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

# CERTIFICATE OF NEED APPLICATION

## 1A. Name of Facility, Agency, or Institution

TriStar Spring Hill Hospital
**Name**

3001 Reserve Boulevard | Maury County
**Street or Route** | **County**

Spring Hill | Tennessee | 37174
**City** | **State** | **Zip**

https://tristarhealth.com/
**Website Address**

**Note:** The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.

## 2A. Contact Person Available for Responses to Questions

David Whelan | Vice President of Strategy
**Name** | **Title**

TriStar Health | david.whelan@hcahealthcare.ocm
**Company Name** | **Email Address**

1000 Health Park Drive
**Street or Route**

Brentwood | Tennessee | 37027
**City** | **State** | **Zip**

Executive | 615-886-4900
**Association with Owner** | **Phone Number**

## 3A. Proof of Publication

Attach the full page of newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent. (Attachment 3A)

**Date LOI was Submitted:** 04/15/24

**Date LOI was Published:** 04/15/24

**RESPONSE:** Affidavits from The Tennessean and The Daily Herald are attached. See 3A attachment.

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

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

Initiation of HealthCare services

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

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

## 5A. Type of Institution *(Check all appropriate boxes – more than one response may apply)*

- [x] Hospital
- [ ] Ambulatory Surgical Treatment Center (ASTC) – Multi-Specialty
- [ ] Ambulatory Surgical Treatment Center (ASTC) – Single Specialty
- [ ] Home Health
- [ ] Hospice
- [ ] Intellectual Disability Institutional Habilitation Facility (ICF/IID)
- [ ] Nursing Home
- [ ] Outpatient Diagnostic Center
- [ ] Rehabilitation Facility
- [ ] Residential Hospice
- [ ] Nonresidential Substitution Based Treatment Center of Opiate Addiction

☐ Other

Other -

Hospital -
General Medical and Surgical

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

Spring Hill Hospital, Inc.

**Name**

| One Park Plaza | | 615-886-4900 |
|---|---|---|
| **Street or Route** | | **Phone Number** |
| Nashville | Tennessee | 37203 |
| **City** | **State** | **Zip** |

## 7A. Type of Ownership of Control *(Check One)*

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Limited Partnership
- ☑ Corporation (For Profit)
- ☐ Corporation (Not-for-Profit)
- ☐ Government (State of TN or Political Subdivision)
- ☐ Joint Venture
- ☐ Limited Liability Company
- ☐ Other (Specify)

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's website at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx If the proposed owner of the facility is government owned must attach the relevant enabling legislation that established the facility. (Attachment 7A)

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

**RESPONSE:** The proposed TriStar Spring Hill Hospital ("TSHH") is owned by Spring Hill Hospital, Inc. The Applicant is ultimately owned by HCA Healthcare, Inc. ("HCA Healthcare") through several wholly-owned subsidiary corporations. Please see Attachments 7A-1, 7A-2 and 7A-3 for Spring Hill Hospital, Inc.'s corporate status from the Tennessee Division of Business Services Department of State, Charter, Certificate and Assumed Name, respectively. Attachment 7A-4 contains a copy of Spring Hill Hospital Inc.'s organizational chart. Attachment 7A-5 contains a listing of Spring Hill Hospital Inc.'s directors and officers.

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

**Name**

**Street or Route** | **County**

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

**Website Address**

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

## 9A. Legal Interest in the Site

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

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

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

**RESPONSE:** The Applicant owns the project site, a 77-acre campus. Please see attachment 9A for the deeds associated with its ownership.

## 10A. Floor Plan

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

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

**RESPONSE:** The proposed hospital is a three-story structure which will encompass with the existing TriStar Spring Hill ER, which will be incorporated into the TSHH license and operations. See Attachment 10A for a copy of the floor plans of the three-story structure. There is one page for each level. A summary of the functions on each floor is as follows: First Floor: New construction will include 4 surgery suites, 2 endoscopy suites, 2 cardiac cath labs, a pre and post-operative unit, imaging, full service laboratory, pharmacy, dietary services, support departments, admitting and lobby. There are also future expansion zones for surgery, pharmacy, lab and support areas. This first floor also shows the connector from the existing emergency department which has 12 existing beds. There is an expansion zone between the existing ER and the hospital labeled as imaging/ED expansion. Second Floor: The second floor includes an 8-bed intensive care unit (ICU), 10 labor/delivery/ recovery/postpartum (LDRP) rooms, 2 C-section rooms, 8-bed neonatal

intensive care unit (NICU), well baby nursery, respiratory therapy and support spaces for ICU, obstetrics and neonatal services. There is also space for horizontal expansion adjacent to the ICU. Third Floor: The third floor includes 42-bed private medical/surgical patient rooms, therapy, inpatient dialysis and med/surg support spaces; there is also an expansion zone on this floor, above the expansion zone on the second floor.

## 11A. Public Transportation Route

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

**RESPONSE:** The proposed TSHH is located at 3001 Reserve Boulevard, Spring Hill, Maury County, TN 37174. The TSHH campus is visible from and sits off Saturn Parkway (SR 396), which connects to I-65 and U.S. 31 (Columbia Pike) and is accessible using multiple roadways. Reserve Boulevard is accessible from Kedron Road, which is accessible to the north from Beechcroft Road or U.S. 31 and immediately to the south from an exit on Saturn Parkway. Accordingly, the site is easily accessible by car, ambulance, and other ground transportation. HCA Healthcare paid to construct Reserve Boulevard and its bridge to access the TriStar Spring Hill ER and contributed to its extension to the east. This road/bridge construction brought essential access to the City of Spring Hill's designated healthcare innovation area and served as a new west-east connector between Kedron Road and Port Royal Road. There are no public bus routes in this area. South Central Tennessee Development District Public Transportation service includes Maury County, providing on-demand public transportation services. See https://www.sctdd.org/ There is no route map as this is an on-demand service.

## 12A. Plot Plan

Unless relating to home care organization, briefly describe the following and attach the requested documentation on a letter size sheet of white paper, legibly labeling all requested information. It **must** include:

- Size of site (in acres);
- Location of structure on the site;
- Location of the proposed construction/renovation; and
- Names of streets, roads, or highways that cross or border the site.

(Attachment 12A)

**RESPONSE:** The TriStar Spring Hill campus is 77 acres, which contains the existing TriStar Spring Hill ER, TriStar Spring Hill Medical Park, helipad and associated infrastructure. TSHH will be a 200,000 square foot addition adjacent and connected to the existing ER and three-story medical office building. The site plan shows the proposed hospital location adjacent to and connected with the existing structure. It also shows its access from Reserve Boulevard into the campus along with access to Reserve Boulevard from Kedron Road. Saturn Parkway (SR 396) is situated on the south side of the property providing excellent visibility and easy access to Kedron Road from this major roadway in Spring Hill. Please see the plot plan included in Attachment 12A for the site relative to the entire parcel, location of the existing structure on the site, the location of the proposed construction, and the names of adjacent roads.

## 13A. Notification Requirements

- TCA §68-11-1607(c)(9)(B) states that "... If an application involves a healthcare facility in which a county or municipality is the lessor of the facility or real property on which it sits, then within ten (10) days of filing the application, the applicant shall notify the chief executive officer of the county or municipality of the filing, by certified mail, return receipt requested." Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

- ☐ Notification Attached (Provide signed USPS green-certified mail receipt card for each official notified.)
- ☐ Notification in process, attached at a later date
- ☐ Notification not in process, contact HFC Staff
- ☑ Not Applicable

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

  - ☐ Notification Attached (Provide signed USPS green-certified mail receipt card for each official notified.)
  - ☐ Notification in process, attached at a later date
  - ☐ Notification not in process, contact HFC Staff
  - ☐ Not Applicable

## EXECUTIVE SUMMARY

## 1E. Overview

Please provide an overview not to exceed **ONE PAGE** (for 1E only) in total explaining each item point below.

- Description: Address the establishment of a health care institution, initiation of health services, and/or bed complement changes.

**RESPONSE:**

· **Description:** TSHH will be a full-service, community hospital located at 3001 Reserve Boulevard, Spring Hill, Maury County, TN 37174, the same physical site as the existing TriStar Spring Hill ER. The 68-bed hospital will include new construction of approximately 200,000 square feet connected to the existing ER. The hospital will have 42 med/surg beds, 8 ICU beds, 10 obstetrics beds, and 8 Level II NICU bassinets. Ancillary services, in addition to the existing 12 treatment room ER, will include 4 surgery suites, 2 endoscopy suites, 2 cardiac catheterization labs, a pre and post-operative unit, imaging (including MRI), laboratory, pharmacy, respiratory therapy, and inpatient dialysis.

Spring Hill is the largest city in Tennessee without a hospital. Its population has more than tripled since 2005 (17,325) and has more than doubled in population since 2010 (from 27,700 to nearly 58,000) and is expected to continue growing significantly, conservatively reaching 64,000 by 2028.[1] Since the Spring Hill community lacks a hospital, all must travel to other cities for inpatient care. As population in this area continues to increase, the congestion attendant to such growth will continue to make it even more difficult to get to existing hospitals in other cities. The Service Area is made up of three zip codes: 37174 (Spring Hill), 37179 (Thompson's Station) and 38401, the zip code that includes Columbia. Patients from these zip codes make up 75 percent of the patients cared for at the TriStar Spring Hill ER, and they will likewise make up 75 percent of the inpatients at TSHH. TriStar Spring Hill ER is the largest provider of ER services to the residents of Spring Hill; over 40 percent of ER visits from 37174 (Spring Hill) are to the TriStar Spring Hill ER. About 18 percent of ER visits from 37179 and 38401 are to the TriStar Spring Hill ER.

**Need:** TSHH is needed:

· **To Provide Access/Availability:** With no hospital in Spring Hill, residents of the Service Area confront geographic isolation and programmatic access challenges and lengthy times to reach hospital inpatient services. TSHH will provide currently unavailable inpatient care in Spring Hill. Patients will receive inpatient care in their community where their families can more readily visit and participate in their recuperation. Cardiac cath, MRI, and NICU services will also be provided.

· **To Address Population Growth:** The Spring Hill population tripled since 2005, is the 2nd fastest growing city in the State and is forecasted to increase to more than 64,000 by 2028. Continued growth highlights the need for a hospital.

v The need for a hospital in Spring Hill has been apparent for nearly 20 years. Even with one-third the population at the time, in 2006, the HSDA approved a CON for a 56-bed Spring Hill Hospital. This approval was reversed by the Chancery Court of Davidson County under the prior version of the CON law before it was substantially reformed in 2021. Impact on other providers was a factor under the old law. It is not under the 2021 CON reform statute. On February 29, 2024, the HFC held that "Under the 2021 revisions to the Tennessee CON law, the impact of a project on existing providers is no longer a criterion for consideration."

· **To Reduce Patient Out-Migration:** More than 50 percent of Maury County residents leave Maury County for inpatient hospital care while 89 percent of Spring Hill residents leave Maury County for such care. The natural travel

pattern for northern Maury County residents is to the north. No hospital exists in northern Maury County or Spring Hill. TSHH will be the only hospital in the area and will significantly reduce the outflow of Spring Hill and Maury County residents needing inpatient care.

· **To Eliminate Patient Transfers and EMS Bypass:** During the past 5 years, TriStar Spring Hill ER transferred approximately 6,700 ER patients out of the area, with the majority being transferred to TriStar Centennial Medical Center ("TriStar Centennial") in Nashville, which is 50 to 60 minutes away depending on time/day. In addition to ER to hospital transfers, EMS annually transports more than 1,900 emergencies from Spring Hill to hospitals in other cities. By having a full-service, community hospital in Spring Hill, the local EMS service will not have to carry acute patients needing hospitalization to other cities and counties for care, which will mean that EMS services will be more readily available in the community.

[1] 2023 and 2028 population from the Tennessee Comptroller; other forecasts are also referenced in the CON Application.

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- Ownership structure

  **RESPONSE:** TSHH will be owned and operated by Spring Hill Hospital, Inc., whose ultimate parent company is HCA Healthcare, Inc. TSHH is part of HCA Healthcare's TriStar Health, which operates 11 hospitals in Middle Tennessee. HCA Healthcare operates 186 hospitals in 20 states and the U.K.

- Service Area

  **RESPONSE:** The service area is defined as three zip codes 37174 – Spring Hill and 38401 – Columbia, both in Maury County, and 37179 – Thompson's Station in Williamson County.

- Existing similar service providers

  **RESPONSE:** There is no hospital in Spring Hill. There is one existing hospital in Maury County, Maury Regional Hospital ("MRH"), which is in Columbia and is 14 miles to the southwest of TSHH. There is a hospital in Williamson County, outside of the service area, Williamson Medical Center "(WMC"), which is in Franklin and is 17 miles northeast of TSHH.

- Project Cost

  **RESPONSE:** The estimated capital cost of the project is $250,000,000.

- Staffing

  **RESPONSE:** The proposed hospital will be staffed by 283 FTEs including 45 FTEs currently employed at the campus. With more than 2,750 HCA employees who reside in Maury and Williamson Counties of which ~1,000 are TriStar Health direct care positions, the Applicant is confident it will successfully recruit the needed complement to staff the hospital.

## 2E. Rationale for Approval

A Certificate of Need can only be granted when a project is necessary to provide needed health care in the area to be served, will provide health care that meets appropriate quality standards, and the effects attributed to competition or duplication would be positive for consumers

Provide a brief description not to exceed ONE PAGE (for 2E only) of how the project meets the criteria necessary for granting a CON using the data and information points provided in criteria sections that follow.

- Need

  **RESPONSE:** • TSHH is needed to provide inpatient hospital care to the City of Spring Hill and the surrounding communities. The City of Spring Hill is the largest city in Tennessee without a hospital, requiring all its residents to leave Spring Hill for inpatient care. Spring Hill is one of the fastest growing cities in the State, both historically and expected into the future. More than 50 percent of Maury County residents, 89 percent of Spring Hill residents and 38 percent of Columbia residents leave Maury County for inpatient care.(2) No other Tennessee city has a population exceeding 48,000 without a hospital. There are 69 Tennessee cities smaller than Spring Hill with at least 1 hospital.(3) Spring Hill residents must travel on consistently heavily congested roads to reach the nearest out-of-town hospitals. MRH is 14 miles to the southwest and on the other side of Columbia. WMC is 17 miles to the Northeast in Franklin. Hospitals in Nashville are an hour away. As for the added services in TSHH, the live birth rate confirms Level II NICU bassinets are needed in Spring Hill and the Criteria and Standards are met for additional cardiac catheterization and MRI services. • TSHH will bring needed hospital services into the community where patients live. With no hospital in Spring Hill, community residents confront geographic and programmatic access challenges and lengthy times to reach existing similar services. The proposed hospital will provide inpatient, ICU, obstetrics, cardiac cath, and NICU services, all of which are unavailable services in Spring Hill. • TriStar Spring Hill ER is a robust ER transferring between 1,100 and 1,800 patients per year for inpatient and specialized services. More than 75 percent of these are transferred to TriStar Health facilities and 87 percent require services that will be available at TSHH. Avoiding these transfers will decrease healthcare costs and reduce out-migration, which are appropriate health planning considerations for approval of a hospital. • Currently, local EMS units transport emergencies from Spring Hill to hospitals in other cities, a total of 1,900+ times per year. The current EMS service bypasses the closest TriStar Spring Hill ER in favor of a full-service hospital with surgical, procedural and inpatient capabilities. Redirection of these EMS transports to a Spring Hill hospital will improve access for the patients and their families, reduce out-migration, reduce EMS transport costs, and provide local EMS with increased presence and availability in Spring Hill to respond to the next incident. 2. THA data is 2021; JARs data is 2022. 3. Kingsport is about the same size as Spring Hill and has 2 acute care hospitals – over 340 beds. Spring Hill has zero (0).

- Quality Standards

  **RESPONSE:** As part of TriStar Centennial, the existing Spring Hill ER is a 5-star CMS-rated facility, the only such facility in the Nashville Area, and has excellent quality scores. TSHH will operate under the same quality standards as its ER currently does and will seek to perform similarly. The proposed hospital will provide high quality care that is accessible for all patients in the Service Area. The hospital will be appropriately licensed and accredited by The Joint Commission. In addition, as part of HCA Healthcare, it will have a robust Quality Assurance and Performance Improvement ("QAPI") and Utilization Review Program to maintain and ensure quality of care and patient safety.

- Consumer Advantage
  - Choice

    **RESPONSE:** TSHH will be the only hospital in Spring Hill, the most populated city in the state without its own hospital and one which is geographically isolated from other hospitals in the region. It will bring a choice of

providers and convenience to the community. The added choice is highlighted by the fact that currently more than 89 percent of Spring Hill residents and 50 percent of Maury County patients (5,000+ annually) leave Maury County for inpatient hospital care.

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

**RESPONSE:** TSHH will improve access by (1) establishing a hospital where none exists; (2) bringing inpatient and specialized services to a community with needs for such services; (3) reducing travel time to hospital services; (4) reducing out-migration to hospitals in other cities; (5) reducing EMS transports out of the area; and (6) satisfying consumer demand for a hospital.

○ Affordability

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

## 3E. Consent Calendar Justification

☐ Letter to Executive Director Requesting Consent Calendar (Attach Rationale that includes addressing the 3 criteria)

☑ Consent Calender NOT Requested

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

## 4E. PROJECT COST CHART

| | |
|---|---|
| A. Construction and equipment acquired by purchase: | |
| 1. Architectural and Engineering Fees | $10,130,000 |
| 2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees | $150,000 |
| 3. Acquisition of Site | $0 |
| 4. Preparation of Site | $12,000,000 |
| 5. Total Construction Costs | $145,605,000 |
| 6. Contingency Fund | $13,969,000 |
| 7. Fixed Equipment (Not included in Construction Contract) | $17,815,000 |
| 8. Moveable Equipment (List all equipment over $50,000 as separate attachments) | $35,478,000 |
| 9. Other (Specify): Testing, Inspection, Escalation, Building Fees and Pre-Planning | $14,808,000 |
| B. Acquisition by gift, donation, or lease: | |
| 1. Facility (inclusive of building and land) | $0 |
| 2. Building only | $0 |
| 3. Land only | $0 |
| 4. Equipment (Specify): | $0 |
| 5. Other (Specify): | $0 |
| C. Financing Costs and Fees: | |
| 1. Interim Financing | $0 |
| 2. Underwriting Costs | $0 |
| 3. Reserve for One Year's Debt Service | $0 |
| 4. Other (Specify): | $0 |
| D. Estimated Project Cost (A+B+C) | $249,955,000 |
| E. CON Filing Fee | $45,000 |
| F. Total Estimated Project Cost (D+E) **TOTAL** | $250,000,000 |

## GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with TCA §68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, will provide health care that meets appropriate quality standards, and the effect attributed to completion or duplication would be positive for consumers." In making determinations, the Agency uses as guidelines the goals, objectives, criteria, and standards adopted to guide the agency in issuing certificates of need. Until the agency adopts its own criteria and standards by rule, those in the state health plan apply.

Additional criteria for review are prescribed in Chapter 11 of the Agency Rules, Tennessee Rules and Regulations 01730-11.

The following questions are listed according to the three criteria: (1) Need, (2) the effects attributed to competition or duplication would be positive for consumers (Consumer Advantage), and (3) Quality Standards.

## NEED

The responses to this section of the application will help determine whether the project will provide needed health care facilities or services in the area to be served.

**1N.** Provide responses as an attachment to the applicable criteria and standards for the type of institution or service requested. A word version and pdf version for each reviewable type of institution or service are located at the following website. https://www.tn.gov/hsda/hsda-criteria-and-standards.html (Attachment 1N)

**RESPONSE:**

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

With respect to the proposed TSHH, four criteria and standards are relevant and applicable, as follows:

- Acute Care Beds Criteria and Standards;
- Neonatal Intensive Care Unit (NICU) Criteria and Standards;
- Cardiac Catheterization Criteria and Standards; and
- Magnetic Resonance Imaging Criteria and Standards.

Accordingly, responses to each of the criteria and standards applicable to the proposal in this CON Application are individually provided in **Attachment 1N**. As is shown in these four sections within **Attachment 1N**, the need for the proposed TSHH is overwhelmingly demonstrated.

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**2N.** Identify the proposed service area and provide justification for its reasonable ness. Submit a county level map for the Tennessee portion and counties boarding the state of the service area using the supplemental map, clearly marked, and shaded to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply

to the project. Please include a discussion of the inclusion of counties in the border states, if applicable. (Attachment 2N)

**RESPONSE:**

See attached/uploaded document: 2N (CON Form pages 12 to 24).

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

**PROJECTED UTILIZATION**

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

| Service Area Counties | Projected Utilization Recent Year 1 (Year = 2027) | % of Total |
|---|---|---|
| Maury | 1,003 | 39.18% |
| Maury | 781 | 30.51% |
| Williamson | 136 | 5.31% |
| Other not primary/secondary county | 640 | 25.00% |
| Total | 2,560 | 100% |

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

**RESPONSE:**

See attached/uploaded document: 3N (CON Form pages 25 to 35). Part A is on pages 25 through 33 and Part B with table is on pages 34 and 35.

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

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

**RESPONSE:**

See attached/uploaded document: 3N (CON Form pages 25 to 35). Part A is on pages 25 through 33 and Part B with table is on pages 34 and 35.

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

**RESPONSE:**

See attached/uploaded document: 4N (CON Form pages 36 to 69).

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

**RESPONSE:**

See attached/uploaded document: 5N (CON Form pages 70 to 73).

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

**RESPONSE:**

See attached/uploaded document: 6N (CON Form pages 74 to 89).

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

**RESPONSE:**

The Applicant does not have any outstanding CON applications. The Applicant's TriStar affiliates have several approved CONs as noted above. The status of each is summarized below:

· CN 1707-023 – The StoneCrest Surgery Center CON requested and was granted an extension through May 31, 2025, to evaluate the impact of the acquisition of an existing surgery center in Rutherford County and the impact of the pandemic.

· CN 2205-027 – TriStar Centennial was approved for a new FSED for the Bellevue community in Nashville, Davidson County, at the August 24, 2022, HFC meeting. Construction has commenced, with an opening planned for October 2024.

· CN 2208-036 – Parkridge Medical Center was approved for a new FSED in Soddy Daisy, Hamilton County, on October 26, 2022. Its opening is currently scheduled for May 20, 2024.

· CN 2302-006 - TriStar Skyline Medical Center was approved for a new FSED in East Nashville on April 26, 2023. The CON has been issued and is valid through June 1, 2026.

· CN 2304-010 - TriStar Southern Hills Hospital received approval for a new FSED in Nolensville, Williamson County, Tennessee on June 28, 2023. Construction plans are in development, and construction is expected to begin in February 2025 with a January 2026 opening.

· CN 2308-020 – Chattanooga East Surgicenter was approved on October 25, 2023. It is currently in the development phase.

| CON Number | Project Name | Date Approved | Expiration Date |
|---|---|---|---|
| CN2302-006 | TriStar Skyline East Nashville FSED | 4/26/2023 | 6/1/2026 |
| CN1707-023 | TriStar StoneCrest Surgery Center | 10/25/2017 | 5/31/2025 |
| CN2205-027 | TriStar Centennial Bellevue FSED | 8/24/2022 | 10/1/2025 |
| CN2208-036 | Parkridge Medical Center Soddy Daisy FSED | 10/26/2022 | 12/1/2025 |
| CN2304-010 | TriStar Southern Hills Nolensville FSED | 6/28/2023 | 8/1/2026 |
| CN2308-020 | Chattanooga East Surgicenter | 10/25/2023 | 12/1/2025 |

**CONSUMER ADVANTAGE ATTRIBUTED TO COMPETITION**

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

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

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

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

- [x] Aetna Health Insurance Company
- [x] Ambetter of Tennessee Ambetter
- [x] Blue Cross Blue Shield of Tennessee
- [ ] Blue Cross Blue Shield of Tennessee Network S
- [x] Blue Cross Blue Shiled of Tennessee Network P
- [x] BlueAdvantage
- [ ] Bright HealthCare
- [x] Cigna PPO
- [ ] Cigna Local Plus
- [x] Cigna HMO - Nashville Network
- [x] Cigna HMO - Tennessee Select
- [x] Cigna HMO - Nashville HMO
- [x] Cigna HMO - Tennessee POS
- [x] Cigna HMO - Tennessee Network
- [ ] Golden Rule Insurance Company
- [x] HealthSpring Life and Health Insurance Company, Inc.
- [x] Humana Health Plan, Inc.
- [x] Humana Insurance Company
- [ ] John Hancock Life & Health Insurance Company
- [ ] Omaha Health Insurance Company
- [ ] Omaha Supplemental Insurance Company
- [ ] State Farm Health Insurance Company
- [x] United Healthcare UHC
- [ ] UnitedHealthcare Community Plan East Tennessee
- [x] UnitedHealthcare Community Plan Middle Tennessee
- [ ] UnitedHealthcare Community Plan West Tennessee
- [ ] WellCare Health Insurance of Tennessee, Inc.
- [x] Others

**RESPONSE:** Other plans: Coventry Healthcare; First Health/Coventry National; HCA Employee Benefit Plan; Health Alliance; Magellan Health Service; MultiPlan/PHCS; PPO Plus; Value Options/Beacon Health Services; Oscar; Amerigroup; WellPoint.

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

**RESPONSE:**

**See attached PDF with response to Questions 3C, 4C and 5C.**

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**4C.** Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements, CMS, and/or accrediting agencies requirements, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

**RESPONSE:**

**See attached PDF with response to Questions 3C, 4C and 5C.**

---

**5C.** Document the category of license/certification that is applicable to the project and why. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

**RESPONSE:**

**See attached PDF with response to Questions 3C, 4C and 5C.**

---

**PROJECTED DATA CHART**

☑ Project Only
☐ Total Facility

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

| | | Year 1 | Year 2 |
|---|---|---|---|
| | | 2027 | 2028 |
| A. Utilization Data | | | |
| Specify Unit of Measure Other : Adjusted Discharges | | 7450 | 8944 |
| B. Revenue from Services to Patients | | | |
| 1. Inpatient Services | | $268,926,241.00 | $355,572,169.00 |
| 2. Outpatient Services | | $513,416,338.00 | $609,938,610.00 |
| 3. Emergency Services | | $0.00 | $0.00 |
| 4. Other Operating Revenue (Specify) _____ | | $0.00 | $0.00 |
| | **Gross Operating Revenue** | $782,342,579.00 | $965,510,779.00 |
| C. Deductions from Gross Operating Revenue | | | |
| 1. Contractual Adjustments | | $613,067,000.00 | $766,242,000.00 |
| 2. Provision for Charity Care | | $57,380,100.00 | $66,443,650.00 |
| 3. Provisions for Bad Debt | | $10,125,900.00 | $11,725,350.00 |
| | **Total Deductions** | $680,573,000.00 | $844,411,000.00 |
| **NET OPERATING REVENUE** | | $101,769,579.00 | $121,099,779.00 |

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

**Project Only Chart**

| | Previous Year to Most Recent Year | Most Recent Year | Year One | Year Two | % Change (Current Year to Year 2) |
|---|---|---|---|---|---|
| **Gross Charge** *(Gross Operating Revenue/Utilization Data)* | $0.00 | $0.00 | $105,012.43 | $107,950.67 | 0.00 |
| **Deduction from Revenue** *(Total Deductions/Utilization Data)* | $0.00 | $0.00 | $91,352.08 | $94,410.89 | 0.00 |
| **Average Net Charge** *(Net Operating Revenue/Utilization Data)* | $0.00 | $0.00 | $13,660.35 | $13,539.78 | 0.00 |

**8C.** Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

**RESPONSE:**

TSHH is proposing to establish a new community hospital; it therefore does not have current hospital charges. Its proposed charge structure utilizes a composite of TriStar's four community hospitals in Middle Tennessee, outside Davidson County.[52] It is that composite that was utilized to forecast gross charges as presented in the projected chart on the previous page. Deductions from revenues are based on TriStar's reimbursement experience by payor for both inpatient and outpatient services. TSHH also factors in anticipated bad debt and charity care based on current experience at TriStar Spring Hill ER and forecasted based on a full-service community hospital.

Gross charges do not reflect what either patients or payors pay as payors have discounted rates and insured patients are only responsible for co-pays and deductibles. In reality, the average net charge is what patients and/or payors pay in aggregate for the services received. As reflected in the above chart, the average net charge per adjusted admission at TSHH is estimated to be $13,540 in year two.

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

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**9C.** Compare the proposed project charges to those of similar facilities/services in the service area/adjoining services areas, or to proposed charges of recently approved Certificates of Need.

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

**RESPONSE:**

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

· Comparison of charges for services are not meaningful as gross charges do not reflect what either patients or payors pay for services as payors have discounted rates and insured patients are only responsible for co-pays and deductibles. Self-pay patients and even those with insurance may also qualify for a self-pay discount. In addition, low-income individuals may qualify for charity care.

· The amount that patients pay is largely determined by their health insurance coverage. If a patient does not have health insurance, their financial liability will be determined by the application of TriStar Spring Hill's uninsured discount to their bill for non-elective services.

· Comparisons of charge rates between hospitals will not reflect distinctions in prices due to variations in pricing methodology. For example, if an item or service is priced as a case rate (a set rate for an episode of care) with a particular payor or for a particular hospital, but as a per day rate with a different payer or hospital, then these rates cannot be compared without first determining the patient's length of stay and then applying the applicable contractual enhancements (e.g., stoploss or trauma activation).

More relevant than gross charge comparison is the payment rates or cost of care between facilities. For government payors, payment rates are very likely the same or similar for all providers in the Service Area. On the CMS Hospital Compare website there are four patient conditions for which Medicare publishes what it paid each hospital on average for these conditions. The four conditions and respective payments to MRH and WMC are presented below. Since TSHH is not yet a hospital, it has no such reporting for comparison purposes. However, since the composite of four area hospitals were utilized to estimate charges for TSHH, these four TriStar hospitals are included in the below exhibit. The conclusion that may be drawn from this comparative information is that on average across these four conditions, the Medicare payments are comparable among the TriStar hospitals and MRH and WMC.

**Exhibit 68**

| Condition | Medicare Payments by Condition | | | | | |
|---|---|---|---|---|---|---|
| | TriStar StoneCrest | TriStar NorthCrest | TriStar Horizon | TriStar Hendersonville | MRH | WMC |
| Heart Attack Patients | $25,935 | n/a | $29,311 | $27,298 | $27,890 | $25,611 |
| Heart Failure Patients | $18,235 | $17,178 | $18,601 | $18,894 | $18,646 | $17,368 |
| Hip/Knee Replacement Patients | n/a | $22,014 | $19,582 | $18,589 | $21,070 | $18,760 |
| Pneumonia Patients | $20,264 | $21,634 | $20,486 | $21,182 | $19,158 | $20,223 |

*Source: Centers for Medicare and Medicaid Services, Hospital Compare, April 24, 2024. n/a - not available on CMS website.*

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

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

**Applicant's Projected Payor Mix**

**Project Only Chart**

| Payor Source | Year-2027 | | Year-2028 | |
|---|---|---|---|---|
| | **Gross Operating Revenue** | **% of Total** | **Gross Operating Revenue** | **% of Total** |
| **Medicare/Medicare Managed Care** | $279,777,111.00 | 35.76 | $368,053,000.00 | 38.12 |
| **TennCare/Medicaid** | $106,718,767.00 | 13.64 | $122,688,704.00 | 12.71 |
| **Commercial/Other Managed Care** | $291,446,145.00 | 37.25 | $356,996,605.00 | 36.97 |
| **Self-Pay** | $67,777,900.00 | 8.66 | $78,470,737.00 | 8.13 |
| **Other(Specify)** | $36,622,656.00 | 4.68 | $39,301,733.00 | 4.07 |
| **Total** | $782,342,579.00 | 100% | $965,510,779.00 | 100% |
| **Charity Care** | $57,380,100.00 | | $66,443,650.00 | |

**Needs to match Gross Operating Revenue Year One and Year Two on Projected Data Chart*

Discuss the project's participation in state and federal revenue programs, including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project.

**RESPONSE:** Consistent with TriStar Health policy, TSHH will also offer a prompt pay discount of 20 percent for patients paying estimated deductible and co-pays at the time of service. TSHH will be part of the TriStar network, which requires all facilities within its system to adhere to all financial assistance and charity/indigent care policies. Financial relief is available to those patients who have received non-elective care and do not qualify for state or federal assistance and are unable to establish partial payments or pay their balance. All self-pay patients will receive a discount similar to managed care, referred to as an "uninsured discount." The Uninsured Discount is available to patients who have no third-party payer source of payment or do not qualify for Medicaid, Charity, or any other discount program the facility offers. See Attachment 10C for these policies.

## QUALITY STANDARDS

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

- [x] Yes
- [ ] No

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

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

  - [x] Yes
  - [ ]

- No

- Does the applicant commit to obtaining and maintaining all applicable state licenses in good 3tanding?
  - [x] Yes
  - [ ] No

- Does the applicant commit to obtaining and maintaining TennCare and Medicare certification(s), if participation in such programs are indicated in the application?
  - [x] Yes
  - [ ] No

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

| Credential | Agency | Status (Active or Will Apply) | Provider Number or Certification Type |
|---|---|---|---|
| Licensure | ☑ Health Facilities Commission/Licensure Division<br>☐ Intellectual & Developmental Disabilities<br>☐ Mental Health & Substance Abuse Services | Will Apply | |
| Certification | ☑ Medicare<br>☑ TennCare/Medicaid<br>☐ Other _____ | Will Apply<br>Will Apply | |
| Accreditation(s) | TJC - The Joint Commission | Will Apply | |

**4Q.** If checked "TennCare/Medicaid" box, please list all Managed Care Organization's currently or will be contracted.

- ☐ AMERIGROUP COMMUNITY CARE- East Tennessee
- ☑ AMERIGROUP COMMUNITY CARE - Middle Tennessee
- ☐ AMERIGROUP COMMUNITY CARE - West Tennessee
- ☐ BLUECARE - East Tennessee
- ☑ BLUECARE - Middle Tennessee
- ☐ BLUECARE - West Tennessee
- ☐ UnitedHealthcare Community Plan - East Tennessee
- ☑ UnitedHealthcare Community Plan - Middle Tennessee
- ☐ UnitedHealthcare Community Plan - West Tennessee
- ☐ TENNCARE SELECT HIGH - All
- ☐ TENNCARE SELECT LOW - All
- ☐ PACE
- ☐ KBB under DIDD waiver
- ☐ Others

**5Q.** Do you attest that you will submit a Quality Measure Report annually to verify the license, certification, and/or accreditation status of the applicant, if approved?

