall, directly or indirectly, take any action to solicit or initiate any Acquisition Proposal with respect to the Asset or initiating, continuing, responding to, or engaging in any discussions or negotiations concerning an Acquisition Proposal with any person or entity with respect to the Asset.

15. Confidential Information. All proprietary and confidential information of Seller provided to Buyer hereunder will be used by Buyer solely for the purposes of transactions necessary for or primarily related to the purchase of the Asset. The terms and conditions of this LOI, all information provided hereunder and the transaction described herein, including the identity of the parties hereto, will be held by the parties in strict confidence and will not be disclosed to anyone, other than their legal counsel, capital partners , lenders and third-party clue diligence contractors and accountants who need to know such information in connection with the transaction contemplated hereby; provided, however, that it shall not be a breach of this covenant in the event of disclosure of any of such information if it is or becomes available from other sources which are not subject to this confidentiality obligation. Notwithstanding the foregoing restrictions, nothing herein shall prohibit Buyer or Seller from filing or disclosing any such information (including information regarding Seller or Buyer, as applicable) in connection with, and as may be required by, orders of judicial or regulatory bodies or law enforcement agencies, including such public disclosure obligations required by the Securities Exchange Commission.

16. Non-Binding Effect. With the exception of Sections 13, 14 and 15 (captioned "Public Announcements", "Exclusivity" and "Confidential Information", respectively) this LOI is not intended to, and does not create any binding legal obligation or implied duty of good faith on the part of either party hereto or their representatives or affiliates, and is not intended to be construed as an offer, an agreement in principal, an agreement to agree, a contract or agreement by either party. Both parties hereto make the covenants in Sections 13, 14 and 15 in exchange for the mutual promises contained therein and for other good and valuable consideration, and intend to be legally bound thereby. The parties hereto further acknowledge and agree that the current discussions are preliminary in nature and may be terminated at any time by either party without liability. This LOI supersedes any and all prior discussions or agreements (written or oral) between the parties regarding the transaction contemplated by this LOI. No modification or amendment may be made to this LOI unless such modification or amendment is made in writing and executed by both parties. This LOI shall be construed and governed according laws of the State of Tennessee.

17. Counterparts. This LOI may be executed in one or more counterparts, each of which will be deemed to be an original copy of this LOI and all of which, when taken together, will be deemed to constitute one and the same agreement. This LOI shall be effective when signed below or in counterparts, and photocopy, facsimile, electronic (including email/PDF) or other copies shall have the same effect for all purposes as an ink-signed original.

[signature pages to follow]

If the foregoing terms and conditions meet with your approval, kindly acknowledge by execution below.

Sincerely,

Cleveland Tennessee Hospital Company, LLC

DocuSigned by:

By: Coleman Foss

15F4A249365D4ED...

Title: CEO

Date: 2/26/2018

The Estate of Joe Corn Stuart

DocuSigned by:

By: Elizabeth Foss

978054A8C5554B4...

Title: Co-Trustee / Co-Executor

Date: 2/26/2018

DocuSigned by:

Wes Rodgers

Wesley L. Rodgers

Date: 2/26/2018

DocuSigned by:

Garrison Rodgers

0CDD1C5793AF400...

J. Garrison Rodgers

Date: 2/26/2018

DocuSign Envelope ID: D6D93140-5D62-44A6-BDD2-361ADCD847CC

Exhibit A
DUE DILIGENCE ITEMS

1. Existing Survey
2. Historical Phase I & Physical Reports (if any)
3. Property Tax Bills (Current year and Previous two years)
4. REA (Declarations) (if any)
5. Zoning Confirmation

Attachment A-6B.1

Site Plan

SATELLITE ED

TENNOVA HEALTHCARE - CLEVELAND
680 STUART ROAD N.E.
CLEVELAND, TN 37312

HFR PROJECT NO.: –
DATE: MARCH 12, 2018
PM REVIEWER: –
QC REVIEWER: –

SITE PLAN

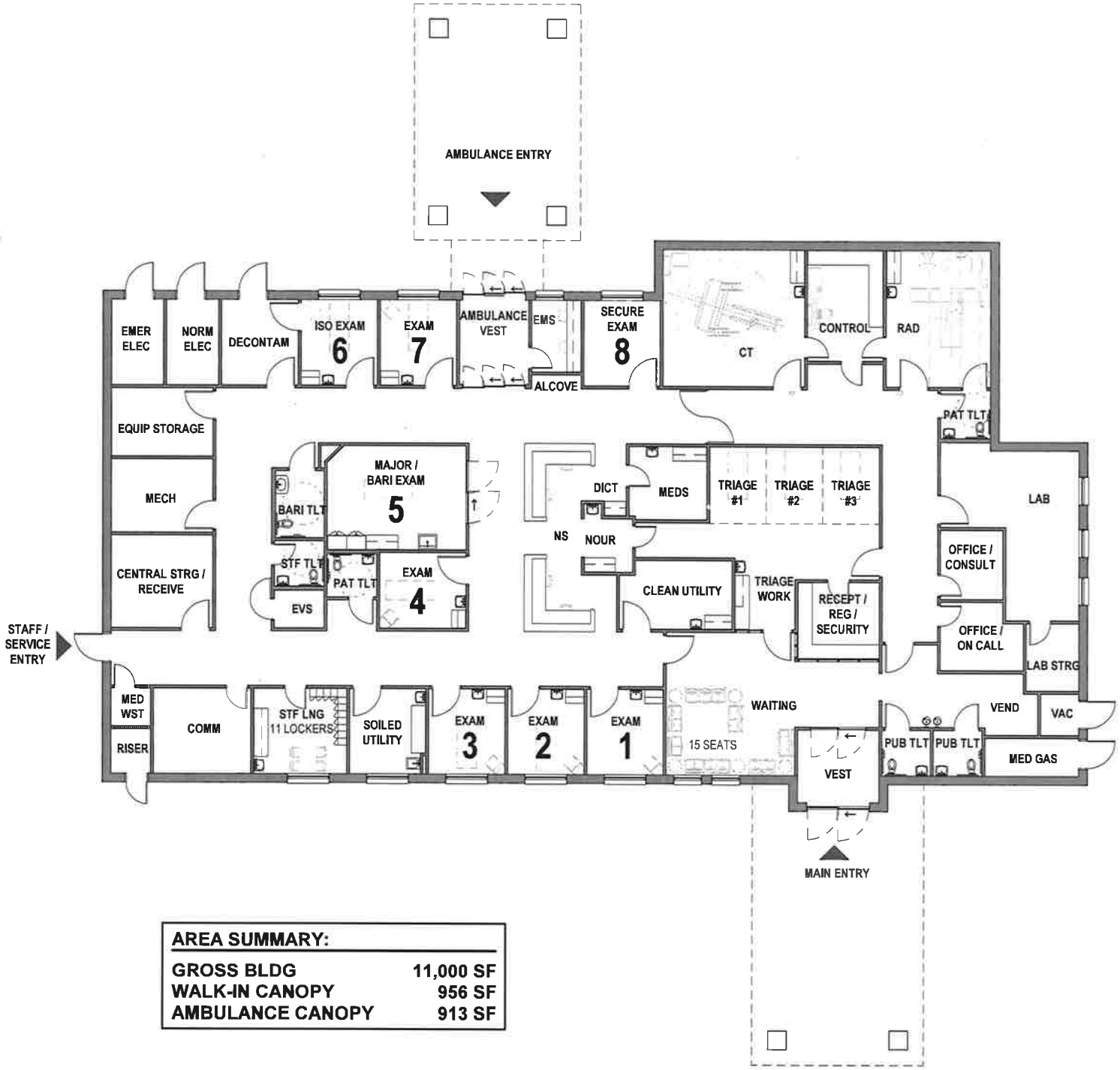
G 2

HFR DESIGN
214 Centerview Drive Suite 300 Brentwood, TN 37027
p 615.370.8500
f 615.370.8530
hfrdesign.com

3/12/2018 4:06:06 PM
C:\Users\frankv\OneDrive - HFR Design\200000 - Potential Projects & Marketing\CHS Cleveland TN FSED\CHS Cleveland TN FSED 03-05-18.rvt
COPYRIGHT 2018 - ALL RIGHTS RESERVED - NO PORTION(S) MAY BE REPRODUCED WITHOUT EXPRESSED WRITTEN CONSENT OF HFR DESIGN, INC.

Attachment A-6B.2

Floor Plan



AREA SUMMARY:	
GROSS BLDG	11,000 SF
WALK-IN CANOPY	956 SF
AMBULANCE CANOPY	913 SF

HFR DESIGN
214 Centerview Drive Suite 300 Brentwood, TN 37027
p 615.370.8500
f 615.370.8530
hfrdesign.com

SATELLITE ED
TENNOVA HEALTHCARE - CLEVELAND
680 STUART ROAD N.E.
CLEVELAND, TN 37312

HFR PROJECT NO.: –
DATE: MARCH 12, 2018
PM REVIEWER: – –
QC REVIEWER: – –

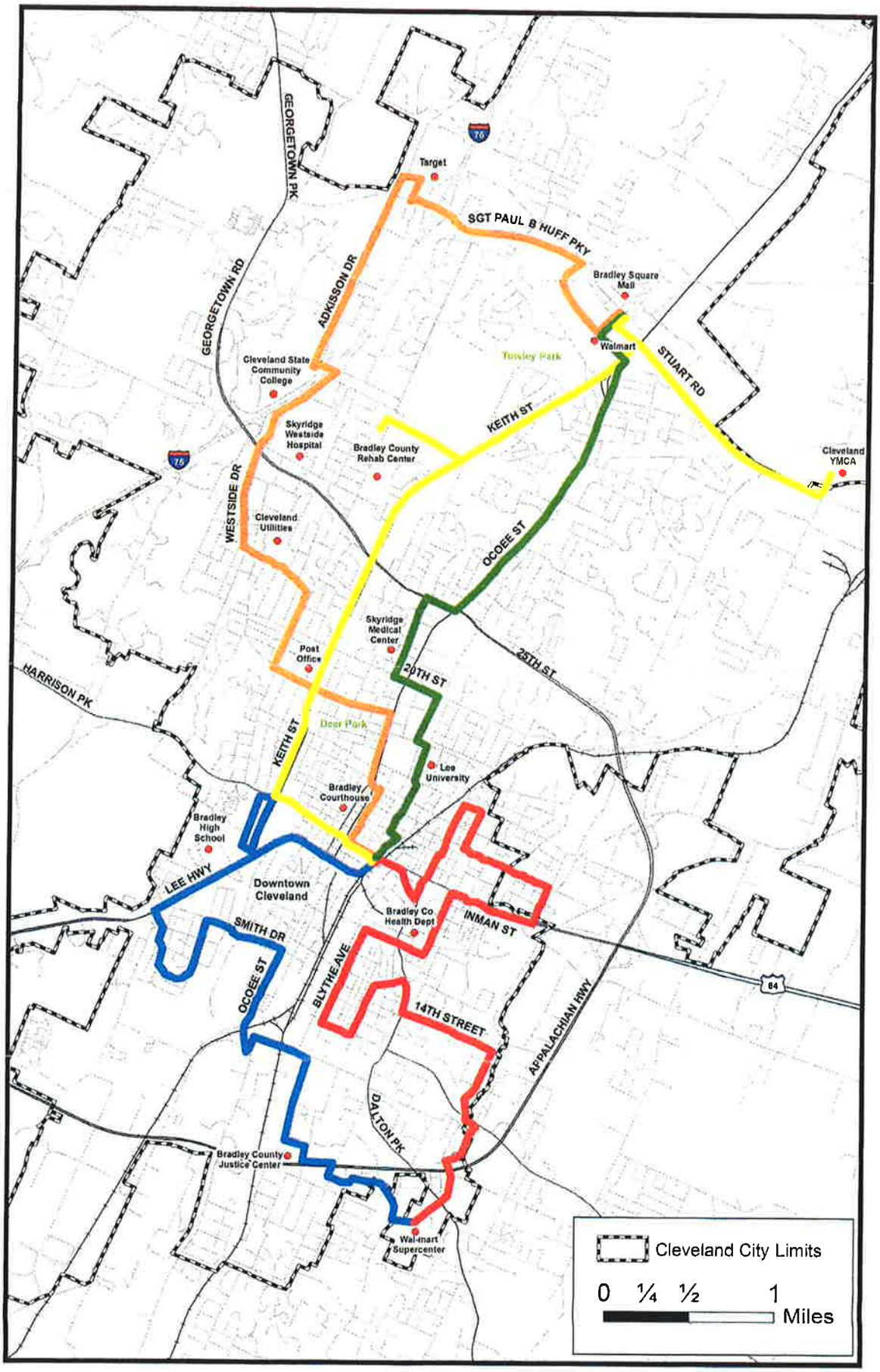
FLOOR PLAN

G 1

3/12/2018 4:06:00 PM
C:\Users\mfranks\OneDrive - HFR Design\20000000 - Potential Projects & Marketing\CHS Cleveland TN FSED\CHS Cleveland TN FSED 03-05-18.rvt
COPYRIGHT 2018 - ALL RIGHTS RESERVED - NO PORTION(S) MAY BE REPRODUCED WITHOUT EXPRESSED WRITTEN CONSENT OF HFR DESIGN, INC.

Attachment A-6B.3

Public Transportation Information


Target
SGT PAUL B HUFF PKY
Bradley Square Mall
Walmart
STUART RD
Tinsley Park
GEORGETOWN PK
GEORGETOWN RD
ADKISSON DR
Cleveland State Community College
Skyridge Westside Hospital
Bradley County Rehab Center
KEITH ST
Cleveland YMCA
WESTSIDE DR
Cleveland Utilities
OCOEE ST
Skyridge Medical Center
Post Office
20TH ST
25TH ST
HARRISON PK
Deer Park
KEITH ST
Lee University
Bradley Courthouse
Bradley High School
LEE HWY
Downtown Cleveland
Bradley Co Health Dept
INMAN ST
SMITH DR
OCOEE ST
BLYTHE AVE
14TH STREET
APPALACHIAN HWY
DALTON PK
Bradley County Justice Center
Wal-mart Supercenter
Cleveland City Limits
0 ¼ ½ 1
Miles

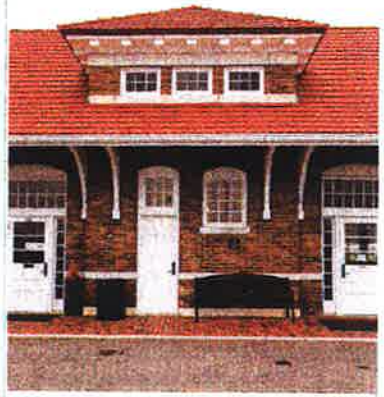
FARES:

Regular Fare—$1.00
Reduced Fare- $ .50
(For Individuals 65 years and older, persons with disabilities or presenting a Medicare Card)

Children Under 4—Free

Students—$ .75

Monthly Eagle Pass:
Regular Fare—$20.00
Reduced Fare—$10.00
Day Pass—$2.00



Cleveland Urban Area Transit System

423-478-1396

165 Edwards Street SE
Cleveland, TN 37311
www.rideclevelandtransit.org

Operated by: Southeast Tennessee
Human Resource Agency
PO BOX 909
Dunlap, TN 37327

Hours of Operation: 6:00 am through 7:00 pm Monday through Friday

Depot	Cleve-land Towers	Sky Ridge Medical Ctr.	North Ocoee at Mouse Creek	Mall	North Ocoee and Mouse Creek	Sky Ridge Medical Ctr.	Cleve-land Towers	Depot
:00	:05	:12	:18	:22	:34	:40	:47	:55
Depot	Library	Collins Market	Cleve-land State CC	Mall	Cleve-land State CC	Collins Market	Library	Depot
:00	:10	:17	:23	:28	:36	:42	:50	:55
Depot	6th and Poplar	Blythe Ave School	14th and Johnson	Wal Mart	14th and Johnson	Blythe Ave. School	6th and Poplar	Depot
:00	:05	:11	:17	:25	:35	:42:	:48	:55
Depot	Grove Avenue	Justice Center	CVS	Wal Mart	CVS	Justice Center	Grove Avenue	Depot
:00	:07	:15	:19	:25	:36	:40	:47	:55
Depot	Post Of-fice	25th and Keith Street	Bi-Lo	Mall	Bi-Lo	25th and Keith Street	Post Office	Depot
:00	:05	:10	:18	:26	:38	:45	:50	:55

Attachment A-10A

Licensed Bed Complement

Attachment A.10A

Bed Complement for Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland*

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 *(combined med/surg)*	278	113				278
2) Surgical						
3) ICU/CCU	24	24				24
4) Obstetrical	12	12				12
5) NICU	3	3				3
6) Pediatric	4	4				4
7) Adult Psychiatric	30	29				30
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL	351	185				351

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

* Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland consists of two campuses, the main hospital campus and Westside, which have a combined total of 351 licensed beds and are operated under a single hospital license and Medicare provider number.

Attachment B-Need-A.1

Letters of Support

Senator Mike Bell

425 5th Avenue North
Suite 730
Nashville, TN 37243
(615) 741-1946

261 County Road 757
Riceville, TN 37370
(423) 829-0058

sen.mike.bell@capitol.tn.gov

Senate Chamber
State of Tennessee

NASHVILLE

9th Senatorial District
Bradley, McMinn, Meigs
Monroe and Polk Counties

COMMITTEES:

Chairman, Government Operations
Judiciary, Energy, Agriculture
and Natural Resources

March 12, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

Please accept this letter in support of Tennova Healthcare – Cleveland's proposed Freestanding Emergency Department. Having been born and raised in Bradley County, I can attest to the need for the proposed project by our local hospital provider.

Tennova Healthcare – Cleveland has a long history of serving our community. As a life-long community member, I experienced the county's growth and watched as the hospital has also grown to meet the needs of its residents. The City of Cleveland as well as Bradley County overall have experienced significant growth over the past few decades. In addition to the continued growth of our resident county population, which now is in excess of 100,000, we have seen many retail, commercial and industrial developments rise from what was once eastern Tennessee farmland.

Our manufacturing and industrial base has grown significantly over the years, to include well-known names such as Duracell, Whirlpool and Mars Chocolates. The hospital has been an important community member, supporting the needs of our employers and all residents. The hospital's critical role in our community was clearly displayed during a significant incident which occurred last year at one of our industrial plants. While the hospital shined during this time (for which we're all thankful), the day-to-day services and community outreach provided by the hospital is also critically important to our citizens.

As part of its continuing commitment to meet its communities' needs, Tennova Healthcare – Cleveland is proposing to expand their existing Emergency Department by

establishing a satellite ED in north Cleveland. The expansion of a second ED location will enhance access to emergency services while simultaneously reducing the current high capacity at the main hospital ED. Moreover, the proposed location of the satellite ED is in the high growth area for residential, retail, and manufacturing along Highway 11.

For all of the reasons stated above, I strongly support the hospital's plans for strategically meeting the growing needs for our community. Tennova Healthcare – Cleveland has served our community for over 65 years; I'm looking forward to the hospital serving the community for decades to come.

Please feel free to contact me with any questions or if I can provide you with additional information.

Sincerely,

Mike Bell

Senator Mike Bell

MB:sl

Office of the
BRADLEY COUNTY MAYOR
D. GARY DAVIS

P.O. Box 1167
Cleveland, Tennessee 37364

Office (423) 728-7141
Facsimile (423) 476-0696

March 6, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare-Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

Please accept this letter in support of Tennova Healthcare – Cleveland's proposed Freestanding Emergency Department. I am the County Mayor of Bradley County and having been a resident for over 60 years, I can attest to the need for the proposed project by our local hospital provider.

Tennova Healthcare – Cleveland has a long history of serving our community. As a (life-long) community member, I experienced the county's growth and watched as the hospital has also grown to meet the needs of its residents. The City of Cleveland as well as Bradley County overall have experienced significant growth over the past few decades. In addition to the continued growth of our resident county population, which now is in excess of 100,000, we have seen many retail, commercial and industrial developments rise from what was once eastern Tennessee farmland.

Our manufacturing and industrial base has grown significantly over the years, to include well-known names such as Duracell, Whirlpool and Mars Chocolates. The hospital has been an important community member, supporting the needs of our employers and all residents. The hospital's critical role in our community was clearly displayed during a significant incident which occurred last year at one of our industrial plants. While the hospital shined during this time (for which we're all thankful), the day-to-day services and community outreach provided by the hospital is also critically important to our citizens.

As part of its continuing commitment to meet its communities' needs, Tennova Healthcare – Cleveland is proposing to expand their existing Emergency Department by establishing a satellite ED in north Cleveland. The expansion of a second ED location will enhance access to emergency services while simultaneously reducing the current high capacity at the main hospital ED. Moreover, the proposed location of the satellite ED is in the high growth area for residential, retail, and manufacturing along HWY 11.

For all of the reasons stated above, I support the hospital's plans for strategically meeting the growing needs for our community. Tennova Healthcare – Cleveland has served our community for over 65 years; I'm looking forward to the hospital serving the community for decades to come.

Please feel free to contact me with any questions or if I can provide you with additional information.

Sincerely,

D. Gary Davis
Bradley County Mayor

"A world class place to call home"

City of Cleveland

CLEVELAND, TENNESSEE
Office of the Mayor

Tom Rowland
Mayor

Cleveland Municipal Building
190 Church Street, N.E.
P.O. Box 1519
(423) 476-8931
(423) 559-3364 Fax

March 6, 2018

Ms Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare-Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I am Tom Rowland, Mayor of the City of Cleveland. Please accept this letter in support of Tennova Healthcare – Cleveland's proposed Freestanding Emergency Department proposed for Stuart Road.

Our local hospital is an important part of our community. For over 65 years, Tennova Healthcare – Cleveland has been serving Bradley County residents. The hospital has delivered so many of our residents at birth and cared for many of our residents in their final days. They provide critically important emergency services for both our residents and the businesses in our community, as well as provide numerous screening and health education services. In short, the hospital keeps our community healthy; we would not be the active and growing community we are today without the hospital meeting the community's health care needs.

As the Mayor of Cleveland for 27 years, I have seen many changes within our community. Bradley County has experienced significant growth, growing from about 70,000 residents when I was first elected mayor to now having over 100,000 residents. During that time, I have also watched the hospital grow and change to meet the needs of our community.

The addition of a freestanding emergency department to meet the needs of our residents is an excellent opportunity for the hospital to add capacity to assist with serving the emergent needs of our residents. The new location for the proposed Freestanding Emergency Department is in a growth area for residential, retail, and manufacturing developments. One only needs to take a short drive down Stuart Road/Paul Huff Parkway to see the number of developments that have recently occurred or are planned for construction. Thus, the proposed location of the satellite ED is yet one more way that Tennova Healthcare – Cleveland is being responsive to the needs of its local community members.

Tennova Healthcare – Cleveland is a fine hospital. From my first-hand experience, I know that they provide quality, patient-focused care. The residents of the City of Cleveland as well as all of Bradley County need to be able to receive care locally instead of having to endure the unnecessary stress and difficulty of traveling into the heavily-congested Chattanooga area.

Thank you for your consideration.

Sincerely,

Tom Rowland, Mayor
City of Cleveland

Office of County Executive

Polk County, Tennessee

HOYT T. FIRESTONE
COUNTY EXECUTIVE

March 12, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I am Hoyt Firestone, the County Executive in Polk County. I am writing this letter in support of Tennova Healthcare – Cleveland's proposed freestanding emergency department project.

As a resident of Polk County, I was saddened by the closure last year of our hospital, Copper Basin Medical Center. We are a rural community at the foothills of the Appalachian Mountains, with approximately 17,000 residents in our county. In addition to tourism, the hospital was one of the major employers in our community. More than just an employer, the hospital was the center of the medical community, providing local care to many of our residents.

Without a local hospital, our residents will access needed medical care, including emergency care, outside of Polk County. Historically, Polk County residents have received care at Tennova Healthcare – Cleveland, including emergency care as well as other needed medical services. Tennova Cleveland offers services closer to home for Polk County residents so that they typically do not have to travel into Chattanooga for healthcare. Travel into Chattanooga from our rural county means that patients and families must endure the stress and difficulty of navigating the highly-congested roadways into the metro area.

Tennova's proposed additional location for emergency services will be very beneficial to the residents of Polk County, especially considering the loss of our home-county hospital. Tennova Cleveland, which is centrally located and easily accessible in Cleveland, is the closest location to meet our inpatient and comprehensive outpatient medical needs. Polk County residents rely on Tennova Cleveland for health care services. The proposed expansion of its emergency services is just one more example of why our residents now turn to Tennova Cleveland when they need healthcare close to home.

P.O. Box 128
Benton, TN 37307

(423) 338-4527
Fax (423) 338-4558

Polk County's residents will most certainly benefit from this addition to the hospital's existing facilities. Please feel free to contact me with any questions or if I can provide you with additional information.

Sincerely,

Hoyt Firestone

Hoyt Firestone
County Executive

CLEVELAND MEDICAL ASSOCIATES, PLLC

1060 William Way N.W.
Cleveland, TN 37312-4369
Phone: (423) 478-1050
Fax: 1 (888) 977-1935
www.clevmeddoc.com

March 12, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I'm an Internal Medicine physician in the Cleveland area. I've been practicing medicine in this county for 20 years; thus, am very familiar with the needs of our community. The purpose of this letter is to make clear to you that I, along with numerous other physicians in the local community, strongly support Tennova Cleveland's proposed freestanding emergency department project.

Tennova Healthcare – Cleveland provides a spectrum of important services to the residents of Bradley and Polk County, from emergency and maternity services to general inpatient acute care services and outpatient behavioral health care. I believe that the hospital's proposed addition of a Freestanding Emergency Department in northern Cleveland is a needed expansion of emergency care for the community.

The hospital's current Emergency Department patient population includes seniors and behavioral health patients (among others), which are two groups of patients that oftentimes have complex cases because of their comorbidities and/or primary illnesses when presenting in crisis to the ED. The complexity of cases oftentimes results in longer throughput for the patient population. Having additional emergency care capacity and an additional location will allow the hospital to enhance access to emergency services while concurrently improving operations in its main campus ED.

The expansion of emergency care services at Tennova Healthcare – Cleveland is extremely beneficial to the residents of our community. Requiring residents to travel into the Chattanooga area for emergency services, or for any health care service that is available locally, is not only a major inconvenience that causes unnecessary stress on the patient and family, but is also disruptive to the relationships that local residents have with their community providers.

I strongly support the proposed Freestanding Emergency Department proposed by our local community hospital. Tennova Healthcare – Cleveland is an important member of our medical community and the addition of emergency care capacity at its hospital will benefit our community.

Thank you for your consideration.

Sincerely,

Azhar Sheikh, M.D.
Cleveland Medical Associates, PLLC
1060 William Way, NW, Cleveland, TN 37312

Rickey Hutcheson, D.O.
Lee Radford, M.D.
Matthew McCartney, D.C.
Anthony Edwards, NP-C
Darrin Compton, NP-C

2350 N Ocoee Street
Cleveland, TN 37311
Ph. 423-476-5554
Fax 423-614-6116

March 8, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

My name is Dr. Rickey Hutcheson. I am an orthopedic surgeon that practices in Cleveland, TN. I have owned Tennessee Valley Bone and Joint since 2008, but have been providing care in Cleveland for over 20 years. I am writing this letter in support of Tennova Healthcare and the proposed freestanding emergency department for development in my hometown.

Our local Tennova Healthcare facility is vital to the widespread area medical community. The addition of a freestanding emergency department in northern Cleveland is an important and significant addition to the spectrum of services that our local community hospital provides.

The existing emergency department within Tennova's hospital campus maintains a busy flow of patients. Expanding the current campus would provide much-needed space at that location but is not a viable alternative due to space limitations. In addition, a renovation of the current emergency department would require some of the vital areas in the department to be temporarily closed off and unavailable for necessary patient care. This would cause a disruption to Tennova's ability to properly care for their patients with emergent needs.

The construction of a new freestanding emergency department will allow Tennova to add the space needed to serve the community. The plan to build at the north side of Bradley County will meet the current demand. The ability to receive care close to home is very important not only for continuity of care but also for community support of friends and family. The residents of Bradley County are best served by receiving care within their home community instead of being transported to Chattanooga when services are available in Cleveland.

I strongly support the proposed freestanding emergency department to be developed by our home-town community hospital. It is crucial to the Cleveland area medical community that Tennova- Cleveland is able to continue providing services to our residents. Please feel free to contact me with any questions or if I can provide you with additional information.

Sincerely,

Rickey Hutcheson, D.O.
Business Owner & Concerned Citizen

Rickey Hutcheson, D.O.
Lee Radford, M.D.
Matthew McCartney, D.C.
Anthony Edwards, NP-C
Darrin Compton, NP-C

2350 N Ocoee Street
Cleveland, TN 37311
Ph. 423-476-5554
Fax 423-614-6116

March 8, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

My name is Dr. Lee Radford. I am a new orthopedic surgeon that practices in Cleveland, TN. I started practicing last year in Cleveland, in part, due to the improvements to the many service lines that Tennova has been able to accomplish over the past 5 years. I am writing this letter in support of Tennova Healthcare and the proposed freestanding emergency department they are developing for the north side of Cleveland.

Our local Tennova Healthcare facility is vital to the widespread area medical community. The addition of a freestanding emergency department in northern Cleveland is an important and significant addition to the spectrum of services that our local community hospital provides.

The existing emergency department within the Tennova's hospital campus is ideally placed to care for the surrounding community. They are a busy campus which lacks the ability to significantly expand without disrupting the many services that are provided to the entire hospital. That being said there is a need for further emergency and behavioral health services in the community, and the north side of Cleveland would be the most logical location. The communities to the south of Cleveland have multiple hospitals with full service lines to choose from. In my opinion, the north side of Cleveland has the least amount of healthcare service availability and would benefit greatly from a freestanding emergency department.

The residents of Bradley and Polk county get the vast majority of their care through the local community hospital. We need to create solutions that will triage, treat, and if necessary transfer to a higher level of care without placing a large burden on the ambulance providers in the area. Tennova Healthcare Cleveland has the ability to take care of the vast majority of health care conditions in our local community. They have many service lines and are constantly striving to

improve care to the community. The hospital is actively engaged in the future of medicine as well with investments in robotic assisted surgery from the orthopedic, urologic, gynecologic and general surgery service lines.

I strongly support the proposed freestanding emergency department to be developed by our home-town community hospital. It is crucial to the Cleveland area medical community that Tennova- Cleveland is able to continue providing services to our residents. Please feel free to contact me with any questions or if I can provide you with additional information.

Sincerely,

Lee Radford M.D.
Total Joint Reconstructive Surgeon

OCOEE REGIONAL HEALTH CORPORATION

P.O. Box 308; Benton, TN 37307

March 9, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I'm a physician in the Cleveland area. I've been practicing medicine in this area for five years; thus, am very familiar with the needs of our community. The purpose of this letter is to make clear to you that I, along with numerous other physicians in the local community, strongly support Tennova Cleveland's proposed freestanding emergency department project.

Tennova Healthcare – Cleveland provides a spectrum of important services to the residents of Bradley and Polk County, from emergency and maternity services to general inpatient acute care services and outpatient behavioral health care. I believe that the hospital's proposed addition of a Freestanding Emergency Department in northern Cleveland is a needed expansion of emergency care for the community.

The hospital's current Emergency Department patient population includes seniors and behavioral health patients (among others), which are two groups of patients that oftentimes have complex cases because of their comorbidities and/or primary illnesses when presenting in crisis to the ED. The complexity of cases oftentimes results in longer throughput for the patient population. Having additional emergency care capacity and an additional location will allow the hospital to enhance access to emergency services while concurrently improving operations in its main campus ED.

The expansion of emergency care services at Tennova Healthcare – Cleveland is extremely beneficial to the residents of our community. Requiring residents to travel into the Chattanooga area for emergency services, or for any health care service that is available locally, is not only a major inconvenience that causes unnecessary stress on the patient and family, but is also disruptive to the relationships that local residents have with their community providers.

I strongly support the proposed Freestanding Emergency Department proposed by our local community hospital. Tennova Healthcare – Cleveland is an important member of our medical community and the addition of emergency care capacity at its hospital will benefit our community.

Thank you for your consideration.

Sincerely,

Terry B Parsons, MD

Terry Parsons, MD
Benton Family Health Care Center

Manufacturers
Chemicals
a subsidiary of **Synalloy**

{March 9, 2018}

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I am the Human Resource Manager for Manufacturers Chemicals in Cleveland. The purpose of this letter is to make clear that I and my employer support of Tennova Healthcare – Cleveland's proposed Freestanding Emergency Department ("FSED").

Tennova Healthcare – Cleveland is an important part of our community. As an employer, having access to a healthy and active workforce is key to plant operations. We rely on our local, community hospital as a partner to help care for our employees in times of injury or illness. Having a FSED located close to our plant will be extremely beneficial to my organization because the hospital's expertise will be even more readily available for a medical emergency, whether it is a heart attack or an on-site injury. Trust me when I tell you that having Tennova Cleveland and its quality staff members nearby is reassuring not only to plant management but also to the entire workforce.

Tennova Healthcare – Cleveland currently operates a very busy Emergency Department on its hospital campus. Additional capacity and a secondary location will definitely benefit our workforce. I understand that the same team of emergency physicians will staff the new FSED, assuring me that the new facility will have the same high quality of care that we currently experience on-site at the hospital.

I strongly support the proposed Freestanding Emergency Department project. Tennova Healthcare – Cleveland is an important part of our local community. The addition of emergency care capacity will most definitely benefit the manufacturing community in Bradley County.

Please feel free to contact me with any questions or if I can provide you with additional information. Thank you for your consideration.

Sincerely,

Robin L Jennings
4325 Old Tassa Rd Ne
Cleveland , Tn 37320
423-476-6518 ext 2245

CORMETECH

Brenda Choate
Human Resources Manager
3300 Old Tasso Road N.E.
Cleveland, TN 37312
choatebs@cormetech.com
(423) 473-6941

March 13, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I am the Human Resource Manager for Cormetech, Inc. in Cleveland. The purpose of this letter is to make clear that I and my employer support of Tennova Healthcare – Cleveland's proposed Freestanding Emergency Department ("FSED").

Tennova Healthcare – Cleveland is an important part of our community. As an employer, having access to a healthy and active workforce is key to plant operations. We rely on our local, community hospital as a partner to help care for our employees in times of injury or illness. Having a FSED located close to our plant will be extremely beneficial to my organization because the hospital's expertise will be even more readily available for a medical emergency, whether it is a heart attack or an on-site injury. Trust me when I tell you that having Tennova Cleveland and its quality staff members nearby is reassuring not only to plant management but also to the entire workforce.

Tennova Healthcare – Cleveland currently operates a very busy Emergency Department on its hospital campus. Additional capacity and a secondary location will definitely benefit our workforce. I understand that the same team of emergency physicians will staff the new FSED, assuring me that the new facility will have the same high quality of care that we currently experience on-site at the hospital.

I strongly support the proposed Freestanding Emergency Department project. Tennova Healthcare – Cleveland is an important part of our local community. The addition of emergency care capacity will most definitely benefit the manufacturing community in Bradley County.

Please feel free to contact me with any questions or if I can provide you with additional information. Thank you for your consideration.

Sincerely,

Brenda Choate

Brenda Choate

Attachment B-Need-A.2

Traffic Congestion Information: Chattanooga

Chattanooga interchange 11th worst in nation, study says

I-24/U.S. 27 among top bottlenecks countrywide and the worst in Tennessee

February 3rd, 2018

by Mike Pare

in Local Regional News.

Motorists stuck Friday in Interstate 24 traffic through Chattanooga likely can blame its junction with U.S. Highway 27, a location that is the nation's 11th worst truck bottleneck, the latest research shows.

The I-24/U.S. 27 interchange is the worst in Tennessee and among nine sites in the state making the top 100 bottlenecks nationally, according to the American Transportation Research Institute.

Tennessee's standing is even worse than Georgia, which has seven of the top 100 — all in Atlanta. The I-285/I-85 interchange in Atlanta, dubbed "spaghetti junction" by travelers, was named the nation's worst for the third consecutive year.

Texas led all states with 11 of the worst 100 bottlenecks for 2018.

The data was revealed Friday at a meeting on infrastructure needs by the Thrive Regional Partnership, which looks at transportation, education and other issues across the 16-county, tri-state region around Chattanooga.

Connie Vaughan, Thrive's chairwoman and a McKee Foods Corp. official, said traffic congestion is an issue that comes up often in talks with people across the region.

WORST 11 BOTTLENECKS

City and location of the nation's top truck bottlenecks for 2018:

1. Atlanta: I-285/I-85

2. Fort Lee, N.J.: I-95/SR 4

3. Chicago: I-290/I-90 and I-94

4. Atlanta: I-285/I-75

5. Los Angeles: SR 60/SR 57

6. Boston: I-95/1-90

7. Baltimore: I-695/I-70

8. Queens, N.Y.: I-495

9. Cincinnati: I-71/I-75

10. Louisville: I-65/I-64 and I-71

11. Chattanooga: I-24/U.S. 27

Source: American Transportation Research Institute

"I hope everyone leaves in a panic," she told a group of about 120 business and political leaders. "One of the things people said is: 'We don't want to be Atlanta or Nashville.'"

State Sen. Todd Gardenhire, R-Chattanooga, said he's not surprised the I-24/U.S. 27 interchange ranked so badly on the national list. He's hopeful that work now going on will help relieve the problem on the interstate in addition to the planned reconstruction of the I-24/I-75 junction.

He said last year's passage of the IMPROVE Act by the Legislature that raised gas taxes to help fund 962 projects spread throughout the state will help Chattanooga.

But, the legislator said more work on I-24 from the Georgia-Tennessee line into Chattanooga is needed to alleviate traffic snarls. He estimated that up to $1 billion in work may be needed.

Gardenhire said passage of an infrastructure bill by Congress would help ease bottlenecks.

"They've got to do that quickly," he said. "It shouldn't be a partisan issue."

State Rep. Mike Carter, R-Ooltewah, said traffic can be "a nightmare" on I-24 from the I-59 intersection, and improvements are needed as the road moves into Chattanooga.

Use of IMPROVE Act funds at the I-24/I-75 interchange will help, he agreed, and the redesign will enable traffic to continue to flow freely, even while the new work is carried out.

Work on that interchange should start in spring 2019, according to the Tennessee Department of Transportation.

Rebecca Brewster, the American Trucking Research Institute president, said at the meeting that the nationwide cost of that congestion to the trucking industry was $63.4 billion a year.

Lost production was set at 996 million hours, she said, or the equivalent of 362,000 truck drivers sitting still for a year.

Meanwhile, more trucks are expected to come to the region as a result of the Appalachian Regional Port, a so-called "inland port" under construction on 42 acres in Murray County, Ga., on U.S. 411 just north of Crandall.

Shipping containers will be transferred from rail cars to semi trucks — and vice versa — after the port opens in October. The shipping containers will arrive in landlocked Murray County after a 388-mile trip by rail on CSX Transportation tracks from the Georgia Port Authority's Garden City Terminal, just northwest of Savannah.

While bringing more economic development to rural Murray County, some worry about increased traffic.

Tennessee State Sen. Mike Bell, R-Riceville, wondered about the truck traffic that will go into Southeast Tennessee from the inland port.

John Trent Sr., director of strategic operations and safety for the Georgia Ports Authority, said 25,000 to 35,000 "lifts" of containers between trains and trucks are expected in the first year. Trucks would take multiple routes, he said.

Trent estimated that up to 30 percent of the traffic would go north on U.S. 411, with many eventually traveling toward Cleveland, Tenn.

In four to five years, the number of container lifts could rise to 100,000 annually, he said.

Bridgett Massengill, Thrive's CEO, said plans are to convene three working groups to look at infrastructure issues over the next four months.

The aim, she said, is to come up with solutions for the region.

Contact staff writer Mike Pare at mpare@timesfreepress.com or 423-757-6318.

State lays out $70 million plan for fixing Chattanooga's I-24/I-75 interchange

November 9th, 2017

by Andy Sher

in Politics State

NASHVILLE — Tennessee transportation officials hope to have bids ready to advertise in the spring and start work by summer on an estimated $70 million project aimed at easing the sometimes deadly Chattanooga traffic bottleneck at the intersection of interstates 24 and 75.

"It's probably the worst intersection we got in the state at this moment," Transportation Commissioner John Schroer told Gov. Bill Haslam on Wednesday during his department's annual budget presentation to the governor.

Schroer said he believes the project will probably take three years — "if things go right."

The commissioner said the I-24/I-75 fix "will be one of the most expensive projects that we will do" in projects receiving funding under the state IMPROVE Act passed last spring by Tennessee lawmakers.

But while the local project's estimated cost is high, it's less than the state had to spend several years ago to straighten out a similar intersection of I-40 and I-240 in Memphis.

"It's not dissimilar to our I-40/240 project in Memphis, which was a $120 million-some-odd-dollar project," Schroer said. "We completed that six months ahead of time."

Schroer said the department has developed experience with large, expensive interchanges.

Approved at the urging of Haslam, business leaders, trucking firms and local officials across the state, the IMPROVE Act raised fuel taxes for the first time in nearly 30 years.

The tax on gas per gallon is rising 6 cents over a three-year period to 27.4 cents and diesel is rising by 10 cents to 28.4 cents. Several non-highway taxes were cut, including the state's sales tax on food.

Haslam promised the money will let Tennessee initiate or accelerate work on 962 specific projects totaling some $10.5 billion over coming years. The I-24/I-75 interchange wouldn't have gotten off the drawing board for years without it, Haslam and local legislators said last spring.

It's one of an estimated 23 Hamilton County projects estimated to cost some $600 million affected by the legislation.

Other projects include widening various portions of I-24 and I-75.

Schroer is proposing a nearly $2.1 billion project for fiscal year 2019, half of which is federal money.

Responding to questions from Haslam, Schroer said that despite Tennessee's passage of the IMPROVE Act, infrastructure funding remains an issue in Tennessee. That road leads to Washington, he said.

While President Donald Trump campaigned on a $1 trillion infrastructure spending program, "they keep pushing it back," said Schroer, the current president of the American Association of State Highway and Transportation Officials, which pushes for transportation help from Washington.

"I don't think we have been funding infrastructure in a manner in which we should, and in transportation we have not changed federally since 1993," Schroer said.

In fact, Schroer and aides warned that Tennessee could lose $178 million annually in several years unless Congress addresses expected shortfalls in the next several years of the federal FAST Act, the last federal funding bill that passed.

"We are going to look at how we do that, or there is going to be a whole lot of burden on the state by themselves," Schroer said.

Following the presentation, Haslam agreed with Schroer's concerns about adequate funding down the road, given federal inaction and the fact that fellow Republicans in the the Tennessee Legislature stripped out Haslam's plan to peg the gas tax to the rate of inflation.

"I think that's the reality," the governor said of Schroer's concerns. "I don't know if that's five years from now or eight years down the road. I can't figure that out. I don't think we've permanently solved the funding issue."

Vehicles continue getting better mileage and roads are costing more, the governor noted.

While states with significant road debt are counting on federal help, Haslam said those "waiting for Washington to bail them out are going to be waiting a while."

Meanwhile, Trump's idea of boosting federal spending calls for public-private partnerships involving issuing bonds and paying them off by use of toll roads and the like and won't get mileage in Tennessee, Schroer said.

That's because Tennessee doesn't use toll roads, Schroer said, noting in most areas of the state there's not enough vehicles to make it viable. The state, meanwhile, is one of only a handful of states that pays for transportation projects in cash as it proceeds on them.

The commissioner said of the 962 new or accelerated projects envisioned under Tennessee's IMPROVE Act, 288 are now underway. Twenty are in the construction phases. Ten bridge projects have already been completed, according to the department.

Contact staff writer Andy Sher at asher@timesfreepress.com or 615-255-0550. Follow him on Twitter @AndySher1.

Reworking of I-75/I-24 split could begin as soon as 2019

March 5th, 2018

by Ben Benton

in Local Regional News

It's going to be a big deal.

Drawings for the proposed improvements at the Interstate 75-Interstate 24 "split" show dramatic changes in store for the notorious interchange where daily backups snarl traffic, cause crashes and force drivers into last-second jockeying for position as if they're going into the first turn at Daytona.

The split, near the Tennessee-Georgia line, sees many crashes and semitractor-trailer rollovers, with speed often being a contributing factor, according to a 2006 report.

"Rear-end and sideswipe crashes were found to be high on I-75 northbound, which are due to short merging distances between the Ringgold Road interchange and the I-24 interchange," the report by Palmer Engineering states. "The on- and off-ramps at the welcome center located between the Ringgold Road and I-24 interchanges also contribute to these crashes."

And the report predicted traffic problems with the existing design would only increase.

In 2017, Tennessee Department of Transportation Commissioner John Schroer called the I-75/I-24 split "about the worst interchange in the state of Tennessee."

State officials said work at the split likely won't start until the summer of 2019, TDOT spokeswoman Jennifer Flynn said.

The project cost is estimated at $65 million, according to the IMPROVE Act list signed into law in April 2017 by Gov. Bill Haslam. A final cost won't be known until the final design work is done. The act and some one-time funding increases combined to move several key transportation projects forward, including others in Blount, Knox, Davidson and Shelby counties.

To streamline the project, the state is using a new approach called "design-build," a project delivery method that combines in a single contract all or some parts of the design and construction phases, including design, right-of-way acquisition, regulatory permit approvals, utility relocation and construction. However, the project is a little behind the original schedule, which planned for the work to start by fall, officials said.

Mississippi-based Neel-Schaffer Inc. was awarded the contract Jan. 5 to provide engineering services as the state's representative on the project leading to the next step in the process. Neel-Schaffer's role will be developing a plan for the project that gives basic design information on how the state thinks the project should be built, Flynn said.

A "design-build" contractor will be selected after a request for proposals is issued later this summer, she said. That contractor will take Neel-Schaffer's plan and refine it to define the cost and function. Flynn said there could be alternative design concepts at that point that improve function, reduce costs and speed up the construction. A finalized plan for the project will be the result of that process.

According to the current proposed plan, most of the existing interchange roadways will be moved and straightened as part of the improvements. The design incorporates less dramatic curves and bridges called "flyways" that allow more room for the interchange ramps to pass under and over each other. The interchange at I-75 and Highway 153 is a scaled-down example of the design.

Flynn said the impact on adjacent properties along the project corridor won't be known until the design-build contractor is selected, and the split project will have no effect on the ongoing work at exit 1.

"That project was designed with the future I-75/I-24 interchange project in mind," Flynn said.

Neel-Schaffer provided design work on road improvements related to the replacement project for the lock at Chickamauga Dam. The firm was selected for the project by the U.S. Army Corps of Engineers. The $6 million project included two bridges, two roundabouts, retaining walls and about a half-mile of roadway, according to project information on the company's website.

Contact staff writer Ben Benton at bbenton@timesfreepress.com or 423-757-6569. Follow him on Twitter @BenBenton or at www.facebook.com/benbenton1.

Attachment B-Need-A.3

Hospital Transfer Agreements & FSED Policy

PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT (the "Agreement") is made as of 5/24/2016, by and between **Cleveland Tennessee Hospital Company, LLC. doing business as Tennova Healthcare – Cleveland** and **Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System**, each individually referred to herein as "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of the Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into an Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into the Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities.

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties agree as follows:

1. TRANSFER OF PATIENTS. In the event any patient of either facility is deemed by Transferring Facility as requiring the services of Receiving Facility and the transfer is deemed medically appropriate, a member of the nursing staff of Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department, whichever is applicable, of Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of The Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to Receiving Facility.

2. RESPONSIBILITIES OF TRANSFERRING FACILITY. Transferring Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, within its capabilities, stabilizing treatment of the patient prior to transfer;

(B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;

(C) Designate a person who has authority to represent Transferring Facility and coordinate the transfer of the patient from the facility;

(D) Notify Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;

(E) Prior to patient transfer, if for direct admission, the transferring physician shall contact and secure a receiving physician at Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

(F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

(G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

(H) Forward to the receiving physician and Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and a copy of the patient's executed Advance Directives. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by Transferring Facility as soon as possible;

(I) Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

(II)

(J) Notify Receiving Facility of the estimated time of arrival of the patient;

(K) Provide Receiving Facility any information available about the patient's coverage under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(N) Recognize the right of a patient to refuse to consent to treatment or transfer;

(O) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to Receiving Facility; and,

(P) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. RESPONSIBILITIES OF RECEIVING FACILITY. Receiving Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, as promptly as possible, confirmation to Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that Receiving Facility has agreed to accept transfer of the patient. Receiving Facility shall respond to Transferring Facility promptly after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

(B) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred, maintain a call roster of physicians at Receiving Facility and provide, on request, the names of on-call physicians to Transferring Facility;

(C) Reserve beds, facilities, and services as appropriate for patients being transferred from Transferring Facility who have been accepted by Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by Receiving Facility for an emergency;

(D) Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

(E) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

(F) Upon discharge of the patient back to Transferring Facility, provide Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

(G) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

(H) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into its facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

(I) Provide for the return transfer of the patients to Transferring Facility when requested by the patient or Transferring Facility and ordered by the patient's attending/transferring physician, if Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to Transferring Facility, provide the items and services required of a Transferring Facility in Section 2 of the Agreement.

(J) Provide Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(K) Upon request, provide current information concerning its eligibility standards and payment practices to Transferring Facility and patient;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. BILLING. All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to the Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. TRANSFER BACK; DISCHARGE; POLICIES. At such time as the patient is ready for transfer back to Transferring Facility or another health care facility or discharge from Receiving Facility, in accordance with the direction from the responsible physician in Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the proper location. If the patient is to be transferred back to Transferring Facility, Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to Transferring Facility. In the event the "transferring facility" transfers a resident with a documented chronic antibiotic resistant infection to the "hospital," the "transferring facility" agrees to re-accept this resident upon discharge from the acute "hospital" provided all other transfer and admission criteria is met. Any return transfer must meet acute care admission criteria and be approved by Receiving Facility's case management nurse.

6. COMPLIANCE WITH LAW. Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. INDEMNIFICATION; INSURANCE. The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. In addition, each party shall maintain, throughout the term of the Agreement, comprehensive general and professional liability insurance and property damage insurance coverage, with the option to self-insure, and shall provide evidence of such coverage upon request.

Notwithstanding any provision of this Agreement to the contrary, any liability of Erlanger Health System under this Agreement is limited to the coverages, amounts and procedural requirements of the Tennessee Governmental Tort Liability Act, and any other local, state, or federal law or regulation limiting the liability of Erlanger or its trustees, officers, employees or agents, and this liability is expressly subject to the provisions of such laws, as such now exist or may be hereafter amended, revised or interpreted.

8. TERM; TERMINATION. The term of the Agreement shall be **thirty-six (36) months**, commencing on the **11/15/2016**, and ending on **11/14/2019**, unless sooner terminated as provided herein. Either party may terminate the Agreement without cause upon **thirty (30) days** advance written notice to the other party. Either party may terminate the Agreement upon breach by the other party of any material provision of the Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. The Agreement may be terminated immediately upon the occurrence of any of the following events:

(A) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or

(B) Either facility loses its license, or Medicare certification.

9. ENTIRE AGREEMENT; MODIFICATION. The Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior

agreements, oral or written, and all other communications between the parties relating to such subject matter. The Agreement may not be amended or modified except by mutual written agreement.

10. GOVERNING LAW. The Agreement shall be construed in accordance with the laws of the state of Tennessee.

11. PARTIAL INVALIDITY. If any provision of the Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of the Agreement.

12. NOTICES. All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to

Chattanooga-Hamilton County Hospital Authority
d/b/a Erlanger Health System,
975 East Third Street,
Chattanooga, TN 37403
Attn: Chief Executive Officer

With copy to:

Chattanooga-Hamilton County Hospital Authority
d/b/a Erlanger Health System
975 East Third Street
Chattanooga, TN 37403
Attn: Chief Legal Officer

If to

Cleveland Tennessee Hospital Company, LLC
d/b/a Tennova Healthcare – Cleveland,
2305 Chambliss Avenue,
Cleveland, TN 37311
Attention: Chief Executive Officer

With copy to:

Legal Department
4000 Meridian Blvd.
Franklin, TN 37067

or to such other persons or places as either party may from time to time designate by written notice to the other.

13. WAIVER. A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

14. ASSIGNMENT; BINDING EFFECT. Facilities shall not assign or transfer, in whole or in part, the Agreement or any of Facilities' rights, duties or obligations under the Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. The Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

15. CHANGE IN LAW. Notwithstanding any other provision of the Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while the Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under the Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend the Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If the Agreement is not so amended in writing within three (3) days after said notice was given, the Agreement shall terminate as of midnight local time on the third (3rd) day after said notice was given.

16. EXECUTION OF AGREEMENT. The Agreement shall not become effective or in force until all of the below named parties have fully executed the Agreement.

IN WITNESS WHEREOF, the parties hereto have executed the Agreement as of the day and year written above.

FACILITY
Chattanooga-Hamilton County Hospital
d/b/a Erlanger Health System

By: [signature]

Title: EVP & COO

Date: 11/01/16

CHSPSC, LLC HOSPITAL
Cleveland Tennessee Hospital Company,LLC
d/b/a Tennova Healthcare – Cleveland

By: Coleman Foss
Coleman Foss (Nov 14, 2016)

Title: CEO

Date: Nov 14, 2016

TRANSFER AGREEMENT

THIS AGREEMENT made effective as of April 1, 2014 by and between Cleveland Tennessee Hospital Company, LLC d/b/a SkyRidge Medical Center (Company), a facility duly licensed under the laws of Tennessee with a current provider agreement issued pursuant to Title XVIII and/or Title XIX of the Social Security Act, whose address is 2305 Chambliss Avenue, Cleveland, Tennessee 37311 ("**COMPANY**") and MEMORIAL HEALTH CARE SYSTEM, INC., a Kentucky nonprofit corporation, d/b/a Memorial Hospital and Memorial North Park Hospital, general acute care hospitals duly licensed under the laws of Tennessee with current provider agreements issued pursuant to Title XVIII of the Social Security Act, whose address is 2525 deSales Avenue, Chattanooga, Tennessee 37404 ("**MEMORIAL**").

WITNESSETH:

WHEREAS, by means of agreement, both COMPANY and MEMORIAL recognize the need to have prearranged transfer agreements such that an individual with a potential emergency condition can be transferred from one facility to the other in the event that the transferring facility does not have the specialized capability required by the individual, or in the event that a facility needs to transfer patients for other reasons, such as an emergency situation in which an evacuation of the facility or of the facility's Emergency Department is necessary; and

WHEREAS, by means of an agreement, both COMPANY and MEMORIAL desire to assist physicians, other care providers and the parties hereto in facilitating timely patient transfers which includes providing available medical records and other information necessary to the further the care and treatment of the patients transferred.

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, and for other valuable consideration the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. **Patient Transfer**. COMPANY and MEMORIAL agree to the following provisions related to patient transfers between the parties:

   (a) In the event that one party does not have the specialized capability or capacity required by an individual with an emergency medical condition ("**EMC**") and the other party has the specialized capability and capacity to receive the individual, then the receiving party agrees to accept the transfer of such patient to its facility in order to render stabilizing treatment or other medically appropriate treatment following an appropriate medical screening examination by the transferring facility within its capability.

   (b) In the event that an emergency or public health situation exists whereby one of the parties to this Agreement may need to transfer patients to the other party in order to evacuate the hospital or evacuate the Emergency Department, the receiving facility agrees to accept transfer of such patients.

   (c) In the event that one party does not have the specialized capability to treat a medical condition required by a hospital inpatient and the other party has the specialized capability and capacity to receive the individual, then the receiving party agrees to accept the patient in order to render appropriate medical treatment.

   (d) All transfers between the parties shall be made in accordance with all applicable federal and state laws and regulations, including the Emergency Medical Treatment and Active Labor Act

("EMTALA"), the standards of The Joint Commission ("TJC") and any other applicable accrediting bodies, and reasonable policies and procedures of the parties.

(e) Neither the decision to transfer a patient nor the decision to accept or not to accept a patient transfer shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's ability or inability to pay for services rendered by either party.

(f) The transferring facility's responsibility for patient care shall end and the receiving facility's responsibility for patient care shall begin when the patient arrives on the premises of the receiving facility.

2. **Provision Of Information To Each Party.** COMPANY and MEMORIAL agree:

(a) To provide the other party with the names and/or classifications of persons authorized to initiate, confirm, and accept the transfer of patients on behalf of each party; and

(b) That any transfer procedures shall be made available to the personnel of each of the parties that are involved in patient transfers.

3. **Responsibilities of the Transferring Facility.** The transferring facility shall be responsible for the following:

(a) Providing, within its capabilities, a medical screening examination and stabilizing treatment for any emergency department patient prior to transfer, in accordance with applicable federal and state regulations.

(b) Arranging for appropriate and safe transportation of the patient through the use of qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures during the patient's transfer to the receiving facility, in accordance with applicable federal and state regulations.

(c) Receiving confirmation from the receiving facility that it has the capability and capacity to accept the patient.

(d) Contacting and securing a receiving physician at the receiving facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care prior to patient transfer.

(e) Explaining to the patient prior to transfer the risks and benefits of transfer and obtaining the patient's written consent, or the patient's legal guardian's written consent, prior to transfer. In the event that patient has an EMC, the hospital's obligations under EMTALA must be explained to the patient in addition to the risks and benefits of transfer, in accordance with applicable federal and state regulations.

(f) Obtaining written physician certification that the benefits of patient transfer outweigh the risks of such transfer in cases where the patient being transferred has an EMC, in accordance with applicable federal and state regulations.

(g) Sending a copy of the patient's informed written consent and/or certification required for transfer.

(h) Recognizing the right of a patient to request transfer of his/her care to a physician and/or a facility of the patient's choosing.

(i) Recognizing the right of a patient to refuse to consent to treatment or to transfer and obtaining, or attempting to obtain, an informed refusal of treatment or transfer in writing.

(j) Completing, executing, and sending a copy of the Memorandum of Transfer form to the receiving facility for every patient who is transferred that presented to the transferring facility with an EMC.

(k) Transferring personal effects entrusted to an authorized officer or agent of the transferring facility, particularly money and valuables, and information related to these items. Any personal effects specifically entrusted to an authorized officer or agent of the transferring facility shall be transferred upon signed receipt from a similarly designated individual of the receiving facility.

4. **Responsibilities of the Receiving Facility.** The receiving facility shall be responsible for the following:

(a) Accepting appropriate patient transfers to the facility if the receiving facility has the specialized capabilities not available at the transferring facility and the receiving facility has the capacity to treat the individual.

(b) Accepting appropriate patient transfers to the facility if the receiving facility has the capacity to treat the individual in the event that the transferring facility requires an evacuation of a specific treatment area or of the entire facility.

(c) Cooperating with the transferring facility in coordinating an appropriate patient transfer.

5. **Patient Information and Confidentiality.** The transferring facility will complete and send with each patient at the time of transfer all available medical and demographic information necessary for the receiving facility to provide continuity of care for the patient. The transferring facility will send any additional information that becomes available as necessary for treatment of the patient. Each party agrees to maintain the confidentiality of the medical information so as to comply with all federal and state laws, rules and regulations regarding the confidentiality of patient records.

6. **Payment For Services.** Charges for services performed shall be collected by the party rendering such services directly from the patient, third-party payor or other sources normally billed by the party. The parties to this Agreement shall not have any liability to the other party for such charges. (This provision does not preclude separate written agreements between the parties, for example, the sale, purchase or exchange of supplies or services, or diagnostic or therapeutic services.)

7. **No Payment/Requirement for Referrals.** Nothing in this Agreement shall be construed to require either institution to make referrals of patients to the other institution. No payment shall be made under this Agreement in return for the referral of patients or in return for ordering, purchasing or leasing of products or services.

8. **Independent Contractor.** In performing this Agreement, each party shall be at all times acting as an independent contractor of the other. Neither party shall have, nor exercise or have the right to exercise, any control or direction over the provision of services hereunder by the other party, except as specifically provided herein. Nothing contained in this Agreement shall be construed to create a

partnership or joint venture between the parties, or to authorize either party to act as a general or special agent of the other party, except as specifically set forth herein. The governing body of each party shall have exclusive control of policies, management, assets and affairs of its respective institution. Nothing in this Agreement shall affect or interfere with the rules and regulations of each party as they relate to medical staff membership or privileges of physicians in that facility. The parties shall not assume any liability of the other party by virtue carrying out the terms of this Agreement.

9. **Insurance**. Each party shall, at its sole cost and expense, procure, keep and maintain throughout the term of this Agreement, insurance coverage in the minimum amounts of: One Million Dollars ($1,000,000) per occurrence and One Million Dollars ($1,000,000) annual aggregate for commercial general liability; One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) annual aggregate for professional liability; One Million Dollars each and every occurrence for automobile liability; and applicable state statutory limits for workers compensation. Said coverage may be in form of commercial policies or through a program of self-insurance. In addition to the coverage's specifically listed herein, each party shall maintain any other usual and customary policies of insurance applicable to the work being performed pursuant to this Agreement. Said policy(ies) shall cover all of the parties' services hereunder. By requiring insurance herein, the parties do not represent that coverage and limits will necessarily be adequate to protect the other party, and such coverage and limits shall not be deemed as a limitation on the other party's liability under the indemnities granted to the parties in this Agreement. In the event either party procures a "claims-made" policy to meet the insurance requirements herein, the party agrees to purchase "tail" coverage upon the termination of any such policy or upon termination of this agreement. Said "tail" coverage shall provide for an indefinite reporting period. The parties will obtain all insurance coverage's specified herein from insurers with a current A. M. Bests financial rating of A- or better. In the event that one or more of either party's insurers does not have an A. M. Bests rating, the name of the insurer(s) with appropriate financial information will be forwarded to the other party for review. The use of any insurer that does not have an A. M. Bests rating must be agreed to in advance by the other party. The party will furnish to the other party at least annually or upon renewal, a certificate of insurance evidencing all of the herein specified policies of insurance with an insurer and with limits meeting the requirements of this Agreement. Said policies shall be primary with respect to any insurance maintained by the parties. The parties shall provide copies of any and all insurance policies within ten (10) days of the other party's request for said policies. Failure to maintain the required insurance, as set forth in this Agreement, may result in immediate termination of this Agreement by either party.

10. **Indemnification**. COMPANY agrees to indemnify and hold harmless MEMORIAL, its directors, officers, employees, agents, representatives, successors, assigns, and subcontractors from and against any and all claims, demands, actions, settlements or judgments, including reasonable attorneys' fees and litigation expenses, based upon or arising out of the activities described in this Agreement, where such claims, demands, actions, settlements or judgments relate to the negligence, actions or omissions of COMPANY. MEMORIAL agrees to indemnify and hold harmless COMPANY, its directors, officers, employees, agents, representatives, successors, assigns, and subcontractors from and against any and all claims, demands, actions, settlements or judgments, including reasonable attorneys' fees and litigation expenses, based upon or arising out of the activities described in this Agreement, where such claims, demands, actions, settlements or judgments relate to the negligence, actions or omissions of MEMORIAL. The duties to indemnify and hold harmless shall survive the termination and expiration of this Agreement.

11. **Agreement Not Exclusive**. No part of this Agreement shall be interpreted as limiting the right of either party to make an agreement with any other facility.

12. **Promotional Use/Publicity/Endorsement Authority**. The parties shall not use the existence of this Agreement or the name of either MEMORIAL or COMPANY in connection with any promotional, marketing or advertising material in any medium, including television, radio, written materials including technical or trade publications and journals, electronic, including Internet and intranet, or any other medium, and this Agreement shall not constitute an endorsement by one party of the other party to this Agreement.

13. **Term**. This Agreement shall be in force and effect for an initial term of one (1) year beginning on the Effective Date (the "**Initial Term**"), unless earlier terminated in accordance with its terms. This Agreement shall automatically renew for additional one (1) year terms (each an "**Extended Term**" and together with the Initial Term, the "**Term**") unless otherwise terminated by the parties under the terms of this Agreement.

14. **Termination.**

(a) Automatic Termination. This Agreement shall automatically terminate, without regard to the notice requirements contained in Section fifteen (15), upon the date that either party to this Agreement: (1) ceases to have a valid provider agreement with the Secretary of the Department of Health, Education and Welfare under Title XVIII of the Social Security Act, or subsequent statutory authority amending or replacing said Title; or (2) fails to renew, has suspended, or has revoked its license or registration issued by this State to operate as a health care facility.

(b) Termination With Cause. Either party may terminate this Agreement if the other party has breached a term or condition of this Agreement, provided that the nonbreaching party has given the breaching party written notice of the alleged breach, and the breaching party fails to cure such breach within fifteen (15) calendar days of its receipt of such notice.

(c) Termination Without Cause. Either party may at any time during the term of this Agreement upon thirty (30) days written notice to the other party terminate this Agreement. At the end of the thirty (30) days period, this Agreement shall terminate for all purposes, provided the obligations arising prior to the termination shall be governed by the terms set forth herein until satisfied.

(d) Effect of Termination. Upon Termination of this Agreement pursuant to its terms, the rights and obligations of the parties hereunder shall terminate except as otherwise set forth herein; provided, however, that termination shall not relieve either party of those obligations which by their terms survive termination.

15. **Notice**. Whenever under the terms of this Agreement written notice is required or permitted to be given by any party to any other party, such notice shall be in writing and shall be deemed to have been sufficiently given if personally delivered, delivered by a national overnight courier service (such as Federal Express), transmitted by electronic facsimile or deposited in the United States Mail, in a properly stamped envelope, certified or registered mail, return-receipt-requested, addressed to the party to whom it is to be given, at the address hereinafter set forth. Any party hereto may change its address by written notice in accordance with this Section:

If to MEMORIAL: Memorial Health Care System
2525 deSales Avenue
Chattanooga, TN 37404
ATTN: President & CEO

If to COMPANY: SkyRidge Medical Center
2305 Chambliss Avenue
Cleveland, TN 37311
ATTN: Coleman Foss, CEO

16. **Assignment**. Except as otherwise expressly provided in this Agreement, neither party may assign any of its rights or obligations under this Agreement without the prior written consent of the other party; provided, however, MEMORIAL may assign its rights and duties to an entity that controls, or is controlled by, MEMORIAL or Catholic Health Initiatives.

17. **Excluded Provider**. COMPANY hereby represents and warrants that COMPANY is not and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid. COMPANY hereby agrees to immediately notify MEMORIAL of any threatened, proposed, or actual exclusion of COMPANY from any federally funded health care program, including Medicare and Medicaid. In the event that COMPANY is excluded from participation in any federally funded health care program during the Term of this Agreement, or if at any time after the Effective Date of this Agreement it is determined that COMPANY is in breach of this Section, this Agreement shall, as of the effective date of such exclusion or breach, automatically terminate. COMPANY shall indemnify and hold harmless MEMORIAL against all actions, claims, demands and liabilities, and against all loss, damage, costs and expenses, including reasonable attorneys' fees, arising directly or indirectly, out of any violation of this Section by COMPANY, or due to the exclusion of COMPANY from a federally funded health care program, including but not limited to Medicare or Medicaid, or out of an actual or alleged injury to a person or to property as a result of the negligent or intentional act or omission of COMPANY, or any of COMPANY's employees, subcontractors, or agents providing goods or services in connection with COMPANY's obligations under this Agreement, except to the extent any such loss, damage, costs and expenses were caused by the negligent or intentional act or omission of MEMORIAL, its officers, employees or agents.

18. **Compliance With All Laws, Regulations And Standards**. Each party warrants that all services to be provided hereunder, shall fully comport with all applicable federal, state and local statutes, rules and regulations, and that it shall be deemed a material breach of this Agreement if either party shall fail to observe this requirement.

19. **HIPAA and HITECH**. Insofar as both parties are Covered Entities as defined by, and are subject to, the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and implementing regulations ("**HIPAA**"), including the Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Health Information at 45 C.F.R. Parts 160 and 164 and by the Health Information Technology for Economic and Clinical Health Act and implementing regulations ("**HITECH**") (collectively "**Privacy and Security Regulations**"), and insofar as each party is granting access to the other of their respective patients' Protected Health Information, and insofar as both parties may be creating, Using and Disclosing Protected Health Information for their respective treatment, payment and operations purposes, as those terms are defined by the Privacy and Security Regulations, both parties warrant and agree to comply with the provisions of the Privacy and Security Regulations.

20. **Jeopardy**. Notwithstanding anything to the contrary herein contained, in the event the performance by either party hereto of any term, covenant, condition or provision of this Agreement jeopardizes the licensure of the other party, its participation in or the payment or reimbursement from Medicare, state sponsored Medicaid program, Blue Cross or other reimbursement or payment programs, or its full accreditation by The Joint Commission or any other state or nationally recognized accreditation

organization, or the tax-exempt status of the other party, any of its property or financing (or the interest income thereon, as applicable), or will prevent or prohibit any physician, or any other health care professionals or their patients from utilizing the other party or any of its services, or if for any other reason said performance should be in violation of any statute, ordinance, or be otherwise deemed illegal, or be deemed unethical by any recognized body, agency, or association in the medical or hospital fields, the other party may at its option (i) terminate this Agreement immediately; or (ii) initiate negotiations to resolve the matter through amendments to this Agreement and if the parties are unable to resolve the matter within thirty (30) days thereafter, the other party may, at its option, terminate this Agreement immediately.

21. **Confidentiality.** COMPANY and MEMORIAL shall hold in confidence the information contained in this Agreement and each party hereby acknowledges and agrees that all information related to this Agreement, not otherwise known to the public, is confidential and proprietary and is not to be disclosed to third persons without the prior written consent of each of the parties except: (i) to the extent necessary to comply with any law, rule or regulation or the valid order of any governmental agency or any court of competent jurisdiction; (ii) as part of its normal reporting or review procedure, to its auditors and attorneys; (iii) to its insurance agent to the extent necessary to obtain appropriate insurance; or (iv) as necessary to enforce its rights and perform its agreements and obligations under this Agreement. COMPANY shall treat all non-public information obtained as part of this engagement as confidential and shall not, without written authorization from MEMORIAL, release or share such information with any third party, except as may be required by law. COMPANY agrees that prior to reporting any actual or perceived violation of law to any governmental entity, even if required by law to do so, it will first discuss any potential legal or compliance matter with MEMORIAL's Corporate Responsibility Officer and MEMORIAL Legal Counsel and, unless otherwise required by law, provide MEMORIAL with an opportunity to investigate and appropriately report any compliance matter brought to its attention by COMPANY.

22. **Recordkeeping.** If and to the extent required by Section 1395x(v)(1)(i) of Title 42 of the United States Code, until the expiration of four (4) years after the termination of this Agreement, COMPANY shall make available, upon written request by the Secretary of the Department of Health and Human Services, or upon request by the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of goods and/or services provided by COMPANY under this Agreement. Although not permitted without MEMORIALS's prior written consent, in the event COMPANY carries out any of its duties under this Agreement through a subcontract with a related organization with a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain a provision requiring the related organization to make available until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract upon written request to the Secretary of the United States Department of Health and Human Services, or upon request to the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents and records of such organization as are necessary to verify the nature and extent of such costs.

23. **Waiver.** No waiver of or failure by any party to enforce any of the provisions, terms, conditions, or obligations herein shall be construed as a waiver of any subsequent breach of such provision, term, condition, or obligation, or of any other provision, term, condition, or obligation hereunder, whether the same or different in nature. No extension of time for performance of any obligations or acts shall be deemed an extension of the time for performance of any other obligations or acts.

24. **Partial Invalidity**. If any provision of this Agreement is found to be invalid or unenforceable by any court or other lawful forum (including an arbiter), such provision shall be ineffective only to the extent that it is in contravention of applicable laws without invalidating the remaining provisions of this Agreement, unless such invalidity or unenforceability would defeat an essential business purpose of this Agreement.

25. **Governing Law**. This Agreement is made and entered into in the State of Tennessee, and shall be governed and construed in accordance with the laws of the State of Tennessee, without reference to the conflicts of law provisions thereof.

26. **Continuing Obligations**. Whether specifically identified or not, the obligations of the parties under this Agreement which by their nature or content would continue beyond the expiration or termination of this Agreement shall survive any expiration or termination of this Agreement.

27. **Amendment**. This Agreement may be amended at any time by mutual agreement of the parties, provided that before any amendment shall become effective, it shall be reduced to writing and signed by each of the parties.

28. **Entire Agreement**. This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter hereof. This Agreement supersedes any and all other agreements, either oral or in writing, between the parties hereto with respect to the subject matter hereof.

29. **No Joint Venture**. It is expressly agreed and understood by the parties hereto that neither party is an agent, partner or joint venturer with or of the other.

30. **Headings**. The headings of the sections of this Agreement are included for the purposes of convenience only and shall not affect the interpretation of any provision hereof.

31. **Expenses**. Except as may be specifically provided for in this Agreement, all parties shall bear their own expenses incurred in connection with this Agreement and the transaction contemplated herein.

32. **Successors and Assigns**. This Agreement shall be binding on COMPANY and MEMORIAL and shall inure to each party's benefit and its respective successors (to the extent specified in any assignment) and permitted assigns.

33. **No Third Party Rights**. This Agreement has been made and is made sole for the benefit of the parties hereto and their respective successors and permitted assigns. Nothing in this Agreement is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the parties to it and their respective successors and permitted assigns. Nothing in this Agreement is intended to relieve or discharge the obligation or liability of any third persons to any party to this Agreement.

34. **Compliance with CHI Standards of Conduct**. COMPANY recognizes that it is essential to the core values of MEMORIAL that all persons and entities employed by or otherwise contracting with MEMORIAL at all times conduct themselves in compliance with the highest standards of business ethics and integrity and applicable legal requirements, as reflected in the Catholic Health Initiatives Standards of Conduct, as may from time to time be amended by Catholic Health Initiatives. As of the date of this Agreement the Standards of Conduct are set forth in Our Values & Ethics at Work Reference Guide (**"E@W Guide"**), which is available at the following website: http://www.catholichealthinit.org/body.cfm?id=37940. COMPANY acknowledges that COMPANY has

electronically accessed, obtained or otherwise received a copy of the E@W Guide and agrees to act in a manner consistent with, and at all times abide by, such Standards of Conduct, to the extent the same are applicable to COMPANY in the performance of this Agreement. In the event that MEMORIAL determines in good faith that COMPANY has breached its obligations pursuant to this Section, MEMORIAL may immediately terminate this Agreement without penalty.

35. **Ethical and Religious Directives.** COMPANY agrees that all services to be furnished by COMPANY hereunder shall be performed in accordance with the Ethical and Religious Directives for Catholic Health Care Services, Fifth Edition, as promulgated by the United States Conference of Catholic Bishops as amended from time to time, and as interpreted by the local bishop. The Ethical & Religious Directives are available at the following website: http://www.usccb.org/about/doctrine/ethical-and-religious-directives/.

IN WITNESS WHEREOF, we, the undersigned, duly authorize representatives of the parties to this Agreement herein above expressed, have entered into this Agreement without reservation and have read the terms herein.

MEMORIAL:

MEMORIAL HEALTH CARE SYSTEM, INC.

By: James M Hot

Title: CEO

Date: 2-4-14

COMPANY:

SKYRIDGE MEDICAL CENTER

By: [illegible]

Title: CEO

Date: 3.31.14

HELICOPTER MEDICAL TRANSPORTATION SERVICES AGREEMENT

THIS AGREEMENT is entered into by and between AIR EVAC EMS, INC., a Missouri corporation (hereinafter referred to as "**Company**"), and Cleveland Tennessee Hospital Company, LLC d/b/a SkyRidge Medical Center, a Tennessee limited liability company (hereafter referred to as "**Hospital**"), and shall be effective as of Aug 1st, 2011 (the "**Effective Date**") notwithstanding the fact that it is signed by a party or both parties on any other date.

PRELIMINARY STATEMENTS

A. Hospital requires access to helicopter medical transportation services to transfer certain patients from SkyRidge Medical Center, 2305 Chambliss Avenue, Cleveland, TN 37311 ("**Location**") to other medical facilities in a professional, quality, timely, cooperative, consistent and seamless manner.

B. Hospital believes that it can best achieve these goals by being proactive and by pre-selecting and maintaining a relationship with a provider of helicopter medical transportation services; accordingly, Hospital is appointing Company as its preferred provider of air ambulance services. Only with this level of geographical community support and commitment can (or will) Company commit the substantial financial resources necessary to establish an air ambulance at the Location.

C. Company represents and warrants that it is a well-established and respected provider of 24-hour, 365 day-a-year, emergency helicopter medical transportation services for critically ill or injured patients, with a team of specially trained flight nurses, paramedics, communications staff and pilots and maintenance personnel (hereinafter referred to as "**Services**").

D. Company desires to provide the Services upon request.

AGREEMENT

In consideration of the mutual promises and covenants hereinafter set forth, it is mutually understood and agreed upon by the parties hereto that the Preliminary Statements are hereby incorporated into and made a part of this Agreement and, as follows:

1. RELATIONSHIP

1.1 Hospital shall designate Company as its preferred provider of air ambulance services for its patients at the Location. Accordingly, Hospital (i) will request services first from Company when Hospital is the sending facility and one of its patients has a need for air ambulance services (ii) if Hopsital receives a request for air ambulance services from a third party, Hospital agrees to transmit such request in a timely manner to Company unless one of the exceptions below applies. Hospital may use or recommend the services of another air ambulance service provider (A) during any period of time when a Company helicopter is unavailable (whether because it is out of service, in the process of responding to a mission or otherwise) or out of position to respond to a specific call in an appropriate and timely manner (i.e., patient care dictates that a different service be used), (B) based on specific patient or physician request, or (C) where patient's insurance coverage or financial situation so necessitate. At all times that this Agreement is in effect, Hospital will refrain from entering into any other agreements similar in scope with other providers of air ambulance services, and, at all times that this Agreement is in effect, Hospital shall also refrain from entering into any real estate leases with other providers of air ambulance services.

1.2 Company has an obligation to accept such transport requests from Hospital; provided, however, Hospital understands and acknowledges that availability may be limited (in Company's sole and absolute discretion) based upon weather conditions, weight limitations, current use of the aircraft for other missions, aircraft maintenance, or other

conditions. When Company accepts such a request for services, it assumes all responsibility for providing services to such a request, including, but not limited to:

1.2.1 Company shall, at its sole expense, provide a helicopter, fuel, flight crew and maintenance personnel appropriate to its obligations under this Agreement;

1.2.2 To provide a reasonable estimate of timely response to Hospital considering the geographic proximity of the responding unit to the patient's location;

1.2.3 Collection of all patient care information and billing information;

1.2.4 If Company is not available or unable to provide services it will attempt to locate an equivalent provider of services, and will so inform Hospital of the provider and estimated response time; however, Hospital's obligation to call Company ends at the moment that Company rejects or refuses a request for service, or does not timely accept such a request.

2. LANDINGS ON HOSPITAL HELIPAD

2.1 In order to effectively utilize the services, equipment and facilities of Company, Hospital herein authorizes Company to land upon and depart from the property of Hospital, utilizing the designated helicopter landing pad. Hospital shall maintain a landing site in accordance with Hospital's usual business practices. The landing site may be used by other air ambulances, and Company shall promptly move Company's air ambulance when the landing site is needed for other air ambulances.

3. INTENTIONALLY DELETED

4. PATIENT TRANSPORT

4.1 Each patient's physician will decide when a patient is to be transferred and shall also decide to which institution the patient will be transferred, depending on the patient's preference, needs, and the availability of resources to meet those needs and shall certify that the patient requires airborne emergency medical service transport.

4.2 The patient's physician shall be responsible for arranging with the appropriate receiving physician at the designated receiving hospital to assure the continuity of medical care, and assuring that proper arrangements have been made to provide an efficient transfer of the patient. Those arrangements also include: (a) acceptance by receiving physician, (b) medical plan of care for in-flight which shall be under the direction and control of Company, and (c) admission to the receiving hospital.

4.3 Patient care en route will be guided by such protocols, policies and procedures regarding patient safety and care by Company personnel as established by Company.

4.4 Patient preparation prior to transfer by Company will be the responsibility of the patient's physician in consultation with the Company medical team.

4.5 Hospital can make requests for transfer by calling 1-800-568-6806, 1-800-247-3822, or such phone numbers as Company shall notify Hospital in writing.

4.6 Company may respond to any requests for services as specified by Company administrative and medical protocol. However, nothing in this Agreement implies or requires that Company must respond to any or all requests for service. The pilot in command governs dispatch of the helicopter.

5. REGULATORY COMPLIANCE

5.1 The parties intend to fully comply with all applicable state and federal laws and regulations, including but not limited to the Balanced Budget Act of 1997, The Social Security Act, the federal Anti-Kickback Statute, 42 U.S.C. §1320a-7b, the federal False Claims Act, and all applicable state and federal fraud and abuse laws and rules. If any terms or conditions of this Agreement are determined by any court or by the OIG of the Department of Health and Human Services to be contrary to any such statutes or regulations, the parties agree to promptly and in good faith confer and resolve any issues so as to make the performance of this Agreement consistent with all applicable statutes and regulations.

5.2 To the extent applicable, until the expiration of four years after the furnishing of services pursuant to this Agreement, Company shall make available, upon written request, to the United States Secretary of Health and Human Services, the Comptroller General of the United States, or any of their duly authorized representatives, the agreements and books, documents, and records of Company that are necessary to verify the nature and extent of the cost of providing such services.

5.3 This Agreement is evidence of each party's intent to comply with Title VI-VII of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act and all similar laws which prohibit discrimination because of race, color, national origin, handicap, disability, age, sex, religion, sexual or political affiliation in any facet of a party's operation.

5.4 Company and Hospital agree that they will timely comply with the Health Insurance Portability and Accountability Act (hereafter HIPAA), the Privacy Regulations promulgated pursuant thereto (codified as 45 CFR §§160 and 164), and with any other regulations promulgated pursuant to HIPAA from time to time, and any amendments to HIPAA, from time to time. The provisions of this section will survive the termination or expiration of this Agreement.

5.5 All parties hereto agree that any patient transfers shall be in compliance with EMTALA, 42 U.S.C. §1395dd *et seq.* and any amendments thereto, and such other requirements as may be imposed by the Secretary of Health and Human Services, and any applicable State transfer laws.

5.6 Hospital represents and warrants that it is in material compliance with all applicable federal, state and local laws and regulations and that it is duly licensed as a health care facility under the laws of the state of Tennessee. Hospital further agrees to give prompt notice in writing to Company in the event of institution of proceedings for suspension or revocation of its license, and to notify Company in the event of any suspension or revocation of its license within twenty-four (24) hours of its occurrence. This Agreement will immediately terminate upon the revocation or suspension of licensure of Hospital. Further, Company, at its sole discretion, may terminate this Agreement in the event Hospital is given notice of proceedings to suspend or revoke the licensure of Hospital.

5.7 Company represents and warrants that it is in material compliance with all applicable federal, state and local laws and regulations and has all necessary licenses and permits, and that its services and equipment are fully compliant with all air ambulance requirements under the laws of the state of Tennessee.

6. PAYMENTS AND BILLING

6.1 Company will look solely to the patient and/or his/her third party payer for payment of all transportation, medical care, supplies, drugs or other service provided by Company

under the terms of the Agreement. Company will not inquire into the prospect of receiving payment prior to furnishing services.

7. TERM AND TERMINATION

7.1 This Agreement shall continue in force and effect for a period of five (5) years and shall automatically renew for successive two (2) year periods on each anniversary unless one or both parties notifies the other, in writing, of the party's intent not to renew this Agreement. Such notice in writing shall be given at least one hundred twenty (120) days in advance of the date of termination of the initial term or either renewal period.

7.2 Each party shall notify the other in writing of any breach of the terms of this Agreement. If a material breach is not corrected within thirty (30) days of written notice, this Agreement shall be deemed terminated, unless written agreement is appended to this Agreement that the parties agree to continue the terms of this Agreement. Failure of a party to exercise its rights under the terms of this Agreement on any one occasion shall not be construed as a continuing or subsequent waiver of the right to take advantage of any available remedies as specified hereinto or upon a subsequent or continued breech of any covenant or term contained in this agreement. Material breach shall include, but shall not be limited to:

(a) Failure by Company to provide personnel who are qualified to provide the patient care and/or flight operations duties set forth herein, and/or the qualifications established by rule or law.

(b) Professional misconduct of Company or any Company personnel, which makes the presence of Company, Company's air ambulance or equipment, or the presence of any of Company's personnel at the Hospital detrimental to the interest of the Hospital or its patients.

(c) Indicment or conviction of a party or any of its owners, directors, managers or personnel directly providing service at Hospital's location (unless cured by terminating the party's relationship with such person within the applicable cure period) of a crime related to the provision of or billing for healthcare, or a crime of moral turpitude.

(d) Gross professional negligence by Company or any of Company's personnel in connection with the Services.

(e) Any act(s) or omission(s) by Company or any of its owners, directors, managers or personnel directly providing service at Hospital's location which materially diminish the economic viability of the Hospital or materially diminish the Hospital's reputation within the community.

(f) A party or any of its owners, directors, managers or personnel directly providing service at Hospital's location (unless cured by terminating the party's relationship with such person immediately upon receiving notice thereof) loses its eligibility (permanently or temporarily) to participate in the Medicare and/or Medicaid programs (or any other Federal Healthcare Program) or Federal contracting.

7.3 In the event that either party shall become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceedings under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of rights of creditors, then, at the option of either party, this Agreement shall automatically terminate and be of no further force and effect.

7.4 Company may terminate this Agreement with at least 60 days advance written notice to Hospital of Company's intent to terminate due to adverse changes in flight volumes or reimbursement rates which the parties are not able to resolve in a mutually acceptable manner within 30 days following such notice.

8. INSURANCE

8.1 Company shall procure and maintain for the term of this Agreement professional liability insurance in a minimum amount of One Million/Three Million dollars ($1,000,000/$3,000,000). If such coverage is written on a claims-made form following termination of this Agreement, coverage shall survive for a period of no less than five (5) years. Coverage shall provide for a retroactive date of placement coinciding with the effective date of this Agreement. Company shall cause Hospital to be a named insured on its professional liability insurance policy. Each party will hold harmless the other party from any loss, damage, cost or expense to the extent arising from such party's professional negligence. Company shall cause Hospital to be named an additional insured with respect to the operations of Company on Company's professional liability insurance policy.Company shall provide proof of insurance annually and upon request and shall notify Hospital of any material change in insurance.

8.2 Company shall procure and maintain during the term of this Agreement, workers' compensation and employer liability insurance covering all of its employees who are engaged in any work under this Agreement.

8.3 Company shall procure and maintain during the term of this Agreement, insurance for property damage to any of its aircraft.

8.4 During the term of this Agreement, Company will ensure that aviation liability insurance is maintained, covering injuries to passengers or third parties and damage to property in an amount not less than Fifty Million dollars ($50,000,000) for any one accident or series of accidents arising out of any one event. Company shall cause Hospital to be named as additional insured on its aviation liability insurance policy, with respect to the operations of the Company. Company shall provide proof of insurance annually and upon request and shall notify Hospital of any material change in insurance.

8.5 Company shall provide Hospital with Certificates of Insurance evidencing the above coverage. The aggregate amount shall not be reduced by legal costs. Company will notify Hospital of any cancellation or material change thirty (30) days prior to such cancellation or change (10 days for nonpayment of premium). Company's insurance carrier shall provide a waiver of subrogation against Hospital.

9. INDEMNIFICATION

9.1 Each party shall indemnify and hold harmless the other party, its directors, trustees, officers, employees and agents, from and against any judgments, damages, costs and expenses, including reasonable attorney's fees, from any claim, action or proceedings to the extent arising out of its own negligent acts or omissions in the performance of this Agreement. Indemnitor's obligations as set forth in the preceding sentence are conditioned upon (i) Indemnitee promptly notifying Indemnitor of any claim, demand or action, or any incident of which Indemnitee has actual or constructive knowledge, which may reasonably result in a claim, demand or action, and for which Indemnitee will look to Indemnitor for indemnification under this Section, 9.1, (ii) Indemnitee, its directors, officers, and employees, cooperating fully with Indemnitor in Indemnitor's investigation and review of any such claim, demand, action or incident, and (iii) Indemnitee not entering into any admissions, agreements or settlements which may affect the rights of

Indemnitee or Indemnitor without the prior written consent and approval of Indemnitor. Indemnitor reserves the right, in its sole discretion, to assume the defense of Indemnitee in any such claim, action or proceeding. This provision shall survive any termination or expiration of this Agreement.

9.2 Company shall indemnify and hold harmless Hospital, its directors, trustees, officers, employees and agents from and against any judgments, damages, costs and expenses, including reasonable attorney's fees, from any claim, action or proceedings arising out of or related to physical damage caused directly or indirectly by Company, and/or Company's employees, agents, contractors and equipment., and shall cause Company's insurance carrier to grant to Hospital a waiver of subrogation for such physical damage.

10. NOTICE

10.1 Unless otherwise specifically set forth in this Agreement, any and all notices and other communications provided for herein shall be sent by (a) personal delivery, (b) certified mail, returned receipt requested or (c) prepaid Federal Express or other comparable overnight express service to a party at the address shown below, or to such other address as a party may designate from time to time in writing to the other parties. All notices shall be deemed to have been duly given when personally delivered, delivered by overnight courier service, or three business days after deposit in the United States mail. In the event that any notice is not delivered to any party entitled thereto because such party has moved and the address is unknown, or because such party has refused to accept such notice, then such notice shall be deemed to be effective as if delivered.

Company:	Air Evac EMS, Inc. P.O. Box 768 – 306 Davis Drive West Plains, MO 65775 Attn: Vice President of Operations
With Copy to:	Air Evac EMS, Inc. P.O. Box 768 – 306 Davis Drive West Plains, MO 65775 Attn: General Counsel
Hospital:	Skyridge Medical Center 2305 Chambliss Avenue Cleveland, TN 37311 Attn: Chief Executive Officer
With Copy to:	Community Health Systems, Inc. Legal Department 4000 Meridian Boulevard Franklin, TN 37067 Attn: General Counsel

11. ASSIGNMENT OF CONTRACT

11.1 The parties agree they will not subcontract or transfer any of its rights or obligations under this Agreement to a third party without the prior written consent of the other party except that either party may assign this contract to a subsidiary or to an affiliated entity under common control.

12. INDEPENDENT CONTRACTOR

12.1 Neither Hospital nor Company shall exercise any control or direction over each other or the services that each other renders and nothing in this Agreement is intended to create any right of either party to intervene in any manner in the methods or means by which either party shall render medical or transportation services. Company and Hospital agree that they are independent contractors performing duties pursuant to this Agreement, and are not partners, agents, or parties in a joint venture.

13. CORPORATE RESPONSIBILITY

13.1 Company has in place a corporate compliance plan, which has as its goal to ensure that Company complies with federal, state and local laws and regulations. It focuses on risk management, the promotion of good corporate citizenship, including a commitment to uphold a high standard of ethical and legal business practices, and the prevention of misconduct. Hospital acknowledges Company's commitment to corporate responsibility and agrees to conduct all business transactions that occur pursuant to this Agreement in accordance with the underlying philosophy and objectives of corporate responsibility adopted by Company as just expressed.

13.2 Both as a material condition to this Agreement and as a continuing representation and warranty for the duration of this Agreement, Company represents and warrants that neither it nor any of its owners, officers, directors or employees, or to its knowledge any agents or subcontractors, have been suspended, excluded or debarred from any government payor program.

14. WRITTEN AMENDMENT/WAIVERS

14.1 This Agreement cannot be amended, modified, supplemented or rescinded except in writing signed by the parties hereto. No waiver of any provision of this Agreement shall be valid unless such waiver is in writing signed by the parties hereto.

15. ENTIRE AGREEMENT, SEVERABILITY

15.1 The provisions of this Agreement, supersede any and all other oral or written representations or agreements of the parties and may not be amended except through written consent of the parties.

15.2 The provisions of this Agreement shall be severable. If any provision of this Agreement is found or asserted to be illegal for any reason and the remaining provisions can reasonably be interpreted in a manner which will effectuate the original intent of the parties and not cause substantial hardship to either party, then such remaining provisions shall remain in force and effect and the illegal provision shall be severed. If any provision of this Agreement is deemed unenforceable by a court of law with competent jurisdiction, it shall be severed insofar as it is declared invalid and the balance of the agreement shall in no wise be affected hereby.

16. GOVERNING LAW

16.1 This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee, without giving effect to its rules governing the conflict of laws. Each party hereto irrevocably submits to the non-exclusive jurisdiction of the District Court of the State of Tennessee, St. Francis County, in any action or proceeding arising out of or relating to this Agreement; provided, however, that matters which are under the exclusive jurisdiction of the Federal courts shall be brought in the Federal District Court for the Eastern District of Tennessee. Each party hereto consents to service of process by any

means authorized by the applicable law of the forum in any action brought under or arising out of this Agreement.

17. BINDING EFFECT

17.1 This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors or assigns; provided, however, that neither party hereto shall assign this Agreement or any rights or obligations hereunder without the prior written consent of the other party hereto, which consent is exercisable within the party's sole and absolute discretion.

18. NOTIFICATION OF LIABILITY

18.1 The parties agree to notify each other as soon as possible in writing of any incident, occurrence, or claim arising out of or in connection with the Agreement, which could result in a liability or claim of liability to the other party. Further, the notified party shall have the right to investigate said incident or occurrence and the notifying party will cooperate fully in this investigation.

19. CONFIDENTIALITY

19.1 The parties agree to maintain confidentiality in compliance with all laws of all information which relates to or identifies a particular patient, including but not limited to the name, address, medical treatment or condition, financial status, or any other personal information which is deemed to be confidential in accordance with applicable state and federal law and standards of professional ethics and will so notify its employees, contractors, subcontractors, agents, and representatives of such agreement.

20. PUBLIC RELATIONS

20.1 The parties agree they will not use the other party's name or the name of any programs of the other party in any advertising, promotional material, press release, publication, public announcement, or through other public media, written; or oral, whether to the public press, to holders of publicly owned stock, or without the prior written consent of the party whose name is to be used.

21. MISCELLANEOUS

21.1 The headings used in this Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement.

21.2 Each party shall execute all documents and take such other actions as any party may reasonably request in order to consummate the transactions contemplated hereby and to accomplish the purposes of this Agreement.

21.3 For the convenience of the parties hereto, this Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument, without necessity of production of the others. Signatures may be exchanged by facsimile transmission, with original signatures to follow. Each party to this Agreement agrees that it will be bound by its own facsimile signature and that it accepts the facsimile signature of the other party to this Agreement.

21.4 Neither this Agreement nor any amendment or modification hereto shall be effective or legally binding upon Hospital, or any officer, director, employee or agent thereof, unless

and until it has been reviewed and approved electronically by a Division President of Community Health Systems Professional Services Corporation, Hospital's Management Company, and by Hospital's Legal Counsel.

21.5 This Agreement is identified on a master list of contracts maintained on an electronic database.

[SIGNATURES EXECUTED ON FOLLWING PAGE]

IN WITNESS WHEREOF, the parties hereto have caused this AGREEMENT to be executed by their duly authorized representatives and thereby becomes effective on the date specified above.

Company: AIR EVAC EMS, INC., a Missouri corporation

TMC

Daniel Sweeza, Vice President of Operations

Date: 8-11-11

Hospital: Cleveland Tennessee Hospital Company, LLC,
d/b/a SkyRidge Medical Center, a Tennessee limited liability company

Mr. Coleman Foss, Chief Executive Officer

Date: 7-26-11

BRADLEY COUNTY EMS General
Contract for Services

1. Parties

This Transportation services contract (hereto referred to as "the agreement") entered into as of **January 01, 2011** is by and between **Tennova Healthcare-Cleveland** with a principal place of business located at: 2305 Chambliss Avenue, Cleveland, 37311 (hereto) referred to as "the facility or hospital") and ***BRADLEY COUNTY EMERGENCY MEDICAL SERVICE,*** with a principal place of business located at 499 Paul Huff Parkway, PO Box 1478, Cleveland, TN 37364-1478 (hereto referred as "the service provider").

2. Duties and responsibility of the Service Provider

2.1 The Service Provider agrees to maintain an applicable business license, and assure that all applicable licenses are current.

2.2 The Service Provider shall maintain professional, workers' compensation and general liability insurance coverage for Service Provider and its employees and authorized agents in the amount required by State Law.

2.3 The service provider agrees to maintain current licenses of all employees providing services to the facility. These licenses shall be available for facility inspection, during normal business hours.

2.4 The service provider agrees that it is a provider in good standing with both Medicare and the facility's Fiscal intermediary.

2.4 Service Provider agrees to be responsible for conduct and behavior of its employees. Furthermore the service provider agrees to handle any and all disciplinary issues involving its employees.

2.5 Service provider agrees to handle all calls for transportation in a timely manner with an average daily emergency response time of around six minutes, and include the service delivered to the Facilities' Cardiac patient transfers. Furthermore the Service agrees to provide a minimum of an Advance Life Support Ambulance and crew to any acute care patient transfers, utilizing Critical Care Paramedics as availability allows.

3. Duties and Responsibility of the Facility

3.1 The Facility agrees to provide adequate access for the performance of said provider services to its patients and provide responding EMS crew with a verbal patient report.

3.2 The Facility will provide with patient transfer, all written information necessary to assist Service Provider in patient care, medical reporting, and billing.

3.3 The Facility further agrees to provide an accurate and current patient face sheet of billing information on all patients transferred to Facility by Service Provider for admission to either, ED, Regular, or ICU admission in a timely, daily or weekly fashion.

3.4 The Facility will offer Service Provider all transfers appropriate for ground transfer.

4. Billing

4.1 The Service Provider agrees to Invoice Facility in a timely manner of patient transports and the billing be appropriate, for the level of care provided. The Service Provider further agrees to Invoice the Facility bimonthly for transports made the previous two weeks.

5. Discounts

5.1 The Service Provider will offer Facility the current "Medicare Allowable Rate" plus mileage for such transfers that are payable by the Facility, if paid within 14 days of receiving an accurate and timely submitted statement of charges. The Service will, with patient billing provide the Facility with a copy of the current Medicare patient allowable for the Service Provider. Payment discount off of charges will be consistent with guidelines provided by Medicare established fee schedules for Medicare Part B services and should not exceed such fee schedule charges if paid in an agreeable timely manner.

6. Transfers payable by the facility

6.1 Transfers requested by the facility or its staff: for inpatient intra facility transfers, outpatient transfers for services not available at Tennova while an inpatient of Tennova. (or any campus or department with the same NPI number, as per Medicare guidelines).

6.2 Other transfers where the patient transportation is a (patient insurance, uncovered service) and is by the choice of Tennova Hospital or its staff and originates with said facility will be the responsibility of the Tennova Hospital.

6.3 Patients requiring medical clearance for potential PineRidge or other psychiatric facility admissions. (or any campus or department with the same NP1 number, as per Medicare guidelines).

6.4 Other non-covered transfers that have been pre- arranged by Tennova administration with Bradley Co. EMS administration.

7. Indemnification

7.1 Fraud and Abuse - Notwithstanding any unrestricted effect of any provision of this Agreement, neither party hereto will knowingly or intentionally conduct itself in such a

manner as to violate the prohibition of fraud and abuse in connection with the Medicare and Medicaid programs (42 USC Section 1320 A-7 B)

8. Confidentiality

8.1 Facility will not disclose or otherwise disseminate, either directly or intentionally, to any person, agency, or entity or use for its benefit or for the benefits of others, any aspect of the Service Provider contract or other confidential information received in connection with this Agreement unless required by law.

9. Termination

9.1 This Agreement shall be effective as of the date hereof and shall continue, for a term of six months, and thereafter it shall be renewed automatically for successive periods of one year, unless otherwise terminated as herein provided. Notwithstanding the foregoing, this Agreement may be terminated by either party for any reason by giving 30 days written notice to the other party.

10. Changes in Medicare rules

10.1 Both parties acknowledge that this agreement should comply with Medicare rules and regulations. It is agreed by both parties that any changes in the Medicare program that has impact on the legality of this contract shall result in that portion of the contract being null and void.

_____ Bradley County EMS
Signature

Print name, title and date Shawn Fairbanks EMS Director

_____ Tennova Healthcare-Cleveland
Signature

Print name, title and date COLEMAN FOSS, CEO 6.26.17

Policy Title: Emergency Transfer of Patient to Another Facility Policy or the Host Hospital

Audience: Free Standing ED Staff and ED Providers; Host Hospital ED Staff and ED Providers

I. PURPOSE:

A. To provide guidelines for transporting the patient requiring inpatient care or emergency care at the host hospital or care at another facility.

B. To provide guidelines allowing skilled personnel and the equipment necessary to deliver the specialized care needed to stabilize, maintain, and transport a patient

II. POLICY:

A. Patients requiring further inpatient procedures or emergency room care/treatments beyond the scope of care of the Free Standing Emergency Room will be transferred to a facility with the necessary services at the discretion of the physician.

III. PROCEDURE:

EXAMPLE

A. The ED Provider requesting transfer is responsible for making arrangements with the accepting facility and the accepting physician.

B. If transferring to the host hospital - the Free Standing Emergency Department (FSED) provider will determine if the patient will be admitted as a direct admit, needs to go to the host hospital Emergency Department (ED) for further evaluation, or needs a subspecialty to see the patient in the host hospital ED. The patient will keep the same FIN number from the FSED to the main ED.

B. Positive acceptance by the receiving facility and physician is necessary prior to transfer.

C. Notify family members of transfer as soon as possible.

E. Patient's condition should be stabilized to a degree that allows for transport based on physician discretion.

F. Ensure that all personal effects accompany the patient or given to family.

G. Give verbal report of patient condition to accepting facility.

H. Copies of ALL relevant patient records and cath images will sent to the receiving facility.

I. Documentation of the mode of transfer, who will accompany the patient and acceptance by a physician, must be documented on the patient's medical record.

Attachment B-Need-A.4

Quality Assurance Program

Policy/Procedure Title	QI Plan/Policy	Manual Location	Administrative Manual / Quality Improvement		
Policy/Procedure #	P-7	Effective	01/04	Page	1 of 23
Department Generating Policy	Quality				
Affected Departments	All				
Prepared By	Jeanette Fetter	Dept/Title	CQO		
Dept / Committee Approval (If Applicable)	QIC	Date/Title	1/9/18		
Medical Staff Approval (If Applicable)	MEC	Date/Title	1/18/18		
Board Approval (If Applicable)	Board	Date/Title	2/27/18		

Tennova Healthcare - Cleveland
Organization-wide Quality Assessment and Performance Improvement Program
2018

Approved By:

Quality Improvement Council – January 8, 2018
Medical Executive Committee – January 18, 2018
Board of Trustees – February 27, 2018

Formulated By:
Jeanette Fetter
Chief Quality Officer
Revised 1/18

Tennova Healthcare - Cleveland
Organization-wide Quality Assessment and Improvement Program
2018

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Tennova Healthcare - Cleveland
Mission Statement

I. Mission and Vision

Mission Statement

Tennova Healthcare – Cleveland is committed to promoting health and wellness by providing excellence in the delivery of comprehensive and compassionate healthcare services.

Vision Statement

Tennova Healthcare – Cleveland's vision is to be recognized as the leading regional healthcare system, by providing superior services and clinical quality.

Values Statement

- We recognize the value of each employee in providing high quality, personalized care to our patients.
- We encourage employee involvement in quality improvement to improve processes on an ongoing basis. We advocate participation in community activities.
- We are committed to involving physicians in partnership, both as consumers of services and as providers in ensuring quality care.
- We are devoted through services, quality, and innovation to providing continued health care leadership in the communities we serve. We are dedicated to compliance with all federal, state, and local laws, rules and regulations, including confidentiality of patient information.

II. INTRODUCTION:

A. Purpose

Tennova Healthcare - Cleveland is dedicated to meeting the needs of our patients in a manner which is consistent with our mission, vision and belief statements. The Organizational Quality Assessment and Performance Improvement plan is designed to provide a systematic and organized program for the promotion of safe, quality patient care and services. The plan outlines improvement principles, organizational structure and approach to continually strive toward our purpose of (1) doing the right things, (2) doing the right things well, and (3) continually improving. Activities are interdisciplinary and collaborative in order to respond to the needs of the customer, patient, physician, employee and community.

Through an interdisciplinary and integrated process, patient care and processes that affect patient care outcomes shall be continuously monitored and evaluated to promote optimal achievements, with appropriate accountability assumed by the Governing Board, Medical Staff, Administration, and support personnel.

B. Quality Definition

We believe quality is a never-ending cycle of continuous improvement.

C. Quality Values

SAFETY & QUALITY

***Patient Safety and Quality*:** Improving patient safety by proactively identifying and improving systems causes of medical errors. We will promote a fair culture in identification of risks to patient safety.

PEOPLE

Effective Communication and Teamwork: We will show all members of our healthcare team respect, empowering them to make decisions and giving them the tools and resources they need to get the job done. We will work as a team to efficiently complete our tasks and to eliminate barriers between departments, job classifications and titles.

Health Promotion: We will partner with our community to provide patients, community members, and Employees with programs and services that increase their control over factors that improve personal health.

Education: We will strive to continuously learn about quality and service excellence, the tools we need to achieve both, and how we can incorporate quality and service excellence into our daily life.

GROWTH

Data – Driven Leadership: Rather than guess, we will measure our performance and progress, discovering where we are, deciding where we could be, and determining how to get there.

FINANCE

Finance/Utilization Management: Improving patient care and safety will be foremost in our minds. Working together, we will monitor and improve resource utilization and efficiency, clinical outcomes, and patient satisfaction.

SERVICE

Service Excellence: Customers come first. We strive to respond to customer needs quickly, efficiently, and graciously.

Our Quality Assumptions:

(1) The quality of a service or product is determined by a careful understanding of the needs & expectations of our customers.
(2) The improvement of the quality of a product or service is continuous.
(3) Quality Improvement involves every staff member in the organization.

D. GOALS

Goals of the Quality Improvement Program are as follows:

- To improve the quality, safety and reliability of patient care processes and outcomes.
- To promote patient safety by prevention and reduction of medical errors.
- To integrate the principles of high reliability into our quality structure and culture.

- Shift the primary focus from the performance of individuals to the performance of the organization's systems and processes, while continuing to recognize the importance of the individual competence of medical staff members and other professional staff.

- To utilize internal and external customer feedback to improve the services necessary to excel in a competitive health care environment.

- To organize data into useful information, including comparison to internal and external data sources.

- To utilize external information sources representing "Best Practices" in the design of systems to improve patient outcomes and processes.

- To promote a culture of continual survey readiness.

- To enhance communication between the Medical Staff, Hospital Department/Services, and the Governing Body regarding the conclusions and recommendations resulting from data analysis and the actions taken to address the findings and recommendations.

E. Scope of Activities

The scope of the Organizational Quality Assessment and Performance Improvement Program encompasses measurement and assessment activities of the Medical Staff, Nursing and Ancillary or support services. Processes and outcomes of care are designed, measured and analyzed by appropriate departments.

Quality Improvement activities will address both clinical and organizational functions. These activities are designed to assess key functions of patient care and to identify, study, and correct problems and improvement opportunities found in the processes of care delivery.

The Board of Trustees, Administration, Department Leaders and leaders of the organized Medical Staff regularly communicate with each other on issues of safety and quality.

III. Organization and Responsibilities of Leaders

A. Responsibilities

Participation in Quality Improvement activities are the responsibility of everyone employed by, on the medical staff of, or contracted with Tennova Healthcare - Cleveland. The organizational Plan for Quality is reviewed and approved annually by the Quality Improvement Council, MEC, and Governing Body.

Governing Board

The Governing Board shall be responsible to ensure the provision of optimal quality care, safety, and organization-wide performance. The Board is ultimately accountable for safety and quality, and has legal responsibility and operational authority for hospital performance. While maintaining overall responsibility, the Board delegates operational responsibility to the Medical Staff and Administration. The Governing Board authorizes the establishment of a multidisciplinary Quality Improvement Council to implement the Quality Improvement Program. The Board shall facilitate Quality Improvement by:

1) Providing direction in setting performance improvement priorities based on our mission, vision, and strategic goals;
2) Establishing an organizational culture that supports a commitment to quality and patient safety;
3) Ensuring the quality program reflects the complexity of the hospital's organization and services;
4) Ensures the quality program is focused on metrics related to improved health outcomes and the prevention and reduction of medical errors;
5) Approve the QAPI Plan;
6) Providing adequate resources, both material and manpower, to accomplish the QAPI function;

7) Reviewing, accepting or rejecting periodic reports on findings, actions, and results of program activities regarding the effectiveness of organization-wide quality and safety activities;
8) Evaluating on an annual basis, the effectiveness of the quality program as a whole, and if necessary, require modification to organizational structure and systems to improve outcomes;
9) Require a process designed to assure that all individuals responsible for the treatment and/or care of patients, whether provided through internal mechanisms or contracted services, are competent.
10) Specifies the detail and frequency of data collection;
11) Annually, reviews a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.

Medical Executive Committee

The Medical Executive Committee, accountable to the Board, shall be responsible for the ongoing quality and safety of medical care and professional services provided by all individuals with clinical privileges, and

1) Participate in organization-wide improvement activities;
2) Have representation on the Quality Improvement Council;
3) Approve the QAPI Plan;
4) Involve Medical Staff members in medical staff departmental measurement, assessment and improvement activities, including peer review;
5) Review results of medical staff quality improvement activities, including OPPE and FPPE

The medical staff shall determine its important aspects of care and priorities and shall also monitor the findings and recommendations of Pharmacy and Therapeutics, Utilization Management Committee, Infection Control and Patient Safety Committee.

Medical Staff

The Quality Assessment and Performance Improvement Program may include monitoring and analysis of a selection of the following medical staff functions as a means for Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation:

Unexpected Complications Review
Medication Use Monitoring
Record of Care Review / Quality of the H&P Review
Blood / Blood Component Usage Review
Mortality / Autopsy Review
Operative / Invasive Procedure Review
Risk Management
Monitoring for Sentinel/ Serious Safety Event
Patient Safety
Infection Control
Utilization Management
Publicly reported metrics/data
Pathology & Radiology Review

Findings from quality review activities are part of ongoing professional practice evaluation, focused professional practice evaluation and the reappointment of medical staff members and those individuals not permitted by the hospital to practice independently. Results of quality review activities are individually profiled for evaluating purposes.

The organized medical staff:

- Participates in developing specific indicators to systematically evaluate practitioner care. This may be accomplished by individual medical staff departments or medical staff committees;

- Identifies and analyzes problems and opportunities, takes appropriate actions and monitors the effect of the actions taken to determine that problems have been resolved or there has been significant improvement to the highest achievable level that can be expected;

- Monitors the appropriateness of clinical practice patterns and significant departures from established patterns of clinical practice;

- Reports Medical Staff QAPI results to the Quality Improvement Council, MEC and Board by way of written reports and summaries.

Senior Leadership

Senior leadership supports the maintenance of the QAPI process through allocation of staff and resources necessary to fulfill the requirements of the program. Leaders also:

- Promote the participation of appropriate staff members and departments in the program through collaborative monitoring and evaluation of patient outcomes and important functions through the Quality Improvement Council;

- Analyze data and information in decision-making that supports the safety and quality of care;

- Perform evaluations of clinically contracted services in collaboration with the respective department director and reporting the results of the evaluation to the Quality Improvement Council, Medical Executive Committee and the Board.

- Regularly evaluate the culture of safety and quality using valid and reliable tools.

Nursing Leadership

Nursing Leadership leads performance improvement initiatives for nurse sensitive indicators and is accountable to Administration, the Quality Improvement Council and the Board for the quality and safety of care/services and performance of their staff and departments. The CNO, ACNO and Nurse Managers are responsible for the systematic monitoring and analysis of the quality and safety of care provided in their departments. These Leaders will:

- ❑ Communicate opportunities for improvement to the Quality Improvement Council for prioritization
- ❑ Promote the development of standards of care and criteria to objectively measure the quality and safety of care/services rendered in their departments.
- ❑ Monitor, analyze and report the processes in their areas that affect patient care, safety, outcomes, efficiency, and satisfaction.
- ❑ Design and redesign work processes to improve safety and quality.
- ❑ Nursing Leadership members are responsible to collect data as appropriate, including:

    - Operative/invasive procedure review
    - Use and outcomes of moderate sedation or anesthesia
    - Blood/blood components and transfusion reactions (Laboratory/Nursing)
    - Results of resuscitation and rapid response processes
    - Falls
    - Infections
    - Complaints and Grievances
    - Restraint Use

- ❑ Participate in quality improvement teams.

- ❑ Report Quality Improvement findings and actions taken to the Chief Quality Officer/Quality Director, Quality Council, Medical Staff, and others as appropriate.
- ❑ Communicate the status of departmental quality, patient safety, and survey readiness initiatives regularly to departmental staff members.
- ❑ Evaluate the performance of all clinically contracted services and report the results of the evaluation to the Quality Management Department for reporting in applicable committee(s).

Quality and Regulatory Compliance

The Quality and Regulatory Compliance department shall be responsible to support the organization's Quality Improvement principles, strategies, priorities, approach, and methodologies, which includes but is not limited to the following tasks:

1) Working with the Medical Staff, patient care and other hospital departments/services, and teams to effectively measure, assess, analyze, and improve the quality and safety of care and services.
2) Coordinate Quality Improvement orientation, education and training.
3) Facilitate and support Quality Improvement teams.
4) Coordinate survey preparations and facilitate a culture of continual survey readiness.
5) Maintain the database for all QAPI activities including quality improvement teams, departmental quality measures, medical staff quality and peer review activities.
6) Conducts an annual organization-wide evaluation of the Quality Program.
7) Communicates quality improvement activities throughout the organization and regularly to the Quality Council, MEC, Medical Staff and Board.
8) Works closely with Risk Management to monitor/analyze serious safety events and/or sentinel events and promote patient safety.
9) Ensures the hospital selects meaningful quality measures that address the needs of the patients it serves.
10) Provides reports using statistical tools & techniques to analyze and display data.
11) Compares internal data over time to identify patterns, trends and variations.
12) Compares data with external sources.

Hospital Departments

The Department Leaders are accountable to Administration, the Quality Improvement Council and the Board for the quality and safety of care/services and performance of their staff and departments. Department Directors and Managers are responsible for the systematic monitoring and analysis of the quality and safety of care provided in their departments. Directors will:

- ❑ Communicate opportunities for improvement to the Quality Improvement Council for prioritization
- ❑ Promote the development of standards of care and criteria to objectively measure the quality and safety of care/services rendered in their departments.
- ❑ Monitor, analyze and report the processes in their areas that affect patient care, safety, outcomes and satisfaction.
- ❑ Design and redesign work processes to improve safety and quality.
- ❑ Department Managers are responsible to collect data as appropriate, including:
    - Blood/blood components and transfusion reactions (Laboratory/Nursing)
    - Results of resuscitation and rapid response processes
    - Patient complaints/grievances
    - Adverse Events
- ❑ Participate in quality improvement teams.
- ❑ Report Quality Improvement findings and actions taken to the Chief Quality Officer/Quality Director, Quality Council, Medical Staff, and others as appropriate.
- ❑ Communicate the status of departmental quality, patient safety, and survey readiness initiatives regularly to departmental staff members.

- ❑ Evaluate the performance of all clinically contracted services and report the results of the evaluation to the Quality Management Department for reporting in applicable committee(s).

Quality Improvement Council

Quality Improvement Council is the hospital-based multidisciplinary body that serves to oversee, coordinate and direct organizational quality improvement activities. The Council's primary function is to set guidelines for monitoring and evaluation of patient care and safety and to direct improvement action when those measures do not meet expectation. Membership includes but is not limited to representatives from both clinical and non-clinical areas including the Medical Staff, Senior leadership (CEO, CNO, CQO, CFO), Quality Coordinator, Risk Management/Patient Safety Officer and other clinical and non-clinical staff as appropriate on an ad hoc basis. Council meetings are at minimum, ten per year. All members may vote. Activities include but are not limited to:

1) Develop, evaluate, modify, and approve the Quality Improvement Plan
2) Considers the setting, scope and services provided and selects meaningful measures addressing the needs of the patients served
3) Set priorities for ongoing measurement of important processes
4) Evaluating the need to reprioritize improvement activities in response to unusual or urgent events identified through measurement and/or changes in the environment of care or community
5) Receive and review reports regarding the effectiveness of organization-wide QAPI activities
6) Review new service proposals ensuring appropriate quality measures are established
7) Analyze and identify trends or patterns that might suggest an improvement opportunity
8) Compare data with external sources when available
9) Review and act upon Opportunity/Process Improvement Referrals
10) Support quality improvement teams, acting upon their recommendations
11) Convening multidisciplinary QI teams for specific improvement efforts, some of which may be triggered by the results of ongoing measurement and/or customer feedback
12) Communicating relevant activities, as necessary, throughout the organization
13) Review Customer Service Surveys, QI Teams, Risk Management, Hospital Committees, Resource Management reports and other executive level data/information impacting organization quality and safety
14) Evaluate the effectiveness of the QAPI activities of the hospital departments and teams
15) Integrate findings and outcomes of reviews conducted by the Medical Staff that identify systems process issues
16) Determine the education and training needs of the organization related to Quality Improvement
17) Evaluate and validate corrective action has resulted in improvement
18) Reporting to the Medical Staff and Board of Trustees
19) Maintain a permanent record of council proceedings

Quality and Patient Safety Integration

It is essential the Patient Safety Program and Quality Assessment and Performance Improvement Program are integrated to assure the flow of information to the appropriate areas for review, action, and/or follow-up. The Quality and Risk Management programs seek to reduce the frequency and severity of adverse events, thus minimizing loss and contributing to Quality Improvement through risk identification, evaluation, control and education. The Chief Quality Officer and Risk Manager and/or Patient Safety Officer both identify conditions/significant events which could or have caused injury or loss; will monitor resolution of risk-related problems; plan/provide appropriate education to employees, Medical Staff, Governing Body and interact with the Medical Staff Administration; Nursing and Clinical Services.

Risk Management analysis of Safety Events includes the adequacy of staffing, including nurse staffing. The adequacy of staffing includes the number, skill mix and competency of staff.

Annually provides a written report to the Board on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.

The Risk Manager and/or Patient Safety Officer attend(s) the Quality Improvement Council and provide reports as specified by the Council.

- ❑ EOC and Patient Safety reports are presented to Quality Council at least quarterly
- ❑ Event Reports involving potential or actual quality issues will be referred to and evaluated by the Risk Management Department. Issues are referred to the Chief Quality Officer for Medical Staff review as appropriate.
- ❑ A quarterly summary of the above will be reported through the established hospital committees reporting channels.

B. Establishing Priorities for Quality Improvement

Priorities for Quality Improvement shall be established collaboratively by the Board, Senior Leadership and Medical Staff Leadership. The following criteria will be considered in establishing priorities:

- ❑ Mission, Vision and Values
- ❑ Strategic Plan, Community needs
- ❑ Needs and expectations of patients and families and other customers
- ❑ Input from Medical Staff and Employees
- ❑ High Volume diagnoses/procedures/processes
- ❑ High Risk diagnoses/procedures/processes
- ❑ High cost diagnoses/procedures/processes
- ❑ Problem prone procedures/processes
- ❑ Input from external sources (licensing, regulatory agencies)
- ❑ Clinical competency and training needs
- ❑ Resources required to make the improvement, both human and material
- ❑ Prioritization Tool (Attachment)

Prioritization

The Quality Improvement Council will oversee the setting of priorities for quality improvement activities. Items/topics will be evaluated by the Quality Improvement Council utilizing the priority scoring grid (see attached). The Council will evaluate the combined scores of each opportunity prioritized and take appropriate actions using the following guide:

Score	Potential Council Decisions
0 – 10	Trend data
11 – 24	Refer to Department Chairperson or Manager for action
25-34	Refer to Administration
35-45	Possible Improvement Team or other single action
Over 45	Required Quality Improvement Team

Reprioritization

Quality Improvement activities may be re-prioritized by the Quality Improvement Council based on needs and resources. Issues may be reprioritized in response to sentinel/serious safety events identified, through quality indicators tracking and trending, unanticipated adverse occurrences affecting patients, changes in regulatory requirement, changes in patient population, in the environment of care, and/or changes in the expectations or needs of patients, staff or the community.

Reporting

Quality Council reports the results of monitoring activities and the improvement action plans as appropriate to the Medical Executive Committee, Administration, and Board on at least a quarterly basis.

C. QUALITY IMPROVEMENT TEAMS

Composition:

Teams are made up of individuals with expertise relating to the processes of care being evaluated. *(Refer to "Guidelines for Quality Improvement Teams" manual).*

Activating a Team

Any employee or Medical Staff member may forward a request for a team to the Quality Improvement Council. Each referral will be evaluated and prioritized by the QIC or a sub-committee assigned by the QIC. If the problem/process involves more than one department, the QIC may authorize the formation of the Team, and assign a Team Leader. If the problem/process affects a single department, the QIC will forward the referral to a single department for intra-departmental team development. It is imperative that departmental leadership allow staff member(s) time to participate in order for the team to be successful.

IV. Design – Quality Methodology

A. Methodology

The IDEA Cycle model/process for performance improvement is utilized as the methodical approach to Quality Assessment and Performance Improvement initiatives.

B. Measure

The monitoring and analysis process will include at least the following activities:

- Core Measures and other Value-Based Purchasing (VBP) metrics
- The use of blood and blood components
- All reported and confirmed transfusion reactions
- Significant medication errors
- Significant adverse drug reactions
- Processes related to the National Patient Safety Goals
- Pharmacy and Therapeutic Evaluation
- Medication Variances and the Medication Management System
- Analyze the Organ Procurement conversion rate data as provided by the OPO
- Morbidity and Mortality
- Operative, Invasive and Non-invasive Procedures that place the patient at risk
- Significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- Medical Record Completion & Timeliness, including the quality of the H&P
- Infection Control Surveillance
- Financial/Resource Data (financial consideration as it relates to care and services provided).
- Utilization Review
- Patient perception of the safety & quality of care, treatment or services
- Autopsy Reviews

- Risk Management/Patient Safety data and reports, including the effectiveness of fall reduction activities
- Restraint Reduction Activities; Serious Safety Events
- The use of seclusion; use of restraint
- Adverse Events related to using moderate or deep sedation and anesthesia
- Pain Assessment and Management to Include Safe Use of Opioids
- Surveillance of Equipment and Utilities Maintenance Programs
- Surveillance of Safety and Life Safety Programs
- Review of unexpected and/or serious complications
- Comparison of hospital performance through reference databases
- Analyzing and responding to reports of surveys, assessments, licensing, regulatory, and reimbursement authorities
- Evaluation of the needs, expectations, and satisfaction of patients, physicians, employees
- Staff willingness to report adverse events and suggestions for improving patient safety & quality of care
- The results of resuscitation and Rapid Response Processes
- Grievances and Complaints
- Evaluation of processes in response to Patient Safety Alerts from internal or external sources
- Evaluation of processes in response to The Joint Commission Sentinel Event Alerts
- The results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.
- Behavior management and treatment
- Evaluation & improvement of conditions in the environment
- Infection Prevention
- Review and analysis of incidents where the radiation dose index (Computed Tomography Dose Index), dose length product, or size-specific dose estimate from diagnostic CT exams exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks.
- Pain management
- Quality Control monitoring in:

  Clinical laboratory services
  Diagnostic radiology services
  Nutrition/Food services
  Equipment PM
  Nursing Services
  Pharmacy
  Physical Therapy

- Processes related to ongoing professional practice evaluation and focused professional practice evaluation

- Sentinel Event Occurrences/Serious Safety Events as specified in Sentinel Event Policy.

  - Other occurrences such as "Never Events" that may be classified as a Sentinel Event

The hospital will conduct a root cause analysis, and other investigations as appropriate, in response to a sentinel event, serious safety event or significant near miss. The root cause analysis involves an internal investigation and assessment of the sentinel event to reduce variations and prevent the event from recurring in the future.

Design of New Processes

When it is established that there is a need or opportunity to initiate a new service, extend product lines, occupy a new facility, or significantly change existing functions or processes, the design will be based upon the organization's mission, vision and plans. The needs of the patients, staff, and all who use this service will be considered and up-to-date sources of information shall be used to design the process or service.

Quality Measures

Measures for periodic assessment and improvement arise from Employees, Leadership Group, Quality Improvement Council, Medical Staff and other sources. Important functions and processes of care are selected on the basis of which most significantly impact patient care. These may be included, but not limited to the following:

- ❑ Problem Prone/High Risk/Volume Processes
- ❑ Utilization Review and Risk management findings
- ❑ Results of ongoing activities designed to control and prevent infections
- ❑ Patient Safety and the reduction of medical errors
- ❑ Importance to patient/customer

Data Collection

The staff collects, organizes and analyzes data necessary to determine root causes, track performance, benchmarking, etc. Data is organized in such a manner as to facilitate comparison and trends. The data collection is conducted in a timely and efficient manner. Statistical techniques and data displaying "tools" will be utilized. Tools may include but are not limited to: charts and graphs, Run Charts, Histograms, Pareto Charts, Flow Charts, Cause and Effect diagrams (Fishbone Diagrams), Control Charts, etc.

Frequency of Data Collection

The frequency of data collection and measurement is related to:

1) The frequency of the event (affect a large percentage of patients)
2) Problem prone processes
3) The significance of the event or process monitored:

    a) What the leaders view as most important
    b) The extent to which the important aspect of care, processes, and outcomes monitored has been demonstrated to meet expectation or be problem free
    c) Customer satisfaction responses to measure the extent that the organization meets the needs and expectation of patients/families
    d) Priority issues and adverse/significant events may require more detail and frequency of measurement activities.

The Governing Body specifies the frequency and detail of data collection.

Sample Size

When sampling is appropriate, the representative sample number is determined by the situation or process under review, i.e. intensive review vs. random review. The Quality Improvement Council or medical staff may assist in determining sample size. The below illustration is also recommended as a guide for sample size:

- For a population size of fewer than 30 cases, sample 100% of available cases.
- For a population size of 30 to 100 cases, sample 30 cases.
- For a population size of 101 to 500 cases, sample 50 cases.
- For a population size greater than 500 cases, sample 70 cases.

A *case* refers to a single instance in which a situation related to a survey finding occurs.

Population size totals may be interpreted as "annually" unless otherwise specified by the QIC or medical staff.

C. ASSESS

Monitoring and Analysis:

Responsibility for measurement activities is assigned/delegated by the QIC. Data resources available for use in QI activities includes, but is not limited to:

- Core Measures, STAR Ratings and Other Publicly Reported Data
- The Medical Record
- Department Specific Indicators
- QIO Data
- Organ Procurement Organization
- Tumor Registry
- Mortality and Morbidity Reviews
- Clinical Outcomes Review
- Federal and State generated outcome data reports (including QIO reports, OBQI, Nursing Home Compare)
- Established standards of care
- Financial data
- Staff interviews or observations
- Data originating from third party payers/fiscal intermediaries
- Preventive maintenance records
- External benchmarking reports
- Internal databases
- Surveillance surveys (safety, life safety, infection control, hazardous materials)
- Vital Statistics
- Sentinel Event Alerts and other external sources of patient safety information
- Census/Financial data
- Utilization Review findings
- Autopsy Reviews
- Risk Management/Patient Safety Data and reports
- Customer Service Reports; Patient, Staff and Physicians
- Surveillance surveys (safety, life safety, infection control, hazardous materials)
- Comparison of hospital performance through reference databases
- The adequacy of staffing, including nurse staffing

Quality Improvement statistical tools will be used to assess and/or compare the Organization:

- ❑ With self over time, through assessment of variations, patterns, and trends
- ❑ With others, including the use of data bases from Corporate and/or private industry
- ❑ With standards such as practice guidelines/parameters
- ❑ With best practices

The assessment process includes conduction of specific and intensive assessment for:

- Important major discrepancies between pre-op and post-op
- For confirmed hemolytic transfusion reaction
- For significant adverse drug reaction as defined by Pharmacy
- Patterns or trends outside those expected
- Variation in the organization's performance data as compared to that of other organizations, or a recognized standard
- When the organization wishes to improve already good performance

When evaluating the results from an intensive assessment, the hospital will focus on processes, however, when the findings from intensive assessment are relevant to individual performance, the following shall occur:

Medical Staff:

- ❑ Referral to appropriate Medical Staff Leader or Committee for individual case review
- ❑ A focused review may be initiated when a trend or pattern develops, or when a practitioner exceeds established OPPE triggers (see Appendix D of the Medical Staff Bylaws)

Hospital Staff:

Each department Manager will review information relevant to individual staff performance and this information will be used to prioritize and strategize individual and unit education needs.

D. IMPROVE

Improvement opportunities are identified by departmental and organizational QI activities, customer satisfaction surveys, sentinel/serious safety events, hospital/medical staff committees, opportunity for improvement forms and through formal and informal networking of all Employees.

Appropriate action will be recommended and implemented to eliminate or reduce variations identified or to improve quality of care. Multidisciplinary QI Teams will be initiated at the direction of the Quality Improvement Council to address identified opportunities.

Re-design/Design of Improvement Initiatives (Re-Assessment Process)

The effectiveness of any action taken is assessed and documented. Periodic monitoring of the results of correction action, including re-design of processes, will be conducted to make sure that any problems identified have been alleviated or eliminated and the improvement sustained. Any design/re-design initiative(s) will be evaluated for their effectiveness. If the specific area does not show improvement, new actions/design will be taken and, once again, the effectiveness will be assessed.

V. Communication and Reporting

To coordinate the quality improvement activities throughout the organization, the Chief Quality Officer/Quality Director will receive and have access to all QI information. Department leaders will communicate their quality activities and performance to their Employees, to the Senior Leader to whom they report, and/or to the Quality Coordinator (due by the 15th of the following month), using the approved reporting forms and format. Measurement and assessment activities are reported to the Quality Improvement Council, Medical Executive Committee, and to the Governing Board on at least a quarterly basis. (see attachment Organizational Committee Structure/Information Flow)

Feedback from organizational QAPI activities is provided at Leadership group meetings, in departmental staff meetings, hospital newsletters and between the Quality Improvement Council, Medical Executive Committee and Board as appropriate.

VI. Staff Development/Education

Staff will be introduced to Quality Assessment and Performance Improvement concepts and objectives during new Employee orientation, department staff meetings, hospital publications and inservices as needed. Employees are encouraged to participate in the team process which provides additional "just in time" training.

VII. Annual Program Evaluation

The effectiveness of the Quality Assessment and Performance Improvement Program is evaluated annually and revised as necessary. Results of the evaluation will be compiled and reported to MEC, Board of Trustees, Quality Council and Department Leaders.

VIII. Conflict of Interest

The Hospital manages conflict between leadership groups to protect the quality and safety of care.

IX. Confidentiality

Confidentiality shall be maintained, based on full respect of the patient's right to privacy and in keeping with Hospital Policy and State and Federal Regulations governing the confidentiality of quality improvement work products. Information reported to or provided by the CHS PSO will be protected in accordance with the policies and procedures of the CHS PSO, LLC.

X. Retention of Records

All minutes of meetings are maintained permanently either in their original form or electronically. Cumulative quality improvement activity reports are maintained for three years either in their original form, or electronically.

XII. APPENDICES

A. QAPI Model (i.e. PDCA, IDEA Cycle or other Performance Improvement Model)

B. Opportunity Referral System

   Opportunity Referral Form

C. Committee Structure

   Flow of Information

D. Priority Scoring Grid

   Team Assignment Form, Charter Team Form, Interim Team Report, Team Final Report

E. Medical Record Review

   Sample Medical Record Review Form

F. Medication Use Review

   Sample MUE Report

G. Operative/Invasive Procedure Review

Sample Review Calendar

Sample Review Tool

H. Mortality / Autopsy Review

Sample Review Tool

I. Blood Usage Review

Sample Blood Products Review Form

Sample Monitoring Tool

OTHER:

Peer Review Appendix D to the Medical Staff Bylaws

External Peer Review

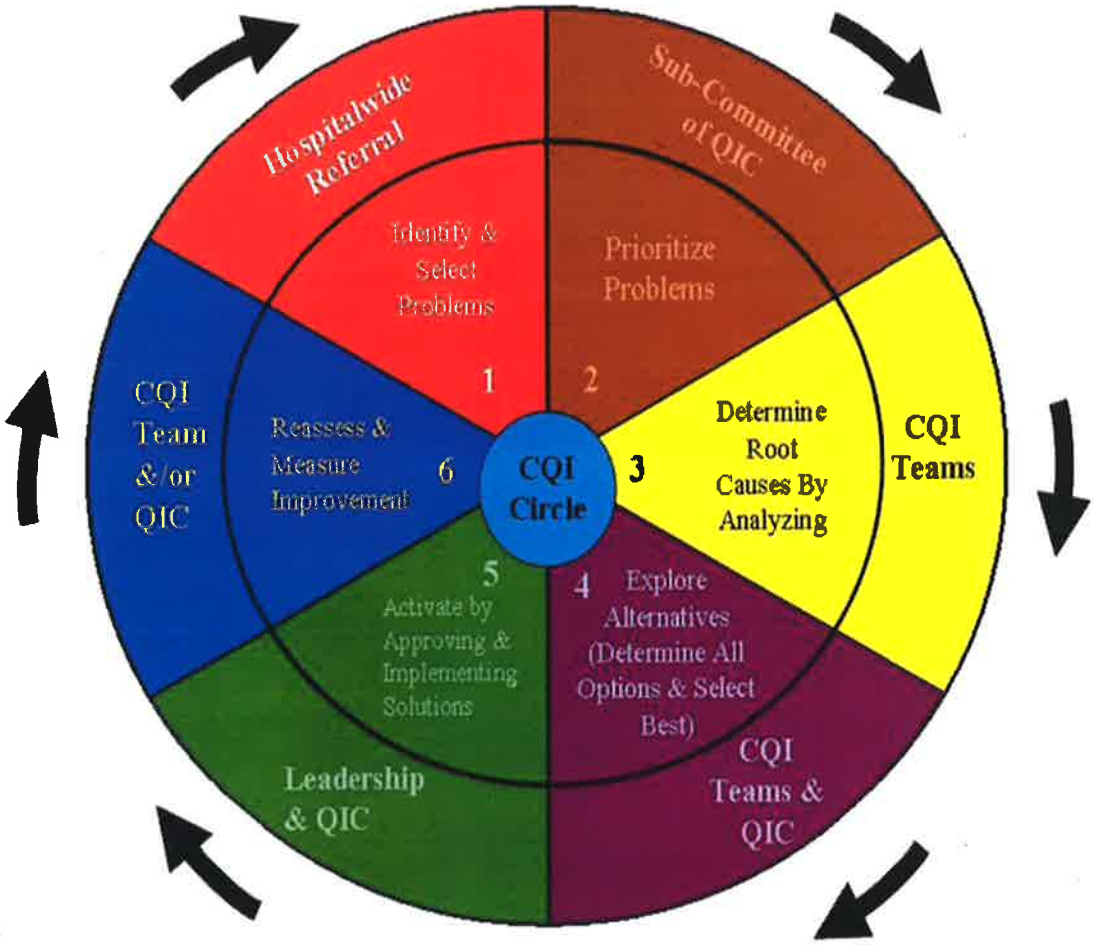
Pathology Peer Review

Radiology Peer Review

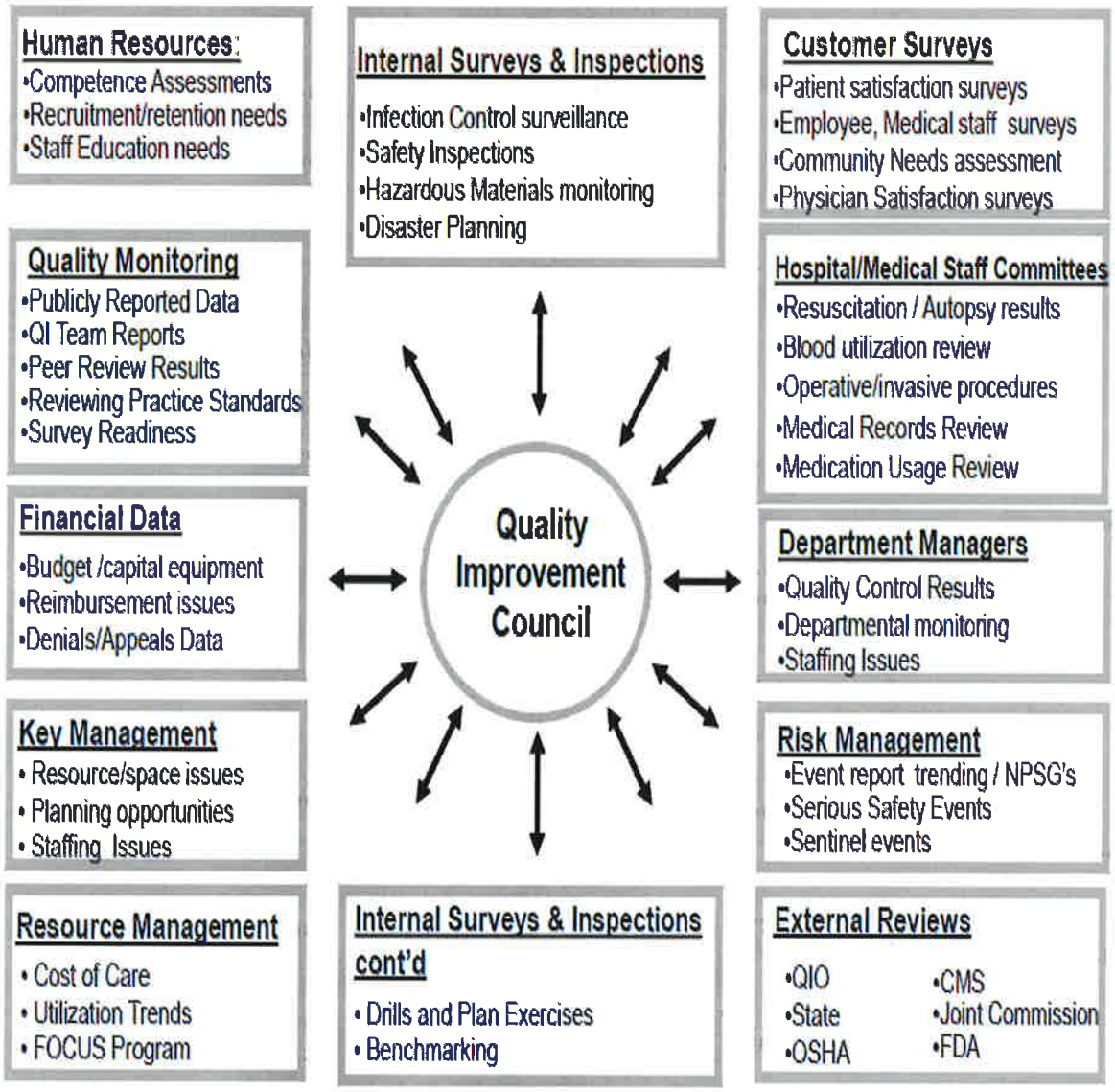
The *IDEA* Cycle

The CQI Approach to Problem Solving

Plan - Design - Measure - Assess - Improve



IDEA Cycle
Opportunity Referral System



APPENDIX B

Opportunity for Improvement Form (OFI)

Date: _____ FROM: _____

Opportunity / Problem:

How Long/Often Has This Occurred?

Previous Action(s) Taken to Solve Problem (if known)

Reason For Referral:

____ **Opportunity for Improvement** ____ **Solve a Known Problem**

____ **Evaluate Stability of Process** ____ **Other**

Process / Outcome is Being Measured Because it is:

____ **High Risk** ____ **High Volume** ____ **Problem Prone** ____ **Other**

Does the Problem Cross Departmental Lines? ____ **Yes** ____ **No**

List All Affected Departments:

Circle All Priorities Impacted By This Problem:

Life Threatening	**Potential Liability**	**Safety/Patient Safety**
Ethical Impact	**↓Customer Satisfaction**	**Impacts Regulatory Compliance**
Public Relations	**Increased Cost**	**Potential for Complications**

What Are Possible Solutions To This Problem?

Any Additional Comments:

NOTE: Prioritization scoring will be completed by the Quality Improvement Council or at a Department Manager Meeting using the approved Prioritization Form, with results to be reported to and confirmed by the Quality Improvement Council.

ONLY the Quality Improvement Council charters Quality Improvement Teams.

Quality Improvement Council designee to complete this section:

PRIORITIZATION SCORE: _____

RECOMMENDED ACTION:

_____ Trend Data

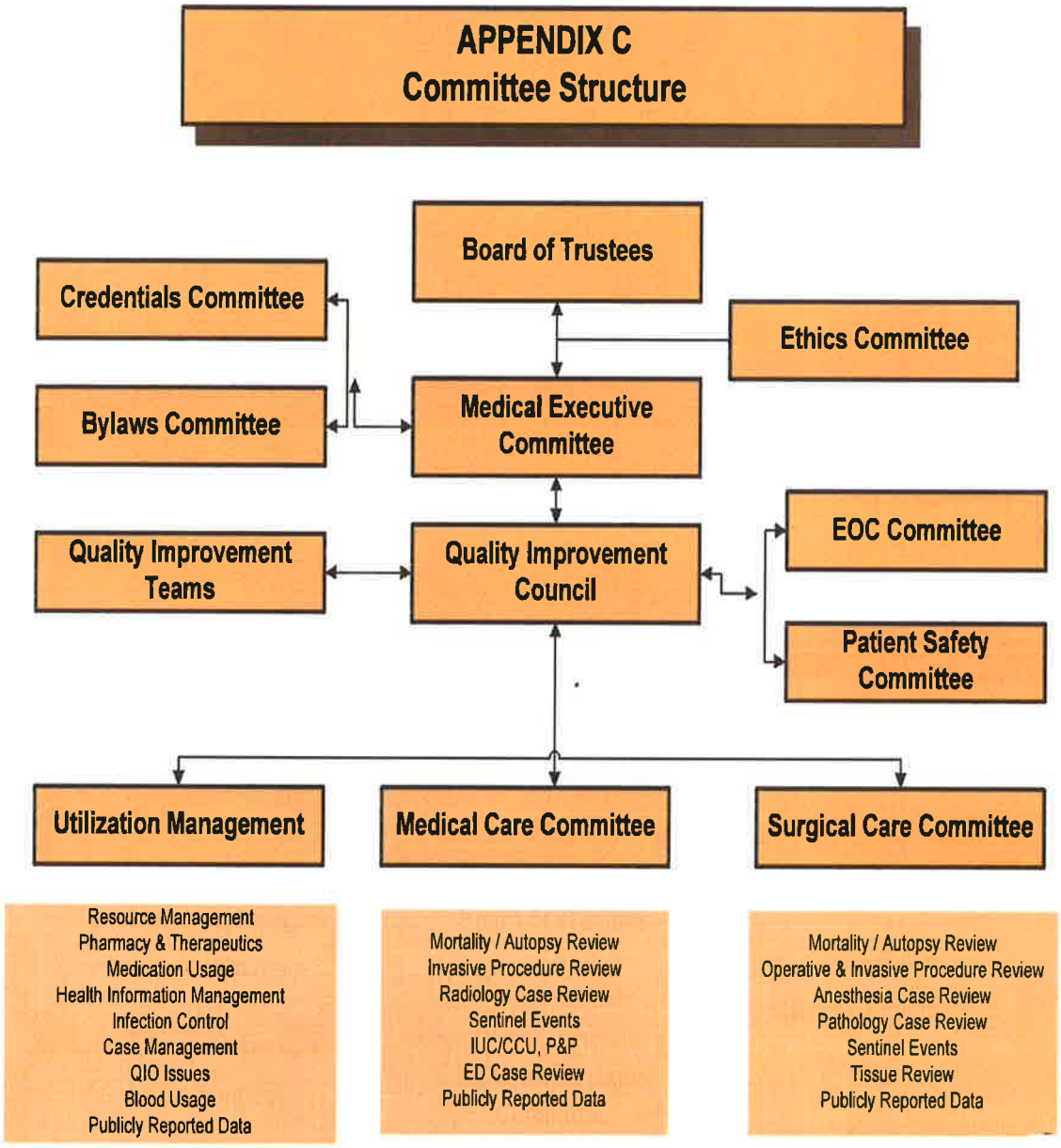
_____ Referred to Department Manager

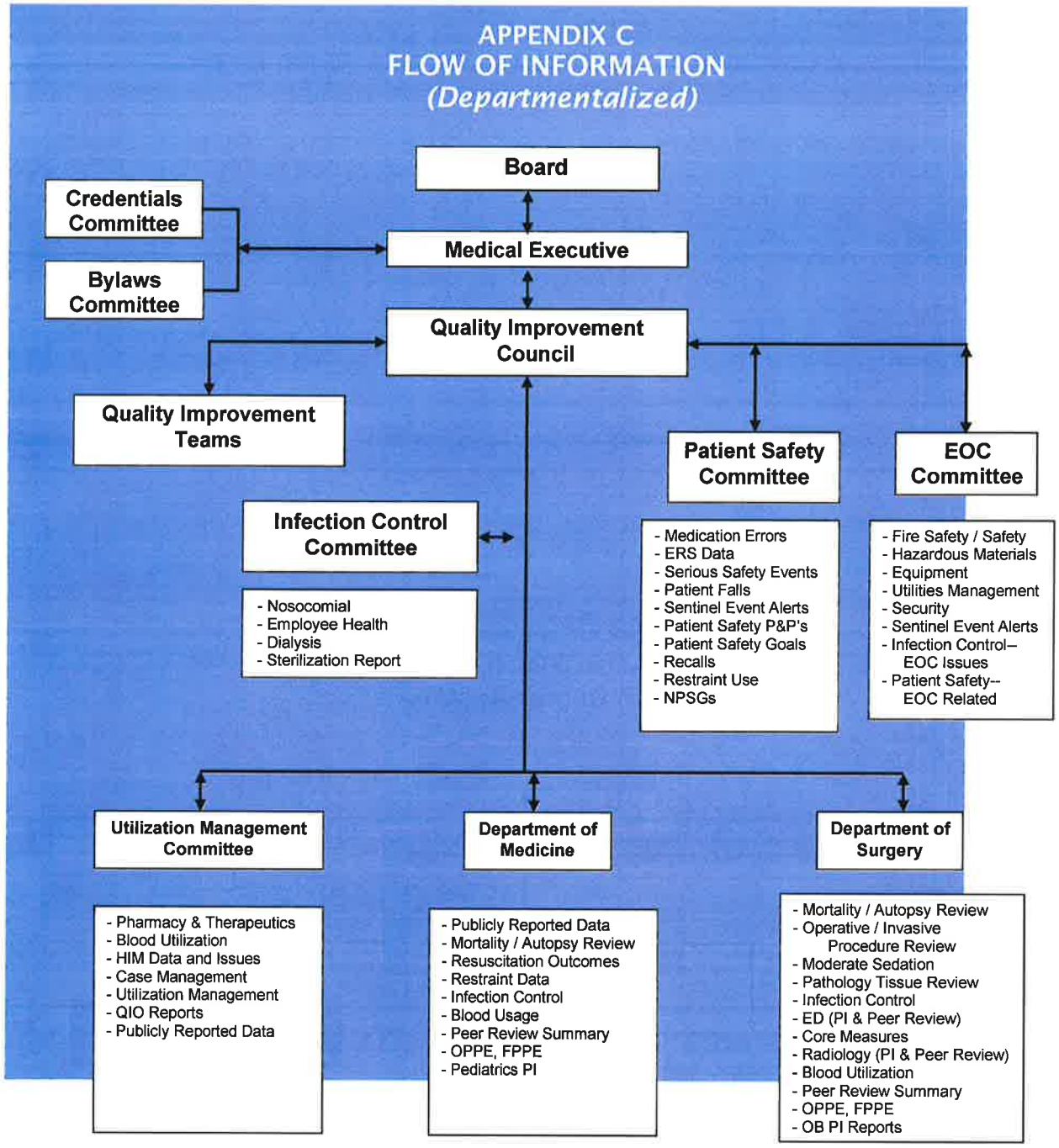
_____ Referred to Administration

_____ Quality Improvement Team

_____ Other

APPENDIX C


APPENDIX C
Committee Structure
Board of Trustees
Credentials Committee
Ethics Committee
Bylaws Committee
Medical Executive Committee
Quality Improvement Teams
Quality Improvement Council
EOC Committee
Patient Safety Committee
Utilization Management
Medical Care Committee
Surgical Care Committee
Resource Management
Pharmacy & Therapeutics
Medication Usage
Health Information Management
Infection Control
Case Management
QIO Issues
Blood Usage
Publicly Reported Data
Mortality / Autopsy Review
Invasive Procedure Review
Radiology Case Review
Sentinel Events
IUC/CCU, P&P
ED Case Review
Publicly Reported Data
Mortality / Autopsy Review
Operative & Invasive Procedure Review
Anesthesia Case Review
Pathology Case Review
Sentinel Events
Tissue Review
Publicly Reported Data


APPENDIX C
FLOW OF INFORMATION
(Departmentalized)
Board
Credentials Committee
Bylaws Committee
Medical Executive
Quality Improvement Council
Quality Improvement Teams
Patient Safety Committee
EOC Committee
Infection Control Committee
- Nosocomial
- Employee Health
- Dialysis
- Sterilization Report
- Medication Errors
- ERS Data
- Serious Safety Events
- Patient Falls
- Sentinel Event Alerts
- Patient Safety P&P's
- Patient Safety Goals
- Recalls
- Restraint Use
- NPSGs
- Fire Safety / Safety
- Hazardous Materials
- Equipment
- Utilities Management
- Security
- Sentinel Event Alerts
- Infection Control– EOC Issues
- Patient Safety-- EOC Related
Utilization Management Committee
Department of Medicine
Department of Surgery
- Pharmacy & Therapeutics
- Blood Utilization
- HIM Data and Issues
- Case Management
- Utilization Management
- QIO Reports
- Publicly Reported Data
- Publicly Reported Data
- Mortality / Autopsy Review
- Resuscitation Outcomes
- Restraint Data
- Infection Control
- Blood Usage
- Peer Review Summary
- OPPE, FPPE
- Pediatrics PI
- Mortality / Autopsy Review
- Operative / Invasive Procedure Review
- Moderate Sedation
- Pathology Tissue Review
- Infection Control
- ED (PI & Peer Review)
- Core Measures
- Radiology (PI & Peer Review)
- Blood Utilization
- Peer Review Summary
- OPPE, FPPE
- OB PI Reports

APPENDIX D

APPENDIX D
Quality Improvement Priority Scoring Grid

Issues Identified							
Impact	***Value***						
Life Threatening	10						
Potential for complication	8						
Safety	8						
Increased Cost	5						
↓ Customer Satisfaction	5						
Potential Liability	5						
Impacts Regulatory Compliance	8						
Ethical Impact	2						
Public Relations	2						
Strategic Plan Impact	Yes / No						
Mission/Vision Impact	Yes / No						
Total Points	53						
QC Actions	Date						

Quality Improvement Action Guidelines

Score:	0 - 5	Trend Data
	6 - 10	Refer to Department Chairperson or Manager of Action
	11 - 15	Refer to Executive Committee or Key Management
	16 - 25	Possible Quality Action Team
	Over 25	Required Quality Action Team

A team decision is when:	*An individual decision is when:*
• The need exists to combine old and new information requiring brainstorming, data gathering, and innovation.	• There is no need for extensive data gathering.
• The situation does not require an immediate action	• Quick decision is required.
• Consensus is needed to make the solution work	• Consensus is not needed.
• The problem is a process problem	• The problem is a people or performance problem.
• The problem crosses departmental boundaries.	• The problem stays within one department
• The process seems to be very complex.	