- ☑ Yes
- ☐ No

**6Q.** For an existing healthcare institution applying for a CON:

- Has it maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action should be discussed to include any of the following: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions and what measures the applicant has or will put into place to avoid similar findings in the future.

  - ☐ Yes
  - ☐ No
  - ☑ N/A

- Has the entity been decertified within the prior three years? If yes, please explain in detail. (This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility.)

  - ☐ Yes
  - ☐ No
  - ☑ N/A

**7Q.** Respond to all of the following and for such occurrences, identify, explain, and provide documentation if occurred in last five (5) years.

**Has any of the following:**

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

**Been subject to any of the following:**

- Final Order or Judgement in a state licensure action;

  - ☐ Yes
  - ☑ No

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

  - ☐ Yes
  - ☑ No

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

  - ☐ Yes
  - ☑ No

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

  - ☐ Yes
  - ☑ No

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

  - ☐ Yes
  - ☑ No

- Suspension or termination of participation in Medicare or TennCare/Medicaid programs; and/or

  - ☐ Yes
  - ☑ No

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

  - ☐ Yes
  - ☑ No

**8Q.** Provide the project staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions.

☑ Existing FTE not applicable (Enter year)

| Position Classification | Existing FTEs(enter year) | Projected FTEs Year 1 |
|---|---|---|
| **A. Direct Patient Care Positions** | | |
| Registered Nurses Direct Care | 0.00 | 94.50 |
| Clinical Specialists/Professional | 0.00 | 24.10 |
| LPN / LVN Direct Care | 0.00 | 10.10 |
| Patient Care Support | 0.00 | 37.20 |
| Clinical Technicians | 0.00 | 32.90 |
| **Total Direct Patient Care Positions** | N/A | 198.8 |

| | | |
|---|---|---|
| **B. Non-Patient Care Positions** | | |
| Clerical and Other Admin | 0.00 | 6.30 |
| Clinical Specialists/Professional | 0.00 | 7.50 |
| Environ/Food Service/Plant Op | 0.00 | 17.60 |
| Management & Supervision | 0.00 | 20.40 |
| Non-Clinical Specialists/Professional | 0.00 | 7.70 |
| **Total Non-Patient Care Positions** | N/A | 59.5 |
| **Total Employees** *(A+B)* | 0 | 258.3 |

| | | |
|---|---|---|
| **C. Contractual Staff** | | |
| Contractual Staff Position | 0.00 | 24.30 |
| **Total Staff** *(A+B+C)* | 0 | 282.6 |

## DEVELOPMENT SCHEDULE

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

- Complete the Project Completion Forecast Chart below. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
- If the CON is granted and the project cannot be completed within the standard completion time period (3 years for hospital and nursing home projects and 2 years for all others), please document why an extended period should be approved and document the "good cause" for such an extension.

## PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HFC action on the date listed in Item 1 below, indicate the number of days from the HFC decision date to each phase of the completion forecast.

| **Phase** | **Days Required** | **Anticipated Date (Month/Year)** |
|---|---|---|
| 1. Initial HFC Decision Date | | 06/26/24 |
| 2. Building Construction Commenced | 340 | 05/31/25 |
| 3. Construction 100% Complete (Approval for Occupancy) | 1000 | 03/22/27 |
| 4. Issuance of License | 1060 | 05/21/27 |
| 5. Issuance of Service | 1090 | 06/20/27 |
| 6. Final Project Report Form Submitted (Form HR0055) | 1210 | 10/18/27 |

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

LocaliQ
Tennessee
GANNETT

PO Box 631340 Cincinnati, OH 45263-1340

# AFFIDAVIT OF PUBLICATION

Suite 500
HCA Healthcare TriStar Divisio
300 Centerview Drive #432
Brentwood TN 37027

STATE OF WISCONSIN, COUNTY OF BROWN

The Tennessean, a newspaper published in the city of Nashville, Davidson County, State of Tennessee, and personal knowledge of the facts herein state and that the notice hereto annexed was Published in said newspapers in the issue:

04/15/2024

and that the fees charged are legal.
Sworn to and subscribed before on 04/15/2024

Legal Clerk

Notary, State of WI, County of Brown 8.15.26

My commission expires

| | | |
|---|---|---|
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MARIAH VERHAGEN
Notary Public
State of Wisconsin

# NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Facilities Commission and all interested parties, in accordance with T.C.A. §68-11-1601 et seq., and the Rules of the Health Facilities Commission, that TriStar Spring Hill Hospital, a/an newly formed entity owned by Spring Hill Hospital, Inc. with an ownership type of Corporation (For Profit) and to be managed by itself intends to file an application for a Certificate of Need for TriStar Spring Hill Hospital which is a d/b/a of Spring Hill Hospital, Inc., to establish a full service acute care hospital with 68 licensed beds. The project also seeks to initiate diagnostic and therapeutic cardiac catheterization services, magnetic resonance imaging (MRI) services, and will include a Level II neonatal intensive care unit (NICU). The facility will encompass the existing TriStar Spring Hill Emergency Room. The address of the
project will be 3001 Reserve Boulevard, Spring Hill, Maury County, Tennessee, 37174. The estimated project cost will be $250,000,000.

The anticipated date of filing the application is 05/01/2024

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

The published Letter of Intent must contain the following statement pursuant to T.C.A. §68-11-1607 (c)(1). (A) Any healthcare institution wishing to oppose a Certificate of Need application must file a written notice with the Health Facilities Commission no later than fifteen (15) days before the regularly scheduled Health
Facilities Commission meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application may file a written objection with the Health Facilities Commission at or prior to the consideration of the application by the Commission, or may appear in person to express opposition. Written notice may be sent to: Health Facilities Commission, Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243 or email at hsda.staff@tn.gov .
April 15 2024
LOKR0086132

LOCALiQ

Oak Ridger
The Daily Herald

PO Box 631340 Cincinnati, OH 45263-1340

## AFFIDAVIT OF PUBLICATION

Suite 500
HCA Healthcare TriStar Divisio
300 Centerview Drive #432
Brentwood TN 37027

STATE OF TENNESSEE, COUNTY OF MAURY

The Daily Herald, a newspaper published in the City of Columbia, in said county and state, and that the publication of which the annexed slip is a true copy, was published in said newspaper in the issues dated:

04/15/2024

and that the fees charged are legal.

This legal notice was published online at www.columbiadailyherald.com and http://www.publicnoticeads.com/TN/ during the duration of the run dates listed. This publication fully complies with Tennessee Code annotated 1-13-120.

Sworn to and subscribed before on 04/15/2024

Legal Clerk Keegan Moran

Notary, State of WI, County of Brown 2·14·28

My commission expires

| | | |
|---|---|---|
| Publication Cost: | $148.12 | |
| Order No: | 10062570 | # of Copies: |
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| PO #: | LOKR0086176 | |

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KEEGAN MORAN
Notary Public
State of Wisconsin

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April 15 2024
LOKR0086176

Attachment 7A-1

Charter / Articles

# Secretary of State
**Division of Business Services**
**312 Eighth Avenue North**
**6th Floor, William R. Snodgrass Tower**
**Nashville, Tennessee 37243**

DATE: 03/23/06
REQUEST NUMBER: 5719-2635
TELEPHONE CONTACT: (615) 741-2286
FILE DATE/TIME: 03/23/06 1122
EFFECTIVE DATE/TIME: 03/23/06 1122
CONTROL NUMBER: 0516492

TO:
CT CORPORATION SYSTEM
1201 PEACHTREE ST NE
SUITE 1240
ATLANTA, GA 30361

Davidson County CHARTER
Recvd: 03/23/06 15:44 2 pgs
Fees:7.00 Taxes:0.00
20060323-0033531

RE:
SPRING HILL HOSPITAL, INC.
CHARTER - FOR PROFIT

CONGRATULATIONS UPON THE INCORPORATION OF THE ABOVE ENTITY IN THE STATE OF TENNESSEE, WHICH IS EFFECTIVE AS INDICATED.

A CORPORATION 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 CORPORATION'S FISCAL YEAR. ONCE THE FISCAL YEAR HAS BEEN ESTABLISHED, PLEASE PROVIDE THIS OFFICE WITH THE WRITTEN NOTIFICATION. THIS OFFICE WILL MAIL THE REPORT DURING THE LAST MONTH OF SAID FISCAL YEAR TO THE CORPORATION 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 CORPORATION TO ADMINISTRATIVE DISSOLUTION.

WHEN CORRESPONDING WITH THIS OFFICE OR SUBMITTING DOCUMENTS FOR FILING, PLEASE REFER TO THE CORPORATION CONTROL NUMBER GIVEN ABOVE. PLEASE BE ADVISED THAT THIS DOCUMENT MUST ALSO BE FILED IN THE OFFICE OF THE REGISTER OF DEEDS IN THE COUNTY WHEREIN A CORPORATION HAS ITS PRINCIPAL OFFICE IF SUCH PRINCIPAL OFFICE IS IN TENNESSEE.

---

FOR: CHARTER - FOR PROFIT ON DATE: 03/23/06

FROM:
C T CORPORATION SYSTEM (ATLANTA, GA.)
1201 PEACHTREE ST NE
SUITE 1240
ATLANTA, GA 30361-0000

| | FEES | |
|---|---|---|
| RECEIVED: | $100.00 | $0.00 |
| TOTAL PAYMENT RECEIVED: | | $100.00 |

RECEIPT NUMBER: 00003901717
ACCOUNT NUMBER: 00000009

Riley C. Darnell

RILEY C. DARNELL
SECRETARY OF STATE

SS-4450

(6)

State of Tennessee

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

# CHARTER
## (For-Profit Corporation)

RECEIVED
STATE OF TENNESSEE
2006 MAR 23 AM 11:22
SECRETARY OF STATE

FILED
For Office Use Only

5719.2935

**The undersigned acting as incorporator(s) of a for-profit corporation under the provisions of the Tennessee Business Corporation Act adopts the following Articles of Incorporation.**

1. The name of the corporation is:

Spring Hill Hospital, Inc.

**[NOTE: Pursuant to Tennessee Code Annotated § 48–14–101(a)(1), each corporation name must contain the words *corporation*, *incorporated*, or *company* or the abbreviation *corp.*, *inc.*, or *co.*]**

2. The number of shares of stock the corporation is authorized to issue is: 1,000

3. The name and complete address of the corporation's initial registered agent and office located in the State of Tennessee is:

C T Corporation System
*( Name )*

800 S. Gay Street, Suite 2021, Knoxville TN 37929
*( Street Address)* *(City)* *(State/Zip Code)*

Knox
*( County )*

4. List the name and complete address of each incorporator:

Dora A. Blackwood — One Park Plaza, Nashville, TN 37203
*( Name )* *( Include: Street Address, City, State and Zip Code )*

*( Name )* *( Street Address, City, State and Zip Code )*

*( Name )* *( Street Address, City, State and Zip Code )*

5. The complete address of the corporation's principal office is:

One Park Plaza | Nashville | TN/Davidson/37203
*( Street Address )* | *( City )* | *( State/County/Zip Code )*

6. The corporation is for profit.

7. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time are:

Date _____, _____, Time _____ (Not to exceed 90 days.)

8. Other provisions:

March 22, 2006
Signature Date

Dora A. Blackwood
Incorporator's Signature

Dora A. Blackwood
Incorporator's Name *(typed or printed)*

SS-4417 (Rev. 9/04) Filing Fee: $100 RDA 1678

TN001 - 03/25/2005 C T System Online

Attachment 7A-2

Certificate of Good Standing

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

KRISTINA BAGWELL
ONE PARK PLAZA
NASHVILLE, TN 37203

November 8, 2023

**Request Type: Certificate of Existence/Authorization**
Request #: 0555420

Issuance Date: 11/08/2023
Copies Requested: 1

**Document Receipt**

Receipt # : 008450887 — Filing Fee: $20.00

Payment-Credit Card - State Payment Center - CC #: 3861681370 — $20.00

**Regarding:** **SPRING HILL HOSPITAL, INC.**

Filing Type: For-profit Corporation - Domestic
Formation/Qualification Date: 03/23/2006
Status: Active
Duration Term: Perpetual
Business County: DAVIDSON COUNTY

Control # : 516492
Date Formed: 03/23/2006
Formation Locale: TENNESSEE
Inactive Date:

## CERTIFICATE OF EXISTENCE

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

**SPRING HILL HOSPITAL, INC.**

* is a Corporation duly incorporated under the law of this State with a date of incorporation and duration as given above;

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

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

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

* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Processed By: Cert Web User

**Verification #: 063915825**

Attachment 7A-3

Spring Hill Hospital, Inc. d/b/a Documentation

**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

SPRING HILL HOSPITAL, INC.
LEGAL DEPT.
1 PARK PLZ
NASHVILLE, TN 37203-6527

April 9, 2024

## Filing Acknowledgment

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

Control # : 516492 Status: Active
Filing Type: For-profit Corporation - Domestic

Document Receipt

| | | |
|---|---|---|
| Receipt # : 008919821 | Filing Fee: | $20.00 |
| Payment-Credit Card - State Payment Center - CC #: 3871726426 | | $20.00 |

Amendment Type: Assumed Name
Filed Date: 04/09/2024 2:01 PM
Image # : B1547-0348

This will acknowledge the filing of the attached assumed name with an effective date as indicated above. When corresponding with this office or submitting documents for filing, please refer to the control number given above. The name registration is effective for five years from the date the original registration was filed with the Secretary of State.

Tre Hargett
Secretary of State

Processed By: Corp Web User

| Field Name | Changed From | Changed To |
|---|---|---|
| New Assumed Name | No Value | TriStar Spring Hill Hospital |

007286596

# APPLICATION FOR REGISTRATION OF ASSUMED NAME

SS-4230

**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
(615) 741-2286

Filing Fee: $20.00

*For Office Use Only*

-FILED-

Amendment # 007286596

Pursuant to the Tennessee Business Corporation Act, Tennessee Nonprofit Corporation Act, Tennessee Limited Liability Company Act, Tennessee Revised Limited Liability Company Act, or the Tennessee Revised Uniform Partnership Act, this application for registration of an assumed name is submitted to the Tennessee Secretary of State.

1. The Secretary of State Control Number is: 000516492
and the true name of the business entity is:
SPRING HILL HOSPITAL, INC.

2. The state or country of organization is:
TENNESSEE

3. The business entity intends to transact business under an assumed name.

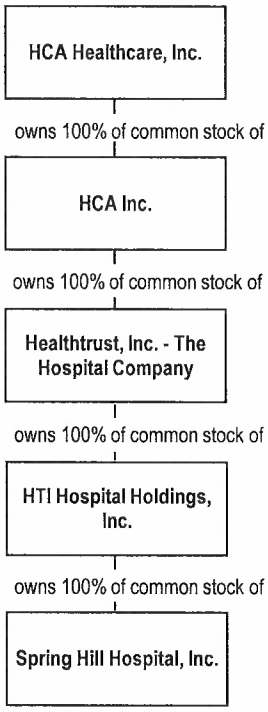
4. The assumed name the business entity proposes to use is:
TriStar Spring Hill Hospital
*The assumed name must satisfy the statutory requirements for that type of entity.*

| | |
|---|---|
| 04/09/2024 | Electronic |
| Signature Date | Signature |
| Vice President and Assistant Secretary | John M. Franck II |
| Signer's Capacity | Name (typed or printed) |

***Note: Pursuant to T.C.A. § 10-7-503 all information on this form is public record.***

Attachment 7A-4

Organizational Chart


HCA Healthcare, Inc.
owns 100% of common stock of
HCA Inc.
owns 100% of common stock of
Healthtrust, Inc. - The Hospital Company
owns 100% of common stock of
HTI Hospital Holdings, Inc.
owns 100% of common stock of
Spring Hill Hospital, Inc.

Attachment 7A-5

Spring Hill Hospital, Inc.

Officers and Directors

**January 1, 2024**

OFFICERS AND DIRECTORS
OF
SPRING HILL HOSPITAL, INC.

| | | |
|---|---|---|
| * **Samuel N. Hazen** | **President** | **One Park Plaza<br>Nashville, TN 37203** |
| Mitch Edgeworth | Senior Vice President | 1000 Health Park Drive, Ste 500<br>Brentwood, TN 37027 |
| Jon M. Foster | Senior Vice President | One Park Plaza<br>Nashville, TN 37203 |
| John M. Hackett | Senior Vice President and Treasurer | One Park Plaza<br>Nashville, TN 37203 |
| Michael R. McAlevey | Senior Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Tim McManus | Senior Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Joseph A. Sowell, III | Senior Vice President | One Park Plaza<br>Nashville, TN 37203 |
| * **Christopher F. Wyatt** | **Senior Vice President** | **One Park Plaza<br>Nashville, TN 37203** |
| Kevin A. Ball | Vice President and Assistant Secretary | One Park Plaza<br>Nashville, TN 37203 |
| Mike T. Bray | Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Monica Cintado | Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Natalie H. Cline | Vice President and Secretary | One Park Plaza<br>Nashville, TN 37203 |
| Jaime DeRensis | Vice President and Assistant Secretary | One Park Plaza<br>Nashville, TN 37203 |
| Wes Fountain | Vice President | 1000 Health Park Drive, Ste 500<br>Brentwood, TN 37027 |
| * **John M. Franck II** | **Vice President and Assistant Secretary** | **One Park Plaza<br>Nashville, TN 37203** |
| Ronald Lee Grubbs, Jr. | Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Seth A. Killingbeck | Vice President and Assistant Secretary | One Park Plaza<br>Nashville, TN 37203 |

| | | |
|---|---|---|
| Todd Maxwell | Vice President | 1100 Dr. Martin L. King, Jr. Blvd<br>Suite 1500<br>Nashville, TN 37203 |
| Jeff McInturff | Vice President | One Park Plaza<br>Nashville, TN 37203 |
| T. Scott Noonan | Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Peter Rossell | Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Brad Spicer | Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Russ Young | Vice President | One Park Plaza<br>Nashville, TN 37203 |
| Doug L. Downey | Assistant Secretary | One Park Plaza<br>Nashville, TN 37203 |
| Deborah H. Mullin | Assistant Secretary | One Park Plaza<br>Nashville, TN 37203 |
| Shirley Scharf-Cheatham | Assistant Secretary | One Park Plaza<br>Nashville, TN 37203 |
| John I. Starling | Assistant Secretary | One Park Plaza<br>Nashville, TN 37203 |

***Directors**

Persons employed in the capacity of Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Administrator and Assistant Administrator of facilities owned and/or operated by this Company or by a partnership for which this Company acts as general partner or by a limited liability company for which this Company acts as managing member, are hereby authorized to, subject to the Company's policies and procedures, (a) manage the facilities and all day-to-day operations of, and the employees and agents of the Company at, such facilities, and take such other acts as are necessary or appropriate for the proper functioning of the facilities, and (b) negotiate and enter into contracts and agreements necessary to conduct the day-to-day business of such facilities, including, but not limited to, physician contracts, personal property leases, purchase agreements, cost reports, and similar documents (but specifically excluding any contracts or leases relating to real estate, except for leases to tenants in buildings owned by or leased to the Company entered into pursuant to the Company's policies and procedures) which with the advice of legal counsel shall be deemed appropriate and advisable, and to execute and deliver Certificates of Resolution required in connection with such contracts and agreements.

Attachment 8A

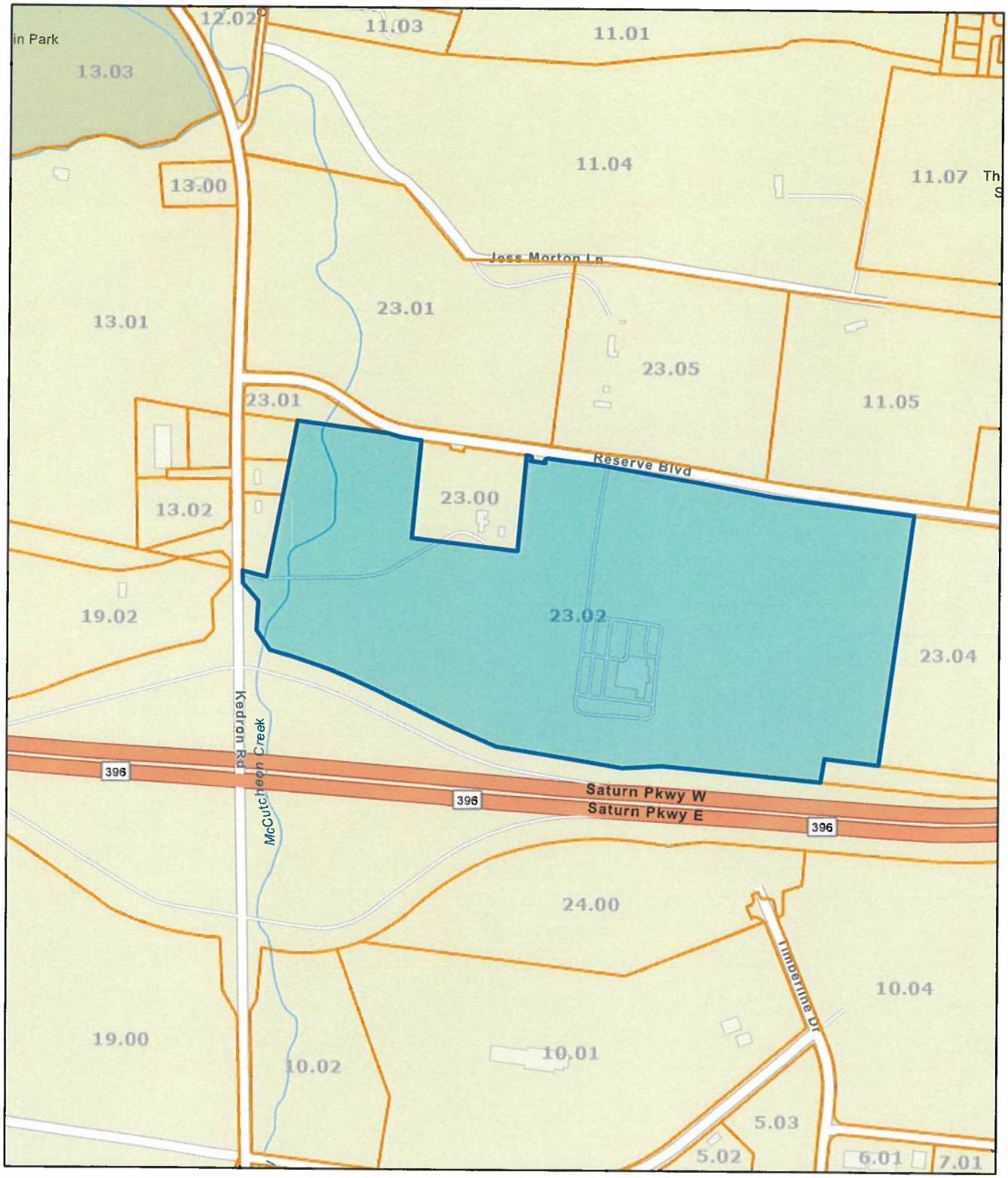
Management Agreement

NOT APPLICABLE

Attachment 9A-1

Current GIS Map of Site

# Maury County - Parcel: 028 023.02




Date: February 19, 2024

County: Maury
Owner: SPRING HILL HOSPITAL INC
Address: RESERVE BLVD 3001
Parcel Number: 028 023.02
Deeded Acreage: 0
Calculated Acreage: 77
Date of TDOT Imagery: 2021
Date of Vexcel Imagery: 2023

1:9,028

0 0.05 0.1 0.2 mi

0 0.1 0.2 0.4 km

Attachment 9A-2

2006 Quit Claim Deed

QUITCLAIM DEED

| Address of New Owner: | Send Tax Bills to: | Map-Parcel No. |
|---|---|---|
| Spring Hill Hospital, Inc. | (same) | Map 28 |
| One Park Plaza | | Parcel 23.01 |
| Nashville, TN 37203 | | (Part of) |
| Attention: Tax Department | | |

PREPARED BY: WALLER LANSDEN DORTCH & DAVIS, LLP, 511 Union Street, Suite 2700, Nashville, TN 37219-1760

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

The actual consideration for this transfer is $-0-.

Affiant – Jeffrey A. Calk, Attorney for Grantee

Subscribed and sworn to before me, this the 21st day of July, 2006.

NOTARY PUBLIC

ROBERTA R. SANDERS STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TENN.

My Commission Expires JULY 19, 2008

My Commission Expires: 7/19/08

FOR AND IN CONSIDERATION of Ten Dollars ($10.00), and other good and valuable consideration, PETER JENKINS AND WIFE, RITA JENKINS, hereinafter called the GRANTORS, do hereby quitclaim and convey unto SPRING HILL HOSPITAL, INC., a Tennessee corporation, hereinafter called the GRANTEE, its successors or assigns, all of Grantors' right, title and interest in that certain tract or parcel of land in Maury County, State of Tennessee, described as follows, to wit:

SEE EXHIBIT A ATTACHED HERETO AND INCORPORATED BY REFERENCE AS FULLY AS THOUGH COPIED HEREIN.

This is unimproved property located on Saturn Parkway, Spring Hill, Maury County, Tennessee.

1226042.3

IN WITNESS WHEREOF, GRANTORS have caused this Quitclaim Deed to be executed on the 21st day of July, 2006.

Peter Jenkins

Rita Jenkins

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

Personally appeared before me, the undersigned, a Notary Public in and for said County and State, the within named **Peter Jenkins**, the bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged that he executed the within instrument for the purposes therein contained.

Witness my hand and seal, at office in Nashville, Tennessee, this the 21st day of July, 2006.

NOTARY PUBLIC

My Commission Expires: 7/19/08

ROBERTA R. SANDERS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.
My Commission Expires JULY 19, 2008

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

Personally appeared before me, the undersigned, a Notary Public in and for said County and State, the within named **Rita Jenkins**, the bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged that she executed the within instrument for the purposes therein contained.

Witness my hand and seal, at office in Nashville, Tennessee, this the 21st day of July, 2006.

NOTARY PUBLIC

My Commission Expires: 7/19/08

ROBERTA R. SANDERS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY, TENN.
My Commission Expires JULY 19, 2008

1226042.3

## Exhibit A

## Legal Description

Located in the Third Civil District of Maury County, Tennessee, and bounded on the north by the Peter Jenkins' 57.19-acre tract and the James A. Cathey tract, on the east by J. P. Gunnel tract, on the south by the Bobby Garland tract, and on the west by the Barbara Jenkins' 42.0-acre tract, and more particularly described as follows:

Beginning at an iron pipe in the south boundary of the Peter Jenkins' 57.19-acre tract, being also the northeast corner of the Barbara Jenkins' 42.0-acre tract and the northwest corner of the tract herein described; thence with the east boundary of the Barbara Jenkins' 42.0-acre tract south 11 deg. 30 min. west 1312 ft. to a pipe; thence with the north boundary of the Bobby Garland tract south 87 deg. east 1254 ft. to an iron pipe; thence north 4 deg. east 88.4 ft. to an iron pipe, and south 87 deg. east 1763.2 ft. to a point; thence with the west boundary of the J. P. Gunnel tract north 1 deg. east 486.9 ft., south 87 deg. east 473.4 ft., and north 3 deg. 30' east 727.8 ft. to an iron pipe; thence with the south boundary of the James A. Cathey tract north 85 deg. 41' 10" west 970.09 ft. to an iron pipe, and north 86 deg. 45' 10" west 1626.58 ft. to an iron pipe; and thence with the south boundary of Peter Jenkins' 57.19-acre tract north 86 deg. 21' 20" west 844.57 ft. to the point of beginning, containing 92.28 acres according to survey by James T. Brewer, Tennessee, registered land surveyor no. 170, dated March 8, 1988.

Being the eastern 92.78 acres of 134.28 acres conveyed to Peter Jenkins and his former wife, Barbara Jenkins, by deed of record in Book 689, page 178, of the Register's Office of Maury County, Tennessee; and being a portion of the property conveyed to Peter Jenkins from Barbara Jenkins by an Assumption Quitclaim Deed of record in Book 819, page 271, of the Register's County of Maury County, Tennessee.

Mail:

LAWYERS TITLE INSURANCE CORP
424 CHURCH STREET
SUITE 950
NASHVILLE, TN 37219

BK/PG:R1931/504-506

06011563

| | |
|---|---|
| 3 PGS : AL - QUITCLAIM DEED | |
| NANCY BATCH: 52632 | |
| 07/24/2006 - 10:10 AM | |
| VALUE | 0.00 |
| MORTGAGE TAX | 0.00 |
| TRANSFER TAX | 0.00 |
| RECORDING FEE | 15.00 |
| DP FEE | 2.00 |
| REGISTER'S FEE | 0.00 |
| TOTAL AMOUNT | 17.00 |

STATE of TENNESSEE, MAURY COUNTY
JOHN FLEMING
REGISTER OF DEEDS

1226042.3

Attachment 9A-3

2006 Special Warranty Deed

FROM: Peter Jenkins and wife, Rita Jenkins

TO: Spring Hill Hospital, Inc.

---

| Address of New Owner: | Send Tax Bills to: | Map-Parcel No. |
|---|---|---|
| Spring Hill Hospital, Inc. | (same) | Map. 28 |
| One Park Plaza | | Parcel 23.01 |
| Nashville, TN 37203 | | (Part of) |
| Attention: Tax Department | | |

---

PREPARED BY: WALLER LANSDEN DORTCH & DAVIS, LLP, 511 Union Street, Suite 2700, Nashville, TN 37219-1760

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

The actual consideration or value, whichever is greater, for this transfer is $11,475,000.00.

ROBERTA R. SANDERS STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TENN.

Affiant – Jeffrey A. Calk, Attorney for Grantee

Subscribed and sworn to before me, this the 21st day of July, 2006.

NOTARY PUBLIC

My Commission Expires: 7/19/08

My Commission Expires JULY 19, 2008

---

**SPECIAL WARRANTY DEED**

FOR AND IN CONSIDERATION OF the sum of Ten Dollars, cash in hand paid by the hereinafter named GRANTEE, and other good and valuable considerations, the receipt of which is hereby acknowledged, PETER JENKINS AND WIFE, RITA JENKINS, hereinafter called the GRANTORS, have bargained and sold, and by these presents do transfer and convey unto SPRING HILL HOSPITAL, INC., a Tennessee corporation, hereinafter called the GRANTEE, its successors or assigns, a certain tract or parcel of land in Maury County, State of Tennessee, described as follows (the "Real Property"), to wit:

SEE EXHIBIT A ATTACHED HERETO AND INCORPORATED BY REFERENCE AS FULLY AS THOUGH COPIED HEREIN.

1225656.2

This is unimproved property located on Saturn Parkway, Spring Hill, Maury County, Tennessee.

TO HAVE AND TO HOLD the Real Property together with all appurtenances and hereditaments thereunto belonging or in any wise appertaining to GRANTEE, its successors or assigns forever, subject only to the matters set forth on Exhibit B attached hereto and made a part hereof (the "Permitted Encumbrances").

GRANTORS further covenant and bind themselves, their representatives, heirs and assigns to warrant specially and forever defend the title to the Real Property to GRANTEE, its successors or assigns, against the lawful claims of all persons claiming through and under GRANTORS (other than claims arising out of the Permitted Encumbrances), but not further or otherwise. Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

[Signatures follow on the next page.]

IN WITNESS WHEREOF, GRANTORS have caused this Special Warranty Deed to be executed on the 21st day of July, 2006.

Peter Jenkins

Rita Jenkins

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

Personally appeared before me, the undersigned, a Notary Public in and for said County and State, the within named **Peter Jenkins**, the bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged that he executed the within instrument for the purposes therein contained.

Witness my hand and seal, at office in Nashville, Tennessee, this the 21st day of July, 2006.

NOTARY PUBLIC

My Commission Expires: 7/19/08

ROBERTA R. SANDERS STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TENN.
My Commission Expires JULY 19, 2008

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

Personally appeared before me, the undersigned, a Notary Public in and for said County and State, the within named **Rita Jenkins**, the bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged that she executed the within instrument for the purposes therein contained.

Witness my hand and seal, at office in Nashville, Tennessee, this the 21st day of July, 2006.

NOTARY PUBLIC

My Commission Expires: 7/19/08

ROBERTA R. SANDERS STATE OF TENNESSEE NOTARY PUBLIC DAVIDSON COUNTY, TENN.
My Commission Expires JULY 19, 2008

1225656.2

## Exhibit A

### Legal Description of the Real Property

BEING A TRACT OF LAND LOCATED IN SPRING HILL, MAURY COUNTY, TENNESSEE, SAID TRACT OF LAND BEING A PORTION OF PARCEL 23.01 ON TAX MAP 28, OF RECORD IN BOOK 689, PAGE 178, AND BOOK 819, PAGE 271, REGISTER'S OFFICE FOR MAURY COUNTY, TENNESSEE, AND MORE PARTICULARLY DESCRIBED AS FOLLOWS:

COMMENCING AT AN IRON PIPE OLD IN THE EASTERLY RIGHT OF WAY LINE OF KEDRON ROAD, THE SAID PIPE BEING THE SOUTHWEST CORNER OF THE PETER JENKINS PROPERTY, AS OF RECORD IN BOOK 689, PAGE 178, R.O.M.C., TN. AND BOOK 819, PAGE 271, R.O.M.C., TN AND BEING THE NORTHWEST CORNER OF THE BARBARA JENKINS TRUSTEE PROPERTY OF RECORD IN BOOK R1683 PAGE 76 R.O.M.C., TN;

THENCE, LEAVING KEDRON ROAD RIGHT OF WAY LINE WITH BARBARA JENKINS PROPERTY AND A FENCE LINE THE FOLLOWING BEARINGS AND DISTANCES:
SOUTH 78 DEG 45 MIN 36 SEC EAST, 431.69 FEET TO AN IRON PIN OLD,
SOUTH 82 DEG 47 MIN 11 SEC EAST, 410.03 FEET TO AN IRON PIN OLD,
SOUTH 82 DEG 08 MIN 15 SEC EAST, 508.34 FEET TO AN IRON PIN OLD AND A FENCE CORNER, AND SOUTH 80 DEG 39 MIN 31 SEC EAST, 236.22 FEET TO AN IRON PIN OLD AT THE TRUE POINT OF BEGINNING FOR THIS PROPERTY DESCRIPTION SAID POINT BEING THE NORTHEAST CORNER OF BARBARA JENKINS COMMON WITH THE REMAINING PORTION OF THE PETER JENKINS PROPERTY;

THENCE, LEAVING BARBARA JENKINS AND RUNNING WITH THE REMAINING PORTION OF THE PETER JENKINS PROPERTY SOUTH 82 DEG 02 MIN 44 SEC EAST, 844.92 FEET TO AN IRON PIPE OLD AND A FENCE CORNER, BEING THE SOUTHEAST CORNER OF MAHER JOHN BUILDERS, INC. OF RECORD IN BOOK R1827 PAGE 451, R.O.M.C.,TN;

THENCE, WITH MAHER JOHN BUILDERS, INC. AND A FENCE, THE FOLLOWING BEARINGS AND DISTANCES:
SOUTH 82 DEG 26 MIN 07 SEC EAST, 1,626.49 FEET TO AN IRON PIN NEW,
SOUTH 84 DEG 41 MIN 03 SEC EAST, 1,009.71 FEET TO AN IRON PIN OLD AND A FENCE INTERSECTION, SAID POINT BEING THE NORTHWEST CORNER OF N. HOUSTON PARKS PROPERTY OF RECORD IN BOOK R1821, PAGE 1149, R.O.M.C.,TN;

THENCE, WITH THE SAID PARKS PROPERTY AND A FENCE, THE FOLLOWING BEARINGS AND DISTANCES:
SOUTH 07 DEG 45 MIN 35 SEC WEST, 739.23 FEET TO AN IRON PIN NEW;
SOUTH 72 DEG 41 MIN 47 SEC WEST, 85.35 FEET TO AN IRON PIN NEW;
NORTH 82 DEG 31 MIN 59 SEC WEST, 393.76 FEET TO AN IRON PIN OLD AND A FENCE CORNER;

SOUTH 04 DEG 28 MIN 06 SEC WEST, 177.65 FEET TO A FENCE POST OLD AND A FENCE INTERSECTION, SAID POINT BEING IN THE NORTHERLY RIGHT OF WAY LINE OF SATURN PARKWAY;

THENCE, LEAVING PARKS AND RUNNING WITH THE NORTHERLY RIGHT OF WAY OF SATURN PARKWAY, THE FOLLOWING BEARINGS AND DISTANCES:
SOUTH 73 DEG 34 MIN 19 SEC WEST, 32.75 FEET TO A CONCRETE MONUMENT OLD;
SOUTH 73 DEG 25 MIN 38 SEC WEST, 244.26 FEET TO A CONCRETE MONUMENT OLD;
ALONG A CURVE TO THE RIGHT HAVING A RADIUS OF 2,808.57 FEET, A DELTA ANGLE OF 09 DEG 37 MIN 07 SEC, A CHORD BEARING AND DISTANCE OF SOUTH 78 DEG 14 MIN 11 SEC WEST, 470.94 FEET, AND AN ARC LENGTH OF 471.49 FEET TO AN IRON PIN NEW, BEING THE NORTHEASTERLY CORNER OF A PORTION OF THE SAID PARKS PROPERTY;

THENCE, LEAVING SATURN PARKWAY AND RUNNING WITH PARKS AND A FENCE, THE FOLLOWING BEARINGS AND DISTANCES:
NORTH 83 DEG 42 MIN 36 SEC WEST, 1,056.26 FEET TO AN IRON PIN NEW AND A FENCE CORNER;
SOUTH 04 DEG 09 MIN 54 SEC WEST, 87.45 FEET TO AN IRON PIPE OLD AND A FENCE INTERSECTION, BEING THE SOUTHWESTERLY CORNER OF PARKS AND THE NORTHEASERLY CORNER OF THE RYDER TRUCK RENTAL, INC. PROPERTY OF RECORD IN BOOK 1142, PAGE 517 R.O.M.C.,TN AND BEING ON THE NORTHERLY RIGHT OF WAY LINE OF SATURN PARKWAY;

THENCE, LEAVING SATURN PARKWAY AND RUNNING WITH RYDER AND A FENCE NORTH 82 DEG 36 MIN 20 SEC WEST, 1,256.15 FEET TO AN IRON PIN OLD, BEING THE SOUTHEASTERLY CORNER OF BARBARA JENKINS TRUSTEE AND IN THE NORTHERLY LINE OF THE RYDER PROPERTY;

THENCE, LEAVING RYDER AND RUNNING WITH BARBARA JENKINS, NORTH 07 DEG 02 MIN 09 SEC EAST, 1,302.98 FEET TO THE POINT OF BEGINNING, AND CONTAINING: 3,989,602 SQUARE FEET, OR 91.589 ACRES, MORE OR LESS.

BEING A PORTION OF THE PROPERTY CONVEYED TO PETER JENKINS AND HIS FORMER WIFE, BARBARA JENKINS, BY DEED OF RECORD IN BOOK 689, PAGE 178, OF THE REGISTER'S OFFICE OF MAURY COUNTY, TENNESSEE; AND BEING A PORTION OF THE PROPERTY CONVEYED TO PETER JENKINS FROM BARBARA JENKINS BY AN ASSUMPTION QUITCLAIM DEED OF RECORD IN BOOK 819, PAGE 271, OF THE REGISTER'S COUNTY OF MAURY COUNTY, TENNESSEE.

DESCRIPTION FROM PREVIOUS DEEDS.

## Exhibit B

## Permitted Encumbrances

1. Zoning and building laws, ordinances, resolutions and regulations.

2. 2006 real estate taxes and assessments for public improvements that are not delinquent and not yet due and payable.

3. Easements and Rights-of-Way vested in the United States of America upon the relation and for the use and benefit of the Tennessee Valley Authority, as set forth in the Declaration of Taking recorded in Book 843, page 733 and in Judgment recorded in Book 1117, page 530, both in the Register's Office for Maury County, Tennessee.

Mail:

LAWYERS TITLE INSURANCE CORP
424 CHURCH STREET
SUITE 950
NASHVILLE, TN 37219

BK/PG:R1931/498-503
06011562

| | |
|---|---|
| 6 PGS : AL - WARRANTY DEED | |
| NANCY BATCH: 52632 | |
| 07/26/2006 - 10:10 AM | |
| VALUE | 11475000.00 |
| MORTGAGE TAX | 0.00 |
| TRANSFER TAX | 42457.50 |
| RECORDING FEE | 30.00 |
| DP FEE | 2.00 |
| REGISTER'S FEE | 1.00 |
| TOTAL AMOUNT | 42490.50 |

STATE of TENNESSEE, MAURY COUNTY
JOHN FLEMING
REGISTER OF DEEDS

Attachment 9A-4

2008 General Warranty Deed

Mail: BANKERS TITLE AND ESCROW CORPORATION
3310 WEST END AVENUE
SUITE 410
NASHVILLE, TN 37203

FROM: Barbara Jenkins, Trustee U/A/D December 11, 2002 of the Barbara Jenkins Revocable Living Trust Agreement

TO: Spring Hill Hospital, Inc.

| Address of New Owner: | Send Tax Bills to: | Map-Parcel No. |
|---|---|---|
| Spring Hill Hospital, Inc. | (same) | Map 28 |
| One Park Plaza | | Parcel 23.00 |
| Nashville, TN 37203 | | (Part of) |
| Attention: Tax Department | | |

PREPARED BY: WALLER LANSDEN DORTCH & DAVIS, LLP, 511 Union Street, Suite 2700, Nashville, TN 37219-1760

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

The actual consideration or value, whichever is greater, for this transfer is $4,900,000.00.

Monica Acker
Affiant

Subscribed and sworn to before me, this the 4 day of Nov, 2008.

NOTARY PUBLIC

My Commission Expires May 8, 2012

R. L. MOORE NOTARY PUBLIC AT LARGE DAVIDSON COUNTY, TENN

**GENERAL WARRANTY DEED**

FOR AND IN CONSIDERATION OF the sum of Ten Dollars, cash in hand paid by the hereinafter named GRANTEE, and other good and valuable considerations, the receipt of which is hereby acknowledged, BARBARA JENKINS, TRUSTEE U/A/D DECEMBER 11, 2002 OF THE BARBARA JENKINS REVOCABLE LIVING TRUST AGREEMENT, hereinafter called the GRANTOR, has bargained and sold, and by these presents do transfer and convey unto SPRING HILL HOSPITAL, INC., a Tennessee corporation, hereinafter called the GRANTEE, its successors or assigns, a certain tract or parcel of land in Maury County, State of Tennessee, described as follows (the "**Real Property**"), to wit:

SEE EXHIBIT A ATTACHED HERETO AND INCORPORATED BY REFERENCE AS FULLY AS THOUGH COPIED HEREIN.

2469010.4

This is unimproved property located on Kedron Road, Spring Hill, Maury County, Tennessee.

Said Property is transferred free and clear of all limitations, restrictions, and encumbrances except for the following matters:

1. Those matters set forth on Exhibit B attached hereto and made a part hereof (the "**Permitted Encumbrances**"); and

2. Grantee's right of first refusal to purchase Grantor's Adjacent Property (as defined in Exhibit C to this Deed) as set forth in Exhibit C attached hereto and incorporated herein by reference; and

3. The use restrictions and restrictive covenants encumbering the Adjacent Property, as more fully set forth in Exhibit D attached hereto and incorporated herein by reference; and

4. A reserved easement for pedestrian and vehicular ingress and egress as more fully set forth in Exhibit E attached hereto and incorporated herein by reference.

TO HAVE AND TO HOLD the said Property, with the appurtenances, estate, title and interest thereto belonging to the said GRANTEE, its successors and assigns, forever, and GRANTOR does covenant with the said GRANTEE that it is lawfully seized and possessed of said Property in fee simple, has a good right to convey it, and the same is unencumbered except for the Permitted Encumbrances; and GRANTOR does further covenant and bind itself, its heirs and assigns, to warrant and forever defend the title to the said Property to the said GRANTEE, its successors and assigns, against the lawful claims of all persons whomsoever. Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

[Signatures follow on the next page.]

IN WITNESS WHEREOF, GRANTOR has caused this General Warranty Deed to be executed on the 14th day of November, 2008.

Barbara Jenkins, Trustee

Barbara Jenkins, Trustee U/A/D December 11, 2002
of the Barbara Jenkins Revocable Living Trust Agreement

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

Personally appeared before me, the undersigned, a Notary Public in and for said County and State, the within named **Barbara Jenkins**, Trustee U/A/D December 11, 2002 of the Barbara Jenkins Revocable Living Trust Agreement, the bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged that she executed the within instrument for the purposes therein contained.

Witness my hand and seal, at office in Nashville, Tennessee, this the 14th day of November, 2008.

NOTARY PUBLIC

My Commission Expires: May 8, 2012

R. L. MOORE
NOTARY PUBLIC AT LARGE
DAVIDSON COUNTY, TENN

2469010.4

**Exhibit A to General Warranty Deed**

**Legal Description of the Real Property**

A tract of land in the Third Civil District Maury County, Tennessee. Being Bounded on the north by Tract 1 of J.O. Morton Jr. Property as of record in Plat Book 6, Page 489-A, Register's Office Maury County, Tennessee(ROMC), also being the Peter and Rita Jenkins property as recorded in Book R2006, Page 387, ROMC, on the east by Spring Hill Hospital Inc. as recorded in Book 1931, Page 504, ROMC on the south by Ryder Truck Rental Inc. as recorded in Book 1142, Page 517, ROMC and by the Northern Right-of-Way (ROW) of Saturn Parkway (ROW Varies) and on the west the eastern ROW of Kendron Road, by Clyde E. and Nancy Harris as recorded in Book 407, Page 93, ROMC, Charles G. and Azilee M. Smith as recorded in Book 613, Page 191, ROMC and by Charles and Carol Raines as recorded in Book R1804, Page 1228, ROMC. Tract being described as follows.

POINT OF BEGINNING being a ½" iron rod old, said iron rod being the southwestern corner of the said Spring Hill Hospital Inc. Tract; thence with the northern line of said Ryder Truck Rental Inc. North 82°34'54"West 343.56 feet to an iron rod old with a cap RLS 1335; thence with the northern ROW of said Saturn Parkway North 64°28'40"West 205.22 feet to a highway monument old; thence North 62°46'14"West 260.79 feet to an iron rod new; thence with a curve to the left having a central angle of 12°51'06", a radius of 2000.00 feet, a length of 448.61 feet and a chord bearing and distance of North 69°11'47'West 447.67 feet to an iron rod new; thence North 75°37'20" West 93.79 feet to a highway monument old; thence North 31°29'51" West 117.14 feet to an highway monument old; thence North 00°27'04" West 149.17 feet to an highway monument old; thence North 42°41'29" West 102.16 feet to an highway monument old on the eastern ROW of said Kendron Road; thence with said eastern ROW North 03°30'55" West 37.30 feet to an iron rod old with a Barge-Wagner cap, said iron rod also being the southwestern corner of said Clyde E. and Nancy Harris tract; thence with the southern line of said Harris tract South 77°27'36" East 98.45 feet to a 3/8" iron rod old; thence with the eastern line of said Harris Tract, Smith tract and the Raines tract North 12°46'58" East 730.05 feet to an iron rod new at the southwestern corner of the said Jenkins Tract; thence with the southern line of the said Jenkins South 78°07'02" East 163.54 feet; thence continuing with said Jenkins Tract South 82°03'22" East 1154.51 feet to an iron rod old with a Carrol cap, said iron rod old being the northwestern corner of said Spring Hill Hospital Inc tract; thence with the western line of said Spring Hill Hospital Inc tract South 07°03'22" West 1302.97 feet to the point of beginning.

Containing 1,627,912 square feet or 37.37 acres.

INCLUDED IN THE ABOVE LEGAL DESCRIPTION BUT EXPRESSLY EXCLUDED FROM THE REAL PROPERTY CONVEYED BY THIS GENERAL WARRANTY DEED IS THE FOLLOWING DESCRIBED TRACT:

> A tract of land in the Third Civil District Maury County, Tennessee, bounded on the north by Tract 1 of J.O. Morton Jr. Property as of record in Plat Book 6, Page 489-A, Register's Office Maury County, Tennessee (ROMC), also being the Peter and Rita Jenkins property as recorded in Book R2006, Page 387, ROMC, on the east, south and

west by the remaining lands of Barbara Jenkins as recorded in Book R1683, Page 76 ROMC. Lot being described as follows;

POINT OF COMMENCEMENT being a ½" iron rod old, at the northwestern corner of Spring Hill Hospital Inc. Tract as recorded in Book 1931, Page 504, ROMC, thence along the southern line of said Tract 1 of J.O. Morton Jr. Property as of record in Plat Book 6, Page 489-A, North 82°03'22" West 261.32 feet to the actual and true POINT OF BEGINNING, Thence leaving said northern line South 05°34'03" West 446.56 feet to a point; Thence, North 82°43'50" West 485.71 feet to a point; Thence, North 05°45'46" East 452.22 feet to a point on said southern line of Tract 1 of J.O. Morton Jr. Property; Thence, along said southern common line South 82°03'22" East 484.37 feet to the Point of Beginning

Containing 217,845 square feet or 5.001 acres.

Being a portion of the property conveyed to Barbara Jenkins, Trustee U/A/D December 11, 2002 of the Barbara Jenkins Revocable Living Trust Agreement, by Quitclaim Deed recorded at Book R1683, page 76 in the Register's Office for Maury County, Tennessee.

The above legal descriptions were prepared by and in accordance with the survey of Robert M. Searson, Tennessee Registered Surveyor's No. 1666, dated October 31, 2008.

2469010.3

TOTAL P.002

## Exhibit B to General Warranty Deed

## Permitted Encumbrances

1. Zoning and building laws, ordinances, resolutions and regulations.

2. "Roll-back taxes" for the statutory period if the land is converted to a use other than those stipulated in the applicable provisions of the Tennessee Code.

3. Sanitary Sewer Easements of record in Book 645, page 301 and Book 789, page 477 in the Register's Office for Maury County, Tennessee.

4. Temporary Construction Easement of record in Book 1911, page 834, said Register's Office.

5. Lack of direct access to Saturn Parkway, a controlled access highway, as set forth in Consent Judgment and Final Decree of record in Lien Book 15, page 278, said Register's Office.

## Exhibit C to General Warranty Deed

## Right of First Refusal to Purchase Grantor's Adjacent Property

If at anytime Grantor or any future owner of a fee simple interest in the Adjacent Property (as hereinafter defined) or any portion thereof (an "**Adjacent Property Owner**") shall receive a bona fide offer from any third party for the purchase of the Adjacent Property or any part thereof, which offer such Adjacent Property Owner desires to accept, or if the Adjacent Property Owner desires to sell or make a bona fide offer to sell the Adjacent Property or any part thereof to a third party, such Adjacent Property Owner shall promptly deliver to Grantee a written notice setting forth the full terms and conditions of the proposed transaction, and if available, a copy of such offer. Grantee may, within thirty (30) days after receipt of such notice, elect to purchase the Adjacent Property or such portion thereof which is subject to any offer as described above (the "**Offer Property**") on the same terms and conditions as those set forth in such notice; except that in the case of any purchase, Grantee shall be credited, against the purchase price to be paid by Grantee, the sum equal to the amount of the brokerage commission, if any, which Adjacent Property Owner shall save by sale to Grantee. The failure of Grantee to exercise this right of first refusal with respect to any proposed sale by Adjacent Property Owner shall not result in the termination of the right of first refusal with respect to the Adjacent Property or any portion thereof sold, but this right of first refusal shall be a continuing right binding upon Adjacent Property Owner and all future Adjacent Property Owners with respect to all subsequent proposed sales of the Adjacent Property or any portion thereof. Furthermore, in the event that any proposed sale as to which Grantee did not exercise its right of first refusal as above provided, is not completed and closed by the Adjacent Property Owner within one (1) year after notice thereof was given to Grantee, or if prior to the closing of such transaction the terms available to the proposed purchaser are modified and made materially more favorable, then the Offer Property must be reoffered to Grantee in the same manner provided above and Grantee shall have thirty (30) days from receipt of the Adjacent Property Owner's notice of the modified offer within which to exercise the right of first refusal. This right of first refusal is a personal right of Grantee, its successors and assigns, and shall not run with the land.

If the consideration to be paid pursuant to any acceptable third party offer to purchase the Offer Property or otherwise acquire the same from Adjacent Property Owner shall include property other than cash, Grantee may exercise its right of first refusal with respect to such transaction and shall pay as consideration therefor the same amount of cash and the same exchange property as set forth in the proposed offer, or an all cash purchase price in an amount equal to the sum of the cash portion of the consideration, plus the fair cash value of the property which the purchaser proposed to exchange for the Offer Property. If any acceptable third party offer to a Adjacent Property Owner for the Offer Property shall include other property owned by such Adjacent Property Owner, Grantee's right of first refusal shall, at the election of Grantee, be either (a) applicable to the Adjacent Property or the applicable portion thereof or interest therein and the other property covered by such offer; or (b) applicable to the Adjacent Property or the applicable portion thereof or interest therein alone, at a purchase price which shall be that part of the price offered by the third party which the value of the Adjacent Property or any portion thereof bears to the value of all the property included in such third party offer.

Any long term lease of the Adjacent Property or any portion thereof for a term in excess of 25 years shall be deemed a "sale" for purposes of Grantee's right of first refusal.

2469010.4

The term "**Adjacent Property**" shall mean that certain tract of land described as follows together with all improvements located thereon:

A tract of land in the Third Civil District Maury County, Tennessee, bounded on the north by Tract 1 of J.O. Morton Jr. Property as of record in Plat Book 6, Page 489-A, Register's Office Maury County, Tennessee (ROMC), also being the Peter and Rita Jenkins property as recorded in Book R2006, Page 387, ROMC, on the east, south and west by the remaining lands of Barbara Jenkins as recorded in Book R1683, Page 76 ROMC. Lot being described as follows;

POINT OF COMMENCEMENT being a ½" iron rod old, at the northwestern corner of Spring Hill Hospital Inc. Tract as recorded in Book 1931, Page 504, ROMC, thence along the southern line of said Tract 1 of J.O. Morton Jr. Property as of record in Plat Book 6, Page 489-A, North 82°03'22" West 261.32 feet to the actual and true POINT OF BEGINNING, Thence leaving said northern line South 05°34'03" West 446.56 feet to a point; Thence, North 82°43'50" West 485.71 feet to a point; Thence, North 05°45'46" East 452.22 feet to a point on said southern line of Tract 1 of J.O. Morton Jr. Property; Thence, along said southern common line South 82°03'22" East 484.37 feet to the Point of Beginning

Containing 217,845 square feet or 5.001 acres.

Being a portion of the property conveyed to Barbara Jenkins, Trustee U/A/D December 11, 2002 of the Barbara Jenkins Revocable Living Trust Agreement, by Quitclaim Deed recorded at Book R1683, page 76 in the Register's Office for Maury County, Tennessee.

## Exhibit D to General Warranty Deed

## Permissible Uses and Restrictions Applicable to Adjacent Property

The Adjacent Property (as defined in Exhibit C to this Warranty Deed) shall be burdened with the following restrictions upon use, which are for the benefit of the Hospital Land and the Hospital Land Owner (as hereinafter defined):

(a) In no event shall the Adjacent Property or any part thereof be used for the following activities without the prior written consent of the Hospital Land Owner, which consent may be granted or denied in its sole and absolute discretion:

(i) for the provision or operation of any "Ancillary Medical Care Service or Facility" (as hereinafter defined); or

(ii) as an acute care general hospital, a medical/surgical hospital, a specialty hospital, a rehabilitation center, an extended care facility or nursing home, an outpatient or inpatient surgery center, an emergency center, a home health service, a health maintenance organization or similar direct care provider, an ambulance service, a birthing center or an inhalation, respiratory or physical therapy center.

As used herein, an "**Ancillary Medical Care Service or Facility**" shall mean and include, (A) any form of testing for diagnostic or therapeutic purposes, (B) provision or operation of a laboratory (including, without limitation, a pathology laboratory or a clinical laboratory), (C) diagnostic imaging services (which include, without limitation, the following testing facilities: fluoroscopy, x-ray, plane film radiography, computerized tomography (CT), ultrasound, radiation therapy, mammography and breast diagnostics, nuclear medicine testing and magnetic resonance imaging), (D) physical therapy services, or respiratory therapy service, and (E) the provision of any medical or related service to or for any person that is in addition to the examination and diagnosis of patients performed directly by a physician or by other health care professionals under the direct supervision of a physician, or a facility operated for the provision of any such service.

As used herein, the following terms shall have the meanings described hereinafter:

"**Hospital Land**" shall mean all of the land conveyed to Grantee by Special Warranty Deed, dated July 21, 2006, by Peter and Rita Jenkins and recorded in Book R1931, page 498 in the Register's Office for Maury County, Tennessee.

"**Hospital Land Owner**" shall mean any person or entity that is the owner of record fee simple title to the Hospital Land (or any portion thereof), but only during and with respect to the period of such person's or entity's ownership. In the event that the Hospital Land is subdivided so that there is more than one person or entity that is a Hospital Land Owner, that person or entity that is the record fee simple owner of the land on which an acute care hospital is located shall be deemed the sole "Hospital Land Owner." In the event that the Hospital Land is subdivided so that there is more than one person or entity that is a Hospital Land Owner and at such time there is not an acute care hospital located on the Hospital Land, the person or entity that is the record fee simple owner of the most acres comprising the Hospital Land shall be deemed the sole "Hospital Land Owner."

(b) Nothing set forth in this General Warranty Deed requires or shall require or shall be interpreted to require any physician or any person associated with any physician to refer any patient to or order or purchase any item of service from the Hospital Land Owner, Grantee, or any of their affiliates. No payment or consideration of any kind under or in connection with this General Warranty Deed is or shall be made for any such referrals, orders or purchases, if any.

(c) The provisions of this Exhibit D shall remain in effect and be enforceable for a period of ninety (90) years after the date of this General Warranty Deed.

(d) The covenants and restrictions set forth in this Exhibit D shall run with the land and burden the Adjacent Property and shall run as an appurtenance with and benefit the Hospital Land and shall be enforceable by the Hospital Land Owner.

Notwithstanding anything set forth in this Exhibit D to the contrary, the Adjacent Property may be used for the operation of a retail pharmacy.

**Exhibit E to Warranty Deed**

**Temporary Access Easement**

(a) Grantor reserves, grants and declares to and for the benefit of the Adjacent Property and the owner of the Adjacent Property a temporary, non-exclusive right and easement for pedestrian and motor vehicle ingress and egress upon and across an existing unpaved private road (the "**Temporary Access Easement**") in order to provide access to and from the Adjacent Property and Kedron Road. The easement rights granted herein shall not include the right to park vehicles in the easement area. The Temporary Access Easement is located over that portion of the Property more particularly described as follows (the "**Temporary Access Easement Area**"):

> Being a 20' Access Easement running on, over and across the lands of Barbara Jenkins located in the Third Civil District Maury County, Tennessee, being bounded on the north by Clyde E. and Azilee M. Smith property as recorded in Book 407, Page 93, Register's Office Maury County, (ROMC), on the north, east and south by the remainder of the said Barbara Jenkins property and on the west by the eastern Right-of-Way (ROW) of Kendron Road. Easement being described as follows:
>
> POINT OF BEGINNING being a iron rod (old) with a Barge Wagner cap, said iron rod being on the eastern ROW of said Kendron Road and being the southwestern corner of said Clyde E. and Azilee M. Smith property; thence leaving said ROW with the southern line of said Clyde E. and Azilee M. Smith property South 77°27'36" East 98.45 feet a 3/8" iron rod (old), said iron rod being on the southeastern corner of said Clyde E. and Azilee M. Smith property and being on the western line of said Barbara Jenkins property; thence leaving said western line North 88°52'16" East 436.11 feet to a point; thence with a curve to the left having a central angle of 29°39'52", a radius of 365.00 feet, a length of 188.98 feet and a chord bearing and distance of North 74°02'20" East 186.87 feet to a point; thence North 59°12'24"E 193.40 feet to a point on the southern line of a proposed lot; thence with the southern line of said proposed lot South 82°43'50" East 32.44 feet to a point; thence leaving said southern line South 59°12'24" West 218.94 feet to a point; thence with a curve to the right having a central angle of 29°39'52", a radius of 385.00 feet, a length of 199.33 feet and a chord bearing and distance of South 74°02'20" West 197.11 feet to a point; thence South 88°52'16" West 438.51 feet to a point; thence North 77°27'36" West 95.09 feet to a point on the eastern ROW of said Kendron Road; thence with the eastern ROW North 03°30'55" West 32.44 feet to the point of beginning.
>
> Containing 18,687 square feet or 0.42 acres.

(b) Grantee shall have the right to relocate the Temporary Access Easement Area to another location on the Property provided that: (i) such relocated Temporary Access Easement Area provides the Adjacent Property with a means of access, ingress and egress to and

from the Adjacent Land and Kedron Road; and (ii) any such relocation shall be at Grantee's sole cost and expense.

(c) Grantee shall have the right to grant similar easements and licenses to others for the use of the Temporary Access Easement Area as it shall determine in its sole discretion to be necessary, appropriate or desirable. Grantee may impose reasonable rules and regulations and construct and install barriers and other devices to control the use of and access to the Temporary Access Easement Area as it now exists or as relocated so long as the use of such Temporary Access Easement shall not be unreasonably impaired.

(d) Grantee, Hospital Land Owner and their respective successors, assigns and tenants shall have the non-exclusive right to use the unpaved road in the Temporary Access Easement Area for (i) pedestrian and motor vehicle access and (ii) installation, maintenance and operation of installation of utility structures and improvements (above and below ground) necessary for the transmission and/or provision of electricity and electrical services, natural gas services, sanitary sewer services, storm sewer services, telephone and telecommunications services and water and water services to the Property or the Hospital Land.

(e) At its sole cost and expense, Grantor shall be responsible to maintain the Temporary Access Easement Area and the unpaved road therein.

(f) In the event Grantee constructs a roadway along the northern boundary of the Adjacent Property which is accepted as a public road by the City of Spring Hill or the County of Maury, the Temporary Access Easement granted herein shall automatically terminate and Grantor agrees to execute a memorandum memorializing such termination suitable for recording in the Register's Office for Maury County, Tennessee upon the request of Grantee.

BK/PG:R2057/1112-1123
08014346
12 PGS : AL - WARRANTY DEED
NANCY BATCH: 86891
11/05/2008 - 08:45 AM
VALUE 6900000.00
MORTGAGE TAX 0.00
TRANSFER TAX 18130.00
RECORDING FEE 60.00
DP FEE 2.00
REGISTER'S FEE 1.00
TOTAL AMOUNT 18193.00
STATE of TENNESSEE, MAURY COUNTY
JOHN FLEMING
REGISTER OF DEEDS

2469010.4

Attachment 9A-5

2012 General Warranty Deed

General Warranty Deed

FROM: **JV PROPERTIES, LLC**, a Tennessee limited liability company

TO: **SPRING HILL HOSPITAL, INC.**, a Tennessee corporation

| Address of New Owner: | Send Tax Bills to: | Map-Parcel No.: |
|---|---|---|
| Spring Hill Hospital, Inc. | (same) | Map 28 |
| One Park Plaza | | Parcel 024.00 |
| Nashville, TN 37203 | | (Part of) |
| Attention: Tax Department | | |

PREPARED BY: WALLER LANSDEN DORTCH & DAVIS, LLP, 511 Union Street, Suite 2700, Nashville, TN 37219-1760

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

The actual consideration or value, whichever is greater, for this transfer is $ 35,000 .

Clayton H Hann
Affiant

Subscribed and sworn to before me, this the 22 day of August, 2012.

Ashley King
NOTARY PUBLIC

ASHLEY KING STATE OF TENNESSEE NOTARY PUBLIC MAURY COUNTY, TENN.

My Commission Expires: April 22, 2014

**GENERAL WARRANTY DEED**

FOR AND IN CONSIDERATION OF the sum of Ten Dollars, cash in hand paid by the hereinafter named GRANTEE, and other good and valuable considerations, the receipt of which is hereby acknowledged, **JV PROPERTIES, LLC**, a Tennessee limited liability company, hereinafter called the GRANTOR, has bargained and sold, and by these presents does transfer and convey unto **SPRING HILL HOSPITAL, INC.**, a Tennessee corporation, hereinafter called the GRANTEE, its successors or assigns, a certain tract or parcel of land in Maury County, State of Tennessee, described as follows (the "**Real Property**"), to wit:

SEE EXHIBIT A ATTACHED HERETO AND INCORPORATED BY REFERENCE AS FULLY AS THOUGH COPIED HEREIN.

This is unimproved property located on Saturn Parkway, Spring Hill, Maury County, Tennessee.

Said Property is transferred free and clear of all limitations, restrictions, and encumbrances except for those matters set forth on Exhibit B attached hereto and made a part hereof (the **"Permitted Encumbrances"**); and

TO HAVE AND TO HOLD the said Property, with the appurtenances, estate, title and interest thereto belonging to the said GRANTEE, its successors and assigns, forever, and GRANTOR does covenant with the said GRANTEE that it is lawfully seized and possessed of said Property in fee simple, has a good right to convey it, and the same is unencumbered except for the Permitted Encumbrances; and GRANTOR does further covenant and bind itself, its heirs and assigns, to warrant and forever defend the title to the said Property to the said GRANTEE, its successors and assigns, against the lawful claims of all persons whomsoever. Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

IN WITNESS WHEREOF, GRANTOR has caused this General Warranty Deed to be executed on the 22nd day of August, 2012.

**JV PROPERTIES, LLC**, a Tennessee limited liability company

By: _____
Name: CLAYTON H. HARRIS
Title: MEMBER

STATE OF TENNESSEE)
COUNTY OF MAURY)

Personally appeared before me, the undersigned, a Notary Public in and for said County and State, the within named CLAYTON H. HARRIS, as MEMBER of **JV PROPERTIES, LLC**, a Tennessee limited liability company, the bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged that he/she executed the within instrument for the purposes therein contained.

Witness my hand and seal, at office in Columbia, Tennessee, this the 22 day of August, 2012.