APPENDIX D

QUALITY IMPROVEMENT TEAM
Charter Request Form

Opportunity Referred From: _____ Date: - _____

Process / Outcome to be Measured or Addressed:

Opportunity Statement:

Does the process stay within a department? _____Yes_____ No Dept: _____

Does the process cross departmental lines? _____Yes _____ No

Department		Person(s) Involved	

How long / often has the problem/issue occurred?

Previous actions taken to solve (if known):

Reason: Opportunity for Improvement _____ Solve a Known Problem/Process _____

_____ Evaluate Stability of Process _____ Other

Process is being measured because it is:_____ High Risk _____ High Volume _____ Problem Prone

When and where is the problem occurring?

When	Where

Indicate the areas you feel are impacted by the problem/issue:

	Life Threatening		Safety/Patient Safety		Decreased Satisfaction
	Impacts Regulatory Compliance		Public Relations		Potential for Complications
	Increased Cost		Potential Liability		Ethical Impact

Important Functions which process/problem relates to:

	Patient Rights/Ethics		Improving Organizational Performance
	Education		Environment of Care
	Leadership		Human Resources
	Infection Control		Patient Safety
	Management of Information		Provision of Care

Dimensions of Performance Measured:

	Efficacy		Appropriateness		Availability
	Timeliness		Effectiveness		Continuity
	Safety / Patient Safety		Efficiency		Respect and Caring

Anticipated length of time for Team Problem Resolution:_____

Additional Comments:

_____

_____ Signature

_____ Department

_____ Extension

*Scoring to be completed at department manager's meeting. All results to be reported to Quality Improvement Council and communicated to staff at their department meetings. All teams must be approved by the Quality Improvement Council prior to formation.

For Quality Improvement Council Use Only

Date:_____ Prioritization Score: _____

Referred To:_____ Trend Data_____ Dept Manager_____
Administration_____

QI Team_____ Other _____

First Report Due: _____

Appendix D

QUALITY IMPROVEMENT TEAM
Team Assignment

Date:
To:
Chairperson:
PI Team:

<See attached Quality Improvement Charter Form>

Assigned Team Members	Department

Special Instructions:

Responses Due: _____ Interim Status Report Date: _____

_____ Final Recommendation Date: _____

Quality Improvement Council Contact:

Quality Officer:

APPENDIX D

QUALITY IMPROVEMENT TEAM
Team Interim Report

Date: _____

TO: Quality Improvement Council

FROM: _____ Chairperson

TEAM: _____

Current Team Status:

Action / Activity	Yes	No
Has the problem/issue been analyzed?		
Is the attendance of team members a problem?		
Is additional information needed?		
Has information been requested?		
Is progress being made toward a recommendation for corrective action?		
How many times has the team met?		
Expected date of completion:		

Comments:

APPENDIX D

SUMMARY OF QI PROJECT
Team Final Report

To be completed by team leader upon resolution of project

IDENTIFY

Category: ☐ Team ☐ Task Force ☐ Focus Study

Improvement Opportunity Identified:

_____

_____

Project Initiation Date: _____ Project Resolution Date: _____

Key Function Improved:

_____

Dimensions of Performance Addressed: ☐ Efficiency ☐ Continuity ☐ Availability

☐ Respect & Caring ☐ Appropriateness ☐ Safety
☐ Timeliness ☐ Effectiveness

DETERMINE

Summary of recommended/implemented improvement actions:

_____

_____

_____

_____

EXPLORE

Evidence of Resolution or Improvements:

_____

_____

Outcome(s) Achieved:

☐ Reduced costs ☐ Improved patient outcomes ☐ Reduced employee turnover

☐ Improved skills ☐ Increased ability to recruit/retain staff ☐ Increased staff satisfaction
☐ Improved continuity of care ☐ Improved productivity/efficiency ☐ Meet JC requirements
☐ Reduced errors ☐ Improved hospital/physician relations
☐ Other: _____ ☐ Increased customer satisfaction

ACTIVATE

Planned Follow-up:

_____
_____
_____
_____

Team Leader _____ Date _____

Appendix E

Medical Record Review

PURPOSE:

The medical record review process measures a practitioner's compliance with documentation and other clinical documentation requirements and medical recordkeeping standards.

REVIEW PROCESS:

Medical records will be reviewed on an ongoing basis at the point of care. The review of medical records is based upon hospital defined indicators that address the following:

- Presence;
- Timeliness;
- Readability (whether handwritten or printed);
- Quality;
- Consistency;
- Clarity;
- Accuracy;
- Completeness, and
- Authentication

The HIM Director and the Quality Officer/QMRC will develop a collaborative process for conducting medical record review and reporting results. The process for review will be based upon the facility's unique needs and internal processes.

- Medical record review is an interdisciplinary process and should include at a minimum the following members; quality management, health information management, utilization management, nursing, administration, food and nutrition, pharmacy, surgery and ancillary departments as appropriate.

- Results will be aggregated, analyzed and reported to the Utilization Management Committee, Quality Improvement Council, and appropriate Medical Staff Committee. Action items must be established to address improvement and problem areas when thresholds are not met. Physician-specific data will be forwarded to the Quality Department for inclusion in Ongoing Professional Practice Evaluation (OPPE). Records determined to require additional review are forwarded to the Medical Staff, Nursing Department or other clinical discipline for further review.

- Results of record reviews completed during other routine monitoring such as Core Measures abstraction, survey readiness tracer activity, OPPE, and other QI activities should be captured as a part of this medical record review process.

- Sample sizes for review will be based on the average number of discharges for the previous quarter prior to review. At a minimum, each facility will review 30 charts.

When the focus of additional reviews requires sampling, the following guide may be used:

Population (# of discharges/qtr)	Number of Charts to Review
≤100	**30 charts**
101 – 500	**50 charts**
>500	**70 charts**

If the total number of medical record reviews reported during routine quality monitoring activities does not meet the minimum number required under sampling guidelines, additional records must be reviewed to complete the sample. "Discharges per quarter" includes inpatient, outpatient surgery, ED and other ambulatory settings.

DATA COLLECTION PROCESS

1. The facility will utilize a tool for data gathering and incorporating aggregate results for data analysis (refer to sample data collection tool). The facility may use other means of recording and capturing data.

2. Specific issues related to physician and staff legibility, timeliness, etc., will be addressed and tracked at the time of review. Physician legibility results will be tracked through OPPE.

3. At a minimum, each physician on active medical staff with inpatient admitting privileges will be reviewed annually. Ongoing Professional Practice Evaluation for H&P's will be conducted by a physician reviewer. The required elements of the H&P may be found in the *Medical Staff Bylaws.*

4. The Health Information Management Director in collaboration with the CQO/QMRC will maintain the review tool, results of the reviews, correspondence and corrective action plan by month. This information may be maintained in paper or electronic format.

ANNUAL Appraisal

Medical Record Review process will be reviewed annually by the HIM Director and the Utilization Management Committee to assure the ongoing validity of the indicators and effectiveness of the efforts taken to continually improve performance. Revisions will be made as needed.

Appendix E

SAMPLE
Medical Record Review Tool

Patient Account #	Attending:	DC Date:	Record Type: ☐ IP ☐ OBS ☐ SDS
Reviewer:			

Criteria	Total	Y	N	N/A	Comments
Administration					
Consent to treat signed by patient or legal representative Consent section - Form No. ADM-1701G					
Advance Directive on chart					
Clinical					
Unapproved abbreviations are not used in the record					
Verbal and Telephone orders read back and documented					
ALL critical labs called to MD - look for white stickers on Physician Progress Notes Section- if no white sticker - check off N/A					
Entries are legible					
Patient education documented by multidisciplines					
PRN Orders clarified/documented					
All record entries Timed and Dated					
Nursing Assessment Completed Within 24 hours of Admission					
Pain assessment prior to med (First Check MAR to see if on pain meds)					
Pain reassessment after medication administered					
Case management discharge disposition complete Case Management Section					
Interdisciplinary plan of care documented					
Physician					
Physician progress notes signed, timed and dated (1st count number of progress notes and place in 1st Column - Under the Y column enter # of PN that were signed/timed and dated - Under N column enter # that were missing any of the 3 components).					
Admission med reconciliation signed by MD<24 hours					
H&P on the chart within 24 hours of admission History and Physical Section (Check the Dictation/Transcription date)					
H&P dated 30 days prior to admission and updated within 24 hours of admission					
H&P Contains:					
-Chief complaint					

-Details of present illness					
-Relevant past medical, social and family history (age specific)					
-Review of systems					
-Psychosocial needs addressed (age specific) - might not say Psychosocial (look for drinking, smoking, etc.					
-Physical exam					
-Provisional diagnosis - look for any diagnosis					
-Plan for care					
-H&P signed					
Criteria	Total	Y	N	N/A	Comments
Consult on chart (if no consult ordered, check N/A					
Progress notes recorded daily					
Orders timed & dated					
Telephone order authenticated within 48 hrs signed/timed/dated Under 1st column place number of VO/TO, under Y column indicate all VO/TO that met all 3 components - Under N column, indicate total that did not meet all 3)					
Physician legibility					
PRN orders include indications					
No RESUME orders in record					
No double range orders in record					
Discharge reconciliation signed by MD					
Discharge summary with outcome of hospitalization, disposition of case and provisions for follow up care. (if patient stay is under 48 hours - check N/A					
Final diagnosis with completion of medical records within 30 days following discharge					
Operative Care					
Pre Anesthesia assessment performed by LIP					
Informed Consent includes risks, benefits, and alternatives					
Complete H&P on the chart prior to surgery					
Patient monitored during administration of moderate or deep sedation					
Immediate post op note					
Time out completed including procedure, patient, site					
Post anesthesia note completed by LIP within 48 hours after surgery (inpatients)					
Transfer					
Reason for transfer documented					
Stability of the patient documented					
Acceptance by the receiving organization documented					
Transfer forms complete					
Copies of relevant patient information/test results sent with the patient?					

Appendix F

Medication Use Evaluation

PURPOSE:

Medical staff, nursing services, pharmacy, administration, and other departments and individuals shall participate and collaborate in medication use improvement activities. Oversight of medication use improvement activities and reporting is a responsibility of the Director of Pharmacy and the Utilization Management Committee.

FOCUS OF MEDICATION USE IMPROVEMENT ACTIVITIES

Medication use improvement activities shall focus on one or more of the following processes. Emphasis shall be on the effective, appropriate, and safe use of drugs.

- Selection, procurement, and storage of drugs (e.g., ensuring their integrity and security)
- Ordering/prescribing drugs (e.g., improving the clarity of drug orders and preventing duplicate drug therapy, adjusting doses and routes of administration to provide optimal patient outcomes and reduce adverse events)
- Dispensing/preparing drugs (e.g., reducing pharmacy dispensing errors and ensuring timely delivery of drugs)
- Administration of drugs (e.g., reducing drug administration errors and improving drug administration techniques)
- Monitoring the effects of drugs on patients (e.g., improving the detecting, reporting, and assessing of adverse drug reactions and less than optimal patient outcomes)
- Antibiotic Stewardship
- Safe Use of Opioids

MEDICATION USE EVALUATION

The Medication Use Evaluation program should be conducted on an ongoing basis with the goal to complete an evaluation of a different medication each quarter. Certain medications may be evaluated on an ongoing basis (e.g., all patients receiving aminoglycoside antibiotics, all patients receiving TPN, etc.) and others should be selected to evaluate certain high-risk, high-cost, frequently used medication or specific indication (e.g., all patients treated for community acquired pneumonia).

The drugs selected for quarterly MUE should be approved by the appropriate medical staff committee annually.

PRIORITIES

If specific drugs are targeted, the emphasis should be on drugs that are:

- Frequently prescribed
- Known or suspected of presenting a significant risk to patients
- Known or suspected to be problem prone
- A critical component of care provided for a specific diagnosis, condition, or procedure.

CRITERIA

If specific drugs are targeted, medication use improvement activities may include the use of criteria against which drug use can be compared. Criteria may describe the presence of the absence of critical structures, processes, desirable outcomes, and undesirable outcomes.

COLLECTION OF DATA

Data may be collected from pharmacy patient profiles, patient medical records, laboratory reports, adverse drug reaction reports, medication administration records, the clinical documentation system, and other sources. Data collected for required meaningful use indicators can be submitted to CMS. The clinical documentation system can create a list of patients with the following filters applied to the search: admission date range, patient type and status, patient sex, birth date range, diagnosis, problem, specific drug, generic drug, therapeutic class, immunization, and laboratory results.

EVALUATION OF CARE

Medication use shall be evaluated when important single events or variances occur and when patterns and trends signal opportunities to improve the quality of medication use.

SELECTION/PROCUREMENT/STORAGE OF DRUGS

The pharmacy shall monitor the selection/procurement/storage of drugs. The findings shall be recorded. Any form (e.g., a Pharmacy Intervention Log or similarly named form) may be used for recording the findings. The pharmacy shall review the findings, identify problems to resolve or processes to improve, and work within the framework of the organization-wide performance improvement program to improve the processes.

ORDERING/PRESCRIBING DRUGS

The pharmacy shall monitor the ordering/prescribing of drugs. The findings shall be recorded. Any form (e.g., a Pharmacy Intervention Log or similarly named form) may be used to record the findings. The pharmacy shall review these findings, identify problems, and work to resolve or improve processes while working within the framework of the organization-wide PI program.

PREPARING AND DISPENSING DRUGS

The pharmacy shall monitor the preparation and dispensing of drugs and shall document dispensing errors (e.g., those related to accuracy and contraindications). The pharmacy shall review the findings, identify problems to resolve or processes to improve, and work within the framework of the organization-wide PI program to improve the preparation and dispensing of drugs.

ADMINISTRATION OF DRUGS

The pharmacy shall cooperate with nursing service to monitor and document drug administration errors. The pharmacy shall participate, as necessary, in the review of drug administration errors to help identify problems to resolve and offer recommendations that improve drug administration procedures and safety. The Director of Pharmacy shall have access to medication variance reports to identify trends and opportunities for process improvements to improve medication safety.

MONITORING THE EFFECTS OF DRUGS (PATIENT DRUG MONITORING)

The pharmacy shall cooperate with the medical staff and nursing services to monitor the effects of drugs. The pharmacy shall participate in the facility's adverse drug reaction reporting program to help identify opportunities for improvement. Additional sources (e.g., patient laboratory data) may also be used to identify opportunities to improve monitoring the effectiveness of prescribed drugs.

ACTIONS TO IMPROVE MEDICATION USE

The facility shall systematically improve its medication use processes. Actions to improve medication use include, but are not limited to, the following:

- Revising processes
- Providing educational programs
- Education of facility staff
- Developing, revising, and implementing policies and procedures that improve medication safety
- Establishing formulary and prescribing restrictions
- Developing standardized drug therapy protocols
- Implementing therapeutic substitution policies
- Requiring special order forms for selected drugs

ASSESSMENT, DOCUMENTATION, AND REPORTS

Assessment, documentation, and reports of medication use improvement activities may include, as appropriate, one or more of the following:

- Findings (e.g., data, variances, and unjustified variances)
- Conclusions (e.g., problems identified, opportunities to improve medication use, causes of problems, and usage patterns and trends)
- Recommendations (e.g., proposed actions and what should be done)
- Action taken (e.g., what has been done to date)
- Effectiveness or results of action taken (e.g., problems resolved and improvements in medication use)

ANNUAL Appraisal

Medication Use Improvement Review will be reviewed annually by the Pharmacy Director and Pharmacy and Therapeutics Committee to assure the ongoing validity of the indicators and effectiveness of the efforts taken to continually improve performance of all processes in the use of medications. Revisions will be made as needed.

APPENDIX F

SAMPLE MUE TEMPLATE
Meperidine MUE

Introduction

Between *insert date* and *insert date* ___ patients have been prescribed meperidine. The number of doses of meperidine administered by floor is described in the table below.

Floor	*# of doses*
MSU	
ER	
PACU	
CCU	
OR	

Over the last ___ months, meperidine has been involved in _____ adverse drug events, ranging from *Insert Description here*.

Meperidine is a synthetic opioid derivative. It has similar properties to morphine without the anti-tussive effects. It is not as potent of an analgesic as morphine or hydromorphone but has more rapid onset and a shorter duration of action than morphine. Meperidine is not recommended for chronic pain and because of potential accumulation of its neurotoxic metabolite, normeperidine, it should not be used for more than 48 hours. Hepatic impairment and renal impairment will extend the half-life of the drug that can lead to toxicity or increased effects of tremor, myoclonus, hallucination, confusion and possibly seizures. Common side effects include dizziness, nausea, vomiting, sedation and respiratory depression.

Meperidine can be administered orally or via IV or IM injections. The intramuscular route is not recommended due to the increased pain at the injection site and erratic absorption. The dose should not exceed 600mg within a 24- hour period for patients with normal renal function.

Meperidine should be used with caution in patients with uncontrolled hypothyroidism, seizure disorder, BPH, and those taking MAO inhibitors in addition to those with renal or hepatic dysfunction. Additionally, patients 65 and over may be at increased risk of side effects due to decreased metabolism/clearance of meperidine/normeperidine. Generally, meperidine is recommended as a third or fourth line option for controlling pain. This medication use evaluation (MUE) will describe usage characteristics for meperidine between the time frames above.

Data Collection:

Charts and electronic medical information for *insert number* patients who received meperidine between __/__/____ and __/__/____ were reviewed. Information collected included: age, gender, admit and discharge dates, prescriber, opioid allergy history, serum creatinine, calculated creatinine clearance (CrCl), indication for use, dose, duration of therapy, pain scores (when available), total amount of meperidine potentially available based on the order, number of breakthrough pain medication doses given, adverse effects, and patient outcomes.

Results:

Insert Number patients were identified as receiving at least one dose of meperidine. Age range was __ to __ years of age with a mean age of __ years and a median age of __. There were __ patients 65 year or older (__%).

Demographics	
Number of Patients	
Age, years (mean, range)	
Genders (*n*) Male Female	
Ethnicities	
Creatinine Clearance (*n*) < 10 ml/min 10-50 ml/min >50 ml/min not checked	
Allergy to (*n*) morphine hydromorphone fentanyl oxycodone codeine hydrocodone	
Routes (*n*) IV IM Oral PCA Other	
Seizure history (*n*)	
Taking med that lowers seizure threshold (*n*)	

Insert Graph of Indications Here

Dose & length of therapy:

___ patients could have received greater than 600 mg in 24 hours based on the order. ___ patients actually received greater than 600mg in 24 hours. __ patients received meperidine for ≥ 48 hours consecutively.

The most common dose ordered was ___ mg (__ patients), followed by __ mg and __ mg. __ orders were for intravenous (IV), __ for PCA, __ for intramuscular (IM), __ for oral, and __ for epidural. The most commonly prescribed frequency was _____.

Of the __ patients who received more than 48 hours of meperidine the following was found:

- ___ were over the age of 65
- ___ had renal insufficiency or a creatinine clearance less than 50.

____ patients had a post-dose pain score of ≤2 or that was 50% less than the pre-dose pain score for 50% of the doses they received. These patients received a mean of ____ mg every 24 hours.

Adverse Events:

Insert Chart of ADEs Here

Outcomes

Insert Chart of Outcomes Here

Conclusion:
Recommendations:

- Use of meperidine should be reserved for those patients who have normal hepatic and renal function (CrCl > 50 ml/min).
- Meperidine should not be used for longer than 48 hours consecutively; automatic soft stops.
- Prescribers should be contacted on all meperidine orders that may allow > 600mg in 24 hours
- IV administration should be the only allowable route.
- Patients with uncontrolled hypothyroidism or those who are taking MAOI's should not receive meperidine for pain management.

Reference:
Micromedex, 2006
Meperidine: A Critical Review. Am Journal of Therapeutics: 2002 no. 9; 53-68
Clinical practice guideline, No. 1 AHCPR Pub no. 92-002 – Agency for Health Care Policy & Research
Quality improvement guidelines for the treatment of acute pain and cancer pain: consensus statement. JAMA, 1995, Dec.: 274(23); 1874-1880.
Recognizing normeperidine toxicity. Nursing Mar 2003

APPENDIX G

Operative and Invasive Procedure Review

PURPOSE

The purpose of operative and invasive procedure review is to define the process for monitoring quality of care outcomes and procedure appropriateness through the use of medical staff approved criteria. Review will consider those procedures identified as high risk, high volume, low volume, or problem prone and will include both the inpatient and outpatient population. Other procedures may be selected for review as necessary by the medical staff.

Review of operative and invasive procedures is conducted as part of the ongoing and focused professional practice evaluation processes as outlined in Appendix D of the Medical Staff Bylaws.

SELECTION OF PROCEDURES

On at least an annual basis, the applicable medical staff committee will identify and approve procedures for review. Procedures are identified through review of hospital-specific historical data for the previous twelve months. These selected procedures will be displayed on an annual review calendar *(refer to Attachment 1 Sample Operative/Invasive Procedure Review Calendar)*. Consideration will be given to any new service line and/or procedure that may be added during the year for inclusion on the annual review calendar.

SCREENING CRITERIA

Review will be conducted by screening cases using evidence-based clinical criteria. Examples of review criteria include InterQual® *SIM Plus*™ or criteria published by the American College of Cardiology (ACC) or other nationally recognized professional association/society. Criteria utilized for procedure reviews must be approved by the applicable medical staff committee prior to use. Cases determined to require additional review are forwarded to the Quality Department for distribution to the appropriate Medical Staff Committee individual case review.

REVIEW PROCESS

Staff will screen records of patients having undergone selected operative/invasive procedures using medical staff approved criteria. The following processes will be evaluated:

- Appropriateness of patient selection
- Patient preparation including pre-anesthesia assessment
- Informed Consent
- Timeliness of History and Physical Exam
- Patient Safety Processes including site marking, surgical checklist procedure completion and patient identification (Universal Protocol)
- Intraoperative or intraprocedural care and monitoring of the patient
- Post-procedure monitoring including post-anesthesia evaluation
- Discharging the patient from the service or setting
- Unexpected Complications/Outcomes
- Patient/Family Education

Reviews may be conducted on a prospective or retrospective basis. *(See Attachment 2 Sample Review Tool).*

TISSUE REVIEW:

Tissue review will be conducted as outlined in the Pathology Peer Review Policy.

OUTCOMES REVIEW:

Clinical staff in all areas where operative/invasive procedures are performed will assist in the identification of the presence of adverse outcomes, including any of the following:

- Unplanned admission following outpatient procedure
- Unscheduled return to Operating Room
- All postoperative or intraoperative deaths
- Complications in association with diagnostic invasive procedures
- Anesthesia complications including:
  - Cardiac arrest
  - Suspected MI
  - Neurological deficit or stroke not present prior to anesthesia
  - Death
  - Possible aspiration
  - Malignant Hyperthermia
  - Unplanned transfer to a higher level of care
  - Anesthesia awareness

When adverse outcomes are identified, the clinical staff will complete an Event Report and forward to Risk Management immediately. Event reports will be entered into the event reporting system and data will be forwarded to the Quality Management Department to be summarized for presentation to the appropriate Medical Staff Committee and QIC.

REPORTING

On a quarterly basis, the appropriate Medical Staff Committee and QIC will review the summary report, draw conclusions, make recommendations and take action as needed based upon the findings presented. Results of operative and invasive procedure review will be trended and reported via the practitioner-specific OPPE scorecard at least every six months. When indicated, individual case review may be performed for those review outcomes indicating the procedure was:

- Performed when not indicated;
- Not performed when indicated;
- Performed poorly or incorrectly, or
- Resulted in a significant adverse complication

CONFIDENTIALITY

Information, data sheets, reports, findings, and other work products related to the review of operative/invasive procedures are generated under the auspices of the hospital-wide Quality Improvement Program and are to be treated as protected documents in accordance with state statute governing peer review activities.

ATTACHMENTS: Attachment 1: Sample Review Calendar; Attachment 2: Sample Review Tool

APPENDIX G

OPERATIVE AND INVASIVE REVIEW Example

Invasive Procedure	Procedure Code	Problem Prone	Prior YTD Volume		Select for review	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec
Medicine Services																	
Endoscopic Polypectomy of Lg Intestine	45.42		High	70													
EGD / EGD with Biopsy	45.16/ 45.13		High	300													
Colonoscopy	45.23	X	High	575	X	X											
Endoscopic Biopsy of Bronchus	33.24/ 33.26	X	High	229	X		X										
Endoscopic Biopsy of Lung	33.24/ 33.27	X	High	188													
Bone Marrow Biopsy	41.31		High	93													
GYN Services																	
Total Abdominal Hysterectomy	68.49		Low	50													
LAVH	68.51	X	High	175	X			X									
Lap Total Abdominal Hysterectomy	68.41		High	90													
Orthopedic Services																	
Total Hip Arthroplasty	81.52	X	High	129	X				X								
Total Knee Arthroplasty	81.51	X	High	427	X					X							
Cruciate Ligament Repair NEC	83.99/ 81.45		High	51													
Carpal Tunnel Release	4.43		High	119													
Imaging Services																	
Percutaneous Needle Biopsy Liver	50.11	X	Low	26	X						X						
Urology																	
Urinary Incont Repair	59.79		Low	29													
ESWL Kidney/Ureter/Bladder	98.51		High	193													
Surgery																	
Lap Appendectomy	47.01		Low	37	X							X					
Lap Cholecystectomy	51.23		High	294	X								X				
Hernia Repair			Low	31													
Colon Resection			Low	23	X									X			
Cardiology/Cardiovascular																	
CAB of Coronary	36.11/	X	Low	39	X												

Artery 2/3/4	36.12																
Implant Cardiac Defib	0.51		Low	45	X											X	
Rt/Lt Heart Cath	37.23	X	High	602	X				X								X
PTC A	0.66	X	High	421	X												X

Sampling Criteria:

Fewer than 30 cases, review 100%
30 – 100 cases, sample 30 cases
101-500 cases, sample 50 cases
>500, sample 70 cases

APPENDIX G

Operative/Invasive Procedure Review Tool

Procedure Reviewed: Cholecystectomy

Patient Label

Date of Procedure:

Date of Review:

Case Reviewer Name:

Operative Practitioner:

Anesthesia Provider:

	INDICATOR	YES	NO	N/A	COMMENTS
INDICATIONS	Acute Cholecystitis: **ALL** 1A Symptoms: ***ONE*** -1 Biliary colic/pain in upper abdomen/back -2 Nausea/vomiting 1B RUQ tenderness 1C Findings: ***ONE*** -1 Temperature > 100.4F -2 WBC > 12,000/cu.mm 1D Imaging: ***ONE*** -1 + Positive US findings -2 Nonvisualization of gallbladder by HIDA scan				
PRE-OPERATIVE	Procedure indications met				
	H&P timely and updated prior to procedure				
	Informed consent, risk, benefits, alternatives documented				
	Anesthesia plan, ASA Score and Mallampati documented				
	Immediate re-assessment prior to induction				
	Universal protocol checklist completed				
INTRA-OPEARTIVE	Cancellation of procedure after induction				
	Procedure complication (circle): Cardiac arrest Suspected MI Neuro deficit or stroke Death Possible aspiration Malignant Hyperthermia Anesthesia awareness Other				
POST-	Post-op note present immediately following				
	Anesthesia post-operative evaluation complete				

ADDITIONAL COMMENTS: ACTION:_____ No action _____Forward to Department Chief/Chief of Staff/Surgery Committee

APPENDIX H

Mortality Review

PURPOSE:

Mortality review is performed as a means to analyze and identify systems processes that may have an adverse impact on patient mortality. The review encompasses the identification of appropriate care setting, use of evidence-based guidelines, and identification of potential patterns of harm including the failure to plan, failure to recognize a change in the patient's condition, failure to effectively communicate concerns about the change; and failure to respond in a timely and appropriate manner to concerns that are communicated.

REVIEW PROCESS

Patient deaths are reviewed using a structured review tool *(Attachment Appendix H)*. The review process is intended to identify if a (1) failure to recognize; (2) failure to rescue; (3) failure to communicate, (4) hospital-acquired condition or serious safety event occurred during the course of the patient's care. Systems processes are established to facilitate case review as expeditiously as possible following the death in order to promote a concurrent review process. The review process should include involvement of the clinical documentation improvement (CDI) staff when necessary. Results of the review are aggregated, analyzed and reported on at least a quarterly basis. Those cases in which a care concern is identified will be forwarded to the appropriate department, unit, or forwarded into the medical staff peer review process. Practitioner-specific mortality rates are also trended for the purposes of Ongoing Professional Practice Evaluation (OPPE). Mortality data reported via external or publicly reported databases will be reviewed, reported, and improvement action taken as needed. The IHI 2X2 analysis is completed and reported on an annual basis.

REPORTING

Review outcomes are reported to the Quality Improvement Council, Utilization Management Committee, applicable medical staff department/committee, and the Governing Board. Improvement opportunities are identified and implemented as needed.

CONFIDENTIALITY

Information, data sheets, reports, findings, and other work products related to mortality and autopsy review are generated under the auspices of the Hospitalwide Quality Assessment and Performance Improvement Program and are to be treated as protected documents in accordance with state statute governing peer review activities.

ANNUAL MORTALITY REVIEW APPRAISAL

The Mortality/Autopsy Review process will be reviewed annually by the QMRC/CQO and Quality Improvement Council to assure the ongoing validity of the indicators and effectiveness of the efforts taken to continually improve performance. Revisions will be made as needed.

Attachments

Mortality Review Tools

APPENDIX H
Mortality Review Tool
Privileged and Confidential Quality and Patient Safety Work Product

Patient Information

Name	Account #	Medical Record #	Admit Date	Date of Death
Sex ☐ Male ☐ Female	Age	Primary Physician		Consulting Physician(s)
Admitting Diagnosis(es)		Final Diagnosis(es)		

Move The Dot

Unit where first admitted: ☐ ICU ☐ Stepdown ☐ Med/Surg/Telemetry ☐ OB ☐ Peds ☐ Other _____

Was the patient admitted for comfort care: ☐ Yes ☐ No	☐ Box 1 - ICU - Comfort Care	☐ Box 2 - Non-ICU - Comfort Care
	☐ Box 3 - ICU - No Comfort Care	☐ Box 4 - Non-ICU - No Comfort Care

Care Setting

Patient admitted from: ☐ Home ☐ Skilled Care ☐ Transfer from acute care ☐ Other _____

Was this a readmission (inpatient) within 30 days? ☐ Yes ☐ No If yes, initial admission discharge date:

Comfort Care/Palliative Care/Hospice

On admission, was the patient a good candidate for hospice care? ☐ Yes ☐ No ☐ Unable to determine ☐ Already a hospice patient

When was hospice/comfort care ordered? ☐ On admission ☐ < 24 hrs of admission ☐ Not assigned ☐ > 24 hrs of admission

Advance Directive in chart? ☐ Yes ☐ No

Unit where death occurred: ☐ ICU ☐ Stepdown ☐ Med/Surg/Telemetry ☐ OB ☐ Peds ☐ Other _____

Adverse Events

Refer to the back of this tool for the IHI Global Trigger Tool. Perform the appropriate review.
The Care Module and Medication Module Triggers should be completed on ALL records.
The Emergency Department, ICU, Perinatal and Surgical Modules should be completed if the patient received any of these services.
Additional IHI modules are available in the Mortality Review Appendices.

If a trigger has been selected during review, this indicates the presence of a trigger, not necessarily an adverse event.
Recommend that a physician assist with the determination of an adverse event and the assignment of a category of harm.

Assignment of a Category of Harm

		NCC MERP Severity Index Coding (from NCC MERP Index for Categorizing Medication Errors, Copyright 2001)					
IHI Global Triggers	**# of Triggers**	**Code E**	**Code F**	**Code G**	**Code H**	**Code I**	**Description of events**
Care Module							
Medication Module							
Surgical Module							

ICU Module							
Perinatal Module							
ED Module							
Other:							
NCC MERP Coding	E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.					
	F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.					
	G	An error occurred that may have contributed to or resulted in permanent patient harm.					
	H	An error occurred that required intervention necessary to sustain life.					
	I	An error occurred that may have contributed to or resulted in the patient's death.					

See the HPE Safety Event Classification (SEC) Levels of Harm Harmonization with NECC MERP Severity Index Coding for a crosswalk of the IHI Global Triggers to the High Reliability Organization Program.

Any positive triggers that are assigned a Category of Harm above should also be reviewed for a Serious Safety Event.

After reviewing all questions, could "perfect care" during this hospitalization have prevented this death? □ **Yes** □ **No**

Conclusions of review

□ No issues requiring further review □ Refer for physician review - forward to _____

Person(s) performing this review: Date :

APPENDIX H
IHI Global Trigger Tool for Measuring Adverse Events Worksheet

Patient Identifier: **Total # of Events:** **Total LOS:**

Write descriptions of the events in greater detail on a separate sheet and attach.

Cares Module Triggers		+	Event Description and Harm Category (E - I)	Medication Module Triggers		+	Event Descriptic and Harm Categor (E - I)
C1	Transfusion or use of blood products			M1	*Clostridium Difficile* positive stool		
C2	Code/arrest/rapid response team			M2	PTT > than 100 seconds		
C3	Acute dialysis			M3	INR > 6		
C4	Positive blood culture			M4	Glucose < 50 mg/dl		
C5	X-ray or Doppler studies for emboli or DVT			M5	Rising BUN or serum creatinine > 2 times baseline		
C6	Decrease of > 25% in hemoglobin or hematocrit			M6	Vitamin K administration		
C7	Patient fall			M7	Benadryl (Diphenhydramine) use		
C8	Pressure ulcers			M8	Romazicon (Flumazenil) use		
C9	Readmission within 30 days			M9	Naloxone (Narcan) use		
C10	Restraint use			M10	Anti-emetic use		
C11	Healthcare-associated infection			M11	Over-sedation/hypotension		
C12	In-hospital stroke			M12	Abrupt medication stop		
C13	Transfer to higher level of care			M13	Other		
C14	Any procedure complication						
C15	Other						
Surgical Module Triggers		**+**	**Event Description and Harm Category (E - I)**	**Intensive Care Module Triggers**		**+**	**Event Descriptic and Harm Categor (E - I)**
S1	Return to surgery			I1	Pneumonia onset		
S2	Change in procedure			I2	Readmission to intensive care		
S3	Admission to intensive care post-op			I3	In-unit procedure		
S4	Intubation/reintubation/BiPap in PACU			I4	Intubation/reintubation		
S5	X-ray intra-op or in PACU						
S6	Intra-op or post-op death			**Perinatal Module Triggers**		**+**	**Event Descriptic and Harm Categor (E - I)**
S7	Mechanical ventilation > 24 hours post-op						
S8	Intra-op epinephrine, norepinephrine, naloxone, or romazicon			P1	Terbutaline use		
				P2	3rd or 4th degree lacerations		
S9	Post-op troponin level > 1.5 mg/ml			P3	Platelet count < 50,000		

S10	Injury, repair, or removal of organ			P4	Estimated blood loss > 500 ml (vaginal) or > 1,000 ml (C-section)		
S11	Any operative complication						
				P5	Specialty consult		
Emergency Department Module Triggers		+	**Event Description and Harm Category (E - I)**	P6	Oxytocic agents		
				P7	Instrumental delivery		
E1	Readmission to ED within 48 hours			P8	General anesthesia		
E2	Time in ED > 6 hours						

APPENDIX I

QI Program

Blood Utilization Review & Screening Criteria

PURPOSE:

The administration of blood and blood components carries the potential for serious complication for the patient. This potential exposure to risk must be considered along with potential therapeutic benefit when making the clinical decision to administer blood to the patient. Failure to administer blood when indicated reduces the likelihood of positive patient outcomes. Administration of blood when not indicated places the patient unnecessarily at risk. Even when used appropriately, administration of blood carries the inherent risk of certain complications, which may be unavoidable. Because of these factors, blood usage must be carefully monitored in the effort to review and improve patient care.

METHODS:

1. Sample Size

Review of blood and blood components will be conducted by the Pathologist based upon targeted sampling. Sentinel events related to blood administration will be reviewed as outlined in the Sentinel Event Policy.

2. Scope of Review

The processes related to blood usage that must be measured include at least the following:

- Ordering
- Distribution, handling and dispensing
- Administration
- Monitoring the effects on patients

REVIEW PROCESS

Blood utilization review is an interdisciplinary process conducted by the Laboratory in an ongoing, systematic manner. Blood utilization review involves the Medical Staff, Laboratory, Nursing, and Quality Management. The evaluation includes a review of cases receiving transfusion of blood, blood components, or blood derivatives to measure the quality and appropriateness of blood usage by focusing on key processes. Measurement will be conducted by screening cases using approved indicators to determine variations. Cases representing a variation will require further review to determine if the variation is appropriate and/or acceptable.

The Laboratory will collect data concerning the ordering of blood/blood products, distribution, handling, and dispensing of blood/blood products. Nursing staff will collect data related to the administration of blood/blood products and monitoring the effects of the blood on patients.

REPORTING OF BLOOD USAGE FINDINGS

Data from all processes will be forwarded to the Laboratory to be reviewed and included in a summary report to be presented to the Utilization Management Committee, QIC, and Medical Executive Committee (MEC) and Board, on at least a quarterly basis. Copies of individual physician reviews will be forwarded to Quality Management & Regulatory Compliance for inclusion into the Physician Quality Profile.

The Utilization Management Committee will review the summary report, draw conclusions, make recommendations, and take action as needed based upon the findings presented. When indicated, peer review will be conducted.

Written reports of conclusions, recommendations and actions taken will be maintained and reported to the MEC, Governing Body, as necessary, and, as appropriate, to the hospital staff involved in transfusion administration.

CONFIDENTIALITY

Information, data sheets, reports, findings, and other work products related to the review of transfusion practices and blood usage are generated under the auspices of the Hospital wide Quality Improvement Program and are to be treated as protected documents in accordance with state statute governing peer review activities.

IMPROVING PERFORMANCE

When an opportunity to improve the performance of key processes in the use of blood and blood components has been identified, the Laboratory Director in conjunction with the Laboratory Medical Director (Pathologist) will take actions for improvement.

Actions taken by the Laboratory Director and the Medical Director (Pathologist) will be monitored until improvement or resolution is attained and sustained performance is demonstrated. Unresolved problems and significant peer review findings suggesting the need for medical staff action will be referred to the MEC.

ANNUAL BLOOD UTILIZATION REVIEW APPRAISAL

Blood Utilization Review will be reviewed annually by the Laboratory Director and Medical Director (Pathologist) to assure its completeness, ongoing validity of the indicators, and effectiveness of the efforts taken to continually improve performance of all processes in the use of blood and blood components. Revisions to the review process will be made as needed.

APPENDIX I

Transfusion Appropriateness Review Example

Place patients demographic label here.

Ordering Physician:_____

This Form will be initiated when Blood and/or Blood products are released from the Laboratory

Completed Forms are to delivered to the Laboratory - Blood Bank for Review

A new form must be used for each additional transfusion order

Transfusion Order: Indicate # of products to be transfused. Indicate reason for transfusion from list below.

RBC #	Cryo #	Other
_____	_____	_____
FFP #	PLT#	
_____	_____	

Justification for transfusion:

RBC Transfusion	FFP Transfusion
[ ] Active bleeding (no matter what Hemoglobin is) [ ] Hgb <7.0 g and/or Hct <25 % [ ] Hct 30% or < and falling with active bleeding [ ] Systolic B/P 90 mm/Hg or less and active bleeding [ ] Heart rate >100 bpm and active bleeding [ ] Orthostatic hypotension (>30mmHg or pulse change >20 bpm) with active bleeding [ ] >1000 ml blood loss or 20% of blood volume [ ] Operative patient with surgical blood loss Procedure: _____ [ ]Symptomatic Chronic Anemia,<8.0 Hgb and/or <25 Hct [ ] Autologous [ ]Other Explain:_____ _____	[ ] PT >15 or INR >1.5 with impending invasive surgery [ ] PT >15 or INR >1.5 with active bleeding [ ] aPTT ≥ 50 [ ] DIC [ ] Coumadin therapy [ ] Fibrinogen deficiency [ ] Factor II, V, VII, IX, X, XI, XIII or FIB deficiency [ ] Liver disease unresponsive to Vitamin K [ ] Liver disease with documented coagulopathy and bleeding [ ] Massive RBC transfusion with bleeding with coagulopathy [ ] Other _____
Cryoprecipitate Transfusion	**Platelet Transfusion**
[ ] Hemophilia A and bleeding or surgery [ ] Hypofibrinogenemia (fibrinogen levels <160 mg/dL) [ ] Von Willebrands disease unresponsive to DDAVP [ ] Active bleeding in OR and/or concentrations cannot be measured in a timely fashion [ ] Other _____	[ ] Platelet count < 20,000 for prophylaxis in chemotherapy pt's. [ ] Platelet count < 50,000 with active bleeding [ ] Platelet count < 60,000 in patient undergoing surgery [ ] Documented platelet dysfunction with active bleeding [ ] Massive RBC transfusion of >7 units in succession [ ] Other _____

BLOOD BANK USE ONLY

[ ] Transfusion deemed appropriate, no further review needed

[ ] Units not transfused

[ ] Justification Not Met. Lab Medical Director to review.

Date sent for review _____

[ ] Forwarded to Quality Date _____

Unit Numbers:

APPENDIX I

Blood Products Utilization Review Example

Review

Patient Name: _____ MR #: _____

MD: _____ Adm. Date: _____ Review Date: _____

Diagnosis: _____

Procedure(s): _____

_____

Pathologist Screening Summary:

_____

_____

_____

_____

_____

_____

_____

Response

The above mentioned chart needs further justification. Your response for justification in administering _____ units of _____ on _____ (date) is needed within 21 days from today's date. Please write your response in the space provided below.

A copy of the Blood Usage Review Criteria for the mentioned component is attached. If you have any questions, please feel free to call:

Barry Smith, MD
Medical Director, Laboratory, Phone: XXX-XXX-XXXX

Return your response to ANYWHERE Community Hospital Laboratory Department, 2545 N. Washington Ave., ANYWHERE, Tennessee 38012. Thank you for your time and consideration to quality patient care.

Response by Physician

_____

_____

_____

_____

_____

_____

Signed: _____ Date: _____

APPENDIX I

BLOOD UTILIZATION MONITORING TOOL EXAMPLE

Ordering Blood Components/Usage	Jan	Feb	Mar	Apr
# Crossmatched				
# Transfused				
C/T Ratio	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
%Transfused	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Transfusion Reactions				
Febrile				
Other Adverse Reactions				
Confirmed transfusion related				
Units Wasted				
RBC				
Plts				
FFP				
Total units wasted	0	0	0	0
Component Storage Handling and Distribution				
Nurse notified of ready status				
# Crossmatched				
# called w/i 15 minutes				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Transfusion started within 30 min of pickup				
# reviewed				
# acceptable				
%acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Unit Identified by 2 people prior to release				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Dr. order to transfuse reviewed				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Tech signature missing				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Released signature(s) missing				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Nurse signature(s) missing (release)				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Nurse signature(s) missing (transfusion)				
# reviewed				
# acceptable				

% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Testing documentation incomplete on record				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Criteria for transfusion not documented				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Administration of Blood				
Recipient Identified correctly				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Vitals documented correctly				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Start/stop times documented				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Unit transfused within 4 hours				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Informed consent obtained correctly				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Adverse reactions investigated if indicated				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Monitoring effects of transfusion therapy				
Pretransfusion Hg obtained for RBCs				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Pretransfusion PT/PTT for FFP				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Post transfusion testing obtained				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Criteria for transfusion met				
# reviewed				
# acceptable				
% acceptable	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Attachment B-Need-A.5

Licensure and Accreditation Documents

Board for Licensing Health Care Facilities

State of Tennessee

0000000031

No. of Beds 0351

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

CLEVELAND TENNESSEE HOSPITAL COMPANY, LLC *to conduct and maintain a*

Hospital TENNOVA HEALTHCARE - CLEVELAND

Located at 2305 CHAMBLISS AVENUE NW, CLEVELAND

County of BRADLEY *, Tennessee.*

This license shall expire APRIL 20 *,* 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 7TH *day of* APRIL *,* 2017 *.*

In the Distinct Category(ies) of: GENERAL HOSPITAL
PEDIATRIC GENERAL HOSPITAL

By Vincent J. Dawson, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By John J. Dreyzehner, MD
COMMISSIONER

Cleveland Tennessee Hospital Company, LLC

Tennova Heatlhcare-Cleveland

Cleveland, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

August 12, 2016

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #7819
Print/Reprint Date: 10/14/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

The Joint Commission

October 13, 2016

Re: # 7819
CCN: #440185
Program: Hospital
Accreditation Expiration Date: August 12, 2019

Coleman Foss
CEO
Cleveland Tennessee Hospital Company, LLC
2305 Chambliss Avenue, NW
Cleveland, Tennessee 37311

Dear Mr. Foss:

This letter confirms that your August 09, 2016 - August 11, 2016 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on September 21, 2016 and October 03, 2016 and the successful on-site unannounced Medicare Deficiency Follow-up event conducted on September 20, 2016, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of August 12, 2016. We congratulate you on your effective resolution of these deficiencies.

§482.12 Governing Body
§482.41 Physical Environment

The Joint Commission is also recommending your organization for continued Medicare certification effective August 12, 2016. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

Cleveland Tennessee Hospital Company, LLC
d/b/a Tennova Health Care - Cleveland
2305 Chambliss Avenue, Cleveland, TN, 37311-3847

Cleveland Tennessee Hospital Company, LLC
2800 Westside Drive, Cleveland, TN, 37312-3501

Cleveland Tennessee Hospital Company, LLC
2253 Chambliss Avenue, Suite 101, Cleveland, TN, 37311-3861

The Joint Commission

Tennova Health Care - Cleveland Outpatient Therapy Center
220 Urbane Road, Suite B, Cleveland, TN, 37312-4757

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

RECEIVED
MAY 11 2009
Administration

May 5, 2009

Coleman Foss, Administrator
Skyridge Medical Center
2305 Chambliss Avenue
Cleveland TN 37311

Dear Mr. Foss:

The East Tennessee Regional Office of Health Care Facilities conducted a licensure survey at your facility on March 25, 2009. On April 9, 2009, an acceptable Plan of Correction was received in this office.

A revisit was completed April 30, 2009, to verify that your facility has achieved and maintained compliance. Based on our revisit, we found that your facility has demonstrated compliance with the deficiencies cited.

If you have any questions, please contact the East Tennessee Regional office at (865) 588-5656.

Sincerely,

Faye Vance

Faye Vance, R.N., B.S., M.S.N.
Public Health Nurse Consultant Manager

FV/ djm

PRINTED: 03/26/2009
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP5316	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 03/25/2009
NAME OF PROVIDER OR SUPPLIER SKYRIDGE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2305 CHAMBLISS AVE NW CLEVELAND, TN 37311		

(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
P 002	1200-8-30 No Deficiencies During the annual licensure survey, conducted on March 23 - 25, 2009, no deficient practices were cited under Chapter 1200-8-30, Standards for Pediatric Emergency Care Facilities.	P 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE CEO

(X6) DATE 4-9-09

STATE FORM 6899 W75J11

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP5316	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2009
NAME OF PROVIDER OR SUPPLIER SKYRIDGE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2305 CHAMBLISS AVE NW CLEVELAND, TN 37311		

(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 001	1200-8-1 Initial This Rule is not met as evidenced by: For the purpose of identification of locations surveyed, "Building A" shall refer to the main campus, located at 2305 Chambliss Ave NW, Cleveland, Tn.; and "Building B" shall refer to the satellite facility, located at 2800 Eastside Dr NW, Cleveland Tn.	H 001	SkyRidge CAP: H 403 1200-8-1-.04 (3) Hep B – emp 2005 Existing (applicable) employee health files will be audited by 4/30/09 to ensure that all employees have been vaccinated and/or have completed their titers. If any are found incomplete, the employees will receive a letter offering them the Hepatitis B vaccination series, the opportunity to have titers drawn and/or to complete a declination statement. An annual review of existing (applicable) employees will also be completed to ensure ongoing compliance. In addition, all new applicable employee files will be audited with a check list that includes the Hepatitis B series.	
H 403	1200-8-1-.04 (3) Administration (3) When licensure is applicable for a particular job, the number and renewal number of the current license must be maintained in personnel. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Adequate medical screenings to exclude communicable disease shall be required of each employee. This Rule is not met as evidenced by: Based on employee health record review and interview, the facility failed to provide a complete health screening for one employee (#15) out of seventeen employees reviewed. The findings included: Record review of employee #15"s health records revealed a hire date of May 16, 2005, and a statement entered into the health screening portion of the file which stated the employee was in the process of receiving the series of vaccinations for the Hepatitis B virus. Record review revealed the employee was a registered nurse and accepted into a position in surgery without any further information provided related to	H 403		

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H 403	Continued From page 1 immunity status to the Hepatitis B virus. Interview in the conference room on March 24, 2009, at 3:50 p.m., with the Employee Health Manager confirmed there was no documentation in the file the employee completed the series of vaccines for Hepatitis B or the immunity status of the employee. Building A	H 403		
H 630	1200-8-1-.06 (3)(a) Basic Hospital Functions (3) Infection Control. (a) The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure clean and soiled items were stored in separate areas on the Step Down Unit. The findings included: Observation of the Soiled Utility Room of the Step Down Unit, on March 24, 2009, at 8:30 a.m., revealed the following clean items located in the soiled utility room: one box of isolation gowns, one box of protective masks, and one 2 inch roll of cloth tape. Interview in the Soiled Utility Room of the Step Down Unit, on March 24, 2009, at 8:30 a.m., with the Assistant Chief Nursing	H 630	H 630 1200-8-1-.06 (3)(a) Clean items in soiled utility on 5S All nursing staff will be educated at the annual skills fair 4/22 – 4/23/09 regarding the need to not store clean items in the soiled utility rooms nor dirty items in the clean utility rooms. Laminated signs will also be placed in all utility rooms as a reminder of this issue. EOC audits occur twice monthly and this issue will be assessed on areas inspected.	

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H 630	Continued From page 2 Officer and the Educator for Critical Care, confirmed the items were available for patient or staff use and were not to be stored in a soiled area. Building A	H 630		
H 642	1200-8-1-.06 (3)(f) Basic Hospital Functions (3) Infection Control. (f) The facility shall have an annual influenza vaccination program which shall include at least: 1. The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility; 2. A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications; 3. Education of all direct care personnel about the following: (i) Flu vaccination, (ii) Non-vaccine control measures, and (iii) The diagnosis, transmission, and potential impact of influenza; 4. An annual evaluation of the influenza vaccination program and reasons for non-participation; 5. The requirements to complete vaccinations or declination statements are suspended by the Medical Director in the event of a vaccine	H 642	H 642 1200-8-1-.06 (3)(f) Flu Vaccine Program: Vax or Declination Existing employee health files will be audited by 4/30/09 to ensure that all employees have been vaccinated and/or have completed a declination statement. If any are found incomplete, the employees will receive a letter re-educating them of the need to be vaccinated annually. However, if they choose not to, that a declination statement must be completed. In addition, during future annual vaccination offerings (beginning 10/1/09) all employees who refuse a vaccination will be required to complete a declination statement each calendar year. An annual review of employees will also be completed to ensure ongoing compliance	

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H 642	Continued From page 3 shortage. This Rule is not met as evidenced by: Based on review of the employee health records and interview, the facility failed to have an annual influenza vaccination program and evidence of the annual influenza vaccination being offered to two employees (#16 and #17) of 17 records reviewed. The findings included: Review of the record for Employee #16 revealed a hire date of September 28, 2004, and the employee was working in the operating room (OR) as a Registered Nurse. Review of the record for Employee #17 revealed a hire date of February 24, 1986, and the employee was working as a Registered Nurse. Review of the health records for Employees #16 and #17 revealed no evidence the annual influenza vaccination had been offered. Interview on March 24, 2009, at 4:30 p.m., in the McNulty Conference Room with the Employee Health Manager confirmed the records for Employee #16 and #17 did not contain documentation the employees were offered the 2008 influenza vaccination. Interview with the Infection Control Nurse on March 25, 2009, at 10:53 a.m., in the McNulty Conference Room revealed the annual influenza vaccination program was to be done annually in October.	H 642		
H 679	1200-8-1-.06 (4)(f) Basic Hospital Functions (4) Nursing Services.	H 679	H 679 1200-8-1-.06 (4)(f) On 3/25/09 began one-on-one mentorship with nurse who completed	

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H 679	Continued From page 4 (f) The hospital must ensure that an appropriate individualized plan of care is available for each patient. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to assure an Individualized Care Plan was developed for one patient (#2) of twenty-one patients reviewed. The findings included: Patient #2 was admitted to the facility on March 19, 2009, with diagnoses to include Alcohol Abuse, Schizoaffective Disorder, Chronic Obstructive Pulmonary Disease, Back Pain, Right Below the Knee Amputation, and Seizure Disorder. Medical record review of the Care Plan dated March 19, 2009, revealed Alcohol Abuse as the only problem identified. Interview at the nurse's station, on March 23, 2009, at 1:45 p.m., with the Assistant Chief Nursing Officer and Clinical Coordinator for Adult Psychiatric Services, confirmed the patient's psychiatric and medical issues were not identified in the Care Plan as problem areas to be monitored. Building B	H 679	this particular care plan. In addition, one-on-one education is occurring with all nurses regarding completion of comprehensive care plans. Education will be completed by 4/30/09. Weekly chart audits will occur to ensure compliance. These results will be reported no less than quarterly via the QI process.	
H 680	1200-8-1-.06 (4)(g) Basic Hospital Functions (4) Nursing Services. (g) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient ' s needs and the specialized qualifications and competence of the	H 680	H 680 1200-8-1-.06 (4)(g) All nurses in L&D re-trained on AED beginning 3/23/09 with all re-training	

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H 680	Continued From page 5 nursing staff available. All nursing personnel assigned to special care units shall have specialized training and a program in-service and continuing education commensurate with the duties and responsibilities of the individual. All training shall be documented for each individual so employed, along with documentation of annual competency skills. This Rule is not met as evidenced by: Based on observation, review of training in-services, and interview, the facility failed to assure two of three nurses in the labor and delivery unit were adequately trained in the use of emergency equipment. The findings included: Observation of the Labor and Delivery (L&D) unit on March 23, 2009, at 10:20 a.m., revealed an emergency cart near the nurses' station. Observation with the Registered Nurse (RN) Charge Nurse revealed a machine on top of the emergency cart with a combined defibrillator and automated external defibrillator (AED). During interview at the emergency cart with the RN Charge Nurse on March 23, 2008, at 10:30 a.m., the RN stated, "the AED is a new machine...had it about three months..." During interview, the RN reported he/she had not received any training on the new machine. Continued interview revealed three nurses were on duty and two of the three nurses had not received training on the new AED. Interview on March 23, 2009, at 10:40 a.m., with the staff nurse (RN#1) on the L&D unit, verified RN #1 had not received any training on the new	H 680	complete on 4/30/09. In addition, all education rosters related to new equipment in-servicing will be reviewed on an ongoing basis to ensure all applicable staff has received training.	

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H 680	Continued From page 6 AED. Review of the training in-service records revealed no documentation of training on the AED for either the RN Charge Nurse or RN #1. Interview on March 23, 2009, at 2:05 p.m., in the McNulty conference room, with the Chief Quality Officer, confirmed the facility failed to assure all the staff in the labor and delivery unit received training for the new emergency equipment. Building A	H 680		
H 683	1200-8-1-.06 (4)(j) Basic Hospital Functions (4) Nursing Services. (j) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Rule is not met as evidenced by: Based on observation, review of manufacturer's recommendations, and interview, the facility failed to remove fluids from the warmer prior expiration date; failed to assure fluids in the warmer were maintained at the recommended temperature in the labor and delivery unit; failed to properly store medications for one (#6) patient of sixteen in-patients reviewed; and failed to assure medications were secured at the Infusion Therapy nurse's station. The findings included:	H 683	H 683 1200-8-1-.06 (4)(j) **L&D Fluid Warmer** **Action taken during survey** Fluid warmer moved to department from Building B until a new one can be ordered. All fluids discarded and new ones replaced and labeled with applicable date. Labels also indicate expiration date (28 days). All L&D staff educated on process beginning on 3/23/09 with education complete on 4/30/09. Temperatures are monitored daily and recorded on temp log which indicates what the correct range is for this warmer type. In addition, all fluid labels are now checked daily for expiration and recorded on the log. Any expired fluids are discarded.	

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H 683	Continued From page 7 Observation of the Labor and Delivery unit on March 23, 2009, at 12:15 p.m., revealed a warmer outside the surgery suite used to perform cesarean sections. Observation revealed the warmer contained three 500 ml bottles of 0.9% sodium chloride for irrigation; four 1000 ml bottles of 0.9% sodium chloride for irrigation; and three 2000 ml bottles of 0.9% sodium chloride for irrigation. Observation of the bottles revealed no documentation to indicate when they were placed in the warmer. Continued observation revealed a temperature log posted to the outside of the warmer. Review of the log titled 'Blanket Warmer Fluid Temperature Control' revealed the temperature was recorded once for each day of March 1-23, 2009. Review of the log revealed nine of twenty-three entries with a temperature recorded above 104 degrees Fahrenheit. Review of the manufacturer's recommendations revealed the fluids are not to be in the warmer longer than fourteen days. Review of the facility policy titled, 'Blanket Warmer Guidelines' reads, "Blanket warmers that contain fluids shall be maintained at a temperature between 84 and 104 degrees Fahrenheit." Interview in the McNulty conference room on March 23, 2009, at 11:55 a.m., with the Chief Quality Officer, confirmed the facility failed to date fluids at time of placement in the warmer to indicate when to remove fluids prior expiration and failed to assure the fluids were maintained at the proper temperature. Building A	H 683		

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H 683	Continued From page 8 Observation of the Intensive Care Unit (ICU) on March 23, 2009, at 1:35 p.m., with the Registered Nurse (RN) Charge Nurse, revealed patient #6 was intubated and on mechanical ventilation. Observation of patient #6's room revealed a plastic basin in the window sill. Observation of the basin revealed it contained two IV (intravenous) bags of Levaquin (antibiotic) 750mg/150ml; one IV bag of Zyvox (antibiotic) 600mg/300ml; one pre-packaged syringe of Lovenox 100mg/ml; and one bag of Ampicillin 1gram/100mls. Review of facility policy #13-02 revealed, "Drugs shall not be left at a patient's bedside or in a patient's room..." Interview on March 23, 2009, at 1:45 p.m., with the RN Charge Nurse in the ICU, at the nurse's station, confirmed the facility failed to properly store the medications. Building A	H 683	H 683 1200-8-1-.06 (4)(j) (cont.) **ICU – IV fluids/medications in window** One-on-one education to staff member involved, as well as re-education to all other staff members on 4/2/09. The nurse manager and clinical coordinator will monitor for compliance on daily unit rounds. Results of these rounds will be reported no less than quarterly via the QI process.	
	Observation, of the Infusion Therapy nurse's station, on March 24, 2009, at 9:15 a.m., with the Assistant Chief Nursing Officer (ACNO) and the Manager of Ambulatory Care Center, revealed an unlocked cabinet containing two 4 ml syringes of Heparin Lock Flush 100 units per ml and one 300 ml bag of Zyvox 600 mg per ml. Observation revealed the nurse's station had an unlocked door to the central public hall and a nurse was not present in the nurse's station. Interview in the Infusion Therapy nurse's station, on March 24, 2009, at 9:15 a.m., with the ACNO and the Manager of the Ambulatory Care Center, confirmed all medications were to be secured. Building A		**Infusion Therapy Center meds not secured** **Action taken during survey** Cabinet locked date of discovery. All staff re-educated date of discovery that cabinet is to remain locked at all times. In addition, the cabinet will be assessed on the department manager's daily rounds to ensure it continues to be locked. This will be logged on a QI report and reported no less than quarterly via the QI process.	

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H 698	1200-8-1-.06 (5)(j) Basic Hospital Functions 5) Medical Records. (j) All entries must be legible, complete, dated and authenticated according to hospital policy. This Rule is not met as evidenced by: Based on medical record review, and interview, the facility failed to assure the order for sedation was completed by the physician for one (#6) patient of twenty-one patients reviewed. The findings included: Observation of patient #6 in the intensive care unit (ICU) on March 23, 2009, at 1:35 p.m., revealed the patient was sedated while on mechanical ventilation. Further observation revealed a continuous IV (intravenous) infusion of Propofol (medication for sedation) via peripherally inserted central catheter (PICC) line. Medical record review of the physician's orders dated March 21, 2009, revealed a pre-printed order for a continuous infusion of Propofol signed by the physician and included, "Additional bolus...every 10 minutes may be used until the desired effect is obtained..." Record review of the pre-printed order revealed the 'Levels of Sedation RASS Assessment (Richmond Agitation Sedation Scale) section at the bottom of the order had not been completed by the physician. Interview with the RN Charge Nurse at the ICU nurses' station on March 23, 2009, at 1:45 p.m., verified the order for Propofol was to be accompanied by a specified level of sedation and confirmed the physician failed to complete the	H 698	H 698 1200-8-1-.06 (5)(j) ICU Propofol for sedation – MD did not order RASS scale, yet nurses titrating to RASS. Re-education to all applicable staff and physicians on 4/2/09 that RASS scale must be included in the sedation order before titration may commence. The nurse manager and clinical coordinator will audit no less than 30 medical records quarterly and report results via the QI process.	

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H 698	Continued From page 10 order. Building A	H 698		
H 703	1200-8-1-.06 (5)(k)5. Basic Hospital Functions (5) Medical Records. (k) All records must document the following: 5. Properly executed informed consent forms for procedures and treatments specified by hospital policy, or by federal or state law if applicable, as requiring written patient consent; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to assure a properly executed consent was obtained for the use of psychotropic medications for one patient (#2) of twenty-one records reviewed. The findings included: Patient #2 was admitted to the facility on March 19, 2009, with diagnoses to include Alcohol Abuse, Schizoaffective Disorder, Chronic Obstructive Pulmonary Disease, Back Pain, Right Below the Knee Amputation, and Seizure Disorder. Medical record review of a Physician's Order, dated March 20, 2009, at 12:10 p.m., revealed, "... Seroquel (anti-psychotic medication) 50 mg po (by mouth) q (every) hs (night)..." Medical record review of the Informed Consent for Psychotropic Medications revealed the form had not been initiated and the consent was not	H 703	H 703 1200-8-1-.06 (5)(k) 5 On 3/25/09 began one-on-one education with all nurses and physicians regarding completion of consents Education will be completed by 4/30/09. Weekly chart audits will occur to ensure compliance. These results will be reported no less than quarterly via the QI process.	

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H 703	Continued From page 11 signed by the patient. Interview at the nurse's station, on March 23, 2009, at 1:50 p.m., with the Assistant Chief Nursing Officer and the Clinical Manger for Adult Psychiatric Services, confirmed the Informed Consent for Psychotropic Medication form was not completed. Building B	H 703		
H 737	1200-8-1-.06 (9)(e)3. Basic Hospital Functions (9) Food and Dietetic Services. (e) Menus must meet the needs of the patients. 3. A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a current approved diet manual. The findings included: Review of the signature page of the diet manual revealed the last signed approval was dated March 2006. Interview in the Assistant Chief Executive office with Assistant Chief Executive Officer #1 on March 23, 2009, at 1:50 p.m. confirmed the facility had not updated the approval for the diet manual since March 2006. Building A and Building B	H 737	H 737 1200-8-1-.06 (9)(e) 3 Diet Manual: 2006 The Diet Manual will be updated and approved by hospital and medical staff leadership for 2009 by 4/10/09. In addition, the approval process has been modified so that annual approval will occur during the first quarter of each year.	

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H 739	Continued From page 12	H 739		
H 739	1200-8-1-.06 (9)(g) Basic Hospital Functions (9) Food and Dietetic Services. (g) A minimum of three (3) meals in each twenty-four (24) hour period shall be served. A supplemental night meal shall be served if more than fourteen (14) hours lapse between supper and breakfast. Additional nourishment shall be provided to patients with special dietary needs. This Rule is not met as evidenced by: Based on interview the A and B buildings had fifteen (15) hours between supper and breakfast and failed to serve a supplemental night meal to the patients. The findings included: Interview on March 23, 2009, at 10:35 a.m., in the A building dietary department with the A and B buildings' Food Service Director (FSD) revealed the patient meal schedule for the A building was breakfast at 7:00 a.m., and supper at 4:00 p.m. Interview revealed the A building did not provide patients with a supplemental night meal. Interview on March 24, 2009, at 8:40 a.m., in the B building dietary department with the cook revealed the patient meal schedule for the B building was breakfast at 7:30 a.m., and supper at 4:30 p.m. Interview with the cook revealed the B building did not provide patients with a supplemental night meal. Interview on March 23, 2009, at 3:45 p.m., in the A building office of the A and B buildings Food Service Director (FSD) with the FSD revealed the B building's patient meal hours exceeded the 14 hours between	H 739	H 737 1200-8-1-.06 (9)(e) 3 Diet Manual: 2006 The Diet Manual will be updated and approved by hospital and medical staff leadership for 2009 by 4/10/09. In addition, the approval process has been modified so that annual approval will occur during the first quarter of each year.	

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	TNP5316		03/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYRIDGE MEDICAL CENTER	2305 CHAMBLISS AVE NW CLEVELAND, TN 37311

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H 739	Continued From page 13 supper and breakfast. Building A and Building B	H 739	H 741 1200-8-1-.06 (9)(i) **'B' Building** Mixer and microwave not totally clean **Action Taken During Survey:** Both the mixer and microwave were cleaned the same day as the survey. Also, the mixer will be removed no later then 4/10/09 as it has not been used for food prep in several weeks. The microwave is on the daily cleaning list. This will be monitored by auditing the cleaning list and department audit no less than weekly. **'A' Building** Hood filters over range, fryer and grill area with build-up and in disrepair **Action Taken During Survey:** Removed and cleaned during survey. Six stainless steel panels, or baffles, were ordered to replace all existing panels. Cleaning schedule was increased from monthly to weekly. In addition, this will be monitored by auditing the departmental cleaning list no less than weekly. Ceiling with build up **Action Taken During Survey:** All ceilings in the coolers and over the dishwasher have been cleaned and have been added to the monthly departmental audit to ensure that the preventive. schedule is sufficient to prevent gathering of dust within the dietary department. In addition, this will be monitored by auditing the departmental cleaning list no less than monthly.	
H 741	1200-8-1-.06 (9)(i) Basic Hospital Functions (9) Food and Dietetic Services. (i) Food shall be protected from sources of contamination whether in storage or while being prepared, served and/or transported. Perishable foods shall be stored at such temperatures as to prevent spoilage. Potentially hazardous foods shall be maintained at safe temperatures as defined in the current " U.S. Public Health Service Food Service Sanitation Manual " . This Rule is not met as evidenced by: Based on observation and interview, the A building dietary department failed to store, prepare, and maintain food to prevent contamination in the produce and dairy walk-in refrigerators, over the ice in the ice machine, and any food being prepared on the range top, grill or fryers; failed to maintain the dish machine wash and final rinse temperatures per the manufacturer's recommended level; failed to notify infection control of the malfunctioning dish machine; and failed to serve patient cold food at or less than 40 degrees Fahrenheit. Based on observation and staff interview, the B building dietary department failed to maintain a mixer in optimal working condition; and failed to maintain a clean mixer and microwave used in patient food production. The findings included:	H 741		

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NAME OF PROVIDER OR SUPPLIER SKYRIDGE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2305 CHAMBLISS AVE NW CLEVELAND, TN 37311		

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H 741	Continued From page 14 Observation beginning at 10:45 a.m., on March 23, 2009, of the A building dietary department with the A/ B building Food Service Director (FSD) and Assistant Chief Executive Officer (ACEO) #1 present revealed the following: The produce walk-in refrigerator ceiling in front of the condenser unit had blackened debris hanging from the ceiling and the light fixture. This produce refrigerator contained uncovered cases of apples, cantaloupe, red and white onions, lemons, yellow squash, zucchini, oranges, cucumbers, grapes and several plastic packages with holes containing tomatoes and strawberries. The dairy walk-in refrigerator had a four (4) tier shelving unit with 9 cases of pasteurized eggs stored on the bottom shelf. The right side of the bottom shelf was hanging down and was in direct contact with the refrigerator floor. The filters in the hood over the range, fryer and grill area had an accumulation of grease and blackened debris. One filter unit had broken slats revealing the hood vent interior. Two filter units were not in contact with one another which exposed the interior of the hood vent. The ice machine in the dish room had a rusted interior metal plate located over the stored dispensed ice. Interview during the observations beginning at 10:45 a.m., with the FSD and/or ACEO #1 confirmed the produce refrigerator ceiling area had debris with exposed food stored on the shelving units; dairy refrigerator shelving unit was in disrepair and was touching the floor; filters in the hood had accumulation of grease and debris, one filter was in disrepair and two filters were not in contact thus exposing the hood interior to any food that would be on the stove, fryer, and grill; and the ice machine interior metal plate was rusted.	H 741	Ice machine rusty inside **Action Taken During Survey:** The ice machine was cleaned day of survey with a baking powder and water paste. This was added to the departmental weekly cleaning list and will be monitored by auditing the departmental cleaning list no less than weekly. Broken shelf in walk-in fridge with one part on floor **Action Taken During Survey and Request:** Shelf repaired on date of discovery. Dishwasher with temps frequently lower than 150° for wash and 180° for rinse cycles and no action. **Action Taken and Continuing:** Wash temperature is now at appropriate range with replacement of a heating element and increased breaker. The final rinse temperature is now at appropriate range after company that maintains boilers were contacted and made site visit on 3/27/09 to increase temperature of inflowing water. The temperature logs are now being sent to the Infection Control Director on a monthly based for inclusion in the Infection Control and Review Process. Debris on ceiling in dishwashing room **Action Taken During Survey:** Removed debris day of survey. This was added to the departmental weekly cleaning list and will be monitored by auditing the departmental cleaning list no less than weekly.	

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H 741	Continued From page 15 Observation on March 23, 2009, beginning at 1:40 p.m., of the A building dish room with the A/B building FSD present revealed the following: The dish machine was in operation and the manufacturer's recommendation were 150 degrees Fahrenheit (F) minimum for wash and 180 degrees F minimum for the final rinse. Observation revealed temperatures of three (3) wash cycles revealed 138, 140, 142 degrees F and the final rinse cycles 170, 174, and 178 degrees F. Review of the documentation on the dish machine temperature log from January 3, 2009, through March 23, 2009, lunch operation revealed the following: 1.) Wash temperatures less than 150 degrees following: 55 breakfast; 47 lunch; and 26 supper. 2.) Wash temperatures not recorded: 15 breakfast; 11 lunch; and 41 supper. 3.) Final rinse less than 180 degrees following: 64 breakfast; 66 lunch; and 30 supper. 4.) Final rinse temperature not recorded: 15 breakfast; 11 lunch; and 39 supper. Further review revealed no documentation of any action taken when temperatures were less than the manufacturer's recommended minimum temperature. Interview, at the time of the observation in the dish room, with the A/B building FSD confirmed the actual temperatures during the operation of the machine were less than the 150 degrees F for the wash cycle and 180 degrees F for the final rinse cycle. Further interview regarding the dish machine wash and rinse temperature log confirmed the documented temperatures were not per the manufacturer's recommendation and there was no documentation of action taken when temperatures were not per the recommendation. Interview with the Director of Infection Control on March 25, 2009, at 11:20 a.m. in the McNulty Conference Room revealed the Director had not	H 741	Walk-in produce cooler with debris on ceiling and some produce containers open **Action Taken During Survey And Request:** Debris from ceiling has been removed. This was added to the departmental weekly cleaning list and will be monitored by auditing the departmental cleaning list no less than weekly. Staff re-educated regarding maintaining cold items in appropriate fridge in order to maintain correct temperatures. The supervisors will perform daily pre-tray line audits of not only food temps, but also proper storage of cold items. Daily audit logs per meal will be documented by the supervisors and audited by the Director.	