_____
NOTARY PUBLIC

ASHLEY KING
STATE OF TENNESSEE NOTARY PUBLIC
MAURY COUNTY, TENN.

My Commission Expires: April 22, 2014



9060396.3

## Exhibit A to General Warranty Deed

## Legal Description of the Real Property

**Portion of Map 28, Parcel 24**
**Property Description**

A strip of land located in the Third Civil District of Spring Hill, Maury County, Tennessee, being a portion of Parcel 24.00 on Maury County Tax Map 28, and being the property of JV Properties, LLC of record in Book R2157, page 954 in the Register's Office for Maury County, Tennessee, and being the northerly portion of Parcel 24 that was severed by Saturn Parkway Right-of-Way:

Beginning at an iron pin old and common corner with Map 28, Parcel 23.03 property of Spring Hill Hospital Inc. of record in Book R2057, page 1112 and being approximately 1,005' from the intersection of the easterly right-of-way of Kedron Road and the Northerly right-of-way of Saturn Parkway and being the northwest corner of the herein described tract;

Thence, with said Parcel 23.03, S 82 deg. 34' 47" E, 343.82' to an iron pin old and common corner with Map 28, Parcel 23.02 property of Spring Hill Hospital Inc. of record in Book R1931, page 498;

Thence, with Parcel 23.02, S 82 deg. 36' 20" E, 1,256.15' to a concrete monument old in the northerly right-of-way of Saturn Parkway and being a common corner with Map 28, Parcel 10 property of N. Houston Parks of record in Book R1821, page 1157 and being the northeast corner of the herein described tract;

Thence with the north right-of-way of Saturn Parkway for the following 6 calls:
N 85 deg. 22' 33" W, 699.41' to a concrete monument old;
S 88 deg. 30' 47" W, 180.92' to a concrete monument old;
N 79 deg. 33' 17" W, 344.34' to a concrete monument old;
N 79 deg. 34' 57" W, 239.72' to a concrete monument old;
N 71 deg. 50' 04" W, 107.86' to a concrete monument old;
N 64 deg. 45' 06" W, 35.12' to the Point of Beginning, and containing 49,699 square feet, or 1.141 acres, more or less.

BEING A PORTION of the property conveyed to JV Properties, LLC by deed of record in Book R2157, page 954 in the Register's Office for Maury County, Tennessee.

## Exhibit B to General Warranty Deed

## Permitted Encumbrances

1. Zoning and building laws, ordinances, resolutions and regulations.

2. 2012 real estate taxes and assessments for public improvements that are not delinquent and not yet due and payable.

3. Easement of record in Book 645, Page 275 in the Register's Office, Maury County, Tennessee.

BK/PG:R2201/1239-1242

12009571

| | |
|---|---|
| 4 PGS : AL - WARRANTY DEED | |
| SUSIE BATCH: 127936 | |
| 08/27/2012 - 08:00 AM | |
| VALUE | 35000.00 |
| MORTGAGE TAX | 0.00 |
| TRANSFER TAX | 129.50 |
| RECORDING FEE | 20.00 |
| DP FEE | 2.00 |
| REGISTER'S FEE | 1.00 |
| TOTAL AMOUNT | 152.50 |

STATE of TENNESSEE, MAURY COUNTY

JOHN FLEMING

REGISTER OF DEEDS

RETURN TO:
COMMERCIAL SERVICES
FIRST AMERICAN TITLE
3077 PRIMACY PARKWAY, SUITE 121 B
MEMPHIS, TN 38119
NCS-554699-NAS

Attachment 9A-6

2012 Quit Claim Deed

QUITCLAIM DEED

| Address of New Owner: | Send Tax Bills to: | Map-Parcel No. |
|---|---|---|
| Spring Hill Hospital, Inc. | (same) | Map 28 |
| One Park Plaza | | Parcel 24.00 |
| Nashville, TN 37203 | | (Part of) |
| Attention: Tax Department | | |

PREPARED BY: WALLER LANSDEN DORTCH & DAVIS, LLP, 511 Union Street, Suite 2700, Nashville, TN 37219-1760

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

The actual consideration for this transfer is $-0-.

Affiant

Subscribed and sworn to before me, this the 22 day of August, 2012

NOTARY PUBLIC

My Commission Expires: April 22, 2014

ASHLEY KING STATE OF TENNESSEE NOTARY PUBLIC MAURY COUNTY, TENN.

FOR AND IN CONSIDERATION of Ten Dollars ($10.00), and other good and valuable consideration, JV PROPERTIES, LLC, a Tennessee limited liability company, hereinafter called the GRANTOR, does hereby quitclaim and convey unto SPRING HILL HOSPITAL, INC., a Tennessee corporation, hereinafter called the GRANTEE, its successors or assigns, all of Grantor's right, title and interest in that certain tract or parcel of land in Maury County, State of Tennessee, described as follows, to wit:

SEE EXHIBIT A ATTACHED HERETO AND INCORPORATED BY REFERENCE AS FULLY AS THOUGH COPIED HEREIN.

This is unimproved property located on Saturn Parkway, Spring Hill, Maury County, Tennessee.

BK/PG:R2201/1243-1246

12009572

| | |
|---|---|
| 4 PGS : AL - QUITCLAIM DEED | |
| SUSIE BATCH: 127936 | |
| 08/27/2012 - 08:00 AM | |
| VALUE | 0.00 |
| MORTGAGE TAX | 0.00 |
| TRANSFER TAX | 0.00 |
| RECORDING FEE | 20.00 |
| DP FEE | 2.00 |
| REGISTER'S FEE | 0.00 |
| TOTAL AMOUNT | 22.00 |

STATE of TENNESSEE, MAURY COUNTY

JOHN FLEMING
REGISTER OF DEEDS



9060454.2

IN WITNESS WHEREOF, GRANTOR has caused this Quitclaim Deed to be executed on the 22nd day of August, 2012.

**JV PROPERTIES, LLC**, a Tennessee limited liability company

By: Clayton H Harris
Name: CLAYTON H. HARRIS
Title: MEMBER

STATE OF TENNESSEE)
COUNTY OF MAURY )

Personally appeared before me, the undersigned, a Notary Public in and for said County and State, the within named CLAYTON H. HARRIS, as MEMBER of **JV PROPERTIES, LLC**, a Tennessee limited liability company, the bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged that he/she executed the within instrument for the purposes therein contained.

Witness my hand and seal, at office in Columbia, Tennessee, this the 22 day of August, 2012.

Ashley King
NOTARY PUBLIC

ASHLEY KING
STATE OF TENNESSEE NOTARY PUBLIC
MAURY COUNTY, TENN.

My Commission Expires: April 22, 2014

RETURN TO:
COMMERCIAL SERVICES
FIRST AMERICAN TITLE
6077 PRIMACY PARKWAY, SUITE 121 B
MEMPHIS, TN 38119
NCS-554699-NAS



9060454.2

**Exhibit A**

**Legal Description**

Being a tract of land in the third (3rd) Civil District of Maury County, Tennessee, and located on the North margin of Saturn Parkway, and North of and across Saturn Parkway from Parcel 1 [as defined in Grantor's vesting deed recorded in Book R2157, page 954], and along the beginning of the Westbound off ramp to Kedron Road in Spring Hill, Tennessee, and being more particularly described as follows:

Beginning at an iron rod old at a fence corner post located 2' West from a concrete monument in the North margin of Saturn Parkway, said Iron rod being the Easternmost point of the herein described tract, and said iron rod being Northerly across Saturn Parkway from the Northeast comer of the Parcel 1 [as defined in Grantor's vesting deed recorded in Book R2157, page 954] as described in Call Number 15 of the Parcel 1 Property description [as defined in Grantor's vesting deed recorded in Book R2157, page 954], and being located N 05°54'30" E a distance of 320.23' from the Northeast corner of Parcel 1 [as defined in Grantor's vesting deed recorded in Book R2157, page 954];

1. Thence with the North margin of said Saturn Parkway N 85°21'17" W a distance of 697.27' to a concrete monument;

2. Thence continuing with the North margin of said parkway S 88°27'50" W a distance of 181.27' to a concrete monument;

3. Thence continuing with the North margin of said parkway N 79°32'02" W a distance of 344.01' to a concrete monument;

4. Thence continuing with the North margin of said parkway N 79°37'23" W a distance of 239.74' to a concrete monument;

5. Thence continuing with the North margin of said parkway and the Westbound off ramp to Kedron Road and with a curve to the right (said curve having a radius of 1 056.20', a delta angle of 05°51'00", a chord bearing of N 71°51'22" W, and a chord distance of 107.79) a curve length of 107.84' to a concrete monument;

6. Thence continuing with the North margin of said parkway and the Westbound off ramp N 63°54'55" W a distance of 29.88' to an iron rod new, said point being in the South line of Jenkins as evidenced in Deed Book 1683, page 076, and said iron rod being the Westernmost point of the herein described tract;

7. Thence leaving the North margin of said Saturn Parkway and along the South line of Jenkins, said line also being the North line of the herein described parcel S 82°38'29" E a distance of 1592.67' to a concrete monument, which is the Point of Beginning, containing 1.12 acres, more or less, according to a survey by Steve Northcutt RLS # 1721, dated 04-28-2008.

BEING A PORTION of the property conveyed to JV Properties, LLC by deed of record in Book R2157, page 954 in the Register's Office for Maury County, Tennessee ("Grantor's Vesting Deed"). It being the intention of this Quitclaim Deed to convey Grantor's right, title and interest in the property described as "Tract 1, Parcel 2" in Grantor's Vesting Deed.

Attachment 9A-8

2021 Special Warranty Deed to Green Mills

THIS INSTRUMENT PREPARED BY:
Andrew P. Gulotta, Esq.
HCA Healthcare, Inc.
1100 Dr. Martin L. King Jr. Blvd., Suite 500
Nashville, Tennessee 37203

STATE OF Tennessee )
COUNTY OF Williamson )

The actual consideration or value, whichever is greater, for this transfer is $4,500,000.00.

Affiant

Subscribed and sworn to before me this 16th day of December, 2021.

Notary Public

My Commission Expires: 05-04-2025

BK/PG:R2800/391-398
21027334

| | |
|---|---|
| 8 PGS : WARRANTY DEED | |
| JANE JOURNEY 265002 - 21027334 | |
| 12/17/2021 - 12:34 PM | |
| VALUE | 4500000.00 |
| MORTGAGE TAX | 0.00 |
| TRANSFER TAX | 16650.00 |
| RECORDING FEE | 40.00 |
| DP FEE | 2.00 |
| REGISTER'S FEE | 1.00 |
| TOTAL AMOUNT | 16693.00 |

STATE of TENNESSEE, MAURY COUNTY
JOHN FLEMING
REGISTER OF DEEDS

JACKIE LAMPLEY STATE OF TENNESSEE NOTARY PUBLIC WILLIAMSON COUNTY My Commission Expires 05-04-2025

**********

| ADDRESS OF NEW OWNER: | SEND TAX BILL TO: | MAP-PARCEL NO. |
|---|---|---|
| Greens Mill Road, LLC<br>P.O. Box 681727<br>Franklin, Tennessee 37068-1727 | SAME | 028-023.02 (Portion) |

**********

## SPECIAL WARRANTY DEED

FOR AND IN CONSIDERATION OF the sum of $10.00, cash in hand paid by the hereinafter named Grantee, and other good and valuable considerations, the receipt and sufficiency of which are hereby acknowledged, **SPRING HILL HOSPITAL, INC.**, a Tennessee corporation, (***"Grantor"***), has bargained and sold, and by these presents does transfer and convey unto **GREENS MILL ROAD, LLC**, a Tennessee limited liability company (***"Grantee"***), its successors and assigns, a certain tract or parcel of land in the City of Spring Hill, County of Maury, State of Tennessee, described as follows, to-wit:

See attached Exhibit A

Said property is transferred subject to real estate taxes for 2021, not yet due or payable, applicable zoning, subdivision and building regulations, all matters of record and all matters which would be disclosed by an accurate survey or inspection of the Property and those restrictions provided on Exhibit B to this Special Warranty Deed (collectively, ***"Permitted Exceptions"***).

TO HAVE AND TO HOLD the said tract or parcel of land, with the appurtenances, estate, title and interest thereto belonging to the said Grantee, its successors and assigns, forever, and Grantor does covenant with the said Grantee that it is lawfully seized and possessed of said land in fee simple, has a good right to convey it, and the same is unencumbered, unless otherwise herein set out; and Grantor does

further covenant and bind itself, its successors and assigns, to warrant and forever defend the title to the said land to the said Grantee, its successors and assigns, against the lawful claims of all persons claiming by, through or under Grantor only, excepting however, the Permitted Exceptions. Wherever used, the singular number shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

*[Remainder of Page Intentionally Left Blank; Signature Page to Follow]*

SIGNATURE PAGE TO SPECIAL WARRANTY DEED

17th IN WITNESS WHEREOF Grantor has caused this Special Warranty Deed to be executed on the day of December, 2021.

**SPRING HILL HOSPITAL, INC.,**
a Tennessee corporation

By: _____
Nicholas L. Paul, Vice President

Date: Dec 6, 2020

STATE OF TENNESSEE )
COUNTY OF DAVIDSON )

Before me, the undersigned, a Notary Public in and for the County and State aforesaid, personally appeared Nicholas L. Paul, with whom I am personally acquainted, (or proved to me on the basis of satisfactory evidence), and who upon oath acknowledged himself to be the Vice President of Spring Hill Hospital, Inc., the within named bargainor, a Tennessee corporation, and that he, as such Vice President, being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation as such Vice President.

Witness my hand and seal this the 6 day of December, 2021.

_____
Notary Public

My Commission Expires: 7/7/25

ANNE MARIE GEBEL
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

*[Remainder of Page Intentionally Left Blank; Exhibit A to Follow]*

## EXHIBIT A TO SPECIAL WARRANTY DEED

### LEGAL DESCRIPTION

A parcel of land, being the East 45 acres of Lot 1, as shown on "Final Plat, Spring Hill Hospital" of record in Plat book P20, page 277 in the Register's Office of Maury County, Tennessee (R.O.M.C., TN.), and further described as follows;

Beginning at an iron pin & cap set at the Southwest corner of lands owned by John D. & Janice W. Ring, of record in deed book R1904, page 145, R.O.M.C., TN. Said point being the Southeast corner of the herein described tract and on the Northerly right-of-way of Saturn Parkway;

Thence, along the Northerly right-of-way of Saturn Parkway and along the South line of said Lot 1, South 72°40'40" West, a distance of 85.35 feet to an iron pin & cap set at the East most corner of Tract 1, lands owned by N Houston Parks, of record in deed book R1821, page 1157, R.O.M.C., TN.;

Thence, along the North line of said lands of N Houston Parks, North 82°33'06" West, a distance of 393.76 feet to a found pin at the Northwest corner of said lands of N Houston Parks;

Thence, along the West line of said lands of N Houston Parks, South 04°26'59"West, a distance of 177.65 feet to a found metal fence post on the Northerly line of Saturn Parkway;

Thence, along the Northerly line of Saturn Parkway the following three (3)courses;

South 73°33'12" West, a distance of 32.75 feet to a concrete monument found;

Thence, South 73°24'31" West, a distance of 244.26 feet to a concrete monument found;

Thence, along a curve concave to the north having a radius of 2808.57 feet and a central angle of 9°37'07" and being subtended by a chord which bears South 78°13'04" West 470.94 feet; thence westerly along said curve, a distance of 471.49 feet to an iron pin & cap set at the East most corner ofTract 2, lands owned by N Houston Parks, of record in deed book R1821, page 1157, R.O.M.C., TN.;

Thence, along the North line of Tract 2, of said lands of N Houston Parks, North 83°43'43" West, a distance of 782.53 feet to a iron pin & cap set, at a new point;

Thence, along a new dividing line, through Said Lot 1 of "Final Plat, Spring Hill Hospital", North 08°24'59" East, a distance of 1165.75 feet to a point on the South right of way of Reserve Boulevard, (70 feet wide) of record in plat book P21, page 57, R.O.M.C., TN;

Thence, along the South right of way of Reserve Boulevard the following 8 (eight) courses;

Thence, South 82°26'26" East, a distance of 461.31 feet to a found iron rod & cap;

thence, along a curve concave to the north having a radius of 2535.00 feet and a central angle of 2°48'28" and being subtended by a chord which bears South 83°50'40" East 124.22 feet; thence easterly along said curve, a distance of 124.23 feet to a found iron rod & cap;

Thence, South 85°14'54" East, a distance of 265.66 feet to a found iron rod & cap;

thence along a curve concave to the south having a radius of 2465.00 feet and a central angle of 3°22'09" and being subtended by a chord which bears South 83°33'49" East 144.93 feet; thence easterly along said curve, a distance of 144.95 feet to a point;

Thence, South 81°52'45" East, a distance of 264.88 feet to a found iron rod & cap;

Thence, along a curve concave to the north having a radius of 2535.00 feet and a central angle of 2°48'38" and being subtended by a chord which bears South 83°17'04" East 124.34 feet; thence easterly along said curve, a distance of 124.35 feet to a found pin, bent;

Thence, South 84°41'23" East, a distance of 331.96 feet to a found iron pin;

Thence, along a curve concave to the south having a radius of 565.00 feet and a central angle of 22°41'08" and being subtended by a chord which bears South 73°20'49" East 222.25 feet; thence easterly and southeasterly along said curve, a distance of 223.70 feet to a found bent pin, at the Northeast corner of lands owned by John D. & Janice W. Ring, of record in deed book R1904, page 145, R.O.M.C., TN;

Thence, leaving the right-of-way of Reserve Blvd, along the East line of said Lot 1 and the West line of said lands owned by Ring, South 08°38'29" West, a distance of 660.89 feet to the Point of Beginning. Containing 45.000 Acres, more or less. According to a Boundary Survey, by Homeland Surveying & Mapping, LLC, dated November 17, 2021.

Being a portion of the property conveyed to Spring Hill Hospital, Inc., a Tennessee corporation, by the following instruments:

- Deed from JV Properties, LLC, of record in Book R2201, Page 1239, in the Register's Office of Maury County, Tennessee.
- Deed from JV Properties, LLC, of record in Book R2201, Page 1243, in the Register's Office of Maury County, Tennessee.
- Deed from Barbara Jenkins, Trustee u/a/d December 11, 2002 of The Barbara Jenkins Revocable Living Trust Agreement, of record in Book R2057, Page 1112, in the Register's Office of Maury County, Tennessee.
- Deed from Peter Jenkins and wife, Rita Jenkins, of record in Book R1931, Page 498, in the Register's Office of Maury County, Tennessee.
- Deed from Peter Jenkins and wife, Rita Jenkins, of record in Book R1931, Page 504, in the Register's Office of Maury County, Tennessee

[*Remainder of Page Intentionally Left Blank; Exhibit B to Follow*]

**EXHIBIT B TO SPECIAL WARRANTY DEED**

**USE RESTRICTIONS**

1. USE RESTRICTIONS.

(a) Permitted Uses. The Property may be used for any purposes allowed by applicable zoning codes and regulations except for the uses prohibited in Section (b) below.

(b) Prohibited Uses. The Property (and any portion or subdivided part of the Property) shall not, under any circumstances, be used for any of the following uses without the prior written consent of Grantor, which consent may be granted or withheld in Grantor's sole and absolute discretion: (i) an acute care hospital, medical or surgical or specialty hospital, or any other hospital facility, whether general or special, (ii) an outpatient or inpatient clinic, (iii) a facility providing surgery services, (iv) a facility providing birthing services, (v) a facility providing inhalation, respiratory, or physical therapy services, (vi) a facility providing rehabilitation services, (vii) an extended care facility, skilled nursing facility, or nursing home, (viii) a facility providing urgent care, emergency care or similar medical services, (ix) an ambulance service, (x) a home health service, a health maintenance organization or similar direct care provider, or (xi) a facility providing Ancillary Medical Care Services or Facilities (defined below). Notwithstanding the preceding sentence, nothing in this Exhibit prohibits any Physician (defined below) who conducts a medical practice at the Property from performing on or providing to such Physician's own patients Ancillary Medical Care Services or Facilities (i) so long as such Ancillary Medical Care Services or Facilities are (A) the kind and type usually and customarily provided by Physicians of similar experience and training to patients in such Physicians' own offices, and (B) ancillary and incidental to such Physician's primary medical practice and do not constitute the Physician's primary medical practice or specialty nor the predominant services rendered by the Physician to the Physician's patients, and (ii) so long as such patients for whom such Ancillary Medical Care Services or Facilities are performed are not referred to such Physician primarily for the purpose of obtaining such Ancillary Medical Care Services or Facilities. Further notwithstanding the foregoing, nothing in this Exhibit prohibits the use of the Property as an independent living, assisted living, age-restricted or active senior living residential community.

"***Ancillary Medical Care Services or Facilities***" means and includes, (i) any form of testing for diagnostic or therapeutic purposes, (ii) the provision or operation of a laboratory (including, without limitation, a pathology laboratory or clinical laboratory), (iii) diagnostic imaging services (which include, without limitation, the following testing facilities: fluoroscopy, x-ray, plane film radiography, computerized tomography (CT), ultrasound, radiation therapy, mammography and breast diagnostics, nuclear medicine testing and magnetic resonance imaging (MRI)), (iv) physical therapy services, or respiratory therapy service, and (v) the provision of any medical or related service to or for any person that is in addition to the examination and diagnosis of patients performed directly by a licensed physician (a "***Physician***") or by other health care professionals under the direct supervision of a Physician, or a facility operated for the provision of any such service.

2. MISCELLANEOUS. This Exhibit shall be governed, construed and enforced in accordance with the laws of the state in which the Property is situated. If any covenant, condition, restriction, or other provision of this Exhibit is unlawful, void or voidable for the violation of any rule of law, including, but not limited to, the rule against perpetuities, any law regarding unreasonable restraints on alienation or any similar rule of law, then such provision shall continue only until the date that is 21 years after the death of the last survivor of the now-living lineal descendants of Elizabeth II, Queen of England. Except as otherwise provided in this Exhibit, the covenants and restrictions provided for in this Exhibit will be

effective upon the date of this deed and run with the land for a term of 99 years. The agreements and restrictions provided for herein shall inure to the benefit of and be binding upon the (i) the Grantor and its successors and assigns; (ii) the Grantee, and (iii) the respective successors, successors-in-title, assigns, heirs and lessees of the Grantee, and their respective agents, employees, lessees and invitees. The covenants and restrictions provided for in this Exhibit shall remain in full force and effect and shall be unaffected by any change in ownership of the Property, or by any change of use, demolition, reconstruction, expansion or other circumstances, except as specified herein. Irreparable harm will result to Grantor by reason of any breach of the agreements, covenants and restrictions set forth in this Exhibit, and, therefore, Grantor shall be entitled to relief by way of injunction or specific performance to enforce the provisions of this Exhibit, as well as any other relief available at law or equity. The failure of Grantor, in any one or more instances, to insist upon compliance with any of the terms and conditions of this Exhibit, or to exercise any right or privilege conferred in this Exhibit, shall not constitute or be construed as the waiver of such or any similar restriction, right, option, or privilege, but the same shall continue and remain in full force and effect as if no such forbearance had occurred.

[*Remainder of Page Intentionally Left Blank; End of Exhibit B*]

True Copy Certification

I, Mary Kate C. Brandon, do hereby make oath that I am a licensed attorney and/or the custodian of the electronic version of the attached document tendered for registration herewith and that this is a true and correct copy of the original document executed and authenticated according to law on 12/17/2021.

Signature

Date: 12/17/2021

State of Tennessee

County of Davidson

Personally appeared before me, JoDean M King, a notary public for this county and state, Mary Kate C. Brandon who acknowledges that this certification of an electronic document is true and correct and whose signature I have witnessed.

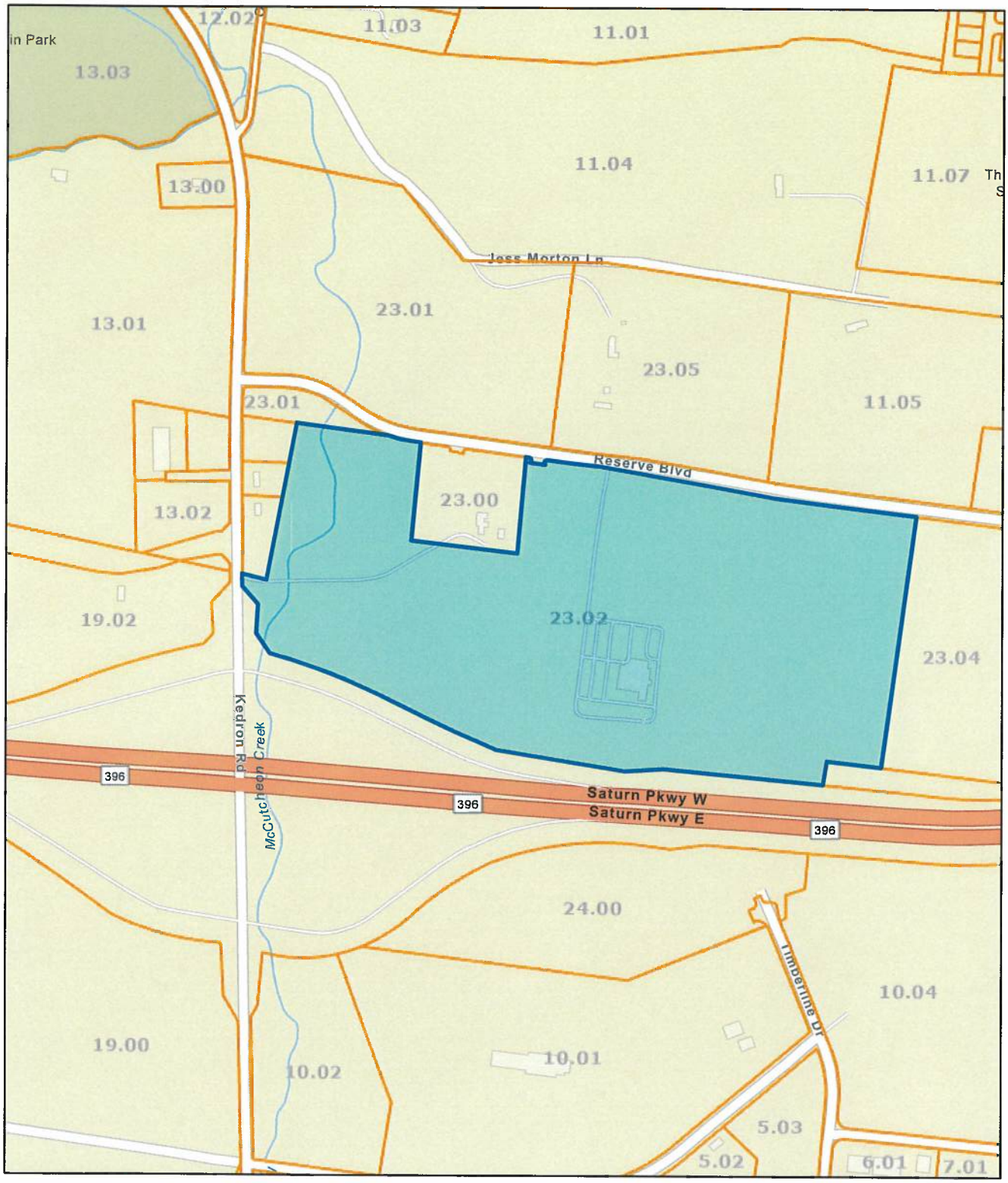
Notary's Signature

My Commission Expires: 7/22/2025

Notary Seal

JODEAN M. KING
STATE OF TENNESSEE NOTARY PUBLIC
ROBERTSON COUNTY

# Maury County - Parcel: 028 023.02




Date: February 19, 2024

County: Maury
Owner: SPRING HILL HOSPITAL INC
Address: RESERVE BLVD 3001
Parcel Number: 028 023.02
Deeded Acreage: 0
Calculated Acreage: 77
Date of TDOT Imagery: 2021
Date of Vexcel Imagery: 2023

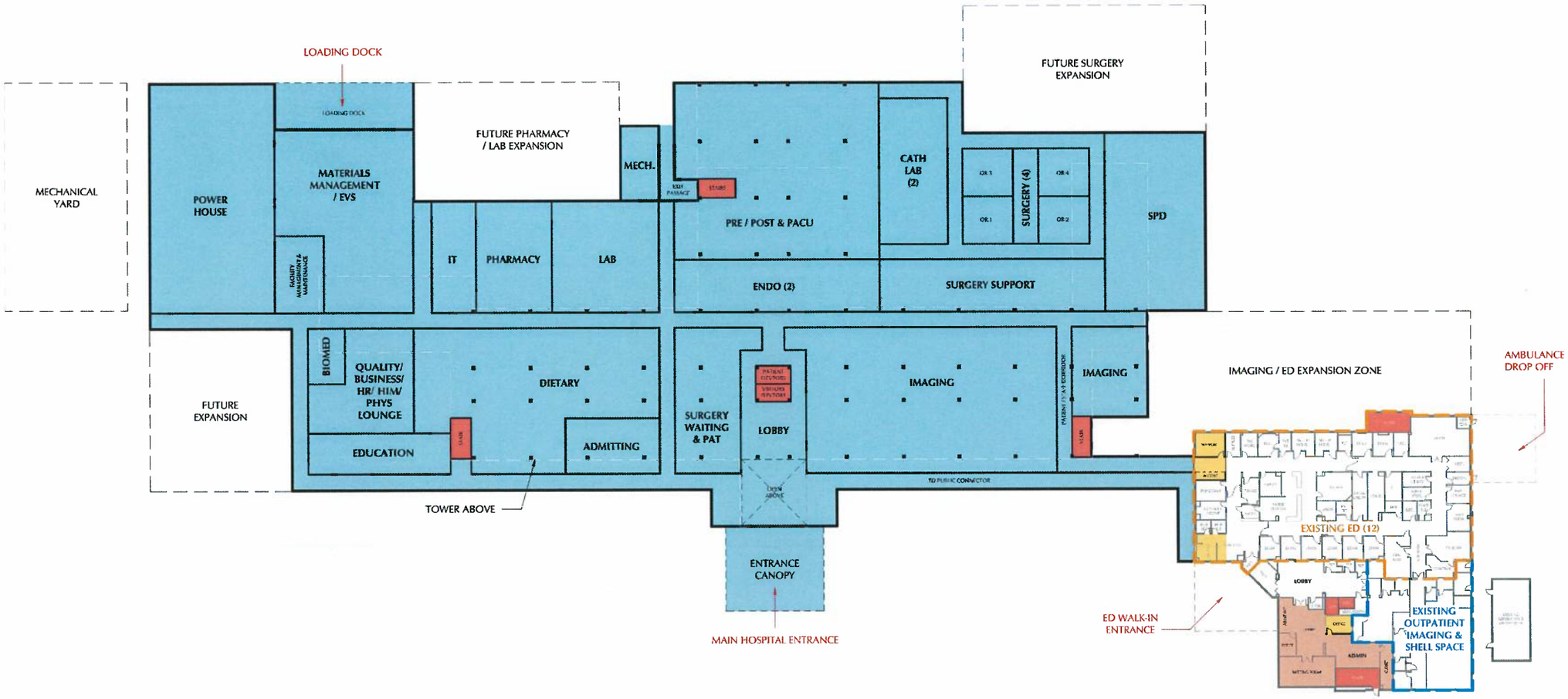
1:9,028

0 0.05 0.1 0.2 mi

0 0.1 0.2 0.4 km

Attachment 10A

Proposed Floor Plans




1 PROPOSED FIRST FLOOR PLAN

1" = 60'-0"

0 30 60 120 180 FEET

TMPartners, PLLC
Architecture Interiors Planning
211 Franklin Road
Suite 200
Brentwood, TN 37027
615.377.9773 Office
615.370.4147 Fax
www.TMPartners.com

STANDARD COLOR LEGEND
- NEW CONSTRUCTION
- MAJOR RENOVATION
- MINOR RENOVATION
- COSMETIC RENOVATION

TRISTAR SPRING HILL
NEW HOSPITAL
SPRING HILL, TN

TMP Project No.: A07723
08 / 31 / 2023

FIRST FLOOR PLAN


1 PROPOSED SECOND FLOOR PLAN

1" = 60'-0"

0 30 60 120 180 FEET


TMPartners, PLLC
Architecture Interiors Planning
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615.370.4147 Fax
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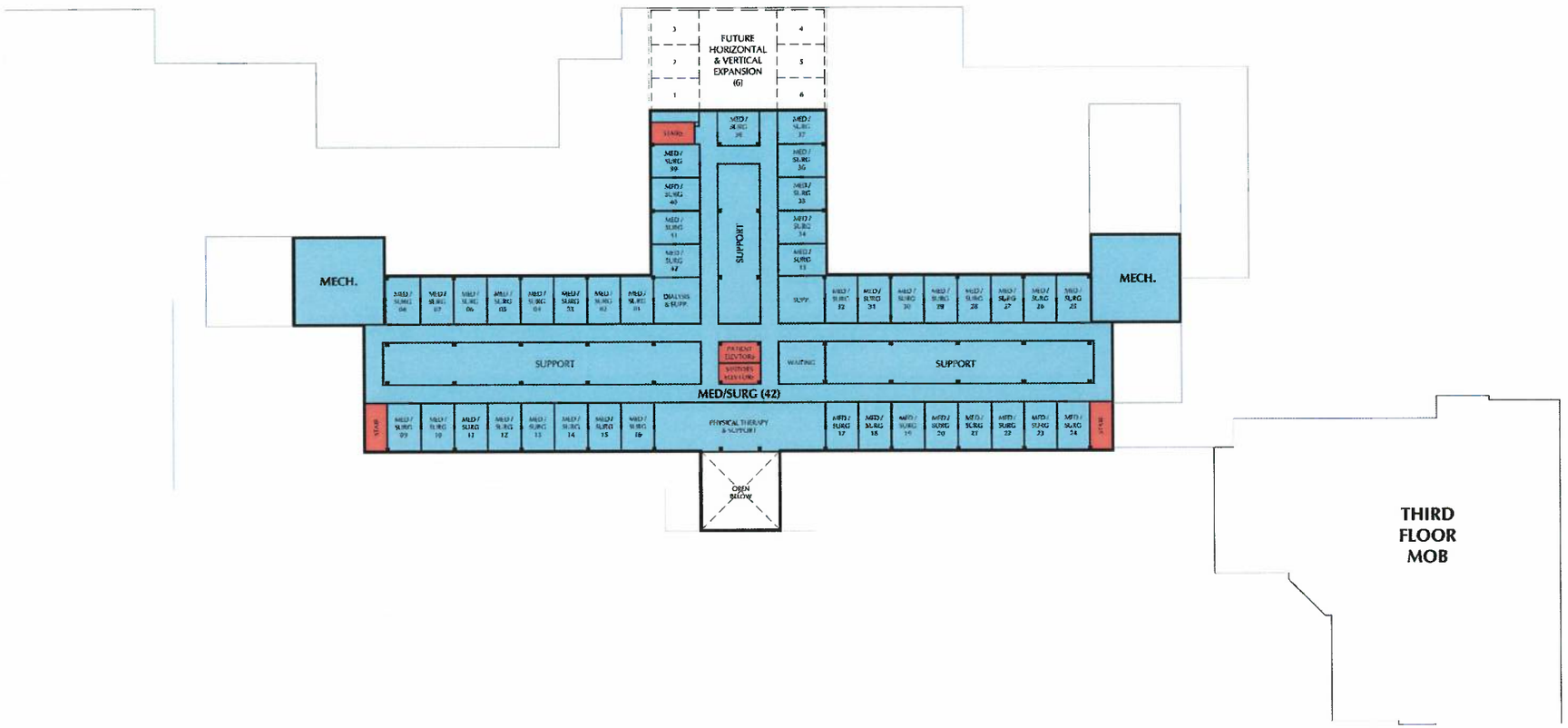
STANDARD COLOR LEGEND

- NEW CONSTRUCTION
- MAJOR RENOVATION
- MINOR RENOVATION
- COSMETIC RENOVATION

TRISTAR SPRING HILL
NEW HOSPITAL
SPRING HILL, TN

TMP Project No.: A07723
08 / 31 / 2023

SECOND FLOOR PLAN




1 PROPOSED THIRD FLOOR PLAN

1" = 60'-0"

0 30 60 120 180 FEET


**TMPartners, PLLC**
Architecture Interiors Planning
211 Franklin Road
Suite 200
Brentwood, TN 37027
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STANDARD COLOR LEGEND

- NEW CONSTRUCTION
- MAJOR RENOVATION
- MINOR RENOVATION
- COSMETIC RENOVATION

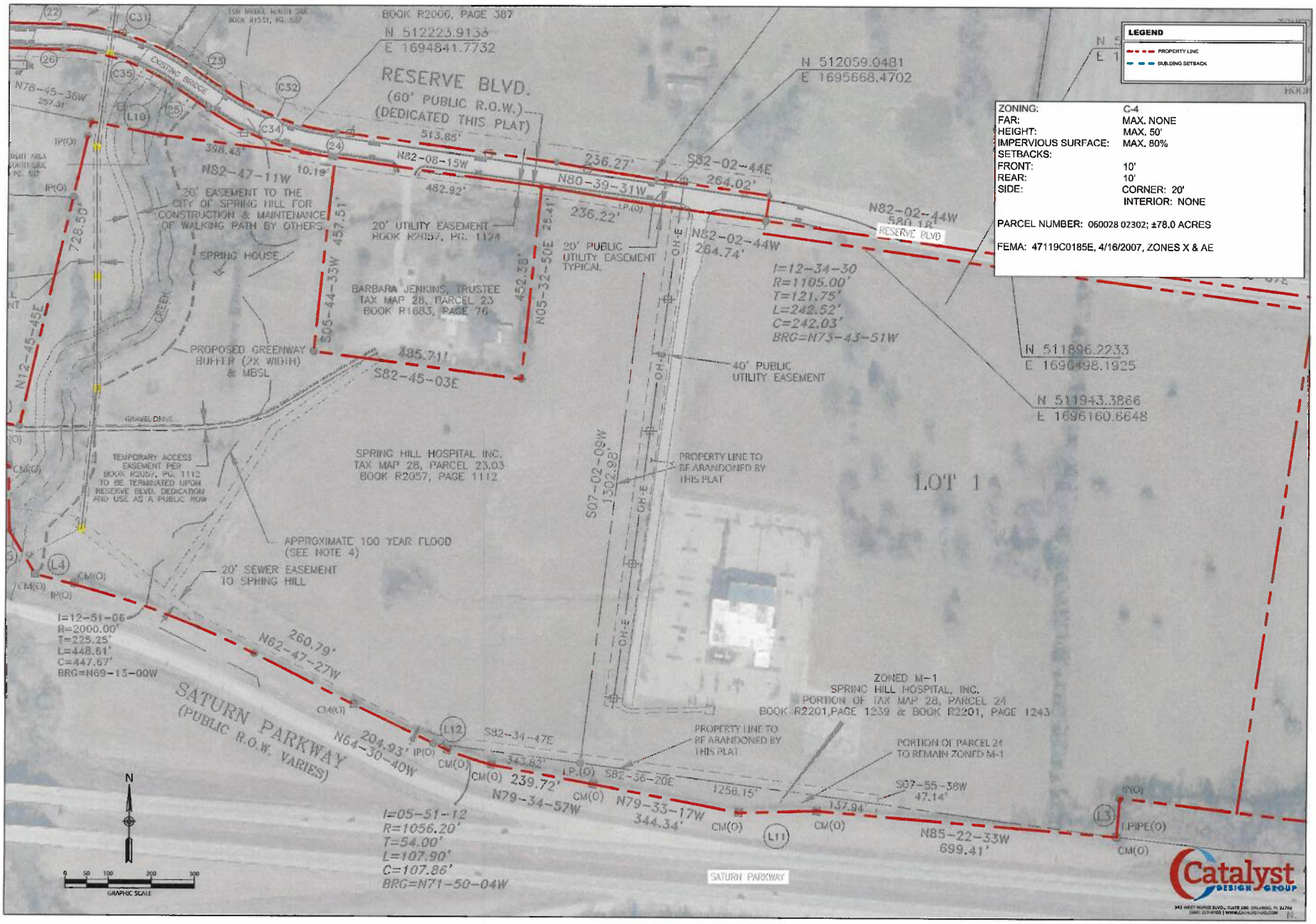
TRISTAR SPRING HILL
NEW HOSPITAL
SPRING HILL, TN

TMP Project No.: A07723
08 / 31 / 2023

THIRD FLOOR PLAN

Attachment 12A

Plot Plan





TMPartners, PLLC
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211 Franklin Road
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Brentwood, TN 37027
615.377.9773 Office
615.370.4147 Fax
www.TMPartners.com

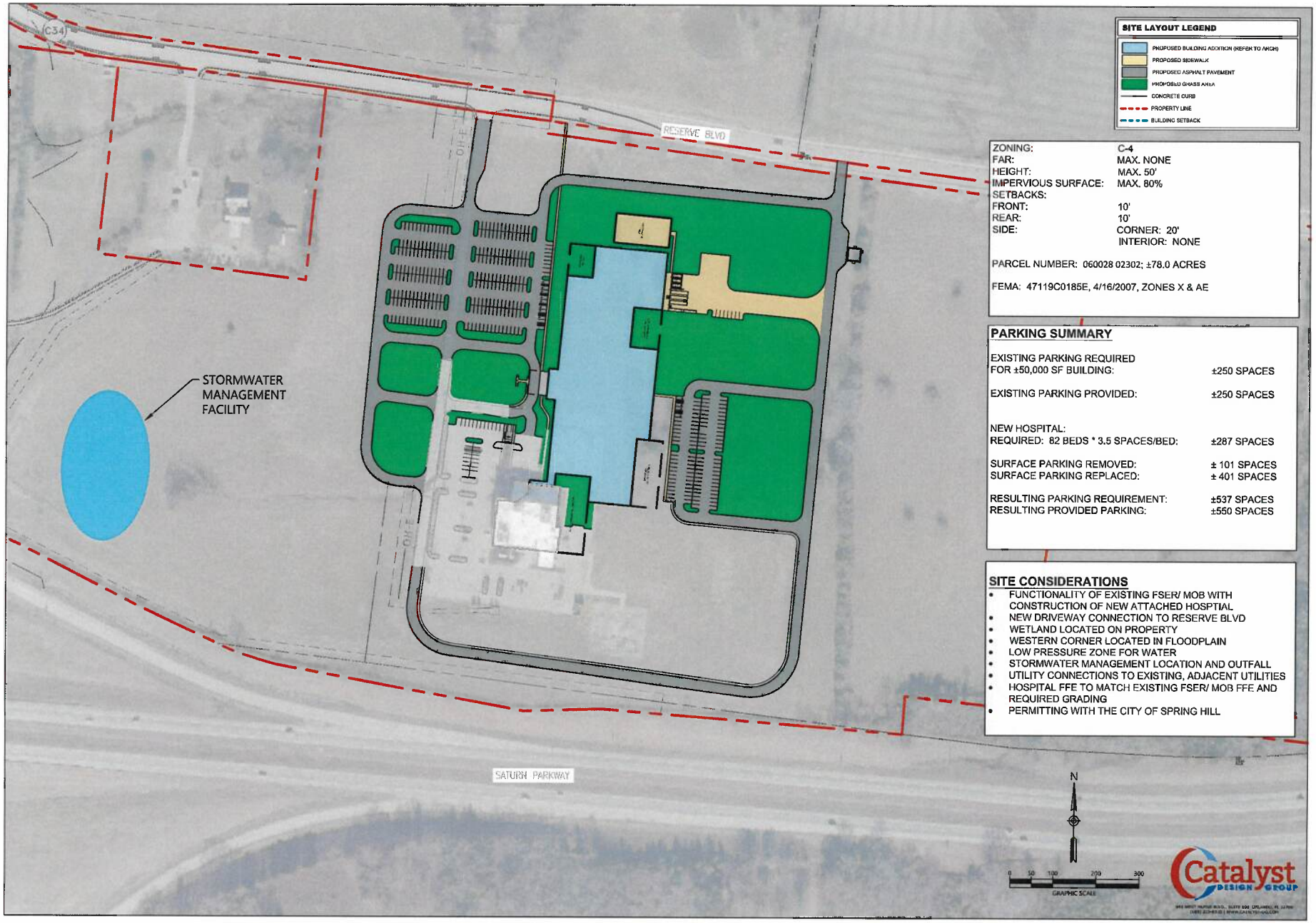

TRISTAR SPRING HILL
NEW HOSPITAL
SPRING HILL, TN

TMP Project No.: A07723
08 / 31 / 2023

COMPONENT: 1-2

EXISTING CONDITION

DRAWING
1 OF 7




**SITE LAYOUT LEGEND**

- PROPOSED BUILDING ADDITION (REFER TO ARCH)
- PROPOSED SIDEWALK
- PROPOSED ASPHALT PAVEMENT
- PROPOSED GRASS AREA
- CONCRETE CURB
- PROPERTY LINE
- BUILDING SETBACK

| | |
|---|---|
| ZONING: | C-4 |
| FAR: | MAX. NONE |
| HEIGHT: | MAX. 50' |
| IMPERVIOUS SURFACE: | MAX. 80% |
| SETBACKS: | |
| FRONT: | 10' |
| REAR: | 10' |
| SIDE: | CORNER: 20' |
| | INTERIOR: NONE |

PARCEL NUMBER: 060028 02302; ±78.0 ACRES

FEMA: 47119C0185E, 4/16/2007, ZONES X & AE

**PARKING SUMMARY**

| | |
|---|---|
| EXISTING PARKING REQUIRED FOR ±50,000 SF BUILDING: | ±250 SPACES |
| EXISTING PARKING PROVIDED: | ±250 SPACES |
| NEW HOSPITAL: REQUIRED: 82 BEDS * 3.5 SPACES/BED: | ±287 SPACES |
| SURFACE PARKING REMOVED: | ± 101 SPACES |
| SURFACE PARKING REPLACED: | ± 401 SPACES |
| RESULTING PARKING REQUIREMENT: | ±537 SPACES |
| RESULTING PROVIDED PARKING: | ±550 SPACES |

**SITE CONSIDERATIONS**

- FUNCTIONALITY OF EXISTING FSER/ MOB WITH CONSTRUCTION OF NEW ATTACHED HOSPTIAL
- NEW DRIVEWAY CONNECTION TO RESERVE BLVD
- WETLAND LOCATED ON PROPERTY
- WESTERN CORNER LOCATED IN FLOODPLAIN
- LOW PRESSURE ZONE FOR WATER
- STORMWATER MANAGEMENT LOCATION AND OUTFALL
- UTILITY CONNECTIONS TO EXISTING, ADJACENT UTILITIES
- HOSPITAL FFE TO MATCH EXISTING FSER/ MOB FFE AND REQUIRED GRADING
- PERMITTING WITH THE CITY OF SPRING HILL

TMPartners, PLLC
Architecture Interiors Planning
211 Franklin Road
Suite 200
Brentwood, TN 37027
615.377.9773 Office
615.370.4147 Fax
www.TMPartners.com

TRISTAR SPRING HILL
NEW HOSPITAL
SPRING HILL, TN

TMP Project No.: A07723
08 / 31 / 2023

COMPONENT: 1-2

SITE LAYOUT

DRAWING
2 OF 7

Attachment 4E

Equipment List > $50,000

**Facility: TRISTAR DIVISION OFFICE**

**Project / Budget: New Facility-Spring Hill Medical Center / Springhill 68 Bed Hospital**

| Item # | Item Description | Class | Vendor | Dept | Space | Item Qty | Cost per Unit |
|---|---|---|---|---|---|---|---|
| 101187 | Vivid Ultrasound E95 | | GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag | IMAGING | ECHO CARDIOLOGY ROOM | 1 | $187,014.00 |
| 725393 | VIDEO EQUIPMENT, ARTHROSCOPIC / LAPAROSCOPIC | | STRYKER ENDOSCOPY | SURGERY | OR - GENERAL | 3 | $175,000.00 |
| 725393 | VIDEO EQUIPMENT, ARTHROSCOPIC / LAPAROSCOPIC | | STRYKER ENDOSCOPY | SURGERY | OR - ORTHOPEDIC | 1 | $175,000.00 |
| 709085 | PORTABLE X-RAY OPTIMA XR240 WITH 30KW | | GE PRECISION HEALTHCARE LLC | IMAGING | PORTABLE OPTIMA XR240 WITH 2 FLASHPAD HD PLATES | 2 | $171,438.00 |
| 101034 | C-ARM - Elite CFD 21cm Super-C with OEC Touch ESP | | GE HEALTHCARE - OEC MEDICAL SYSTEMS INC | SURGERY | OR - ORTHOPEDIC | 1 | $171,130.50 |
| 727496 | ULTRASOUND, LOGIQ E10 XDCLEAR | | GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag | IMAGING | ULTRASOUND LOGIQ E10 4D XDCLEAR | 2 | $123,663.30 |
| 709083 | PORTABLE X-RAY - AMX NAVIGATE | | GE PRECISION HEALTHCARE LLC | SURGERY | PORTABLE X-RAY | 1 | $113,257.00 |
| 728272 | Digital Imaging System, Opthalmic - Retcam Shuttle Wide-Field 20-000515 | | NATUS MEDICAL INC | NURSERY | SPECIAL TECHNOLOGY | 1 | $113,000.00 |
| 101752 | C-ARM, MINI SURGICAL - TAU 2020 | | ORTHOSCAN | SURGERY | SPECIAL INSTRUMENTS | 1 | $95,500.00 |
| 717610 | ANESTHESIA MACHINE - AISYS CS2 WITH B850 MONITOR | | GE HEALTHCARE DATEX-OHMEDA | SURGERY | OR - ORTHOPEDIC | 1 | $86,562.84 |
| 717610 | ANESTHESIA MACHINE - AISYS CS2 WITH B850 MONITOR | | GE HEALTHCARE DATEX-OHMEDA | SURGERY | OR - GENERAL | 3 | $86,562.84 |
| 727503 | ULTRASOUND, POC - VENUE | | GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag | SURGERY | SPECIAL INSTRUMENTS | 1 | $67,732.13 |
| 727503 | ULTRASOUND, POC - VENUE | | GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag | CATHETERIZATION LAB | CATH LAB BASIC | 2 | $67,732.13 |
| 727503 | ULTRASOUND, POC - VENUE | | GE MEDICAL SYSTEMS - Ultrasound & Primary Care Diag | ICU/CCU | SPECIALTY EQUIPMENT | 1 | $67,732.13 |
| 101404 | ANESTHESIA MACHINE; AISYS | | GE HEALTHCARE DATEX-OHMEDA | BIRTHING CENTER | DELIVERY ROOM / C-SECTION | 2 | $64,545.00 |
| 835278 | TEMP MANAGEMENT SYSTEM - ARCTIC SUN STAT | | BARD MEDICAL DIVISION-OR DIVISION | ICU/CCU | SPECIALTY EQUIPMENT | 1 | $64,000.00 |
| 717595 | AESTIVA/5 MRI | | GE HEALTHCARE DATEX-OHMEDA | IMAGING | MRI - 1.5T | 1 | $60,480.00 |
| 100813 | BALLOON PUMP, CARDIOSAVE HYBRID | | GETINGE USA SALES LLC | ICU/CCU | SPECIALTY EQUIPMENT | 1 | $55,775.00 |
| 100813 | BALLOON PUMP, CARDIOSAVE HYBRID | | GETINGE USA SALES LLC | CATHETERIZATION LAB | CATH LAB BASIC | 2 | $55,775.00 |
| 101949 | INSTRUMENTATION (PLACEHOLDER) - QUOTE CONFIGURED BY FACILITY | | TBD-EQUIPMENT | BIRTHING CENTER | DELIVERY ROOM / C-SECTION | 2 | $50,000.00 |

# 1N

## Acute Care Standards and Criteria

## History of TriStar in Spring Hill

### Spring Hill seeks a hospital and TriStar responds

In November 2005, leaders from the Spring Hill community, including the Spring Hill mayor, approached HCA Healthcare, Inc. ("HCA Healthcare") about developing a hospital to meet the growing needs of the community.

In April 2006, after determining that a need existed and in response to the City's request, Spring Hill Hospital, Inc., a subsidiary of HCA Healthcare, applied for a CON requesting approval of a 56-bed hospital in Spring Hill, at the location of the current TriStar Spring Hill ER and the location of the proposed TSHH, at a cost of approximately $105,000,000.

At this time the issues under the CON law were:

1. Need,
2. Economic feasibility, and
3. Orderly development.[1]

On July 26, 2006, the Health Services Development Agency ("HSDA")[2] considered the Spring Hill Hospital CON Application (CN0604-028). Despite vigorous opposition from Maury Regional Hospital ("MRH") and Williamson Medical Center ("WMC"), the HSDA granted the CON by a vote of 7 to 1 in favor of the new Spring Hill Hospital ("SHH"). The Spring Hill community overwhelmingly supported the CON application as shown by city leaders, business leaders and residents of the Spring Hill area who sought to have the hospital established and attended the HSDA meeting at which the CON was considered.

In August 2006, MRH and WMC challenged the CON by petitioning for a contested case hearing. In April 2007, a trial was conducted before an Administrative Law Judge ("ALJ").

On October 12, 2007, the ALJ issued his Initial Order. In that Initial Order, the ALJ found against the SHH CON. In a thirty-eight page opinion, the ALJ found that the Need and Orderly Development requirements were not met. The ALJ found the Need element lacking, in part, because he believed the population projections by SHH's expert witness to be unreasonable. Further, the ALJ found the impact on WMC and MRH caused the Orderly Development requirement to not be met.

On October 25, 2007, SHH petitioned the HSDA to review the ALJ's Initial Order. On February 27, 2008, the HSDA reviewed SHH project in another full hearing before the Agency.

On March 19, 2008, the HSDA issued its 42-page Final Order granting the CON for SHH. The Final Order "Overruled and Modified" the ALJ's decision.

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[1] In 2021, this law was substantially amended to remove "economic feasibility" and "orderly development. Under current law, the requirements for a CON are: (1) Need, (2) Quality, and (3) Consumer Advantage ("the effects attributed to competition or duplication would be positive for consumers"). Tenn. Code Ann. § 68-11-1609(b) (2021).

[2] The HSDA became the Health Facilities Commission ("HFC") pursuant to the Tennessee Health Services and Planning Act of 2021, Tennessee Code Annotated § 68-11-1601, *et. seq.* ("2021 CON Law").

With regard to Need and the population issue, the HSDA found:

> Spring Hill is a rapidly growing city. In 2000, the U.S. Census found a Spring Hill population of 7,715. In 2005, the City conducted its own Special Census, which concluded that the population of Spring Hill was 17,325. This represents a 17.6% compound annual growth rate between 2000 and 2005. The Special Census was properly conducted. The State of Tennessee certified the Special Census after a detailed verification process. TR at p. 10.
>
> * * *
>
> **Moreover, no matter whose population projections are accepted, the evidence establishes that there will be a sufficient population in Spring Hill between the years 2010 and 2014 to support a 56 bed hospital.** TR at 36 (emphasis added).

With regard to Orderly Development, the HSDA found that **"there is no evidence in the record that either MRH or WMC would likely be less able to provide for the health care needs of citizens in their service areas."** TR at 39 (emphasis added).

In its Final Order, HSDA concluded that SHH was needed, was economically feasible, and would contribute to the Orderly Development of healthcare in the service area.

> Maury Regional Hospital and Williamson Medical Center have not established by a preponderance of the evidence that the application for a Certificate of Need for Spring Hill Hospital fails to meet the statutory and regulatory criteria. Further, **Spring Hill Hospital has established by a preponderance of the evidence that the application for a Certificate of Need for Spring Hill Hospital does meet the statutory and regulatory criteria.**
>
> THEREFORE, it is hereby ORDERED that the Certificate of Need filed for the Spring Hill Hospital be GRANTED and the Initial Order is modified as set forth herein.

*In re Spring Hill Hospital, Inc.* No: 25.00-092967J (HSDA Final Order, March 19, 2008) at p. 41 (emphasis added).[3]

In May 2009, MRH and WMC appealed the Final Order to the Chancery Court for Davidson County, Tennessee.[4]

On September 3, 2009, the Chancery Court reversed the HSDA's Final Order. *Maury Regional Hospital & Williamson Medical Center v. HSDA,* No. 08-1331-I (Davidson Chancery Ct. Sept. 3, 2009) ("Chancery Court Ruling").[5] The Chancellor reversed the HSDA's approval of the Spring Hill Hospital for "[b]ecause the [HSDA] failed to use the state health plan (Guidelines) and because the Agency did not focus upon the objective merit of increasing hospital beds.

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[3] A full copy of the HSDA's Final Order is attached hereto as Attachment 1N-1, Acute, Spring Hill Hospital, HSDA Final Order Granting CON.

[4] An Agreed Amendment to the Final Order was entered on April 24, 2009, and is attached hereto as Attachment 1N-2, Acute, Spring Hill Hospital, Agreed Amendment to Final Order.

[5] Chancellor Bonnyman's September 3, 2009, decision is attached hereto as Attachment 1N-3, Acute, Spring Hill Hospital.

In analyzing the HSDA's decision to grant the CON, the Chancellor based her ruling on portions of the CON law that no longer exist. For example, the Chancellor correctly noted that under the law that applied in 2006, "The General Assembly has decided that the Agency will exert tight control over the allocation of hospital beds, a bed being necessary for a 24-hour stay. An increase of even one bed in a hospital bed count must be approved by the Agency with a grace period for the smaller hospitals." Chancery Court Ruling at p. 21.

This is no longer the law. With the 2021 CON Law, the General Assembly removed the CON requirement for an existing hospital to add beds.[6]

The Chancellor also chastised the HSDA for ignoring the Department of Health Review.[7] A Department of Health review of the CON Application is no longer part of the CON Application process.[8]

The final part of the Chancellor's disagreement with the HSDA involved the reallocation of beds from other Middle Tennessee locations to the new Spring Hill Hospital.[9] There is no longer any need to reallocate beds from other hospitals because, as noted, under current law, existing hospitals can add beds without a CON.

In addition, the Chancellor questioned two factual findings by the HSDA concerning whether the record in the trial before the ALJ referenced primary care doctors or specialist and whether the testimony of three citizens who had challenges getting to a hospital was pertinent. *See* Ch. Ruling at p. 22.

**TriStar Spring Hill ER**

In response to this 2009 Chancery Court Ruling, HCA Healthcare, through its TriStar Division, engaged with the leaders in the City of Spring Hill and others in restructuring its plan to address the health care needs of the Spring Hill community. Through this process, the decision was made to request a freestanding emergency department and supportive outpatient and ancillary services, which would expand as demand warranted.

In June 2010, TriStar Centennial Medical Center filed a CON application (CN1006-023) to establish a freestanding emergency department in Spring Hill ("TriStar Spring Hill ER"). This project was unchallenged, and the HSDA approved the CON for the FSED in November 2010.

---

[6] "Hospitals may add acute or rehabilitation beds if they are already licensed for that category of beds." https://www.tn.gov/content/dam/tn/hfc/documents/HSDA%20CON%20Reform%20Presentation.pdf (2021 CON Reform Working Group Presentation by Logan Grant).

[7] "Further, the Agency ignored and disregarded the Certificate of Need Department of Health Review of hospital bed needs, even though this sister agency expends public monies to plan and evaluate population and health needs." Chancery Court Ruling at p. 21.

[8] *See* HFC review of CON Process at https://www.tn.gov/hfc/certificate-of-need-information/con-process-and-how-to-apply.html.

[9] "Finally, the Agency left the decision of where 56 beds will be located up to SHH and HCA, contrary to the Agency's planning authority. According to the Agency, HCA may locate 56 beds in Spring Hill but must move 56 beds from another, undetermined, Middle Tennessee location. There was no discussion about the impact this removal of Middle Tennessee hospital beds might have on overall acute hospital bed counts or upon pending certificate of need applications in Middle Tennessee, if any." Chancery Court Ruling at pp. 21-22.

In February 2013, the TriStar Spring Hill ER was licensed. Since opening, TriStar Spring Hill ER has served 150,000 patients, with more than 40 percent of Spring Hill residents now receiving their emergency care at this ER.

**CON Law Changed**

In 2021, the Tennessee General Assembly substantially amended the CON law, removing "orderly development" and "economic feasibility" from the statutory requirements and adding "the effects attributed to competition or duplication would be positive for consumers" ("Consumer Advantage"). Tenn. Code Ann. § 68-11-1609(b) (2021).

The February 2024 decision by the HFC in the *Vanderbilt Rutherford Hospital* case demonstrates that the CON law today is far different than it was in the Spring Hill Hospital case in 2009.

On February 28, 2024, the HFC issued a Final Order approving the *Vanderbilt Rutherford Hospital* by a 6-1 vote. In the Final Order, the HFC made conclusions pertinent to this case, including:

- "Impact of a project on existing providers is no longer a criterion for consideration under the 2021 CON Law."
- "The establishment of a new, state-of-the-art community hospital in Murfreesboro will significantly enhance patient accessibility and choice in Rutherford County."
- "Community support is one factor to be weighed among others in consideration of an application, and in this case the community support weighs in favor of approval."

*In re Vanderbilt Rutherford Hospital,* No. 25.00-220022J (HFC Final Order, February 29, 2024), at pp. 17, 22, and 23.[10]

**Conclusion**

Thus, the legal issues in a CON for a new hospital in Spring Hill today are not the same as they were under the prior law in 2009. The facts today are also different. Spring Hill is three-times larger today (58,000) than it was in 2005 (17,325), and it still has no hospital. Further, as shown by the HFC's construction of the 2021 CON Law in the *Vanderbilt Rutherford Hospital* case, a CON should be granted for the proposed TriStar Spring Hill Hospital ("TSHH").

[10] A copy of the Redacted Version of the Final Order is attached hereto as Attachment 1N-4, Acute, VRH-2 Final Order.

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

**RESPONSE:**

The Tennessee Department of Health forecasts the need for hospital beds by county four years into the future using both licensed and staffed beds. As identified in Question 2N in the CON Form, the defined Service Area for the proposed TSHH, which will be located in Maury County, is three zip codes as follows:

**Exhibit 1N, Acute – 1**

| | |
|---|---|
| 37174 – Spring Hill | Home Zip, Maury County (*) |
| 38401 – Columbia | Maury County |
| 37179 – Thompson's Station | Williamson County |

(*) *This zip code traverses the Maury/Williamson County line; however, due to 75% of its geography being situated in Maury County, it is assigned to Maury County for census purposes. The TriStar Spring Hill campus is situated in Maury County in an Innovation Area which is the Spring Hill area master planned for medical facilities, technology, research facilities and ancillary uses.*

The Applicant has defined its service area – as is permitted – by zip code. In the Applicant's defined 3-zip code Service Area, there is 1 hospital: MRH, which is on the south side of the Service Area. The 3-zip code service area straddles 2 counties and there is another hospital in the other county in which the Service Area sits: WMC. In that the question in 1N requires that we identify all hospitals in the counties in which the service area is located, there are 2: MRH and WMC.

MRH is located approximately 14.6 miles from TriStar Spring Hill.[11] Given the population dynamics, roadways and traffic patterns, travel times required for Spring Hill residents to access MRH can be as much as 45 minutes depending on time of day and day of week. WMC is 17 miles from TSHH.[12] Like MRH, travel times for Spring Hill residents to access WMC can be as much as 45 minutes.

Exhibit 1N, Acute – 2 provides the bed need computation from the Department of Health.

**Exhibit 1N, Acute – 2**

| COUNTY | 2022 | | CURRENT* | SERVICE AREA POPULATION | | | PROJECTED 2024 | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | INPATIENT DAYS | AVERAGE DAILY CENSUS (ADC) | NEED | 2022 | 2024 | 2028 | ADC-2024 | NEED 2024 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury | 49,667 | 136 | 163 | 102,878 | 106,039 | 112,011 | 140 | 168 | 148 | 177 | 255 | 208 | -87 | -31 |
| Williamson | 37,523 | 103 | 126 | 257,824 | 270,313 | 295,116 | 108 | 132 | 118 | 143 | 203 | 203 | -71 | -60 |
| | | | | | | | | | | | | | | |
| TOTAL | 87,190 | 239 | 290 | 360,702 | 376,352 | 407,127 | 248 | 300 | 266 | 319 | 458 | 411 | -158 | -92 |

*Source: Tennessee Department of Health, Acute Care Bed Need Projections 2024 to 2028 with Population Corrected from Boyd Center files.*

[11] 14.6 miles is using the shortest normal route on Google Maps.

[12] In the Spring Hill Hospital case, the HSDA entered a finding of fact regarding the distance of the location of the proposed hospital to MRH and WMC. "The proposed SHH would be located in Maury County (close to the Williamson County line), approximately 14 miles from MRH in Columbia and approximately 17 miles from WMC in Franklin." HSDA Final Order, at p. 3.

Although the Tennessee State Health Plan's bed need formula ("Bed Need Formula") shows that Maury and Williamson Counties currently have a surplus of inpatient beds, there are some limitations to the Bed Need Formula.

- First, the Bed Need Formula only looks at Tennessee residents. More specifically, the Bed Need Formula uses inpatient days reported at Schedule G, #5, Patient Origin of a hospital's Joint Annual Report ("JAR") page 34 which only includes Tennessee residents utilizing each of the hospital. Here, if total patient days (excluding normal newborns) from Schedule G, #3, Payor (page 30) of the JAR is included, the bed need is greater and the surplus reduced. As shown below in Exhibit 1N, Acute – 3, using patient days by payor in Schedule G, reduces the surplus by a total of 8 beds.

**Exhibit 1N, Acute – 3**

| COUNTY | 2022 | | CURRENT* | SERVICE AREA POPULATION | | | PROJECTED 2024 | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | INPATIENT DAYS | AVERAGE DAILY CENSUS (ADC) | NEED | 2022 | 2024 | 2028 | ADC-2024 | NEED 2024 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury | 50,731 | 139 | 166 | 102,878 | 106,039 | 112,011 | 143 | 171 | 151 | 180 | 255 | 208 | -84 | -28 |
| Williamson | 38,739 | 106 | 130 | 257,824 | 270,313 | 295,116 | 111 | 136 | 121 | 147 | 203 | 203 | -67 | -56 |
| | | | | | | | | | | | | | | |
| TOTAL | 89,470 | 245 | 297 | 360,702 | 376,352 | 407,127 | 255 | 307 | 273 | 327 | 458 | 411 | -151 | -84 |

*Source: Tennessee Department of Health, Acute Care Bed Need Projections 2024 to 2028 with Population Corrected from Boyd Center files. Patient Days for both WMC and MRH are from 2022 JARs, Schedule G, page 30.*

- Second, the Bed Need Formula does not consider use of staffed beds to care for observation patients. Both MRH and WMC report using inpatient beds to treat observation patients.[13] Observation bed utilization at MRH has been increasing with an average daily census ("ADC") as of FY 2022 of 19 patients. Combined with WMC 2022 observation bed utilization results in a census of 31 patients. Including observations days in the bed need formula by County reduces the surplus to 6 beds in Maury County and 40 beds in Williamson County:

**Exhibit 1N, Acute – 4**

| COUNTY | 2022 | | CURRENT* | SERVICE AREA POPULATION | | | PROJECTED 2024 | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | INPATIENT DAYS PLUS OBSERVATION DAYS IN INPATIENT BEDS | AVERAGE DAILY CENSUS (ADC) | NEED | 2022 | 2024 | 2028 | ADC-2024 | NEED 2024 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury | 57,610 | 157.8 | 187.1 | 102,878 | 106,039 | 112,011 | 163 | 192.4 | 172 | 202.4 | 255 | 208 | -63 | -6 |
| Williamson | 43,209 | 118.4 | 143.7 | 257,824 | 270,313 | 295,116 | 124 | 150.1 | 136 | 162.6 | 203 | 203 | -53 | -40 |
| | | | | | | | | | | | | | | |
| TOTAL | 100,819 | 276 | 331 | 360,702 | 376,352 | 407,127 | 287 | 342 | 307 | 365 | 458 | 411 | -116 | -46 |

*Source: Tennessee Department of Health, Acute Care Bed Need Projections 2024 to 2028 with Population Corrected from Boyd Center files. Patient Days from JARs, page 30 and Schedule F observation days.*

- Third, the reported staffed beds are self-reported. As discussed in detail in response to Question 4N in the CON Form, while MRH reports 208 staffed beds in its 2022 JAR, the published room and floor plans available on its website, a copy of which is attached 1N-5, Acute, differs significantly. Based on review of those plans, it appears that MRH has 36 less stepdown beds, or 172 staffed beds. Accordingly, using 172 staffed beds results in a shortage of 30 beds in Maury County.