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H 741	Continued From page 16 been made aware of the malfunctioning dish machine nor was the dish machine part of the infection control review process. Continued observation revealed a ceiling vent and the ceiling area around this vent, located over the end of the dish machine dispensing the clean dishes, had a heavy accumulation of blackened debris hanging from the ceiling and the vent. Continued observation revealed a dietary staff employee was cleaning the exterior and interior of the patient tray delivery carts in the dish room. Above the carts the employee was cleaning was a ceiling vent and the ceiling area around this vent with a heavy accumulation of blackened debris hanging from the ceiling and the vent. Interview with the FSD of observations beginning at 1:40 p.m., confirmed the two ceiling vents and surrounding ceiling areas had debris accumulation and were located over clean dishes and delivery equipment. Observation of the A building patient mid-day meal trayline on March 24, 2009, beginning at 11:10 a.m., revealed the trayline was in operation. Interview with the A/B building FSD, present during the observation beginning at 11:10 a.m., revealed two patient delivery carts had been delivered. Observation revealed a dietary staff member obtaining the milk temperature stored in an opened door reach-in refrigerator on the trayline. Interview with this staff member confirmed the milk was 45.5 degrees Fahrenheit (F) and the door had been open for about twenty (20) minutes. Further interview revealed the temperature was to be at or less than 40 degrees F. Observation of the B building dietary department	H 741		

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H 741	Continued From page 17 on March 24, 2009, beginning at 7:30 a.m. revealed a table top mixer with numerous dried white and tan colored splatters on the underside of the beating arm. Further observation of the mixer revealed gear grease had penetrated the seal and was running down the side of the top of the mixer base and could drip into the mixer bowl. Observation of the microwave revealed a heavy accumulation of dried debris attached to the interior ceiling of the microwave. Interview with the B building cook at 8:30 a.m. on March 24, 2009, confirmed the table top mixer had dried splatters and grease on the side of the unit and the microwave interior were not clean.	H 741		
H1209	1200-8-1-.12 (2) Patient Rights (2) Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment (including resuscitative services). This right of self-determination may be effectuated by an advance directive. Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to assure Advance Directives were clarified for three patients (#1, #7, and #11) of twenty-one records reviewed. The findings included: Patient #1 was admitted to the facility for an out-patient Colonoscopy (invasive procedure	H1209	H 1209 1200-8-1-.12 (2) Nurses not documenting intent of Advance Directives. MD not documenting discussion of DNR order with pt/no rationale in progress notes. By 4/30/09 the nursing electronic documentation tool will require completion of the DNR intent before allowing nursing to go to the next field. Nurses will be educated about this topic during the 4/22 – 4/23/09 annual skills fair. Physicians will be re-educated regarding documentation of DNR rationale at the 4/14/09 general medical staff meeting and via memo. No less then 30 audits will be completed per unit per quarter to ensure compliance with documentation. These audits will be reported via the QI process.	

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H1209	Continued From page 18 requiring sedation), on March 23, 2009, with diagnoses to include Follow Up Malignant Neoplasm with History of Colon Cancer. Medical record review of the nurse's Initial Interview, dated March 23, 2009, at 6:57 a.m., revealed "...Do you have a living will? "yes"...Intent of living will? (left blank)..."; and review of the Informed Consent for Treatment, dated March 23 2009, revealed "...I have executed Advanced Directives..." Interview, at the nurse's station, on March 23, 2009, at 12:15 p.m., with the Assistant Chief Nursing Officer, confirmed the patient had identified having Advanced Directives and the wishes of the patient related to end of life care decisions were not clarified. Building B Patient #11 was admitted, in transfer from the medical floor, to the facility's Step Down Unit on March 22, 2009, with diagnoses to include Gastro-intestinal Bleeding, Congestive Heart Failure, and Deep Vein Thrombosis. Medical record review of the Physician's Transfer Orders, dated March 22, 2009, at 12:20 p.m., revealed "...Full Code (take all measures to sustain/maintain life)..." Medical record review of the Consent to Treatment form, dated March 20, 2009, revealed "...I have Executed Advanced Directives (copy requested)..." Continued medical record review of the nurse's Initial Interview, dated March 20, 2009, at 4:22 p.m., revealed "...Do you have a living will? "yes"...Intent of living will? "son"..." Interview, in the patient's room, by the Assistant Chief Nursing Officer, revealed the patient's daughters confirmed the patient had given the facility a copy	H1209		

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H1209	Continued From page 19 of the living will on a previous admit and, to their knowledge, the patient did not want extra measures to prolong life. Interview, at the nurse's station of the Step Down Unit, on March 24, 2009, at 10:40 a.m., with the Assistant Chief Nursing Officer, confirmed the patient had been identified as having Advance Directives; the physician's order for Full Code would be carried out if the patient's heart and/or breathing ceased; and the patient's wishes had not been clarified. Building A Medical record review revealed patient #7 was admitted on March 23, 2009, with diagnoses including Multiple Melanoma. Interview and observation at 2:00 p.m., with patient #7 on March 23, 2009, revealed a unit of blood was infusing and the patient related a history of cancer and presently being on chemotherapy. Medical record review of the physician's orders revealed a DNR (Do Not Resuscitate) order written March 23, 2009, without an accompanying progress note. Interview on March 23, 2009, with the manager of the third floor nursing unit, at 2:20 p.m., verified the physician had not indicated the rational for the order within the medical record. During the interview, the nurse manager obtained a copy of the hospital's policy for DNR orders (last revised July 2008) which stated a POST (Physician's Order for Scope of Treatment) form was to be used for DNR orders and, "...The attending physician should write a note in the progress section of the medical record indicating the rational for the DNR order..." Interview confirmed the DNR order as written was not acceptable because the physician did not define who had been involved in the decisionmaking or when the decision had been made for the patient	H1209		

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H1209	Continued From page 20 to be a DNR. Building A	H1209		
H1345	1200-8-1-.13 (30)(a) Pol. & Proced. for Health Care Dec. Making (30) Universal Do Not Resuscitate Order (DNR). (a) The Physicians Order for Scope of Treatment (POST) form, a mandatory form meeting the provisions of the Health Care Decision Act and approved by the Board for Licensing Health Care Facilities, shall be used as the Universal Do Not Resuscitate Order by all facilities. A universal do not resuscitate order (DNR) may be issued by a physician for his/her patient with whom he/she has a physician/patient relationship, but only: 1. with the consent of the patient; or 2. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient ' s behalf under the Tennessee Health Care Decisions Act; or 3. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient ' s behalf under the Tennessee Health Care Decisions Act is not reasonably available, the physician determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.	H1345	H 1345 1200-8-1-.13 (30)(a) All Case Managers have been re-educated regarding use and completion of the POST form for transfers. Education regarding the POST form will be added to nursing orientation and will be included in annual nursing re-orientation by 4/30/09. In addition, all current nursing staff will receive education on 4/22 and 4/23/09 during the organization's annual skills fair. No less then 30 audits will be completed per unit per quarter to ensure compliance with documentation. These audits will be reported via the QI process.	

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H1345	Continued From page 21 This Rule is not met as evidenced by: Based on records review, policy review, and interview, the facility failed to provide a POST (Physician's Order for Scope of Treatment) form for patients with a DNR (Do Not Resuscitate) order when being transferred from the hospital to another healthcare provider. The findings included: Interview on March 23, 2009, in the conference room the Chief Nursing Officer (CNO) at 10:35 a.m., revealed the CNO was unable to provide information related to the hospital's utilization of the POST. Review of the "2009 General Re-Orientation" document provided by the CNO on March 24, 2009, revealed the following, "DNR (POST) Form: "...used for definition and order of scope of treatment...If a patient is transferred to another facility, the POST form must accompany the patient..." Interview on March 23, 2009, with a Discharge Planning nurse at the third floor nursing station at 2:25 p.m., revealed the hospital's nursing staff and the discharge planning nurses had not utilized the POST form. Interview revealed a longstanding transfer form, with a "Resuscitation Status" at the bottom of the form, continued to be used at the present time and the discharge planning nurse stated he/she was unfamiliar with the POST as a required document for patients with a DNR order transferring to another facility.	H1345		

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H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Rule is not met as evidenced by: Based on observation, the facility failed to assure the building is constructed and maintained to ensure the safety of the residents and staff. The Findings include: Observation on March 23, 2009 at 11:45 a.m. revealed one (1) electrical junction box above the ceiling on the fourth (4th) floor at patient room 428 has no cover installed with exposed wiring. Observation on March 23, 2009 at 2:30 p.m. revealed the Automatic Sprinkler System riser room located in the Emergency Department had three (3) rolling storage barrels blocking the riser room doorway.	H 871	H 871 1200-8-1-.08 (1) Electric Junction Box with no cover/wires exposed and ED sprinkler covered by 3 rolling storage barrels. Completed 3/26/09. EOC audits occur twice monthly and this issue will be assessed on areas inspected.	
H 872	1200-8-1-.08 (2) Building Standards (2) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to assure the condition of the physical plant and the overall Hospital environment is maintained to ensure the safety and well-being of the residents and staff. The findings include: Observation on March 23, 2009 at 10.00 a.m. revealed a heavy build up of dirt and rust on the air diffuser in the food storage room located in the kitchen area. Observation on March 23, 2009 at 10:45 a.m.	H 872	H 872 1200-8-1-.08 (2) Heavy build up of dirt and rust in air diffuser in food storage area in kitchen. Completed 4/01/09. EOC audits occur twice monthly and this issue will be assessed on areas inspected. Numerous penetrations above fire rated doors at entrance to Infusion Center. Completed 3/27/09. EOC audits occur twice monthly and this issue will be assessed on areas inspected.	

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(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 872	Continued From page 1 revealed numerous penetrations above the fire rated doors at the entrance to the infusion center located on the fifth (5th) floor. Observation on March 23, 2009 at 11:00 a.m. revealed numerous penetrations above the ceiling in the electrical room on the fourth (4th) floor near patient room 403.	H 872	H 893 1200-8-1-.08 (23) EVS closet in kitchen with no negative air flow. Completed 4/02/09 No positive air flow in clean linen room in EDNO 1 on 5th floor. Completed 4/02/09	
H 893	1200-8-1-.08 (23) Building Standards (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observation, the facility failed to assure a negative air pressure is maintained in all soiled (dirty) areas. The findings include: Observation on March 23, 2009 at 10:10 a.m. revealed the housekeeping closet located in the kitchen has no negative air flow installed. Based on observation, the facility failed to assure a positive air pressure is maintained in all clean areas. The findings include: Observation on March 23, 2009 at 10:30 a.m. revealed no positive air flow installed in the clean linen room located in the ENDO1 procedure room on the fifth (5th) floor. Observation on March 23, 2009 at 2:00 a.m. revealed no positive air flow installed in the clean linen room located in the labor/delivery staff lounge area. Other findings revealed no door installed to	H 893	No positive air flow in clean linen room in L&D staff area. No door installed to maintain positive air pressure in the clean linen room in the L&D staff lounge area. Door ordered to be completed By 4/20/09 EOC audits occur twice monthly and this issue will be assessed on areas inspected.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP5316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED 03/24/2009
NAME OF PROVIDER OR SUPPLIER SKYRIDGE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2305 CHAMBLISS AVE NW CLEVELAND, TN 37311		

(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 893	Continued From page 2 maintain a positive pressure in the clean linen room located in the labor/delivery staff lounge area.	H 893	Fire alarm strobe light installed in kitchen area is blocked by a rolling dish cart. Completed on 3/23/09	
H 902	1200-8-1-.09 (2) Life Safety (2) The hospital shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for hospital personnel in each separate patient-occupied hospital building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of patient(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information. Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. This Rule is not met as evidenced by: Based on observation, the facility failed to assure the necessary fire fighting equipment is installed	H 902	One smoke detector installed within 3 feet of an air diffuser in the North storage closet in the surgery unit. Completed 3/30/09 No auto sprinkler installed in the auxiliary AC unit room in ICU. Completed 3/27/09 EOC audits occur twice monthly and this issue will be assessed on areas inspected.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP5316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED 03/24/2009
NAME OF PROVIDER OR SUPPLIER SKYRIDGE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2305 CHAMBLISS AVE NW CLEVELAND, TN 37311		

(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 902	Continued From page 3 and maintained to ensure the safety of the residents and staff. The findings include: Observation on March 23, 2009 at 10:00 a.m. revealed the fire alarm strobe light installed in the kitchen area is blocked by rolling dish storage cart. Observation on March 23, 2009 at 1:00 p.m. revealed one (1) smoke detector installed within three (3) feet of an air diffuser located in the North storage closet in the Surgery unit. Observation on March 23, 2009 at 2:45 p.m. revealed no automatic sprinkler head installed in the auxiliary a/c unit room located in the ICU area.	H 902		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNSAT024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WESTSIDE CAMPUS B. WING	(X3) DATE SURVEY COMPLETED 03/24/2009
NAME OF PROVIDER OR SUPPLIER SKYRIDGE MEDICAL CENTER - WESTSIDE CA	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 WESTSIDE DRIVE CLEVELAND, TN 37311		

(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 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Rule is not met as evidenced by: Based on observation, the facility failed to assure the building is constructed and maintained to ensure the safety of the residents and staff. The Findings include: Observation on March 24, 2009 at 12:45 p.m. revealed one (1) electrical junction box above the ceiling on the 300 wing at the exit doors has no cover installed with exposed wiring.	H 871	SkyRidge Westside Building CAP: H 871 1200-8-1-.08 (1) Electric Junction Box with no cover/wires exposed above the ceiling on the 300 wing at the exit doors. Completed 3/24/09. EOC audits occur twice monthly and this issue will be assessed on areas inspected.	
H 893	1200-8-1-.08 (23) Building Standards (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observation, the facility failed to assure a negative air pressure is maintained in all soiled (dirty) areas. The findings include: Observation on March 24, 2009 at 12:30 p.m. revealed the housekeeping closet located on the 300 hall near registration has no negative air flow. Observation on March 24, 2009 at 12:55 p.m. revealed the soiled linen room located in day surgery area has no negative air flow. Based on observation, the facility failed to assure a positive air pressure is maintained in all clean	H 893	H 893 1200-8-1-.08 (23) EVS closet on 300 hall with no negative air flow. Soiled linen room in day surgery area with no negative air flow. Exhaust Fan ordered to be completed by 4/12/09 No positive air pressure in clean linen room on 300 hall. Completed 4/02/09 EOC audits occur twice monthly and this issue will be assessed on areas inspected.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNSAT024	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - WESTSIDE CAMPUS B. WING	(X3) DATE SURVEY COMPLETED 03/24/2009
NAME OF PROVIDER OR SUPPLIER SKYRIDGE MEDICAL CENTER - WESTSIDE CA	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 WESTSIDE DRIVE CLEVELAND, TN 37311		

(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 893	Continued From page 1 areas. The findings include: Observation on March 24, 2009 at 12:35 p.m. revealed the clean linen room (door 42) on the 300 hall has no positive air flow.	H 893		

The Joint Commission

April 6, 2017

Coleman Foss
CEO
Cleveland Tennessee Hospital Company, LLC
2305 Chambliss Avenue, NW
Cleveland, TN 37311

Joint Commission ID #: 7819
Program: Laboratory Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 04/06/2017

Dear Mr. Foss:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing**

This accreditation cycle is effective beginning February 04, 2017 and is customarily valid for up to 24 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

The following laboratory services have been surveyed under Joint Commission standards in accordance with the Clinical Laboratory Improvement Amendments of 1988 :

CLIA# 44D0309307 for the specialties and subspecialties of Bacteriology, Mycobacteriology, Mycology, Parasitology, Virology, General Immunology, Routine Chemistry, Urinalysis, Endocrinology, Toxicology, Andrology, Coagulation, Hematology, Blood Transfusion Services, Immunohematology(ABO Group and RH, Antibody Transfusion, Antibody Non-Transfusion, Antibody Identification, Compatibility Testing), Histopathology, Oral Pathology, Dermatopathology, Cytology, Therapeutic Phlebotomy and Tissue Banking. Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

Attachment B-Economic Feasibility-A.1

Filing Fee Check Copy

CHECK NO. 274706 DATE 3/09/18
VENDOR H100

INVOICE NUMBER	INVOICE DATE	INVOICE DESCRIPTION	GROSS AMOUNT	DISCOUNTS	NET AMOUNT THIS CHECK
FSED CON 030918	3/09/18	CON FILING FEE FSED	69069.72		69069.72
PAGE 1		TOTALS	GROSS AMOUNT 69069.72	DISCOUNT AMOUNT	NET AMOUNT 69069.72

ORIGINAL CHECK HAS A COLORED BACKGROUND PRINTED ON CHEMICAL REACTIVE PAPER - SEE BACK FOR DETAILS

CLEVELAND TENNESSEE HOSPITAL COMPANY
2305 CHAMBLISS AVENUE
CLEVELAND, TN
37311

66-156
531
WELLS FARGO BANK

CHECK DATE 3/09/18

CHECK NUMBER 274706

PAY THIS AMOUNT
$********69,069.72

PAY EXACTLY ****SIXTY-NINE THOUSAND SIXTY-NINE DOLLARS AND 72 CENTS

PAY TO THE ORDER OF
HEALTH SERV & DEVELOP AGENCY
ANDREW JACKSON ST OFFICE BLD
500 DEADRICK ST,STE 850
NASHVILLE, TN 37243-0000

⑈274706⑈ ⑆053101561⑆ 2079900621343⑈

Attachment B-Economic Feasibility-A.3

Equipment Quotes

GE Healthcare

Date:	02-07-2018
Quote #:	PR4-C112657
Version #:	1

Tennova Healthcare Cleveland
2305 Chambliss Ave NW
Cleveland TN 37311-3847

Attn: Shannon Ricco
2305 Chambliss Ave NW Cleveland
TN 37311-3847

Customer Number : 1-25POLC
Quotation Expiration Date: 05-03-2018

The terms of the Master Purchasing Agreement, Strategic Alliance Agreement or GPO Agreement referenced below as the Governing Agreement shall govern this Quotation. No additional or different terms shall apply unless agreed to in writing by authorized representatives of both parties.

Governing Agreement:	HPG
Terms of Delivery:	FOB Destination
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	NET 30
Total Quote Net Selling Price:	$319,755.57

Please Select Tax Status Of Order

☐ Exempt from Sales and Use Tax (Note: GEHC must have a Current Tax Exemption Certificate)

☐ Subject to Sales and Use Tax

INDICATE FORM OF PAYMENT:

If "GE HEF Loan" or "GE HEF Lease" is NOT selected at the time of signature, then you may NOT elect to seek financing with GE Healthcare Equipment Finance (GE HEF) to fund this arrangement after shipment.

____Cash/Third Party Loan

____GE HEF Lease

____GE HEF Loan

____Third Party Lease (please identify financing company) _____

By signing below, each party certifies that it has not made any handwritten modifications. Manual changes or mark-ups on this Agreement (except signatures in the signature blocks and an indication in the form of payment section below) will be void.

Each party has caused this agreement to be executed by its duly authorized representative as of the date set forth below.

CUSTOMER

_____ _____
Authorized Customer Signature Date

_____ _____
Print Name Print Title

_____
Purchase Order Number (if applicable)

GE HEALTHCARE
Tracy Vaught 02-15-2018
Signature Date

Imaging Account Manager

Email: Tracy.Scherer@ge.com
Office: +1 205 876 4350
Mobile: 205-876-4350
Fax: 205-449-9428

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General Electric Company, GE Healthcare Division

GE Healthcare

Date:	02-07-2018
Quote #:	PR4-C112657
Version #:	1

Total Quote Selling Price	**$319,755.57**
Trade-In and Other Credits	$0.00

Total Quote Net Selling Price	**$319,755.57**

To Accept this Quotation

Please sign and return this Quotation together with your Purchase Order To:
Tracy Vaught
Office: +1 205 876 4350
Mobile: 205-876-4350
Email: Tracy.Scherer@ge.com
Fax: 205-449-9428

Payment Instructions

Please **Remit** Payment for invoices associated with this quotation to:
GE Healthcare
P.O. Box 96483
Chicago, IL 60693

To Accept This Quotation

- Please sign the quote and any included attachments (where requested).
- If requested, please indicate, your form of payment.
- If you include the purchase order, please make sure it references the following information
  - The correct Quote number and version number above
  - The correct Remit To information as indicated in **"Payment Instructions"** above
  - The correct SHIP TO site name and address
  - The correct BILL TO site name and address
  - The correct Total Quote Net Selling Price as indicated above

"Upon submission of a purchase order in response to this quotation, GE Healthcare requests the following to evidence agreement to contract terms.
Signature page on quote filled out with signature and P.O. number.
**********OR**********
Verbiage on the purchase order must state one of the following: (i) Per the terms of Quotation #_____; (ii) Per the terms of GPO#_____; (iii) Per the terms of MPA #_____; or (iv) Per the terms of SAA #_____. Include the applicable quote/agreement number with the reference on the purchase order.
In addition, source of funds (choice of: Cash/Third Party Loan or GE HFS Lease or GE HFS Loan or Third Party Lease through _____), must be indicated, which may be done on the quote signature page (for signed quotes), on the purchase order (where quotes are not signed) or via a separate written source of funds statement (if provided by GE Healthcare)."

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General Electric Company, GE Healthcare Division

GE Healthcare

Date:	02-07-2018
Quote #:	PR4-C112657
Version #:	1

02-07-2018

GPO Agreement Reference Information

Customer:	Shannon Ricco
Contract Number:	500043, 500352, 500174, 500072, 500151, 500150, 500277, 1451, 1450, 000903
Start Date:	
End Date:	05/31/2020
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	NET 30
Shipping Terms:	FOB Destination

For a copy of the GPO contract or summary, please go to your GPO Membership login page scrubs.healthtrustpg.com. If a copy of the contract is not available on your membership page, please contact your GPO client manager.

Offer subject to the Terms and Conditions of the applicable Group Purchasing Agreements currently in effect between GE Healthcare and HealthTrust Purchasing Group includes 500043 (Imaging).

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General Electric Company, GE Healthcare Division

GE Healthcare

Date: 02-07-2018
Quote #: PR4-C112657
Version #: 1

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
	1		**GOLDSEAL VCT64**			
1	1	S9330ST	GoldSeal VCT64 Used Tube 1700MM, ASiR This product complies with NEMA Standard XR 29-2 2013 8Mhu tube, Original tube Your VCT64 slice/channel will ship with the following options: Hardware: Gantry, Console, Table, PDU including: GOC6.6 console USB Trackball Global Scan Control Box (SCIM) Single Bay Peripheral tower with DVD read/write drive 3 button USB Optical mouse LCD Monitors 2 Axial Head Holder Metaless Supine Coronal head holder Cradle extender QA Phantom 185mm Poly Phantom Rear cable cover Freshly painted gantry/table covers VCT cable set In ship collector B7864JD: Operator stool, service cabinet, IV Pole, New gantry base covers, patient positioning wedges/straps, table tray Standard Software: Adaptive Statistical Iterative Reconstruction 35 frame per second reconstruction Interchange sw key, DVD Data Export sw key, DVD DMPR sw key, DVD Exam Split sw key, DVD Larg Image Series sw key, DVD Auto MA sw key, no DVD Smart Prep sw key, DVD VCT 64 slice sw key, DVD Neuro Filter sw key, DVD Connect Pro sw key, DVD Dynamic Z-axis tracking Auto Filter and Transfer sw key, DVD 85kw s/w key, DVD Volume Viewer s/w key The LightSpeed VCT(tm) provides technologies that deliver true clinical	$800,000.00	65.81%	$273,511.51

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General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			performance with the ability to acquire sub mm resolution with wider coverage. V-Res (TM) Detector technology providing 40mm of volume acquisition capability with 58,368 individual detector elements comprised of 64 rows of 0.625mm thickness at isocenter delivering up to 0.35mm of resolution for optimized MPR and 3D imaging. Diode technology providing true 64 channel acquisition and a platform for future growth. 40mm anatomical coverage per rotation with 0.625mm slices. Enhanced features for cardiac applications including: ECG waveform display on the console, cardiac optimized bowtie filters for dose reduction and cardiac specific image filters. Complete workflow solutions to support the acquisition of 64 sub-mm slices per rotation. DMPR that enables the move from 2D review to prospective 3D image review of axial, sagittal, coronal and oblique planes...automatically. Exam Split delivering the capability to "split" a series of patient images into separate groups for networking. Vari-Speed, GE's exclusive variable speed capability for enhanced coronary angiography (0.4s, 0.42, 0.45, 0.47, 0.5, 0.6, 0.7, 0.8, 0.9, 1.0s). Performix(tm) Pro VCT (tm) 100 tube			

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General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			and generator technology delivering 85kW,700mA. ASiR Adaptive Statistical Iterative Reconstruction Our exclusive ASiR* reconstruction technology brings high diagnostic image quality at optimized dose to your clinical practice. ASiR is a leap ahead in dose management. ASiR may allow for reduced mA in the acquisition of diagnostic images, thereby reducing the dose required ASiR may enable improvement in low-contrast detectability ASiR may help achieve confident diagnosis with lower dose Disclaimer: In clinical practice, the use of ASiR 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 a particular task. ASiR is a trademark of General Electric Company Table: Patient Positioning System sets the standard for comfort, function and form. The table is designed for the needs of today and tomorrow with 500lb (227kg) patient weight capacity, with full cradle extension. Two configurations, with up to 2000* mm scannable range (or 1700mm), for longer runoff studies, flexible patient positioning, and easy room			

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General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			siting. Faster motion with smooth acceleration and Deceleration As demanded by next generation Volume CT scanners. True vertical motion, without translation in z, improves Patient positioning and productivity for biopsies. InSite Broadband Built In includes hardware install support essential for systems to be ready for high speed internet connection. Enables customer to access services designed to: improve quality, enhance performance, increase productivity, reduce costs, reduce downtime, expand imaging capabilities, and increase privacy and security of data transmission. NOTE: THIS SYSTEM WILL ONLY INSTALL INTO A ROOM WITH A MINIMUM ROOM WIDTH 14FT 6IN For US and Canadian Customers, this quotation includes access to the DoseWatch Explore application for a period of time concurrent with the system warranty. DoseWatch Explore is an introductory dose management software application that provides you secure access, via any PC with internet access, to dose and protocol data from this system. An InSite connection to the system and completion of the registration process is required to use the DoseWatch Explore application. SITING CONSIDERATIONS See the			

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General Electric Company, GE Healthcare Division

GE Healthcare

Date: 02-07-2018
Quote #: PR4-C112657
Version #: 1

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			Pre-Installation manuai for details of the siting requirements for LightSpeed VCT(tm). REGULATORY COMPLIANCE This product is designed to comply with Control for Health and Safety Act of 1968. Laser alignment devices contained with this product are appropriately labeled according to the requirements of the Center for Devices and Radiological Health. This product is a CT-compliant device which satisfies regulations regarding Electro Magnetic Compatibility (EMC) and Electro-Magnetic Interference (EMI), pursuant to IEC-601. Warranty This product, including the accompanying X-ray tube, comes with a one year warranty. Availability Since GoldSeal(tm) Preowned Equipment may be Offered Simultaneously to Several Customers, its Sale to You is Subject to Availability and Subject to Prior Sale at the Time You Offer to Purchase It. If the Equipment is no Longer Available, (1) We Will Attempt to Identify Other GoldSeal(tm) Preowned Equipment in Our Inventory that Meets Your Needs, and (2) if Substitute Equipment is Not Acceptable to You, We Will Cancel Your Order and Refund Any Deposit You Have Paid us for the Canceled Order.			
2	1	B7900LC	Low Dose CT Lung Screening Option	Incl.	Incl.	Incl.

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General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			with Indication For Use This option provides lung screening reference protocols that are tailored to the CT system, patient size (small, average large), and the most current recommendations from a wide range of professional medical and governmental organizations. Now, qualified GE Healthcare CT scanners with this option are formally indicated for, and can be confidently used by physicians for low dose CT lung cancer screening of identified high-risk patient populations. These protocols deliver low dose, short scan times, and clear and sharp images for the detection of small lung nodules. Early detection from an annual lung screening with low dose CT in high-risk individuals can prevent a substantial number of lung cancer-related deaths. All new GE 64-slice and greater CT scanners, and virtually all of the 16-slice CT scanners that GE Healthcare sells are qualified for this screening option. This solution is also available to thousands of qualified GE CT scanners currently in use, increasing access to the quality scanners that satisfy both patient and physician needs. The new protocols, do include the choice for the user to be able to utilize GE Healthcare's industry-leading technologies such as ASiRTM, ASiR-VTM and VeoTM that are designed to reduce image noise, which is undesirable for physicians			

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General Electric Company, GE Healthcare Division

GE Healthcare

Date: 02-07-2018
Quote #: PR4-C112657
Version #: 1

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			looking for small nodules. This option contains two documents. Lung Cancer Screening Option Reference Protocol Guide, and the Lung Cancer Screening Option User Manual / Technical Reference Manual i) The following GE Healthcare CT scanners are qualified to receive the new low dose CT Lung Cancer Screening Option: LightSpeed 16, BrightSpeed Elite, LightSpeed Pro16, Optima CT540, Discovery CT590 RT, Optima CT580, Optima CT580 W, Optima CT590 RT, LightSpeed Xtra, LightSpeed RT16, LightSpeed VCT, LightSpeed VCT XT, LightSpeed VCT XTe, LightSpeed VCT Select, Optima CT660, Revolution EVO, Discovery CT750 HD, Revolution HD, Revolution CT, Revolution Frontier. ii) Moyer V. Screening for Lung Cancer: U.S. Preventive Services Task Force Recommendation Statement. Ann Intern Med. 2014;160:330-338. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/lung			
3	1	B7820GN	GANTRY IF - VCT IB GANTRY IF - VCT IB	$12,000.00	65.81%	$4,102.67
4	1	E4502F	14 KVA 3-Phase Partial UPS for VCT The 14KVA Partial UPS has been specifically designed to coordinate with GE Healthcare CT & PET/CT scanners. In the event of a power outage a partial system UPS provides	$27,000.00	21.00%	$21,330.00

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Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			continuous backup			
			power to the scanner host and control computers,			
			thus assuring no loss of usable scan data.			
			o Critical circuits in the gantry and table			
			remain powered which facilitate the safe			
			removal of the patient from the scanner.			
			o If power is restored within the battery			
			hold-up time, the operator can continue			
			scanner operations without the need to			
			reboot the system.			
			o When longer power outages are anticipated,			
			the UPS provides time for the operator to			
			safely remove the patient and complete an			
			orderly shutdown of the system software			
			o Maintains system electronics and allows			
			critical scanner operations to continue for			
			10 minutes (typical) after loss of power			
			o Protects electronics from under voltage,			
			brownouts, line sags, over voltage			

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General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			and transients SPECIFICATIONS o Dimensions (H x W x D): 49" x 12" x 32" o Weight: 620 lbs. o Output Frequency: 50 or 60 Hz, auto-sensing NOTE: ITEM IS NON-RETURNABLE AND NON-REFUNDABLE NOTE: REMOVAL/DISPOSAL OF OLD UPS IS THE CUSTOMER'S RESPONSIBILITY NOTE: INSTALLATION AND RIGGING IS NOT INCLUDED NOTE: CONTACT GE SERVICE OR EATON FOR START-UP ASSISTANCE			
5	1	E4502AE	125A Main Disconnect Panel (US) The 125 Amp CT System Main Disconnect Panel (MDP) serves as the main facility power disconnect source installed ahead of the system PDU. The MDP will disconnect system power on first loss of incoming power, helping to prevent damage to system components. It also includes an automatic restart control circuit which restores power to the CT System PDU after a power outage. • Can reduce installation time and cost by eliminating delays in obtaining individually enclosed components and on site assembly (ex: main circuit breaker, feeder overcurrent devices, magnetic contactors	$9,671.00	21.00%	$7,640.09

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			and UPS emergency power off are combined into a single panel • Configuration flexibility - can be used as a stand-alone main disconnect or with the optional partial system UPS. (On systems where the optional partial system UPS is used the main disconnect panel also provides NEC mandated emergency power off control to both the PDU and UPS • Designed and tested for GEHC CT products SPECIFICATIONS • Automatic restart incorporates an adjustable time delay to delay main power until the power has stabilized for 5 seconds • One flush wall mounted remote emergency off pushbutton furnished with each system • UL, cUL and CE labeled			
6	1	E8016AZ	CT Table Slicker with Cushion - 1700 Systems (2-pc Set) CT Table Slicker with Cushion - 1700 Systems (2 Piece Set) FEATURES/BENEFITS • Two-piece, sealed slicker cushion set has comfort pads enclosed inside the slicker cover and extender cover • Durable, clear PVC plastic cover	$420.00	21.00%	$331.80

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			facilitates faster, more thorough cleanup of blood and fluids • Increase system uptime by protecting table from spills and particulate contaminants • Thermo-sealed seams and flaps prevent contaminate buildup in hard to clean areas COMPATIBILITY • VCT with GT 1700 Table, CT HD750			
7	1	E8016BA	CT Footswitch Slicker - 2000 & 1700 Systems CT Footswitch Slicker - 2000 & 1700 Systems The footswitch slicker for CT VCT 2000 and 1700 systems is made of durable, clear PVC plastic that protects the footswitch and facilitates faster, more thorough cleanup of contamination caused by blood and other body fluids. Cover is held securely in place with Velcro...H	$50.00	21.00%	$39.50
8	1	W0113CT	TiP CT Basic Training 6 Days Onsite 10 Hours TVA TiP CT Basic Training 6 Days Onsite 10 Hours TVA TiP Applications CT Basic Training for LightSpeed, LightSpeed VCT and BrightSpeed Systems includes: • 6 onsite days covered in two site visits • 10 hrs. TVA	$12,800.00	0.00%	$12,800.00

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date:	02-07-2018
Quote #:	PR4-C112657
Version #:	1

Item No.	Qty	Catalog No.	Description	Contract Price	Discount	Ext Sell Price
			All elements of the programs are completed within 36 months post installation. Onsite training and TVA are delivered Monday through Friday between 8AM and 5PM. T&L expenses are included.			

Quote Summary:

Total Contract List Price:	**$861,941.00**
Total Discount:	**($542,185.43)**
Total Extended Selling Price:	**$319,755.57**
Total Quote Net Selling Price	**$319,755.57**

(Quoted prices do not reflect state and local taxes if applicable. Total Net Selling Price Includes Trade In allowance, if applicable.)

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

CHS Service Program Service Contract Addendum

Quote ID: B8183A2

TENNOVA HEALTHCARE CLEVELAND

CHS

Physical Location Account #: 151061

Optional: Person(s) to be notified when this document is processed:

Name(s): _____

Email(s): _____

Support and prices quoted below are valid provided the customer signs and returns this quote to GE Healthcare by 4/15/2018

Equipment Identifiers	Trans. Type	Equipment	Effective Date	Offering	Options	Features	Incremental Annual Amount
System ID: TBD1 Contract: 1-192829860063 Cost Center:	ADD POS	GE CT LIGHTSPEED VCT (64 SLICE) (C#107D)	End of Warranty through 9/30/2019	CHS Full Coverage	INCLUDED: • ILINQ RESPONSE TIME: 30 MIN. • SYSTEM AND TUBE COVERAGE EXCLUDED: • MOBILE UNIT • PERIPHERAL DEVICES • Printers • UNINTERRUPTED POWER SUPPLY • WORKSTATION	• DoseWatch Explore: Excluded • FE Coverage Weekdays: MON-FRI, 8AM-5PM • FE Coverage Weekend: NO COVERAGE HRS • FE Onsite Response Time: 2-Hours • iCenter - Maintenance: SILVER • InSite/Tech Phone Support • PM Cov.: Mon-Fri, 7AM-9PM, 4 per Year • Repair Parts: Included, Next Day 10:30 AM LST-CT • Software Upgrades and Updates: Software and Quality Updates • TiP Answer Line • Uptime Commitment: 97%	$56,650

NET ADJUSTMENT TO CONTRACT:	$56,650

The Agreement is hereby amended as follows. The Product above is added, deleted, or modified as indicated. Service for additions or modifications continues until Agreement expiration. In the event of conflict between this Addendum and the Agreement, this Addendum prevails. The Addendum start date is: (a) the above Effective Date if Customer signs and returns this Addendum within 30 calendar days of that date; or (b) the date of signature if Customer does not sign and return this Addendum within 30 calendar days of the above date.

Customer:

Approved By: _____ Title: _____

Signature: _____ Date: _____

GE Healthcare:

Approved By: _____ Title: _____

Signature: _____ Date: _____

GE Healthcare

Date:	02-07-2018
Quote #:	PR6-C107705
Version #:	1

Tennova Healthcare Cleveland
2305 Chambliss Ave NW
Cleveland TN 37311-3847

Attn: Shannon Ricco
2305 Chambliss Ave NW Cleveland
TN 37311-3847

Customer Number : 1-25POLC
Quotation Expiration Date: 04-30-2018

The terms of the Master Purchasing Agreement, Strategic Alliance Agreement or GPO Agreement referenced below as the Governing Agreement shall govern this Quotation. No additional or different terms shall apply unless agreed to in writing by authorized representatives of both parties.

Governing Agreement:	HPG
Terms of Delivery:	FOB Destination
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	NET 30
Total Quote Net Selling Price:	$109,957.00

Please Select Tax Status Of Order

☐ Exempt from Sales and Use Tax (Note: GEHC must have a Current Tax Exemption Certificate)

☐ Subject to Sales and Use Tax

INDICATE FORM OF PAYMENT:

If "GE HEF Loan" or "GE HEF Lease" is NOT selected at the time of signature, then you may NOT elect to seek financing with GE Healthcare Equipment Finance (GE HEF) to fund this arrangement after shipment.

____Cash/Third Party Loan

____GE HEF Lease

____GE HEF Loan

____Third Party Lease (please identify financing company) _____

By signing below, each party certifies that it has not made any handwritten modifications. Manual changes or mark-ups on this Agreement (except signatures in the signature blocks and an indication in the form of payment section below) will be void.

Each party has caused this agreement to be executed by its duly authorized representative as of the date set forth below.

CUSTOMER

_____ _____
Authorized Customer Signature Date

_____ _____
Print Name Print Title

_____
Purchase Order Number (if applicable)

GE HEALTHCARE
Tracy Vaught 02-15-2018
Signature Date

Imaging Account Manager

Email: Tracy.Scherer@ge.com
Office: +1 205 876 4350
Mobile: 205-876-4350
Fax: 205-449-9428

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date:	02-07-2018
Quote #:	PR6-C107705
Version #:	1

Total Quote Selling Price	**$109,957.00**
Trade-In and Other Credits	$0.00

Total Quote Net Selling Price	**$109,957.00**

To Accept this Quotation

Please sign and return this Quotation together with your Purchase Order To:
Tracy Vaught
Office: +1 205 876 4350
Mobile: 205-876-4350
Email: Tracy.Scherer@ge.com
Fax: 205-449-9428

Payment Instructions

Please **Remit** Payment for invoices associated with this quotation to:
GE Healthcare
P.O. Box 96483
Chicago, IL 60693

To Accept This Quotation

- Please sign the quote and any included attachments (where requested).
- If requested, please indicate, your form of payment.
- If you include the purchase order, please make sure it references the following information
  - The correct Quote number and version number above
  - The correct Remit To information as indicated in **"Payment Instructions"** above
  - The correct SHIP TO site name and address
  - The correct BILL TO site name and address
  - The correct Total Quote Net Selling Price as indicated above

"Upon submission of a purchase order in response to this quotation, GE Healthcare requests the following to evidence agreement to contract terms.
Signature page on quote filled out with signature and P.O. number.
**********OR**********
Verbiage on the purchase order must state one of the following: (i) Per the terms of Quotation #_____; (ii) Per the terms of GPO#_____; (iii) Per the terms of MPA #_____; or (iv) Per the terms of SAA #_____. Include the applicable quote/agreement number with the reference on the purchase order.
In addition, source of funds (choice of: Cash/Third Party Loan or GE HFS Lease or GE HFS Loan or Third Party Lease through _____), must be indicated, which may be done on the quote signature page (for signed quotes), on the purchase order (where quotes are not signed) or via a separate written source of funds statement (if provided by GE Healthcare)."

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date:	02-07-2018
Quote #:	PR6-C107705
Version #:	1

02-07-2018

GPO Agreement Reference Information

Customer:	Shannon Ricco
Contract Number:	500043, 500352, 500174, 500072, 500151, 500150, 500277, 1451, 1450, 000903
Start Date:	
End Date:	05/31/2020
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	NET 30
Shipping Terms:	FOB Destination

For a copy of the GPO contract or summary, please go to your GPO Membership login page scrubs.healthtrustpg.com. If a copy of the contract is not available on your membership page, please contact your GPO client manager.

Offer subject to the Terms and Conditions of the applicable Group Purchasing Agreements currently in effect between GE Healthcare and HealthTrust Purchasing Group includes 500043 (Imaging).

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date: 02-07-2018
Quote #: PR6-C107705
Version #: 1

Item No.	Qty	Catalog No.	Description
	1		**GoldSeal Optima XR220AMX**
1	1	S9500SA	GoldSeal Optima XR220amx / XR200amx 15KW The GoldSeal Optima XR220amx / XR200amx w/ Flashpad* is a self-contained battery operated mobile radiographic digital X-Ray imaging system designed for performing radiographic exams at the point of care Key Features • 15kW generator • Wireless Digital Flashpad* Detector with 6:1 removable grid, Back-up tether, QAP Quality Assurance Procedure) • Dose Area Product Meter (DAP) • Capable of 100-240V nominal, 50/60Hz operation • Stand-by mode to eliminate boot up cycles and allow exposure within 25 seconds. • Exposures can be taken and processed while the unit is charging • Detector battery charges automatically while the detector is in the bin • Optimized GUI - Technique, image acquisition and display tools in a single integrated user interface • The detector can be used in additional wireless enabled GE radiographic systems: please refer to the current literature for system compatibility Productivity • Up to 1,200 W of power available to minimize charge time • System can be driven within 4 seconds of activation • Pre-programmed techniques per anatomy and patient size • Systems can be used without the detector • Modality Perform Procedure Step (MPPS; SPS/PPS configurable) • Automated and customizable image transfer to PACS and printers • Can reprocess images post acquisition and during an exam • Usage reporting tools by individuals and user groups • Bin stores detector and grid • Built in storage for cleaning wipes, gloves and lead apron • Self-propelled single drive handle control with variable speed of up to 5 km/h (3.1 mph on flat surfaces) forward and reverse to automatically adjust to the operator's pace Wireless Digital Detector Specifications • Detector battery can take up to 45 exposures per hour and provide enough power for 3 hours of use on a single charge

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description
			• Single panel (non-tiled) amorphous silicon detector with a Cesium Iodide scintillator • Image area 40.4 cm x 40.4 cm (15.9 in x 15.9 in) • Active matrix 2022 x 2022 pixels • 8 MB raw image file size • Pixel Pitch 200 microns • Typical upper dynamic range 7.8mR • Typical DQE @ 0lp/mm: 68%) • 2 handgrips • Wireless point-to-point network between the system and detector for transferring image data - Communication over 500 MHz channels to achieve high data rates - Designed to co-exist with 802.11 networks without interference - Frequency: 3.2-10.6 GHz - Max Power Output: -41.3 dBm - Max PHY Data rate: 480 Mbps - Effective Throughput: 30-70 Mbps Networking Worklist can be retrieved from HIS/RIS systems and images can be transmitted through the DICOM** interface to printers, archival devices (PACS), servers or review workstations. • RJ45 10/100/1000 Base T Ethernet port Please refer to DICOM conformance statement for complete definition of supported DICOM services. Generator • 300 mA max • kVp and mAs controls • Less than 2% low frequency ripple • Frequency: greater than 100 kHz • Super resonant inverter with varying frequency X-ray Source • Nominal Tube Voltage (Radiographic) 40 ~ 150kV • Nominal Focal Spot size (IEC 60336): - Large Focus: 1.3mm - Small Focus: 0.6mm • Anode Rotation Speed (minimal): 3200 min-1 • Permanent Filtration: 0.9mm A1/75 kV IEC60522: 1999 • Maximum X-ray Tube Current - Large Focus: 500 mA - Small Focus: 200 mA Maximum Continuous Heat Dissipation: Without Air-circulator: 170W (238 HU/s) Collimator A pair of independent collimator blades controls the X-ray field • 180 lux (1000 Lumen/mt2) light field lamp

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description
			• The collimator rotates +/- 180 degrees with detents at -180, -90, 0, +90 & +180 degrees • Full 43cm x 43cm (17in) coverage at a 100cm SID Tube Positioning • The column may be rotated up to +/- 270 degrees from the park position Environmental and Safety Features • Drive Inhibit keypad access • Password protected access to patient information • Automatic safety brake: Operator must hold drive handles to allow system movement • Integrated front bumper stops unit and activates brakes when activated Warranty This product, including the accompanying X-ray tube, comes with a one year warranty. Availability Since GoldSeal Refurbished Equipment may be offered simultaneously to several customers, its sale to you is subject to availability and subject to prior sale at the time you offer to purchase it. If the equipment is no longer purchase it. If the equipment is no longer GoldSeal Refurbished Equipment in our inventory that meets your needs, and (2) if substitute equipment is not acceptable to you, GE will cancel your order and refund any deposit you have paid us for the canceled order. *Trademark of General Electric Company. **DICOM is a trademark of National Electrical Manufacturers Association. Please note: This product is subject to FCC rules and will comply with appropriate FCC rules applicable to WiFi enabled devices before delivery to the customer or distributor
2	1	S2000RE	Wireless Connectivity Wireless Connectivity for Optima XR220amx and Optima XR200amx 802.11 a/b/g n-compatible wireless connectivity to hospital network Wi-Fi Certified Compatible with: • 802.11i, Wi-Fi Protected Access 2 (WPA2), WPA 802.1X • AES - TKIP • 64-, 128-WEP

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description
			• VPN: IPSec - IKE • Management Frame Protection (MFP) EAP Types: - LEAP - LEAP + 128-WEP - LEAP + WPA - EAP - TLS - EAP-TTLS/MSCHAPv2 - EAP-FAST - PEAP-GTC - PEAP/MSCHAPV2
3	1	S2000RL	Auto Protocol Assist Auto Protocol Assist for Optima XR200amx, Optima XR220amx, and Optima XR240amx; this APA is for the existing customer license from Optima XR220amx to Optima XR240amx.
4	1	S2000RS	Repeat/Reject Analysis Repeat/Reject Analysis for Optima XR220amx/Upgraded Optima XR200amx, and Optima XR240amx
5	1	E7009HB	Sterile Protective Drapes - Detector Drape Sterile Protective Drapes - Detector Drape
6	1	W0001RA	X-ray TiP Training, 1 Day Onsite X-ray TiP Training, 1 Day Onsite One Day X-ray Onsite Training provided from 8AM to 5PM, Monday through Friday. Includes T&L expenses. This training program must be scheduled and completed within 12 months after the date of product delivery.

Quote Summary:

Total Quote Net Selling Price **$109,957.00**

(Quoted prices do not reflect state and local taxes if applicable. Total Net Selling Price Includes Trade In allowance, if applicable.)

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date:	02-07-2018
Quote #:	PR6-C107705
Version #:	1

Item No.	Qty	Catalog No.	Description

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

CHS Service Program Service Contract Addendum

Quote ID: FC6C686

TENNOVA HEALTHCARE CLEVELAND

CHS

Physical Location Account #: 151061

Optional: Person(s) to be notified when this document is processed:

Name(s): _____

Email(s): _____

Support and prices quoted below are valid provided the customer signs and returns this quote to GE Healthcare by 4/8/2018

Equipment Identifiers	Trans. Type	Equipment	Effective Date	Offering	Options	Features	Incremental Annual Amount
System ID: TBD1 Contract: 1-192829860063 Cost Center:	ADD POS	GE XR OPTIMA XR220AMX - DIGITAL MOBILE X-RAY SYSTEM (pure digital) (X#7P3)	End of Warranty through 9/30/2019	CHS Custom Coverage	INCLUDED: • AUTOMATIC EXPOSURE CONTROL • BATTERY REPLACEMENT COVERAGE • TUBE COVERAGE: Discount EXCLUDED: • DETECTOR • PERIPHERAL DEVICES • Printers • UNINTERRUPTED POWER SUPPLY • WORKSTATION	• FE Coverage Weekdays: MON-FRI, 8AM-5PM • FE Coverage Weekend: NO COVERAGE HRS • FE Onsite Response Time: 4-Hours • HBS Tube Replacement Charge: $4000 • iCenter - Maintenance: SILVER • InSite/Tech Phone Support • PM Cov.: Mon-Fri, 8AM-5PM, 2 per Year • Repair Parts: Included, Next Day 10:30 AM LST-GDXR • Software Upgrades and Updates: Software and Quality Updates • TiP Answer Line • Uptime Commitment: 97%	$2,633
System ID: TBD2 Contract: 1-192829860063 Cost Center:	ADD POS	GE XR FlashPad - Digital Wireless Detector (X#0D7A)	End of Warranty through 9/30/2019	CHS Full Coverage	INCLUDED: • BATTERY REPLACEMENT COVERAGE • DETECTOR • Grid Replacement	• Acc Cov: Unlimited replacements at $5K • FE Coverage Weekdays: MON-FRI, 8AM-5PM • Note 01: Unlimited Replacements Due to Normal Wear & Tear • Repair Parts: Included, Next Day 10:30 AM LST-GDXR • Replacements Due to Abuse, Theft, Loss, Fire: Excluded	$10,000

NET ADJUSTMENT TO CONTRACT:	$12,633

The Agreement is hereby amended as follows. The Product above is added, deleted, or modified as indicated. Service for additions or modifications continues until Agreement expiration. In the event of conflict between this Addendum and the Agreement, this Addendum prevails. The Addendum start date is: (a) the above Effective Date if Customer signs and returns this Addendum within 30 calendar days of that date; or (b) the date of signature if Customer does not sign and return this Addendum within 30 calendar days of the above date.

Customer:

Approved By: _____ Title: _____

Signature: _____ Date: _____

GE Healthcare:

Approved By: _____ Title: _____

Signature: _____ Date: _____

GE Healthcare

Date:	02-15-2018
Quote #:	PR4-C113361
Version #:	1

Tennova Healthcare Cleveland
2305 Chambliss Ave NW
Cleveland TN 37311-3847

Attn: Shannon Ricco
2305 Chambliss Ave NW Cleveland
TN 37311-3847

Customer Number : 1-25POLC
Quotation Expiration Date: 05-16-2018

The terms of the Master Purchasing Agreement, Strategic Alliance Agreement or GPO Agreement referenced below as the Governing Agreement shall govern this Quotation. No additional or different terms shall apply unless agreed to in writing by authorized representatives of both parties.

Governing Agreement:	HPG
Terms of Delivery:	FOB Destination
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	Net Due in 30 Days
Total Quote Net Selling Price:	$148,070.00

Please Select Tax Status Of Order

☐ Exempt from Sales and Use Tax (Note: GEHC must have a Current Tax Exemption Certificate)
☐ Subject to Sales and Use Tax

INDICATE FORM OF PAYMENT:

If "GE HEF Loan" or "GE HEF Lease" is NOT selected at the time of signature, then you may NOT elect to seek financing with GE Healthcare Equipment Finance (GE HEF) to fund this arrangement after shipment.

____Cash/Third Party Loan

____GE HEF Lease

____GE HEF Loan

____Third Party Lease (please identify financing company) _____

By signing below, each party certifies that it has not made any handwritten modifications. Manual changes or mark-ups on this Agreement (except signatures in the signature blocks and an indication in the form of payment section below) will be void.

Each party has caused this agreement to be executed by its duly authorized representative as of the date set forth below.

CUSTOMER

_____ _____
Authorized Customer Signature Date

_____ _____
Print Name Print Title

_____
Purchase Order Number (if applicable)

GE HEALTHCARE
Dionte Madden 02-15-2018
Signature Date

Email: dionte.madden@ge.com
Office: +1 262 364 4130

GE Healthcare Confidential & Proprietary

GE Healthcare

Date:	02-15-2018
Quote #:	PR4-C113361
Version #:	1

Total Quote Selling Price	**$148,070.00**
Trade-In and Other Credits	$0.00

Total Quote Net Selling Price	**$148,070.00**

To Accept this Quotation

Please sign and return this Quotation together with your Purchase Order To:
Dionte Madden
Office: +1 262 364 4130
Email: dionte.madden@ge.com

Payment Instructions

Please **Remit** Payment for invoices associated with this quotation to:
GE Medical Systems
Ultrasound Primary Care Diagnostics, LLC
75 Remittance Drive, Suite #1080
Chicago, IL 60675-1080

To Accept This Quotation

- Please sign the quote and any included attachments (where requested).
- If requested, please indicate, your form of payment.
- If you include the purchase order, please make sure it references the following information
  - The correct Quote number and version number above
  - The correct Remit To information as indicated in **"Payment Instructions"** above
  - The correct SHIP TO site name and address
  - The correct BILL TO site name and address
  - The correct Total Quote Net Selling Price as indicated above

"Upon submission of a purchase order in response to this quotation, GE Healthcare requests the following to evidence agreement to contract terms.
Signature page on quote filled out with signature and P.O. number.
**********OR**********
Verbiage on the purchase order must state one of the following: (i) Per the terms of Quotation #_____; (ii) Per the terms of GPO#_____; (iii) Per the terms of MPA #_____; or (iv) Per the terms of SAA #_____. Include the applicable quote/agreement number with the reference on the purchase order.
In addition, source of funds (choice of: Cash/Third Party Loan or GE HFS Lease or GE HFS Loan or Third Party Lease through _____), must be indicated, which may be done on the quote signature page (for signed quotes), on the purchase order (where quotes are not signed) or via a separate written source of funds statement (if provided by GE Healthcare)."

GE Healthcare Confidential & Proprietary

GE Healthcare

Date:	02-15-2018
Quote #:	PR4-C113361
Version #:	1

02-15-2018

GPO Agreement Reference Information

Customer:	Shannon Ricco
Contract Number:	500043, 500352, 500174, 500072, 500151, 500150, 500277, 1451, 1450, 000903
Start Date:	
End Date:	05/31/2020
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	Net Due in 30 Days
Shipping Terms:	FOB Destination

For a copy of the GPO contract or summary, please go to your GPO Membership login page scrubs.healthtrustpg.com. If a copy of the contract is not available on your membership page, please contact your GPO client manager.

Offer subject to the Terms and Conditions of the applicable Group Purchasing Agreements currently in effect between GE Healthcare and HealthTrust Purchasing Group include 500043 (Imaging) and 500352 (Ultrasound).

GE Healthcare Confidential & Proprietary

GE Healthcare

Date: 02-15-2018
Quote #: PR4-C113361
Version #: 1

Item No.	QTY	CATALOG	DESCRIPTION	Ext Sell Price
	1		**LOGIQ E9 XDclear 2.0**	
1	1	H4915US	LOGIQ E9 XDclear 2.0 Console for U.S.A.	$120,600.00
			Through the combination of extraordinary images, easy workflow and expert tools, the LOGIQ E9 XDclear 2.0 provides the latest GE technology to help enhance diagnostic confidence and workflow efficiency every day in a variety of challenging exams. Innovative features: Agile Acoustic Architecture with flexible clinically based mathematical models of the body for enhanced image quality and XDclear transducer technology capabilities. The LOGIQ E9 XDclear 2.0 also includes: B-flow technology to help visualize real-time hemodynamic flow and vessel wall definition; Compare Assistant, a workflow enhancement tool that enables easy side by side comparison of previous ultrasound or other modality images with a live ultrasound image; Scan Assistant procedure automation program that intuitively assists the user with customizable system functions at each step of the study to streamline productivity, enhance consistency and reduce keystrokes; LOGIQVIEW an integrated, extended field of view B-mode imaging with measurement capability; LOGIQ E9 Wireless Version 3 an integrated wireless capability allows for wireless DICOM transfer within a 802.11ac/a/b/g/n wireless network - includes support for Enterprise authentication; and B-Steer+ which can be used for B mode steering image to help improve needle visualization/reflectivity. Also included: CrossXBeam (spatial compounding), SRI HD (Speckle Reduction Imaging in High Definition) with Organ Specific Imaging, and Coded Harmonics. Productivity can be enhanced through many features such as Raw Data for post-processing of images, Automatic Optimization, Virtual Convex, and Advanced 3D (w/ multiplanar displays). Advanced ergonomics including 22 wide screen high resolution OLED display (1920 x 1080) with articulating arm, motorized adjustable console, 10.4 inch color LED touch screen, four active transducer ports with patented cable hook. Scanning modes include B-Mode, M-Mode, Color Flow, Pulsed Wave, and Power Doppler. Other system features include: Windows** Embedded Standard 7 operating platform, 776 MB cine memory, 500GB internal hard drive, DVD-R, image archive, built-in gel warmer, user footrest, integrated on-board	

GE Healthcare Confidential & Proprietary

GE Healthcare

Date: 02-15-2018
Quote #: PR4-C113361
Version #: 1

Item No.	QTY	CATALOG	DESCRIPTION	Ext Sell Price
			black and white printer bay, and user programmable model parameters. Includes comprehensive software annotation, calculations, and worksheets supporting obstetrical, gynecological, vascular and general imaging applications. Includes a DICOM*** software package providing Verify, Print, Store, Multiframe, Modality Worklist, MPPS (Modality Performed Procedure Step), Storage Commitment, Media Exchange and Enhanced US Volume Storage. Additionally, supports Query/Retrieve and Structured Reporting. Does not include network hardware, which may be required. Includes initial installation and connection to customer network. Includes one-year warranty and three days of On-site Applications Training. Additional On-site Applications Training days are available for purchase. Training must be completed within six (6) months after Product delivery, otherwise GE Healthcare's obligation to provide the training will expire without refund. Participating in advanced technology training at the GE Healthcare Education Center in Metro Milwaukee can be purchased separately. Customer workflow permitting and abiding by SDMS criteria, sonographer install CE's may be provided during install training. *Trademark of General Electric Company. **Third party trademarks are the property of their respective owners. *** DICOM is the registered trademark of the National Electrical Manufacturers Association for its standard publications relating to digital communications of medical information.	
2	1	H40452LG	ML6-15-D Matrix Linear Array Probe Wideband Matrix Linear Array Probe. Applications vary depending on the ultrasound system and may include Small Parts, Vascular, Pediatrics, Neonatal, Breast, Thyroid, and Scrotal. Datasheets for specific ultrasound systems contain additional details including specific applications, biopsy availability, and additional probe technical specifications.	$6,030.00
3	1	H40442LM	9L-D Linear Array Probe Wideband Linear Array Probe. Applications vary depending on the ultrasound system and may include Vascular, Small Parts, Pediatric, and Abdominal. Datasheets for specific ultrasound	$4,690.00

GE Healthcare Confidential & Proprietary

GE Healthcare

Date: 02-15-2018
Quote #: PR4-C113361
Version #: 1

Item No.	QTY	CATALOG	DESCRIPTION	Ext Sell Price
			systems contain additional details including specific applications, biopsy availability, and additional probe technical specifications..	
4	1	H40452LL	L8-18i-D Linear Probe Broad-spectrum linear probe. Preferred applications: musculoskeletal, small parts, vascular, intraoperative.	$6,030.00
5	1	H40442LK	IC5-9-D Microconvex Array Probe Wideband Microconvex Intercavity Array Probe. Applications vary depending on the ultrasound system and may include OB/GYN and Urology . Datasheets for specific ultrasound systems contain additional details including specific applications, biopsy availability, and additional probe technical specifications..	$4,020.00
6	1	H40472LT	C1-6-D XDclear Probe XDclear is GE's highest performing transducer technology which is a proprietary combination of advanced materials and innovative acoustic design. Convex transducer with XDclear technology helps achieve impressive depth on patients with difficult body habitus. Applications: abdominal, obstetrics, gynecological, urology, and vascular. Biopsy kit available..	$6,700.00

Quote Summary:

Total List Price:	**$442,000.00**
Total Discount	**($293,930.00)**
Total Extended Selling Price:	**$148,070.00**
Total Quote Net Selling Price	**$148,070.00**

(Quoted prices do not reflect state and local taxes if applicable.)

GE Healthcare Confidential & Proprietary

GE Healthcare

CHS Service Program Service Contract Addendum

Quote ID: B94826C

TENNOVA HEALTHCARE CLEVELAND

CHS

Physical Location Account #: 151061

Optional: Person(s) to be notified when this document is processed:

Name(s): _____

Email(s): _____

Support and prices quoted below are valid provided the customer signs and returns this quote to GE Healthcare by 4/16/2018

Equipment Identifiers	Trans. Type	Equipment	Effective Date	Offering	Options	Features	Incremental Annual Amount
System ID: TBD LE9 Phy Loc Acct: 151061 Contract: 1-192829860063 Cost Center:	ADD POS	GE UL LOGIQ E9 R4/R5 & ABOVE (U#3E4)	End of Warranty through 9/30/2019	CHS Custom Coverage	INCLUDED: • DVR • EXTERNAL DVD R/W • PEDOF PROBE • Printers • VCR EXCLUDED: • GENERAL/SPECIALTY PROBES	• FE Coverage Weekdays: MON-FRI, 8AM-5PM • FE Coverage Weekend: NO COVERAGE HRS • FE Onsite Response Time: 4-Hours • InSite/Tech Phone Support • Number of Annual EQC/IQC: 2-EQCs (excludes any IQCs) per year, Mon-Fri 8AM-5PM • Repair Parts: Included, Next Day 10:30 AM LST-UL • Uptime Commitment: 97%	$5,662

NET ADJUSTMENT TO CONTRACT:	$5,662

The Agreement is hereby amended as follows. The Product above is added, deleted, or modified as indicated. Service for additions or modifications continues until Agreement expiration. In the event of conflict between this Addendum and the Agreement, this Addendum prevails. The Addendum start date is: (a) the above Effective Date if Customer signs and returns this Addendum within 30 calendar days of that date; or (b) the date of signature if Customer does not sign and return this Addendum within 30 calendar days of the above date.

Customer:

Approved By: _____ Title: _____

Signature: _____ Date: _____

GE Healthcare:

Approved By: _____ Title: _____

Signature: _____ Date: _____

GE Healthcare

Date:	02-16-2018
Quote #:	PR1-C118504
Version #:	2

Tennova Healthcare Cleveland
2305 Chambliss Ave NW
Cleveland TN 37311-3847

Customer Number : 1-25POLC
Quotation Expiration Date: 04-30-2018

The terms of the Master Purchasing Agreement, Strategic Alliance Agreement or GPO Agreement referenced below as the Governing Agreement shall govern this Quotation. No additional or different terms shall apply unless agreed to in writing by authorized representatives of both parties.

Governing Agreement:	HPG
Terms of Delivery:	FOB Destination
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	NET 30
Total Quote Net Selling Price:	$137,480.01

Please Select Tax Status Of Order

☐ Exempt from Sales and Use Tax (Note: GEHC must have a Current Tax Exemption Certificate)
☐ Subject to Sales and Use Tax

INDICATE FORM OF PAYMENT:

If "GE HEF Loan" or "GE HEF Lease" is NOT selected at the time of signature, then you may NOT elect to seek financing with GE Healthcare Equipment Finance (GE HEF) to fund this arrangement after shipment.

____Cash/Third Party Loan

____GE HEF Lease

____GE HEF Loan

____Third Party Lease (please identify financing company) _____

By signing below, each party certifies that it has not made any handwritten modifications. Manual changes or mark-ups on this Agreement (except signatures in the signature blocks and an indication in the form of payment section below) will be void.

Each party has caused this agreement to be executed by its duly authorized representative as of the date set forth below.

CUSTOMER

_____ _____
Authorized Customer Signature Date

_____ _____
Print Name Print Title

_____
Purchase Order Number (if applicable)

GE HEALTHCARE
Tracy Vaught 02-16-2018
Signature Date

Imaging Account Manager

Email: Tracy.Scherer@ge.com
Office: +1 205 876 4350
Mobile: 205-876-4350
Fax: 205-449-9428

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date:	02-16-2018
Quote #:	PR1-C118504
Version #:	2

Total Quote Selling Price	**$137,480.01**
Trade-In and Other Credits	$0.00

Total Quote Net Selling Price	**$137,480.01**

To Accept this Quotation

Please sign and return this Quotation together with your Purchase Order To:
Tracy Vaught
Office: +1 205 876 4350
Mobile: 205-876-4350
Email: Tracy.Scherer@ge.com
Fax: 205-449-9428

Payment Instructions

Please **Remit** Payment for invoices associated with this quotation to:
GE Healthcare
P.O. Box 96483
Chicago, IL 60693

To Accept This Quotation

- Please sign the quote and any included attachments (where requested).
- If requested, please indicate, your form of payment.
- If you include the purchase order, please make sure it references the following information
  - The correct Quote number and version number above
  - The correct Remit To information as indicated in **"Payment Instructions"** above
  - The correct SHIP TO site name and address
  - The correct BILL TO site name and address
  - The correct Total Quote Net Selling Price as indicated above

"Upon submission of a purchase order in response to this quotation, GE Healthcare requests the following to evidence agreement to contract terms.
Signature page on quote filled out with signature and P.O. number.
**********OR**********
Verbiage on the purchase order must state one of the following: (i) Per the terms of Quotation #_____; (ii) Per the terms of GPO#_____; (iii) Per the terms of MPA #_____; or (iv) Per the terms of SAA #_____. Include the applicable quote/agreement number with the reference on the purchase order.
In addition, source of funds (choice of: Cash/Third Party Loan or GE HFS Lease or GE HFS Loan or Third Party Lease through _____), must be indicated, which may be done on the quote signature page (for signed quotes), on the purchase order (where quotes are not signed) or via a separate written source of funds statement (if provided by GE Healthcare)."

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date:	02-16-2018
Quote #:	PR1-C118504
Version #:	2

02-16-2018

GPO Agreement Reference Information

Customer:	
Contract Number:	500043, 500352, 500174, 500072, 500151, 500150, 500277, 1451, 1450, 000903
Start Date:	
End Date:	05/31/2020
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	NET 30
Shipping Terms:	FOB Destination

For a copy of the GPO contract or summary, please go to your GPO Membership login page scrubs.healthtrustpg.com. If a copy of the contract is not available on your membership page, please contact your GPO client manager.

Offer subject to the Terms and Conditions of the applicable Group Purchasing Agreements currently in effect between GE Healthcare and HealthTrust Purchasing Group includes 500043 (Imaging).

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date: 02-16-2018
Quote #: PR1-C118504
Version #: 2

Item No.	Qty	Catalog No.	Description
	1		**GoldSeal Proteus**
1	1	S9500LA	GoldSeal Proteus XR/a 65kW LHNT GoldSeal* Proteus XR/a 65kW Radiographic System With Non-Tilting Vertical Bucky Left Hand Load 65kW High Frequency Generator System (Includes Overhead Tube Support and High Speed X-ray Tube) Proteus XR/a is a Full-Featured General Radiographic System Designed to assist in Meeting The Radiographic Imaging and Throughput Requirements Of Modern Healthcare Facilities. 65kW High Frequency Generator - 380-480 VAC +/-10%, 50/60-Hz +/-6% - kV Range: 40 to 150 kV - mA Range: 800 mA @ 80kV, 630mA @ 100kV, 400mA @ 150kV - mAs Range: 0.5 to 630mAs - Time: 1 msec. to 6.3 sec. Overhead Tube Support Remote Console - Minimum Vertical Height: 716mm (28.2 Inches) - Vertical Travel: ~1500mm - Bridge: 2 or 3 Meter Bridge - Transverse Travel: 1200/2110mm (47 Inches/ 83 Inches) Tube Rotation: +/-180 Degrees (30 Degree Tube Rotation is turning about the vertical colu - Patient-Side Technique and Receptor Controls - Technique, SID, Angle Display Generator Operator Console - Color LCD Touch Screen - 10.4 Inch Display - APR • Wall Mount Assembly X-Ray Tube - Focal Spot: 0.6/1.25mm - Anode Angle: 12.5 Degrees - Anode Heat Capacity: 260kJ - Heat Dissipation: 925W - Anode Speed: 10,800 rpm - Tube Fan Kit - Operation Manual Also Includes: • Elevating Table with cables, foot pedals and table top • Automatic Collimation • Non-Tilting Vertical Bucky Left Hand Load • Wallstand Knee Spacer

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description
			• PA/LAT Patient Positioning Bars • Drape with 3M Bridge • Cable Assembly for 3M Bridge • 3M IB Bridge for Proteus/Condor • OTS Cover Kit Proteus XR/A • 18M Wallstand Cables • 19 Foot Inboard Rail Pair • SID Detent Kit for Inboard Bridge Warranty This product, including the accompanying X-ray tube, comes with a one year warranty Availability Since GoldSeal Refurbished Equipment may be offered simultaneously to several customers, its sale to you is subject to availability and subject to prior sale at the time you offer to purchase it. If the equipment is no longer purchase it. If the equipment is no longer GoldSeal Refurbished Equipment in our inventory that meets your needs, and (2) if substitute equipment is not acceptable to you, GE will cancel your order and refund any deposit you have paid us for the canceled order. *Trademark of General Electric Company.
2	1	S39262JC	Proteus FlashPad Wireless Detector and Kit Proteus XR/a Wireless DR Imaging Option powered by FlashPad detector The Proteus XR/a DR Imaging Option consists of a FlashPad detector, a wall-stand detector tray 130cm grid, a table detector tray and 100cm grid a snap-on grid with 130cm focus, 6:1 ratio, an acquisition workstation and system interface unit that can be easily integrated into an existing or new Proteus XR/a rooms. The radiographic imaging detector can be shared between compatible systems with a maximum of ten detectors per acquisition workstation. Primary components include: Wireless DR imaging Option with table and wallstand detector trays and a FlashPad wireless DR detector. Wireless Detector comes with two rechargeable batteries and tether • One wireless FlashPad DR detector • Two rechargeable detector batteries • 7m (23.0 ft.) detachable detector cable that allows for battery-less and wired operation

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General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description

- Detector tray for Table Bucky with fixed 100cm Focus Grid 13:1 70 l/cm Detector tray for Wallstand Bucky with fixed 130cm Focus Grid
- 130cm Focus Grid 13:1 70 l/cm Snap-on Grid with 130cm focus for FlashPad

Aquisition Workstation Offers a full range of automated image display, processing and annotation functions:

- 19 in. touch-screen user interface with keyboard and mouse
- Multiple set of pre-defined and customizable image processing "looks"
- Advanced Noise Reduction (ANR) that reduces image noise while preserving detail
- EMI reduction algorithm to reduce artifacts generated from environmental electromagnetic interference
- Tissue equalization algorithm that provides dynamic range control to enhance contrast in under-penetrated or over-penetrated areas
- Detector Exposure Index (DEI) dose tracking and QC metric
- Smart Windowing algorithm for automatic adjustment of brightness/contrast
- Off-center imaging with Intelligent Collimation Edge Detection (ICED) algorithm
- Left/Right Markers and image annotation
- Image rotation, zoom, manual shuttering and grayscale invert
- Stores up to 16,000 images
- System access and authorization control to support HIPAA Compliance
- iLinq remote system diagnostic service support is available through the GE Online Center to the DR imaging option (does not include remote support to existing analog system)
- A System Interface Unit that captures exposure and technique information from the existing X-ray products
- Technique transfer Common power On/Off DICOM Networking

Images may be transmitted through the DICOM interface to printers, archival devices, servers or review workstations

- RJ45 10/100/1000 Base T Ethernet port
- IHE Certified Profiles: Scheduled Workflow and Patient Information Reconciliation
- DICOM 3.0 compliant services
- DICOM IOD generated - DX or CR
- Image auto send/transfer: DX or CR (supports multiple destinations)
- DICOM storage: SCU
- DICOM storage commitment SCP
- DICOM modality worklist for HIS/RIS: SCU (with programmable auto refresh)

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General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description
			• DICOM grayscale print: manual and auto (with print layout options) • Multi-format printing • DICOM CD-R media exchange (DX only) • Verification of connectivity for SCU & SCP services • DICOM Modality Perform Procedure Step (MPPS) feedback to the HIS/RIS (SPS PPS configurable) • VOI Look-up Tables (LUT) burn on send • Exposure technique information Please refer to the DICOM Conformance Statement for complete definition of supported DICOM connectivity services • Quality Assurance Program (QAP) with QAP phantom • Operator Manual • Detector battery charger • A detector bin to store the detector and the snap-on grid. Allows the detector to charge with battery still in the detector • Proteus XR/a dose display allows for viewing and storage of the calculated patient dose based upon imaging system parameters • Digital imaging system protocol assist allows system to be configured to automatically select the category and exam on the wireless DR imaging system based upon HIS/RIS parameters • Tether storage and connection box provides connection point for detector storage when in use and storage location when tether is not in use • Ultra Wideband (UWB) interface box and antenna
3	1	S3918JS	Console Pedestal Generator Console - Pedestal To allow the Generator Console to be Free-standing
4	1	S3918JW	Patient Compression Band Patient Compression Band
5	1	S3918JY	Patient Hand Grip Proteus Table Patient Hand Grips
6	1	S3918JZ	Lateral Cassette Holder

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

Item No.	Qty	Catalog No.	Description
			Lateral Cassette Holder
7	1	S39262JP	Table Top FlashPad Lateral Detector Holder Table Top Lateral Detector Holder Wireless DR detector holder, designed specifically for GE, secures the detector in a vertical position on the tabletop for cross-table imaging.
8	1	S39262JL	Repeat/Reject Analysis Option Repeat/Reject Analysis RRA is a quality assurance tool that allows for images to be captured and categorized by technologist for follow-up quality reviews.
9	1	E4502ST	25 KAIC X-Ray Main Disconnect Panel 80 Amp, 480 V / 208 V 25 KAIC X-Ray Main Disconnect Panel 80 Amp, 480 V / 208 V FEATURES/BENEFITS • Serves as the main power disconnect between the X-Ray system and the facility 480V or 208V power source • Provides emergency shut down, undervoltage protection and overcurrent protection for the X-Ray power distribution cabinet • Standardized design provides a platform for future upgrades of the system • Offers a number of advantages by combining a variety of individual components into a single pre-engineered and factory tested panel • UL and cUL listed for compliance with NEC Article 100 and Article 110-3 • Remote emergency off pushbutton located by X-Ray control provides immediate shut down of the entire system to comply with NEC required disconnecting means • Surface or semi-flush mounting SPECIFICATIONS • Dimensions (H x W x D): 48" x 20" x 6.68" • Weight: 80 lbs. • Mounting: via keyhole slots; Width is 16" on centers, Height is 45.5" on centers COMPATIBILITY • GE Three Phase X-Ray generators NOTES:

GE Healthcare Confidential and Proprietary
General Electric Company, GE Healthcare Division

GE Healthcare

Date: 02-16-2018
Quote #: PR1-C118504
Version #: 2

Item No.	Qty	Catalog No.	Description
			• Customer is responsible for rigging and arranging for installation with a certified electrician • ITEM IS NON-RETURNABLE AND NON-REFUNDABLE
10	1	W0003RA	X-ray TiP Training, 3 Consecutive Days Onsite X-ray TiP Training, 3 Consecutive Days Onsite Three Days X-ray Onsite Training provided from 8AM to 5PM, Monday through Friday. Includes T&L expenses. Days provided consecutively. This training program must be scheduled and completed within 12 months after the date of product delivery.
11	1	S2100JF	Xt Extension Select XT Extension Select
	1		**NonProducts**
12	1		Rigging for Current Rad System (TBD)

Quote Summary:

Total Quote Net Selling Price **$137,480.01**

(Quoted prices do not reflect state and local taxes if applicable. Total Net Selling Price Includes Trade In allowance, if applicable.)