[13] MRH and WMC JARs Schedule F.

**Exhibit 1N, Acute – 5**

| COUNTY | 2022 | | CURRENT* | SERVICE AREA POPULATION | | | PROJECTED 2024 | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | INPATIENT DAYS PLUS OBSERVATION DAYS IN INPATIENT BEDS | AVERAGE DAILY CENSUS (ADC) | NEED | 2022 | 2024 | 2028 | ADC-2024 | NEED 2024 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury | 57,610 | 157.8 | 187.1 | 102,878 | 106,039 | 112,011 | 163 | 192.4 | 172 | 202.4 | 255 | 172 | -63 | 30 |

- Fourth, the Bed Need Formula fails to account for out-migration from the Service Area. Rather, the Bed Need Formula only considers patients who are treated at the hospitals located within each county. In 2022, approximately 62.8 percent of patients in Williamson County and 51.5 percent of the patients in Maury County out-migrated. Out-migration of the magnitude experienced in Maury County and Williamson County, indicates inadequate access, including problematic geographic and programmatic access to hospital facilities and services. The following table shows that more than half of the resident discharges from each county seek services outside their home county.

**Exhibit 1N, Acute – 6**

| Hospital Discharges by County of Residence - Migration Patterns | | | | | |
|---|---|---|---|---|---|
| | FY 2018 | FY 2019 | FY 2020 | FY 2021 | FY 2022 |
| **Maury County Resident Discharges** | | | | | |
| To Maury County Hospitals | 5,317 | 5,509 | 5,254 | 5,236 | 4,976 |
| Outmigration from Maury County | 5,693 | 4,920 | 5,481 | 5,315 | 5,291 |
| Total Maury County Resident Admissions | 11,010 | 10,429 | 10,735 | 10,551 | 10,267 |
| Percent Outmigration from Maury County | 51.7% | 47.2% | 51.1% | 50.4% | 51.5% |
| | | | | | |
| **Williamson County Resident Discharge** | | | | | |
| To Williamson County Hospitals | 4,966 | 5,284 | 4,888 | 5,115 | 5,446 |
| Outmigration from Williamson County | 8,979 | 9,753 | 8,679 | 8,961 | 9,181 |
| Total Williamson County Resident Admissions | 13,945 | 15,037 | 13,567 | 14,076 | 14,627 |
| Percent Outmigration from Williamson County | 64.4% | 64.9% | 64.0% | 63.7% | 62.8% |

*Source: Joint Annual Report Hospital Summary, 2018 through 2022*

Maury County out-migration of approximately 5,300 discharges equates to an approximate ADC of 58 based on an average length of stay of 4 days. 73 additional beds would be needed to accommodate these patients. Williamson County out-migration of nearly 9,200 discharges per year equates to an ADC of 101, or additional need for 126 beds. If out-migrating patients were considered in the bed need formula, enabling these residents to be treated in their home county, bed need which show a shortage of beds in each county as shown in Exhibit 1N, Acute – 7.

**Exhibit 1N – Acute, 7**

| COUNTY | 2022 | | CURRENT* | SERVICE AREA POPULATION | | | PROJECTED 2024 | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Maury County** | INPATIENT DAYS | ADC | NEED | 2022 | 2024 | 2028 | ADC-2024 | NEED 2024 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury Patient Days | 50,731 | 139 | | | | | | | | | | | | |
| Maury Observation Days | 6,879 | 19 | | | | | | | | | | | | |
| Maury Outmigration | 21,164 | 58 | | | | | | | | | | | | |
| TOTAL | 71,895 | 197 | 230 | 102,878 | 106,039 | 112,011 | 203 | 236 | 214 | 249 | 255 | 208 | -19 | 41 |
| | | | | | | | | | | | | | | |
| **Williamson County** | INPATIENT DAYS | ADC | NEED | 2022 | 2024 | 2028 | ADC-2024 | NEED 2024 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Williamson Patient Days | 38,739 | 106 | | | | | | | | | | | | |
| Williamson Observation Days | 4,470 | 12 | | | | | | | | | | | | |
| Williamson Outmigration | 36,724 | 101 | | | | | | | | | | | | |
| TOTAL | 75,463 | 207 | 240 | 257,824 | 270,313 | 295,116 | 217 | 251 | 237 | 272 | 203 | 203 | 48 | 69 |

*Outmigration days estimated at ALOS of 4.0 days.*

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

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

**RESPONSE:**

There is only one existing hospital in the 3-zip code Service Area: MRH. TSHH's reasonable Service Area includes one zip code in Williamson County. Therefore, WMC has been identified as a hospital in that county.

MRH reports 255 licensed beds and 208 staffed beds on its most recent JAR, which results in 47 unstaffed beds.[14] This is presented in the below table.[15] When including observation days and the reported staffed beds, occupancy in 2022 was 76 percent, with patient days increasing 11 percent in the past two years. This confirms that by 2028, four years into the future, its occupancy rate will exceed 80 percent. Further, when considering the staffed beds identified on its website, MRH's occupancy actually exceeded the 80 percent benchmark for more than one year.

[14] This has been the reported licensed and staffed beds for 2020 and 2022; 2021 identified 220 staffed beds.

[15] As noted above, MRH's website shows that it only in fact staffs 172 beds, not 208 as reported in its JAR.

**Exhibit 1N, Acute – 8**

**Maury Regional Hospital, Licensed and Staffed Beds and Patient Days, FY 2020 through FY 2022**

| Beds by Type | County | 2022 Staffed Beds | Bed Days Available | Patient Days | | | Occupancy Rate | | | % Change in Patient Days 2020-2022 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | |
| Licensed Beds | Inpatient Days | 255 | 93,075 | 47,162 | 51,372 | 50,731 | 51% | 55% | 55% | 8% |
| | Inpatient Plus Observation Days | 255 | 93,075 | 52,005 | 56,782 | 57,610 | 56% | 61% | 62% | 11% |
| | | | | | | | | | | |
| Staffed Beds | Inpatient Days | 208 | 75,920 | 47,162 | 51,372 | 50,731 | 62% | 68% | 67% | 8% |
| | Inpatient Plus Observation Days | 208 | 75,920 | 52,005 | 56,782 | 57,610 | 68% | 75% | 76% | 11% |
| | | | | | | | | | | |
| Restated Staffed Beds per Website | Inpatient Days | 172 | 62,780 | 47,162 | 51,372 | 50,731 | 75% | 82% | 81% | 8% |
| | Inpatient Plus Observation Days | 172 | 62,780 | 52,005 | 56,782 | 57,610 | 83% | 90% | 92% | 11% |

*Source: JARs for respective years; patient days from Schedule 5, #3, Payor, page 30 and Schedule F, page 28 and website floor plans included in 1N, Acute.*

WMC's historical three-year occupancy is provided as Exhibit 1N, Acute – 30 on page 42. It reports its licensed beds as 203 and also reports the same number as being staffed. WMC's patient days increased 20 percent during the past two years.

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

**RESPONSE:**

As of the HFC's latest report, dated March 25, 2024, there are not any outstanding CON projects for new acute care beds in the proposed Service Area.

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

**RESPONSE:**

Not applicable. The Applicant is not an existing hospital.

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

**RESPONSE:**

TSHH is a new hospital and does not have any operating history. However, the existing TriStar Spring Hill ER, operates as a satellite department of TriStar Centennial, at the site, and has done so since February 2013. With the licensure of TSHH, the TriStar Spring Hill ER will become a department of the new hospital. Even after TSHH is licensed and operational, the foundational relationships between TriStar Centennial's physicians and services and those currently available in Spring Hill will not only continue but also expand.

Given its 10-year history in Spring Hill as the host hospital to the freestanding emergency room, TriStar Centennial's quality ratings are relevant. It is the only CMS 5-Star hospital in the Nashville area.[16] It is a full-service tertiary hospital, which, among other things, is accredited by The Joint Commission for both Hospitals and Behavioral Healthcare, the American College of Surgeons Commission on Cancer, the American College of Surgeons Metabolic and Bariatric Surgery, and the American College of Surgeons National Accreditation Program for Breast Centers.

The quality metrics relevant to emergency services including TriStar Spring Hill ER compare extremely favorably to both Tennessee and National benchmarks as shown below.

**Exhibit 1N, Acute – 9**

| | TriStar Centennial Medical Center | National Benchmark | Tennessee Benchmark |
|---|---|---|---|
| Percent of patients who left emergency department without being seen | 1.0% | 3.0% | 3.0% |
| Average time patients in the emergency department before leaving from the visit | 138 | 194 | 194 |

*Source: Medicare.gov/CMS Compare, April 24, 2024, release.*

With respect to the TriStar Spring Hill ER, its individual quality metrics include the following:

- Extremely low 'left prior to medical screening' at 0.6 percent;
- Less than 8 minutes from arrival to bed;
- 18.17 minutes from disposition to discharge; and
- Less than 5-minute EMS offload time.

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

**RESPONSE:**

The proposed Service Area for TSHH, as discussed at length in the CON Form, consists of:

- 37174 – Spring Hill;
- 37179 – Thompson's Station; and
- 38401 – Columbia.

[16] Reported by Medicare.gov/CMS Compare, January 31, 2024, release.

TSHH will be in 37174 - Spring Hill, which contains 56,270 residents.[17] 38401 - Columbia and 37179 - Thompson's Station contain 68,840 and 19,114 residents, respectively.

Approximately 75 percent of the TriStar Spring Hill ER patients reside in three zip codes, 37174 (Spring Hill), 38401 (Columbia) and 37179 (Thompson's Station), which is shown in the table below:

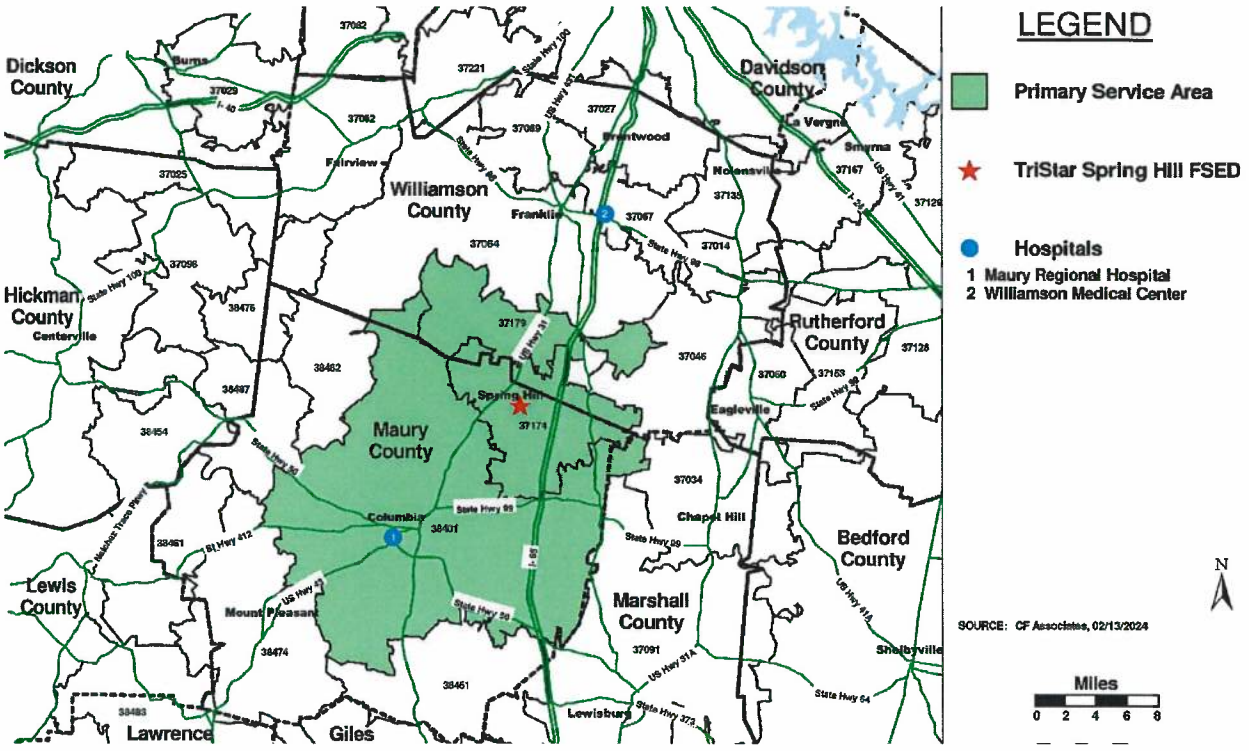
**Exhibit 1N, Acute – 10**

| | TriStar Spring Hill ER Visits by Zip Code | | | | | 5-Year |
|---|---|---|---|---|---|---|
| Zip Code | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | Total |
| 37174 - Spring Hill | 5,451 | 4,747 | 5,635 | 5,784 | 5,911 | 27,528 |
| 38401 - Columbia | 5,585 | 4,181 | 4,834 | 5,559 | 5,426 | 25,585 |
| 37179 - Thompson's Station | 646 | 503 | 579 | 655 | 638 | 3,021 |
| Subtotal | 11,682 | 9,431 | 11,048 | 11,998 | 11,975 | 56,134 |
| All Other | 3,802 | 3,197 | 3,436 | 3,935 | 3,925 | 18,295 |
| Total | 15,484 | 12,628 | 14,484 | 15,933 | 15,900 | 74,429 |
| | | | | | | |
| | TriStar Spring Hill ER Percent of Total Visits | | | | | 5-Year |
| Zip Code | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | Total |
| 37174 - Spring Hill | 35.2% | 37.6% | 38.9% | 36.3% | 37.2% | 37.0% |
| 38401 - Columbia | 36.1% | 33.1% | 33.4% | 34.9% | 34.1% | 34.4% |
| 37179 - Thompson's Station | 4.2% | 4.0% | 4.0% | 4.1% | 4.0% | 4.1% |
| Subtotal | 75.4% | 74.7% | 76.3% | 75.3% | 75.3% | 75.4% |
| All Other | 24.6% | 25.3% | 23.7% | 24.7% | 24.7% | 24.6% |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

*Source: Internal records, CY 2019 through CY 2023*

The following map presents the Service Area relative to Maury, Williamson and surrounding counties. As observed visually, a small portion of the Service Area is in southern Williamson County, while the majority is in northern Maury County. The dark bold line crossing the Service Area north of the TSHH red star is the county border.

[17] 2024 population by zip code per Claritas. The City of Spring Hill believes population exceeds 60,000 in 2024 and is undergoing a Special Census to confirm the 2024 population count. The Tennessee Controller reports that the population of Spring Hill in 2023 was 57,932 (https://comptroller.tn.gov/content/dam/cot/pa/documents/district-infographics/cities/spring_hill.html).




Both 37174 and 38401 are assigned by the US Postal Service to Maury County; 37179 is assigned to Williamson County. The Service Area is reasonable and supportable based on the following facts regarding the three zip codes:

- Individually, the three Service Area zip codes generate the greatest number of emergency department visits at the existing TriStar Spring Hill ER.
- In aggregate, the three Service Area zip codes represent 75 percent of total ER visits at TriStar Spring Hill ER, which is a reasonable and cohesive service area from a health planning perspective.
- Individually, the three Service Area zip codes also generate the greatest number of outpatient visits (imaging, lab, etc.) at the other hospital based ancillary services located at TSHH campus.
- 37174 (Spring Hill) is central to these three zip codes and generates the most ER visits at TriStar Spring Hill ER:
    - TriStar Spring Hill ER has the greatest number of ER visits and patient utilization of any ER for residents of 37174 ranging between 40 and 44 percent of total resident ER visits each year in the past five years. Achieving this level of patient utilization without inpatient services is significant, and it is expected to increase further with a full-service hospital that provides surgery, catheterizations, and other procedures in addition to inpatient services.
- 38401 (Columbia) is to the south of and contiguous to the Spring Hill zip code.
    - TriStar Spring Hill ER accounts for the second greatest number of ER visits and patient utilization of any ER for residents of 38401. During the past five years, between 17 and 18.3 percent of total resident ER visits came from this zip code.

- 37179 (Thompson's Station) is to the north of and contiguous to the Spring Hill zip code.
    - TriStar Spring Hill ER also has the second greatest number ER visits and patient utilization of any ER for residents of 37179, ranging between 16.3 and 19.4 percent of total resident ER visits each year during the past five years.

37174 (Spring Hill) is central to the defined Service Area with one zip code to the north and one geographically large zip code to the south. TSHH being central to this Service Area is a consumer advantage for improved access and reduced travel times.

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

**RESPONSE:**

There is no acute care hospital in Spring Hill. MRH is the only acute care hospital physically located in the three zip codes; it is located on the south side of the Service Area in 38401. 38401 is a geographically large zip code, so much so that MRH is located 14.6 miles away from the proposed TSHH. Due to the fact that TSHH's proposed Service Area includes one zip code in Williamson County, WMC is identified. Occupancy and utilization are presented in the following tables, with the first table identifying licensed beds and related occupancy and the second table addressing staffed beds and including observation patient days.

**Exhibit 1N, Acute – 11**

| Facility | County | 2022 Licensed Beds | Bed Days Available | Patient Days | | | Licensed Occupancy | | | % Change in Patient Days 2020-2022 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | |
| Maury Regional Hospital | Maury | 255 | 93,075 | 47,162 | 51,372 | 50,731 | 51% | 55% | 55% | 8% |
| Williamson Medical Center | Williamson | 203 | 74,095 | 32,398 | 35,205 | 38,739 | 44% | 48% | 52% | 20% |

*Source: Joint Annual Report for Hospitals for respective hospital and years*

**Exhibit 1N, Acute – 12**

| Facility | County | 2022 Staffed Beds | Bed Days Available | Patient Days | | | Staffed Occupancy | | | % Change in Patient Days 2020-2022 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | |
| Maury Regional Hospital | Maury | 208 | 75,920 | 47,162 | 51,372 | 50,731 | 62% | 68% | 67% | 8% |
| Williamson Medical Center | Williamson | 203 | 74,095 | 32,398 | 35,205 | 38,739 | 44% | 48% | 52% | 20% |
| | | | | | | | | | | |
| **Patient Days Including Observation Days in Staffed Beds** | | | | **Patient + Observation Days** | | | **Staffed Occupancy** | | | |
| Maury Regional Hospital | Maury | 208 | 75,920 | 52,005 | 56,782 | 57,610 | 68% | 75% | 76% | 11% |
| Williamson Medical Center | Williamson | 203 | 74,095 | 37,319 | 38,693 | 43,209 | 50% | 52% | 58% | 16% |
| **MRH Adjusted for Staffed Beds per Website Floor Plans** | | | | **Patient + Observation Days** | | | **Staffed Occupancy** | | | |
| Maury Regional Hospital | Maury | 172 | 62,780 | 52,005 | 56,782 | 57,610 | 83% | 90% | 92% | 11% |

*Source: Joint Annual Report for Hospitals for respective hospital and years*

**Adjust formula to 366 days if base year is a leap year*

**TriStar Spring Hill Hospital**

TSHH is the next step in a longstanding commitment to the Spring Hill community, which began almost 20 years ago. Currently, TriStar Spring Hill ER sees almost 16,000 patients annually. It also provides imaging, laboratory and GI services on the campus and private physician office space. However, with no available hospital in Spring Hill, residents of the Service Area confront geographic and programmatic access challenges and lengthy times to reach existing services, including OB. TSHH will achieve multiple goals, including:

- Improve access to care for Service Area residents, including reduction of transfers from TriStar Spring Hill ER and curtailing patients needing to go outside the service area for treatment;
- Provide currently unavailable services in Spring Hill and reduce travel times to access such services;
- Reduce TriStar Spring Hill ER bypass due to any concerns about the ER not having operating rooms and inpatient beds to treat certain conditions;
- Reduce EMS transports of Service Area patients out of the Service Area which are traveling significant distances with associated time out of the area;
- Establish a locally accessible women's health program in conjunction with Diana Health to enable birthing mothers to deliver close to home, avoid unnecessary travel and experience a holistic and nurturing environment of care;[18]
- Provide 24/7 OB hospitalists on site to be available for deliveries of private practice and community physician patients;
- Establish a locally accessible cardiac program in conjunction with Centennial Heart which has significant patient draw from the Service Area; and
- Address the community's concerns about geographic isolation, and inferior and prolonged access to reach needed healthcare services.

The existing ER service currently treats approximately 16,000 patients per year, some of whom require inpatient treatment.

**Improve Access to Care for Residents**

The first goal of TSHH is to improve access to care for residents through, among other things, reducing transfers from TriStar Spring Hill ER to acute care hospitals outside of the defined Service Area and eliminating the need for TriStar patients to seek care outside the service area. This will permit patients to receive care close to home, reduce direct and indirect costs to consumers, and reduce the time it takes for a resident to receive care.

**Reduction of Transfers from TriStar Spring Hill ER to Providers in Other Cities**

[18] Diana Health partners with hospital and health system leadership to structure their women's health programs with a clinical redesign of labor and delivery. The model delivers a tech-enabled, holistic care experience for women and families, deploying integrated care teams of Certified Nurse Midwives, OB/GYNs, mental health and wellness providers. Diana Health's approach helps hospitals improve health outcomes, lowering rates of cesarean section and neonatal intensive care unit admissions.

TriStar Spring Hill ER is a significant source of patient transfers to inpatient acute care. The number of patient transfers by year from this ER average between 100 and 140 per month. The following table provides these historical numbers (out-migration) by year from the TriStar Spring Hill ER to hospital facilities in other cities. This level of admissions shows a substantial base line of patient activity which in and of itself supports an inpatient hospital in Spring Hill.

**Exhibit 1N, Acute – 13**

| | TriStar Spring Hill ER Visits and Transfers | | | | | 5-Year |
|---|---|---|---|---|---|---|
| Factor | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | Total |
| Total Patients Transferred to a Hospital | 1,643 | 1,581 | 1,151 | 1,204 | 1,118 | 6,697 |
| Total Visits at TriStar Spring Hill ER | 15,484 | 12,628 | 14,484 | 15,933 | 15,900 | 74,429 |
| Percent Transferred/Admitted | 10.6% | 12.5% | 7.9% | 7.6% | 7.0% | 9.0% |

*Source: Internal records, CY 2019 through CY 2023*

Approximately 70 percent of the above transfers are to TriStar Centennial with an additional 7 percent to other TriStar Health hospitals. All other remaining hospitals to which patients are transferred represent between 0.1 and 6.9 percent of the total patient transfers.

When examining the transfers by service line, on average, during the past five years, between 86 and 90 percent of these patients could have been treated locally with the proposed services planned at TSHH as summarized below:

**Exhibit 1N, Acute – 14**

| | Transfers from TriStar Spring Hill ER by Type | | | | | 5-Year |
|---|---|---|---|---|---|---|
| Factor | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | Averge |
| Community/Non-Tertiary | 1,442 | 1,362 | 988 | 1,084 | 976 | 1,170 |
| Tertiary/Specialized | 201 | 219 | 163 | 120 | 142 | 169 |
| Total Transfers | 1,643 | 1,581 | 1,151 | 1,204 | 1,118 | 1,339 |
| % Community Non-Tertiary | 87.8% | 86.1% | 85.8% | 90.0% | 87.3% | 87.4% |

*Source: Internal records, CY 2019 through CY 2023*

TSHH will result in the elimination of most of the identified transfers, which are only expected to increase based on forecasted population dynamics. This elimination will establish a significant nucleus of patients at the full-service community hospital, reducing transfer time and costs, and enhancing access for this patient population.

**Reduce the Number of Patients Seeking Treatment Away From Home**

Expanding the TriStar Spring Hill ER into a full-service hospital will improve access for patients who leave the Service Area to access care at hospitals away from the areas where they live.

*To TriStar Health Facilities*

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

As shown in Exhibit 1N, Acute – 15[19] below, TriStar Health facilities is a significant source of care in the Service Area. More specifically, of the total 37174 (Spring Hill) residents requiring acute care hospitalization, an average of 18 percent sought services at TriStar Health hospitals during the past three years, with 16 of the 18 percent being admitted at TriStar Centennial. Of total 37179 (Thompson's Station) residents requiring hospitalization, an average of 13 percent sought services at TriStar Health hospitals during the past three years with 11 of the 13 percent being admitted at TriStar Centennial. Finally, of total 38401 (Columbia) residents requiring hospitalization, an average of 7.6 percent sought services at TriStar Health hospitals during the past three years with 6.2 of the 7.6 percent being admitted at TriStar Centennial.

This means that, for example, on average, 11.4 percent of patients in the Service Area are driving between 33 and 41 miles and upwards of 50 to 60 minutes to receive care at TriStar Centennial. Given the roots TriStar Centennial physicians have in Spring Hill, a significant portion of Service Area residents seeking services at TriStar Centennial will not have to go to these lengths to receive care from their chosen providers.

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

**Exhibit 1N, Acute – 15**

| Zip Code and Hospital Destination | CY 2020 | CY 2021 | CY 2022 |
|---|---|---|---|
| **37174 - Spring Hill Resident Discharges** | | | |
| TriStar Centennial | 502 | 454 | 422 |
| All Other Tristar | 57 | 68 | 61 |
| All Other Hospitals | 2,153 | 2,491 | 2,571 |
| Total | 2,712 | 3,013 | 3,054 |
| Total Who Left Both Maury and Williamson Counties | 1,431 | 1,503 | 1,446 |
| | | | |
| Percent Outmigration to TriStar Centennial | 18.5% | 15.1% | 13.8% |
| Percent Outmigration to TriStar Overall | 20.6% | 17.3% | 15.8% |
| Percent to TriStar of Those Who Left Maury/Williamson Counties | 39.1% | 34.7% | 33.4% |
| | | | |
| **38401 - Columbia Resident Discharges** | | | |
| TriStar Centennial | 339 | 340 | 358 |
| All Other Tristar | 84 | 63 | 88 |
| All Other Hospitals | 5,195 | 5,252 | 4,930 |
| Total | 5,618 | 5,655 | 5,376 |
| Total Who Left Maury County | 2,147 | 2,188 | Masked |
| | | | |
| Percent Outmigration to TriStar Centennial | 6.0% | 6.0% | 6.7% |
| Percent Outmigration to TriStar Overall | 7.5% | 7.1% | 8.3% |
| Percent to TriStar of Those Who Left Maury County | 19.7% | 18.4% | Masked |
| | | | |
| **37179 - Thompson's Station Resident Discharges** | | | |
| TriStar Centennial | 111 | 70 | 112 |
| All Other Tristar | 18 | 10 | 26 |
| All Other Hospitals | 820 | 832 | 775 |
| Total | 949 | 912 | 913 |
| Total Who Left Williamson County | 542 | 490 | Masked |
| | | | |
| Percent Outmigration to TriStar Centennial | 11.7% | 7.7% | 12.3% |
| Percent Outmigration to TriStar Overall | 13.6% | 8.8% | 15.1% |
| Percent to TriStar of Those Who Left Williamson County | 23.8% | 16.3% | Masked |
| | | | |
| **Total Service Area** | | | |
| TriStar Centennial | 952 | 864 | 892 |
| All Other Tristar | 159 | 141 | 175 |
| Total TriStar | 1,111 | 1,005 | 1,067 |

*Source: THA data. The nearly 1,100 patients are based on CY 2022 population and patients. By the time TSHH is licensed (2027), there will be further increases to this redirection count. 2022 data is masked.*

Additionally, this redirection of patients from TriStar Health hospitals to TSHH will not impact existing providers as these patients are already bypassing those facilities in favor of TriStar Health facilities.

*County Out-Migration*

In addition, TSHH will improve access to care for Williamson and Maury County residents that are already seeking care outside of where they reside.

Overall, Maury County residents leave Maury County for inpatient acute hospital services more than 50 percent of the time. This represents total hospital utilization including tertiary, non-tertiary, obstetrics, neonatology and other specialized services. Most of those out-migrating travel past the City of Spring Hill to hospitals to the north of Maury County. Even more drastic is that Williamson County residents leave Williamson County for inpatient acute hospital services on average 63 percent of the time during the past three years. A summary of this out-migration is presented in the following table.

**Exhibit 1N, Acute – 16**
**Hospital Admissions by County of Residence - Migration Patterns**

| | FY 2020 | FY 2021 | FY 2022 |
|---|---|---|---|
| **Maury County Resident Admissions** | | | |
| To Maury County Hospitals | 5,254 | 5,236 | 4,976 |
| Outmigration from Maury County | 5,481 | 5,315 | 5,291 |
| Total Maury County Resident Admissions | 10,735 | 10,551 | 10,267 |
| Percent Outmigration from Maury County | 51.1% | 50.4% | 51.5% |
| | | | |
| **Williamson County Resident Admissions** | | | |
| To Williamson County Hospitals | 4,888 | 5,115 | 5,446 |
| Outmigration from Williamson County | 8,679 | 8,961 | 9,181 |
| Total Williamson County Resident Admissions | 13,567 | 14,076 | 14,627 |
| Percent Outmigration from Williamson County | 64.0% | 63.7% | 62.8% |
| *Source: Joint Annual Report Hospital Summary, 2020 through 2022* | | | |

Notably of those out-migrating from the above two counties, on average 1 of 6 patients (16.5 percent) are being admitted to TriStar Centennial. This significant patient draw from these counties (not just the three Service Area zip codes) to Patterson Street, Davidson County demonstrates that TriStar Health is a significant provider in these counties. As a result, it will be even more effective in reducing out-migration with the establishment of TSHH.

*Service Area Out-Migration, Non-Tertiary Med-Surg Patients*

The Spring Hill zip code has more than 56,000 residents and is expected to increase to more than 62,000 during the next five years.[20] City leaders also expect further growth this decade, expected to reach between 68,000 and 94,000 residents by 2029.[21] Notwithstanding this significant population base, there is no hospital in Spring Hill.

[20] City leaders believe the current population now exceeds 60,000; to confirm this the city is now undertaking a special census (2024) to obtain a more accurate count. If the 2024 population is revised upward, that would have further implications for the forecasted population likely resulting in population in the upper 60,000's within five years. Forecasts throughout this CON Application conservatively use the Claritas counts.

[21] Major Thoroughfare Plan, 2021, page 7 of its Future Conditions Report, indicates 81,000 by 2040. This estimate is roughly in the middle of the UGB forecast for 2029 of 68,000 to 94,000 but 11 years later. The special census results will be informative relative to these future projections.

In 2013, the TriStar Spring Hill ER opened as TriStar Health first approved phase in the development of its Spring Hill healthcare campus. This ER has now been operating for more than 10 years and is a significant provider in the Service Area. On average annually it treats between 40 and 44 percent of Spring Hill's emergency room needs. It also treats between 16.3 and 19.4 percent of those residing in Thompson's Station and between 17 and 18.3 percent of those residing in Columbia.

From a hospital admission perspective, a significant number of patients leave the service area for in-patient services in other cities. Embedded within the data is that 100 percent of Spring Hill residents out-migrate to other cities because Spring Hill has no hospital.

A primary reason for patients leaving the area for hospital services is the unavailability of these services. MRH is the only hospital in the Service Area and it is over 14 miles from Spring Hill on often congested roadways. Spring Hill and Thompson's Station have no hospital in their communities. As the largest city in the Service Area, Spring Hill residents have very limited access to hospital services because there is no hospital in Spring Hill. Accordingly, implementation of TSHH will improve healthcare access for most of the Service Area population.

Of patients out-migrating from the Service Area, on average, 17 percent are being admitted to TriStar Centennial. An additional 3 percent are admitted to other TriStar Health facilities. This significant patient draw from the Service Area demonstrates that TriStar Health is a significant provider of inpatient care to Service Area residents even though it has no hospital in the Service area. As a result, the establishment of TSHH will reduce out-migration to TriStar Health hospitals because most of the community hospital patients who would have gone to TriStar Centennial or other TriStar hospitals can receive the same TriStar quality care at TSHH.

TSHH will be a full-service community hospital primarily serving the inpatient acute care needs of non-tertiary and obstetrics patients. Therefore, the migration analysis presented herein is separated into non-tertiary medical surgical and obstetrics migration patterns. [22]

37174 (Spring Hill) resident out-migration from Maury County is around 90 percent. Spring Hill residents leaving both Maury and Williamson County approximated 45 percent, a 2-point decrease from total med-surg cases, confirming the significant out-migration is not attributable to the acuity of the patient. The next exhibit presents this information: the non-tertiary medical surgical patients of the Service Area zip codes and their respective migration patterns.

[22] Tertiary medical surgical cases are defined as transplants, trauma care, cardiac surgery, thoracic surgery, neurosurgery, burns, radiotherapy, neonatology and other complex interventions. Non-tertiary medical-surgical are the remaining inpatient services, excluding specialty services (behavioral health and medical rehabilitation). Obstetrics is also considered non-tertiary but is separately analyzed throughout this CON application.

**Exhibit 1N, Acute -17**

| Non-Tertiary Med Surg Hospital Admissions by Zip Code of Residence - Migration Patterns | | | |
|---|---|---|---|
| | **CY 2020** | **CY 2021** | **CY 2022** |
| **37174 - Spring Hill Resident Admissions** | | | |
| To Maury County Hospitals | 171 | 230 | |
| Outmigration from Maury County | 1,666 | 1,756 | |
| Total 37174 Resident Admissions | 1,837 | 1,986 | 1,991 |
| Percent Outmigration from Maury County | 90.7% | 88.4% | |
| *Because 37174 Crosses County Line, Add:* | | | |
| *To Williamson County Hospitals* | *724* | *835* | |
| *Percent Outmigration from Maury and Williamson Counties* | *51.3%* | *46.4%* | *44.9%* |
| | | | |
| **38401 - Columbia Resident Admissions** | | | |
| To Maury County Hospitals | 2,766 | 2,761 | Masked |
| Outmigration from Maury County | 1,477 | 1,527 | |
| Total 38401 Resident Admissions | 4,243 | 4,288 | |
| Percent Outmigration from Maury County | 34.8% | 35.6% | |
| | | | |
| **37179 - Thompson's Station Resident Admissions** | | | |
| To Williamson County Hospitals | 288 | 276 | Masked |
| Outmigration from Williamson County | 345 | 293 | |
| Total 37179 Resident Admissions | 633 | 569 | |
| Percent Outmigration from Williamson County | 54.5% | 51.5% | |
| *Source: THA data, CY 2020 through CY 2022, excludes obstetrics* | | | |

Non-tertiary Thompson's Station out-migration from Williamson County approximates 53 percent. Similarly, Columbia out-migration from Maury County is approximately 35 percent. This information confirms that the out-migration from the TSHH Service Area is not only excessive but also results in non-tertiary patients traveling lengthy distances to access available community hospital services elsewhere. TSHH will mitigate out-migration, improve access and provide available community hospital services in Spring Hill.

*Service Area Out-Migration, Obstetrics Patients*

Obstetrics patients are defined as those being categorized within major diagnostic category (MDC) 14,[23] Pregnancy, Childbirth & the Puerperium. Most obstetrics cases are deliveries of infants. In addition, there are admissions for false labor, antepartum complications and other conditions associated with a pregnancy. Like total acute hospital patients and those with non-tertiary diagnoses, obstetrics patients experience significant out-migration from their home area for services.

[23] DRGs in MDC 14 include 768, 769, 770, 783-788, 796-798, and 817-819.

**Exhibit 1N, Acute -18**

| Obstetrics Hospital Admissions by Zip Code of Residence - Migration Patterns | | | |
|---|---|---|---|
| | CY 2020 | CY 2021 | CY 2022 |
| **37174 - Spring Hill Resident Admissions** | | | |
| To Maury County Hospitals | 74 | 93 | |
| Outmigration from Maury County | 481 | 533 | |
| Total 37174 Resident Admissions | 555 | 626 | 681 |
| Percent Outmigration from Maury County | 86.7% | 85.1% | |
| *Because 37174 Crosses County Line, Add:* | | | |
| *To Williamson County Hospitals* | *251* | *271* | |
| *Percent Outmigration from Maury and Williamson Counties* | *41.4%* | *41.9%* | *37.0%* |
| Total Outmigration | 230 | 262 | 252 |
| | | | |
| **38401 - Columbia Resident Admissions** | | | |
| To Maury County Hospitals | 532 | 530 | Masked |
| Outmigration from Maury County | 263 | 259 | |
| Total 38401 Resident Admissions | 795 | 789 | |
| Percent Outmigration from Maury County | 33.1% | 32.8% | |
| | | | |
| **37179 - Thompson's Station Resident Admissions** | | | |
| To Williamson County Hospitals | 100 | 117 | Masked |
| Outmigration from Williamson County | 104 | 104 | |
| Total 37179 Resident Admissions | 204 | 221 | |
| Percent Outmigration from Williamson County | 51.0% | 47.1% | |
| *Source: THA data, CY 2020 through CY 2022* | | | |

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

**TSHH Will Reduce Spring Hill EMS Transports Out of the Area**

As part of its analysis of the Spring Hill Service Area, TSHH acquired the biospatial EMS dataset described in Question 4N of the CON Form. This EMS dataset includes EMS agency, zip code and hospital destination information to identify the level of transport from Spring Hill, and surrounding areas. The following exhibit provides the EMS transports counts from each of the Service Area zip codes.

**Exhibit 1N, Acute – 19**

| EMS Transports by Service Area Zip Code | | | |
|---|---|---|---|
| **Zip Code of EMS Call** | **CY 2021** | **CY 2022** | **CY 2023** |
| 37174, Spring Hill | 1,831 | 2,242 | 2,341 |
| 38401, Columbia | 5,953 | 6,145 | 6,533 |
| 37179, Thompson's Station | 378 | 412 | 520 |
| Total | 8,162 | 8,799 | 9,394 |

*Source: biospatial proprietary database, March 2024.*
*Note: The above data was generated from the report by EMS agency; when EMS agency sort is deselected, total transports increase by 126 as certain transports are suppressed for various reasons.*

Biospatial confirms that its data is not 100 percent reported. It therefore estimates by county the percentage of transports in its database that it represents of the total using its proprietary algorithm. For Williamson and Maury Counties, its algorithms suggest the above transports represent between 70 and 90 percent of total transports. As a result, the Service Area transports above (and in its database) are the minimum occurring and could conceivably be 10 to 30 percent greater.

As with travel time and distance, those transports emanating from 37174 (Spring Hill) have the longest distance to travel to reach a hospital for treatment. The following exhibit provides more detail on the 37174 transports by year, including hospitals which accepted the patient.

**Exhibit 1N, Acute – 20**

| Spring Hill Zip Code 37174 EMS Transports | | | |
|---|---|---|---|
| **EMS Service/Destination** | **CY 2021** | **CY 2022** | **CY 2023** |
| **Maury County EMS** | | | |
| Maury Regional Hospital | 125 | 144 | 167 |
| TriStar Spring Hill ER | 91 | 83 | 59 |
| TriStar Centennial | 0 | 0 | 6 |
| Williamson Medical Center | 113 | 128 | 116 |
| Total | 329 | 355 | 348 |
| | | | |
| **Williamson County EMS** | | | |
| Ascension St Thomas West | 0 | 25 | 36 |
| Maury Regional Hospital | 142 | 197 | 244 |
| TriStar Spring Hill ER | 236 | 403 | 343 |
| TriStar Centennial | 46 | 58 | 50 |
| VA Medical Center | 0 | 0 | 17 |
| Vanderbilt University Medical Center | 93 | 77 | 105 |
| Monroe Carell Children's Hospital | 76 | 131 | 115 |
| Williamson Medical Center | 906 | 994 | 1,083 |
| Total | 1,499 | 1,885 | 1,993 |
| | | | |
| All Other | 3 | 2 | 0 |
| | | | |
| Total | 1,831 | 2,242 | 2,341 |

*Source: biospatial proprietary database, March 2024*

Of the 2,341 EMS transports in CY 2023, only 402 were transported to TriStar Spring Hill ER; 1,939 were transported out of the City of Spring Hill. Collectively, during the last three years, 81 percent of Spring Hill EMS patients were transported to emergency rooms out of Spring Hill. These transports are for both inpatient and outpatient diagnosis and treatment. The next exhibit summarizes the above data for the two closest destination hospitals (MRH and WMC) and TriStar Spring Hill ER.

**Exhibit 1N, Acute – 21**

| Spring Hill Zip Code 37174 EMS Transports | | | |
|---|---|---|---|
| **Destination** | **CY 2021** | **CY 2022** | **CY 2023** |
| Transports to WMC | 1,019 | 1,122 | 1,199 |
| Transports to MRH | 267 | 341 | 411 |
| Total | 1,286 | 1,463 | 1,610 |
| Percent to WMC/MRH | 70.2% | 65.3% | 68.8% |
| | | | |
| TriStar Spring Hill ER | 327 | 486 | 402 |
| Percent to TriStar Spring Hill ER | 17.9% | 21.7% | 17.2% |

*Source: biospatial proprietary database, March 2024*

Based on the travel time, TSHH will be the closest hospital for transport within 37174 (Spring Hill). As a result, based on Tennessee EMS guidelines, one would expect that a substantial portion of the 37174 transports would be re-directed to TSHH once it becomes licensed as a full-service community hospital.

With the establishment of TSHH, Spring Hill residents will be afforded the opportunity to receive services at their local community hospital resulting in reduced out-migration and geographic access improvement for patients and families. Spring Hill residents will be provided with a hospital where they live, work and play. The community will also benefit as EMS will be able to remain in the community thus reducing costs for transport out of the area and enabling EMS to be available locally for the next call.

With respect to 38401 (Columbia), one would expect transports from the northern part of Columbia are closer to TSHH. EMS transport data, like hospital utilization data, is not available at the census tract level. Accordingly, Exhibit 1N, Acute – 22 provides the data for the entire zip code.

**Exhibit 1N, Acute – 22**

| Columbia Zip Code 38401 EMS Transports | | | |
|---|---|---|---|
| **EMS Service** | **CY 2021** | **CY 2022** | **CY 2023** |
| **Maury County EMS** | | | |
| Ascension St Thomas Midtown | 11 | 0 | 12 |
| Ascension St Thomas West | 12 | 21 | 0 |
| Maury Regional Hospital | 5,400 | 5,592 | 6,010 |
| TriStar Spring Hill ER | 103 | 76 | 27 |
| TriStar Centennial | 14 | 16 | 18 |
| TriStar Skyline | 4 | 0 | 0 |
| Vanderbilt University Medical Center | 115 | 110 | 112 |
| Monroe Carell Children's Hospital | 31 | 40 | 56 |
| Williamson Medical Center | 225 | 229 | 262 |
| Total | 5,915 | 6,084 | 6,497 |
| **Vanderbilt LifeFlight** | | | |
| Ascension St Thomas West | 0 | 1 | 0 |
| Vanderbilt University Medical Center | 38 | 44 | 36 |
| Total | 38 | 45 | 36 |
| | | | |
| All Other | 0 | 16 | 0 |
| | | | |
| Total | 5,953 | 6,145 | 6,533 |

*Source: biospatial proprietary database, March 2024.*
*Biospatial estimates that the data collected within Maury County represents approximately 92 percent of total transports during this three year period.*

Given the geography of 38401 (Columbia), population growth in northern Columbia and current travel patterns, one would expect a portion of the above EMS transports being redirected to TriStar Spring Hill ER to provide the emergency patient with access to the closest hospital with the available services it requires.

With respect to 37179 (Thompson's Station) transports would also be closer to TSHH as demonstrated by the Travel Time Study. Accordingly, one would expect a portion of the transports presented in the next exhibit would also be re-directed to TSHH once it is a full-service hospital.

**Exhibit 1N, Acute – 23**

| Thompson's Station Zip Code 37179 EMS Transports | | | |
|---|---|---|---|
| **EMS Service** | **CY 2021** | **CY 2022** | **CY 2023** |
| **Williamson County EMS** | | | |
| Maury Regional Hospital | 11 | 14 | 11 |
| TriStar Spring Hill ER | 24 | 34 | 34 |
| TriStar Centennial | 6 | 3 | 10 |
| Vanderbilt University Medical Center | 38 | 36 | 40 |
| TriStar Southern Hills | 0 | 0 | 2 |
| TriStar Summit | 0 | 0 | 1 |
| Monroe Carell Children's Hospital | 36 | 44 | 65 |
| Williamson Medical Center | 263 | 281 | 357 |
| Total | 378 | 412 | 520 |

*Source: biospatial proprietary database, March 2024*
*Note: biospatial estimates that the above data collected within Williamson County represents approximately 69 percent of total transports during this three-year period.*

Collectively this data demonstrates there is a substantial time and economic burden on local EMS services to transport thousands of patients annually out of the Spring Hill Service Area. Enabling a measurable portion of these residents to be diagnosed and treated where they reside is a distinct consumer advantage. It will also result in reduced out-migration and geographic access improvement for patients and families.

**Redirection of TriStar Spring Hill ER Patient Population**

Prior to 2021, a greater number of clinically appropriate patients with conditions appropriate for TriStar Spring Hill ER were transported to TriStar Spring Hill ER. However, when the Spring Hill Emergency Medical Services ("SHEMS") vendor was changed from AMR to WMC, many other patients were also diverted in the field by SHEMS. Transporting patients out of the area when they could be appropriately treated locally impairs access for this patient population who were diverted, and their families.

Historical analysis of transferred patients both pre and post change in the EMS vendor delineates this situation. In the three years prior to change in vendor, the percent of ER visits transferred from TriStar Spring Hill averaged 11.4 percent and were at its peak of 12.5 percent in 2020. Since the change in vendor, the transfer rate has decreased to between 7 and 8 percent. The next exhibit identifies TriStar Spring Hill ER visits by disposition (discharge or transfer) for the past six years.

**Exhibit 1N, Acute – 24**

| Factor | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | Change, 2018 to 2023 |
|---|---|---|---|---|---|---|---|
| Discharged Patients | 13,364 | 13,841 | 11,047 | 13,333 | 14,729 | 14,782 | 10.6% |
| Transferred Patients | 1,703 | 1,643 | 1,581 | 1,151 | 1,204 | 1,118 | -34.4% |
| Total Patients | 15,067 | 15,484 | 12,628 | 14,484 | 15,933 | 15,900 | 5.5% |
| Percent Transferred/Admitted | 11.3% | 10.6% | 12.5% | 7.9% | 7.6% | 7.0% | |
| *Source: Internal records* | | | | | | | |

Patients transferred decreased 34 percent between 2018 and 2023, while at the same time discharged patients increased nearly 11 percent. This is confirmed by the acuity of the patients at TriStar Spring Hill ER during this same time frame which shows a decrease in acuity. The decrease in transfer rate is the result of the SHEMS bypassing TriStar Spring Hill ER and bringing the patient to an alternate ER either in Williamson or Davidson County.

Had the prior experience of EMS transport patterns not been altered with the new SHEMS vendor, an estimated 12.5 percent of ER visits would require transfer for more comprehensive or specialized care. This would have increased overall ER visits at TriStar Spring Hill during the past three years. To estimate the number of bypassed ER patients based on this change in transport patterns, a 12.5 percent transfer rate was applied to total ER visits in 2021 through 2023. The computation is presented in the below table, estimating between 662 and 873 bypassed visits during the past three years.

**Exhibit 1N, Acute – 25**

| | CY 2020 | CY 2021 | CY 2022 | CY 2023 |
|---|---|---|---|---|
| Total Patients | 12,628 | 14,484 | 15,933 | 15,900 |
| Bypassed Patients Since 2020: | | | | |
| At 2020 Rate | 1,581 | 1,813 | 1,995 | 1,991 |
| Less Actual | 1,581 | 1,151 | 1,204 | 1,118 |
| *Bypass Estimate* | *0* | *662* | *791* | *873* |

Moreover, had these patients, who are estimated to have bypassed TriStar Spring Hill ER, been delivered by EMS to TriStar Spring Hill ER, the ER would have been responsible for any subsequent transfer of the patient. This would have left the SHEMS ambulance in service in Spring Hill for its next emergency call.

**Accessible Women's Health Program**

The establishment of a locally accessible women's health program in conjunction with Diana Health will enable birthing mothers to deliver close to home, avoid unnecessary travel and experience a holistic and nurturing environment of care. Such a program is currently not reasonably accessible for Spring Hill mothers. Spring Hill is a thriving and growing family community with one-third of the population between the ages of 18 and 44, also known as child-bearing ages. Given the population dynamics of Spring Hill and it being the largest city in Tennessee without its own hospital, it is not unexpected that women's health services and birthing locations are not easily accessible from Spring Hill.

To demonstrate how egregious the travel times for expectant Spring Hill mothers to access hospitals for deliveries is, we undertook an analysis of deliveries[24] throughout the area, including Maury, Williamson, Davidson and surrounding counties in the region. For each zip code in these counties, deliveries were identified for the past three years. Of these zip codes, 24 had greater than 400 deliveries. For each zip code with 400+ deliveries, we then identified the closest hospital and used google maps to identify the actual travel miles from the zip code[25] to the closest hospital.

The zip codes were arrayed in descending order by distance from the zip code centroid to the closest hospital. Spring Hill has the greatest distance to the closest hospital with an obstetrics program. Accordingly, Spring Hill is listed first in the following table.

**Exhibit 1N, Acute – 26**

| Zip Code | CY 2020 | CY 2021 | CY 2022 | % Change, 2020 to 2022 | Closest Hospital | Distance (Miles) | Travel Miles |
|---|---|---|---|---|---|---|---|
| 37174 - Spring Hill | 519 | 594 | 650 | 25.2% | Williamson Medical Center | 16.0 | 10,400 |
| 37072 - Goodlettsville | 322 | 335 | 417 | 29.5% | TriStar Hendersonville Medical Center | 11.6 | 4,837 |
| 37221 - Nashville | 448 | 465 | 449 | 0.2% | TriStar Centennial Medical Center | 11.5 | 5,164 |
| 37209 - Nashville | 579 | 670 | 680 | 17.4% | TriStar Centennial Medical Center | 10.1 | 6,868 |
| 37064 - Franklin | 590 | 595 | 596 | 1.0% | Williamson Medical Center | 9.7 | 5,781 |
| 37130 - Murfreesboro | 685 | 733 | 709 | 3.5% | Ascension St Thomas Rutherford | 9.6 | 6,806 |
| 37122 - Mount Juliet | 636 | 693 | 742 | 16.7% | TriStar Summit Medical Center | 8.7 | 6,455 |
| 37013 - Antioch | 1,493 | 1,564 | 1,673 | 12.1% | TriStar StoneCrest Medical Center | 8.2 | 13,719 |
| 37211 - Nashville | 1,368 | 1,343 | 1,391 | 1.7% | Vanderbilt University Medical Center | 8.1 | 11,267 |
| 37115 - Madison | 520 | 551 | 568 | 9.2% | TriStar Hendersonville Medical Center | 7.9 | 4,487 |
| 37027 - Brentwood | 419 | 435 | 448 | 6.9% | Williamson Medical Center | 7.1 | 3,181 |
| 37217 - Nashville | 511 | 520 | 561 | 9.8% | TriStar Summit Medical Center | 7.0 | 3,927 |
| 37129 - Murfreesboro | 622 | 646 | 709 | 14.0% | Ascension St Thomas Rutherford | 6.8 | 4,821 |
| 37207 - Nashville | 640 | 602 | 612 | -4.4% | Ascension St Thomas Midtown | 6.7 | 4,100 |
| 37206 - Nashville | 459 | 483 | 416 | -9.4% | TriStar Centennial Medical Center | 6.4 | 2,662 |
| 37128 - Murfreesboro | 837 | 872 | 928 | 10.9% | Ascension St Thomas Rutherford | 5.8 | 5,382 |
| 37087 - Lebanon | 602 | 605 | 712 | 18.3% | Vanderbilt Wilson County Hospital | 5.8 | 4,130 |
| 38401 - Columbia | 742 | 744 | 680 | -8.4% | Maury Regional Hospital | 5.7 | 3,876 |
| 37086 - La Vergne | 546 | 587 | 615 | 12.6% | TriStar Stonecrest Medical Center | 5.7 | 3,506 |
| 37076 - Hermitage | 476 | 486 | 542 | 13.9% | TriStar Summit Medical Center | 3.8 | 2,060 |
| 37167 - Smyrna | 816 | 765 | 883 | 8.2% | TriStar Stonecrest Medical Center | 3.4 | 3,002 |
| 37075 - Hendersonville | 693 | 680 | 730 | 5.3% | TriStar Hendersonville Medical Center | 2.6 | 1,898 |
| 37066 - Gallatin | 644 | 695 | 671 | 4.2% | Sumner Regional Medical Center | 2.3 | 1,543 |

*Source: THA Discharges by year and zip code; deliveries only (not total obstetrics).*

*Note: 37160 Shelbyville with 526 deliveries (CY 2022) is excluded from the above table as there is an existing hospital in Shelbyville that chose to discontinue obstetrics services requiring Shelbyville residents to drive 18.5 miles to Vanderbilt Tullahoma Hospital. This access hardship was prompted by the community hospital action which is dissimilar to Spring Hill that has no hospital.*

Exhibit 1N, Acute – 26 shows that 37174 (Spring Hill) also had the second greatest increase in deliveries in the CY 2020 through CY 2022 period at 25.2 percent. Spring Hill deliveries are expected to continue to increase, which means travel miles will correspondingly continue to increase more than in comparative locations throughout the region.

[24] Deliveries are defined by DRGs 768, 783-788, and 796-798 and are a subset of total Obstetrics Discharges presented elsewhere throughout this CON Application.

[25] Google maps uses the geographic centroid of the zip code when determining mileage from a zip code to a location. As shown on Exhibit 15 in the CON Form, WMC is closer than MRH to the centroid of 37174.

When computing total travel miles for expectant mothers accessing the 'closest' obstetrics program, Spring Hill had the third highest travel miles of any zip code in the region. Deliveries multiplied by distance for Spring Hill expectant mothers equaled 10,400 miles. If the actual location of where these out-migrating patients had their babies was analyzed, travel miles would be even greater because 55 percent of the deliveries that occurred during this three-year period did not occur at the closest hospital to 37174 (Spring Hill). Rather, residents traveled further to Davidson County hospitals, including TriStar Centennial. There is clear evidence that a hospital with maternity services is needed in Spring Hill.

The maternity program at TSHH will be different than existing providers based on the introduction of Diana Health's partnership with TSHH. The relationship with Diana Health will form the foundation of TSHH's maternity program and its NICU. Diana Health's care model includes a 24/7 OB hospitalist program and midwifery-led laborist services within an integrated model of care. There is no such program in Spring Hill or Maury or Williamson Counties, further distinguishing the TSHH program from other resources. Having an obstetrician on campus 24/7 assures rapid response in case of emergency, enables the obstetrician to oversee the midwifery service and provides meaningful interaction with staff, patients and families.

Diana Health is a private OB practice that incorporates a full-scope model that brings wellness-focused care that women love together with a clinical redesign on labor and delivery that is delivered through its midwifery-led laborist service. It serves as an extension of the hospital's service line leadership, which sets it apart from other providers through a model that puts women at the center of decision-making and empowers them with the information and support they need to achieve their health and wellness goals.

Through integrated care teams, smart technology and a thoughtfully designed care experience, the proposed TSHH OB program will align incentives across patients and providers and set TSHH's obstetrics service up for sustainability and success. The availability of the OB hospitalist model not only benefits the Diana Health physicians but also community obstetricians who want to engage the OB hospitalists to cover their private practice during nights, weekends, vacations or other absences.

Labor and Delivery at TSHH with the Diana Health team will include the following:

- An early familiarity with the obstetrics unit, including tour and meeting the staff.
- 24/7 Support caring team in the hospital 24/7 and will be by a patient's side every step of the way.
- When admitted, a patient's entire Care Team will review the birth plan, and, should plans need to change, work with the patient to make collaborative decisions.
- Each patient will be in a spacious, private room during labor and postpartum, with remote monitoring devices available if you want to move around.
- The program will support a variety of birth choices and pain management options. From nitrous oxide to aromatherapy, to water therapy and calming music, the patient is in complete control of the birthing environment.
- After delivery, the patient will meet virtually with a Care Navigator and the patient's OB or Midwife 24, 48, and 72 hours post-discharge, and will also have access to support groups and classes to get the new mother off to a strong start.
- Patient can access immersion tubs, aromatherapy diffusers, luxurious blankets, swedish bars, rebozo technique, birth stool, birth balls, bassinets that snuggles up to bed, and plush robes.

Another advantage for the obstetrics patients in Spring Hill who will utilize the new hospital is its affiliation with TriStar Centennial. This will be a destination hospital for tertiary patients including higher level

obstetric and neonatal patients. TriStar Centennial has several attributes that are not available in either Maury or Williamson Counties. These include the following:

- OB Medical Director is board certified in maternal-fetal management of patients.
- Nursery Medical Director is a board-certified neonatologist (not the case for WMC).
- Subspecialty Consultants at more than 2/3 full time at the hospital:
    - Obstetrics: Perinatal Sonologist, Hematologist and Cardiologist
    - Neonatal: Pediatric Radiologist, Pediatric Cardiologist, Pediatric Neurologist, Pathologist and Pediatric Surgeon. Of these, MRH has a pediatric radiologist; WMC has none.

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

**Accessible Cardiac Program**

As presented in Attachment 1N, Cardiac Catheterization Services, the existing MRH cardiac catheterization program in Maury County operates at 137 percent of optimal capacity. This confirms MRH is not readily available to the TSHH Service Area population. Additionally, given travel times and normal migration patterns, MRH does not appear to be accessible to Service Area residents. Like total discharges, more than half of Maury County residents leave the county for cardiac catheterization procedures.

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

Per the travel times presented in response to Question 4N in the CON Form, time to reach hospitals outside the City of Spring Hill requires between 14 to 45 minutes additional time than accessing TSHH. The availability of TSHH and its proposed catheterization laboratories in Spring Hill would save these patients up to 45 minutes in the symptom-to-balloon time. Reducing such time should reduce the degree of damage and ultimately improve patient outcomes. Shorter symptom-to-balloon times for individual patients is also associated with lower mortality at 30-days and at 1 year. Time is muscle, and these minutes are critical in patient outcomes.

Establishing a locally accessible cardiac program in conjunction with TriStar Centennial's Heart program, which has significant presence in the Service Area, will improve access for the Spring Hill area residents. Currently practicing within the TriStar Spring Hill campus are three cardiology providers who are affiliated with Centennial Heart Cardiovascular Consultants ("Centennial Heart"). This physician group includes 45 non-invasive cardiologists, invasive cardiologists, interventional cardiologists and cardiac surgeons, most of whom are located in Middle Tennessee including Maury and Williamson Counties. Centennial Heart will be partnered with TriStar Spring Hill to oversee and provide the cardiologists to staff the proposed catheterization laboratory at TSHH. The expertise of Centennial Heart is widely recognized as they currently work throughout Middle Tennessee including at one of the busiest and most robust cardiology programs, TriStar Centennial which has 9 catheterization labs with approximately 7,000 catheterizations performed annually and 5 open heart surgery suites with 1,265 surgeries performed annually.[26]

[26] 2023 volume per internal records, to be included in 2023 JAR.

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

Current Centennial Heart physicians named at this early stage to be practicing at TriStar Spring Hill include Jeffrey Webber, MD and John Riddick, MD. An advanced practice provider will be selected to work with these physicians. In addition to those at TriStar Spring Hill, other Centennial Heart providers may be rotated among other TriStar hospitals and TSHH to provide for continuity and collaboration of cardiac catheterization services amongst the practitioners and hospitals. The cardiac services planned for the TSHH and its heart program include the following:

**Exhibit 1N, Acute – 27**
**Cardiac Diagnostic, Testing & Procedures Proposed for TriStar Spring Hill Hospital**

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

The proposed cardiac catheterization program will include both diagnostic and therapeutic catheterizations. By providing therapeutic catheterizations, local EMS will be provided with a rapidly accessible hospital to transport probable AMIs within minutes, as opposed to traveling out of the area to MRH, WMC or Davidson County hospitals. This considerable time savings likely results in saving lives.

**Respond to Calls from the Community**

Members of the local community have expressed considerable concern about Spring Hill's geographic isolation from needed healthcare services. Their observations can be summarized as having inadequate access to healthcare based on extended travel times to reach required services, lack of available and accessible hospital services in Spring Hill and requirement to be EMS transported out of the area due to unavailability of surgical, catheterizations and other specialized services in Spring Hill. Please refer to the CON Form for community engagement and support and Attachment 4N for letters of support accompanying this CON Application.

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

**RESPONSE:**

TSHH will provide care to all patients regardless of race, ethnicity, income or other factors. This will include providing services to underinsured, uninsured and low-income populations, including TennCare. While the Applicant is not yet licensed, the TriStar Spring Hill ER which will be incorporated into the proposed hospital has been operational for 10+ years. It has a demonstrated commitment to all population groups which will continue. As reported in its most recent Joint Annual Report, 36.7 percent of the Spring Hill ER visits during CY 2022 were for TennCare/Medicaid patients. An additional 12.6 percent were self-pay patients.[27]

In addition, an average of 3 percent of its ER patients are classified as behavioral health patients. TriStar Spring Hill ER has specialized expertise in treating behavioral health patients who are often triaged to Pinewood Springs, a 60-bed behavioral health hospital in Maury County jointly owned by TriStar Health and MRH. Given this community-wide specialty resource, behavioral health patients are not underserved thereby not requiring the need for additional programming at TriStar Spring Hill. The current relationship and referral pattern will continue with the licensure of TSHH.[28]

TSHH is part of TriStar Health which operates hospitals throughout Middle Tennessee. Its commitment to TennCare/Medicaid and uninsured patients is not just specific to TriStar Centennial and the Applicant. As a Tennessee provider, HCA Healthcare is the largest provider statewide of services to TennCare/Medicaid patients. Per Exhibit 1N, Acute – 28, HCA Healthcare, in 2022, admitted nearly 16 percent of TennCare/Medicaid patients, or 1 of 6 patients statewide. Regarding uninsured patients, it had the second highest statewide at 11 percent or 1 in 9 patients were treated at a TriStar Health facility. This information is presented in the following table:

**Exhibit 1N, Acute – 28**

| Health System Name | Medicaid/TennCare IP - % of Total Admissions | Medicaid/TennCare IP - % of Total Inpatient Days | % of Total Uninsured Patients |
|---|---|---|---|
| HCA Healthcare | 15.7% | 13.3% | 11.0% |
| Vanderbilt University Medical Center | 9.9% | 11.3% | 4.4% |
| Ballad Health | 7.8% | 6.1% | 6.0% |
| Covenant Health | 7.6% | 5.1% | 7.0% |
| Methodist LeBonheur Healthcare | 7.4% | 9.3% | 10.8% |
| Baptist Memorial Healthcare | 5.7% | 4.5% | 3.1% |
| Ascension Saint Thomas | 4.7% | 4.7% | 6.0% |
| Erlanger Health System | 4.5% | 4.4% | 8.6% |
| West Tennessee Healthcare | 4.3% | 3.7% | 2.8% |
| Community Health Systems | 3.6% | 2.7% | 12.8% |

*Source: JARs 2022.*

[27] CY 2022 Joint Annual Report, Schedule I.1, page 44.

[28] Per its CY 2022 Joint Annual Report, more than 50 percent of its admissions are TennCare/Medicaid and approximately 35 percent of its outpatient visits including partial hospitalization and intensive outpatient are TennCare/Medicaid.

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

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

**RESPONSE:**

TSHH will address the inpatient acute care needs of the service area population.

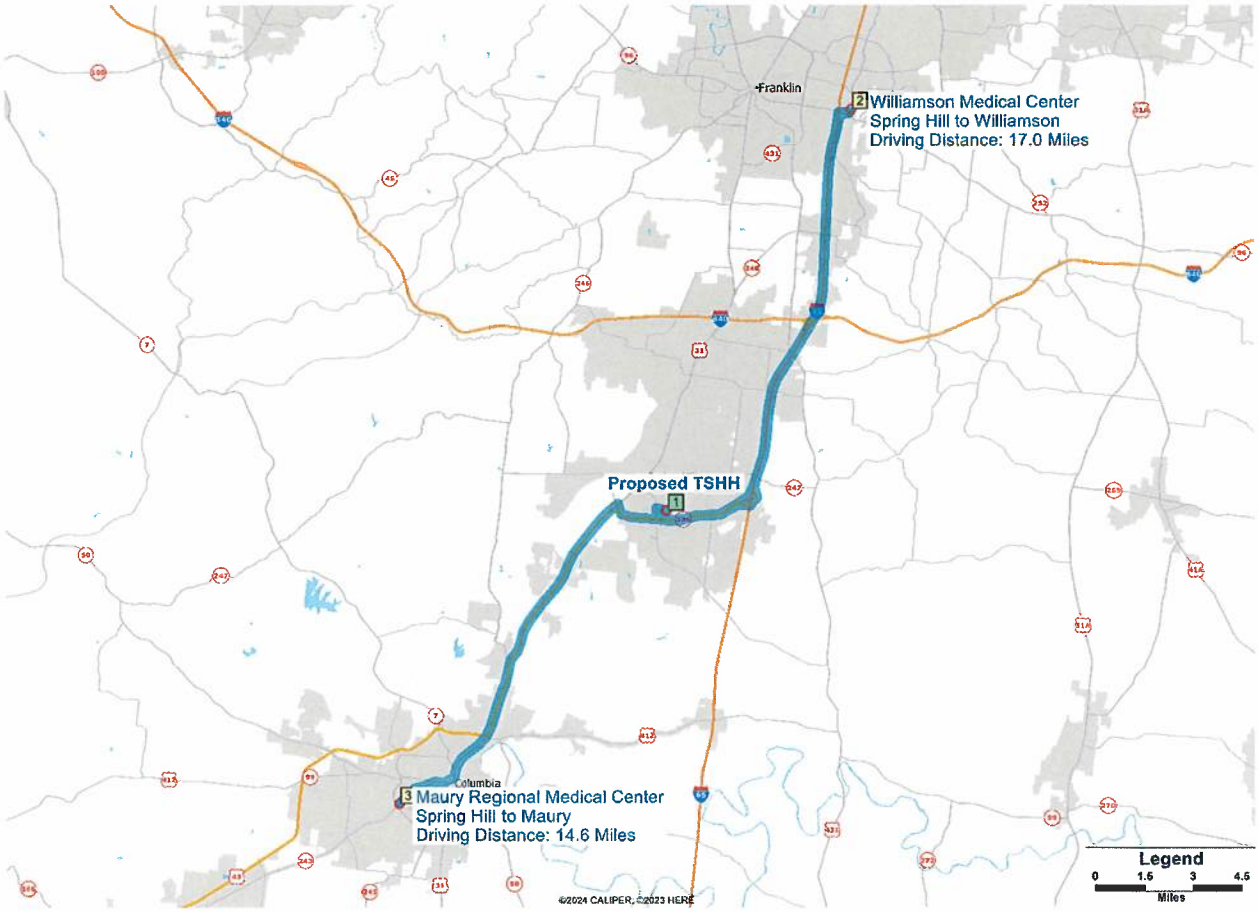
The Spring Hill area is an underserved geographic area otherwise referenced as a geographically isolated area for inpatient acute care services. Within Spring Hill, there is no acute care hospital but there is the TriStar Spring Hill ER which meets the emergency needs of the population. Within the Service Area, there is one hospital: MRH. That hospital is geographically located on the south side of the Service Area and is 14.6 miles away from the proposed TSHH. Travel times from Spring Hill to MRH differ dramatically throughout the day and week based on travel and traffic patterns. It can take up to 45 minutes to travel from Spring Hill to MRH.