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General Electric Company, GE Healthcare Division

Attachment B-Economic Feasibility-A.5

Architect's Letter

HFR DESIGN

March 12, 2018

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: **Certificate of Need Application**
Tennova Healthcare - Cleveland

To Whom It May Concern:

The project consists of new construction to create an approximately 11,000 SF freestanding emergency department. Based on historical cost data of similar projects, we believe a reasonable construction cost estimate for the building is $4,998,300.

Additionally, this project will be designed and built to conform with all applicable codes referenced below.

- **State of TN Department of Health Code Requirements:**
  2012 International Building Code
  2012 LSC - NFPA – 101 Life Safety Code
  2012 International Fire Code
  2012 International Plumbing Code
  2012 International Mechanical Code
  2009 International Energy Conservation Code
  2011 National Electric Code
  2012 International Fuel Gas Code
  1999 – 2004 North Carolina Accessibility Code with 2004 Amendments
  2004 ADA Americans with Disabilities Act Accessibility Guidelines
  2010 FGI (formally AIA) Guidelines for Design and Construction of Hospital and Health Care Facilities.

- **City of Cleveland, TN Code Requirements:**
  2012 International Building Code
  ICC A117.1-2009 Accessible and Usable Buildings and Facilities
  2012 International Plumbing Code
  2012 International Mechanical Code
  2012 International Fuel and Gas Code, to include Appendix B
  2008 National Electric Code
  2012 International Property Maintenance Code
  2009 Energy Conservation Code
  2012 International Fire Code

Should you have any questions or require further information, please do not hesitate to contact our office.

Sincerely,

HFR Design, Inc.

Martin Franks
Senior Vice President

pc: File

Attachment B-Economic Feasibility-B

Project Funding Letter

CHS

March 12, 2018

Ms. Melanie Hill
Executive Director
Tennessee Health Services and Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Funding Support for Cleveland Tennessee Hospital Company, LLC (d/b/a Tennova Healthcare-Cleveland)

COMMUNITY
HEALTH
SYSTEMS

4000 Meridian Boulevard
Franklin, TN 37067
Tel: (615) 465-7000

P.O. Box 689020
Franklin, TN 37068-9020

Dear Ms. Hill:

CHS/Community Health Systems, Inc., the parent of Cleveland Tennessee Hospital Company, LLC (d/b/a Tennova Healthcare-Cleveland), has internal funds available for the commitment to the following project, which has an approximate project cost of $12,081,195.

CHS/Community Health Systems, Inc. had cash flow from operating activities of $1.137 billion in its fiscal year ending December 31, 2016. Moreover, as of September 30, 2017, the availability to CHS/Community Health Systems, Inc. for additional borrowings under our Credit Facility, as $929 million pursuant to the $929 million Revolving Credit Facility, after taking into account the $0 million outstanding at that date, of which $63 million was set aside for outstanding letters of credit.

We believe that these funds, along with internally generated cash and continued access to the capital markets, will be sufficient to finance the commitment to the above specified project, without interest. CHS/Community Health Systems, Inc. will advance funds as necessary to complete this project.

Should you need anything further, I can be reached at 615-465-7015.

Regards,

Edward W. Lomicka
Vice President and Treasurer

"Community Health Systems" is a registered trade name of CHSPSC, LLC.

Attachment B-Economic Feasibility-F1

CHS Audited Financial Information

UNITED STATES SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the year ended December 31, 2017
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number 001-15925

COMMUNITY HEALTH SYSTEMS, INC.

(Exact name of registrant as specified in its charter)

Delaware *(State of incorporation)*	**13-3893191** *(IRS Employer Identification No.)*
4000 Meridian Boulevard **Franklin, Tennessee** *(Address of principal executive offices)*	**37067** *(Zip Code)*

Registrant's telephone number, including area code:
(615) 465-7000

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $.01 par value	New York Stock Exchange
Contingent Value Rights	The Nasdaq Stock Market LLC

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ☑ NO ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES ☐ NO ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES ☑ NO ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of the Form 10-K or any amendment to the Form 10-K. ☑

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act:

Large accelerated filer ☑ Accelerated filer ☐ Smaller reporting company ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company) Emerging growth company ☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). YES ☐ NO ☑

The aggregate market value of the voting stock held by non-affiliates of the Registrant was $796,301,699. Market value is determined by reference to the closing price on June 30, 2017 of the Registrant's Common Stock as reported by the New York Stock Exchange. The Registrant does not (and did not at June 30, 2017) have any non-voting common stock outstanding. As of February 27, 2018, there were 114,627,148 shares of common stock, par value $.01 per share, outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Certain information required for Part III of this annual report is incorporated by reference to portions of the Registrant's definitive proxy statement for its 2018 annual meeting of stockholders to be filed with the Securities and Exchange Commission within 120 days after the end of the Registrant's fiscal year ended December 31, 2017.

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Item 8. ***Financial Statements and Supplementary Data***

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and the Board of Directors of
Community Health Systems, Inc.
Franklin, Tennessee

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Community Health Systems, Inc. and subsidiaries (the "Company") as of December 31, 2017 and 2016, the related consolidated statements of (loss) income, comprehensive (loss) income, stockholders' (deficit) equity, and cash flows for each of the three years in the period ended December 31, 2017, and the related notes and the schedule listed in the Index at Item 15 (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2017 and 2016, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2017, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 28, 2018, expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Deloitte & Touche LLP

Nashville, Tennessee
February 28, 2018

We have served as the Company's auditor since 1996.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF (LOSS) INCOME

	Year Ended December 31,		
	2017	2016	2015
	(In millions, except share and per share data)		
Operating revenues (net of contractual allowances and discounts)	$ 18,398	$ 21,275	$ 22,564
Provision for bad debts	3,045	2,837	3,127
Net operating revenues	15,353	18,438	19,437
Operating costs and expenses:			
Salaries and benefits	7,376	8,624	8,991
Supplies	2,672	3,011	3,048
Other operating expenses	3,864	4,248	4,520
Government and other legal settlements and related costs	(31)	16	4
Electronic health records incentive reimbursement	(28)	(70)	(160)
Rent	394	450	457
Depreciation and amortization	861	1,100	1,172
Impairment and (gain) loss on sale of businesses, net	2,123	1,919	68
Total operating costs and expenses	17,231	19,298	18,100
(Loss) income from operations	(1,878)	(860)	1,337
Interest expense, net of interest income of $11, $14 and $15 in 2017, 2016 and 2015, respectively	931	962	973
Loss from early extinguishment of debt	40	30	16
Gain on sale of investments in unconsolidated affiliates	-	(94)	-
Equity in earnings of unconsolidated affiliates	(16)	(43)	(63)
Loss from continuing operations before income taxes	(2,833)	(1,715)	411
(Benefit from) provision for income taxes	(449)	(104)	116
(Loss) income from continuing operations	(2,384)	(1,611)	295
Discontinued operations, net of taxes:			
Loss from operations of entities sold or held for sale	(6)	(7)	(27)
Impairment of hospitals sold or held for sale	(6)	(8)	(5)
Loss on sale, net	-	-	(4)
Loss from discontinued operations, net of taxes	(12)	(15)	(36)
Net (loss) income	(2,396)	(1,626)	259
Less: Net income attributable to noncontrolling interests	63	95	101
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$ (2,459)	$ (1,721)	$ 158
Basic (loss) income per share attributable to Community Health Systems, Inc. common stockholders:			
Continuing operations	$ (21.89)	$ (15.41)	$ 1.69
Discontinued operations	(0.11)	(0.13)	(0.31)
Net (loss) income	$ (22.00)	$ (15.54)	$ 1.38
Diluted (loss) income per share attributable to Community Health Systems, Inc. common stockholders:			
Continuing operations	$ (21.89)	$ (15.41)	$ 1.68
Discontinued operations	(0.11)	(0.13)	(0.31)
Net (loss) income	$ (22.00)	$ (15.54)	$ 1.37
Weighted-average number of shares outstanding:			
Basic	111,769,821	110,730,971	114,454,674
Diluted	111,769,821	110,730,971	115,272,404

See accompanying notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE (LOSS) INCOME

	Year Ended December 31,		
	2017	2016	2015
		(In millions)	
Net (loss) income	$(2,396)	$(1,626)	$259
Other comprehensive income (loss), net of income taxes:			
Net change in fair value of interest rate swaps, net of tax (benefit) of $10, $10 and $(3) for the years ended December 31, 2017, 2016 and 2015, respectively	19	17	(6)
Net change in fair value of available-for-sale securities, net of tax	8	(11)	(5)
Amortization and recognition of unrecognized pension cost components, net of tax of $9, $2, and $1 for the years ended December 31, 2017, 2016, and 2015, respectively	14	3	1
Other comprehensive income (loss)	41	9	(10)
Comprehensive (loss) income	(2,355)	(1,617)	249
Less: Comprehensive income attributable to noncontrolling interests	63	95	101
Comprehensive (loss) income attributable to Community Health Systems, Inc. stockholders	$(2,418)	$(1,712)	$148

See accompanying notes to the consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2017	2016
	(In millions, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 563	$ 238
Patient accounts receivable, net of allowance for doubtful accounts of $3,870 and $3,773 at December 31, 2017 and 2016, respectively	2,384	3,176
Supplies	444	480
Prepaid income taxes	17	17
Prepaid expenses and taxes	198	187
Other current assets	462	568
Total current assets	4,068	4,666
Property and equipment		
Land and improvements	671	782
Buildings and improvements	6,971	7,438
Equipment and fixtures	3,855	4,202
Property and equipment, gross	11,497	12,422
Less accumulated depreciation and amortization	(4,445)	(4,273)
Property and equipment, net	7,052	8,149
Goodwill	4,723	6,521
Deferred income taxes	62	15
Other assets, net of accumulated amortization of $883 and $929 at December 31, 2017 and 2016, respectively	1,545	2,593
Total assets	$17,450	$21,944
LIABILITIES AND EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 33	$ 455
Accounts payable	967	995
Accrued liabilities:		
Employee compensation	685	731
Accrued interest	229	207
Other	442	499
Total current liabilities	2,356	2,887
Long-term debt	13,880	14,789
Deferred income taxes	19	411
Other long-term liabilities	1,360	1,575
Total liabilities	17,615	19,662
Redeemable noncontrolling interests in equity of consolidated subsidiaries	527	554
Commitments and contingencies (Note 17)		
EQUITY		
Community Health Systems, Inc. stockholders' (deficit) equity:		
Preferred stock, $.01 par value per share, 100,000,000 shares authorized; none issued	-	-
Common stock, $.01 par value per share, 300,000,000 shares authorized; 114,651,004 shares issued and outstanding at December 31, 2017, and 113,876,580 shares issued and outstanding at December 31, 2016	1	1
Additional paid-in capital	2,014	1,975
Accumulated other comprehensive loss	(21)	(62)
Accumulated deficit	(2,761)	(299)
Total Community Health Systems, Inc. stockholders' (deficit) equity	(767)	1,615
Noncontrolling interests in equity of consolidated subsidiaries	75	113
Total (deficit) equity	(692)	1,728
Total liabilities and equity	$17,450	$21,944

See accompanying notes to the consolidated financial statements.

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COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' (DEFICIT) EQUITY

		Community Health Systems, Inc. Stockholders								
		Common Stock			Treasury Stock					
	Redeemable Noncontrolling Interests	Shares	Amount	Additional Paid-in Capital	Shares	Amount	Accumulated Other Comprehensive Income (Loss)	Retained Earnings (Accumulated Deficit)	Noncontrolling Interests	Total Stockholders' (Deficit) Equity
					(In millions, except share data)					
Balance, December 31, 2014	$ 531	117,701,087	$ 1	$ 2,095	(975,549)	$ (7)	$ (63)	$ 1,977	$ 80	$ 4,083
Comprehensive income	74	-	-	-	-	-	(10)	158	27	175
Contributions from noncontrolling interests	47	-	-	-	-	-	-	-	-	-
Distributions to noncontrolling interests	(70)	-	-	-	-	-	-	-	(30)	(30)
Purchase of subsidiary shares from noncontrolling interests	(25)	-	-	(16)	-	-	-	-	5	(11)
Disposition of less-than-wholly owned hospital	(8)	-	-	-	-	-	-	-	(2)	(2)
Other reclassifications of noncontrolling interests	(1)	-	-	-	-	-	-	-	1	1
Noncontrolling interests in acquired entity	2	-	-	-	-	-	-	-	5	5
Adjustment to redemption value of redeemable noncontrolling interests	21	-	-	(21)	-	-	-	-	-	(21)
Repurchases of common stock	-	(5,532,188)	-	(159)	-	-	-	-	-	(159)
Issuance of common stock in connection with the exercise of stock options	-	712,235	-	25	-	-	-	-	-	25
Issuance of shares in exchange for HMA common stock	-	(56)	-	-	-	-	-	-	-	-
Cancellation of restricted stock for tax withholdings on vested shares	-	(417,019)	-	(20)	-	-	-	-	-	(20)
Stock-based compensation	-	1,268,874	-	59	-	-	-	-	-	59
Balance, December 31, 2015	571	113,732,933	1	1,963	(975,549)	(7)	(73)	2,135	86	4,105
Comprehensive income (loss)	71	-	-	-	-	-	9	(1,721)	24	(1,688)
Distributions to noncontrolling interests, net of contributions	(69)	-	-	-	-	-	-	-	(23)	(23)
Purchase of subsidiary shares from noncontrolling interests	(14)	-	-	(9)	-	-	-	-	4	(5)
Disposition of less-than-wholly owned hospital	(3)	-	-	-	-	-	-	-	-	-
Noncontrolling interests in acquired entity	-	-	-	-	-	-	-	-	33	33
Adjustment to redemption value of redeemable noncontrolling interests	6	-	-	(6)	-	-	-	-	-	(6)
Distribution of Quorum Health Corporation	(8)	-	-	-	-	-	2	(713)	(11)	(722)
Cancellation of treasury stock	-	(975,549)	-	(7)	975,549	7	-	-	-	-
Cancellation of restricted stock for tax withholdings on vested shares	-	(368,945)	-	(6)	-	-	-	-	-	(6)
Income tax payable increase from vesting of restricted shares	-	-	-	(6)	-	-	-	-	-	(6)
Stock-based compensation	-	1,488,141	-	46	-	-	-	-	-	46
Balance, December 31, 2016	554	113,876,580	1	1,975	-	-	(62)	(299)	113	1,728
Comprehensive income (loss)	38	-	-	-	-	-	41	(2,459)	25	(2,393)
Contributions from noncontrolling interests	-	-	-	-	-	-	-	-	5	5
Distributions to noncontrolling interests	(71)	-	-	-	-	-	-	-	(29)	(29)
Purchase of subsidiary shares from noncontrolling interests	(4)	-	-	(2)	-	-	-	-	-	(2)
Disposition of less-than-wholly owned hospital	2	-	-	-	-	-	-	-	(10)	(10)
Other reclassifications of noncontrolling interests	29								(29)	(29)
Noncontrolling interests in acquired entity	1	-	-	-	-	-	-	-	-	-
Adjustment to redemption value of redeemable noncontrolling interests	(22)	-	-	22	-	-	-	-	-	22
Distribution of Quorum Health Corporation	-	-	-	-	-	-	-	(3)	-	(3)
Cancellation of restricted stock for tax withholdings on vested shares	-	(560,098)	-	(5)	-	-	-	-	-	(5)
Stock-based compensation	-	1,334,522	-	24	-	-	-	-	-	24
Balance, December 31, 2017	$ 527	114,651,004	$ 1	$ 2,014	-	$ -	$ (21)	$ (2,761)	$ 75	$ (692)

See accompanying notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2017	2016	2015
		(In millions)	
Cash flows from operating activities:			
Net (loss) income	$(2,396)	$(1,626)	$ 259
Adjustments to reconcile net (loss) income to net cash provided by operating activities:			
Depreciation and amortization	861	1,100	1,174
Deferred income taxes	(454)	(116)	103
Government and other legal settlements and related costs	9	16	4
Stock-based compensation expense	24	46	59
Loss on sale, net	-	-	4
Impairment of hospitals sold or held for sale	6	8	5
Impairment and (gain) loss on sale of businesses, net	2,123	1,919	68
Loss from early extinguishment of debt	40	30	16
Gain on sale of investments in unconsolidated affiliates	-	(94)	-
Other non-cash expenses, net	35	31	47
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	732	(96)	(219)
Supplies, prepaid expenses and other current assets	(33)	25	(68)
Accounts payable, accrued liabilities and income taxes	(69)	(137)	(478)
Other	(105)	31	(53)
Net cash provided by operating activities	773	1,137	921
Cash flows from investing activities:			
Acquisitions of facilities and other related businesses	(6)	(123)	(57)
Purchases of property and equipment	(564)	(744)	(953)
Proceeds from disposition of hospitals and other ancillary operations	1,692	143	155
Proceeds from sale of property and equipment	7	15	15
Purchases of available-for-sale securities	(125)	(505)	(162)
Proceeds from sales of available-for-sale securities	208	464	156
Proceeds from sale of investments in unconsolidated affiliates	-	403	-
Distribution from Quorum Health Corporation	-	1,219	-
Increase in other investments	(143)	(242)	(205)
Net cash provided by (used in) investing activities	1,069	630	(1,051)
Cash flows from financing activities:			
Proceeds from exercise of stock options	-	-	25
Repurchase of restricted stock shares for payroll tax withholding requirements	(5)	(6)	(20)
Stock buy-back	-	-	(159)
Deferred financing costs and other debt-related costs	(66)	(26)	(30)
Proceeds from noncontrolling investors in joint ventures	5	-	47
Redemption of noncontrolling investments in joint ventures	(6)	(19)	(36)
Distributions to noncontrolling investors in joint ventures	(100)	(92)	(100)
Proceeds from sale-lease back	-	159	-
Borrowings under credit agreements	841	4,879	4,922
Issuance of long-term debt	3,100	-	-
Proceeds from receivables facility	105	107	206
Repayments of long-term indebtedness	(5,391)	(6,715)	(5,050)
Net cash used in financing activities	(1,517)	(1,713)	(195)
Net change in cash and cash equivalents	325	54	(325)
Cash and cash equivalents at beginning of period	238	184	509
Cash and cash equivalents at end of period	$ 563	$ 238	$ 184
Supplemental disclosure of cash flow information:			
Interest payments	$ (852)	$ (930)	$ (925)
Income tax (payments) refunds, net	$ (4)	$ 16	$ (12)

See accompanying notes to the consolidated financial statements.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

Business. Community Health Systems, Inc. is a holding company and operates no business in its own name. On a consolidated basis, Community Health Systems, Inc. and its subsidiaries (collectively the "Company") own, lease and operate general acute care hospitals in communities across the country. As of December 31, 2017, the Company owned or leased 125 hospitals, included in continuing operations, including two stand-alone rehabilitation or psychiatric hospitals, licensed for 20,850 beds in 19 states. Throughout these notes to the consolidated financial statements, Community Health Systems, Inc. (the "Parent") and its consolidated subsidiaries are referred to on a collective basis as the "Company." This drafting style is not meant to indicate that the publicly-traded Parent or any particular subsidiary of the Parent owns or operates any asset, business, or property. The hospitals, operations and businesses described in this filing are owned and operated, and management services provided, by distinct and indirect subsidiaries of Community Health Systems, Inc.

As of December 31, 2017, Florida, Texas, Pennsylvania and Indiana represent the only areas of significant geographic concentration. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Florida, as a percentage of consolidated operating revenues, were 14.8% in 2017, 14.1% in 2016 and 13.6% in 2015. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Texas, as a percentage of consolidated operating revenues, were 12.1% in 2017, 11.4% in 2016 and 11.1% in 2015. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Pennsylvania, as a percentage of consolidated operating revenues, were 9.2% in 2017, 11.2% in 2016 and 10.6% in 2015. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Indiana, as a percentage of consolidated operating revenues, were 9.9% in 2017, 8.6% in 2016 and 7.3% in 2015.

Use of Estimates. The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements. Actual results could differ from these estimates under different assumptions or conditions.

Principles of Consolidation. The consolidated financial statements include the accounts of the Parent, its subsidiaries, all of which are controlled by the Parent through majority voting control, and variable interest entities for which the Company is the primary beneficiary. All intercompany accounts, profits and transactions have been eliminated. Noncontrolling interests in less-than-wholly-owned consolidated subsidiaries of the Parent are presented as a component of total equity to distinguish between the interests of the Parent and the interests of the noncontrolling owners. Revenues, expenses and income from continuing operations from these subsidiaries are included in the consolidated amounts as presented on the consolidated statements of (loss) income, along with a net income measure that separately presents the amounts attributable to the controlling interests and the amounts attributable to the noncontrolling interests for each of the periods presented. Noncontrolling interests that are redeemable or may become redeemable at a fixed or determinable price at the option of the holder or upon the occurrence of an event outside of the control of the Company are presented in mezzanine equity on the consolidated balance sheets.

Cost of Revenue. Substantially all of the Company's operating costs and expenses are "cost of revenue" items. Operating costs that could be classified as general and administrative by the Company would include the Company's corporate office costs at its Franklin, Tennessee office which were collectively $189 million, $197 million and $266 million for the years ended December 31, 2017, 2016 and 2015, respectively. Included in these corporate office costs is stock-based compensation of $24 million, $46 million and $59 million for the years ended December 31, 2017, 2016 and 2015, respectively.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Cash Equivalents. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

Supplies. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

Marketable Securities. The Company's marketable securities are classified as trading or available-for-sale. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholders' (deficit) equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Other comprehensive (loss) income, net of tax, included an unrealized gain of $8 million during the year ended December 31, 2017 and an unrealized loss of $11 million and $5 million during the years ended December 31, 2016 and 2015, respectively, related to these available-for-sale securities.

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (3 to 20 years), buildings and improvements (5 to 40 years) and equipment and fixtures (3 to 18 years). Costs capitalized as construction in progress were $222 million and $227 million at December 31, 2017 and 2016, respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized related to construction in progress was $11 million, $9 million and $16 million for the years ended December 31, 2017, 2016 and 2015, respectively. Purchases of property and equipment and internal-use software accrued in accounts payable and not yet paid were $166 million and $115 million at December 31, 2017 and 2016, respectively.

The Company also leases certain facilities and equipment under capital leases (see Note 10). Such assets are amortized on a straight-line basis over the lesser of the term of the lease or the remaining useful lives of the applicable assets. During the year ended December 31, 2017, the Company had non-cash investing activity of $31 million related to certain facility and equipment additions that were financed through capital leases and other debt.

Goodwill. Goodwill represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired. Goodwill arising from business combinations is not amortized. Goodwill is required to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is more likely than not that impairment may exist. The Company performs its annual testing of impairment for goodwill in the fourth quarter of each year. As further discussed in Note 5, the Company recorded impairment charges of $1.419 billion and $1.395 billion during the years ended December 31, 2017 and 2016, respectively.

Other Assets. Other assets consist of the insurance recovery receivable from excess insurance carriers related to the Company's self-insured malpractice general liability and workers' compensation insurance liability; costs to recruit physicians to the Company's markets, which are deferred and expensed over the term of the respective physician recruitment contract, generally three years, and included in amortization expense; and capitalized internal-use software costs, which are expensed over the expected useful life, which is generally three years for routine software and eight to ten years for major software projects, and included in amortization expense.

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $93.6 billion, $98.2 billion and $95.3 billion for the years ended December 31, 2017, 2016 and 2015, respectively. Net operating revenues are recognized when services are provided and are reported at the estimated net realizable amount from patients, third-party payors and others for services rendered. Also included

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

in the provision for contractual allowance shown above is the value of administrative and other discounts provided to self-pay patients eliminated from net operating revenues which was $3.6 billion, $3.2 billion and $3.0 billion for the years ended December 31, 2017, 2016 and 2015, respectively.

Throughout 2017 and culminating with the financial close process at December 31, 2017, the Company developed new accounting methodologies and processes to implement ASU 2014-09, the new accounting standard for revenue recognition that was adopted effective January 1, 2018. By implementing new data extraction techniques and updated hindsight information on historical collection data, the Company was able to better estimate the net amount after contractual allowances owed by the third-party payor and what will be owed by the patient based on historical experience. Such updated information included portfolio-level data related to historical collection amounts on an individual hospital and patient level that previously had not been readily available. Using this information the Company created a new accounting process by which it can estimate contractual allowances on a per patient basis. In addition to this new accounting methodology, the Company also revised its methods of estimating contractual allowances to (1) expand the hindsight period over which the Company analyzes payors' historical paid claims data to estimate contractual allowances, (2) expand the basis for payor denied claims to refine the hindsight reserve for such denials, and (3) adjust the contractual allowances for certain categories of commercial payors using more precise historical experience based on recent patterns of account reimbursement. Additionally, the Company evaluated the estimated collection of those amounts due from the patient as part of the Company's estimate of the allowance for doubtful accounts. This analysis also included an evaluation of patient accounts receivable retained after the divestiture of 30 hospitals throughout 2017, and certain other revenues. Based on these new accounting processes and methodologies, the Company recorded a change in estimate during the three months ended December 31, 2017 to increase contractual allowances by approximately $197 million, and to record additional provision for bad debts and increase the allowance for doubtful accounts by $394 million. The total impact of the change in estimate recorded during the three months ended December 31, 2017 was a decrease to net operating revenues of $591 million.

In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. The Company's policy is to not pursue collections for such amounts; therefore, the related charges for those patients who are financially unable to pay and that otherwise do not qualify for reimbursement from a governmental program are not reported in net operating revenues or in the provision for bad debts, and are thus classified as charity care. The Company determines amounts that qualify for charity care primarily based on the patient's household income relative to the federal poverty level guidelines, as established by the federal government.

Included in the provision for contractual allowance shown above is $482 million, $487 million and $453 million for the years ended December 31, 2017, 2016 and 2015, respectively, representing the value (at the Company's standard charges) of these charity care services that are excluded from net operating revenues.

The estimated cost incurred by the Company to provide these charity care services to patients who are unable to pay was approximately $62 million, $64 million and $64 million for the years ended December 31, 2017, 2016 and 2015, respectively. The estimated cost of these charity care services was determined using a ratio of cost to gross charges and applying that ratio to the gross charges associated with providing care to charity patients for the period.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid patients. These programs are designed with input from the Centers for Medicare and Medicaid Services and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being considered by other states. After these supplemental programs are signed into law, the Company recognizes revenue and related expenses in the period in which amounts are estimable and collection is

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

reasonably assured. Reimbursement under these programs is reflected in net operating revenues and fees, taxes or other program-related costs are reflected in other operating expenses.

Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), recognized during the years ended December 31, 2017, 2016 and 2015, were as follows (in millions):

	Year Ended December 31,		
	2017	2016	2015
Medicare	$ 4,188	$ 5,089	$ 5,439
Medicaid	1,900	2,234	2,532
Managed Care and other third-party payors	9,991	11,354	11,816
Self-pay	2,319	2,598	2,777
Total	$18,398	$21,275	$22,564

Third-Party Reimbursement. Net patient service revenue is reported at the estimated net realizable amount from patients, third-party payors and others for services rendered. Operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 33.1%, 34.4% and 35.3% of operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), for the years ended December 31, 2017, 2016 and 2015, respectively, are related to services rendered to patients covered by the Medicare and Medicaid programs. Revenues from Medicare outlier payments are included in the amounts received from Medicare and were approximately 0.33%, 0.38% and 0.28% of operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), for the years ended December 31, 2017, 2016 and 2015, respectively. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at operating revenues (net of contractual allowances and discounts). These net operating revenues are an estimate of the net realizable amount due from these payors. The process of estimating contractual allowances requires the Company to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments the Company receives could be different from the amounts it estimates and records. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. Adjustments to previous program reimbursement estimates are accounted for as contractual allowance adjustments and reported in the periods that such adjustments become known.

Amounts due to third-party payors were $156 million and $99 million as of December 31, 2017 and 2016, respectively, and are included in accrued liabilities-other in the accompanying consolidated balance sheets. As part of the change in estimate to contractual allowances recorded during the three months ended December 31, 2017 discussed above, the Company recorded additional amounts due to third-party payors related to estimated amounts owed or expected to be recouped under certain state Medicaid disproportionate share reimbursement programs. These estimates were based on the results of completed audits and an estimate of probable outcomes of future audits considering the cost limits defined under the respective state program. Amounts due from third-party payors were $153 million and $186 million as of December 31, 2017 and 2016, respectively, and are included in other current assets in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2014.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Allowance for Doubtful Accounts. Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. Substantially all of the Company's receivables are related to providing healthcare services to patients at its hospitals and affiliated businesses.

The Company estimates the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and any anticipated changes in trends. As discussed above, the Company's historical accounting systems and processes to estimate net operating revenues from third-party payors did not have the ability to specifically identify the portion of an insured patient account that was due from the patient (e.g., deductibles and co-payments), and did not provide portfolio-level data related to historical collection amounts on an individual hospital or patient level. As part of the new accounting methodologies and processes developed in 2017 to implement the new accounting standard on revenue recognition, which was required to be adopted on January 1, 2018, the Company changed its methodology for estimating those amounts that are recorded as part of the receivable with the primary insurance payor but will ultimately be due from the patient. While the Company's historical estimation process for the allowance for doubtful accounts utilized historical write-off and collection information on a consolidated basis, the new processes and related data obtained from the hindsight analysis provided updated information on the ultimate collectability of all patient accounts for the amount at the date of service that will ultimately be due from the patient. Such information was evaluated at a portfolio level by payor and by hospital rather than on a consolidated basis.

Collections are impacted by the economic ability of patients to pay and the effectiveness of the Company's collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the Company's collection of accounts receivable and the estimates of the collectability of future accounts receivable and are considered in the Company's estimates of accounts receivable collectability. The Company also continually reviews its overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, the composition of self-pay receivables between pure self-pay patients and the patient responsibility portion of third-party insured receivables and the impact of recent acquisitions and dispositions.

As discussed above, during the three months ended December 31, 2017, the Company recorded $394 million of additional provision for bad debts and a corresponding increase to the allowance for doubtful accounts. As required by generally accepted accounting principles, the Company adopted the new revenue recognition accounting standards in ASU 2014-09 on January 1, 2018. In connection with the adoption of this ASU, during the fourth quarter of 2017, the Company completed an extensive analysis of its patient revenues and patient accounts receivable and developed new accounting processes and methodologies. This analysis also included an evaluation of patient accounts receivable retained after the divestiture of 30 hospitals throughout 2017, and certain other revenues.

During the fourth quarter of 2015, the Company recorded $169 million of additional provision for bad debts and a corresponding increase to the allowance for doubtful accounts. The additional amount was the result of new information obtained since the end of the third quarter of 2015 related to the deterioration in the overall collectability of self-pay accounts receivable. As a result, the Company refined its estimate of the allowance for doubtful accounts and the additional amount was recorded as a change in estimate for the year ended December 31, 2015.

Electronic Health Records Incentive Reimbursement. The federal government has implemented a number of regulations and programs designed to promote the use of electronic health records ("EHR") technology and,

pursuant to the Health Information Technology for Economic and Clinical Health Act ("HITECH"), established requirements for a Medicare and Medicaid incentive payments program for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. The Company utilizes a gain contingency model to recognize EHR incentive payments. Recognition occurs when the eligible hospitals adopt or demonstrate meaningful use of certified EHR technology for the applicable payment period and have available the Medicare cost report information for the relevant full cost report year used to determine the final incentive payment.

Medicaid EHR incentive payments are calculated based on prior period Medicare cost report information available at the time when eligible hospitals adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Since the information for the relevant full Medicare cost report year is available at the time of attestation, the incentive income from resolving the gain contingency is recognized when eligible hospitals adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Medicare EHR incentive payments are calculated based on the Medicare cost report information for the full cost report year that began during the federal fiscal year in which meaningful use is demonstrated. Since the necessary information is only available at the end of the relevant full Medicare cost report year and after the cost report is settled, the incentive income from resolving the gain contingency is recognized when eligible hospitals demonstrate meaningful use of certified EHR technology and the information for the applicable full Medicare cost report year to determine the final incentive payment is available.

In some instances, the Company may receive estimated Medicare EHR incentive payments prior to when the Medicare cost report information used to determine the final incentive payment is available. In these instances, recognition of the gain for EHR incentive payments is deferred until all recognition criteria described above are met.

Eligibility for annual Medicare incentive payments is dependent on providers successfully attesting to the meaningful use of EHR technology. Medicaid incentive payments are available to providers in the first payment year that they adopt, implement or upgrade certified EHR technology; however, providers must demonstrate meaningful use of such technology in any subsequent payment years to qualify for additional incentive payments. Medicaid EHR incentive payments are fully funded by the federal government and administered by the states; however, the states are not required to offer EHR incentive payments to providers.

The Company recognized approximately $28 million, $70 million and $160 million for the years ended December 31, 2017, 2016 and 2015, respectively, of incentive reimbursement for HITECH incentives from Medicare and Medicaid related to certain of the Company's hospitals and for certain of the Company's employed physicians that have demonstrated meaningful use of certified EHR technology or have completed attestations to their adoption or implementation of certified EHR technology. These incentive reimbursements are presented as a reduction of operating costs and expenses on the consolidated statements of (loss) income. The Company received cash related to the incentive reimbursement for HITECH incentives of approximately $41 million, $123 million and $75 million for the years ended December 31, 2017, 2016 and 2015, respectively. The Company recorded no deferred revenue in connection with the receipt of these cash payments at either December 31, 2017 or 2016.

Physician Income Guarantees. The Company enters into physician recruiting agreements under which it supplements physician income to a minimum amount over a period of time, typically one year, while the physicians establish themselves in the community. As part of the agreements, the physicians are committed to practice in the community for a period of time, typically three years, which extends beyond their income guarantee period. The Company records an asset and liability for the estimated fair value of minimum revenue guarantees on new agreements. Adjustments to the ultimate value of the guarantee paid to physicians are recognized in the period that the change in estimate is identified. The Company amortizes an asset over the life of

the agreement. As of December 31, 2017 and 2016, the unamortized portion of these physician income guarantees was $29 million and $37 million, respectively.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company's facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare was $220 million and $402 million at December 31, 2017 and 2016, respectively, representing 4% and 6% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2017 and 2016, respectively.

Accounting for the Impairment or Disposal of Long-Lived Assets. During the year ended December 31, 2017, the Company recorded a total combined impairment charge and loss on disposal of approximately $388 million to reduce the carrying value of certain hospitals that have been deemed held for sale based on the difference between the carrying value of the hospital disposal groups compared to estimated fair value less costs to sell. Included in the carrying value of the hospital disposal groups at December 31, 2017 is a net allocation of approximately $7 million of goodwill allocated from the hospital operations reporting unit goodwill based on a calculation of the disposal groups' relative fair value compared to the total reporting unit. The Company will continue to evaluate the potential for further impairment of the long-lived assets of underperforming hospitals as well as evaluating offers for potential sale. Based on such analysis, additional impairment charges may be recorded in the future.

Additionally, the Company recorded an impairment charge of approximately $341 million during the three months ended December 31, 2017 for several underperforming hospitals as well as for certain hospitals deemed held for sale or where the Company has received offers or executed non-binding letters of intent to sell the hospital.

During the year ended December 31, 2016, the Company recorded a total impairment charge of $326 million to reduce the carrying value of certain hospitals that have been deemed held for sale based on the difference between the carrying value of the hospital disposal groups compared to estimated fair value less costs to sell. Additionally, the Company recorded an impairment charge of approximately $270 million for several underperforming hospitals to their estimated fair value. The impairment charge for the year ended December 31, 2016 also included approximately $19 million recorded on the sale or closure of certain of the Company's hospitals during the year based on the remaining net book value of the assets at the date of disposal. In total, the Company recorded impairment charges of approximately $615 million on its long-lived assets other than the impairment charge taken on the hospital reporting unit goodwill that is further discussed in Note 5. Included in the carrying value of the hospital disposal groups is an allocation of approximately $365 million of goodwill allocated from the hospital reporting unit goodwill based on a calculation of the disposal groups' relative fair value compared to the total reporting unit.

Income Taxes. The Company accounts for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change in tax rates is recognized in the consolidated statement of loss during the period in which the tax rate change becomes law.

Comprehensive Loss. Comprehensive loss is the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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Segment Reporting. A public company is required to report annual and interim financial and descriptive information about its reportable operating segments. Operating segments, as defined, are components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker in deciding how to allocate resources and in assessing performance. Aggregation of similar operating segments into a single reportable operating segment is permitted if the businesses have similar economic characteristics and meet the criteria established by U.S. GAAP.

The Company operated in two distinct operating segments during 2016, represented by the hospital operations (which includes the Company's acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services) and the home care agencies operations (which provide in-home outpatient care). U.S. GAAP requires (1) that financial information be disclosed for operating segments that meet a 10% quantitative threshold of the consolidated totals of net revenue, profit or loss, or total assets; and (2) that the individual reportable segments disclosed contribute at least 75% of total consolidated net revenue. Based on these measures, only the hospital operations segment meets the criteria as a separate reportable segment. Financial information for the home care agencies segment does not meet the quantitative thresholds and is therefore combined with corporate into the all other reportable segment. Additionally, as discussed in Note 3, on December 31, 2016, the Company sold 80% of its ownership interest in the home care segment. In 2017 and in future periods, the Company will only operate in one operating segment.

Derivative Instruments and Hedging Activities. The Company records derivative instruments on the consolidated balance sheet as either an asset or liability measured at its fair value. Changes in a derivative's fair value are recorded each period in earnings or other comprehensive income ("OCI"), depending on whether the derivative is designated and is effective as a hedged transaction, and on the type of hedge transaction. Changes in the fair value of derivative instruments recorded to OCI are reclassified to earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument determined to be ineffective under the standard is recognized in current earnings.

The Company has entered into several interest rate swap agreements. See Note 8 for further discussion about the swap transactions.

New Accounting Pronouncements. In May 2014, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2014-09, which outlines a single comprehensive model for recognizing revenue and supersedes most existing revenue recognition guidance, including guidance specific to the healthcare industry. This ASU provides companies the option of applying a full or modified retrospective approach upon adoption. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted for annual periods beginning after December 15, 2016. The Company adopted this ASU on January 1, 2018 and during the fourth quarter of 2017 it completed its plan for adoption, including updating its revenue recognition policies, procedures and control framework and evaluating the resulting impact on its consolidated financial position, results of operations and cash flows. A significant element of executing this plan was the process of reviewing sources of revenue and evaluating the patient account population to determine the appropriate distribution of patient accounts into portfolios with similar characteristics that, when evaluated under the new revenue standard, will result in a materially consistent revenue amount for such portfolios as if each patient account was evaluated on a contract-by-contract basis. As part of this evaluation, the Company invested significant time and resources to evaluate the estimates of how much of its insured patient accounts receivable will ultimately be due from the patient as a co-pay or deductible, and of that amount, how much will ultimately be collectible. The application of these new processes and methodologies to evaluate updated collection data to determine the patient portfolios and estimate the implicit price concessions and constraints on revenue required by this new accounting standard resulted in new information that reflected a required reduction to the amount of net patient accounts receivable on the Company's consolidated statement of financial position. As a result, the

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Company recorded a change in estimate through additional contractual allowances and allowance for doubtful accounts at December 31, 2017 as further discussed above with respect to the Company's accounting policies on net operating revenues and the allowance for doubtful accounts. The Company does not expect the adoption of this ASU to have a material impact on its consolidated results of operations on a prospective basis.

The Company also assessed the impact of the new standard on various reimbursement programs that represent variable consideration, including settlements with third party payors, disproportionate share payments, supplemental state Medicaid programs, bundled payment of care programs and other reimbursement programs in which the Company's hospitals participate. Industry guidance is continuing to develop around this issue, and any conclusions in the final industry guidance that is inconsistent with the Company's application could result in changes to the Company's expectations regarding the impact that this new accounting standard could have on the Company's financial statements. The Company does not believe such industry guidance will have an impact on its current accounting policies and procedures related to third party settlements. Final drafts of industry guidance on these and other reimbursement programs unique to the healthcare industry are expected later in 2018. The Company is monitoring the development of such guidance.

Additionally, the adoption of the new accounting standard will impact the presentation on the Company's statement of operations for a significant component of its provision for bad debts. After adoption of the new standard, the majority of what is currently classified as the provision for bad debts will be reflected as an implicit price concession as defined in the standard and therefore a reduction to net patient revenue. The Company will consider certain changes in collectability on its self-pay patient accounts receivable resulting from certain credit and collection issues not assessed at the date of service and recognize such amounts in the provision for bad debts included in operating expenses on the statement of operations.

Previously, the Company disclosed its intention to apply the full retrospective approach to implementing this ASU upon adoption at January 1, 2018. During the last several months, as the Company has developed and implemented new processes for accumulating detailed financial information on patient revenue at the portfolio level, management concluded that the full retrospective approach to applying this ASU to prior periods would be significantly impacted by the number of hospitals that the Company has divested or spun-off in recent years, and the effect of those transactions on the portfolios. As a result, the Company has applied the modified retrospective approach to adopting this ASU.

In January 2016, the FASB issued ASU 2016-01, which amends the measurement, presentation and disclosure requirements for equity investments, other than those accounted for under the equity method or that require consolidation of the investee. The ASU eliminates the classification of equity investments as available-for-sale with any changes in fair value of such investments recognized in other comprehensive income, and requires entities to measure equity investments at fair value, with any changes in fair value recognized in net income. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. The Company adopted this ASU on January 1, 2018, and does not expect the adoption of this ASU will have a material impact on its consolidated financial position and results of operations.

In February 2016, the FASB issued ASU 2016-02, which amends the accounting for leases, requiring lessees to recognize most leases on their balance sheet with a right-of-use asset and a lease liability. Leases will be classified as either finance or operating leases, which will impact the expense recognition of such leases over the lease term. The ASU also modifies the lease classification criteria for lessors and eliminates some of the real estate leasing guidance previously applied for certain leasing transactions. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The Company expects to adopt this ASU on January 1, 2019. Because of the number of leases the Company utilizes to support its operations, the adoption of this ASU is expected to have a significant impact on the Company's consolidated financial position and results of operations. Management is currently evaluating the extent of this anticipated impact on the Company's

consolidated financial position and results of operations, and the quantitative and qualitative factors that will impact the Company as part of the adoption of this ASU, as well as any changes to its leasing strategy that may occur because of the changes to the accounting and recognition of leases. Most recently, the Company has organized an implementation group of cross-functional departmental management to ensure the completeness of its lease information, analyze the appropriate classification of current leases under the new standard, and develop new processes to execute, approve and classify leases on an ongoing basis. The Company has also engaged outside experts to assist in the development of this plan, as well as the identification and selection of software tools and processes to maintain lease information critical to applying the new standard.

In March 2016, the FASB issued ASU 2016-09, which was issued to simplify some of the accounting guidance for share-based compensation. Among the areas impacted by the amendments in this ASU is the accounting for income taxes related to share-based payments, accounting for forfeitures, classification of awards as equity or liabilities, and classification on the statement of cash flows. This ASU is effective for fiscal years beginning after December 15, 2016. The Company adopted this ASU on January 1, 2017. Because of the recent decline in the Company's stock price below the Company's stock price at the stock award grant date for outstanding share-based awards, the principal impact from adopting this ASU has been a $16 million increase in the Company's current provision for income taxes due to the deficiency created by a difference between the actual tax deduction that will be recognized from the vesting of outstanding share-based awards during the year ended December 31, 2017, compared to the higher stock compensation expense previously recorded over the vesting period as determined based on the fair value of the restricted stock at the grant date.

In January 2017, the FASB issued ASU 2017-04, which simplifies the accounting for goodwill impairment by eliminating step two from the goodwill impairment test. Instead of a two-step impairment model, if the carrying amount of a reporting unit exceeds its fair value as determined in step one of the impairment test, an impairment loss is measured at the amount equal to that excess, limited to the total amount of goodwill allocated to that reporting unit. This ASU is effective for any interim or annual impairment tests for fiscal years beginning after December 15, 2019, with early adoption permitted. During the fourth quarter of 2017, the Company performed its annual goodwill impairment analysis. Prior to the completion of the annual goodwill impairment analysis, the Company identified additional indicators of impairment that required an interim goodwill impairment evaluation, which was performed as of November 30, 2017. The result of that step one analysis indicated that the carrying value of the hospital reporting unit exceeded the estimated fair value. At that time, the Company elected to early adopt the simplified goodwill impairment model in ASU 2017-04, and as a result recorded a non-cash impairment charge of $1.419 billion to goodwill during the three months ended December 31, 2017.

In March 2017, the FASB issued ASU 2017-07, which changes the presentation of the components of net periodic benefit cost for sponsors of defined benefit plans for pensions. Under the changes in this ASU, the service cost component of net periodic benefit cost will be reported in the same income statement line as other employee compensation costs arising from services during the reporting period. The other components of net periodic benefit cost will be presented separately in a line item outside of operating income. This ASU is effective for fiscal years beginning after December 15, 2017, with early adoption permitted. The Company adopted this ASU on January 1, 2018, and has determined that adoption will have an immaterial impact on the Company's consolidated financial position and results of operations. Since the changes required in this new ASU only change the income statement classification of the components of net periodic benefit cost, no changes are expected to income from continuing operations or net income. Currently, the Company reports all of the components of net periodic benefit cost as a component of salaries and benefits on the consolidated statement of income.

In August 2017, the FASB issued ASU 2017-12, which was issued to amend hedge accounting recognition and disclosure requirements to improve transparency and simplify the application of hedge accounting for certain

hedging instruments. The amendments in this ASU that will have an impact on the Company include simplification of the periodic hedge effectiveness assessment, elimination of the benchmark interest rate concept for interest rate swaps, and enhancement of the ability to use the critical-terms match method for its cash flow hedges of forecasted interest payments. This ASU is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The Company early adopted this ASU on January 1, 2018, and concluded the adoption of this ASU will not have a material impact on its consolidated financial position and results of operations.

2. ACCOUNTING FOR STOCK-BASED COMPENSATION

Stock-based compensation awards have been granted under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan, amended and restated as of March 20, 2013 (the "2000 Plan"), and the Community Health Systems, Inc. Amended and Restated 2009 Stock Option and Award Plan, which was amended and restated as of March 16, 2016 and approved by the Company's stockholders at the annual meeting of stockholders held on May 17, 2016 (the "2009 Plan").

The 2000 Plan allowed for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code (the "IRC"), as well as stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Prior to being amended in 2009, the 2000 Plan also allowed for the grant of phantom stock. Persons eligible to receive grants under the 2000 Plan include the Company's directors, officers, employees and consultants. All options granted under the 2000 Plan have been "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10-year contractual term, options granted in 2005 through 2007 have an eight-year contractual term and options granted in 2008 through 2011 have a 10-year contractual term. The Company has not granted stock option awards under the 2000 Plan since 2011. Pursuant to the amendment and restatement of the 2000 Plan dated March 20, 2013, no further grants will be awarded under the 2000 Plan.

The 2009 Plan provides for the grant of incentive stock options intended to qualify under Section 422 of the IRC and for the grant of stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Persons eligible to receive grants under the 2009 Plan include the Company's directors, officers, employees and consultants. To date, all options granted under the 2009 Plan have been "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted in 2011 or later have a 10-year contractual term. The amendment and restatement of the 2009 Plan, as approved by the Company's stockholders at the 2016 Annual Meeting, increased the number of shares of common stock available for grant under the 2009 Plan by an additional 5,000,000 shares. As of December 31, 2017, 4,022,248 shares of unissued common stock were reserved for future grants under the 2009 Plan.

The exercise price of all options granted under the 2000 Plan and the 2009 Plan has been equal to the fair value of the Company's common stock on the option grant date.

The following table reflects the impact of total compensation expense related to stock-based equity plans on the reported operating results for the respective periods (in millions):

	Year Ended December 31,		
	2017	2016	2015
Effect on (loss) income from continuing operations before income taxes	$ (24)	$ (46)	$ (59)
Effect on net (loss) income	$ (16)	$ (27)	$ (35)

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At December 31, 2017, $16 million of unrecognized stock-based compensation expense related to outstanding unvested restricted stock and restricted stock units (the terms of which are summarized below) was expected to be recognized over a weighted-average period of 19 months. There is no expense to be recognized related to stock options. There were no modifications to awards during the years ended December 31, 2017 and 2016, other than those required by the Employee Matters Agreement ("EMA") entered into as part of the spinoff of Quorum Health Corporation ("QHC"), as further discussed below.

Options outstanding and exercisable under the 2000 Plan and the 2009 Plan as of December 31, 2017, and changes during each of the years in the three-year period prior to December 31, 2017, were as follows (in millions, except share and per share data):

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term	Aggregate Intrinsic Value as of December 31, 2017
Outstanding at December 31, 2014	1,953,727	$ 32.94		
Granted	-	-		
Exercised	(711,568)	35.15		
Forfeited and cancelled	(10,001)	34.96		
Outstanding at December 31, 2015	1,232,158	31.65		
Granted	-	-		
Exercised	-	-		
Forfeited and cancelled	(46,838)	27.44		
Outstanding at December 31, 2016	1,185,320	28.12		
Granted	-	-		
Exercised	-	-		
Forfeited and cancelled	(69,653)	33.52		
Outstanding at December 31, 2017	1,115,667	$ 31.56	2.0 years	$ -
Exercisable at December 31, 2017	1,115,667	$ 31.56	2.0 years	$ -

The weighted-average exercise prices in the table above for periods prior to the April 29, 2016 spin-off of QHC reflect the historical prices at those dates. No stock options were granted during the years ended December 31, 2017, 2016 and 2015. The aggregate intrinsic value (calculated as the number of in-the-money stock options multiplied by the difference between the Company's closing stock price on the last trading day of the reporting period ($4.26) and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on December 31, 2017. This amount changes based on the market value of the Company's common stock. There were no options exercised during the years ended December 31, 2017 and 2016. The aggregate intrinsic value of options exercised during the year ended December 31, 2015 was $9 million. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

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In accordance with the terms of the EMA, on April 29, 2016, the exercise prices of all stock options outstanding as of that date were modified to reflect the reduction in the Company's stock price that occurred as a result of the distribution of QHC to the Company's stockholders in order to maintain a consistent intrinsic value before and following the QHC distribution. There were no other modifications to the term or number of the outstanding options. The Company evaluated the fair value of the stock options immediately before and after the exercise price modification, and concluded that no incremental stock compensation expense should be recorded.

The Company has also awarded restricted stock under the 2000 Plan and the 2009 Plan to its directors and employees of certain subsidiaries. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date. Certain of the restricted stock awards granted to the Company's senior executives contain a performance objective that must be met in addition to any time-based vesting requirements. If the performance objective is not attained, the awards will be forfeited in their entirety. For such performance-based awards granted prior to 2017, once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. For performance-based awards granted beginning in March 2017, the performance objective is measured cumulatively over a three-year period. With respect to these performance-based awards granted beginning in March 2017, if the performance criteria are met at the end of three years, then the restricted stock award will vest in full. Additionally, for these awards, based on the level of achievement for the performance criteria, the number of shares to be issued in connection with the vesting of the award can be adjusted to decrease or increase the number of shares specified in the original award. Notwithstanding the above-mentioned performance objectives and vesting requirements, the restrictions with respect to restricted stock granted under the 2000 Plan and the 2009 Plan will lapse earlier in the event of death, disability or termination of employment by the Company for any reason other than for cause of the holder of the restricted stock, or change in control of the Company. Restricted stock awards subject to performance standards that have not yet been satisfied are not considered outstanding for purposes of determining earnings per share until the performance objectives have been satisfied.

On April 29, 2016, the Company cancelled 106,005 restricted stock awards from the March 1, 2016 grant that were held by former employees whose employment with the Company terminated as the result of commencing employment with QHC in connection with the spin-off. This cancellation did not include the issuance of replacement awards by the Company. As a result, the Company recorded approximately $2 million of compensation expense related to the unrecognized stock compensation expense for those awards at the cancellation date. This expense is recorded as part of the costs related to the spin-off of QHC presented in other operating expenses on the accompanying consolidated statement of (loss) income for the year ended December 31, 2016.

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Restricted stock outstanding under the 2000 Plan and the 2009 Plan as of December 31, 2017, and changes during each of the years in the three-year period prior to December 31, 2017, were as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2014	2,760,639	$ 39.82
Granted	1,254,500	47.69
Vested	(1,156,226)	37.61
Forfeited	(13,334)	41.32
Unvested at December 31, 2015	2,845,579	44.18
Granted	1,611,049	14.11
Vested	(1,343,003)	43.39
Forfeited	(144,340)	19.99
Unvested at December 31, 2016	2,969,285	29.39
Granted	1,502,000	9.10
Vested	(1,586,855)	33.91
Forfeited	(240,511)	18.20
Unvested at December 31, 2017	2,643,919	16.17

Restricted stock units ("RSUs") have been granted to the Company's outside directors under the 2000 Plan and the 2009 Plan. On March 1, 2015, each of the Company's outside directors received a grant under the 2009 Plan of 3,504 RSUs. On March 1, 2016, each of the Company's outside directors received a grant under the 2009 Plan of 11,017 RSUs. On March 1, 2017, each of the Company's outside directors received a grant under the 2009 Plan of 18,498 RSUs. Each of the 2015, 2016 and 2017 grants had a grant date fair value of approximately $170,000. Vesting of these RSUs occurs in one-third increments on each of the first three anniversaries of the award date.

In connection with the spin-off of QHC, holders of outstanding RSUs were credited with a total of 22,021 incremental RSUs at a ratio calculated to maintain a consistent intrinsic value before and following the QHC distribution. There were no other changes to the awards and the incremental RSUs will vest in accordance with the initial vesting period of the corresponding original award.

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RSUs outstanding under the 2000 Plan and the 2009 Plan as of December 31, 2017, and changes during each of the years in the three-year period prior to December 31, 2017, were as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2014	49,362	$ 36.07
Granted	21,024	47.70
Vested	(27,708)	31.76
Forfeited	-	-
Unvested at December 31, 2015	42,678	44.59
Granted	99,140	16.90
Vested	(21,432)	43.87
Forfeited	-	-
Unvested at December 31, 2016	120,386	22.06
Granted	110,988	9.19
Vested	(59,296)	24.90
Forfeited	-	-
Unvested at December 31, 2017	172,078	12.78

3. ACQUISITIONS AND DIVESTITURES

Acquisitions

The Company accounts for all transactions that represent business combinations using the acquisition method of accounting, where the identifiable assets acquired, the liabilities assumed and any noncontrolling interest in the acquired entity are recognized and measured at their fair values on the date the Company obtains control in the acquiree. Such fair values that are not finalized for reporting periods following the acquisition date are estimated and recorded as provisional amounts. Adjustments to these provisional amounts during the measurement period (defined as the date through which all information required to identify and measure the consideration transferred, the assets acquired, the liabilities assumed and any noncontrolling interests has been obtained, limited to one year from the acquisition date) are recorded when identified. Goodwill is determined as the excess of the fair value of the consideration conveyed in the acquisition over the fair value of the net assets acquired.

Excluding acquisition and integration expenses related to the 2014 acquisition of HMA, acquisition and integration expenses related to prospective and closed acquisitions included in other operating expenses on the consolidated statements of (loss) income were $2 million, $5 million and $8 million during the years ended December 31, 2017, 2016 and 2015, respectively. Approximately $1 million of acquisition and related integration expense related to the HMA acquisition was recognized during the year ended December 31, 2015.

On April 1, 2016, one or more subsidiaries of the Company completed the acquisition of an 80% interest in Physicians' Specialty Hospital (20 licensed beds), a Medicare-certified specialty surgical hospital in Fayetteville, Arkansas. The total cash consideration paid for the 80% ownership interest in this joint venture was approximately $12 million, with additional consideration of $2 million assumed in liabilities, for a total consideration of $14 million. The value of the noncontrolling interest at acquisition was $2 million. Based upon the Company's final purchase price allocation relating to this acquisition as of December 31, 2016, approximately $12 million of goodwill has been recorded.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

On March 1, 2016, one or more subsidiaries of the Company completed the acquisition of an 80% ownership interest in a joint venture entity with Indiana University Health that includes substantially all of the assets of IU Health La Porte Hospital ("La Porte") in La Porte, Indiana (227 licensed beds) and IU Health Starke Hospital ("Starke") in Knox, Indiana (50 licensed beds), and affiliated outpatient centers and physician practices. The total cash consideration paid for the 80% ownership interest in this joint venture was approximately $96 million with additional consideration of $8 million assumed in liabilities, for a total consideration of $104 million. The value of the noncontrolling interest at acquisition was $25 million. Based upon the Company's final purchase price allocation relating to this acquisition as of December 31, 2016, approximately $45 million of goodwill has been recorded.

There were no hospital acquisitions in either of the years ended December 31, 2017 and 2015. The table below summarizes the allocations of the purchase price (including assumed liabilities) for the above hospital acquisition transactions in 2016 (in millions):

	2016
Current assets	$ 7
Property and equipment	69
Goodwill	57
Intangible assets	10
Other long-term assets	3
Liabilities	(10)
Noncontrolling interests	(28)
Total identifiable net assets	$ 108

The operating results of the foregoing transactions have been included in the accompanying consolidated statements of (loss) income from their respective dates of acquisition, including net operating revenues of $214 million for the year ended December 31, 2016, from hospital acquisitions that closed during that year.

Other Acquisitions

During the years ended December 31, 2017, 2016 and 2015, one or more subsidiaries of the Company paid approximately $6 million, $16 million and $51 million, respectively, to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by the Company's affiliated hospitals. In connection with these acquisitions, during the year ended December 31, 2017, the Company allocated approximately $2 million of the consideration paid to property and equipment and net working capital and the remainder, approximately $4 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. No value was allocated to noncontrolling interest recorded in these acquisitions. During 2016, the Company allocated approximately $8 million of the consideration paid to property and equipment and net working capital and the remainder, approximately $14 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. The value of noncontrolling interest acquired in these acquisitions was $6 million. During 2015, the Company allocated approximately $19 million of the consideration paid to property and equipment and net working capital and the remainder, approximately $39 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. The value of noncontrolling interest acquired in these acquisitions was $7 million.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Divestitures

In April 2014, FASB issued ASU 2014-08, which changed the requirements for reporting discontinued operations. Under this accounting standard, a discontinued operation is a disposal that represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. Additional disclosures are required for significant components of the entity that are disposed of or are held for sale but do not qualify as discontinued operations. This ASU was adopted on January 1, 2015 and is required to be applied on a prospective basis for disposals or components initially classified as held for sale after adoption. As a result, the following divestitures occurring subsequent to the date of adoption are included in continuing operations for the years ended December 31, 2017 and 2016. Additionally, the impact of the hospitals and other assets spun off to QHC are discussed in Note 4 below.

The following table provides a summary of hospitals included in continuing operations that the Company divested during the years ended December 31, 2017, 2016, and 2015:

Hospital	Buyer	City, State	Licensed Beds	Effective Date
2017 Divestitures:				
Highlands Regional Medical Center	HCA Holdings, Inc. ("HCA")	Sebring, FL	126	November 1, 2017
Merit Health Northwest Mississippi	Curae Health, Inc.	Clarksdale, MS	181	November 1, 2017
Weatherford Regional Medical Center	HCA	Weatherford, TX	103	October 1, 2017
Brandywine Hospital	Reading Health System	Coatesville, PA	169	October 1, 2017
Chestnut Hill Hospital	Reading Health System	Philadelphia, PA	148	October 1, 2017
Jennersville Hospital	Reading Health System	West Grove, PA	63	October 1, 2017
Phoenixville Hospital	Reading Health System	Phoenixville, PA	151	October 1, 2017
Pottstown Memorial Medical Center	Reading Health System	Pottstown, PA	232	October 1, 2017
Yakima Regional Medical and Cardiac Center	Regional Health	Yakima, WA	214	September 1, 2017
Toppenish Community Hospital	Regional Health	Toppenish, WA	63	September 1, 2017
Memorial Hospital of York	PinnacleHealth System	York, PA	100	July 1, 2017
Lancaster Regional Medical Center	PinnacleHealth System	Lancaster, PA	214	July 1, 2017
Heart of Lancaster Regional Medical Center	PinnacleHealth System	Lititz, PA	148	July 1, 2017
Carlisle Regional Medical Center	PinnacleHealth System	Carlisle, PA	165	July 1, 2017
Tomball Regional Medical Center	HCA	Tomball, TX	350	July 1, 2017
South Texas Regional Medical Center	HCA	Jourdanton, TX	67	July 1, 2017
Deaconess Hospital	MultiCare Health System	Spokane, WA	388	July 1, 2017
Valley Hospital	MultiCare Health System	Spokane Valley, WA	123	July 1, 2017
Lake Area Medical Center	CHRISTUS Health	Lake Charles, LA	88	June 30, 2017
Easton Hospital	Steward Health, Inc.	Easton, PA	196	May 1, 2017
Sharon Regional Health System	Steward Health, Inc.	Sharon, PA	258	May 1, 2017
Northside Medical Center	Steward Health, Inc.	Youngstown, OH	355	May 1, 2017
Trumbull Memorial Hospital	Steward Health, Inc.	Warren, OH	311	May 1, 2017
Hillside Rehabilitation Hospital	Steward Health, Inc.	Warren, OH	69	May 1, 2017

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Hospital	Buyer	City, State	Licensed Beds	Effective Date
Wuesthoff Health System – Rockledge	Steward Health, Inc.	Rockledge, FL	298	May 1, 2017
Wuesthoff Health System – Melbourne	Steward Health, Inc.	Melbourne, FL	119	May 1, 2017
Sebastian River Medical Center	Steward Health, Inc.	Sebastian, FL	154	May 1, 2017
Stringfellow Memorial Hospital	The Health Care Authority of the City of Anniston	Anniston, AL	125	May 1, 2017
Merit Health Gilmore Memorial	Curae Health, Inc.	Amory, MS	95	May 1, 2017
Merit Health Batesville	Curae Health, Inc.	Batesville, MS	112	May 1, 2017
2016 Divestitures:				
Alliance Health Blackwell *	The Blackwell Hospital Trust Authority	Blackwell, OK	53	September 3, 2016
Lehigh Regional Medical Center	Prime Healthcare Services, Inc. ("Prime")	Lehigh Acres, FL	88	February 1, 2016
Bartow Regional Medical Center	BayCare Health Systems, Inc.	Bartow, FL	72	January 1, 2016
2015 Divestitures:				
Payson Regional Medical Center *	Banner Health	Payson, AZ	44	July 31, 2015
Fallbrook Hospital *	Fallbrook Healthcare District	Fallbrook, CA	47	June 30, 2015
Chesterfield General Hospital	M/C Healthcare, LLC	Cheraw, SC	59	April 1, 2015
Marlboro Park Hospital	M/C Healthcare, LLC	Bennettsville, SC	102	April 1, 2015
Dallas Regional Medical Center	Prime	Mesquite, TX	202	March 1, 2015
Riverview Regional Medical Center	Prime	Gadsden, AL	281	March 1, 2015
Harris Hospital	White County Medical Center	Newport, AR	133	February 1, 2015
Carolina Pines Regional Medical Center	Capella Healthcare	Hartsville, SC	116	January 1, 2015

* Divestiture relates to termination of a prior lease for the hospital.

On December 31, 2016, one or more subsidiaries of the Company sold an 80% majority ownership interest in the home care division to a subsidiary of Almost Family, Inc. for $128 million. In connection with the divestiture of a controlling interest in the home care division, the Company recorded a gain of approximately $91 million during the year ended December 31, 2016.

During the year ended December 31, 2014, the Company made the decision to sell and began actively marketing several smaller hospitals. There is one hospital still included in discontinued operations resulting from the Company's decision to sell these hospitals in 2014 that is currently being actively marketed for sale. In addition to this hospital, HMA entered into a definitive agreement to sell Williamson Memorial Hospital (76 licensed beds) located in Williamson, West Virginia prior to the HMA merger, and the Company has continued the effort to divest this facility. In connection with management's decision to sell these two hospitals, the Company has classified the results of operations of such hospitals as discontinued operations in the accompanying consolidated statements of (loss) income, and classified these hospitals as held for sale in the accompanying consolidated balance sheets.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

On May 1, 2017, one or more subsidiaries of the Company sold AllianceHealth Pryor (52 licensed beds) in Pryor, Oklahoma, and its associated assets to Ardent Health Services Inc. for approximately $1 million in cash. This hospital has been reported in the condensed consolidated statements of loss in discontinued operations.

Net operating revenues and loss from discontinued operations for the respective periods are as follows (in millions):

	Year Ended December 31,		
	2017	2016	2015
Net operating revenues	$ 79	$ 99	$114
Loss from operations of entities sold or held for sale before income taxes	$ (10)	$ (11)	(42)
Impairment of hospitals sold or held for sale	(8)	(12)	(8)
Loss on sale, net	(1)	-	(6)
Loss from discontinued operations, before taxes	(19)	(23)	(56)
Income tax benefit	(7)	(8)	(20)
Loss from discontinued operations, net of taxes	$ (12)	$ (15)	$ (36)

As part of its ongoing evaluation of the fair value of the hospitals it is marketing for sale, the Company recorded an impairment charge on the carrying value of the long-lived assets at these hospitals in discontinued operations of $6 million and $8 million, net of tax, for the years ended December 31, 2017 and 2016, respectively. Interest expense was allocated to discontinued operations based on sale proceeds available for debt repayment.

The following table discloses amounts included in the consolidated balance sheet for the hospitals classified as held for sale as of December 31, 2017 and 2016 (in millions):

	December 31,	
	2017	2016
Other current assets	$ 8	$ 117
Other assets, net	12	878
Accrued liabilities	2	81

Financial and statistical data reported in this Annual Report on Form 10-K ("Form 10-K") includes operating results for hospitals held for sale at December 31, 2017 and for the 30 hospitals that were divested through 2017 through the effective date of each respective transaction. Summary financial results of these hospitals included in continuing operations for the periods included in the accompanying consolidated statements of (loss) income are as follows:

	Year Ended December 31,		
	2017	2016	2015
(Loss) income from operations before income taxes	$ (544)	$ (517)	$ 27
Less: Income attributable to noncontrolling interests	(1)	(1)	(2)
(Loss) income from operations before income taxes attributable to Community Health Systems, Inc. stockholders	$ (545)	$ (518)	$ 25

The operating results for these held for sale or divested hospitals included impairment charges of approximately $368 million and $463 million that were allocated to the divestitures during the years ended December 31, 2017 and 2016, respectively. No impairment charges were allocated to the divestitures for the year ended December 31, 2015.

Other Hospital Closures

During the three months ended March 31, 2016, the Company announced the planned closure of McNairy Regional Hospital in Selmer, Tennessee. The Company recorded an impairment charge of approximately $7 million during the three months ended March 31, 2016, to adjust the fair value of the supplies inventory and long-lived assets of this hospital, including property and equipment and capitalized software costs, based on their estimated fair value and future utilization. McNairy Regional Hospital closed on May 19, 2016. No additional impairment was recorded related to the closure of this facility.

4. SPIN-OFF OF QUORUM HEALTH CORPORATION

On April 29, 2016, the Company completed the spin-off of 38 hospitals and Quorum Health Resources, LLC into Quorum Health Corporation, an independent, publicly traded corporation. The transaction was structured to be generally tax free to the Company and its stockholders. The Company distributed, on a pro rata basis, all of the shares of QHC common stock to the Company's stockholders of record as of April 22, 2016. These stockholders of record as of April 22, 2016 received a distribution of one share of QHC common stock for every four shares of Company common stock held as of the record date plus cash in lieu of any fractional shares. In recognition of the spin-off, the Company recorded a non-cash dividend of approximately $713 million during the year ended December 31, 2016, representing the net assets of QHC distributed to the Company's stockholders. Immediately following the completion of the spin-off, the Company's stockholders owned 100% of the outstanding shares of QHC common stock. Following the spin-off, QHC became an independent public company with its common stock listed for trading under the symbol "QHC" on the New York Stock Exchange.

In connection with the spin-off, the Company and QHC entered into a separation and distribution agreement as well as certain ancillary agreements on April 29, 2016. These agreements allocate between the Company and QHC the various assets, employees, liabilities and obligations (including investments, property and employee benefits and tax-related assets and liabilities) that comprise the separate companies and govern certain relationships between, and activities of, the Company and QHC for a period of time after the spin-off.

The results of operations for QHC through the date of the spin-off are presented in continuing operations in the consolidated statements of (loss) income as the Company has determined that the spin-off of QHC does not meet the criteria as discontinued operations under ASU 2014-08.

Financial and statistical data reported in this Form 10-K include QHC operating results through April 29, 2016. Summary financial results of QHC for the periods included in the accompanying consolidated statements of (loss) income are as follows:

	Year Ended December 31, 2016
Loss from operations before income taxes	$ (12)
Less: Income attributable to noncontrolling interests	(1)
Loss from operations before income taxes attributable to Community Health Systems, Inc. stockholders	$ (13)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

5. GOODWILL AND OTHER INTANGIBLE ASSETS

Goodwill

The changes in the carrying amount of goodwill for the years ended December 31, 2017 and 2016 are as follows (in millions):

	Year Ended December 31,	
	2017	2016
Balance, beginning of year	$ 6,521	$ 8,965
Goodwill acquired as part of acquisitions during current year	5	71
Consideration and purchase price allocation adjustments for prior year's acquisitions and other adjustments	(27)	-
Goodwill allocated to QHC in the spin-off	-	(709)
Goodwill in the home care operations reporting unit included in the sale of a majority interest in the home care division	-	(46)
Goodwill allocated to hospitals held for sale	(357)	(365)
Impairment of goodwill	(1,419)	(1,395)
Balance, end of year	$ 4,723	$ 6,521

Goodwill is allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company's operating segments meet the criteria to be classified as reporting units. During the year ended December 31, 2016, the Company allocated approximately $709 million of goodwill to the spin-off of QHC, including approximately $33 million of goodwill related to the former management services reporting unit and approximately $676 million of goodwill allocated from the hospital operations reporting unit based on the relative fair value of the hospitals that were included in the QHC distribution. Additionally, the Company allocated approximately $46 million of goodwill related to the sale of the home care operations reporting unit on December 31, 2016. At December 31, 2016, after giving effect to the disposition of QHC, the sale of an 80% majority ownership interest in the Company's home care division and the $1.395 billion impairment charge discussed below, the Company had approximately $6.5 billion of goodwill recorded, all of which resides at its hospital operations reporting unit. At December 31, 2017, after giving effect to 2017 divestiture activity and the $1.419 billion impairment charge discussed below, the Company had approximately $4.7 billion of goodwill recorded.

Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. Prior to the adoption of ASU 2017-04 that is further discussed below, there was a two-step method for determining goodwill impairment. Step one was to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicated the fair value was less than the carrying value, then step two was required to compare the implied fair value of the reporting unit's goodwill utilizing a hypothetical purchase price allocation with the carrying value of the reporting unit's goodwill. The Company performed its last annual goodwill evaluation during the fourth quarter of 2017. The next annual goodwill evaluation will be performed during the fourth quarter of 2018, or sooner if the Company identifies certain indicators of impairment.

The Company estimates the fair value of the related reporting units using both a discounted cash flow model as well as a market multiple model. The cash flow forecasts are adjusted by an appropriate discount rate based on the Company's estimate of a market participant's weighted-average cost of capital. These models are both based on the Company's best estimate of future revenues and operating costs and are reconciled to the Company's

consolidated market capitalization, with consideration of the amount a potential acquirer would be required to pay, in the form of a control premium, in order to gain sufficient ownership to set policies, direct operations and control management decisions.

During the three months ended December 31, 2017, the Company identified certain indicators of impairment occurring following its annual goodwill evaluation that required an interim goodwill impairment evaluation, which was performed as of November 30, 2017. Those indicators were primarily a further decline in the Company's market capitalization and fair value of the Company's long-term debt during November 2017. The Company performed an estimated calculation of fair value in step one of the impairment test at November 30, 2017, which indicated that the carrying value of the hospital operations reporting unit exceeded its fair value. Additionally, during the three months ended December 31, 2017 the Company early adopted the accounting guidance in ASU 2017-04, which eliminates the step two calculation to determine the implied value of goodwill, and instead requires an impairment of goodwill equal to the difference between the carrying value and estimated fair value of the reporting unit. As a result of this evaluation and the early adoption of ASU 2017-04, the Company recorded a non-cash impairment charge of $1.419 billion to goodwill during the three months ended December 31, 2017.

During the three months ended June 30, 2016, the Company identified certain indicators of impairment requiring an interim goodwill impairment evaluation. Those indicators were primarily the decline in the Company's market capitalization and fair value of long-term debt during the three months ended June 30, 2016, as well as a decrease in the estimated future earnings of the Company compared to the Company's most recent annual evaluation. The Company performed an estimated calculation of fair value in step one of the impairment test at June 30, 2016, which indicated that the carrying value of its hospital operations reporting unit exceeded its fair value. An initial step two calculation was performed to determine the implied value of goodwill in a hypothetical purchase price allocation. The Company recorded an estimated non-cash impairment charge of $1.4 billion to goodwill at June 30, 2016 based on these analyses, and adjusted the estimated impairment charge based on the final step two valuation of $1.395 billion at September 30, 2016. The decrease in the goodwill impairment as of September 30, 2016, from the original estimate as of June 30, 2016, was primarily due to lower estimated fair values of the individual hospital property and equipment assets as compared to the assumptions used in the June 30, 2016 estimate, resulting in a higher implied goodwill amount when applied to a hypothetical purchase price allocation as required in the step two analysis.

The impairment charges taken during 2017 and 2016 represent the cumulative amount of impairment recorded historically on the Company's goodwill.

The reduction in the Company's fair value and the resulting goodwill impairment charge recorded during 2016 and 2017 reduced the carrying value of the Company's hospital operations reporting unit to an amount equal to its estimated fair value. This increases the risk that future declines in fair value could result in goodwill impairment. The determination of fair value in the Company's goodwill impairment analysis is based on an estimate of fair value for each reporting unit utilizing known and estimated inputs at the evaluation date. Some of those inputs include, but are not limited to, the most recent price of the Company's common stock or fair value of long-term debt, estimates of future revenue and expense growth, estimated market multiples, expected capital expenditures, income tax rates, and costs of invested capital. Future estimates of fair value could be adversely affected if the actual outcome of one or more of these assumptions changes materially in the future, including further decline in the Company's stock price or fair value of long-term debt, lower than expected hospital volumes, higher market interest rates or increased operating costs. Such changes impacting the calculation of fair value could result in a material impairment charge in the future.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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The determination of fair value of the Company's hospital operations reporting unit as part of its goodwill impairment measurement represents a Level 3 fair value measurement in the fair value hierarchy due to its use of internal projections and unobservable measurement inputs.

These impairment charges do not have an impact on the calculation of the Company's financial covenants under the Company's Credit Facility.

Intangible Assets

No intangible assets other than goodwill were acquired during the year ended December 31, 2017. The gross carrying amount of the Company's other intangible assets subject to amortization was $18 million and $41 million at December 31, 2017 and 2016, respectively, and the net carrying amount was $10 million and $14 million at December 31, 2017 and 2016, respectively. The carrying amount of the Company's other intangible assets not subject to amortization was $79 million and $86 million at December 31, 2017 and 2016, respectively. Other intangible assets are included in other assets, net on the Company's consolidated balance sheets. Substantially all of the Company's intangible assets are contract-based intangible assets related to operating licenses, management contracts, or non-compete agreements entered into in connection with prior acquisitions.

The weighted-average remaining amortization period for the intangible assets subject to amortization is approximately six years. There are no expected residual values related to these intangible assets. Amortization expense on these intangible assets was $4 million, $14 million and $15 million during the years ended December 31, 2017, 2016 and 2015, respectively. Amortization expense on intangible assets is estimated to be $3 million in 2018, $1 million in 2019, $1 million in 2020, $1 million in 2021, $1 million in 2022 and $3 million thereafter.

The gross carrying amount of capitalized software for internal use was approximately $1.2 billion and $1.3 billion at December 31, 2017 and 2016, respectively, and the net carrying amount was approximately $416 million and $574 million at December 31, 2017 and 2016, respectively. The estimated amortization period for capitalized internal-use software is generally three years, except for capitalized costs related to significant system conversions, for which the estimated amortization period is generally eight to ten years. There is no expected residual value for capitalized internal-use software. At December 31, 2017, there were approximately $32 million of capitalized costs for internal-use software that is currently in the development stage and will begin amortization once the software project is complete and ready for its intended use. Amortization expense on capitalized internal-use software was $178 million, $201 million and $212 million during the years ended December 31, 2017, 2016 and 2015, respectively. Amortization expense on capitalized internal-use software is estimated to be $153 million in 2018, $93 million in 2019, $69 million in 2020, $47 million in 2021, $33 million in 2022 and $21 million thereafter.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

6. INCOME TAXES

The (benefit from) provision for income taxes for (loss) income from continuing operations consists of the following (in millions):

	Year Ended December 31,		
	2017	2016	2015
Current:			
Federal	$ -	$ 5	$ 7
State	5	7	7
	5	12	14
Deferred:			
Federal	(485)	(88)	103
State	31	(28)	(1)
	(454)	(116)	102
Total (benefit from) provision for income taxes for (loss) income from continuing operations	$(449)	$(104)	$116

The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in millions):

	Year Ended December 31,					
	2017		2016		2015	
	Amount	%	Amount	%	Amount	%
(Benefit from) provision for income taxes at statutory federal rate	$ (991)	35.0 %	$ (600)	35.0 %	$ 144	35.0 %
State income taxes, net of federal income tax benefit	(10)	0.3	(1)	0.1	13	3.3
Net income attributable to noncontrolling interests	(22)	0.8	(33)	1.9	(35)	(8.6)
Change in valuation allowance	26	(0.9)	(1)	0.1	(2)	(0.4)
Federal rate change	32	(1.1)	-	-	-	-
Federal and state tax credits	(5)	0.1	(6)	0.3	(5)	(1.2)
Nondeductible transaction costs			3	(0.2)	-	-
Nondeductible goodwill	504	(17.8)	536	(31.2)	-	-
Other	17	(0.6)	(2)	0.1	1	0.3
(Benefit from) provision for income taxes and effective tax rate for (loss) income from continuing operations	$ (449)	15.8 %	$ (104)	6.1 %	$ 116	28.4 %

The Company's effective tax rates were 15.8%, 6.1% and 28.4% for the years ended December 31, 2017, 2016 and 2015, respectively. Including the net income attributable to noncontrolling interests, which is not tax effected in the consolidated statement of (loss) income, the effective tax rate for the years ended December 31, 2017, 2016 and 2015 would have been 15.5%, 5.7% and 37.6% respectively. This increase in the Company's effective tax rate for the year ended December 31, 2017, when compared to the year ended December 31, 2016, was

primarily due to the difference between the non-deductible nature of certain goodwill written off in those years. The decrease in the Company's effective tax rate for the year ended December 31, 2016, when compared to the year ended December 31, 2015, was primarily due to the non-deductible nature of goodwill written off for impairment and divestitures, as well as the non-deductible nature of certain costs incurred to complete the spin-off of QHC.

Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, 2017 and 2016 consist of (in millions):

	December 31,			
	2017		2016	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 583	$ -	$ 412	$ -
Property and equipment	-	263	-	583
Self-insurance liabilities	78	-	130	-
Prepaid expenses	-	30	-	61
Intangibles	-	128	-	238
Investments in unconsolidated affiliates	-	54	-	81
Other liabilities	-	16	-	22
Long-term debt and interest	6	-	-	12
Accounts receivable	144	-	70	-
Accrued vacation	27	-	56	-
Other comprehensive income	9	-	38	-
Stock-based compensation	10	-	23	-
Deferred compensation	77	-	132	-
Other	89	-	125	-
	1,023	491	986	997
Valuation allowance	(489)	-	(385)	-
Total deferred income taxes	$ 534	$ 491	$ 601	$ 997

The Company believes that the net deferred tax assets will ultimately be realized, except as noted below. Its conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has gross federal net operating loss carryforwards of approximately $610 million and state net operating loss carryforwards of approximately $6.3 billion, which expire from 2018 to 2037. The Company's tax affected federal and state net operating loss and credit carryforwards which it expects to be able to utilize are approximately $136 million and $16 million, respectively. A valuation allowance of approximately $489 million has been recognized for state net operating loss carryforwards, credit carryforwards and deferred tax assets that the Company does not expect to be able to utilize prior to the expiration of the carryforward period. The Company also has unrecognized deferred tax assets primarily related to interest expense that are included in other comprehensive income. If recognized, additional state net operating losses will be created which the Company does not expect to be able to utilize prior to the expiration of the carryforward period. A valuation allowance of approximately $2 million has been recognized for those items. With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company's business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

The valuation allowance increased by $104 million and $49 million during the years ended December 31, 2017 and 2016, respectively, for losses incurred in certain state jurisdictions where the Company concluded associated deferred tax assets would not be realized.

On December 22, 2017, the U.S. government enacted comprehensive tax legislation commonly referred to as the Tax Cuts and Jobs Act (the "Tax Act"). The Tax Act makes broad and complex changes to the U.S. tax code which impacted 2017, including a permanent reduction in the U.S. federal corporate tax rate from 35% to 21% ("Rate Reduction").

The Tax Act also puts into place new tax laws that will apply prospectively, which include, but are not limited to (1) creating a new limitation on deductible interest expense; (2) changing rules related to uses and limitations of net operating loss carryforwards: and (3) modifying the rules governing the deductibility of certain executive compensation.

The SEC staff issued SAB 118, which provides guidance on accounting for the tax effects of the Tax Act. SAB 118 provides a measurement period that should not extend beyond one year from the Tax Act enactment date for companies to complete the accounting under ASC 740. In accordance with SAB 118, a company must reflect the income tax effects of those aspects of the Act for which the accounting under ASC 740 is complete. To the extent that a company's accounting for certain income tax effects of the Tax Act is incomplete but it is able to determine a reasonable estimate, it must record a provisional estimate in the financial statements. If a company cannot determine a provisional estimate to be included in the financial statements, it should continue to apply ASC 740 on the basis of the provisions of the tax laws that were in effect immediately before the enactment of the Tax Act.

The Company has not completed the accounting for the income tax effects of the Tax Act. At December 31, 2017, the Company recorded a discrete net tax expense of $32 million primarily related to provisional amounts under SAB 118 for the remeasurement of U.S. deferred tax assets and liabilities due to Rate Reduction. No additional provisional amounts were recorded as part of the Company's initial accounting for the Tax Act. However, these estimates may differ from the final accounting due to, among other things, future clarification and guidance to be issued, changes in interpretations the Company has made and state tax conformity to federal tax changes. Such changes in estimate could impact the recorded U.S. federal and state deferred tax assets and liabilities as well as valuation allowances in those jurisdictions.

At December 31, 2017, the Company was not able to reasonably estimate and, therefore, has not recorded a provisional amount for the Tax Act's impact on certain state valuation allowances. The Company will record a provisional amount in the first reporting period in which a reasonable estimate can be determined. Such timing will depend upon the Company's ability to obtain, prepare and analyze the necessary information to determine whether a valuation allowance needs to be recognized.

The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, was approximately $7 million as of December 31, 2017. A total of approximately $4 million of interest and penalties is included in the amount of the liability for uncertain tax positions at December 31, 2017. It is the Company's policy to recognize interest and penalties related to unrecognized benefits in its consolidated statements of (loss) income as income tax expense.

It is possible the amount of unrecognized tax benefit could change in the next 12 months as a result of a lapse of the statute of limitations and settlements with taxing authorities; however, the Company does not anticipate the change will have a material impact on the Company's consolidated results of operations or consolidated financial position.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the years ended December 31, 2017, 2016 and 2015 (in millions):

	Year Ended December 31,		
	2017	2016	2015
Unrecognized tax benefit, beginning of year	$ 18	$ 15	$ 16
Gross increases — tax positions in current period	-	4	-
Lapse of statute of limitations	-	(1)	(1)
Unrecognized tax benefit, end of year	$ 18	$ 18	$ 15

The Company, or one of its subsidiaries, files income tax returns in the United States federal jurisdiction and various state jurisdictions. With few exceptions, the Company is no longer subject to state income tax examinations for years prior to 2013. The Company's federal income tax returns for the 2009 and 2010 tax years are currently under examination by the Internal Revenue Service. The Company believes the results of these examinations will not be material to its consolidated results of operations or consolidated financial position. The Company has extended the federal statute of limitations through December 31, 2018 for Community Health Systems, Inc. for the tax periods ended December 31, 2007, 2008, 2009 and 2010 and through September 6, 2019 for the tax period ended December 31, 2014.

Cash paid for income taxes, net of refunds received, resulted in net cash paid of $4 million and $12 million during the years ended December 31, 2017 and 2015, respectively, and net cash refund of $16 million for the year ended December 31, 2016.

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7. LONG-TERM DEBT

Long-term debt, net of unamortized debt issuance costs and discounts or premiums, consists of the following (in millions):

	December 31,	
	2017	2016
Credit Facility:		
Term A Loan	$ -	$ 749
Term F Loan	-	1,445
Term G Loan	1,037	1,528
Term H Loan	1,903	2,811
Revolving credit loans	-	-
8% Senior Notes due 2019	1,925	1,925
7 1/8% Senior Notes due 2020	1,200	1,200
5 1/8% Senior Secured Notes due 2018	-	700
5 1/8% Senior Secured Notes due 2021	1,000	1,000
6 7/8% Senior Notes due 2022	3,000	3,000
6 1/4% Senior Secured Notes due 2023	3,100	-
Receivables Facility	565	677
Capital lease obligations	304	328
Other	48	74
Less: Unamortized deferred debt issuance costs and note premium	(169)	(193)
Total debt	13,913	15,244
Less: Current maturities	(33)	(455)
Total long-term debt	$13,880	$14,789

Credit Facility

The Company's wholly-owned subsidiary, CHS/Community Health Systems, Inc. ("CHS"), has senior secured financing under a credit facility with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. In connection with the HMA merger, the Company and CHS entered into a third amendment and restatement of its credit facility (the "Credit Facility"), providing for additional financing and recapitalization of certain of the Company's term loans, including (i) the replacement of the revolving credit facility with a new $1.0 billion revolving facility maturing in 2019 (the "Revolving Facility"), (ii) the addition of a new $1.0 billion Term A facility due 2019 (the "Term A Facility"), (iii) a Term D facility in an aggregate principal amount equal to approximately $4.6 billion due 2021 (which included certain Term C loans that were converted into such Term D facility (collectively, the "Term D Facility")), (iv) the conversion of certain Term C loans into Term E Loans and the borrowing of new Term E Loans in an aggregate principal amount of approximately $1.7 billion due 2017 and (v) the addition of flexibility commensurate with the Company's post-acquisition structure. In addition to funding a portion of the consideration in connection with the HMA merger, some of the proceeds of the Term A Facility and Term D Facility were used to refinance the outstanding $637 million existing Term A facility due 2016 and the $60 million of Term B loans due 2014, respectively. The Revolving Facility includes a subfacility for letters of credit.

On March 9, 2015, CHS entered into Amendment No. 1 and Incremental Term Loan Assumption Agreement to refinance the existing Term E Loans due 2017 into Term F Loans due 2018, in an original aggregated principal amount of $1.7 billion (the "Term F Facility"). On May 18, 2015, CHS entered into an Incremental Term Loan

Assumption Agreement to provide for a new $1.6 billion incremental Term G facility due 2019 (the "Term G Facility") and a new approximately $2.9 billion incremental Term H facility due 2021 (the "Term H Facility"). The proceeds of the Term G Facility and Term H Facility were used to repay the Company's existing Term D Facility in full. Pursuant to a special distribution paid by QHC to the Company as part of the series of transactions to complete the spin-off, the Company received approximately $1.2 billion in cash generated from the net proceeds of certain financing arrangements entered into by QHC as part of the separation. On April 29, 2016, using part of the cash generated from the QHC spin-off, the Company repaid approximately $190 million of its Term F Facility. On December 5, 2016, CHS entered into Amendment No. 2 to the Credit Facility ("Amendment No. 2") to adjust financial maintenance covenants in the Credit Facility. In connection with Amendment No. 2, the Company agreed to certain other additional undertakings for the benefit of the lenders under the Revolving Facility and the Term A Facility.

On December 30, 2016, using the cash generated from the sale of a majority ownership in the Company's home care division and from the completion of the sale-lease back transaction for ten of the Company's owned medical office buildings, the Company repaid approximately $48 million of the Term F Facility, approximately $26 million of the Term A Facility, approximately $52 million of the Term G Facility and approximately $96 million of the Term H Facility. On March 16, 2017, CHS issued $2.2 billion aggregate principal amount of 6 ¼% Senior Secured Notes due 2023 (the "6 ¼% Senior Secured Notes"), a portion of the net proceeds of which was used to repay the Company's existing Term F Facility in full. On May 4, 2017, using the cash generated from the hospital divestiture transactions completed on May 1, 2017, CHS repaid approximately $39 million of the Term A Facility, approximately $75 million of the Term G Facility and approximately $147 million of the Term H Facility. On May 12, 2017, CHS completed a tack-on offering of $900 million aggregate principal amount of 6 ¼% Senior Secured Notes, a portion of the net proceeds of which was used to repay the Company's existing Term A Facility in full. The tack-on offering increased the total aggregate principal amount of 6 ¼% Senior Secured Notes to $3.1 billion.

On May 30, 2017, CHS entered into a Loan Modification Agreement to the Credit Facility ("Loan Modification Agreement") to extend the maturity date of the Revolving Facility. Following the Loan Modification Agreement, CHS has Revolving Facility commitments through January 27, 2019 of approximately $929 million, of which a $739 million portion represents extended commitments maturing January 27, 2021. In connection with the Loan Modification Agreement, the financial maintenance covenants in the Credit Facility were further adjusted and CHS agreed to certain other additional undertakings for the benefit of the extending Revolving Facility lenders.

On June 30, 2017, using a portion of the cash generated from the July 1, 2017 hospital divestitures that preliminarily closed on June 30, 2017, CHS repaid approximately $122 million of the Term G Facility and approximately $225 million of the Term H Facility.

On July 7, 2017, using a portion of the cash generated from the divestitures that preliminarily closed on June 30, 2017 and that closed on July 3, 2017, CHS repaid approximately $121 million of the Term G Facility and approximately $222 million of the Term H Facility.

On September 29, 2017, using a portion of the cash generated from the divestitures that preliminarily closed on September 29, 2017 and that closed on October 1, 2017, CHS repaid approximately $151 million of the Term G Facility and approximately $277 million of the Term H Facility.

On November 3, 2017, using a portion of the cash generated from the divestitures that closed on November 1, 2017, CHS repaid approximately $21 million of the Term G Facility and approximately $39 million of the Term H Facility.

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The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at CHS' option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus 0.50% or (3) the adjusted London Interbank Offered Rate ("LIBOR") on such day for a three-month interest period commencing on the second business day after such day plus 1% or (b) LIBOR. In addition, the margin in respect of the Revolving Facility will be subject to adjustment determined by reference to a leverage-based pricing grid. Loans in respect of the Revolving Facility currently accrue interest at a rate per annum equal to LIBOR plus 2.50%, in the case of LIBOR borrowings, and Alternate Base Rate plus 1.50%, in the case of Alternate Base Rate borrowings. The Term G Loan and Term H Loan will accrue interest at a rate per annum equal to LIBOR plus 2.75% and 3.00%, respectively, in the case of LIBOR borrowings, and Alternate Base Rate plus 1.75% and 2.00%, respectively, in the case of Alternate Base Rate borrowings. The Term G Loan and the Term H Loan are subject to a 1.00% LIBOR floor and a 2.00% Alternate Base Rate floor.

Under the Term H Facility, CHS is required to make amortization payments in aggregate amounts equal to 1% of the original principal amount of the Term H Facility each year. As of December 31, 2016, no additional amortization payments were required to be made under the Term G Facility.

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by the Company and its subsidiaries, subject to certain exceptions and reinvestment rights (provided that, in connection with the Loan Modification Agreement, CHS agreed with the extending lenders under the Revolving Facility not to exercise such reinvestment rights with respect to certain divestiture announcements), (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables-based financing by the Company and its subsidiaries, subject to certain exceptions, and (3) 50%, subject to reduction to a lower percentage based on the Company's leverage ratio (as defined in the Credit Facility generally as the ratio of total debt on the date of determination to the Company's EBITDA, as defined, for the four quarters most recently ended prior to such date), of excess cash flow (as defined) for any year, subject to certain exceptions. Voluntary prepayments and commitment reductions are permitted in whole or in part, without any premium or penalty, subject to minimum prepayment or reduction requirements.

The borrower under the Credit Facility is CHS. All of the obligations under the Credit Facility are unconditionally guaranteed by the Company and certain of its existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of the Company, CHS and each subsidiary guarantor, including equity interests held by the Company, CHS or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries. Such assets constitute substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the 2021 Senior Secured Notes (as defined below) and the 6 ¼% Senior Secured Notes.

CHS has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to LIBOR borrowings under the Revolving Facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. CHS is obligated to pay commitment fees of 0.50% per annum (subject to adjustment based upon the Company's leverage ratio) on the unused portion of the Revolving Facility.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting the Company's and its subsidiaries' ability, subject to certain exceptions, to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and

enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of the Company's businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change the Company's fiscal year. The Company is also required to comply with specified financial covenants (consisting of a maximum secured net leverage ratio and an interest coverage ratio) and various affirmative covenants. Under the Credit Facility, the secured net leverage ratio is calculated as the ratio of total secured debt, less unrestricted cash and cash equivalents, to consolidated EBITDA, as defined in the Credit Facility, and the interest coverage ratio is the ratio of consolidated EBITDA, as defined in the Credit Facility, to consolidated interest expense for the period. The calculation of consolidated EBITDA as defined in the Credit Facility is a trailing 12-month calculation that begins with net income attributable to the Company, with certain pro forma adjustments to consider the impact of material acquisitions or divestitures, and adjustments for interest, taxes, depreciation and amortization, net income attributable to noncontrolling interests, stock compensation expense, restructuring costs, and the financial impact of other non-cash or non-recurring items recorded during any such 12-month period. For the 12-month period ended December 31, 2017, the secured net leverage ratio financial covenant under the Credit Facility limited the ratio of secured debt to EBITDA, as defined, to less than or equal to 4.50 to 1.00. For the 12-month period ended December 31, 2017, the interest coverage ratio financial covenant under the Credit Facility required the ratio of consolidated EBITDA, as defined, to consolidated interest expense to be greater than or equal to 1.75 to 1.00. The Company was in compliance with all such covenants at December 31, 2017, with a secured net leverage ratio of approximately 4.08 to 1.00 and an interest coverage ratio of approximately 2.10 to 1.00.

Events of default under the Credit Facility include, but are not limited to, (1) CHS' failure to pay principal, interest, fees or other amounts under the credit agreement when due (taking into account any applicable grace period), (2) any representation or warranty proving to have been materially incorrect when made, (3) covenant defaults subject, with respect to certain covenants, to an available cure through the issuance of qualified equity for a period of 60 days after the end of the first three quarters and 100 days after a year end, (4) bankruptcy and insolvency events, (5) a cross default to certain other debt, (6) certain undischarged judgments (not paid within an applicable grace period), (7) a change of control (as defined), (8) certain ERISA-related defaults and (9) the invalidity or impairment of specified security interests, guarantees or subordination provisions in favor of the administrative agent or lenders under the Credit Facility.

As of December 31, 2017, the availability for additional borrowings under the Credit Facility, subject to certain limitations as set forth in the Credit Facility, was approximately $929 million pursuant to the Revolving Facility (which shall reduce to $739 million on January 27, 2019), of which approximately $63 million is in the form of outstanding letters of credit. CHS had the ability to amend the Credit Facility to provide for one or more tranches of term loans or increases in the Revolving Facility in an aggregate principal amount of up to $1.5 billion, only $1.0 billion of which is effectively available because of the Company's additional undertakings in connection with the Loan Modification Agreement. As of December 31, 2017, the weighted-average interest rate under the Credit Facility, excluding swaps, was 5.1%.

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As of December 31, 2017, the term loans and outstanding revolving credit loans are scheduled to be paid with principal payments for future years as follows (in millions):

Year	Amount
2018	$ -
2019	1,037
2020	-
2021	1,903
2022	-
Thereafter	-
Total maturities	2,940
Less: Deferred debt issuance costs	(38)
Total term loans and outstanding revolving credit loans	$ 2,902

As of December 31, 2017, the Company had letters of credit issued, primarily in support of potential insurance-related claims and certain bonds, of approximately $63 million.

8% Senior Notes due 2019

On November 22, 2011, CHS completed a private offering of $1.0 billion aggregate principal amount of 8% Senior Notes due 2019 (the "8% Senior Notes"). The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of up to $1.0 billion aggregate principal amount of CHS' then outstanding 8 7/8% Senior Notes due 2015 and related fees and expenses. On March 21, 2012, CHS completed an offering of an additional $1.0 billion aggregate principal amount of 8% Senior Notes, which were issued in a private placement (at a premium of 102.5%). The net proceeds from this issuance were used to finance the purchase of approximately $850 million aggregate principal amount of CHS' then outstanding 8 7/8% Senior Notes due 2015, to pay related fees and expenses and for general corporate purposes. The 8% Senior Notes bear interest at 8% per annum, payable semiannually in arrears on May 15 and November 15. Interest on the 8% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

CHS is entitled, at its option, to redeem all or a portion of the 8% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
November 15, 2017 to November 14, 2019	100.000%

Pursuant to a registration rights agreement entered into at the time of the issuance of the 8% Senior Notes, as a result of an exchange offer made by CHS, substantially all of the 8% Senior Notes issued in November 2011 and March 2012 were exchanged in May 2012 for new notes (the "8% Exchange Notes") having terms substantially identical in all material respects to the 8% Senior Notes (except that the 8% Exchange Notes were issued under a registration statement pursuant to the Securities Act of 1933, as amended (the "1933 Act")). References to the 8% Senior Notes shall also be deemed to include the 8% Exchange Notes unless the context provides otherwise.

During the year ended December 31, 2016, the Company repurchased approximately $75 million of aggregate principal amount outstanding of the 8% Senior Notes in open market transactions.

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7 1/8% Senior Notes due 2020

On July 18, 2012, CHS completed a public offering of 7 1/8% Senior Notes due 2020 (the "7 1/8% Senior Notes"). The net proceeds from this issuance were used to finance the purchase or redemption of $934 million aggregate principal amount of CHS' then outstanding 8 7/8% Senior Notes due 2015, to pay for consents delivered in connection with a related tender offer, to pay related fees and expenses, and for general corporate purposes. The 7 1/8% Senior Notes bear interest at 7.125% per annum, payable semiannually in arrears on July 15 and January 15. Interest on the 7 1/8% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

CHS is entitled, at its option, to redeem all or a portion of the 7 1/8% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
July 15, 2017 to July 14, 2018	101.781%
July 15, 2018 to July 14, 2020	100.000%

5 1/8% Senior Secured Notes due 2018

On August 17, 2012, CHS completed a public offering of 5 1/8% Senior Secured Notes due 2018 (the "2018 Senior Secured Notes"). The net proceeds from this issuance, together with available cash on hand, were used to finance the prepayment of $1.6 billion of the then outstanding term loans due 2014 under the Credit Facility and related fees and expenses. The 2018 Senior Secured Notes bore interest at 5.125% per annum, payable semiannually in arrears on August 15 and February 15. The 2018 Senior Secured Notes were secured by a first-priority lien subject to a shared lien of equal priority with certain other obligations, including obligations under the Credit Facility and the 2021 Senior Secured Notes, and subject to prior ranking liens permitted by the indenture governing the 2018 Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility and the 2021 Senior Secured Notes.

On May 16, 2016, using part of the cash generated from the QHC spin-off, the Company completed a cash tender offer for $900 million aggregate principal amount outstanding of the 2018 Senior Secured Notes.

During the year ended December 31, 2017, using a portion of the net proceeds from the issuance of the 6 1/4% Senior Secured Notes, CHS completed its tender offer of $469 million of the then $700 million aggregate outstanding principal amount of the 2018 Senior Secured Notes and thereafter redeemed the remaining $231 million aggregate principal amount of 2018 Senior Secured Notes pursuant to a redemption notice previously given by CHS.

5 1/8% Senior Secured Notes due 2021

On January 27, 2014, CHS completed a private offering of $1.0 billion aggregate principal amount of 5 1/8% Senior Secured Notes due 2021 (the "2021 Senior Secured Notes"). The net proceeds from this issuance were used to finance the HMA merger. The 2021 Senior Secured Notes bear interest at 5.125% per annum, payable semiannually in arrears on February 1 and August 1. Interest on the 2021 Senior Secured Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. The 2021 Senior Secured Notes are secured by a first-priority lien, subject to a shared lien of equal priority with certain other obligations, including obligations under the Credit Facility and the 6 1/4% Senior

Secured Notes, and subject to prior ranking liens permitted by the indenture governing the 2021 Senior Secured Notes, on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility and the 6 ¼% Senior Secured Notes.

CHS is entitled, at its option, to redeem all or a portion of the 2021 Senior Secured Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
February 1, 2017 to January 31, 2018	103.844 %
February 1, 2018 to January 31, 2019	102.563 %
February 1, 2019 to January 31, 2020	101.281 %
February 1, 2020 to January 31, 2021	100.000 %

Pursuant to a registration rights agreement entered into at the time of the issuance of the 2021 Senior Secured Notes, as a result of an exchange offer made by CHS, all of the 2021 Senior Secured Notes issued in January 2014 were exchanged in October 2014 for new notes (the "2021 Exchange Notes") having terms substantially identical in all material respects to the 2021 Senior Secured Notes (except that the exchange notes were issued under a registration statement pursuant to the 1933 Act). References to the 2021 Senior Secured Notes shall be deemed to be the 2021 Exchange Notes unless the context provides otherwise.

6 ⅞% Senior Notes due 2022

On January 27, 2014, CHS completed a private offering of $3.0 billion aggregate principal amount of 6 ⅞% Senior Notes due 2022 (the "6 ⅞% Senior Notes"). The net proceeds from this issuance were used to finance the HMA merger. The 6 ⅞% Senior Notes bear interest at 6.875% per annum, payable semiannually in arrears on February 1 and August 1. Interest on the 6 ⅞% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

Prior to February 1, 2018, CHS may redeem some or all of the 6 ⅞% Senior Notes at a redemption price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the indenture governing the 6 ⅞% Senior Notes. After February 1, 2018, CHS is entitled, at its option, to redeem all or a portion of the 6 ⅞% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
February 1, 2018 to January 31, 2019	103.438 %
February 1, 2019 to January 31, 2020	101.719 %
February 1, 2020 to January 31, 2022	100.000 %

Pursuant to a registration rights agreement entered into at the time of the issuance of the 6 ⅞% Senior Notes, as a result of an exchange offer made by CHS, all of the 6 ⅞% Senior Notes issued in January 2014 were exchanged in October 2014 for new notes (the "6 ⅞% Exchange Notes") having terms substantially identical in all material respects to the 6 ⅞% Senior Notes (except that the exchange notes were issued under a registration statement pursuant to the 1933 Act). References to the 6 ⅞% Senior Notes shall be deemed to be the 6 ⅞% Exchange Notes unless the context provides otherwise.

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6 ¼% Senior Secured Notes due 2023

On March 16, 2017, CHS completed a public offering of $2.2 billion aggregate principal amount of 6 ¼% Senior Secured Notes. The net proceeds from this issuance were used to finance the purchase or redemption of $700 million aggregate principal amount of CHS' then outstanding 2018 Senior Secured Notes and related fees and expenses, and the repayment of $1.445 billion of the Term F Facility. On May 12, 2017, CHS completed a tack-on offering of $900 million aggregate principal amount of 6 ¼% Senior Secured Notes, increasing the total aggregate principal amount of 6 ¼% Senior Secured Notes to $3.1 billion. A portion of the net proceeds from this issuance were used to finance the repayment of approximately $713 million aggregate principal amount of CHS' then outstanding Term A Facility and related fees and expenses. The tack-on notes have identical terms, other than issue date and issue price as the 6 ¼% Senior Secured Notes issued on March 16, 2017. The 6 ¼% Senior Secured Notes bear interest at 6.250% per annum, payable semiannually in arrears on March 31 and September 30, commencing September 30, 2017. Interest on the 6 ¼% Senior Secured Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. The 6 ¼% Senior Secured Notes are secured by a first-priority lien subject to a shared lien of equal priority with certain other obligations, including obligations under the Credit Facility and the 2021 Senior Secured Notes, and subject to prior ranking liens permitted by the indenture governing the 6 ¼% Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure CHS' obligations under the Credit Facility and the 2021 Senior Secured Notes.

CHS is entitled, at its option, to redeem all or a portion of the 6 ¼% Senior Secured Notes at any time prior to March 31, 2020, upon not less than 30 nor more than 60 days' notice, at a price equal to 100% of the principal amount of the 6 ¼% Senior Secured Notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the indenture governing the 6 ¼% Senior Secured Notes. In addition, CHS may redeem up to 40% of the aggregate principal amount of the 6 ¼% Senior Secured Notes at any time prior to March 31, 2020 using the net proceeds from certain equity offerings at the redemption price of 106.250% of the principal amount of the 6 ¼% Senior Secured Notes redeemed, plus accrued and unpaid interest, if any.

CHS may redeem some or all of the 6 ¼% Senior Secured Notes at any time on or after March 31, 2020 upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
March 31, 2020 to March 30, 2021	103.125 %
March 31, 2021 to March 30, 2022	101.563 %
March 31, 2022 to March 30, 2023	100.000 %

Receivables Facility

CHS, through certain of its subsidiaries, participates in an accounts receivable loan agreement (the "Receivables Facility") with a group of lenders and banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent, and The Bank of Nova Scotia and PNC Bank, National Association, as managing agents. On June 23, 2017, CHS and certain of its subsidiaries amended the Receivables Facility to replace a managing agent, The Bank of Tokyo-Mitsubishi UFJ, Ltd. with PNC Bank, National Association, to decrease the size of the facility from $700 million to $600 million and to extend the scheduled termination date in respect of $150 million of the previously unextended $250 million portion to expire on November 13, 2018, coterminous with the remaining commitments. The remaining $100 million was repaid with available cash on hand. On November 13, 2017, CHS and certain of its subsidiaries amended the Receivables

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Facility to extend the scheduled termination date and amend certain other provisions thereof. The existing and future non-self pay patient-related accounts receivable (the "Receivables") for certain affiliated hospitals serve as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings is based on the commercial paper rate plus an applicable interest rate spread. Unless earlier terminated or subsequently extended pursuant to its terms, the Receivables Facility will expire on November 13, 2019 in respect of the $600 million of commitments thereunder, subject to customary termination events that could cause an early termination date. CHS maintains effective control over the Receivables because, pursuant to the terms of the Receivables Facility, the Receivables are sold from certain of CHS' subsidiaries to CHS, and CHS then sells or contributes the Receivables to a special-purpose entity that is wholly-owned by CHS. The wholly-owned special-purpose entity in turn grants security interests in the Receivables in exchange for borrowings obtained from the group of third-party lenders and banks of up to $600 million outstanding from time to time based on the availability of eligible Receivables and other customary factors. The wholly-owned special-purpose entity is not a subsidiary guarantor under the Credit Facility or CHS' outstanding notes. The group of third-party lenders and banks do not have recourse to CHS or its subsidiaries beyond the assets of the wholly-owned special-purpose entity that collateralizes the loan. The Receivables and other assets of the wholly-owned special-purpose entity will be available first and foremost to satisfy the claims of the creditors of such entity. The outstanding borrowings pursuant to the Receivables Facility at December 31, 2017 totaled $565 million on the consolidated balance sheet. At December 31, 2017, the carrying amount of Receivables included in the Receivables Facility totaled approximately $1.5 billion and is included in patient accounts receivable on the consolidated balance sheet.

Loss from Early Extinguishment of Debt

The financing and repayment transactions discussed above resulted in a loss from the early extinguishment of debt of $40 million, $30 million and $16 million for the years ended December 31, 2017, 2016 and 2015, respectively, and an after-tax loss of $26 million, $19 million and $10 million for the years ended December 31, 2017, 2016 and 2015, respectively.

Other Debt

As of December 31, 2017, other debt consisted primarily of other obligations maturing in various installments through 2028.

To limit the effect of changes in interest rates on a portion of the Company's long-term borrowings, the Company is a party to 8 separate interest swap agreements in effect at December 31, 2017, with an aggregate notional amount for currently effective swaps of $2.2 billion. On each of these swaps, the Company receives a variable rate of interest based on the three-month LIBOR in exchange for the payment of a fixed rate of interest. The Company currently pays, on a quarterly basis, interest on the Revolving Facility at a rate per annum equal to LIBOR plus 2.50%. The Term G Loan and Term H Loan accrue interest at a rate per annum equal to LIBOR plus 2.75% and 3.00%, in the case of LIBOR borrowings, respectively, and Alternate Base Rate plus 1.75% and 2.00%, respectively, in the case of Alternate Base Rate Borrowings. The Term G Loan and the Term H Loan are subject to a 1.00% LIBOR floor and a 2.00% Alternate Base Rate floor. See Note 8 for additional information regarding these swaps.

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As of December 31, 2017, the scheduled maturities of long-term debt outstanding, including capital lease obligations for each of the next five years and thereafter are as follows (in millions):

Year	Amount
2018	$ 33
2019	3,569
2020	1,210
2021	2,913
2022	3,010
Thereafter	3,347
Total maturities	14,082
Less: Deferred debt issuance costs	(191)
Plus: unamortized note premium	22
Total long-term debt	$13,913

The Company paid interest of $852 million, $930 million and $925 million on borrowings during the years ended December 31, 2017, 2016 and 2015, respectively.

8. FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Company using available market information as of December 31, 2017 and 2016, and valuation methodologies considered appropriate. The estimates presented in the table below are not necessarily indicative of amounts the Company could realize in a current market exchange (in millions):

	December 31, 2017		December 31, 2016	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 563	$ 563	$ 238	$ 238
Available-for-sale securities	252	252	299	299
Trading securities	37	37	80	80
Liabilities:				
Contingent Value Right	2	2	1	1
Credit Facility	2,902	2,826	6,456	6,370
8% Senior Notes	1,922	1,637	1,920	1,615
7 1/8% Senior Notes	1,192	897	1,189	917
5 1/8% Senior Secured Notes due 2018	-	-	698	690
5 1/8% Senior Secured Notes due 2021	978	902	972	930
6 7/8% Senior Notes	2,943	1,729	2,932	2,102
6 1/4% Senior Secured Notes	3,061	2,800	-	-
Receivables Facility and other debt	611	611	749	749

The carrying value of the Company's long-term debt in the above table is presented net of unamortized deferred debt issuance costs. The estimated fair value is determined using the methodologies discussed below in

accordance with accounting standards related to the determination of fair value based on the U.S. GAAP fair value hierarchy as discussed in Note 9. The estimated fair value for financial instruments with a fair value that does not equal its carrying value is considered a Level 1 valuation. The Company utilizes the market approach and obtains indicative pricing from the administrative agent to the Credit Facility to determine fair values or through publicly available subscription services such as Bloomberg where relevant.

Cash and cash equivalents. The carrying amount approximates fair value due to the short-term maturity of these instruments (less than three months).

Available-for-sale securities. Estimated fair value is based on closing price as quoted in public markets or other various valuation techniques.

Trading securities. Estimated fair value is based on closing price as quoted in public markets.

Contingent Value Right. Estimated fair value is based on the closing price as quoted on the public market where the CVR is traded.

Credit Facility. Estimated fair value is based on publicly available trading activity and supported with information from the Company's bankers regarding relevant pricing for trading activity among the Company's lending institutions.

8% Senior Notes. Estimated fair value is based on the closing market price for these notes.

7 1/8% Senior Notes. Estimated fair value is based on the closing market price for these notes.

5 1/8% Senior Secured Notes due 2018. Estimated fair value is based on the closing market price for these notes.

5 1/8% Senior Secured Notes due 2021. Estimated fair value is based on the closing market price for these notes.

6 7/8% Senior Notes. Estimated fair value is based on the closing market price for these notes.

6 1/4% Senior Secured Notes. Estimated fair value is based on the closing market price for these notes.

Receivables Facility and other debt. The carrying amount of the Receivables Facility and all other debt approximates fair value due to the nature of these obligations.

Interest rate swaps. The fair value of interest rate swap agreements is the amount at which they could be settled, based on estimates calculated by the Company using a discounted cash flow analysis based on observable market inputs and validated by comparison to estimates obtained from the counterparty. The Company incorporates credit valuation adjustments ("CVAs") to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance or credit risk, the Company has considered the impact of any netting features included in the agreements.

The Company assesses the effectiveness of its hedge instruments on a quarterly basis. For the years ended December 31, 2017 and 2016, the Company completed an assessment of the cash flow hedge instruments and determined the hedges to be highly effective. The Company has also determined that the ineffective portion of the hedges do not have a material effect on the Company's consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose the Company to credit risk in the event of

nonperformance. However, at December 31, 2017, since the majority of the swap agreements entered into by the Company were in a net liability position such that the Company would be required to make the net settlement payments to the counterparties; the Company does not anticipate nonperformance by those counterparties. The Company does not hold or issue derivative financial instruments for trading purposes.

Interest rate swaps consisted of the following at December 31, 2017:

Swap #	Notional Amount (in millions)	Fixed Interest Rate	Termination Date	Liability (Asset) Fair Value (in millions)
1	$ 400	1.882 %	August 30, 2019	$ (1)
2	200	2.515 %	August 30, 2019	2
3	200	2.613 %	August 30, 2019	2
4	300	2.041 %	August 30, 2020	-
5	300	2.738 %	August 30, 2020	5
6	300	2.892 %	August 30, 2020	6
7	300	2.363 %	January 27, 2021	2
8	200	2.368 %	January 27, 2021	1

The Company is exposed to certain risks relating to its ongoing business operations. The risk managed by using derivative instruments is interest rate risk. Interest rate swaps are entered into to manage interest rate fluctuation risk associated with the term loans in the Credit Facility. Companies are required to recognize all derivative instruments as either assets or liabilities at fair value in the consolidated statement of financial position. The Company designates its interest rate swaps as cash flow hedges. For derivative instruments that are designated and qualify as cash flow hedges, the effective portion of the gain or loss on the derivative is reported as a component of other comprehensive income ("OCI") and reclassified into earnings in the same period or periods during which the hedged transactions affect earnings. Gains and losses on the derivative representing either hedge ineffectiveness or hedge components excluded from the assessment of effectiveness are recognized in current earnings.

Assuming no change in December 31, 2017 interest rates, approximately $22 million of interest expense resulting from the spread between the fixed and floating rates defined in each interest rate swap agreement will be recognized during the next 12 months. If interest rate swaps do not remain highly effective as a cash flow hedge, the derivatives' gains or losses resulting from the change in fair value reported through OCI will be reclassified into earnings.

The following tabular disclosure provides the amount of pre-tax income (loss) recognized as a component of OCI during the years ended December 31, 2017, 2016 and 2015 (in millions):

Derivatives in Cash Flow Hedging Relationships	Amount of Pre-Tax Income (Loss) Recognized in OCI (Effective Portion) Year Ended December 31,		
	2017	2016	2015
Interest rate swaps	$ 2	$ (27)	$ (51)

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The following tabular disclosure provides the location of the effective portion of the pre-tax loss reclassified from accumulated other comprehensive loss ("AOCL") into interest expense on the consolidated statements of (loss) income during the years ended December 31, 2017, 2016 and 2015 (in millions):

Location of Loss Reclassified from AOCL into Income (Effective Portion)	Amount of Pre-Tax Loss Reclassified from AOCL into Income (Effective Portion) Year Ended December 31,		
	2017	2016	2015
Interest expense, net	$ 30	$ 54	$ 42

The fair values of derivative instruments in the consolidated balance sheets as of December 31, 2017 and 2016 were as follows (in millions):

	Asset Derivatives				Liability Derivatives			
	December 31, 2017		December 31, 2016		December 31, 2017		December 31, 2016	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives designated as hedging instruments	Other assets, net	$ 1	Other assets, net	$ -	Other long-term liabilities	$ 18	Other long-term liabilities	$ 49

9. FAIR VALUE

Fair Value Hierarchy

Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the U.S. GAAP fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
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measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability. Transfers between levels within the fair value hierarchy are recognized by the Company on the date of the change in circumstances that requires such transfer. There were no transfers between levels during the years ending December 31, 2017 or December 31, 2016.

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of December 31, 2017 and 2016 (in millions):

	December 31, 2017	Level 1	Level 2	Level 3
Available-for-sale securities	$ 252	$ 132	$ 120	$ -
Trading securities	37	37	-	-
Fair value of interest rate swap agreements	1	-	1	-
Total assets	$ 290	$ 169	$ 121	$ -
Contingent Value Right (CVR)	$ 2	$ 2	$ -	$ -
CVR-related liability	256	-	-	256
Fair value of interest rate swap agreements	18	-	18	-
Total liabilities	$ 276	$ 2	$ 18	$ 256

	December 31, 2016	Level 1	Level 2	Level 3
Available-for-sale securities	$ 299	$ 163	$ 136	$ -
Trading securities	80	80	-	-
Total assets	$ 379	$ 243	$ 136	$ -
Contingent Value Right (CVR)	$ 1	$ 1	$ -	$ -
CVR-related liability	252	-	-	252
Fair value of interest rate swap agreements	49	-	49	-
Total liabilities	$ 302	$ 1	$ 49	$ 252

Available-for-sale securities and trading securities classified as Level 1 are measured using quoted market prices. Level 2 available-for-sale securities primarily consisted of bonds and notes issued by the United States government and its agencies and domestic and foreign corporations. The estimated fair values of these securities are determined using various valuation techniques, including a multi-dimensional relational model that incorporates standard observable inputs and assumptions such as benchmark yields, reported trades, broker/dealer quotes, issuer spreads, benchmark securities, bids/offers and other pertinent reference data.

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Available-for-Sale Securities

Supplemental information regarding the Company's available-for-sale securities (all of which had no withdrawal restrictions) is set forth in the table below (in millions):

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Values
As of December 31, 2017:				
Debt securities and debt-based mutual funds				
Government and corporate	$ 189	$ -	$ (4)	$ 185
Equity securities and equity-based mutual funds				
Domestic	51	10	-	61
International	5	1	-	6
Totals	$ 245	$ 11	$ (4)	$ 252

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Values
As of December 31, 2016:				
Debt securities and debt-based mutual funds				
Government and corporate	$ 232	$ -	$ (9)	$ 223
Equity securities and equity-based mutual funds				
Domestic	67	3	-	70
International	6	-	-	6
Totals	$ 305	$ 3	$ (9)	$ 299

As of December 31, 2017 and 2016, investments with aggregate estimated fair values of approximately $181 million (246 investments) and $232 million (226 investments), respectively, generated the gross unrealized losses disclosed in the above table. At each reporting date, the Company performs an evaluation of impaired securities to determine if the unrealized losses are other-than-temporary. This evaluation considers a number of factors including, but not limited to, the length of time and extent to which the fair value has been less than cost, and management's ability and intent to hold the securities until fair value recovers. Based on the results of this evaluation, management concluded that as of December 31, 2017, there was approximately less than $1 million of other-than-temporary losses related to available-for-sale securities. The recent declines in value of the remaining securities and/or length of time they have been below cost, as well as the Company's ability and intent to hold the securities for a reasonable period of time sufficient for a projected recovery of fair value, have caused management to conclude that the remaining securities, that have generated gross unrealized losses, were not other-than-temporarily impaired. Management will continue to monitor and evaluate the recoverability of the Company's available-for-sale securities.

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The contractual maturities of debt-based securities held by the Company as of December 31, 2017 and 2016, excluding mutual fund holdings, are set forth in the table below (in millions). Expected maturities will differ from contractual maturities because the issuers of the debt securities may have the right to prepay their obligations without prepayment penalties.

	December 31, 2017		December 31, 2016	
	Amortized Cost	Estimated Fair Values	Amortized Cost	Estimated Fair Values
Within 1 year	$ 4	$ 4	$ 2	$ 2
After 1 year and through year 5	46	46	40	40
After 5 years and through year 10	32	31	42	40
After 10 years	41	40	57	54

Gross realized gains and losses on sales of available-for-sale securities and other investment income, which includes interest and dividends, are summarized in the table below (in millions):

	Year Ended December 31,		
	2017	2016	2015
Realized gains	$ 3	$ 28	$ 8
Realized losses	(2)	(6)	(6)
Investment income	8	7	8

Contingent Value Right (CVR)

The CVR represents the estimate of the fair value for the contingent consideration paid to HMA shareholders as part of the HMA merger. The CVR is listed on the Nasdaq and the valuation at December 31, 2017 is based on the quoted trading price for the CVR on the last day of the period. Changes in the estimated fair value of the CVR are recorded through the consolidated statements of (loss) income.

CVR-related Liability

The CVR-related legal liability represents the Company's estimate of fair value at December 31, 2017 of the liability associated with the legal matters assumed in the HMA merger, which are included in other long-term liabilities in the accompanying consolidated balance sheet. This liability did not include those matters previously accrued by HMA as a probable contingency, which were settled and paid during the year ended December 31, 2015. To develop the estimate of fair value, the Company engaged an independent third-party valuation firm to measure the liability. The valuation was made utilizing the Company's estimates of future outcomes for each legal case and simulating future outcomes based on the timing, probability and distribution of several scenarios using a Monte Carlo simulation model. Other inputs were then utilized for discounting the liability to the measurement date. The HMA legal matters underlying this fair value estimate were evaluated by management to determine the likelihood and impact of each of the potential outcomes. Using that information, as well as the potential correlation and variability associated with each case, a fair value was determined for the estimated future cash outflows to conclude or settle the HMA legal matters included in the analysis, excluding legal fees (which are expensed as incurred). Because of the unobservable nature of the majority of the inputs used to value the liability, the Company has classified the fair value measurement as a Level 3 measurement in the fair value hierarchy.

The fair value of the CVR-related legal liability will be measured each reporting period using similar measurement techniques, updated for the assumptions and facts existing at that date for each of the underlying legal matters. Changes in the fair value of the CVR related legal liability are recorded in future periods through the consolidated statements of (loss) income.

Fair Value of Interest Rate Swap Agreements

The valuation of the Company's interest rate swap agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses observable market-based inputs, including forward interest rate curves. The fair value of interest rate swap agreements are determined by netting the discounted future fixed cash payments and the discounted expected variable cash receipts. The variable cash receipts are based on the expectation of future interest rates based on observable market forward interest rate curves and the notional amount being hedged.

The Company incorporates CVAs to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance or credit risk, the Company has considered the impact of any netting features included in the agreements. The CVA on the Company's interest rate swap agreements resulted in a decrease in the fair value of the related liability of $1 million and an after-tax adjustment of less than $1 million to OCI at December 31, 2017. The CVA on the Company's interest rate swap agreements resulted in a decrease in the fair value of the related liability of $3 million and an after-tax adjustment of $2 million to OCI at December 31, 2016.

The majority of the inputs used to value the Company's interest rate swap agreements, including the forward interest rate curves and market perceptions of the Company's credit risk used in the CVAs, are observable inputs available to a market participant. As a result, the Company has determined that the interest rate swap valuations are classified in Level 2 of the fair value hierarchy.

10. LEASES

The Company leases hospitals, medical office buildings, and certain equipment under capital and operating lease agreements. During 2017, 2016 and 2015, the Company entered into capital lease obligations of $31 million, $179 million and $50 million, respectively. All lease agreements generally require the Company to pay maintenance, repairs, property taxes and insurance costs.

Commitments relating to noncancellable operating and capital leases for each of the next five years and thereafter are as follows (in millions):

Year Ending December 31,	Operating (1)	Capital
2018	$ 208	$ 32
2019	161	28
2020	130	23
2021	91	23
2022	70	22
Thereafter	246	299
Total minimum future payments	$ 906	427
Less: Imputed interest		(123)
Total capital lease obligations		304
Less: Current portion		(17)
Long-term capital lease obligations		$ 287

(1) Minimum lease payments have not been reduced by minimum sublease rentals due in the future of $6 million.

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On December 22, 2016, the Company completed the sale and leaseback of ten medical office buildings for net proceeds of $159 million to HCP, Inc. The buildings, with a combined total of 756,183 square feet, are located in five states and support a wide array of diagnostic, medical and surgical services in an outpatient setting for the respective nearby hospitals. Because of the Company's continuing involvement in these leased buildings, the transaction does not qualify for sale treatment and the related leases have been recorded as financing obligations in the Company's consolidated balance sheet at December 31, 2017. Such financing obligations are included with the capital lease obligations discussed throughout these footnotes to the consolidated financial statements.

Assets capitalized under capital leases as reflected in the accompanying consolidated balance sheets were $63 million of land and improvements, $774 million of buildings and improvements and $28 million of equipment and fixtures as of December 31, 2017 and $69 million of land and improvements, $826 million of buildings and improvements and $56 million of equipment and fixtures as of December 31, 2016. The accumulated depreciation related to assets under capital leases was $218 million and $240 million as of December 31, 2017 and 2016, respectively. Depreciation of assets under capital leases is included in depreciation and amortization expense and amortization of debt discounts on capital lease obligations is included in interest expense in the accompanying consolidated statements of (loss) income.

11. EMPLOYEE BENEFIT PLANS

The Company maintains various benefit plans, including defined contribution plans, defined benefit plans and deferred compensation plans, for which certain of the Company's subsidiaries are the plan sponsors. The CHS/Community Health Systems, Inc. Retirement Savings Plan is a defined contribution plan which covers the majority of the employees at subsidiaries owned prior to the HMA merger. Employees at these locations whose employment is covered by collective bargaining agreements are generally eligible to participate in the CHS/Community Health Systems, Inc. Standard 401(k) Plan. The Company also maintains the Health Management Associates, Inc. Retirement Savings Plan, a defined contribution plan covering substantially all of the employees formerly employed by HMA. Total expense to the Company under the 401(k) plans was $94 million, $98 million and $103 million for the years ended December 31, 2017, 2016 and 2015, respectively, and is recorded in salaries and benefits expense on the consolidated statements of (loss) income.

The Company maintains unfunded deferred compensation plans that allow participants to defer receipt of a portion of their compensation. The liability for the deferred compensation plans was $189 million and $229 million as of December 31, 2017 and 2016, respectively, and is included in other long-term liabilities on the consolidated balance sheets. The Company had assets of $173 million and $219 million as of December 31, 2017 and 2016, respectively, in a non-qualified plan trust generally designated to pay benefits of the deferred compensation plans, consisting of trading securities of $37 million and $80 million as of December 31, 2017 and 2016, respectively, and company-owned life insurance contracts of $136 million and $139 million as of December 31, 2017 and 2016, respectively.

The Company provides an unfunded Supplemental Executive Retirement Plan ("SERP") for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for the SERP. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations and net periodic cost in future periods. Benefits expense under the SERP was $16 million, $12 million and $12 million for the years ended December 31, 2017, 2016 and 2015, respectively. The accrued benefit liability for the SERP totaled $83 million and $122 million at December 31, 2017 and 2016, respectively, and is included in other long-term liabilities on the consolidated balance sheets. The weighted-average assumptions used in determining net periodic cost for the year ended December 31, 2017 was a discount rate of 3.6% and annual salary increase of 2.0%. The Company had

available-for-sale securities in a rabbi trust generally designated to pay benefits of the SERP in the amounts of $99 million and $131 million at December 31, 2017 and 2016, respectively. These amounts are included in other assets, net on the consolidated balance sheets.

During the year ended December 31, 2017, certain members of executive management of the Company that were participants in the SERP retired and met the requirements for payout of their SERP retirement benefit. The SERP payout provisions require payment to the participant in an actuarially determined lump sum amount six months after the participant retires from the Company. Such amounts have been or will be paid out of the rabbi trust during the latter half of 2017 and first half of 2018. As required by the pension accounting rules in U.S. GAAP, the Company recognized a non-cash settlement loss of approximately $6 million during the year ended December 31, 2017, and will recognize a non-cash settlement of approximately $1 million during the year ended December 31, 2018, which represent a pro-rata portion of the accumulated unrecognized actuarial loss out of accumulated other comprehensive loss.

The Company maintains the CHS/Community Health Systems, Inc. Retirement Income Plan ("Pension Plan"), which is a defined benefit, non-contributory pension plan that covers certain employees at three of its formerly owned hospitals. The Pension Plan provides benefits to covered individuals satisfying certain age and service requirements. Employer contributions to the Pension Plan are in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended. The Company expects to make no contribution to the Pension Plan in 2018. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for the Pension Plan. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations, net periodic cost and funding requirements in future periods. Benefits expense under the Pension Plan was $7 million for the year ended December 31, 2017, and was less than $1 million for both the years ended December 31, 2016 and 2015. The accrued benefit liability for the Pension Plan totaled $12 million and $16 million at December 31, 2017 and 2016, respectively, and is included in other long-term liabilities on the consolidated balance sheets. The weighted-average assumptions used for determining the net periodic cost for the year ended December 31, 2017 was a discount rate of 4.1% and the expected long-term rate of return on assets of 7.0%.

12. STOCKHOLDERS' (DEFICIT) EQUITY

Authorized capital shares of the Company include 400,000,000 shares of capital stock consisting of 300,000,000 shares of common stock and 100,000,000 shares of preferred stock. Each of the aforementioned classes of capital stock has a par value of $0.01 per share. Shares of preferred stock, none of which were outstanding as of December 31, 2017, may be issued in one or more series having such rights, preferences and other provisions as determined by the Board of Directors without approval by the holders of common stock.

On November 6, 2015, the Company adopted an open market repurchase program for up to 10,000,000 shares of the Company's common stock, not to exceed $300 million in repurchases. The repurchase program will expire on the earlier of November 5, 2018, when the maximum number of shares has been repurchased, or when the maximum dollar amount has been expended. During the year ended December 31, 2015, the Company repurchased and retired 532,188 shares at a weighted-average price of $27.31 per share, which is the cumulative number of shares repurchased and retired under this program. No shares were repurchased under this program during the years ended December 31, 2017 and 2016.

The Company is a holding company which operates through its subsidiaries. The Company's Credit Facility and the indentures governing the senior and senior secured notes contain various covenants under which the assets of the subsidiaries of the Company are subject to certain restrictions relating to, among other matters, dividends and distributions, as referenced in the paragraph below.

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With the exception of a special cash dividend of $0.25 per share paid by the Company in December 2012, historically, the Company has not paid any cash dividends. Subject to certain exceptions, the Company's Credit Facility limits the ability of the Company's subsidiaries to pay dividends and make distributions to the Company, and limits the Company's ability to pay dividends and/or repurchase stock, to an amount not to exceed $200 million in the aggregate plus an additional $25 million in any particular year plus the aggregate amount of proceeds from the exercise of stock options. The indentures governing the senior and senior secured notes also restrict the Company's subsidiaries from, among other matters, paying dividends and making distributions to the Company, which thereby limits the Company's ability to pay dividends and/or repurchase stock. The non-cash dividend of approximately $713 million recorded by the Company during the year ended December 31, 2016 to reflect the distribution of the net assets of QHC was a permitted transaction under the Company's Credit Facility. As of December 31, 2017, under the most restrictive test in these agreements (and subject to certain exceptions), the Company has approximately $318 million remaining available with which to pay permitted dividends and/or repurchase shares of stock or its senior and senior secured notes.

The following schedule discloses the effects of changes in the Company's ownership interest in its less-than-wholly-owned subsidiaries on Community Health Systems, Inc. stockholders' (deficit) equity (in millions):

	Year Ended December 31,		
	2017	2016	2015
Net (loss) income attributable to Community Health Systems, Inc. stockholders	$(2,459)	$(1,721)	$158
Transfers from the noncontrolling interests:			
Net decrease in Community Health Systems, Inc. paid-in-capital for purchase of subsidiary partnership interests	(2)	(9)	(16)
Net transfers from the noncontrolling interests	(2)	(9)	(16)
Change to Community Health Systems, Inc. stockholders' (deficit) equity from net (loss) income attributable to Community Health Systems, Inc. stockholders and transfers to noncontrolling interests	$(2,461)	$(1,730)	$142

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13. EARNINGS PER SHARE

The following table sets forth the components of the numerator and denominator for the computation of basic and diluted (loss) earnings per share for loss from continuing operations, discontinued operations and net loss attributable to Community Health Systems, Inc. common stockholders (in millions, except share data):

	Year Ended December 31,		
	2017	2016	2015
Numerator:			
(Loss) income from continuing operations, net of taxes	$ (2,384)	$ (1,611)	$ 295
Less: Income from continuing operations attributable to noncontrolling interests, net of taxes	63	95	101
(Loss) income from continuing operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ (2,447)	$ (1,706)	$ 194
Loss from discontinued operations, net of taxes	$ (12)	$ (15)	$ (36)
Less: Loss from discontinued operations attributable to noncontrolling interests, net of taxes	-	-	-
Loss from discontinued operations attributable to Community Health Systems, Inc. common stockholders — basic and diluted	$ (12)	$ (15)	$ (36)
Denominator:			
Weighted-average number of shares outstanding — basic	111,769,821	110,730,971	114,454,674
Effect of dilutive securities:			
Restricted stock awards	-	-	449,961
Employee stock options	-	-	357,188
Other equity-based awards	-	-	10,581
Weighted-average number of shares outstanding — diluted	111,769,821	110,730,971	115,272,404

The Company generated a loss from continuing operations attributable to Community Health Systems, Inc. common stockholders for the years ended December 31, 2017 and 2016, so the effect of dilutive securities is not considered because their effect would be antidilutive. If the Company had generated income from continuing operations during the years ended December 31, 2017 and 2016, the effect of restricted stock awards, employee stock options, and other equity-based awards on the diluted shares calculation would have been an increase in shares of 111,464 and 331,518, respectively.

	Year Ended December 31,		
	2017	2016	2015
Dilutive securities outstanding not included in the computation of earnings per share because their effect is antidilutive:			
Employee stock options and restricted stock awards	3,008,919	2,554,627	255,564

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14. EQUITY INVESTMENTS

As of December 31, 2017, the Company owned equity interests of 38.0% in three hospitals in Macon, Georgia, in which HCA owns the majority interest. On December 31, 2016, the Company sold 80% of its ownership interest in the legal entity that owned and operated its home care agency business. As part of the divestiture of its controlling interest in the home care agency business, the Company recorded an equity method investment representing its remaining 20% ownership at a fair value of $32 million.

On April 29, 2016, the Company sold its unconsolidated minority equity interests in Valley Health System, LLC, a joint venture with Universal Health Systems, Inc. ("UHS") representing four hospitals in Las Vegas, Nevada, in which the Company owned a 27.5% interest, and in Summerlin Hospital Medical Center, LLC, a joint venture with UHS representing one hospital in Las Vegas, Nevada, in which the Company owned a 26.1% interest. The Company received $403 million in cash in return for the sale of its equity interests and, as a result, recognized a gain of approximately $94 million on the sale of investments in unconsolidated affiliates during the year ended December 31, 2016.

Summarized combined financial information for these unconsolidated entities in the periods in which the Company owned these equity interests is as follows (in millions):

	December 31, 2016
Current assets	$ 54
Noncurrent assets	112
Total assets	$ 166
Current liabilities	$ 17
Noncurrent liabilities	2
Members' equity	147
Total liabilities and equity	$ 166

	Year Ended December 31,	
	2016	2015
Revenues	$731	$ 1,494
Operating costs and expenses	602	1,287
Income from continuing operations before taxes	129	207

The summarized financial information was derived from the financial information provided to the Company by those unconsolidated entities. Following the sale of its unconsolidated minority equity interests to UHS in 2016, none of the Company's equity investments, individually or in the aggregate, were considered material. As such, summarized combined financial information for these unconsolidated entities is not provided as of or for the year ended December 31, 2017.

In March 2005, the Company began purchasing items, primarily medical supplies, medical equipment and pharmaceuticals, under an agreement with HealthTrust Purchasing Group, L.P. ("HealthTrust"), a group purchasing organization in which the Company is a noncontrolling partner. As of December 31, 2017, the Company had a 19.7% ownership interest in HealthTrust.

The Company's investment in all of its unconsolidated affiliates was $171 million and $177 million at December 31, 2017 and 2016, respectively, and is included in other assets, net in the accompanying consolidated balance sheets. Included in the Company's results of operations is the Company's equity in pre-tax earnings from

all of its investments in unconsolidated affiliates, which was $16 million, $43 million and $63 million for the years ended December 31, 2017, 2016 and 2015, respectively.

15. SEGMENT INFORMATION

The Company operates in one distinct operating segment, represented by hospital operations (which includes its general acute care hospitals and related healthcare entities that provide inpatient and outpatient healthcare services).

Prior to the Company's sale on December 31, 2016 of 80% of its ownership interest in the home care division, the Company also had an additional distinct operating segment represented by its home care agency operations (which provide in-home outpatient care). However, only the hospital operations segment met the criteria as a separate reportable segment due to the fact that the home care agency segment did not meet the quantitative thresholds for a separate identifiable reportable segment and was combined into the corporate and all other reportable segment. Since 2017, the Company has only operated in one operating segment.

The distribution between reportable segments of the Company's net operating revenues, (loss) income from continuing operations before income taxes, expenditures for segment assets and total assets as of and for the years ended December 31, 2016 and 2015, prior to the Company's sale of an 80% ownership interest in the home care division as noted above, is summarized in the following tables (in millions):

	Year Ended December 31,	
	2016	2015
Net operating revenues:		
Hospital operations	$ 18,210	$ 19,234
Corporate and all other	228	203
Total	$ 18,438	$ 19,437
(Loss) income from continuing operations before income taxes:		
Hospital operations	$ (1,418)	$ 767
Corporate and all other	(297)	(356)
Total	$ (1,715)	$ 411
Expenditures for segment assets:		
Hospital operations	$ 727	$ 915
Corporate and all other	17	38
Total	$ 744	$ 953

	December 31, 2016
Total assets:	
Hospital operations	$ 20,582
Corporate and all other	1,362
Total	$ 21,944

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16. OTHER COMPREHENSIVE INCOME

The following tables present information about items reclassified out of accumulated other comprehensive (loss) income by component for the years ended December 31, 2017 and 2016 (in millions, net of tax):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2016	$ (31)	$ (10)	$ (21)	$ (62)
Other comprehensive income before reclassifications	-	8	5	13
Amounts reclassified from accumulated other comprehensive income	19	-	9	28
Net current-period other comprehensive income	19	8	14	41
Balance as of December 31, 2017	$ (12)	$ (2)	$ (7)	$ (21)

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2015	$ (48)	$ 1	$ (26)	$ (73)
Other comprehensive (loss) income before reclassifications	(17)	2	1	(14)
Amounts reclassified from accumulated other comprehensive income	34	(13)	2	23
Net current-period other comprehensive income (loss)	17	(11)	3	9
AOCI distributed to QHC in spin-off	-	-	2	2
Balance as of December 31, 2016	$ (31)	$ (10)	$ (21)	$ (62)

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The following tables present a subtotal for each significant reclassification to net (loss) income out of AOCL and the line item affected in the accompanying consolidated statements of (loss) income for the years ended December 31, 2017 and 2016 (in millions):

Details about accumulated other comprehensive (loss) income components	Amount reclassified from AOCL Year Ended December 31, 2017	Affected line item in the statement where net (loss) income is presented
Gains and losses on cash flow hedges		
Interest rate swaps	$ (30)	Interest expense, net
	11	Tax benefit
	$ (19)	Net of tax
Amortization of defined benefit pension items		
Prior service costs	$ (2)	Salaries and benefits
Actuarial losses	(1)	Salaries and benefits
Settlement losses recognized	(13)	Salaries and benefits
	(16)	Total before tax
	7	Tax benefit
	(9)	Net of tax

Details about accumulated other comprehensive (loss) income components	Amount reclassified from AOCL Year Ended December 31, 2016	Affected line item in the statement where net (loss) income is presented
Gains and losses on cash flow hedges		
Interest rate swaps	$ (54)	Interest expense, net
	20	Tax benefit
	$ (34)	Net of tax
Amortization of defined benefit pension items		
Prior service costs	$ (2)	Salaries and benefits
Actuarial losses	(1)	Salaries and benefits
	(3)	Total before tax
	1	Tax benefit
	$ (2)	Net of tax

17. COMMITMENTS AND CONTINGENCIES

Construction and Other Capital Commitments. Pursuant to a hospital purchase agreement in effect as of December 31, 2017, the Company is required to build replacement facilities in La Porte, Indiana and Knox, Indiana. The estimated construction costs, including equipment costs, for the La Porte and Starke replacement facilities are currently estimated to be approximately $125 million and $15 million, respectively. No costs have been incurred to date on these facilities. In addition, under other purchase agreements outstanding at

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December 31, 2017, the Company has committed to spend approximately $289 million for costs such as capital improvements, equipment, selected leases and physician recruiting. These commitments are required to be fulfilled generally over a five to seven year period after acquisition. Through December 31, 2017, the Company has spent approximately $135 million related to these commitments.

Physician Recruiting Commitments. As part of its physician recruitment strategy, the Company provides income guarantee agreements to certain physicians who agree to relocate to its communities and commit to remain in practice there. Under such agreements, the Company is required to make payments to the physicians in excess of the amounts they earned in their practice up to the amount of the income guarantee. These income guarantee periods are typically for 12 months. Such payments are recoverable by the Company from physicians who do not fulfill their commitment period, which is typically three years, to the respective community. At December 31, 2017, the maximum potential amount of future payments under these guarantees in excess of the liability recorded is $31 million.

Professional Liability Claims. As part of the Company's business of owning and operating hospitals, it is subject to legal actions alleging liability on its part. The Company accrues for losses resulting from such liability claims, as well as loss adjustment expenses that are out-of-pocket and directly related to such liability claims. These direct out-of-pocket expenses include fees of outside counsel and experts. The Company does not accrue for costs that are part of corporate overhead, such as the costs of in-house legal and risk management departments. The losses resulting from professional liability claims primarily consist of estimates for known claims, as well as estimates for incurred but not reported claims. The estimates are based on specific claim facts, historical claim reporting and payment patterns, the nature and level of hospital operations and actuarially determined projections. The actuarially determined projections are based on the Company's actual claim data, including historic reporting and payment patterns which have been gathered over an approximate 20-year period. As discussed below, since the Company purchases excess insurance on a claims-made basis that transfers risk to third-party insurers, the liability it accrues does include an amount for the losses covered by its excess insurance. The Company also records a receivable for the expected reimbursement of losses covered by excess insurance. Since the Company believes that the amount and timing of its future claims payments are reliably determinable, it discounts the amount accrued for losses resulting from professional liability claims using the risk-free interest rate corresponding to the timing of expected payments.

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 2.2%, 1.8% and 1.6% in 2017, 2016 and 2015, respectively. This liability is adjusted for new claims information in the period such information becomes known. The Company's estimated liability for professional and general liability claims was $711 million and $788 million as of December 31, 2017 and 2016, respectively. The estimated undiscounted claims liability was $760 million and $843 million as of December 31, 2017 and 2016, respectively. The current portion of the liability for professional and general liability claims was $115 million and $130 million as of December 31, 2017 and 2016, respectively, and is included in other accrued liabilities in the accompanying consolidated balance sheets, with the long-term portion recorded in other long-term liabilities. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of (loss) income.

The Company's processes for obtaining and analyzing claims and incident data are standardized across all of its hospitals and have been consistent for many years. The Company monitors the outcomes of the medical care services that it provides and for each reported claim, the Company obtains various information concerning the facts and circumstances related to that claim. In addition, the Company routinely monitors current key statistics and volume indicators in its assessment of utilizing historical trends. The average lag period between claim occurrence and payment of a final settlement is between three and four years, although the facts and

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circumstances of individual claims could result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent approximately 1.0% of the total liability at the end of any period.

For purposes of estimating its individual claim accruals, the Company utilizes specific claim information, including the nature of the claim, the expected claim amount, the year in which the claim occurred and the laws of the jurisdiction in which the claim occurred. Once the case accruals for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, geography and claims relating to the acquired HMA hospitals versus claims relating to the Company's other hospitals. Several actuarial methods are used against this data to produce estimates of ultimate paid losses and reserves for incurred but not reported claims. Each of these methods uses company-specific historical claims data and other information. This company-specific data includes information regarding the Company's business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, a variety of hospital census information, employed physician information, professional liability retentions for each policy year, geographic information and other data.

Based on these analyses the Company determines its estimate of the professional liability claims. The determination of management's estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of the management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in the Company's future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of the change may not become evident until years later. Moreover, since the Company's methods and models use different types of data and the Company selects its liability from the results of all of these methods, it typically cannot quantify the precise impact of such factors on its estimates of the liability. Due to the Company's standardized and consistent processes for handling claims and the long history and depth of company-specific data, the Company's methodologies have produced reliably determinable estimates of ultimate paid losses.

The Company is primarily self-insured for professional liability claims; however, the Company obtains excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of self-insured retentions. The Company's excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of the Company's professional and general liability risks were subject to a less than $1 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4 million per claim. Substantially all claims reported on or after June 1, 2005 and before June 1, 2014 are self-insured up to $5 million per claim. Substantially all claims reported on or after June 1, 2014 are self-insured up to $10 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers the Company for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95 million per occurrence and in the aggregate for claims reported on or after June 1, 2003, up to $145 million per occurrence and in the aggregate for claims reported on or after January 1, 2008, up to $195 million per occurrence and in the aggregate for claims reported on or after June 1, 2010, and up to $220 million per occurrence and in the aggregate for claims reported on or after June 1, 2015. In addition, for integrated occurrence malpractice claims, there is an additional $50 million of excess coverage for claims reported on or after June 1, 2014 and an additional $75 million of excess coverage for claims reported on or after June 1, 2015. For certain policy years prior to June 1, 2014, if the first aggregate layer of excess coverage becomes fully utilized, then the Company's self-insured retention will increase to $10 million per claim for any subsequent claims in that policy year until the Company's total aggregate coverage is met.

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Effective June 1, 2014, the hospitals acquired from HMA were insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims reported on or after June 1, 2014 except for physician-related claims with an occurrence date prior to June 1, 2014. Prior to June 1, 2014, the former HMA hospitals obtained insurance coverage through a wholly-owned captive insurance subsidiary and a risk retention group subsidiary which are domiciled in the Cayman Islands and South Carolina, respectively. Those insurance subsidiaries, which are collectively referred to as the "Insurance Subsidiaries," provided (i) claims-made coverage to all of the former HMA hospitals and (ii) occurrence-basis coverage to most of the physicians employed by the former HMA hospitals. The employed physicians not covered by the Insurance Subsidiaries generally maintained claims-made policies with unrelated third party insurance companies. To mitigate the exposure of the program covering the former HMA hospitals and other healthcare facilities, the Insurance Subsidiaries bought claims-made reinsurance policies from unrelated third parties for claims above self-retention levels of $10 million or $15 million per claim, depending on the policy year.

Effective January 1, 2008, the hospitals acquired from Triad were insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims occurring on or after January 1, 2002 and reported on or after January 1, 2008. Substantially all losses for the former Triad hospitals in periods prior to May 1, 1999 were insured through a wholly-owned insurance subsidiary of HCA, Triad's owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the former Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1, 1999. After May 1, 1999 through December 31, 2006, the former Triad hospitals obtained insurance coverage on a claims incurred basis from HCA's wholly-owned insurance subsidiary, with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims occurring during 2007 were self-insured up to $10 million per claim.

Legal Matters. The Company is a party to various legal, regulatory and governmental proceedings incidental to its business. Based on current knowledge, management does not believe that loss contingencies arising from pending legal, regulatory and governmental matters, including the matters described herein, will have a material adverse effect on the consolidated financial position or liquidity of the Company. However, in light of the inherent uncertainties involved in pending legal, regulatory and governmental matters, some of which are beyond the Company's control, and the very large or indeterminate damages sought in some of these matters, an adverse outcome in one or more of these matters could be material to the Company's results of operations or cash flows for any particular reporting period.

With respect to all legal, regulatory and governmental proceedings, the Company considers the likelihood of a negative outcome. If the Company determines the likelihood of a negative outcome with respect to any such matter is probable and the amount of the loss can be reasonably estimated, the Company records an accrual for the estimated loss for the expected outcome of the matter. If the likelihood of a negative outcome with respect to material matters is reasonably possible and the Company is able to determine an estimate of the possible loss or a range of loss, whether in excess of a related accrued liability or where there is no accrued liability, the Company discloses the estimate of the possible loss or range of loss. However, the Company is unable to estimate a possible loss or range of loss in some instances based on the significant uncertainties involved in, and/or the preliminary nature of, certain legal, regulatory and governmental matters.

In connection with the spin-off of QHC, the Company agreed to indemnify QHC for certain liabilities relating to outcomes or events occurring prior to April 29, 2016, the closing date of the spin-off, including (i) certain claims and proceedings that were known to be outstanding at or prior to the consummation of the spin-off and involved multiple facilities and (ii) certain claims, proceedings and investigations by governmental authorities or

private plaintiffs related to activities occurring at or related to QHC's healthcare facilities prior to the closing date of the spin-off, but only to the extent, in the case of clause (ii), that such claims are covered by insurance policies maintained by the Company, including professional liability and employer practices. In this regard, the Company continues to be responsible for HMA Legal Matters (as defined below) covered by the CVR agreement that relate to QHC's business, and any amounts payable by the Company in connection therewith will continue to reduce the amount payable by the Company in respect of the CVRs. Notwithstanding the foregoing, the Company is not required to indemnify QHC in respect of any claims or proceedings arising out of or related to the business operations of Quorum Health Resources, LLC at any time or QHC's compliance with the corporate integrity agreement. Subsequent to the spin-off of QHC, the Office of the Inspector General provided the Company with written assurance that it would look solely at QHC for compliance for its facilities under the Company's Corporate Integrity Agreement; however, the Office of the Inspector General declined to enter into a separate corporate integrity agreement with QHC. In addition, on August 4, 2017, the Company initiated an arbitration against QHC for unpaid amounts due from QHC related to two transition services agreements. QHC filed a counterclaim, claiming breach of contract and tortious interference, among others. The arbitration is set to begin June 18, 2018. The Company believes the counterclaim is without merit and will vigorously defend the case.

HMA Legal Matters and Related CVR

The CVR agreement entitles the holder to receive a one-time cash payment of up to $1.00 per CVR, subject to downward adjustment based on the final resolution of certain litigation, investigations (whether formal or informal, including subpoenas), or other actions or proceedings related to HMA or its affiliates existing on or prior to July 29, 2013 (the date of the Company's merger agreement with HMA) as more specifically provided in the CVR agreement (all such matters are referred to as the "HMA Legal Matters"), which include, but are not limited to, investigation and litigation matters as previously disclosed by HMA in public filings with the SEC and/or as described in more detail below. The adjustment reducing the ultimate amount paid to holders of the CVR is determined based on the amount of losses incurred by the Company in connection with the HMA Legal Matters as more specifically provided in the CVR agreement, which generally includes the amount paid for damages, costs, fees and expenses (including, without limitation, attorneys' fees and expenses), and all fines, penalties, settlement amounts, indemnification obligations and other liabilities (all such losses are referred to as "HMA Losses"). If the aggregate amount of HMA Losses exceeds a deductible of $18 million, then the amount payable in respect of each CVR shall be reduced (but not below zero) by an amount equal to the quotient obtained by dividing: (a) the product of (i) all losses in excess of the deductible and (ii) 90%; by (b) the number of CVRs outstanding on the date on which final resolution of the existing litigation occurs. There are 264,544,053 CVRs outstanding as of the date hereof. If total HMA Losses (including HMA Losses that have occurred to date as noted in the table below) exceed approximately $312 million, then the holders of the CVRs will not be entitled to any payment in respect of the CVRs.

The CVRs do not have a finite payment date. Any payments the Company makes under the CVR agreement will be payable within 60 days after the final resolution of the HMA Legal Matters. The CVRs are unsecured obligations of CHS and all payments under the CVRs will be subordinated in right of payment to the prior payment in full of all of the Company's senior obligations (as defined in the CVR agreement), which include outstanding indebtedness of the Company (subject to certain exceptions set forth in the CVR agreement) and the HMA Losses. The CVR agreement permits the Company to acquire all or some of the CVRs, whether in open market transactions, private transactions or otherwise. As of December 31, 2017, the Company had acquired no CVRs.

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The following table represents the impact of legal expenses paid or incurred and settlements paid or deemed final as of December 31, 2017 and 2016 on the amounts owed to CVR holders (in millions):

		Allocation of Expenses and Settlements Paid		
	Total Expenses and Settlement Cost	Deductible	Company's Responsibility at 10%	Reduction to Amount Owed to CVR Holders at 90%
As of December 31, 2015	$ 58	$ 18	$ 4	$ 36
Settlements paid	1	-	-	1
Legal expenses incurred and/or paid during the year ended December 31, 2016	3	-	-	3
As of December 31, 2016	62	18	4	40
Settlements paid	-	-	-	-
Legal expenses incurred and/or paid during the year ended December 31, 2017	2	-	-	2
As of December 31, 2017	$ 64	$ 18	$ 4	$ 42

Amounts owed to CVR holders are dependent on the ultimate resolution of the HMA Legal Matters and determination of HMA Losses incurred. The settlement of any or all of the claims and expenses incurred on behalf of the Company in defending itself will (subject to the deductible) reduce the amounts owed to the CVR holders.

Underlying the CVR agreement are a number of claims included in the HMA Legal Matters asserted against HMA. The Company has recorded a liability in connection with those claims as part of the acquired assets and liabilities at the date of acquisition pursuant to the provisions of Financial Accounting Standards Board Accounting Standards Codification Topic 805 "Business Combinations." For the estimate of the Company's liabilities associated with the HMA Legal Matters that will be covered by the CVR and were not previously accrued by HMA, the Company recorded a liability of $284 million as part of the acquisition accounting for the HMA merger based on the Company's estimate of fair value of such liabilities as of the date of acquisition. There was a $4 million increase in the liability during the year ended December 31, 2017 and the estimated fair value of such liabilities, after consideration of amounts paid and current estimates of valuation inputs, was $256 million as of December 31, 2017, which is recorded in other long-term liabilities on the accompanying consolidated balance sheet. As of December 31, 2017, there is currently no accrual recorded for the probable contingency claims underlying the CVR agreement. The estimated liability for probable contingency claims underlying the CVR agreement that was previously recorded by HMA, and reflected in the purchase accounting for HMA as an acquired liability has been settled and was paid during the year ended December 31, 2015. In addition, although legal fees are not included in the amounts currently accrued, such legal fees are taken into account in determining HMA Losses under the CVR agreement. Certain significant HMA Legal Matters underlying these liabilities are discussed in greater detail below.

HMA Matters Recorded at Fair Value

Medicare/Medicaid Billing Lawsuits

Beginning during the week of December 16, 2013, eleven qui tam lawsuits filed by private individuals against HMA were unsealed in various United States district courts. The United States has elected to intervene in all or part of eight of these matters; namely U.S. ex rel. Craig Brummer v. Health Management Associates, Inc. et al. (Middle District Georgia) ("Brummer"); U.S. ex rel. Ralph D. Williams v. Health Management Associates, Inc.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

et al. (Middle District Georgia) ("Williams"); U.S. ex rel. Scott H. Plantz, M.D. et al. v. Health Management Associates, Inc., et al. (Northern District Illinois) ("Plantz"); U.S. ex rel. Thomas L. Mason, M.D. et al. v. Health Management Associates, Inc. et al. (Western District North Carolina) ("Mason"); U.S. ex rel. Jacqueline Meyer, et al. v. Health Management Associates, Inc., Gary Newsome et al. ("Jacqueline Meyer") (District of South Carolina); U.S. ex rel. George Miller, et al. v. Health Management Associates, Inc. (Eastern District of Pennsylvania) ("Miller"); U.S. ex rel. Bradley Nurkin v. Health Management Associates, Inc. et al. (Middle District of Florida) ("Nurkin"); and U.S. ex rel. Paul Meyer v. Health Management Associates, Inc. et al. (Southern District Florida) ("Paul Meyer"). The United States has elected to intervene with respect to allegations in these cases that certain HMA hospitals inappropriately admitted patients and then submitted reimbursement claims for treating those individuals to federal healthcare programs in violation of the False Claims Act or that certain HMA hospitals had inappropriate financial relationships with physicians which violated the Stark law, the Anti-Kickback Statute, and the False Claims Act. Certain of these complaints also allege the same actions violated various state laws which prohibit false claims. The United States has declined to intervene in three of the eleven matters, namely U.S. ex rel. Anita France, et al. v. Health Management Associates, Inc. (Middle District Florida) ("France") which involved allegations of wrongful billing and was settled; U.S. ex rel. Sandra Simmons v. Health Management Associates, Inc. et al. (Eastern District Oklahoma) ("Simmons") which alleges unnecessary surgery by an employed physician and which was settled as to all allegations except alleged wrongful termination; and U.S. ex rel. David Napoliello, M.D. v. Health Management Associates, Inc. (Middle District Florida) ("Napoliello") which alleges inappropriate admissions. On April 3, 2014, the Multi District Litigation Panel ordered the transfer and consolidation for pretrial proceedings of the eight intervened cases, plus the Napoliello matter, to the District of the District of Columbia under the name In Re: Health Management Associates, Inc. Qui Tam Litigation. On June 2, 2014, the court entered a stay of this matter until October 6, 2014, which was subsequently extended until February 27, 2015, May 27, 2015, September 25, 2015, January 25, 2016, May 25, 2016, September 26, 2016, December 27, 2016, April 27, 2017, August 28, 2017, December 18, 2017 and now until March 19, 2018. The Company intends to defend against the allegations in these matters, but also continues to cooperate with the government in the ongoing investigation of these allegations. The Company has been in discussions with the Civil Division of the United States Department of Justice ("DOJ") regarding the resolutions of these matters. During the first quarter of 2015, the Company was informed that the Criminal Division continues to investigate former executive-level employees of HMA, and continues to consider whether any HMA entities should be held criminally liable for the acts of the former HMA employees. The Company is voluntarily cooperating with these inquiries and has not been served with any subpoenas or other legal process.

Other Probable Contingencies

Becker v. Community Health Systems, Inc. d/b/a Community Health Systems Professional Services Corporation d/b/a Community Health Systems d/b/a Community Health Systems PSC, Inc. d/b/a Rockwood Clinic P.S. and Rockwood Clinic, P.S. (Superior Court, Spokane, Washington). This suit was filed on February 29, 2012, by a former chief financial officer at Rockwood Clinic in Spokane, Washington. Becker claims he was wrongfully terminated for allegedly refusing to certify a budget for Rockwood Clinic in 2012. On February 29, 2012, he also filed an administrative complaint with the Department of Labor, Occupational Safety and Health Administration alleging that he is a whistleblower under Sarbanes-Oxley, which was dismissed by the agency and was appealed to an administrative law judge for a hearing that occurred on January 19-26, 2016. In a decision dated November 9, 2016, the law judge awarded Becker approximately $1.9 million for front pay, back pay and emotional damages with attorney fees to be later determined. The Company has appealed the award to the Administrative Review Board and is awaiting its decision. At a hearing on July 27, 2012, the trial court dismissed Community Health Systems, Inc. from the state case and subsequently certified the state case for an interlocutory appeal of the denial to dismiss his employer and the management company. The appellate court accepted the interlocutory appeal, and it was argued on April 30, 2014. On August 14, 2014, the court denied the Company's appeal. On October 20, 2014, the Company filed a petition to review the denial with the Washington

Supreme Court. The appeal was accepted and oral argument was heard on June 9, 2015. On September 15, 2015, the court denied the Company's appeal and remanded to the trial court; a previous trial setting of September 12, 2016 has been vacated and not reset. The Company continues to vigorously defend these actions.

Summary of Recorded Amounts

The table below presents a reconciliation of the beginning and ending liability balances (in millions) during the years ended December 31, 2017 and 2016, with respect to the Company's fair value determination in connection with HMA Legal Matters that were not previously accrued by HMA, and the remaining contingencies of the Company in respect of which an accrual has been recorded. In addition, future legal fees (which are expensed as incurred) and costs related to possible indemnification and criminal investigation matters associated with the HMA Legal Matters have not been accrued or included in the table below. Furthermore, although not accrued, such costs, if incurred, will be taken into account in determining the total amount of reductions applied to the amounts owed to CVR holders.

	CVR-Related Liability at Fair Value	Other Probable Contingencies
Balance as of December 31, 2015	$ 261	$ 10
(Income) expense	(8)	14
Reserve for insured claim	-	1
Cash payments	(1)	(11)
Balance as of December 31, 2016	252	14
Expense	4	14
Cash payments	-	(14)
Balance as of December 31, 2017	$ 256	$ 14

With respect to the "Other Probable Contingencies" referenced in the chart above, in accordance with applicable accounting guidance, the Company establishes a liability for litigation, regulatory and governmental matters for which, based on information currently available, the Company believes that a negative outcome is known or is probable and the amount of the loss is reasonably estimable. For all such matters (whether or not discussed in this contingencies footnote), such amounts have been recorded in other accrued liabilities on the consolidated balance sheet and are included in the table above in the "Other Probable Contingencies" column. Due to the uncertainties and difficulty in predicting the ultimate resolution of these contingencies, the actual amount could differ from the estimated amount reflected as a liability on the consolidated balance sheet.

In the aggregate, attorneys' fees and other costs incurred but not included in the table above related to probable contingencies, and CVR-related contingencies accounted for at fair value, totaled $2 million and $4 million for the years ended December 31, 2017 and 2016, respectively, and are included in other operating expenses in the accompanying consolidated statements of (loss) income.

Matters for which an Outcome Cannot be Assessed

For the following legal matter, due to the uncertainties surrounding the ultimate outcome of the case, the Company cannot at this time assess what the outcome may be and is further unable to determine any estimate of loss or range of loss.

Class Action Shareholder Federal Securities Cases. Three purported class action cases have been filed in the United States District Court for the Middle District of Tennessee; namely, Norfolk County Retirement System

v. Community Health Systems, Inc., et al., filed May 9, 2011; De Zheng v. Community Health Systems, Inc., et al., filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., et al., filed June 21, 2011. All three seek class certification on behalf of purchasers of the Company's common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for the Company's common stock. In December 2011, the cases were consolidated for pretrial purposes and NYC Funds and its counsel were selected as lead plaintiffs/lead plaintiffs' counsel. In lieu of ruling on the Company's motion to dismiss, the court permitted the plaintiffs to file a first amended consolidated class action complaint, which was filed on October 5, 2015. The Company's motion to dismiss was filed on November 4, 2015 and oral argument was held on April 11, 2016. The Company's motion to dismiss was granted on June 16, 2016 and on June 27, 2016, the plaintiffs filed a notice of appeal to the Sixth Circuit Court of Appeals. The matter was heard on May 3, 2017. On December 13, 2017, the Sixth Circuit reversed the trial court's dismissal of the case and remanded it to the District Court. The Company filed a renewed partial motion to dismiss on February 9, 2018. The Company believes this consolidated matter is without merit and will vigorously defend this case.

18. SUBSEQUENT EVENTS

The Company has evaluated all material events occurring subsequent to the balance sheet date for events requiring disclosure or recognition in the consolidated financial statements.

On January 31, 2018, one or more subsidiaries of the Company signed a definitive agreement for the sale of Tennova Healthcare – Jamestown (85 licensed beds) in Jamestown, Tennessee, and its associated assets to subsidiaries of Rennova Health, Inc.

On February 14, 2018, one or more subsidiaries of the Company signed a definitive agreement for the sale of Byrd Regional Hospital (60 licensed beds) in Leesville, Louisiana, and its associated assets to subsidiaries of Allegiance Health Management.

On February 26, 2018, the Credit Facility was amended, with requisite revolving lender approval, to remove the EBITDA to interest expense ratio financial covenant, to replace the senior secured net debt to EBITDA ratio financial covenant with a first lien net debt to EBITDA ratio financial covenant, and to reduce the extended revolving credit commitments to $650 million (for a total of $840 million in revolving credit commitments when combined with the non-extended portion of the revolving credit facility). The new financial covenant provides for a maximum first lien net debt to EBITDA ratio of 5.25 to 1.0, reducing to 5.0 to 1.0 on July 1, 2018, 4.75 to 1.0 on January 1, 2019, 4.5 to 1.0 on January 1, 2020 and 4.25 to 1.0 on July 1, 2020. In addition, CHS agreed pursuant to the amendment to modify its ability to retain asset sale proceeds, and instead to apply them to prepayments of term loans based on pro forma first lien leverage. To the extent the ratio of first lien net debt to EBITDA is greater than or equal to 4.5 to 1.0, 100% of net cash proceeds of asset sales will be applied to prepay term loans; to the extent the first lien leverage ratio is less than 4.5 to 1.0 but greater than or equal to 4.0 to 1.0, 50% of such proceeds will be applied to prepay term loans; and to the extent the first lien leverage ratio is less than 4.0 to 1.0, there will be no requirement to prepay term loans with such proceeds. These ratios will be determined on a pro forma basis giving appropriate effect to the relevant asset sales and corresponding prepayments of term loans.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

19. QUARTERLY FINANCIAL DATA (UNAUDITED)

	Quarter				
	1st	2nd	3rd	4th	Total (2)
	(in millions, except share and per share data)				
Year ended December 31, 2017:					
Net operating revenues	$ 4,486	$ 4,144	$ 3,666	$ 3,059	$ 15,353
Loss from continuing operations before income taxes	(176)	(131)	(147)	(2,379)	(2,833)
Loss from continuing operations	(176)	(116)	(88)	(2,004)	(2,384)
Loss from discontinued operations	(1)	(6)	(2)	(3)	(12)
Net loss attributable to Community Health Systems, Inc.	$ (199)	$ (137)	$ (110)	$ (2,013)	$ (2,459)
Basic loss per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ (1.78)	$ (1.17)	$ (0.96)	$ (17.95)	$ (21.89)
Discontinued operations	(0.01)	(0.06)	(0.02)	(0.03)	(0.11)
Net loss	$ (1.79)	$ (1.22)	$ (0.98)	$ (17.98)	$ (22.00)
Diluted loss per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ (1.78)	$ (1.17)	$ (0.96)	$ (17.95)	$ (21.89)
Discontinued operations	(0.01)	(0.06)	(0.02)	(0.03)	(0.11)
Net loss	$ (1.79)	$ (1.22)	$ (0.98)	$ (17.98)	$ (22.00)
Weighted-average number of shares outstanding:					
Basic	111,252,331	111,909,858	111,935,738	111,971,628	111,769,821
Diluted	111,252,331	111,909,858	111,935,738	111,971,628	111,769,821
Year ended December 31, 2016:					
Net operating revenues	$ 4,999	$ 4,590	$ 4,380	$ 4,469	$ 18,438
Income (loss) from continuing operations before income taxes	63	(1,543)	(83)	(152)	(1,715)
Income (loss) from continuing operations	37	(1,405)	(54)	(189)	(1,611)
Loss from discontinued operations	(1)	(1)	(2)	(9)	(15)
Net income (loss) attributable to Community Health Systems, Inc.	$ 11	$ (1,432)	$ (79)	$ (220)	$ (1,721)
Basic earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ 0.11	$ (12.90)	$ (0.69)	$ (1.91)	$ (15.41)
Discontinued operations	(0.01)	(0.01)	(0.02)	(0.09)	(0.13)
Net income (loss)	$ 0.10	$ (12.91)	$ (0.71)	$ (1.99)	$ (15.54)
Diluted earnings (loss) per share attributable to Community Health Systems, Inc. common stockholders(1):					
Continuing operations	$ 0.11	$ (12.90)	$ (0.69)	$ (1.91)	$ (15.41)
Discontinued operations	(0.01)	(0.01)	(0.02)	(0.09)	(0.13)
Net income (loss)	$ 0.10	$ (12.91)	$ (0.71)	$ (1.99)	$ (15.54)
Weighted-average number of shares outstanding:					
Basic	110,247,867	110,879,285	110,888,040	110,905,052	110,730,971
Diluted	110,309,372	110,879,285	110,888,040	110,905,052	110,730,971

(1) Total per share amounts may not add due to rounding.
(2) Total quarterly amounts may not add due to rounding.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

20. SUPPLEMENTAL CONDENSED CONSOLIDATING FINANCIAL INFORMATION

The Senior Notes due 2019, 2020 and 2022, which are senior unsecured obligations of CHS, the 5 1/8% Senior Secured Notes due 2021, and the 6 1/4% Senior Secured Notes due 2023 (collectively, "the Notes") are guaranteed on a senior basis by the Company and by certain of its existing and subsequently acquired or organized 100% owned domestic subsidiaries. The Notes are fully and unconditionally guaranteed on a joint and several basis, with exceptions considered customary for such guarantees, limited to the release of the guarantee when a subsidiary guarantor's capital stock is sold, or a sale of all of the subsidiary guarantor's assets used in operations. The following condensed consolidating financial statements present Community Health Systems, Inc. (as parent guarantor), CHS (as the issuer), the subsidiary guarantors, the subsidiary non-guarantors and eliminations. These condensed consolidating financial statements have been prepared and presented in accordance with SEC Regulation S-X Rule 3-10 "Financial Statements of Guarantors and Issuers of Guaranteed Securities Registered or Being Registered."

The accounting policies used in the preparation of this financial information are consistent with those elsewhere in the consolidated financial statements of the Company, except as noted below:

- Intercompany receivables and payables are presented gross in the supplemental condensed consolidating balance sheets.
- Cash flows from intercompany transactions are presented in cash flows from financing activities, as changes in intercompany balances with affiliates, net.
- Income tax expense is allocated from the parent guarantor to the income producing operations (other guarantors and non-guarantors) and the issuer through stockholders' (deficit) equity. As this approach represents an allocation, the income tax expense allocation is considered non-cash for statement of cash flow purposes.
- Interest expense, net has been presented to reflect net interest expense and interest income from outstanding long-term debt and intercompany balances.

The Company's intercompany activity consists primarily of daily cash transfers for purposes of cash management, the allocation of certain expenses and expenditures paid for by the Parent on behalf of its subsidiaries, and the push down of investment in its subsidiaries. This activity also includes the intercompany transactions between consolidated entities as part of the Receivables Facility that is further discussed in Note 7. The Company's subsidiaries generally do not purchase services from one another; thus, the intercompany transactions do not represent revenue generating transactions. All intercompany transactions eliminate in consolidation.

From time to time, subsidiaries of the Company sell and/or repurchase noncontrolling interests in consolidated subsidiaries, which may change subsidiaries between guarantors and non-guarantors. Effective with the spin-off of QHC, all subsidiaries of the Company that were part of that distribution have been removed as guarantors. Amounts for prior periods have been revised to reflect the status of guarantors and non-guarantors as of December 31, 2017.

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Loss
Year Ended December 31, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (22)	$ 10,765	$ 7,655	$ -	$ 18,398
Provision for bad debts	-	-	2,063	982	-	3,045
Net operating revenues	-	(22)	8,702	6,673	-	15,353
Operating costs and expenses:						
Salaries and benefits	-	-	3,614	3,762	-	7,376
Supplies	-	-	1,628	1,044	-	2,672
Other operating expenses	-	-	2,376	1,488	-	3,864
Government and other legal settlements and related costs	-	-	(31)	-	-	(31)
Electronic health records incentive reimbursement	-	-	(12)	(16)	-	(28)
Rent	-	-	198	196	-	394
Depreciation and amortization	-	-	501	360	-	861
Impairment and (gain) loss on sale of businesses, net	-	-	1,212	911	-	2,123
Total operating costs and expenses	-	-	9,486	7,745	-	17,231
Loss from operations	-	(22)	(784)	(1,072)	-	(1,878)
Interest expense, net	-	327	587	17	-	931
Loss from early extinguishment of debt	-	40	-	-	-	40
Equity in earnings of unconsolidated affiliates	2,459	1,955	865	-	(5,295)	(16)
Loss from continuing operations before income taxes	(2,459)	(2,344)	(2,236)	(1,089)	5,295	(2,833)
Provision for (benefit from) income taxes	-	115	(297)	(267)	-	(449)
Loss from continuing operations	(2,459)	(2,459)	(1,939)	(822)	5,295	(2,384)
Discontinued operations, net of taxes:						
Loss from operations of entities sold or held for sale	-	-	(4)	(2)	-	(6)
Impairment of hospitals sold or held for sale	-	-	(5)	(1)	-	(6)
Loss from discontinued operations, net of taxes	-	-	(9)	(3)	-	(12)
Net loss	(2,459)	(2,459)	(1,948)	(825)	5,295	(2,396)
Less: Net income attributable to noncontrolling interests	-	-	-	63	-	63
Net loss attributable to Community Health Systems, Inc. stockholders	$ (2,459)	$(2,459)	$ (1,948)	$ (888)	$ 5,295	$ (2,459)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Loss
Year Ended December 31, 2016

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (25)	$ 11,089	$ 10,211	$ -	$ 21,275
Provision for bad debts	-	-	1,707	1,130	-	2,837
Net operating revenues	-	(25)	9,382	9,081	-	18,438
Operating costs and expenses:						
Salaries and benefits	-	-	3,754	4,870	-	8,624
Supplies	-	-	1,660	1,351	-	3,011
Other operating expenses	-	-	2,238	2,010	-	4,248
Government and other legal settlements and related costs	-	-	16	-	-	16
Electronic health records incentive reimbursement	-	-	(37)	(33)	-	(70)
Rent	-	-	199	251	-	450
Depreciation and amortization	-	-	614	486	-	1,100
Impairment and (gain) loss on sale of businesses, net	-	-	1,262	657	-	1,919
Total operating costs and expenses	-	-	9,706	9,592	-	19,298
Loss from operations	-	(25)	(324)	(511)	-	(860)
Interest expense, net	-	241	631	90	-	962
Loss from early extinguishment of debt	-	30	-	-	-	30
Gain on sale of investments in unconsolidated affiliates	-	-	(94)	-	-	(94)
Equity in earnings of unconsolidated affiliates	1,721	1,466	585	-	(3,815)	(43)
Loss from continuing operations before income taxes	(1,721)	(1,762)	(1,446)	(601)	3,815	(1,715)
(Benefit from) provision for income taxes	-	(41)	19	(82)	-	(104)
Loss from continuing operations	(1,721)	(1,721)	(1,465)	(519)	3,815	(1,611)
Discontinued operations, net of taxes:						
(Loss) income from operations of entities sold or held for sale	-	-	(9)	2	-	(7)
Impairment of hospitals sold or held for sale	-	-	(1)	(7)	-	(8)
Loss from discontinued operations, net of taxes	-	-	(10)	(5)	-	(15)
Net loss	(1,721)	(1,721)	(1,475)	(524)	3,815	(1,626)
Less: Net income attributable to noncontrolling interests	-	-	-	95	-	95
Net loss attributable to Community Health Systems, Inc. stockholders	$ (1,721)	$(1,721)	$ (1,475)	$ (619)	$ 3,815	$ (1,721)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Income
Year Ended December 31, 2015

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Operating revenues (net of contractual allowances and discounts)	$ -	$ (20)	$ 11,063	$ 11,521	$ -	$ 22,564
Provision for bad debts	-	-	1,944	1,183	-	3,127
Net operating revenues	-	(20)	9,119	10,338	-	19,437
Operating costs and expenses:						
Salaries and benefits	-	-	3,688	5,303	-	8,991
Supplies	-	-	1,586	1,462	-	3,048
Other operating expenses	-	-	2,120	2,400	-	4,520
Government and other legal settlements and related costs	-	-	4	-	-	4
Electronic health records incentive reimbursement	-	-	(76)	(84)	-	(160)
Rent	-	-	189	268	-	457
Depreciation and amortization	-	-	615	557	-	1,172
Impairment and (gain) loss on sale of businesses, net	-	-	55	13	-	68
Total operating costs and expenses	-	-	8,181	9,919	-	18,100
(Loss) income from operations	-	(20)	938	419	-	1,337
Interest expense, net	-	107	717	149	-	973
Loss from early extinguishment of debt	-	16	-	-	-	16
Equity in earnings of unconsolidated affiliates	(158)	(220)	(125)	-	440	(63)
Income from continuing operations before income taxes	158	77	346	270	(440)	411
(Benefit from) provision for income taxes	-	(81)	130	67	-	116
Income from continuing operations	158	158	216	203	(440)	295
Discontinued operations, net of taxes:						
Loss from operations of entities sold or held for sale	-	-	(7)	(20)	-	(27)
Impairment of hospitals sold or held for sale	-	-	-	(5)	-	(5)
Loss on sale, net	-	-	-	(4)	-	(4)
Loss from discontinued operations, net of taxes	-	-	(7)	(29)	-	(36)
Net income	158	158	209	174	(440)	259
Less: Net income attributable to noncontrolling interests	-	-	-	101	-	101
Net income attributable to Community Health Systems, Inc. stockholders	$ 158	$ 158	$ 209	$ 73	$ (440)	$ 158

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Comprehensive Loss
Year Ended December 31, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net loss	$(2,459)	$(2,459)	$(1,948)	$(825)	$5,295	$(2,396)
Other comprehensive income, net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	19	19	-	-	(19)	19
Net change in fair value of available-for-sale securities, net of tax	8	8	8	-	(16)	8
Amortization and recognition of unrecognized pension cost components, net of tax	14	14	14	-	(28)	14
Other comprehensive income	41	41	22	-	(63)	41
Comprehensive loss	(2,418)	(2,418)	(1,926)	(825)	5,232	(2,355)
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	63	-	63
Comprehensive loss attributable to Community Health Systems, Inc. stockholders	$ (2,418)	$ (2,418)	$ (1,926)	$ (888)	$ 5,232	$ (2,418)

Condensed Consolidating Statement of Comprehensive Loss
Year Ended December 31, 2016

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net loss	$ (1,721)	$(1,721)	$ (1,475)	$ (524)	$ 3,815	$ (1,626)
Other comprehensive income (loss), net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	17	17	-	-	(17)	17
Net change in fair value of available-for-sale securities, net of tax	(11)	(11)	(11)	-	22	(11)
Amortization and recognition of unrecognized pension cost components, net of tax	3	3	3	-	(6)	3
Other comprehensive income (loss)	9	9	(8)	-	(1)	9
Comprehensive loss	(1,712)	(1,712)	(1,483)	(524)	3,814	(1,617)
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	95	-	95
Comprehensive loss attributable to Community Health Systems, Inc. stockholders	$ (1,712)	$(1,712)	$ (1,483)	$ (619)	$ 3,814	$ (1,712)

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Comprehensive Income
Year Ended December 31, 2015

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net income	$ 158	$ 158	$ 209	$ 174	$ (440)	$ 259
Other comprehensive (loss) income, net of income taxes:						
Net change in fair value of interest rate swaps, net of tax	(6)	(6)	-	-	6	(6)
Net change in fair value of available-for-sale securities, net of tax	(5)	(5)	(5)	-	10	(5)
Amortization and recognition of unrecognized pension cost components, net of tax	1	1	1	-	(2)	1
Other comprehensive loss	(10)	(10)	(4)	-	14	(10)
Comprehensive income	148	148	205	174	(426)	249
Less: Comprehensive income attributable to noncontrolling interests	-	-	-	101	-	101
Comprehensive income attributable to Community Health Systems, Inc. stockholders	$ 148	$ 148	$ 205	$ 73	$ (426)	$ 148

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Balance Sheet
December 31, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ -	$ -	$ 497	$ 66	$ -	$ 563
Patient accounts receivable, net of allowance for doubtful accounts	-	-	355	2,029	-	2,384
Supplies	-	-	288	156	-	444
Prepaid income taxes	17	-	-	-	-	17
Prepaid expenses and taxes	-	-	146	52	-	198
Other current assets	-	-	152	310	-	462
Total current assets	17	-	1,438	2,613	-	4,068
Intercompany receivable	-	13,381	5,857	7,109	(26,347)	-
Property and equipment, net	-	-	4,448	2,604	-	7,052
Goodwill			2,882	1,841	-	4,723
Deferred income taxes	62	-	-	-	-	62
Other assets, net	15	39	1,594	939	(1,042)	1,545
Net investment in subsidiaries	-	21,717	10,890	-	(32,607)	-
Total assets	$ 94	$35,137	$ 27,109	$ 15,106	$ (59,996)	$ 17,450
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$ -	$ -	$ 25	$ 8	$ -	$ 33
Accounts payable	-	-	663	304	-	967
Accrued interest	-	228	-	1	-	229
Accrued liabilities	-	-	644	483	-	1,127
Total current liabilities	-	228	1,332	796	-	2,356
Long-term debt	-	12,998	216	666	-	13,880
Intercompany payable	833	21,582	24,028	13,310	(59,753)	-
Deferred income taxes	19	-	-	-	-	19
Other long-term liabilities	9	1,018	997	378	(1,042)	1,360
Total liabilities	861	35,826	26,573	15,150	(60,795)	17,615
Redeemable noncontrolling interests in equity of consolidated subsidiaries	-	-	-	527	-	527
Equity:						
Community Health Systems, Inc. stockholders' (deficit) equity:						
Common stock	1	-	-	-	-	1
Additional paid-in capital	2,014	(252)	204	234	(186)	2,014
Accumulated other comprehensive loss	(21)	(21)	(4)	(4)	29	(21)
(Accumulated deficit) retained earnings	(2,761)	(416)	336	(876)	956	(2,761)
Total Community Health Systems, Inc. stockholders' (deficit) equity	(767)	(689)	536	(646)	799	(767)
Noncontrolling interests in equity of consolidated subsidiaries	-	-	-	75	-	75
Total (deficit) equity	(767)	(689)	536	(571)	799	(692)
Total liabilities and equity	$ 94	$35,137	$ 27,109	$ 15,106	$ (59,996)	$ 17,450

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Balance Sheet
December 31, 2016

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
ASSETS						
Current assets:						
Cash and cash equivalents	$ -	$ -	$ 174	$ 64	$ -	$ 238
Patient accounts receivable, net of allowance for doubtful accounts	-	-	799	2,377	-	3,176
Supplies	-	-	297	183	-	480
Prepaid income taxes	17	-	-	-	-	17
Prepaid expenses and taxes	-	-	124	63	-	187
Other current assets	-	-	158	410	-	568
Total current assets	17	-	1,552	3,097	-	4,666
Intercompany receivable	295	14,996	3,150	7,597	(26,038)	-
Property and equipment, net	-	-	4,965	3,184	-	8,149
Goodwill	-	-	3,947	2,574	-	6,521
Deferred income taxes	15	-	-	-	-	15
Other assets, net	-	-	1,869	1,946	(1,222)	2,593
Net investment in subsidiaries	1,728	21,224	10,122	-	(33,074)	-
Total assets	$ 2,055	$36,220	$ 25,605	$ 18,398	$ (60,334)	$ 21,944
LIABILITIES AND EQUITY						
Current liabilities:						
Current maturities of long-term debt	$ -	$ 149	$ 53	$ 253	$ -	$ 455
Accounts payable	-	-	628	367	-	995
Accrued interest	-	205	1	1	-	207
Accrued liabilities	17	-	626	587	-	1,230
Total current liabilities	17	354	1,308	1,208	-	2,887
Long-term debt	-	14,018	232	539	-	14,789
Intercompany payable	-	18,861	20,517	15,071	(54,449)	-
Deferred income taxes	411	-	-	-	-	411
Other long-term liabilities	12	1,259	1,082	444	(1,222)	1,575
Total liabilities	440	34,492	23,139	17,262	(55,671)	19,662
Redeemable noncontrolling interests in equity of consolidated subsidiaries	-	-	-	554	-	554
Equity:						
Community Health Systems, Inc. stockholders' equity:						
Common stock	1	-	-	-	-	1
Additional paid-in capital	1,975	675	939	768	(2,382)	1,975
Accumulated other comprehensive loss	(62)	(62)	(22)	(9)	93	(62)
(Accumulated deficit) retained earnings	(299)	1,115	1,549	(290)	(2,374)	(299)
Total Community Health Systems, Inc. stockholders' equity	1,615	1,728	2,466	469	(4,663)	1,615
Noncontrolling interests in equity of consolidated subsidiaries	-	-	-	113	-	113
Total equity	1,615	1,728	2,466	582	(4,663)	1,728
Total liabilities and equity	$ 2,055	$36,220	$ 25,605	$ 18,398	$ (60,334)	$ 21,944

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2017

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net cash (used in) provided by operating activities	$ (12)	$ (317)	$ 750	$ 352	$ -	$ 773
Cash flows from investing activities:						
Acquisitions of facilities and other related businesses	-	-	(1)	(5)	-	(6)
Purchases of property and equipment	-	-	(365)	(199)	-	(564)
Proceeds from disposition of hospitals and other ancillary operations	-	-	596	1,096	-	1,692
Proceeds from sale of property and equipment	-	-	4	3	-	7
Purchases of available-for-sale securities	-	-	(91)	(34)	-	(125)
Proceeds from sales of available-for-sale securities	-	-	154	54	-	208
Increase in other investments	-	-	(106)	(37)	-	(143)
Net cash provided by investing activities	-	-	191	878	-	1,069
Cash flows from financing activities:						
Repurchase of restricted stock shares for payroll tax withholding requirements	(5)	-	-	-	-	(5)
Deferred financing costs and other debt-related costs	-	(65)	-	(1)	-	(66)
Proceeds from noncontrolling investors in joint ventures	-	-	-	5	-	5
Redemption of noncontrolling investments in joint ventures	-	-	-	(6)	-	(6)
Distributions to noncontrolling investors in joint ventures	-	-	-	(100)	-	(100)
Changes in intercompany balances with affiliates, net	17	1,566	(575)	(1,008)	-	-
Borrowings under credit agreements	-	795	30	16	-	841
Issuance of long-term debt	-	3,100	-	-	-	3,100
Proceeds from receivables facility	-	-	-	105	-	105
Repayments of long-term indebtedness	-	(5,079)	(73)	(239)	-	(5,391)
Net cash provided by (used in) financing activities	12	317	(618)	(1,228)	-	(1,517)
Net change in cash and cash equivalents	-	-	323	2	-	325
Cash and cash equivalents at beginning of period	-	-	174	64	-	238
Cash and cash equivalents at end of period	$ -	$ -	$ 497	$ 66	$ -	$ 563

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2016

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net cash provided by (used in) operating activities	$ 14	$ (335)	$ 1,218	$ 240	$ -	$ 1,137
Cash flows from investing activities:						
Acquisitions of facilities and other related businesses	-	-	(3)	(120)	-	(123)
Purchases of property and equipment	-	-	(474)	(270)	-	(744)
Proceeds from disposition of hospitals and other ancillary operations	-	-	16	127	-	143
Proceeds from sale of property and equipment	-	-	6	9	-	15
Purchases of available-for-sale securities	-	-	(263)	(242)	-	(505)
Proceeds from sales of available-for-sale securities	-	-	218	246	-	464
Proceeds from sale of investments in unconsolidated affiliates	-	-	403	-	-	403
Distribution from Quorum Health Corporation	-	1,219	-	-	-	1,219
Increase in other investments	-	-	(156)	(86)	-	(242)
Net cash provided by (used in) investing activities	-	1,219	(253)	(336)	-	630
Cash flows from financing activities:						
Repurchase of restricted stock shares for payroll tax withholding requirements	(6)	-	-	-	-	(6)
Deferred financing costs and other debt-related costs	-	(26)	-	-	-	(26)
Redemption of noncontrolling investments in joint ventures	-	-	-	(19)	-	(19)
Distributions to noncontrolling investors in joint ventures	-	-	-	(92)	-	(92)
Changes in intercompany balances with affiliates, net	(8)	801	(925)	132	-	-
Proceeds from sale-lease back	-	-	147	12	-	159
Borrowings under credit agreements	-	4,848	28	3	-	4,879
Proceeds from receivables facility	-	-	-	107	-	107
Repayments of long-term indebtedness	-	(6,507)	(64)	(144)	-	(6,715)
Net cash (used in) provided by financing activities	(14)	(884)	(814)	(1)	-	(1,713)
Net change in cash and cash equivalents	-	-	151	(97)	-	54
Cash and cash equivalents at beginning of period	-	-	23	161	-	184
Cash and cash equivalents at end of period	$ -	$ -	$ 174	$ 64	$ -	$ 238

COMMUNITY HEALTH SYSTEMS, INC. AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – (Continued)

Condensed Consolidating Statement of Cash Flows
Year Ended December 31, 2015

	Parent Guarantor	Issuer	Other Guarantors	Non - Guarantors	Eliminations	Consolidated
			(In millions)			
Net cash (used in) provided by operating activities	$ (25)	$ 159	$ 349	$ 438	$ -	$ 921
Cash flows from investing activities:						
Acquisitions of facilities and other related businesses	-	-	(21)	(36)	-	(57)
Purchases of property and equipment	-	-	(600)	(353)	-	(953)
Proceeds from disposition of hospitals and other ancillary operations	-	-	21	134	-	155
Proceeds from sale of property and equipment	-	-	6	9	-	15
Purchases of available-for-sale securities	-	-	(53)	(109)	-	(162)
Proceeds from sales of available-for-sale securities	-	-	46	110	-	156
Increase in other investments	-	-	(143)	(62)	-	(205)
Net cash used in investing activities	-	-	(744)	(307)	-	(1,051)
Cash flows from financing activities:						
Proceeds from exercise of stock options	25	-	-	-	-	25
Repurchase of restricted stock shares for payroll tax withholding requirements	(20)	-	-	-	-	(20)
Stock buy-back	(159)	-	-	-	-	(159)
Deferred financing costs and other debt-related costs	-	(30)	-	-	-	(30)
Proceeds from noncontrolling investors in joint ventures	-	-	-	47	-	47
Redemption of noncontrolling investments in joint ventures	-	-	-	(36)	-	(36)
Distributions to noncontrolling investors in joint ventures	-	-	-	(100)	-	(100)
Changes in intercompany balances with affiliates, net	179	(181)	89	(87)	-	-
Borrowings under credit agreements	-	4,880	34	8	-	4,922
Proceeds from receivables facility	-	-	-	206	-	206
Repayments of long-term indebtedness	-	(4,828)	(77)	(145)	-	(5,050)
Net cash provided by (used in) financing activities	25	(159)	46	(107)	-	(195)
Net change in cash and cash equivalents	-	-	(349)	24	-	(325)
Cash and cash equivalents at beginning of period	-	-	372	137	-	509
Cash and cash equivalents at end of period	$ -	$ -	$ 23	$ 161	$ -	$ 184

Proof of Publication

MAR 14 '18 PM 2:55

Cleveland Daily Banner

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

See Attached

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__ times in said newspaper and online at www.clevelandbanner.com and www.tnpublicnotice.com on the following dates, to wit:
Notice- Tennova Legal Intent ad#218262
March 9, 2018 3col x 11.5"

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

Three hundred forty-eight dollars and 45/100

$_348.45_

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 March 2018.

Vicky Guy
Notary Public

VICKY GUY
STATE OF TENNESSEE NOTARY PUBLIC
BRADLEY COUNTY

My Commission expires:

12/21/2021

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor

502Nashville, TN 37243 Deaderick Street
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

PUBLICATION OF INTENT

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

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland, the existing Hospital in Bradley County owned by Cleveland Hospital Company, LLC with an ownership type of Limited Liability Corporation and to be managed by Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland (itself) intends to file an application for a Certificate of Need for establishment of a Freestanding Emergency Department or "FSED". The FSED will be a provider-based (satellite) Emergency Department of Tennova Healthcare – Cleveland. The proposed FSED will include 8 treatment rooms providing emergency treatment services, and will include ancillary services including but not limited to medical lab, CT, X-Ray, and ultrasound.

The FSED will be located at 680 Stuart Road NE, Cleveland, Tennessee 37312. This street address and location is currently an undeveloped 2.44 acreage parcel of land. The total project cost is estimated to be $12,081,195. This project involves no new licensed inpatient beds, no new healthcare services being initiated, and no major medical equipment.

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

The contact person for this project is Lisa Childers, Assistant Chief Executive Officer, who may be reached at Tennova Healthcare – Cleveland, 2305 Chambliss Avenue, Cleveland, TN 37311, phone number (423) 559-6597.

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 and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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.

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

Lisa Childers, Assistant Chief Executive Officer
Tennova Healthcare-Cleveland
2305 Chambliss Avenue
Cleveland, TN 37311

RE: Certificate of Need Application – Cleveland TN Hospital Company, LLC d/b/a Tennova Healthcare-Cleveland - CN1803-015
The establishment of a satellite emergency department facility with eight treatment rooms at 680 Stuart Road NE, Cleveland (Bradley County), TN. The applicant is owned by Cleveland Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland. It will be under the administrative control of Tennova Healthcare-Cleveland and will operate as an outpatient department of the hospital. The estimated project cost is $12,081,195.

Dear Ms. Childers:

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):

(4) 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.

(5) 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
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
Cleveland TN Hospital Company, LLC d/b/a Tennova Healthcare-Cleveland - CN1803-015

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: Lisa Childers

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

MAR 19 PM 2:06

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 March 9, 2018, for one day.

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland, the existing Hospital in Bradley County owned by Cleveland Hospital Company, LLC with an ownership type of Limited Liability Corporation and to be managed by Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland (itself) intends to file an application for a Certificate of Need for establishment of a Freestanding Emergency Department or "FSED". The FSED will be a provider-based (satellite) Emergency Department of Tennova Healthcare – Cleveland. The proposed FSED will include 8 treatment rooms providing emergency treatment services, and will include ancillary services including but not limited to medical lab, CT, X-Ray, and ultrasound.

The FSED will be located at 680 Stuart Road NE, Cleveland, Tennessee 37312. This street address and location is currently an undeveloped 2.44 acreage parcel of land. The total project cost is estimated to be $12,081,195. This project involves no new licensed inpatient beds, no new healthcare services being initiated, and no major medical equipment.

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

The contact person for this project is Lisa Childers, Assistant Chief Executive Officer, who may be reached at Tennova Healthcare – Cleveland, 2305 Chambliss Avenue, Cleveland, TN 37311, phone number (423) 559-6597.

Lisa Childers	3/7/18	Lisa.Childers@mytennova.com
Signature	Date	Email

==========

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 and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

==========

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.

==========

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor

502Nashville, TN 37243 Deaderick Street
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

PUBLICATION OF INTENT

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

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland, the existing Hospital in Bradley County owned by Cleveland Hospital Company, LLC with an ownership type of Limited Liability Corporation and to be managed by Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland (itself) intends to file an application for a Certificate of Need for establishment of a Freestanding Emergency Department or "FSED". The FSED will be a provider-based (satellite) Emergency Department of Tennova Healthcare – Cleveland. The proposed FSED will include 8 treatment rooms providing emergency treatment services, and will include ancillary services including but not limited to medical lab, CT, X-Ray, and ultrasound.

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

The contact person for this project is Lisa Childers, Assistant Chief Executive Officer, who may be reached at Tennova Healthcare – Cleveland, 2305 Chambliss Avenue, Cleveland, TN 37311, phone number (423) 559-6597.

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 and Development Agency
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502 Deaderick Street
Nashville, Tennessee 37243

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.

Supplemental #1 (Original)

Cleveland TN Hospital Company, LLC dba Tennova Healthcare-Cleveland

CN1803-015

2018 MAR 28 PM 3:59

Tennova Healthcare

Supplemental #1
March 28, 2018
3:58 P.M.

Supplemental Information
Certificate of Need Application CN1803-015
Cleveland TN Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland
Establishment of a Satellite Emergency Department (FSED)

Please see the following Supplemental Information provided in response to the March 23, 2018 letter from Philip M. Earhart, HSD Examiner requesting clarification or additional information on the Certificate of Need Application CN1803-015 submitted to HSDA on March 14, 2018.

1. **Section A, Applicant Profile, Item 1**

   Please include the address of the proposed FSED rather than the main campus address and submit a replacement page 1 labeled as 1R.

RESPONSE: The address of the proposed Tennova Cleveland FSED is 680 Stuart Road, Northeast, Cleveland, Tennessee 37312. A replacement page 1 is included as Attachment 1.

2. **Section A, Applicant Profile, Item 2**

   The contact number of (423) 559-6101 for Lisa Childers, ACEO is noted. However, the Letter of Intent (LOI) notes the phone number is (423) 559-6597. Please clarify.

RESPONSE: The main contact number for Lisa Childers, ACEO, is (423) 559-6101.

3. **Section A, Executive Summary**

   It appears Stuart Road is a four lane road with a turning lane. According to TDOT, what is the average traffic count for Stuart Road?

RESPONSE: The Annual Average Daily Traffic (AADT) count for Stuart Road that is closest to the location of the proposed FSED is Station 000130, Route 03647, located less than half a mile (1/2 mile) from the site. In 2016, the most recent data available, the AADT count was 24,378 for this segment of Stuart Road. The traffic count in 2016 is an increase of 13.4% over the past five years, when the 2011 traffic count was 21,505 for this same segment of Stuart Road.

What is the distance of the proposed FSED from Hwy. 11 and I-75?

RESPONSE: The proposed FSED is located 0.7 miles from U.S. Highway 11, which is northwest of the site. I-75 is located 2.0 miles from the proposed FSED, northwest along Stuart Road as it becomes Paul Huff Parkway.

It appears Paul Huff Parkway intersects with I-75 and turns into Stuart Road. Please clarify if there is an exit at I-75 and Paul Huff Parkway.

RESPONSE: Yes, Exit 27 is a full interstate interchange/exit off I-75 for Paul Huff Parkway. (A full interstate interchange allows for on and off ramps for both north and southbound traffic.) Notably, the Exit 27 area encompasses a significant amount of commercial development, including the Bradley Square Mall retail area located along Paul Huff Parkway between I-75 and U.S. Highway 11.

Please indicate if the proposed FSED will have any trauma designations.

RESPONSE: The proposed FSED will not have a trauma designation. However, Tennova Cleveland is proposing to offer the same level of emergency services at the FSED as are currently available on the main hospital campus, including caring for high-acuity patients.

What is the distance from the proposed satellite ED site to Tennova Healthcare Cleveland located at 2305 Chambliss Avenue, NW, Cleveland, TN, Erlanger Medical Center located at 975 East Third Street, Chattanooga, TN 37403 and Children's Hospital @ Erlanger 910 Blackford Street, Chattannoga, TN 37403? Also, in your response please note whether the distance is east or west of the proposed facility.

RESPONSE: The distances from the proposed Tennova Cleveland FSED to the three identified hospitals, along with the direction from the proposed FSED site, is provided in the table below.

Table 1 – Supplemental Information
Distances and Direction from Select Hospitals to the Proposed FSED

Hospital	Distance from Proposed FSED	Direction to Hospital from Proposed FSED
Tennova Healthcare Cleveland	2.8 Miles	Southwest
Erlanger Medical Center	35.2 Miles	Southwest
Children's Hospital at Erlanger	35.4 Miles	Southwest

Source: Google Maps.
Note: addresses for the identified hospitals are those listed in the question. The address for the FSED is 680 Stuart Road NE, Cleveland TN 37312.

Please clarify if Tennova Healthcare Cleveland is a designated burn center. If not, where are burn patients referred for treatment?

RESPONSE: Tennova Healthcare – Cleveland (the Host Hospital) is not a designated burn center. Currently, burn patients requiring an inpatient admission or additional burn-related care are referred from Tennova Cleveland to Joseph M. Still Burn Center Network, which has

hospitals in Atlanta and Augusta, Georgia. In 2017, a total of 9 patients were transferred to the Burn Center Network two hospitals in Georgia for burn care.

Please indicate how many patients were referred to Erlanger Medical Center's Trauma Units in 2017 from Tennova Healthcare-Cleveland.

RESPONSE: Tennova Cleveland does not specifically identify trauma as a diagnosis or reason for transfer in its electronic medical record. However, the hospital has estimated that 200 patients were transferred to Erlanger Medical Center ("Erlanger") in Chattanooga for trauma-related care in 2017, based on the patient's presenting diagnosis and/or need for discharge to a higher level of care from the hospital's Emergency Department ("ED"). These patients represent a variety of injuries including falls, motor vehicle accidents, severe animal bites, and significant damage to or loss of hands or appendages.

All patients requiring trauma care are transferred to Erlanger Medical Center in Chattanooga, except burn cases which are transferred to Atlanta or Augusta, Georgia. The 200 patients transferred in 2017 include 32 pediatric transfers, accounting for 16% of the total trauma transfers from the Tennova Cleveland's main hospital ED.

In 2017 what was Tennova Healthcare Cleveland's percentage of charity care in relation to gross sales compared to the hospital industry average for Tennessee?

RESPONSE: Tennova Cleveland's Charity Care provisions totaled $62,489,080 in 2017, 4.9% of Gross Operating Revenue which was $1,274,091,292 in 2017. That compares to the hospital industry average for Tennessee of 2.4% for 2016, the most recent data available.

What are the advantages for a service area patient in need of emergency services to bypass a full service hospital (Tennova Healthcare Cleveland) that has a diagnostic and therapeutic cath lab and go to a satellite ED?

RESPONSE: First, it must be noted that Tennova Cleveland currently provides diagnostic and non-emergent therapeutic cath services at its main hospital, and will continue to do so following implementation of the proposed FSED. Importantly, emergency therapeutic cath services will be implemented at Tennova Cleveland in July 2018 so that all patients presenting to the ED, including those with an 'active heart attack' (STEMI patients) can be quickly treating at the presenting ED rather than transported to a distant hospital in Chattanooga.

Tennova Cleveland expects most patients experiencing a cardiac emergency to arrive at the main hospital ED (either by ambulance or personal vehicle) because of the 24/7/365 cardiac care available at the hospital, rather than going to the FSED for cardiac care. To this end, Tennova Cleveland intends to educate the service area about the advantages of timely seeking cardiac emergency care, and doing so at the hospital which has the full capabilities to care for patients with no need to transport, and thus delay cardiac care.

Second, it must be noted that Tennova Cleveland's proposed FSED will provide the same level of emergency services as its main hospital campus ED, thus will be able to care for high-

acuity patients at the FSED. For those patients who present to Tennova Cleveland's FSED with the need for an emergency cath, they will be quickly transferred a short distance (approximately 3 miles) to the main hospital campus for an emergency cardiac cath.

Third and finally, the proposed FSED will allow patients to obtain needed emergency services in a convenient, smaller, outpatient-focused facility that is located in the most populated and fastest-growing northern part of the county, near the significant residential, retail, and commercial/industrial growth along the Highway 11 corridor. Thus, the proposed FSED will oftentimes be more proximate to the residents requiring emergency services than the hospital's main campus, so that residents are not bypassing the hospital to reach the FSED.

What experience does the applicant have in operating an FSED?

RESPONSE: Tennova Cleveland will draw upon CHS' experience operating FSED throughout the U.S. As shown below, CHS (Tennova Cleveland's ultimate parent) affiliates currently operate nine (9) FSEDs, including the Clarksville-Sango FSED which opened in 2017 in Clarksville, Tennessee.

The 9 FSEDs include:

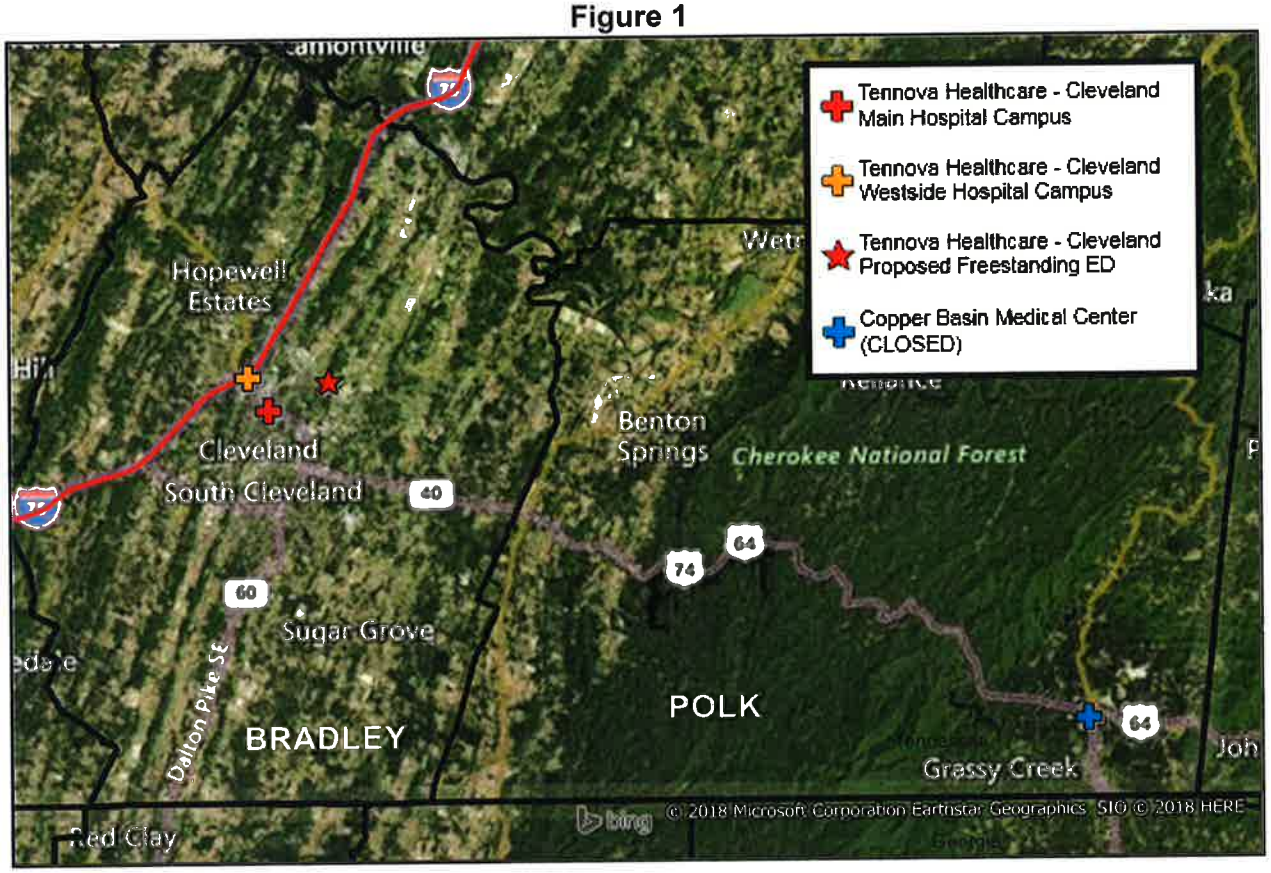
1. FSED/Sango (Clarksville, TN)
2. Emergency Center at Timberidge (Ocala, FL)
3. Detar North (Victoria, TX)
4. Portage Hospital Campus (Portage, IN)
5. Northwest ER at Vail (Tucson, AZ)
6. Valparaiso Medical Center (Valparaiso, IN)
7. Cedar Park Emergency Center/Leander (Leander, TX)
8. Lutheran ER/Statewood (Fort Wayne, IN)
9. FSED on Main (Las Cruces, NM)

Please provide a map that includes Tennova Cleveland's main and satellite campus as well as other facilities, the proposed satellite ED site, and location of the closed Copper Basin Hospital.

RESPONSE: Please see the following map showing the locations of the hospital's existing campuses, proposed FSED, and the closed Copper Basin Medical Center.

Supplemental #1
March 28, 2018
3:58 P.M.

Figure 1



What is the distance from the proposed ED site to Chattanooga's Volkswagen Assembly plant?

RESPONSE: The distance from Tennova Cleveland's proposed FSED to the Volkswagen Assembly plant in Chattanooga is 21.7 miles. (Source: Google Maps.) For comparison purposes, it should be noted that the Volkswagen plant employs approximately 2,000 employees while Bradley County manufacturing plants employ significantly more. Also, the Volkswagen assembly plant in Hamilton County is located in close proximity to Chattanooga area hospitals with emergency services.

Specific to the Bradley County manufacturing and commercial plants, those companies employ more than 7,200 employees, as shown on CON application p. 42 (Table 23). The proposed Tennova Cleveland FSED will provide more geographically accessible emergency services to the many manufacturing and logistics employers in the northern Cleveland and Bradley County area.

4. **Section A, Project Details, Item 6A.**

   Please provide documentation that the Seller, The Estate of Joe Corn Stuart, owns the land.

RESPONSE: Please refer Attachment 2 for a copy of the Warranty Deed for the property.

5. **Section A, 6.B (1) Plot Plan**

   The plot plan is noted. Please label the size of site (in acres) and submit a revised plot plan.

RESPONSE: Please refer to Attachment 3 for a revised copy of the plot plan for the property, indicating the 2.44 acres of the site.

It is noted the proposed project will not include a helipad. In another part of the application, the applicant notes the parking lot may be used as a helicopter landing area. Please explain the reason a helipad was not included in the design of the FSED. If needed, is there room for expansion that includes a helipad.

RESPONSE: The proposed FSED does not include a helipad as part of the development of the facility, as the FSED is not a primary destination point for patients arriving by air transport. The primary method of arrival for patients will be either personal vehicle or ambulance/EMS. In the event of a large scale event (tornado, industrial incident, interstate multi-car accident) in which both the main campus of Tennova Cleveland and the proposed FSED will be required to receive patients via air transport, the parking area of the facility can and will be utilized for helicopter landings. As noted in the original application, the parking area of the facility will also be utilized in the event that a patient at the FSED must be transported by air to a distant tertiary care hospital.

6. **Section A, 6.B (2) Floor Plan**

Please complete the following chart for the applicant's existing hospital EDs and the proposed satellite ED.

Table 2 – Supplemental Information Existing and Proposed Satellite ED Room Configuration			
Patient Care Areas other than Ancillary Services	**# Current Hospital ED**	**# Proposed Satellite ED**	**# Proposed Combined EDs**
Exam/Treatment Rooms			
Multipurpose	26	6	32
Gynecological	2		2
Holding/Secure/Psychiatric	5		5
Isolation	2	1	3
Orthopedic	1		1
Trauma (Major Exam Room)	4	1	5
Other (ENT)	1		1
Total	**41**	**8**	**49**
Useable SF of Main and Satellite ED's	28,280 sf	9,025 sf	37,305 sf

What are the dimensions of the proposed project's waiting room? Is a waiting room capacity of 15 adequate for 8 treatment rooms?

RESPONSE: The dimensions of the waiting room for the proposed FSED are 13x18 for a total of 234 square feet, excluding the general circulation area at the main entrance of the facility. The proposed FSED is designed to transfer patients and family members in a timely manner from the waiting area to a treatment room, so that the waiting room design and size is sufficient to handle the normal flow of patients and family members in the facility.

Notably, the design of Tennova Cleveland's FSED resembles the design of the existing FSED in Clarksville operated by Tennova Healthcare, which is meeting patients and family's needs while operating efficiently.

7. **Section A, Project Details, Item 10 (a) Bed Complement Data Chart**

The Bed Complement Chart is noted. However, the beds total 260 in the last column not 251 as indicated. Please correct and submit a replacement page 13 labeled as 13R.

RESPONSE: The bed complement chart in the submitted application included a typographical error in the bed total for Pediatrics. A corrected replacement page 13 is included as Attachment 4.

8. **Section B, Need, Item 1 (Project Specific Criteria-Freestanding ED)**

   D. Other Applicable Data Related to Need and Capacity

   The chart on page 30 of the application has N/A listed for the statewide averages pertaining to % of Patients Age 65+ and % of Behavioral Health Patients. This data should be available from the Department of Health, Health Statistics.

   Please provide this data.

RESPONSE: The statewide percentages of behavioral health patients, high-acuity patients, and patients age 65 and older are provided in the following chart.

Table 3 – Supplemental Information
Additional Data to Demonstrate Need in the Proposed Service Area

Emergency Department	% of Behavioral Health Patients	Statewide Average	% of High Acuity Patients*	Statewide Average	% of Patients Ages 65+	Statewide Average
Tennova Cleveland	4.5%	1.8%	63.5%	47.7%	20.4%	14.4%

Sources & Notes:
Tennessee Department of Health, Division of Policy, Planning and Assessment. Hospital Discharge Data System, 2016. Nashville, TN. (Provided by Tennessee Department of Health.)
Tennova Cleveland internal data. Data is for CY2017.
*Includes high acuity cases identified by CPT codes 99285, 99284.

9. **Section B, Need, Item 1 (Project Specific Criteria-Freestanding ED)-**

   2. Expansion of Existing Emergency Department Facility

   It appears that in Table 12 on page 31, the applicant has provided the bed quantity standards from the ACEP Guidelines. Please provide the host hospital's actual number of ED beds, Visits/Bed, and Estimated Area/Bed.

RESPONSE: Please see the table below.

Table 4 – Supplemental Information
Tennova Cleveland Current ED (Main Hospital Campus)

	Total Visits	Rooms/Beds	Visits/Room	Square Feet	Visits per Square Foot
Tennova Cleveland	48,501	41	1,183	28,280	1.715

10. Section B, Need, Item 1 (Project Specific Criteria-Freestanding ED)

1. Host Hospital Emergency Department Quality of Care

Please complete the following table. The applicant will need to review each hospital in the state that has an emergency department and rank each hospital to each measure according to the four quartiles as listed in the table below. The applicant will then rank Tennova Cleveland's Emergency Department according to the four quartiles listed below:

Table 5 – Supplemental Information
Quality of Care Provided at the Host Hospital ED
based on Percentile Ranking among Tennessee Hospitals
4/1/2016 to 3/31/2017

Measure		Host Hospital ED Time (or Measurement)	Host Hospital Quartile Ranking Highlighted With Measurement (Time or %) Provided *For each measure, 75th Quartile is the Top Quartile*			
		Tennova Cleveland	25th Percentile	50th Percentile	75th Percentile	No. of Providers
OP-1	Median Time to Fibrinolysis	**N/A**	25 Minutes	20 Minutes	19 Minutes	5
OP-2	Fibrinolytic Therapy Received Within 30 Minutes	**N/A**	73%	80%	82%	5
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	42 Minutes	62 Minutes	52.5 Minutes	**44.25 Minutes**	16
OP-4	Aspirin at Arrival	100%	93.25%	97%	**99%**	82
OP-5	Median Time to ECG	4 Minutes	9 Minutes	6 Minutes	**4 Minutes**	82
OP-18	Median Time from ED Arrival to ED Departure for Discharged ED Patients	207 Minutes	**157.5 Minutes**	129 Minutes	111 Minutes	99
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Professional	19 Minutes	27.5 Minutes	**21 Minutes**	15 Minutes	99
OP-21	ED - Median Time to Pain Management for Long Bone Fracture	94 Minutes	**61.25 Minutes**	52 Minutes	39.75 Minutes	96
OP-22	ED - Patient Left Without Being Seen	5%	**2%**	2%	1%	94
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 Within 45 Minutes of ED Arrival	88%	68%	**82.5%**	91%	42

Source: Medicare.gov Hospital Compare website; March 2018.

RESPONSE: The table above provides Tennova Cleveland's quartile ranking among Tennessee hospitals for the most recent period available (April 2016 – March 2017). In each instance the top quartile is the 75th percentile, regardless of whether the goal is minimal time (e.g., time to transfer) or compliance with a target in terms of percentage (e.g., patients receiving aspirin). The information shown provides the quartile indicators for each quartile listed. The host hospital (Tennova Cleveland) quartile ranking is indicated by the highlight and bold text.

As noted by the Agency, the data available on the CMS website may be somewhat dated. That is the case for Tennova Cleveland because the hospital has made significant strides in its operational efficiencies and total time patients are in the hospital's main campus ED since publication of the data included in the table above.

For example, during the most recent 12 month period, April 2017 – March 2018, Tennova Cleveland has reduced the time patients wait from "door to diagnostic evaluation by a qualified medical professional", *i.e.*, OP-20 indicator, from 19 minutes for 12 months ending March 2017 to 15 minutes. (The 15 minute measurement is based on the most recent complete monthly data, illustrative of Tennova Cleveland's improvement in patient care processes.) Based on current data, Tennova Cleveland would rank in the OP-20 Top Quartile among Tennessee hospitals.

Similarly, Tennova Cleveland has improved its ranking among Tennessee hospitals in terms of the percentage of patients leaving the ED without being seen. In the table above, Tennova Cleveland reported 5% of its ED patients leaving without being seen from April 2016 to March 2017. Most recently, Tennova Cleveland experienced a minimal 1.9% of ED patients leaving without being seen (this month, March 2018), reflecting the hospital's focus on improving patient flow and processes in its main campus ED.

The improvements in Tennova Cleveland's state ranking is due to its recent leadership changes in the main campus ED, including for example, a new ED Medical Director, new ED Director, and hospital Chief Nursing Officer. The combination of new clinical leadership in the ED (and hospital-wide with the CNO) has resulted in improvements in the hospital's ED that ultimately enhance quality of care and patient satisfaction. Similarly, the proposed FSED will further enhance quality of care for all ED patients (main hospital and FSED) by optimizing the existing space within the main campus ED and providing an easily accessible satellite ED in Bradley County.

12. Pediatric Care

Please provide information detailing the expertise, capabilities, and/or training of staff to stabilize or serve pediatric patients.

RESPONSE: Tennova Cleveland ensures that its nursing and clinical staff members have the expertise, capabilities, and training to serve (including stabilization of) pediatric patients by a variety of means, including the following.

Nursing staff caring for pediatric patients at Tennova Cleveland maintain a minimum of an associate degree in nursing and receive pediatric-specific orientation and preceptorship upon

employment ranging from 4 to 12 weeks, depending upon the experience of the new employee. New nursing staff are required to demonstrate appropriate and acceptable skill levels for pediatric nursing care including medication dose calculation for pediatric patients. Each pediatric nurse is required to have Pediatric Advanced Life Support (PALS) certification within 6 months of initial employment.

Annual skill evaluation and age-specific competency validation for all pediatric nursing staff includes assessment of proper use of restraints, use of the Broselow pediatric code cart, computer documentation and use of age-specific equipment such as orthopedic equipment.

The TDOH's Standards of Pediatric Emergency Care licensure survey (January 2017) at Tennova Cleveland found no deficiencies; further documenting Tennova Cleveland's expertise, capabilities and/or training of staff to care for pediatric patients. A copy of the survey is included in Attachment 5.

Specific to its physician staff members, Tennova Cleveland utilizes the proven expertise of TeamHealth ED physicians, all of whom are board-certified and/or board-eligible in emergency services and who have proven skills and experience in caring for ED patients of all ages, including pediatric patients. For example, TeamHealth ED physicians undergo seven (7) hours of pediatric-specific Continuing Medical Education annually, in addition to all other annual CME requirements.

13. Stabilization and Transfer Availability of Emergent Cases

Please indicate if there is room for a dedicated helipad on-site.

RESPONSE: The parking area for the proposed FSED will accommodate the landing of a helicopter in the event that air transport is required to either receive or transfer a patient. An area for a dedicated helipad is not possible without the loss of parking spaces at the facility.

14. Adequate Staffing

A. All Applicants

The 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. If the applicant plans to contract with an emergency physician group, the applicant should provide information on the physician group's ability to meet the staffing requirements. Utilize the following table to demonstrate planned staffing.

Table 6 – Supplemental Information Staffing Patterns			
Position Type	**FTEs Needed for Proposed FSED**	**FTEs Currently Employed**	**FTEs that will be Recruited**
Physicians*	4.2*	N/A	4.2*
Registered Nurses	12.6	49.0	14.0
ED Tech/Nursing Asst.	6.3	13.0	6.3
Radiology Tech	2.1	20.0	1.0
CT Tech	4.2	10.0	4.2
Respiratory Tech	4.2	27.0	4.2
Laboratory Tech	4.2	26.0	6.2
Unit Sec/Nurse Aide	4.2	6.2	1.0
Registrar/PFS	4.2	27.0	4.2
Manager	1.0	1.0	1.0
Other (Security, EVS)	8.4	13.4	2.1
Total FTEs*	**47.2**	**192.6**	**44.2**

Note: ED physician staffing is provided by Board-Certified TeamHealth physicians on a contractual basis; no ED physicians are or will be employed by Tennova Cleveland. However, for completeness, the information above provides estimated physician FTEs for the FSED.
*The total appropriately excludes the contractual physicians, so that the total FTEs match the financial projections and information provided in the original application and the shift-specific staffing table provided in this Supplemental Information response.

18. Community Linkage Plan

Please describe the primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of ED usage.

RESPONSE: Tennova Cleveland provides significant community outreach to patients with mental health and/or substance abuse needs, working with community agencies to provide alternatives to crisis management of patients in hospital EDs. For example, Tennova Cleveland has a dedicated Behavioral Health Liaison who maintains ongoing communication with community resources such as outpatient and inpatient behavioral health providers, primary care physicians, other EDs in the surrounding area, local therapists, mobile crisis response teams, and chemical dependency residential treatment facilities. A goal of Tennova Cleveland's Liaison is to address risk factors leading to the increased likelihood of ED usage, so that ED usage of patients with mental health and/or substance abuse issues may be reduced. The Behavioral Health Liaison frequently provides community outreach and education to groups in Bradley and Polk County, including for example, at-risk groups, industries, local law enforcement and government agencies.

Additionally, Tennova Cleveland offers numerous health fairs and health screenings to community members throughout each year. For example, in addition to community-wide health fairs, Tennova Cleveland provide health screenings geared specifically for seniors and industry employees, just to name a few. Blood pressure, sugar/glucose levels, cardiology assessments, orthopedic screenings, and flu shots are a few examples of the preventive initiatives provided by Tennova Cleveland.

8. Section B, Need, Item E

Using data from the 2104-2016 Hospital JAR, please report ED visit trends for all hospitals reporting 50 or more ED visits from the service area.

RESPONSE: According to the Patient Destination for County Service Area by Hospital report provided by the Tennessee Department of Health, a total of 13 hospitals served 50 or more patients from the 2-county service area of Bradley and Polk counties in 2015. For comparison purposes, the total number of ED visits from the service area that each facility served is shown first, followed by the hospital's total number of ED visits from all locations, i.e., each hospital's ED visit trend as requested by HSDA.

Table 7 – Supplemental Information
ED Visit Trends for all Hospitals Serving ED Visits from the Service Area, 2014-2016

Hospital	County	2015 *Service Area* ED Visits	Each Hospital's Total ED Visits, All Patients Served		
			2014 Total ED Visits	2015 Total ED Visits	2016 Total ED Visits
Tennova Cleveland	Bradley	37,994	49,791	50,533	48,501
Erlanger Medical Center	Hamilton	4,130	90,167	97,099	66,066
Copper Basin Med Center	Polk	3,820	7,542	7,243	6,830
Starr Regional - Etowah	McMinn	1,991	12,043	11,434	11,235
CHI Memorial	Hamilton	1,772	45,512	47,631	48,226
Starr Regional - Athens	McMinn	1,583	37,392	39,297	35,044
Erlanger East Hospital	Hamilton	1,409	22,008	26,172	31,198
Parkridge Medical Center	Hamilton	716	35,619	38,518	38,394
Parkridge East Hospital	Hamilton	631	41,422	47,621	49,947
CHI Memorial Hixson	Hamilton	202	30,566	32,256	32,328
Rhea Medical Center	Rhea	110	20,607	20,293	21,864
Erlanger North Hospital	Hamilton	65	12,738	12,974	14,857
Sweetwater Hospital Assn	Monroe	60	21,766	23,433	23,504

Sources: TDOH, Division of Policy, Planning and Assessment (for 2015 service area total visits); and, Joint Annual Reports (for 2014 – 2016 hospital-specific visit trend data).

Please identify existing urgent care centers in Bradley and Polk Counties by completing the following table.

RESPONSE: The following facilities have been identified as providing urgent care, along with walk-in and immediate appointment primary care services. The Center for Sports Medicine & Orthopedics provides orthopedic-specific urgent care services. The majority of the providers listed below are not dedicated urgent care providers, instead they are primary care practices offering both urgent/immediate and ongoing primary care services at their locations.

Many providers are also closed one hour mid-day for a lunch break and also close or have limited hours of operation on holidays.

Moreover, though a provider may state that they are accepting TennCare patients, some qualify that the providers at the facility must be on the specific plan panel for the visit to be covered by TennCare.

Table 8 – Supplemental Information
Urgent Care Centers in Bradley and Polk County

Urgent Care Center Name	Address	Distance from Proposed ED	Operating Hours	Medicare, TennCare, & Major Ins accepted?
American Family Care Urgent Care	170 Mouse Creek Road, NW, Cleveland, TN 37312	1.0 Miles	M-F 8-8 Sat/Sun 8-5	Medicare, Commercial, Self-Pay Option
Bradley Urgent Care	4021 Keith Street, NW Cleveland, TN 37312	1.8 Miles	M-F 8-8 Sat/Sun 9-6	TennCare, Medicare, Commercial, Self-Pay
Bradley-Polk Walk-In Clinic and Medical Clinic	119 Whitewater Drive Ocoee, TN 37361	10.6 Miles	M-F 8-7 Sat/Sun 8-3	TennCare, Medicare, Commercial, Self-Pay
Center for Sports Medicine & Orthopedics	2400 North Ocoee Street Cleveland, TN 37311	2.6 Miles	M-Th 8-4 F 8-Noon	TennCare, Medicare, Commercial, Self-Pay
CHI Memorial Convenient Care	645 Paul Huff Parkway, NW Suite 105 Cleveland, TN 37312	1.8 Miles	M-F 8-8 Sat/Sun 8-5	TennCare, Medicare, Commercial, Self-Pay
Cleveland Medical Associates	1060 William Way Cleveland, TN 37312	2.2 Miles	M-Th 8-5 F 8-Noon	TennCare, Medicare, Commercial, Self-Pay
CVS Minute Clinic	2424 North Ocoee Street Cleveland, TN 37311	2.6 Miles	M-Th 9-7 F-Sun 9-8	TennCare, Medicare, Commercial, Self-Pay
Fast Access Healthcare	400 Stuart Road, NE Suite 1 Cleveland, TN 37312	0.3 Miles	M-F 8-5	TennCare, Medicare, Commercial, Self-Pay
Physicians First Walk-In Clinic/Primary Care	2725 Keith Street Cleveland, TN 37312	1.8 Miles	M-F 8-8 Sat/Sun 10-6	Medicare, Commercial

Table 8 – Supplemental Information Urgent Care Centers in Bradley and Polk County				
Urgent Care Center Name	**Address**	**Distance from Proposed ED**	**Operating Hours**	**Medicare, TennCare, & Major Ins accepted?**
Physicians Care	1494 Stuart Road Cleveland, TN 37312	0.7 Miles	M-F 8-6 Sat/Sun 9-2	TennCare, Medicare, Commercial, Self-Pay
Tennova Internal Medicine Group – Peerless Crossing	1060 Peerless Crossing Suite 200 Cleveland, TN 37311	2.4 Miles	M-F 7:30-7 Sat 8-1	TennCare, Medicare, Commercial, Self-Pay
Source: provider websites and general internet searches.				

On page 68 the applicant noted "Tennova Cleveland is the fourth (4th) busiest ED of all hospitals serving in patients in the 2-county service area in terms of total ED visits seen in 2016, regardless of the hospital's location (i.e.,home county)". However, the table the applicant was referring includes not only the 2-county service area, but additional surrounding tables. Please clarify.

RESPONSE: The following table includes hospitals located outside of the 2-county service area, *e.g.*, Erlanger in Hamilton County, but that provide ED services to residents of the 2-county area. When the hospitals in surrounding counties are considered, including the tertiary facilities in Chattanooga, it is notable that Tennova Cleveland has the 4th highest volume, evidencing the importance of Tennova Cleveland to its service area residents, who reside outside of the densely populated and congested Hamilton County.

Table 9 – Supplemental Information Visits Per Treatment Room in Existing ED Facilities in the Surrounding Area *Ranked from Highest to Lowest Total ED Visits, 2016*				
Emergency Department (Hospital)	**County**	**Total Visits**	**# of ED Rooms**	**# of Visits per Room**
Erlanger Medical Center	Hamilton	66,006	79	836
Parkridge East Hospital	Hamilton	50,430	19	2,654
CHI Memorial Hospital	Hamilton	49,445	31	1,595
Tennova Healthcare - Cleveland	**Bradley**	**48,501**	**41**	**1,183**
Starr Regional Medical Center - Athens	McMinn	39,297	N/A	N/A
Parkridge Medical Center	Hamilton	38,394	23	1,669
CHI Memorial Hixson	Hamilton	32,674	21	1,556
Erlanger East Hospital	Hamilton	31,197	17	1,835
Sweetwater Hospital Association	Monroe	25,528	15	1,702
Rhea Medical Center	Rhea	23,039	14	1,646
Erlanger North Hospital	Hamilton	14,857	8	1,857
Starr Regional Medical Ctr - Etowah	McMinn	11,000	9	1,222
Copper Basin Med Ctr *(now closed)*	**Polk**	**6,750**	**3**	**2,250**
Source & Notes: 2016 Joint Annual Report of Hospitals (JARs). N/A = data not available in the 2016 JAR.				

9. **Section B, Need, Item F**

   Please complete the following charts for Tennova Cleveland and the proposed Satellite ED Projected Utilization.

RESPONSE: The following table provides historical and projected ED visits by campus.

Table 10 – Supplemental Information Tennova Cleveland ED Volume, Historical and Projected by Campus						
	Actual			**Projected**		
Year	**2015**	**2016**	**2017**	**Year 1**	**Year 2**	**Year 3**
Main Campus Visits	50,533	48,501	47,326	40,110	40,224	40,579
Main Campus Rooms	41	41	41	41	41	41
Main Campus Visits/ Room	1,233	1,183	1,154	978	981	990
Satellite Visits				7,343	7,648	7,715
Satellite Rooms				8	8	8
Satellite Visits Per Room				918	956	964
Total Visits	50,533	48,501	47,326	47,453	47,872	48,294
Total Rooms	41	41	41	49	49	49
Total Visits Per Room	**1,233**	**1,183**	**1,154**	**968**	**977**	**986**

Table 11 – Supplemental Information
Tennova Cleveland and Satellite ED Historical and Projected Utilization
Emergency Severity Index Level of Care**

Acuity Level *(Lowest to Highest)***	CPT Code	Main ED			Project Year 1		
		CY2015	CY2016	CY2017	Main ED	Satellite ED	Combined Year 1
Level 1	99281	2,072	1,649	1,467	1,103	368	1,471
Level 2	99282	3,790	3,104	3,265	2,456	819	3,274
Level 3	99283	14,301	12,707	12,542	9,431	3,144	12,575
Level 4	99284	15,564	15,423	14,624	13,197	1,466	14,663
Level 5	99285	14,806	15,618	15,428	13,923	1,546	15,470
Total		**50,533**	**48,501**	**47,326**	**40,110**	**7,343**	**47,453**

Sources & Notes:
Tennova Cleveland internal data.
Historical distribution of cases for total ED patients by identified CPT Codes, excluding minimal cases (less than or approximately 1% of total ED cases) with unknown or other CPT Codes.

***Please note:** The acuity levels indicated in the table above and throughout the application are based on the above-indicated CPT evaluation and management ("E&M") billing codes, with Level 4 and 5 codes indicating patients with more complex, resource-intensive conditions.

Notably, Tennova Cleveland's use of CPT billing codes to categorize ED patient acuity is consistent with prior applications of Blount Memorial Hospital (CN1603-011) and Gateway Medical Center at Sango (CN1507-027). In both of those previously-approved applications, Level 1 corresponded to CPT Code 99281 (lowest acuity patient) and Level 5 corresponded to CPT Code 99285, highest acuity patient. Moreover, the use of CPT Codes to indicate patient severity/acuity is also consistent with data provided by TDOH.

The use of CPT Codes to categorize the severity of ED patients differs, however, from the Emergency Severity Index ("ESI") ranking of acuity which categorizes ED patients at the time of triage. The ESI ranking is *reverse* of the use of CPT Codes in categorizing patient acuity, with the ESI Level 1 representing the highest acuity and Level 5 representing the lowest. Specifically, ESI ranking at the time of patient triage ranges from Level 1-resuscitation, 2-emergent, 3-urgent, 4-less urgent to Level 5-non-urgent (or lowest acuity).

The information regarding acuity ranking based on CPT billing codes versus ESI is provided for clarity as the application is reviewed, and in anticipation of the HSDA Meeting presentation on this application.

Please clarify the reason ED visits at the Tennova Cleveland decreased from 50,533 in 2015 to 47,326 in 2017.

RESPONSE: The number of urgent care providers and primary care clinics that serve low-acuity urgent care patients has increased over the last several years, providing alternatives for non-emergent patients to receive services outside of the hospital-based ED setting. The result has been for hospitals such as Tennova Cleveland to serve a large and growing percentage of high-acuity, more complex patients in its hospital-based ED, as demonstrated below.

Table 12 – Supplemental Information
Tennova Cleveland's High-Acuity Visits as % of Total ED Visits

CY2015	CY2016	CY2016
60.1%	64.0%	63.5%

Source: Tennova Cleveland internal data.
High acuity cases are CPT Codes 99284 and 99285.

10. Section B Economic Feasibility Item 1 (Project Costs Chart)

Moveable equipment in the amount of $2,242,643 is noted. Please list all equipment over $50,000.

RESPONSE: The medical equipment over $50,000 included in the moveable equipment line item includes the following:

- CT unit
- X-Ray machine (2, one mobile, one 'fixed')
- Ultrasound unit
- PACS system (electronic imaging system for radiology)
- C-Arm for mobile X-Ray unit
- Mini C-Arm for fixed X-Ray unit
- GYN-specific imaging modality

It is also expected that the IT and Telephone systems will each cost more than $50,000, as well as signage for the facility.

11. Section B Economic Feasibility Items C and D. Historical Data Charts and Projected Data Charts

The Historical Data Chart for the Total Facility is noted. However, it appears the 2015 Net Balance Line should be a negative figure ($3,621,276) rather than a positive figure, $3,621,276. Please clarify and provide a replacement page 74 (labeled as 74R) if necessary.

RESPONSE: Please see Attachment 6 for the replacement page.

The Historical Data Chart for the Project Only is noted. However, the 2017 Provisions for Bad Debt line is missing a digit (2,040,72). Please revise and submit a replacement page 75 labeled as 75R.

RESPONSE: Please see Attachment 6 for the replacement page.

The Projected Data Chart for the total facility is noted. However, please include the Net Operating Revenue lines for 2020 and 2021. In addition, total operating expenses for the year 2020 in the amount of $19,415,305 appears to be incorrect. Please make any necessary revisions and submit a replacement page 78 labeled as 78R.

RESPONSE: Please see Attachment 6 for the replacement page.

The Projected Data Chart for the project only is noted. However, total 2020 operating expenses totaling $2,784,787 appears to be calculated incorrectly. Please verify and submit a replacement page 80 labeled as 80R.

RESPONSE: Please see Attachment 6 for the replacement page.

The Projected Data Chart for the ED combined (FSED and Main Campus) is noted. However, it appears 2020 deductions in the amount of $168,274,223 are calculated incorrectly. In addition, it appears 2021 Net Operating Revenue in the amount of $19,047,322 is also calculated incorrectly. If necessary, please male any corrections and submit a replacement page labeled as 82R.

RESPONSE: Please see Attachment 6 for the replacement page.

12. Section B Economic Feasibility Item E.3

The table on page 84 is noted. However, please provide the name of the providers associated with CN1507-027, CN1802-011, and CN1603-011. In addition, please compare the proposed charges to those similar hospitals with emergency departments in the adjoining counties.

RESPONSE: Please find below the charge comparison table with the requested provider name reflected. As shown below, Tennova Cleveland FSED average charges per visit are commensurate with other FSED provider applicants.

Table 13 – Supplemental Information Charge Comparison of FSED Projects			
		Average Charges per Visit	
Application	**Provider Name**	**Project Year 1**	**Project Year 2**
CN1507-27	Gateway Medical Ctr	$ 3,307	$ 3,439
Proposed FSED	Tennova Cleveland	$ 3,245	$ 3,375
CN1802-011	Erlanger Memorial Hospital	$ 2,533	$ 2,842
CN1603-11	Blount Memorial Hospital	$ 1,944	$ 2,003

In response to the Agency's supplemental request to provide a comparison of the proposed charges to those similar hospitals with emergency departments in the adjoining counties, Tennova Cleveland has summarized Medicare Ambulatory Payment Category (APC) charge data for Chattanooga providers, as publicly available from the Centers for Medicare & Medicaid Services (CMS). The APC data compiled is the most recent data available and represents the average charge per APC for the most common APCs provided by Chattanooga providers.

Table 14 – Supplemental Information Requested Charge Comparison to Hospitals with EDs in Surrounding Counties Medicare Ambulatory Payment Category Charge Data, CY2015					
Provider / APC	**0269 - Level I Echocardio-gram Without Contrast**	**0267 - Level III Diagnostic and Screening Ultrasound**	**0634 - Hospital Clinic Visits**	**0377 - Level II Cardiac Imaging**	**0015 - Level II Debridement & Destruction**
Cornerstone Med Center	2,641	1,252	468	6,913	763
Erlanger Medical Center	2,771	942	136	8,593	802
Memorial Hlthcare System	2,843	1,137	172	5,802	580
Parkridge Medical Center	2,224	1,577	216	16,792	n/a
Tennova Cleveland	4,028	2,300	352	16,265	474

Note: APC Summary for Medicare Outpatient Prospective Payment System Hospitals, CY2015
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Outpatient.html

13. Section B Economic Feasibility Item F.2

The Net Operating Margin Ratio table is noted. However, please calculate Year One and Year Two from the Project's (satellite ED) Projected Data Chart and submit a revised page 85 labeled as 85R.

RESPONSE: Please find below the net operating margin ratio table revised to reflect the Year One and Year Two margins for the Project, Only (FSED). Since the proposed project is a new satellite FSED, there is no historical operations data. The historical data presented in this chart is the net operating margin for Tennova Cleveland's existing main campus emergency services. Please see Attachment 6 – Replacement CON Financial Pages.

Table 15 – Supplemental Information
Net Operating Margin

Year	2nd Year previous to Current Year*	1st Year previous to Current Year*	Current Year* (2017)	Projected Year 1**	Projected Year 2**
Net Operating Margin Ratio	33.4%	32.8%	22.0%	0.8%	2.0%

* *Margin ratios represent existing Tennova ED services.*
** *Margin ratios represent the proposed FSED, only.*

14. Section B Economic Feasibility Item F.3

The capitalization of 105.8 is noted. The capitalization ratio measures the proportion of debt financing in a business's permanent financing mix. According to *Modern Healthcare's* March 14, 2018 article (http://www.modernhealthcare.com/article/20180314/NEWS/180319950), Community Health System's long-term debt stands at nearly $14 billion and has hired a firm to address its nearly $4.8 billion in long-term debt maturing in 2019 and 2020. In addition, the report notes in the fourth quarter of 2017, the company's revenue dropped to about $3 billion from about $4.5 billion during the same period in 2016. During the same time period, CHS' total admissions dropped 19%. Please discuss the current financial condition of Community Health System and its ability to sustain the proposed FSED project over the long term.

RESPONSE: Community Health Systems, Inc. expects to carry its momentum from its 2017 fourth quarter positive financial performance through 2018, as CHS executes strategies that will strengthen its core business and drive improved results. During the fourth quarter of 2017, CHS completed its announced divestiture plan and CHS intends to continue to optimize its portfolio in 2018 to help pay down debt and refine its portfolio to stronger markets. In 2018, CHS remains committed to growth initiatives to advance its

competitive position, including expanding its transfer and access program across CHS networks, launching Accountable Care Organizations, and strategically expanding outpatient services such as the proposed Tennova-Cleveland FSED project.

CHS is also committed to driving operational efficiencies, and, as always, is dedicated to patient safety and clinical advancements that improve healthcare for the patients and communities CHS serves.

CHS' ability to fund and sustain the proposed Tennova-Cleveland FSED project over the long term is evidenced by CHS' net assets exceeding $17 billion.

15. Section B. Economic Feasibility Item H.

Please complete the following chart showing the FTE staffing plan for the proposed satellite ED:

RESPONSE: The proposed staffing, by position and by shift, is presented below.

Table 16 – Supplemental Information
FTE Staffing Plan for Proposed FSED

Position	Day 7a - 3p	Evening 3p - 11p	Night 11-7a	Total Staff	Total FTEs
Manager*	1.0	0.0	0.0	1.0	1.0
RN	2.5	3.5	3.0	9.0	12.6
Nurse Asst/ED Tech	2.0	1.5	1.0	4.5	6.3
Nurse Aide/Unit Sec.	1.0	1.0	1.0	3.0	4.2
Resp Therapist	1.0	1.0	1.0	3.0	4.2
Rad Tech	0.8	0.8	0.0	1.5	2.1
Lab Tech	1.0	1.0	1.0	3.0	4.2
CT Tech	1.0	1.0	1.0	3.0	4.2
Other	2.0	2.0	2.0	6.0	8.4
Total per Shift	**12.3**	**11.8**	**10.0**	**34.0**	**47.2**

*Note: Manager will be 5 days/week.

16. Section B. , Orderly Development, Item C

Please discuss how TeamHealth will provide the clinical and professional staff per State of Tennessee and Joint Commission requirements.

RESPONSE: TeamHealth, as it does at all sites it staffs, will staff the proposed FSED with the appropriate number of board-certified physicians and advanced practice providers to provide the optimal level of patient care. TeamHealth's physicians will be licensed to practice in the state of Tennessee, and as part of Tennova Cleveland, will undergo Joint Commission review. Tennova Cleveland is Joint Commission-accredited. As part of the hospital, the proposed FSED will also obtain Joint Commission-accreditation.

Tennova Cleveland currently works with TeamHealth to provide physician staffing for its existing ED on the hospital's main campus. Tennova Cleveland will work with TeamHealth to include coverage in the expanded ED (FSED) to provide around-the-clock staffing for the proposed FSED. TeamHealth's network of providers includes over 20,000 affiliated physicians and advanced practice clinicians representing multiple specialties including emergency services.

TeamHealth has 35 years of experience providing emergency services patient care. TeamHealth will bring its proven programs and services, including its use of best practices, learnings from tough cases, and leading-edge technology, to provide clinical and professional staff per State of Tennessee and Joint Commission requirements at Tennova Cleveland's FSED as it does at the main hospital campus ED.

Please indicate how many FSED's TeamHealth currently staffs in Tennessee.

RESPONSE: TeamHealth currently staffs FSED only outside of Tennessee. TeamHealth currently staffs 60 FSEDs in the United States in 15 states.

17. Section B. , Orderly Development, Item E.1 and E.2

Please provide a response to E.1 a-c on page 91.

The Corporate Integrity Agreement dated July 28, 2014 is noted. Please provide a brief overview of the CIA and the allegations that resulted in the CIA. Please provide a copy of the news clip from the following Department of Justice web-site. https://www.justice.gov/opa/pr/community-health-systems-inc-pay-9815-million-resolve-false-claims-act-allegations

RESPONSE: In July 2014, Community Health Systems, Inc. entered into a Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services in connection with the resolution of certain lawsuits. The Agreement requires the company to engage in various compliance efforts for five years.

Please see Attachment 7 for a copy of the news clip from the Department of Justice website. A copy of the Corporate Integrity Agreement can be found at https://oig.hhs.gov/fraud/cia/agreements/Community_Health_Systems_07282014.pdf.

According to a Department of Justice report dated February 6, 2017 (https://www.justice.gov/opa/pr/healthcare-service-provider-pay-60-million-settle-medicare-and-medicaid-false-claims-act) it appears TeamHealth is possibly under a corporate integrity agreement. Please clarify.

RESPONSE: TeamHealth entered into a five-year Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services in connection with the resolution of a lawsuit involving IPC The Hospitalist Company, Inc. and its subsidiaries ("IPC"), which TeamHealth acquired.

The June 2014 government lawsuit against IPC predated the purchase of the company by TeamHealth because TeamHealth purchased IPC more than a year later, in November 2015. Nonetheless, TeamHealth paid the $60 million settlement and entered into a five-year Corporate Integrity Agreement, as successor in interest to IPC. Copies of the U.S. Department of Justice press releases and notice of TeamHealth's purchase of IPC are included in Attachment 8.

18. Section B. Quality Measures

Please discuss the applicant's commitment to the proposal in meeting appropriate quality standards by addressing each of the following factors:

(a) 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: Tennova Cleveland has not been decertified within the prior three years. Rather, Tennova Cleveland's high quality standards are illustrated by its Joint Commission accreditation, provided in the CON Application Attachment B-Need-A.5. Tennova Cleveland's commitment to meet appropriate quality standards is further illustrated by the hospital's Quality Assurance Program, provided in the CON Application Attachment B-Need-A.4.

(b) 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:

i. The same accrediting standards as the licensed hospital of which it will be a department, for a Freestanding Emergency Department.

RESPONSE: Tennova Cleveland commits to 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. Tennova Cleveland's commitment is illustrated by its current Joint commission accreditation and its proven Quality Assurance Program.

The communities served by Tennova Cleveland recognize the hospital's focus on quality of care, thus support the proposed project to expand the existing emergency services. Letters of support were provided in the CON Application Attachment B-Need.A.1. Additional letters of support are provided in Supplemental Information Attachment 9.

r) For Freestanding Emergency Department projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan

RESPONSE: Tennova Cleveland commits to continuing to satisfy and maintain compliance with standards in the State Health Plan upon opening of the proposed FSED, as it currently does with the provision of services at its main hospital campus and its Westside campus.

Supplemental #1
March 28, 2018
3:58 P.M.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Williamson

NAME OF FACILITY: Tennova Healthcare - Cleveland

I, Martin G. Schweinhart, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title
President, Cleveland Tennessee Hospital Company, LLC

Sworn to and subscribed before me, a Notary Public, this the 28th day of March, 2018, witness my hand at office in the County of Williamson, State of Tennessee.

NOTARY PUBLIC

My commission expires 9/16, 2019.

MARY ANN ECKMAN
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY
My Commission Expires 09-16-2019

HF-0043

Revised 7/02

Supplemental #1
March 28, 2018
3:58 P.M.

Attachments – Supplemental Information
Tennova Cleveland Proposal to Establish a FSED in its Home County
Certificate of Need Application CN1803-015

List of Attachments	
Attachment	**Information Included**
1	Replacement page 1
2	Documentation that the Seller owns the Land
3	Revised Plot Plan (showing acreage)
4	Replacement page 13
5	No Deficiencies in Standards of Pediatric Emergency Care
6	Replacement Financial Pages
7	Press Release from the U.S. Department of Justice re: CHS
8	Press Releases from U.S. Dept. of Justice re: IPC & TeamHealth
9	Letters of Support

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March 28, 2018
3:58 P.M.

Attachment 1 – Supplemental Information

Replacement Page 1

Supplemental #1
March 28, 2018
3:58 P.M.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Healthcare - Cleveland
Name

680 Stuart Road NE — Bradley
Street or Route — County

Cleveland — TN — 37312
City — State — Zip Code

Website address: www.tennova.com

*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

Lisa Childers — ACEO
Name — Title

Cleveland Tennessee Hospital Company, LLC d/b/a
Tennova Healthcare – Cleveland — lisa.childers@mytennova.com
Company Name — Email address

2305 Chambliss Avenue — Cleveland — TN — 37311
Street or Route — City — State — Zip Code

ACEO — 423-559-6101 — 423-559-6653
Association with Owner — Phone Number — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

Supplemental #1
March 28, 2018
3:58 P.M.

Attachment 2 – Supplemental Information

Documentation that the Seller Owns the Land

Supplemental #1

90 NORTH OCOEE, CLEVELAND, TN 37311 423/339-30 March 28, 2018

3:58 P.M.

By preparation of this deed neither George N. McCoin nor Cleveland Abstract and Title Insurance Company, Inc. make any representation as to the status of the title of the real estate or the accuracy of the information of covenants or warranties in the deed. Any representations by George N. McCoin or Cleveland Abstract and Title Insurance Company, Inc. as to the status of the title, legal description or other matters are made solely by separate written title report or title insurance exclusively for the benefit of the parties named therein.

TAX MAP NO: D-4/M-42G-J-3.1 (OUT OF)

PROPERTY ADDRESS:	OWNER'S NAME & ADDRESS:	MORTGAGEE:
	JOE CORN STUART	
	WESLEY L. RODGERS	
	JOSEPH G. RODGERS, III	
	Mail to: 400 Stuart Rd Ste 2	
	37312	

SEND TAX BILLS TO: { X }

WARRANTY DEED

FOR AND IN CONSIDERATION OF THE SUM OF TEN DOLLARS ($10.00), and other good and valuable considerations, the receipt and sufficiency of which is hereby acknowledged, I, **JOE CORN STUART, unmarried,** have this day bargained and sold, and do hereby sell, transfer and convey **an undivided 1/4th interest in the following described parcel unto WESLEY L. RODGERS, AND AN undivided 1/4th interest in the following described parcel unto JOSEPH G. RODGERS, III,** the following described real estate:

Located in the Fourth Civil District of Bradley County, Tennessee, to-wit:

Lot 1, Final Plat of Rodgers Group Property as depicted on plat of record in Plat Book 13, page 210, in the Register's Office of Bradley County, Tennessee.

BEING a portion of the property conveyed to Joe Corn Stuart in Deed Book 387, page 948, 950, 952, 954 and 956, all in the Register's Office of Bradley County, Tennessee.

SUBJECT to easements and setbacks as set out on said plat.

SUBJECT to any applicable governmental zoning ordinances or subdivision regulations in effect thereon.

TO HAVE AND TO HOLD said real estate said **undivided 1/4th interest in the following described parcel unto WESLEY L. RODGERS, AND undivided 1/4th interest in the following described parcel unto JOSEPH G. RODGERS, III,** their heirs and assigns, forever in fee simple. Grantor covenants that she is seized and possessed of said real estate; that she has good and lawful right to sell and convey the same; that the title thereto is clear,

Supplemental #1
March 28, 2018
3:58 P.M.

Joe Corn Stuart
JOE CORN STUART

STATE OF Tennessee
COUNTY OF Bradley

Before me Christy Burbis, the undersigned Notary Public of the County and State aforesaid, personally appeared **JOE CORN STUART,** to me personally known or proven on the basis of satisfactory evidence, to be the person described herein and who, upon oath, acknowledged that she executed the foregoing instrument for the purposes as set out therein and of her own free act and deed.

Witness my hand and official seal, this the 9th day of ~~June~~ Nov., 2001.

Christy J Burbis
Notary Public

My Commission Expires: July 9, 2005

STATE OF TN:
COUNTY OF Bradley:

I hereby swear or affirm that the actual consideration for their transfer or the value of the property transferred, whichever is greater is $ 90,000

Joseph H. Rodgers, III
AFFIANT

Sworn to and subscribed before me this 12 day of November, 2001.

July 9, 2005
MY COMMISSION EXPIRES:

Christy J Burbis
NOTARY PUBLIC

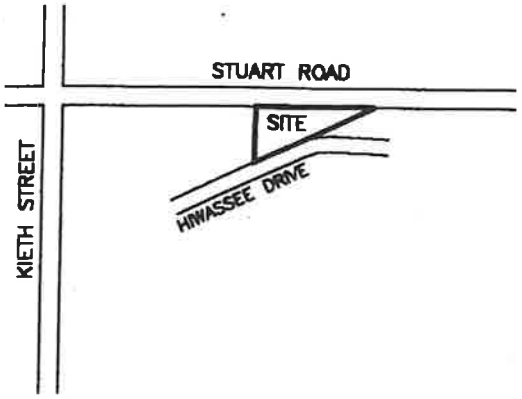
Word/tb/dw-rodgers

State of Tennessee, County of BRADLEY
Received for record the 15 day of
NOVEMBER 2001 at 2:45 PM. (RECH 87560)
Recorded in official records
Book 1160 pages 935- 936
State Tax $ 333.00 Clerks Fee $ 1.00,
Recording $ 12.00, Total $ 346.00.
Register of Deeds HERMAN ODELL SWAFFORD
Deputy Register MELISSA MATHEWS

Supplemental #1
March 28, 2018
3:58 P.M.

Attachment 3 – Supplemental Information

Revised Plot Plan (showing acreage)



TAX MAP 42-G Gr J PORTION 3.1

I HEREBY CERTIFY TH
AND BELIEF THAT THI
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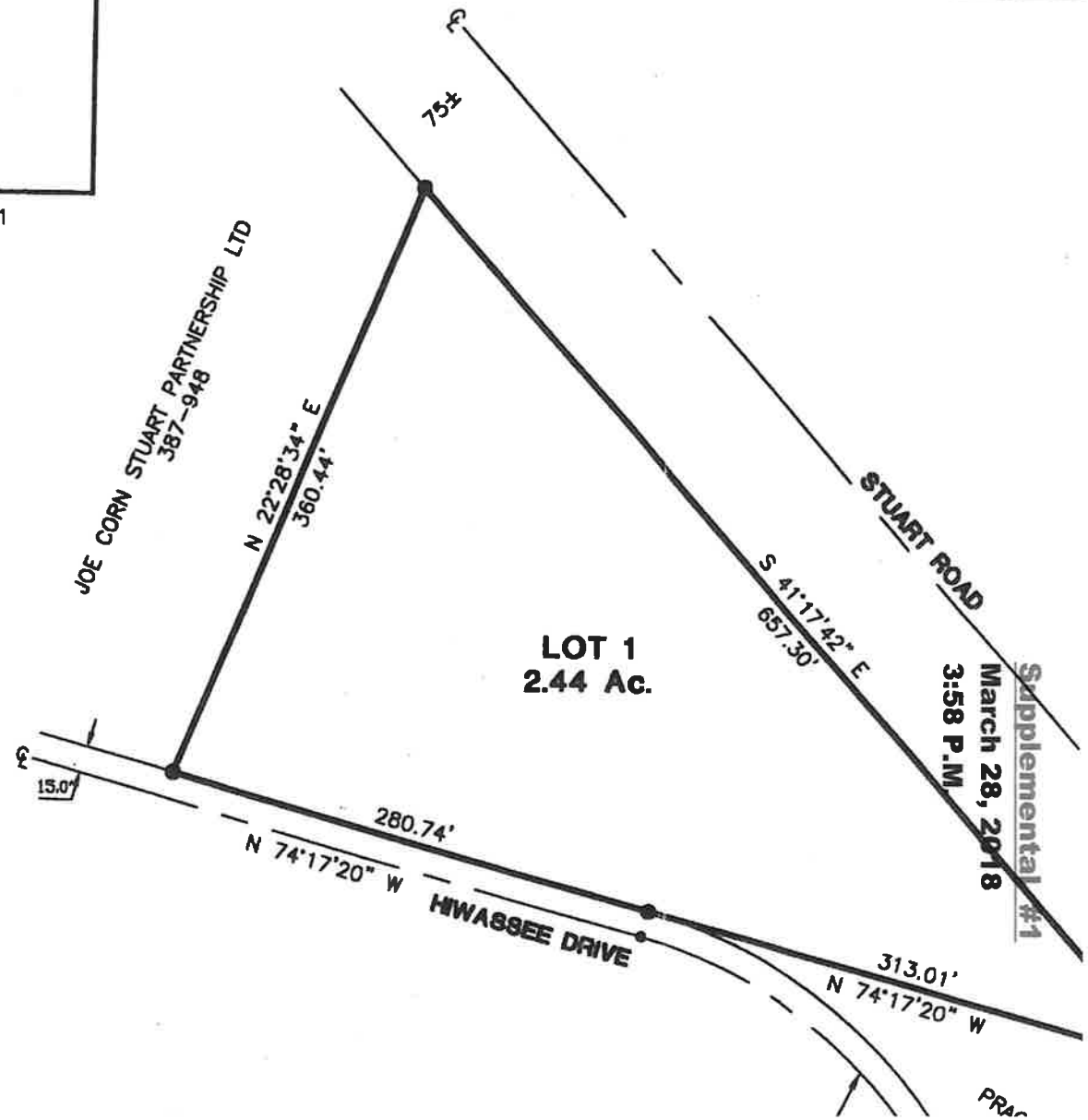
REGULATIONS AS PER

CITY OF CLEVELAND PL



Supplemental #1
March 28, 2018
3:58 P.M.

CHARLES R. BROWN
REGISTERED LAND SURVEYOR
XVI

Supplemental #1
March 28, 2018
3:58 P.M.

Attachment 4 – Supplemental Information

Replacement Page 13

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds. **Main Campus data is below.

**** Please see the bed complement for Tennova Cleveland, including the Westside campus, in Attachment A-10A.**

	Current Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempted	TOTAL Beds at Completion
1) Medical *(combined med/surg)*	208	112				208
2) Surgical						
3) ICU/CCU	24	24				24
4) Obstetrical	12	12				12
5) NICU	3	3				3
6) Pediatric	4	4				4
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital						
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL	251	155				251

**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.

Not Applicable. No changes in bed capacity or allocation are proposed as part of this project.

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(s)	CON Expiration Date	Total Licensed Beds Approved
N/A		

Supplemental #1
March 28, 2018
3:58 P.M.

Attachment 5 – Supplemental Information

No Deficiencies in Standards of Pediatric Emergency Care

TN Department of Health

January 18, 2017

Mr. Coleman Foss, Administrator
Tennova Healthcare - Cleveland
2305 Chambliss Ave NW
Cleveland, TN 37311

RE: TNP5316

Dear Mr. Foss:

The East Tennessee Regional Office conducted a licensure survey at your facility on January 9, 2017. As a result of the survey, no deficiencies were cited under Standards of Pediatric Emergency Care (1200-8-30).

If our office may be of assistance to you, please feel free to call (865) 594-9396.

Sincerely,

Tamra Turberville/cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manger

TT: cw

Division of Health Care Facilities

Supplemental #1
March 28, 2018
3:58 P.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	TNP5316		01/09/2017

NAME OF PROVIDER OR SUPPLIER
TENNOVA HEALTHCARE-CLEVELAND

STREET ADDRESS, CITY, STATE, ZIP CODE
2305 CHAMBLISS AVE NW
CLEVELAND, TN 37311

(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
P 001	1200-8-30 Initial During a licensure survey conducted on 1/9/17 at Tennova Healthcare-Cleveland, no deficiencies were cited under 1200-8-30, Standards for Pediatric Emergency Care Facilities.	P 001		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Supplemental #1
March 28, 2018
3:58 P.M.

Attachment 6 – Supplemental Information

Replacement Financial Pages

Chart Continues Onto Next Page

NET INCOME (LOSS)	**$ 260,406**	**$ 11,744,941**	**$ 8,837,741**
G. Other Deductions			
1. Annual Principal Debt Repayment			
2. Annual Capital Expenditure	3,621,276	6,240,666	4,608,101
Total Other Deductions	**$ 3,621,276**	**$ 6,240,666**	**$ 4,608,101**
NET BALANCE	**$ (3,360,870)**	**$ 5,504,275**	**$ 4,229,640**
DEPRECIATION	**$ 9,311,996**	**$ 9,062,767**	**$ 8,696,012**
FREE CASH FLOW (Net Balance + Depreciation)	**$ 5,951,126**	**$ 14,567,042**	**$ 12,925,652**

X Total Facility

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HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	2015	2016	2017
1. Purchased Services	$ 8,896,848	$ 8,451,371	$ 9,500,981
2. Provider Tax	5,267,461	5,267,461	5,267,461
3. Med Spec Fees	4,359,852	4,478,655	4,664,465
4. Repairs and Maintenance	3,117,482	2,991,792	2,970,916
5. Utilities	2,220,966	2,121,453	2,099,762
6. All Other (Marketing, Insurance, etc.)	1,286,070	2,238,223	3,463,225
Total Other Expenses	**$ 25,148,679**	**$ 25,548,955**	**$ 27,966,810**

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HISTORICAL DATA CHART: EXISTING EMERGENCY DEPARTMENT

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

		2015	2016	2017
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) – **ED Visits**	50,533	48,501	47,326
B.	Revenue from Services to Patients			
	1. Inpatient Services			
	2. Outpatient Services			
	3. Emergency Services	145,088,190	160,257,186	136,594,307
	4. Other Operating Revenue (Specify)_____			
	Gross Operating Revenue	**$145,088,190**	**$160,257,186**	**$136,594,307**
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments	130,494,482	145,172,288	122,990,702
	2. Provision for Charity Care			
	3. Provisions for Bad Debt	2,189,056	2,262,735	2,040,541
	Total Deductions	**$132,683,539**	**$147,435,023**	**$125,031,243**
NET OPERATING REVENUE		**$12,404,651**	**$12,822,163**	**$11,563,064**
D.	Operating Expenses			
	1. Salaries and Wages (*includes Benefits*)			
	c. Direct Patient Care	4,488,030	4,533,364	4,625,882
	d. Non-Patient Care	766,706	774,450	790,255
	2. Physician's Salaries and Wages			
	3. Supplies	824,714	865,885	819,436
	4. Rent			
	a. Paid to Affiliates			
	b. Paid to Non-Affiliates	13,416	13,416	13,416
	5. Management Fees:			
	c. Paid to Affiliates			
	d. Paid to Non-Affiliates			
	6. Other Operating Expenses	2,161,477	2,423,601	2,769,508
	Total Operating Expenses	**$8,254,343**	**$8,610,716**	**$9,018,497**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$4,150,308**	**$4,211,447**	**$2,544,567**
F.	Non-Operating Expenses			
	1. Taxes			
	2. Depreciation			
	3. Interest			
	4. Other Non-Operating Expenses			
	Total Non-Operating Expenses			
NET INCOME (LOSS)		**$4,150,308**	**$4,211,447**	**$2,544,567**

Chart Continues Onto Next Page

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PROJECTED DATA CHART:
TENNOVA CLEVELAND

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **January** (Month).

		2020	2021
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) **Patient Days**	39,635	40,428
B.	Revenue from Services to Patients		
	1. Inpatient Services	568,816,357	580,192,684
	2. Outpatient Services	641,354,177	654,181,260
	3. Emergency Services	140,816,465	143,632,794
	4. Other Operating Revenue (Specify)_Rent, Cafeteria, Misc	1,088,874	1,110,651
	Gross Operating Revenue	**$1,352,075,872**	**$1,379,117,389**
C	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	1,100,994,995	1,123,014,895
	2. Provision for Charity Care	66,313,912	67,640,190
	3. Provisions for Bad Debt	22,435,505	22,884,215
	Total Deductions	**$1,189,744,411**	**$1,213,539,299**
NET OPERATING REVENUE		**162,331,461**	**165,578,090**
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	50,104,554	51,106,645
	b. Non-Patient Care	12,550,468	12,801,477
	2. Physician's Salaries and Wages	8,032,518	8,193,168
	3. Supplies	25,711,517	26,225,748
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	3,540,670	3,611,483
	5. Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	4,299,839	4,385,835
	6. Other Operating Expenses	29,678,602	30,272,174
	Total Operating Expenses	**$133,918,167**	**$136,596,530**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$28,413,294**	**$28,981,560**
F.	Non-Operating Expenses		
	1. Taxes	3,232,431	3,297,080
	2. Depreciation	9,228,278	9,412,843
	3. Interest	6,573,903	6,708,381
	4. Other Non-Operating Expenses		
	Total Non-Operating Expenses	**$19,034,612**	**$19,415,305**
NET INCOME (LOSS)		**$9,378,681**	**$9,566,255**

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Note: Provision for Charity care includes a discount off of all self-pay patient charges; in 207, it was 76% off of charges for self-pay patients. This amount does not include any contractual adjustments for TennCare, Medicare, or Third-Party Payors. Tennova Cleveland has MCO contracts with all existing TennCare plans.

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PROJECTED DATA CHART:
PROPOSED FSED

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **January** (Month).

		2020	2021
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) – **ED Visits**	7,343	7,648
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services		
	3. Emergency Services	23,826,566	25,808,880
	4. Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$23,826,566**	**$25,808,880**
C	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	20,121,719	21,879,941
	2. Provision for Charity Care	76,245	82,588
	3. Provisions for Bad Debt	190,613	206,471
	Total Deductions	**$20,388,577**	**$22,169,001**
NET OPERATING REVENUE		**$3,437,989**	**$3,639,879**
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	2,292,002	2,337,842
	b. Non-Patient Care	261,063	266,285
	2. Physician's Salaries and Wages		
	3. Supplies	146,860	157,549
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	9,600	9,600
	5. Management Fees:		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses	75,221	164,864
	Total Operating Expenses	**$2,784,747**	**$2,936,140**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$653,242**	**$703,739**
F.	Non-Operating Expenses		
	1. Taxes		
	2. Depreciation	621,941	621,941
	3. Interest		
	4. Other Non-Operating Expenses	5,000	7,500
	Total Non-Operating Expenses	**$626,941**	**$629,441**
NET INCOME (LOSS)		**$26,301**	**$74,298**

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PROJECTED DATA CHART:
ED COMBINED (FSED & MAIN CAMPUS)

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in **January** (Month).

		2020	2021
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) – **ED Visits**	47,453	47,872
B.	Revenue from Services to Patients		
	1. Inpatient Services		
	2. Outpatient Services		
	3. Emergency Services	183,487,793	216,636,184
	4. Other Operating Revenue (Specify)_____		
	Gross Operating Revenue	**$183,487,793**	**$216,636,184**
C	Deductions from Gross Operating Revenue		
	1. Contractual Adjustments	165,867,644	194,796,960
	2. Provision for Charity Care	76,245	161,883
	3. Provisions for Bad Debt	2,330,334	2,630,019
	Total Deductions	**$168,274,223**	**$197,588,862**
NET OPERATING REVENUE		**$15,213,570**	**$19,047,322**
D.	Operating Expenses		
	1. Salaries and Wages		
	a. Direct Patient Care	7,129,187	9,573,967
	b. Non-Patient Care	1,087,416	1,370,012
	2. Physician's Salaries and Wages		
	3. Supplies	1,031,656	1,220,154
	4. Rent		
	a. Paid to Affiliates		
	b. Paid to Non-Affiliates	13,890	14,167
	5. Management Fees:		
	a. Paid to Affiliates	9,600	9,600
	b. Paid to Non-Affiliates		
	6. Other Operating Expenses	2,679,385	2,820,164
	Total Operating Expenses	**$11,951,133**	**$15,008,064**
E.	**Earnings Before Interest, Taxes and Depreciation**	**$3,262,437**	**$4,039,258**
F.	Non-Operating Expenses		
	1. Taxes		
	2. Depreciation	1,250,941	1,250,101
	3. Interest		
	4. Other Non-Operating Expenses	5,000	7,500
	Total Non-Operating Expenses	**$1,255,941**	**$1,257,601**
NET INCOME (LOSS)		**$2,006,496**	**$2,781,657**

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Attachment 7 – Supplemental Information

Press Release from the U.S. Dept. of Justice re: CHS

Supplemental #1
March 28, 2018
3:58 P.M.

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Monday, August 4, 2014

Community Health Systems Inc. to Pay $98.15 Million to Resolve False Claims Act Allegations

The Justice Department announced today that Community Health Systems Inc. (CHS), the nation's largest operator of acute care hospitals, has agreed to pay $98.15 million to resolve multiple lawsuits alleging that the company knowingly billed government health care programs for inpatient services that should have been billed as outpatient or observation services. The settlement also resolves allegations that one of the company's affiliated hospitals, Laredo Medical Center (LMC), improperly billed the Medicare program for certain inpatient procedures and for services rendered to patients referred in violation of the Physician Self-Referral Law, commonly known as the Stark Law. CHS is based in Franklin, Tennessee, and has 206 affiliated hospitals in 29 states.

"Charging the government for higher cost inpatient services that patients do not need wastes the country's health care resources," said Assistant Attorney General Stuart F. Delery for the Justice Department's Civil Division. "In addition, providing physicians with financial incentives to refer patients compromises medical judgment and risks depriving patients of the most appropriate health care available. This department will continue its work to stop this type of abuse of the nation's health care resources and to ensure patients receive the most appropriate care."

The United States alleged that from 2005 through 2010, CHS engaged in a deliberate corporate-driven scheme to increase inpatient admissions of Medicare, Medicaid and the Department of Defense's (DOD) TRICARE program beneficiaries over the age of 65 who originally presented to the emergency departments at 119 CHS hospitals. The government further alleged that the inpatient admission of these beneficiaries was not medically necessary, and that the care needed by, and provided to, these beneficiaries should have been provided in a less costly outpatient or observation setting. CHS agreed to pay $89.15 million to resolve these allegations. The settlement does not include hospitals that CHS acquired from Health Management Associates (HMA) in January 2014.

In addition, the government alleged that from 2005 through 2010, one of CHS's affiliated hospitals, LMC in Laredo, Texas, presented false claims to the Medicare program for certain cardiac and hemodialysis procedures performed on a higher cost inpatient basis that should have been performed on a lower cost outpatient basis. The government also alleged that from 2007 through 2012, LMC improperly billed Medicare for services referred to LMC by a physician who was offered a medical directorship at LMC, in

violation of the Stark Law. The Stark Law prohibits a hospital from submitting claims for patient referrals made by a physician with whom the hospital has an improper financial relationship, and is intended to ensure that a physician's medical judgment is not compromised by improper financial incentives, and is instead based on the best interests of the patient. CHS agreed to pay $9 million to resolve the allegations involving LMC.

"This is the largest False Claims Act settlement in this district and it reaffirms this office's commitment to investigate and pursue health care fraud that compromises the integrity of our health care system," said U.S. Attorney David Rivera for the Middle District of Tennessee. "This office is committed to ensuring that all companies billing government healthcare programs are responsible corporate citizens and that hospital providers do not engage in schemes to increase medically unnecessary in-patient admissions of government healthcare program beneficiaries in order to increase profits."

"This settlement demonstrates our commitment to working with our law enforcement partners and with the Department of Justice to protect the integrity of our nation's health care system," said U.S. Attorney Kenneth Magidson of the Southern District of Texas. "Put simply, these types of fraudulent practices will not be tolerated and the investigation and resolution of such claims will continue to be a high priority of this office."

"Health care providers should make treatment decisions based on patients' medical needs, not profit margins," said U.S. Attorney Anne M. Tompkins for the Western District of North Carolina. "We will not allow this type of misconduct to compromise the integrity of our health care system."

As part of today's agreement, CHS entered into a Corporate Integrity Agreement with the U.S. Department of Health and Human Services - Office of Inspector General (HHS-OIG), requiring the company to engage in significant compliance efforts over the next five years. Under the agreement, CHS is required to retain independent review organizations to review the accuracy of the company's claims for inpatient services furnished to federal health care program beneficiaries.

"In an effort to ensure the company's fraudulent past is not its future, CHS agreed to a rigorous multi-year Corporate Integrity Agreement requiring that the company commit to compliance with the law," said Inspector General Daniel R. Levinson, of the U.S. Department of Health and Human Services. "The dedicated work of OIG's investigators, auditors, and attorneys, in concert with our law enforcement partners, has again resulted in the recovery of taxpayer dollars and better protection against fraud in the future."

The settlement resolves lawsuits filed by several whistleblowers under the *qui tam* provisions of the False Claims Act, which permit private parties to file suit on behalf of the government and obtain a portion of the government's recovery. Those relators are Kathleen Bryant, former Director of Health Information Management at CHS's Heritage Medical Center in Shelbyville, Tennessee; Rachel Bryant, former nurse at CHS's Dyersburg Hospital in Dyersburg, Tennessee; Bryan Carnithan, former Emergency Medical Services

Coordinator at CHS' Heartland Hospital in Marion, Illinois; Amy Cook-Reska, former nurse at CHS' LMC in Laredo; Sheree Cook, former nurse at CHS's Heritage Medical Center in Shelbyville; James Doghramji, former internal medicine and emergency room physician at CHS's Chestnut Hill Hospital in Philadelphia; Thomas Mason, former emergency room physician at Lake Norman Regional Medical Center in Mooresville, North Carolina; Scott Plantz, former emergency room physician at CHS's Longview Regional Medical Center in Longview, Texas; and Nancy Reuille, former nurse and Supervisor of Case Management at CHS's Lutheran Hospital in Fort Wayne, Indiana. The relators' share of the settlement has not yet been determined.

This settlement illustrates the government's emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by Attorney General Eric Holder and the Secretary of Health and Human Services. The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered a total of more than $20.2 billion through False Claims Act cases, with more than $14 billion of that amount recovered in cases involving fraud against federal health care programs.

This settlement was the result of a coordinated effort by the U.S. Attorney's Offices for the Middle District of Tennessee, Southern District of Texas, Northern and Southern Districts of Illinois, Northern District of Indiana and Western District of North Carolina; the Civil Division's Commercial Litigation Branch; HHS-OIG; DOD's Defense Health Agency - Program Integrity Office and the FBI.

The lawsuits are captioned *United States ex rel. Bryant v. Community Health Systems, Inc., et al.*, Case No. 10-2695 (S.D. Tex.); *United States ex rel. Carnithan v. Community Health Systems, Inc., et al.*, Case No. 11-cv-312 (S.D. Ill.); *United States ex rel. Cook-Reska v. Community Health Systems, Inc., et al.*, Case No. 4:09-cv01565 (S.D. Tex.); *United States ex rel. James Doghramji; Sheree Cook; and Rachel Bryant v. Community Health Systems Inc., et al.*, Case No. 3-11-cv-00442 (M.D. Tenn.); *United States ex rel. Mason v. Community Health Systems, Inc., et al.*, Case No. 3:12-cv-817 (W.D.N.C.); *United States ex rel. Plantz v. Community Health Systems, Inc., et al.*, Case No. 10C-0959 (N.D. Ill.); *United States ex rel. Reuille v. Community Health Systems Professional Services Corporation, et al.*, Case No. 1:09-cv-007RL (N.D. Ind.). The claims resolved by this agreement are allegations only and there has been no determination of liability.

Component(s):
Civil Division

Press Release Number:
14-822

Updated September 15, 2014

Supplemental #1
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Attachment 8 – Supplemental Information

Press Releases from U.S. Dept. of Justice re: IPC & TeamHealth

Supplemental #1
March 28, 2018
3:58 P.M.

Department of Justice

U.S. Attorney's Office

Northern District of Illinois

SHARE

FOR IMMEDIATE RELEASE

Tuesday, June 17, 2014

U.S. Files Lawsuit Against IPC The Hospitalist Company, Alleges Overbilling Of Federal Health Insurers For Physician Services

CHICAGO — The United States filed a civil lawsuit against California-based IPC The Hospitalist Company, Inc., and its subsidiaries, alleging that IPC submitted false claims to federal health care programs, the U.S. Attorney's Office announced today. The complaint alleges that IPC violated the federal False Claims Acts by knowingly engaging in systematic overbilling for hospital evaluation and management services billed to Medicare, Medicaid, and other federal health benefit programs.

The government's complaint, intervening in a whistleblower's lawsuit, was filed yesterday in U.S. District Court. Last December, when the whistleblower's lawsuit was unsealed, the United States gave notice of its intention to file its own complaint.

IPC, based in North Hollywood, Calif., is one of the largest hospitalist companies in the United States, employing 2,500 hospitalist physicians and other health care providers in more than 1,300 facilities in 28 states. Hospitalists are physicians who work only in hospitals and other long-term care facilities, overseeing and coordinating inpatient care for patients from admission to discharge.

The government's lawsuit alleges that IPC physicians sought payment for higher and more expensive levels of medical service than were actually performed — a practice commonly referred to as "upcoding." Specifically, the lawsuit alleges that IPC encouraged its physicians to bill at the highest levels regardless of the level of service provided and pressured physicians with lower billing levels to "catch up" to their peers.

"IPC's upcoding scheme caused, and still continues to cause, Medicare, Medicaid and other federal payors to overpay millions of dollars to IPC," the suit states. "As a result of corporate/management pressure, and/or in keeping with IPC corporate culture and expectations to maximize billings, IPC hospitalists have routinely and systematically submitted upcoded claims for payment to the United States," it adds.

The lawsuit was originally filed under seal in 2009 by Dr. Bijan Oughatiyan of Dallas, who worked as a hospitalist for IPC in San Antonio from 2003 to 2008, under the qui tam or whistleblower provisions of the False Claims Act. The federal law and similar state statutes permit private individuals to sue for false claims on behalf of the government and to share in any recovery. The Act also allows the government to intervene or take over the lawsuit, as it has done in this case, and to recover three times its damages plus civil penalties ranging from $5,500 to $11,000 for each false claim submitted.

As alleged in the government's complaint, more than half of IPC's revenues have come historically from government medical insurers, including Medicare and Medicaid, as well as the TRICARE Program, the Federal Employee Health Benefits Program, and the Railroad Retirement Medicare Program.

The lawsuit alleges that IPC pressured and encouraged its physicians to engage in systematic overbilling of the codes submitted to government health benefit programs for evaluation and management procedures such as admission, subsequent hospital visits, and discharge of patients. Based on IPC's regular and detailed monitoring of the codes billed by individual physicians, the lawsuit alleges that IPC was aware that its physicians were using the highest-level billing codes (those which require the most work and are reimbursed at the highest amounts) at rates far in excess of what would normally be expected. It further alleges that IPC knew or should have known that its physicians could not have actually been performing the services at the levels for which claims were submitted.

The complaint illustrates the government's emphasis on combating health care fraud. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered more than $17 billion through False Claims Act cases, with more than $12.2 billion of that amount recovered in cases involving fraud against federal health care programs.

The case is being handled by the U.S. Attorney's Office for the Northern District of Illinois and the Fraud Section of the Commercial Litigation Branch of the Justice Department's Civil Division, with assistance from the U.S. Department of Health and Human Service's Office of Inspector General, the Office of Personal Management's Office of Inspector General, and the Railroad Retirement Board's Office of Inspector General. The government is being represented by Assistant U.S. Attorney Eric Pruitt and DOJ Senior Trial Counsel Elizabeth Rinaldo.

The case is captioned United States ex rel. Oughatiyan v. IPC The Hospitalist Company, Inc., et al., No. 09 C 5418 (N.D. Ill.). The claims asserted against IPC are allegations only, and there has been no determination of liability. In a civil case, the government has the burden of proving the allegations by a preponderance of the evidence.

Complaint

Component(s):
USAO - Illinois, Northern

Updated July 27, 2015

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LAW ENFORCEMENT COORDINATING COMMITTEE
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Back to News & Resources

Press release

TeamHealth Completes Acquisition of IPC Healthcare to Create Leading Physician Services Organization

November 23, 2015

ADVISORS

ABOUT TEAMHEALTH

FORWARD LOOKING STATEMENT

Like It? Share It

Team Health Holdings, Inc. today announced it has successfully completed its acquisition of IPC Healthcare, Inc., a national acute hospitalist and post-acute provider organization. The transaction, valued at approximately $1.6 billion, combines two physician-centric organizations to create a national physician services organization spanning multiple specialties in both hospitals and post-acute facilities. With 16,000 clinicians, the combined organization will be better positioned to effectively manage patients across the continuum of care, allowing TeamHealth to lower costs, increase quality and drive better patient experiences. Together, TeamHealth and IPC Healthcare will have a leadership position in the large and increasingly strategic post-acute setting, serving approximately 2,000 post-acute facilities across 28 states.

"The completion of the IPC Healthcare acquisition is a significant milestone for both TeamHealth and IPC Healthcare, and we are excited to move forward together as one organization positioned for continued success and value creation," said Michael D. Snow, president and CEO of TeamHealth. "As an industry leader in the hospital-based and post-acute settings, we now have an expanded network of services and solutions to support our affiliated clinicians, hospital partners and physician groups and influence high-quality and lower cost outcomes across the continuum of patient care. I am pleased to welcome our IPC Healthcare colleagues to the TeamHealth community and look forward to a seamless integration for the benefit of all TeamHealth stakeholders."

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As a result of the completion of the transaction, IPC Healthcare's common stock will cease trading and will no longer be listed on the NASDAQ exchange.

Advisors

Citi serves as financial advisor to TeamHealth and provides the committed financing in connection with the transaction. MTS Health Partners, L.P., also serves as financial advisor to TeamHealth. Simpson Thacher & Bartlett LLP serves as TeamHealth's legal counsel. Credit Suisse serves as lead financial advisor to IPC Healthcare, and Evercore provided a fairness opinion. Sidley Austin LLP serves as IPC Healthcare's legal counsel.

About TeamHealth

At TeamHealth (NYSE: TMH), our purpose is to perfect our physicians' ability to practice medicine, every day, in everything we do. Through our more than 16,000 affiliated physicians and advanced practice clinicians, TeamHealth offers outsourced emergency medicine, hospital medicine, anesthesia, orthopedic hospitalist, acute care surgery, obstetrics and gynecology hospitalist, urgent care, post-acute and medical call center solutions to approximately 3,500 civilian and military hospitals, clinics, physician groups and post-acute care facilities nationwide. Our philosophy is as simple as our goal is singular: we believe better experiences for physicians lead to better outcomes—for patients, partners and physicians alike. Join our team; we value and empower clinicians. Partner with us; we deliver on our promises. Learn more at http://www.teamhealth.com.

The term "TeamHealth" as used throughout this release includes Team Health Holdings, Inc., its subsidiaries, affiliates, affiliated medical groups and providers, all of which are part of the TeamHealth organization."Providers" are physicians, advanced practice clinicians and other healthcare providers who are employed by or contract with subsidiaries or affiliated entities of Team Health Holdings, Inc. All such providers exercise independent clinical judgment when providing patient care. Team Health Holdings, Inc. does not have any employees, does not contract with providers and does not practice medicine.

Forward Looking Statement

This press release contains certain forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 with respect to the financial condition, results of operations and businesses of the Company, IPC Healthcare and the combined businesses of the Company and IPC Healthcare. Some of these statements can be identified by terms and phrases such as "anticipate," "believe," "intend," "estimate," "expect," "continue," "could," "should," "may," "plan," "project," "predict" and similar expressions. The Company cautions that such "forward looking

statements," including without limitation, the realization of the expected benefits of the acquisition of IPC Healthcare, the Company's, IPC Healthcare's and the combined business's future business prospects, revenue, working capital, professional liability expense, liquidity, capital needs, interest costs and income, wherever they occur in this press release or in other statements attributable to the Company or IPC Healthcare are necessarily estimates reflecting the judgment of the Company's and IPC Healthcare's senior management and involve a number of risks and uncertainties that could cause actual results to differ materially from those suggested by the "forward looking statements." Factors that could cause our actual results to differ materially from those expressed or implied in such "forward-looking statements," include but are not limited to the risks that the acquisition of IPC Healthcare disrupts current plans and operations, current or future government regulation of the healthcare industry, exposure to professional liability lawsuits and governmental agency investigations, the adequacy of insurance coverage and insurance reserves, as well as those factors detailed from time to time in the Company's and IPC Healthcare's filings with the Securities and Exchange Commission. The Company's forward looking statements speak only as of the date hereof and the date they are made. The Company disclaims any intent or obligation to update "forward looking statements" made in this press release to reflect changed assumptions, the occurrence of unanticipated events, or changes to future operating results over time.

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Addressing rehab "outcome killers"

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JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Monday, February 6, 2017

Healthcare Service Provider to Pay $60 Million to Settle Medicare and Medicaid False Claims Act Allegations

A major U.S. hospital service provider, TeamHealth Holdings, as successor in interest to IPC Healthcare Inc., f/k/a IPC The Hospitalists Inc. (IPC), has agreed to resolve allegations that IPC violated the False Claims Act by billing Medicare, Medicaid, the Defense Health Agency and the Federal Employees Health Benefits Program for higher and more expensive levels of medical service than were actually performed (a practice known as "up-coding"), the Department of Justice announced today. Under the settlement agreement, TeamHealth has agreed to pay $60 million, plus interest.

"This settlement reflects our ongoing commitment to ensure that health care providers appropriately bill government programs vital to patient health care," said Acting Assistant Attorney General Chad A. Readler of the Justice Department's Civil Division.

The government contended that IPC knowingly and systematically encouraged false billings by its hospitalists, who are medical professionals whose primary focus is the medical care of hospitalized patients. Specifically, the government alleged that IPC encouraged its hospitalists to bill for a higher level of service than actually provided. IPC's scheme to improperly maximize billings allegedly included corporate pressure on hospitalists with lower billing levels to "catch up" to their peers.

"Medical providers who fraudulently seek payments to which they are not entitled will be held accountable," said U.S. Attorney Zachary T. Fardon for the Northern District of Illinois. "False documentation of treatment is not just flawed patient care; it is illegal."

As part of the settlement, TeamHealth entered into a five-year Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) covering the company's hospital medicine division. This CIA is designed to increase TeamHealth's accountability and transparency so that the company will avoid or promptly detect future fraud and abuse.

"When health care companies boost their profits by misrepresenting the services they bill to taxpayer-funded health care programs, our office will make sure they are held accountable for their deceptive schemes and that they make changes to bill these programs appropriately," said Special Agent in Charge Lamont Pugh of HHS-OIG.

The settlement resolves allegations filed in a lawsuit by Dr. Bijan Oughatiyan, a physician formerly employed by IPC as a hospitalist. The lawsuit was filed in a federal court in Chicago, Illinois, under the qui tam, or whistleblower, provisions of the False Claims Act, which permit private individuals to sue on behalf of the government for false claims and to share in any recovery. The Act also allows the government to intervene and take over the action, as it did in this case. Mr. Oughatiyan will receive approximately $11.4 million.

The government's intervention in this matter illustrates the government's emphasis on combating health care fraud. One of the most powerful tools in this effort is the False Claims Act. Tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement, can be reported to the Department of Health and Human Services, at 800-HHS-TIPS (800-447-8477).

The settlement was the result of a coordinated effort by the Civil Division's Commercial Litigation Branch, the U.S. Attorney's Office for the Northern District of Illinois, and HHS-OIG.

The case is captioned United States ex rel. Oughatiyan v. IPC The Hospitalist, Inc., et al., Case No. 09-C-5418 (N.D. Ill.). The claims resolved by the settlements are allegations only and there has been no determination of liability.

Topic(s):
False Claims Act
Health Care Fraud

Component(s):
Civil Division
USAO - Illinois, Northern

Press Release Number:
17-151

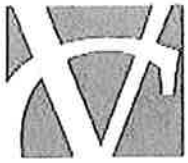
Updated April 27, 2017

Supplemental #1
March 28, 2018
3:58 P.M.

Attachment 9 – Supplemental Information

Letters of Support

Supplemental #1
March 28, 2018
3:58 P.M.



Voytik Center *for* Orthopedic Care

2700 Westside Drive Suite 301, Cleveland, TN 37312
(423) 479-3600 Fax: (423) 303-1212

March 20, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I am Dr. Gary Voytik, a board certified orthopedic surgeon in Cleveland, TN. The purpose of this letter is to make clear that I support Tennova Hospital and their proposal to construct a freestanding emergency department.

Our community has experienced a significant growth in recent years and most recent Copper Basin Medical Center closing which has increased a demand on Tennova Hospital, specifically the demand in their emergency room department.

In addition, I personally do an outreach orthopedic clinic in Polk County. My main reason for doing that is to help with the Medicaid population in that area and to ease the burden of a drive to Cleveland, TN. So, it is safe to say that a freestanding emergency room department will improve access to emergency medical care to residents in both Bradley and Polk County.

Please feel free to contact me with any questions or I can provide you with additional information. Thank you for your consideration.

Sincerely,

Gary Voytik, D.O.

Gary J. Voytik, DO
Board Certified Orthopedic Surgeon
Certified Impact Consultant

Tennova Healthcare

Supplemental #1
March 28, 2018
3:58 P.M.

Cleveland
2305 Chambliss Ave. NW, Cleveland, TN 3731
Tennova.com

March 20, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I am the Physician Recruiter for Tennova Healthcare-Cleveland. I have been employed with Tennova-Cleveland for 9 years and have been in healthcare 30 years. The purpose of this letter is to confirm my support for Tennova Healthcare–Cleveland's proposed Freestanding Emergency Department ("FSED")

Tennova Healthcare–Cleveland is an important part of this community providing excellent healthcare services to patients and industry workers as well as to our own hospital employees. We have been diligent in identifying extremely well qualified physicians to join our medical staff and provide care in our service area. Having a FSED located in an area that is close to industries, businesses and residential communities is a significant need. Currently our ED sees 50K+ patients annually at the main hospital campus. Additional capacity at a secondary location will definitely benefit Bradley County citizens well as the citizens in counties contiguous to Bradley who currently utilize the Cleveland ED.

Our patients deserve to receive the best care possible close to home.

Please do not hesitate to contact me should you have any questions or need additional information. I appreciate your consideration regarding this CON application filed on March 14, 2018.

Sincerely,

Donna Smalley

Donna S. Smalley, CMSR

MAR 28 '18 PM3:59

Supplemental #1
March 28, 2018
3:58 P.M.

March 16, 2018

Ms. Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
502 Deaderick Street, 9th Floor
Nashville, TN 37243

Re: Tennova Healthcare – Cleveland's Proposed Freestanding Emergency Department

Dear Ms. Hill,

I am Deborah Burgess, a nurse in the Cleveland area, and a resident of Polk County. I am writing this letter in support of Tennova Healthcare – Cleveland's proposed Freestanding Emergency Department.

Tennova Healthcare – Cleveland is an important member of our medical community in Bradley County and surrounding counties. The addition of a Freestanding Emergency Department in northern Cleveland is an important and necessary addition to the spectrum of services that our local community hospital provides.

The existing Emergency Department on the main hospital campus is very busy, serving nearly 50,000 patients each year. While an expansion of the ED would provide much-needed additional space, expansion on the main campus is simply not a viable alternative because of campus space limitations.

The construction of a new Freestanding Emergency Department will allow Tennova Healthcare – Cleveland to add needed capacity to serve the growing community in an efficiently-designed, entirely outpatient-focused campus in a growing part of the county.

The ability to receive care close to home is very important not only for continuity of care but also for community support of friends and family, especially after the closure of Copper Basin Medical Center in Polk County. The residents of Bradley County and surrounding counties in need of medical care are best served by receiving care within their home community instead of having to be transported into Chattanooga when services are available right here in Cleveland, which is closer to Polk County residents.

I strongly support the proposed Freestanding Emergency Department to be developed by our home-town community hospital. Tennova Cleveland, and its ability to continue meeting the needs of its local community, is an important part of the health care continuum in our region. Please feel free to contact me with any questions or if I can provide you with additional information.

Sincerely,

Deborah Burgess
109 John Hale Dr. E.
Benton, TN 37307

Supplemental #2 (Original)

Cleveland TN Hospital Company, LLC dba Tennova Healthcare-Cleveland

CN1803-015

MAR 29 '18 12:18

Supplemental #2
March 29, 2018
12:18 P.M.

Supplemental Information #2
Certificate of Need Application CN1803-015
Cleveland TN Hospital Company, LLC d/b/a Tennova Healthcare – Cleveland
Establishment of a Satellite Emergency Department (FSED)

Please see the following Supplemental Information #2 provided in response to the March 28, 2018 letter from Mark A. Farber, Deputy Director requesting clarification or additional information on the Certificate of Need Application CN1803-015 Supplemental Information submitted to HSDA on March 28, 2018.

1. **Expansion of Existing Emergency Department Facility**

   Please complete the following chart:

RESPONSE: Please see the table below. The ACEP sizing measures utilize the High Range Estimates for an emergency department with an annual volume of 45,000 visits.

Table 1 – Supplemental Information #2
Tennova Cleveland Current ED (Main Hospital Campus)

Hospital	2017 Annual Visits	Dept. Gross Area (SF)	ED Beds	ED Visits/Bed	Area/Bed (SF)	ACEP Beds*	ACEP Visits/Bed*	ACEP Area/Bed (SF)*
Tennova Cleveland	47,326	28,280	41	1,155	690	37	1,216	850

Source: Tennova Cleveland internal data.
*ACEP Recommended High Range Estimate

As the 2017 emergency department visits for Tennova Cleveland are represented in Table 1 above, an updated version of Table 4 from the initial Supplemental Information submission is provided below utilizing the applicant's 2017 emergency department visits. For clarification, Table 4 from the initial Supplemental Information submission utilized 2016 emergency department visits.

Table 2 – Supplemental Information #2
Tennova Cleveland Current ED (Main Hospital Campus)

Hospital	2017 Total Visits	Rooms/Beds	Visits/Bed	Square Feet	Visits per Square Foot
Tennova Cleveland	47,326	41	1,155	28,280	1.673

Source: Tennova Cleveland internal data.

2. **Section B Economic Feasibility Item F.2**

Your response to this item is noted; however it appears that net operating margin ratio for the Projected Years are still incorrect, based on the data provided on Page 80R.

Please make the necessary corrections.

RESPONSE: Please find below the net operating margin ratio table revised to reflect the Year One and Year Two margins for the Project, Only (FSED). Since the proposed project is a new satellite FSED, there is no historical operations data. The historical data presented in this chart is the net operating margin for Tennova Cleveland's existing main campus emergency services.

Table 3 – Supplemental Information #2
Net Operating Margin

Year	2nd Year previous to Current Year*	1st Year previous to Current Year*	Current Year* (2017)	Projected Year 1**	Projected Year 2**
Net Operating Margin Ratio	33.4%	32.8%	22.0%	19.0%	19.3%

* *Margin ratios represent existing Tennova ED services.*
** *Margin ratios represent the proposed FSED, only.*

3. **Section B. Quality Measures**

It appears that some of the quality measures were not included in the last supplemental request.

Please address the following quality measures.

Section B, Quality Measures

Please verify and acknowledge the applicant will be evaluated annually whether the proposal will provide health care that meets appropriate quality standards upon the following factors:

(3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:

(a) 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 its CON application.

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

RESPONSE: The applicant commits to obtaining and maintaining all applicable state licenses in good standing.

(c) 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 commits to obtaining and maintaining TennCare and Medicare certifications.

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

RESPONSE: The applicant confirms that it has maintained substantial compliance with applicable federal and state regulations for the three years prior to the submission of this CON application.

MAR 29 '18 PM 12:18

Supplemental #2
March 29, 2018
12:18 P.M.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Williamson

NAME OF FACILITY: Tennova Healthcare - Cleveland

I, Martin G. Schweinhart, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title
President, Cleveland Tennessee Hospital Company, LLC

Sworn to and subscribed before me, a Notary Public, this the 29th day of March, 2018, witness my hand at office in the County of Williamson, State of Tennessee.

NOTARY PUBLIC

My commission expires 9/16, 2019.

MARY ANN ECKMAN
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY
My Commission Expires 09-16-2019

HF-0043

Revised 7/02