While MRH serves the Columbia and Maury County area, its patient draw is limited to admitting only half of Maury County residents admitted to a hospital and only 60 percent of those residing in the Columbia Service Area zip code (38401) who are admitted to a hospital. It is rare for patients in the Spring Hill zip code to seek acute services at MRH.

The Service Area includes a portion of the Spring Hill zip code that, along with Thompson's Station, are in Williamson County. Williamson County also has one hospital, WMC. That hospital is located approximately 17 miles from the proposed TSHH. Travel times to this alternate hospital also differ dramatically throughout the day and week based on travel and traffic patterns. It can take up to 45 minutes to get to WMC depending on the time of day.

WMC serves Williamson County residents at various degrees based on resident location and proximity to the hospital. Interestingly, it admits less than 40 percent of total Williamson County residents admitted to a hospital. And relative to Thompson's Station, it admits approximately 46 percent of its residents, indicating 54 percent left Williamson County for hospitalization.

These two existing hospitals are 30 miles apart, resulting in a large area with tremendously increasing population between the two hospitals that do not have reasonable access to a hospital. The below map shows the two existing hospitals and the TriStar Spring Hill ER, the proposed site for TSHH.




Visually observing the above map demonstrates the hospital void across a large geographic area, the 30+ mile span throughout northern Maury County and southern Williamson County. As will be demonstrated throughout this CON Application, this area has a significant population base, and has experienced dramatic growth during the past 10 to 15 years.[29] Anticipated population increases using Claritas are near the highest in the State as presented herein. Both the current and forecasted population support need for a hospital.[30] Establishment of TSHH will enhance access for the Service Area residents through the creation of a hospital access point designed to reduce geographic inaccessibility to serve the healthcare needs of this population.

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[29] The Tennessee Controller reports that Spring Hill had a population of 57,932 in 2023. https://comptroller.tn.gov/content/dam/cot/pa/documents/district-infographics/cities/spring_hill.html.
City leaders believe the current population now exceeds 60,000; to confirm this the City is now undertaking a Special Census (2024) to obtain a more accurate count. If the 2024 population is revised upward, that would have further implications for the forecasted population likely resulting in population in the upper 60,000's within five years. Forecasts throughout this CON Application conservatively use the Claritas counts presented in Question 3N.

[30] While forecasts currently estimate through 2029, in *its Major Thoroughfare Plan, 2021* the City of Spring Hill estimates a future (2040) population of 81,287 in Spring Hill (page 7 of its Future Conditions Report). In addition, in the city's UGB web page, it estimates a 2029 population ranging between 68,000 and 94,000. https://www.springhilltn.org/728/Urban-Growth-Boundaries-UGB.

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

**RESPONSE:**

TSHH will serve equally all patients who present at its facility, as it does at the existing TriStar Spring Hill ER.

The Applicant should be afforded special consideration under this provision as it is readily evident that there is limited access to inpatient acute care hospital services in the proposed Service Area. The City of Spring Hill is the 11th largest city in the State and is the largest city in Tennessee without a hospital. This city had just 17,000 people in 2005 when the HSDA voted twice to approve a 56-bed Spring Hill hospital. Today, the City's population approximates 58,000. Furthermore, per the City of Spring Hill, by 2040 the population will exceed 81,000 persons and per the City's Urban Growth Boundary ("UGB") web page, population could range between 68,000 and 94,000 in 2029. The analysis throughout this CON Application relies on Claritas' current 2024 and projected 2029 population to justify its approval. However, City leaders' forecast of 68,000 to 94,000 should not go unnoticed. The driving factors that support the need for the proposed hospital and are presented in detail in the CON Form include the following:

*Largest City in Tennessee without a Hospital*

- The City of Spring Hill, a city of with 58,000 people, has no hospital. It is the most populated city in the state without one.
- On average, hospitals in the state serve smaller populations with the average population per hospital at approximately 41,000.
- In Tennessee, there is an average of 354 beds per 100,000 population. Spring Hill has no beds.
- Travel time for Spring Hill residents to reach hospital services is excessive with material access improvements to be realized with the licensure of TSHH.

*Existing Patient Base With No Hospital (2N)*

- There is an existing high volume freestanding emergency room on the proposed site, meeting a significant percentage of the emergent needs of the Service Area population; this includes between 40 and 44 percent of Spring Hill residents' emergency care needs.
- TriStar Spring Hill ER has provided 150,000 emergency visits since opening and currently provides emergency services to approximately 16,000 patients each year, which is substantial evidence of the vast support its 24/7 care has from the local community. However, if a patient requires non-emergency care or a higher level of care, they must be transported 30 minutes to an hour away, depending on traffic and patient preference.
- This ER will be incorporated into TSHH upon its licensure.

*Community Size and Population Dynamics (3N)*

- Population trends and dynamics place, and will continue to place, significant pressure on the healthcare infrastructure in the region. The population of the City of Spring Hill, alone, increased

from 27,700 persons in 2010 to an estimated 56,200 in 2024.[31] This is a 103 percent increase between 2010 and 2024, and is the second fastest growth rate in the state.

- By 2029, the population is expected to exceed 62,600, a further 11 percent increase.[32]
- The City of Spring Hill is currently conducting a special census to determine the population more accurately as city officials estimate the population already exceeds 60,000.[33]

*Access Challenges and Excessive Travel Times*

- Of the cities in the state with populations greater than 24,000 without a hospital, Spring Hill residents have the poorest access to hospitals out of the area based on distance and resulting travel time.
- Given the distance from Spring Hill to out-of-area hospitals and the number of hospital discharges from Spring Hill, its residents collectively travel excessive miles to reach services resulting in some of the greatest aggregate travel miles to reach a hospital in the region.
- Residents of Spring Hill must travel significant distances to access inpatient care, with such travel times being exacerbated each year by the continued population increases.

*Out-Migration is Indicative of Access and Availability Challenges*

- Nearly 90 percent of Spring Hill residents leave Maury County to access inpatient acute care services; and a combined nearly 50 percent of Spring Hill residents leave both Maury and Williamson Counties for inpatient acute care services.[34]
- In addition, more than 50 percent of Maury County residents leave Maury County to access inpatient acute care services; this is significant outmigration indicative of an access problem.
- More than 60 percent of Williamson County residents leave Williamson County to access inpatient acute care services; this is significant outmigration also indicative of an access problem.
- The out-migration percentages and more importantly the number of patients who out-migrate confirm that effective healthcare planning is needed to mitigate these dramatic patient flows and improve access for Service Area patients.
- Of the combined out-migration from Maury and Williamson Counties, approximately 16.5 percent, or an average of 2,350 admissions per year, travel a significant distance to TriStar Centennial, evidence of its standing position in the Service Area.

*Travel Times Necessitate Access Improvement*

- The traffic study carried out by a traffic engineering firm found that in the morning, the average time saved to reach TSHH from the Service Area perimeter locations (furthest from TSHH) compared to WMC and MRH was 11 to 14 minutes; 48 minutes are saved reaching TriStar Centennial. With respect to the Spring Hill locations, the average time saved to reach TSHH is 20 minutes. Reaching TSHH took less than 10 minutes compared to an average of 30 minutes to

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[31] Claritas 2024; the City of Spring Hill's website estimates 2024 population between 57,604 and 66,071, which is approximately 1,400 to nearly 10,000 greater than Claritas estimates.

[32] Claritas 2024; the City of Spring Hill's website estimates 2029 population between 68,000 and 94,000, substantially more than Claritas forecasts. If the estimate is realized, this will result in increased pressure on infrastructure including healthcare services and further support the need for a hospital to be located in the City of Spring Hill.

[33] The City of Spring Hill's UGB report includes two alternate estimates of 2024 population, 57,604 and 66,071. The special census will confirm the 2024 estimate. https://www.springhilltn.org/728/Urban-Growth-Boundaries-UGB.

[34] Zip code and county migration patterns from THA data are based on 2021 data; county data from the JARs are based on 2022 data.

reach either WMC or MRH. This demonstrates measurable access improvement for residents of the Service Area.

- Like the morning travel analysis, KCI found that in the late afternoon, access to hospital services was also improved with TSHH. At this time, the average time saved to reach TSHH from the Service Area perimeter locations compared to WMC and MRH was 10 to 15 minutes; 49 minutes are saved reaching TriStar Centennial. With respect to the Spring Hill locations, the average time saved to reach TSHH compared to WMC and MRH was 14 to 25 minutes. Reaching TSHH took less than 11 minutes compared to an average of 25 to 36 minutes to reach WMC and MRH, respectively.
- Travel miles (product of distance and frequency) to access both inpatient med/surg care and obstetrics services for Spring Hill residents is one of the greatest in the region.

*ER Transfers and EMS Bypass Verify Need*

- The level of patient activity at TriStar Spring Hill ER, number of transfers (87 percent non-tertiary)[35] for inpatient treatment and observation from this ER and their resulting impact on access to healthcare, cost and family hardship, collectively demonstrate the Service Area need for inpatient hospital beds on the TSHH campus.
- Based on its patient base, TriStar Spring Hill ER currently transfers an average of 100 patients per month to Nashville and elsewhere to access inpatient care thereby creating inadequate or delayed access to care. Prior to the past three years, and pre-pandemic, the number of transfers was approximately 140 per month. This difference enables quantification of Spring Hill ER bypasses that have increased during the past three years that could be treated in Spring Hill. In addition, there are additional EMS bypasses that have historically and continue to occur.
- In addition to the direct transfers from TriStar Spring Hill ER to TriStar Centennial, there are additional emergency transports from the Service Area to TriStar Centennial, totaling 84 in CY 2023.
- Local EMS providers which bypass TriStar Spring Hill ER in favor of traveling distances into Williamson County, Davidson County or elsewhere thereby out of service for the Spring Hill population will be able to reduce time spent out of Spring Hill. There were 2,341 documented transports from zip code 37174 with only 402 being transported to TriStar Spring Hill ER, indicating 1,939 were transported away from Spring Hill (CY 2023). There were also 7,000+ transports from 38401 (Columbia), including northern Columbia and 37179 (Thompson's Station), with only 61 being transported to TriStar Spring Hill ER. TSHH will positively impact the EMS services by being accessible and available more rapidly to meet local needs.
- Access for families will be enhanced as only 17 percent of the EMS transports from 37174 are to TriStar Spring Hill ER. 69 percent are to WMC and MRH, and 14 percent are even further, to Davidson County. When some of these patients are no longer diverted out of the area, families will have improved access and relative short travel times to be with their family and participate in any recovery.

*State Health Plan Criteria Are Met*

- The State Health Plan Standards and Criteria includes a Bed-Need Formula, however, the HFC "has the discretion to approve new hospital beds even when not warranted under the State Health Plan criteria when there is a compelling reason to do so, and the Commission has done so when there

[35] Tertiary medical surgical cases are defined as transplants, trauma care, cardiac surgery, thoracic surgery, neurosurgery, burns, radiotherapy, neonatology and other complex interventions. Non-tertiary medical-surgical are the remaining inpatient services, excluding specialty services (behavioral health and medical rehabilitation). Obstetrics is also considered non-tertiary but is separately analyzed throughout this CON Application.

was demonstrated need for additional health services in a particular community."[36] The situation in Spring Hill detailed throughout this CON application demonstrates compelling reasons for TSHH's approval.

- Like many hospitals throughout Tennessee, MRH operates licensed semi-private rooms as private rooms. Furthermore, operational adjustments[37] to the published need tables indicate occupancy at the existing Maury County hospital meets occupancy metrics sufficient to support additional hospital beds in the County.[38]
- The bed need formula for Level II NICU beds confirms the need for additional Level II NICU beds in the Service Area.
- The cardiac catheterization services utilization formula confirms the need for additional cardiac catheterization laboratories in Maury County.
- The MRI services utilization formula confirms the need for an additional MRI in Maury County.
- TSHH will cure geographic isolation and inaccessibility through providing Service Area residents with an accessible and available inpatient hospital thereby enhancing access as demonstrated through health planning metrics and community support.
- Establishment of TSHH will foster quality of care and cost effectiveness through more rapid treatment of the thousands of patients being transferred from TriStar Spring Hill ER each year (and expected to increase), being transported from scenes each year to out of area facilities, minimizing impact on EMS to transport these patients out of the area, reducing the cost to the EMS system, and decreasing the costs to the Service Area residents. More rapid treatment leads to lives being saved.
- The economic impact to the Spring Hill community is meaningfully quantified and demonstrates a Consumer Advantage based on its construction and the ongoing impact of its operations.
- Community leaders and residents alike (the "community") have again raised their voices to state there is an overwhelming need for a hospital in Spring Hill and request TriStar Health implement the full-service hospital envisioned more than a decade ago. Their current impetus is based on the tremendous population growth, challenging traffic patterns extending travel time to service and the need for improved access to inpatient hospital services including obstetrics services.
- Consumer Advantage is meaningfully demonstrated by the community support for TSHH as expressed by city leaders, large community employers, business leaders, physicians, referral sources, elected officials, prior patients and others with personal knowledge and experiences in the Service Area.

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

8. **Adequate Staffing: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area.**

**RESPONSE:**

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[36] VRH-2 Final Order, February 29, 2024.

[37] Inclusion of observation patient days and reduction in staffed beds based on floor plans published on the MRH website. See Exhibit 34 through 37 in the CON Form.

[38] Expansion of beds at MRH while making beds 'available' does nothing to improve access for the Service Area population in need or reduce excess travel times.

HCA Healthcare is the largest private employer in Williamson County, has approximately 2,300 employees residing in Williamson County and more than 450 employees residing in Maury County. At the TSHH campus, it operates a freestanding emergency department, imaging services, lab services, GI suite and provides physician offices to both independent physicians and affiliated physicians. TriStar employs at Spring Hill currently total 45 FTEs. Accordingly, TSHH has a significant foundation of staff upon which it will build its employee and physician base to appropriately staff the proposed hospital.

TriStar Health also has a significant representation of its providers (physicians and extenders) who reside in Maury and Williamson County. Of its more than 600 providers residing in these two counties, 39 currently reside in the Service Area. TSHH will capitalize on the presence of these providers as it develops its medical staff plan for its future operations.

Based on forecasted utilization, TSHH estimates a need for 283 FTEs in its initial year of operations. With the 2,750 HCA Healthcare employees residing in Maury and Williamson Counties, of which approximately 1,000 are in direct patient care roles, and the existing FTE complement at the TSHH campus, the Applicant is confident it will successfully recruit the needed complement to staff the hospital.

TriStar Health and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. In 2021, HCA Healthcare opened in Nashville the Galen College of Nursing, which now has campuses and programs in Tennessee, Kentucky, Ohio, Virginia, South Carolina, Florida and Texas. The Nashville campus offers a 3-year Bachelor of Science in Nursing, an Associate Degree in Nursing (ADN) and an LPN to ADN Bridge program. In its first couple of years of operation, the Galen College of Nursing graduated 45 nurses in 2023. Today, it currently enrolls 700 new students every year. Enrollment is expected to increase by about 5-10 percent each year. By 2025, the Galen College of Nursing expects around 250 annual graduates. It is HCA's experience that 55 percent of the graduates join an HCA hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Health including recruitment for the proposed TSHH.

The Thomas F. Frist, Jr. College of Medicine at Belmont University in Nashville, is a new medical school founded in alliance with HCA Healthcare to focus on training diverse physician leaders who embrace and value a whole-person approach to healing. The Thomas F. Frist, Jr. College of Medicine at Belmont University will be housed in a new building that had its ribbon cutting on April 29, 2024.[39] The nearly 200,000-square-foot building is located within a block of Belmont's Gordon E. Inman Center and McWhorter Hall, which house the University's well-known nursing, physical therapy, occupational therapy, social work and pharmacy programs. The College of Medicine has recruited a leadership team consisting of experts from across the country and is currently recruiting clinical faculty. The College also recently announced that it has achieved accrediting "candidate status" from the LCME accrediting body. Its first class is expected to commence fall 2024.

In Middle Tennessee, TriStar Health is integrally involved in graduate medical education (GME). It currently has 59 residents, with 31 at TriStar Centennial (internal medicine, psychiatry, and transitional year), 20 at TriStar Skyline (emergency medicine, neurology and physical medicine and rehabilitation) and 8 family medicine residents at TriStar Southern Hills. HCA Healthcare has more than 1,850 residents at its hospitals, making it one of the largest GME providers in the country. TriStar Health and HCA Healthcare look forward

[39] https://www.nashvillepost.com/business/health_care/belmont-opens-180m-medical-school-building/article_747f28e8-065e-11ef-a805-972db9b9e527.html.

to working collaboratively with Belmont to support the supply of healthcare professionals entering and staying in the profession and to ensure that they have access to training.

In addition to these programs for nurses and physicians, TriStar is extensively engaged with other educational and training programs throughout Middle Tennessee. These relationships provide for internships and other training opportunities for students at TriStar facilities and also provide a pipeline for future qualified employees. Exhibit 1N, Acute – 29 below provides a summary of programs that currently work with TriStar and the profession for which the students are matriculating and training.

**Exhibit 1N, Acute – 29**

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

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

**RESPONSE:**

Please see the letter from Wes Fountain, CFO of TriStar Division, attached as Attachment 1N, Acute, committing for TSHH to develop and maintain the facility resources equipment and staffing to provide the

appropriate services. HCA Healthcare's most recent Annual Report is accessible at: https://investor.hcahealthcare.com/financials/annual-reports/default.aspx.

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

**RESPONSE:**

TSHH agrees to provide the Department of Health and/or the Health Facilities Commission with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested.

11. **Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system.**

**RESPONSE:**

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

TSHH will be committed to providing a seamless continuum of health care both for individuals and for the community, linking together a full range of health care providers and services. TSHH's goal will be to provide services which are measurably more accessible, affordable, and which are improving in quality on a continuous basis. The continuum of services may begin prior to admission, such as in an ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

Within this context, TSHH will adhere to TriStar Health's plan for improving organizational performance, including planned performance assessment and improvement activities, initiating activities designed to follow-up on unusual occurrences or specific concerns/ issues, which may include following policies and procedures for ensuring staff competency and follow-up as appropriate on patient/family complaints and patient questionnaire results. Input and feedback from patients, staff and physicians will guide the improvement process. TriStar Spring Hill will address methods to ensure and maintain patients' quality of care.

TSHH will be dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. It will maintain the highest standards and quality of care. It will provide a robust Quality Assurance and Performance Improvement ("QAPI") Plan framed by the following essential elements:

- Design and Scope that encompasses the full range of services and departments;

- Governance and Leadership that actively engage with system expectations and priorities;
- Feedback, Data Systems, and Monitoring to continuously assess a wide range of care and service;
- Performance Improvement Projects to improve care or services based on the data captured; and
- Systematic Analysis and Systematic Action to create real impact and long-lasting improvement.

Further, TSHH will provide a robust Utilization Review ("UR") program that provides ongoing concurrent reviews of patient care to determine whether treatments are medically necessary and, if not, to assist in placing patients in more appropriate care settings. Internal case management will play an important advisory purpose in enhancing and maintaining the quality of care provided. Systems will be in place to conduct prospective, concurrent, and retrospective utilization reviews to ensure quality of care and protect revenue integrity. For more details, see Attachment 5C TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence.

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

**RESPONSE:**

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

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

**RESPONSE:**

TSHH will extend the extensive community linkages that TriStar Spring Hill ER currently has with nursing homes, senior living facilities, 55+ communities, and others throughout the Spring Hill area. In addition, the TSHH campus is already home to a number of providers, including two primary care providers, three cardiology providers, three orthopedic providers, two thoracic surgeons, gyn oncology, gastroenterology and neurosurgery. All these community linkages will be extended to and expanded upon with the opening of TSHH.

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

Moreover, in the event that a patient needs behavioral health treatment, TriStar Health, through its joint venture with MRH, operates Pinewood Springs Behavior Health Hospital. This hospital provides a broad range of inpatient and outpatient behavioral health services within a supportive and therapeutic environment. This collaboration combines MRH and the expertise of TriStar Health in a way that benefits the community, including Spring Hill.

## Exhibit 1N, Acute – 30

| Williamson Medical Center, Licensed and Staffed Beds and Patient Days, FY 2020 through FY 2022 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Beds by Type | County | 2022 Staffed Beds | Bed Days Available | Patient Days | | | Occupancy Rate | | | % Change in Patient Days 2020-2022 |
| | | | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | |
| Licensed Beds | Inpatient Days | 203 | 74,095 | 32,398 | 35,205 | 38,739 | 44% | 48% | 52% | 20% |
| | Inpatient Plus Observation Days | 203 | 74,095 | 37,319 | 38,693 | 43,209 | 50% | 52% | 58% | 16% |
| | | | | | | | | | | |
| Staffed Beds | Inpatient Days | 203 | 74,095 | 32,398 | 35,205 | 38,739 | 44% | 48% | 52% | 20% |
| | Inpatient Plus Observation Days | 203 | 74,095 | 37,319 | 38,693 | 43,209 | 50% | 52% | 58% | 16% |

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

# 1N

# Neonatal Intensive Care Standards and Criteria

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

**RESPONSE:**

TSHH proposes to establish an 8-bed Level II Neonatal Intensive Care Unit ("NICU") in the Service Area consisting of Spring Hill (37174), Thompson's Station (37179), and Columbia (38401). Two of these zip codes are in Maury County, and one zip code is in Williamson County. The proposed hospital will be located in Maury County, which has a net need for 4 beds. Additionally, there is a net need for 16 beds in Williamson County. Thus, there is a combined need in the two counties for more than 20 NICU beds.

As shown below in **Exhibit 1N, NICU – 1**, in 2021, the number of live births in Maury County was 1,326 and 2,369 in Williamson County.

**Exhibit 1N, NICU – 1**

**Live Birth Rate by County, 2021**

| County | Live Births | Population | Live Birth Rate |
|---|---|---|---|
| Maury | 1,326 | 101,250 | 13.1 |
| Williamson | 2,369 | 251,578 | 9.4 |
| Total | 3,695 | 352,828 | -- |

*Source: Tennessee Department of Health: https://www.tn.gov/health/health-program-areas/statistics/health-data/birth-statistics.html, TN 2021 data provided by TDOH*

*Source: Tennessee Department of Health, Division of Policy Planning and Assessment, https://www.tn.gov/health/health-program-areas/statistics/health-data/population.html*

Below, **Exhibit 1N, NICU - 2** shows that the combined 2027 bed need for Maury and Williamson County is 37.5 beds based on 9 NICU beds per 1,000 live births. In the two counties, only 17 beds are licensed and there are no approved but not yet licensed beds.[1] Exhibit 1N, NICU – 2 also provides the live birth computation based on the 2021 live birth rate by county projected three years forward (2027) as set forth in the above-described formula.

[1] A March 2023 article regarding renovations at Williamson Medical Center ("WMC") referenced the future addition of 1 NICU bed. This bed is not yet licensed, nor on the HFC approved list.

**Exhibit 1N, NICU – 2**

| Geographic Area | Current Year Population (2024) | Live Birth Rate per 1,000 Population (Service Area) | Projected Population 2027 (3 Years Forward)*** | Live Birth Rate per 1,000 Population Projected (Service Area 3 Years Forward) | Projected Bed Need (C x D) | Existing Service Area Staffed Beds* | Outstanding CON Project Beds (Service Area)** | Net Need |
|---|---|---|---|---|---|---|---|---|
| Maury County (*) | 106,039 | 13.1 | 110,559 | 1,448 | 13.0 | 9 | 0 | 4.0 |
| Williamson County (*) | 270,313 | 9.4 | 288,952 | 2,721 | 24.5 | 8 | 0 | 16.5 |
| Two Counties Combined | 376,352 | -- | 399,511 | 4,169 | 37.5 | 17 | 0 | 20.5 |

*Source: Tennessee Department of Health: https://www.tn.gov/health/health-program-areas/health-data/birth-statistics.html, TN 2021 data provided by TDOH*

** Population from Boyd Center, 2021 use for live birth rate*

While the State does not publish bed need at the zip code level, analyzing the Spring Hill community itself further demonstrates that additional beds are warranted in the Service Area. According to 2022 THA data, there were 650 babies delivered in the Spring Hill community by mothers residing in 37174 (Spring Hill), which equates to a birth rate of 12.3. Forecasting to 2027, results in 739 births in the Spring Hill community. At 9 beds per 1,000 population, the Spring Hill community alone supports the need for 7 NICU beds. This information is presented below in **Exhibit 1N, NICU – 3.**

**Exhibit 1N, NICU – 3**

| Geographic Area | Current Year Population (2024) | Live Birth Rate per 1,000 Population (Service Area) | Projected Population 2027 (3 Years Forward)*** | Live Birth Rate per 1,000 Population Projected (Service Area 3 Years Forward) | Projected Bed Need (C x D) | Existing Service Area Staffed Beds* | Outstanding CON Project Beds (Service Area)** | Net Need |
|---|---|---|---|---|---|---|---|---|
| 37174 Spring Hill | 56,270 | 12.3 | 60,073 | 739 | 7 | 0 | 0 | 7 |

*Source: Zip Code population from Claritas, Birth Rate for zip codes based on 2022 deliveries from THA data divided by total population (formula same as TennesseeeDepartment of Health county birth rate)*

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

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

**RESPONSE:**

TSHH is seeking approval for an 8-bed unit. As explained above, the projections for the NICU bed need in the area is based on 4 staffed beds. However, TSHH believes that an additional 4 beds will allow room for growth when the volume of the unit increases at any given time. The additional 4 beds will further allow the NICU to continue to accommodate additional patients so that the unit is not at risk of being over capacity.

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

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

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

TriStar Health is committed to delivering quality care and needed services in the local community, close to where the consumer resides – a consumer advantage. The proposed Level II NICU at TSHH is needed to provide the appropriate continuum of services in the hospital's maternity program. As described throughout this CON application, birthing mothers and their infants significantly out-migrate from this community for care. TSHH's Level II NICU is needed to mitigate outmigration and give mothers the opportunity to deliver close to home. This will correspondingly allow the hospital to reduce unnecessary transfers and address any risk factors that may arise for infants who may need intermediate care after birth.

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

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

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

**RESPONSE:**

TriStar Spring Hill ER became operational in February 2013 after many years of widespread community support to bring TriStar Health to Spring Hill. While the vision was initially for a full-service hospital, which was approved twice by the then-HSDA, TriStar Spring Hill ER was implemented as a first phase. The initial plan always envisioned a full-service hospital, including when the freestanding ER was proposed as an alternative given the hospital's opposition at the time.

The high volume at Spring Hill ER has been the result of its ideal location, distance from any other emergency room, and highly regarded reputation for the quality healthcare it provides. TriStar Spring Hill ER is the only 24/7 healthcare facility in the City of Spring Hill. Its historical utilization by zip code for the past five calendar years is presented below in **Exhibit 1N, NICU – 4**.

**Exhibit 1N, NICU - 4**

| | TriStar Spring Hill ER Visits by Zip Code | | | | | 5-Year |
|---|---|---|---|---|---|---|
| Zip Code | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | Total |
| 37174 - Spring Hill | 5,451 | 4,747 | 5,635 | 5,784 | 5,911 | 27,528 |
| 38401 - Columbia | 5,585 | 4,181 | 4,834 | 5,559 | 5,426 | 25,585 |
| 37179 - Thompson's Station | 646 | 503 | 579 | 655 | 638 | 3,021 |
| Subtotal | 11,682 | 9,431 | 11,048 | 11,998 | 11,975 | 56,134 |
| All Other | 3,802 | 3,197 | 3,436 | 3,935 | 3,925 | 18,295 |
| Total | 15,484 | 12,628 | 14,484 | 15,933 | 15,900 | 74,429 |
| | | | | | | |
| | TriStar Spring Hill ER Percent of Total Visits | | | | | 5-Year |
| Zip Code | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | Total |
| 37174 - Spring Hill | 35.2% | 37.6% | 38.9% | 36.3% | 37.2% | 37.0% |
| 38401 - Columbia | 36.1% | 33.1% | 33.4% | 34.9% | 34.1% | 34.4% |
| 37179 - Thompson's Station | 4.2% | 4.0% | 4.0% | 4.1% | 4.0% | 4.1% |
| Subtotal | 75.4% | 74.7% | 76.3% | 75.3% | 75.3% | 75.4% |
| All Other | 24.6% | 25.3% | 23.7% | 24.7% | 24.7% | 24.6% |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

*Source: Internal records, CY 2019 through CY 2023*

Approximately 75 percent of the TriStar Spring Hill ER patients reside in three zip codes: 37174 (Spring Hill), 38401 (Columbia) and 37179 (Thompson's Station). This information, supported by market share analyses, provides factual support for TSHH's Service Area. Moreover, TSHH anticipates treating 75 percent of its inpatients and outpatients from this defined Service Area, with the remaining 25 percent expected to come from outside the Service Area.

Accordingly, the defined Service Area for TSHH is the following three zip codes:

- 37174 – Spring Hill
- 37179 – Thompson's Station
- 38401 – Columbia

Both 37174 and 38401 are assigned by the Census Bureau to Maury County; 37179 is assigned to Williamson County. The Service Area is reasonable and supported by the following facts:

- Individually, the three Service Area zip codes generate the greatest number of emergency department visits at the existing TriStar Spring Hill ER.
- In aggregate, the three Service Area zip codes represent 75 percent of total ER visits at TriStar Spring Hill ER, which is a reasonable and cohesive service area from a health planning perspective.
- Individually, the three Service Area zip codes also generate the greatest number of outpatient visits (imaging, lab, etc.) at the other hospital based ancillary services located at TriStar Spring Hill campus.
- 37174 (Spring Hill) is central to these three zip codes and generates the most ER visits at TriStar Spring Hill ER:
    - TriStar Spring Hill ER has the greatest number of ER visits and patient utilization of any ER in the region for residents of 37174 ranging between 40 and 44 percent of total resident ER visits each year in the past five years. Achieving this level of patient utilization without inpatient services is significant, and it is expected to increase further with a full-service hospital that provides surgery, catheterizations, and other procedures in addition to inpatient services.
- 38401 (Columbia) is to the south of and contiguous to the Spring Hill zip code.
    - TriStar Spring Hill ER accounts for the second greatest number of ER visits and patient utilization of any ER in the region for residents of 38401. During the past five years, between 17 and 18.3 percent of total resident ER visits came from this zip code.
- 37179 (Thompson's Station) is to the north of and contiguous to the Spring Hill zip code.
    - TriStar Spring Hill ER also has the second greatest number of ER visits and patient utilization of any ER in the region for residents of 37179, ranging between 16.3 and 19.4 percent of total resident ER visits each year during the past five years.

In the defined Service Area, MRH is the only acute care hospital in zip code 38401. Given the size of this zip code, that hospital is geographically located more than 14 miles from the proposed TSHH. Travel times from Spring Hill to MRH differ dramatically throughout the day and week based on travel and traffic patterns. It can take up to 45 minutes to travel from Spring Hill to MRH.[3]

The defined Service Area is reasonable for the proposed TSHH including its NICU.

[3] Refer to travel time analysis in **Question 4N** in the CON form.

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

**RESPONSE:**

TSHH will serve equally all patients who present at its facility, as it does with the existing TriStar Spring Hill ER.

TSHH should be afforded special consideration under this provision as it is readily evident that there is limited access to inpatient community hospital services – including maternity and neonatal -- in the proposed Service Area. The City of Spring Hill is the largest city in the State of Tennessee without a hospital. In 2005, the City of Spring Hill only had 17,000 residents when the then-HSDA voted twice to approve a Spring Hill hospital. Today, the City's population is approximately 58,000. Furthermore, per the City of Spring Hill, by 2040 population will exceed 81,000 persons and its UGB web page indicates between 68,000 and 94,000 population in 2029. The analysis throughout this CON Application relies on the current 2024 population and the projected 2029 population. However, City leaders' forecast of 68,000 to 94,000 should not go unnoticed.

Women's health services and birthing locations are not easily accessible from Spring Hill, which is not surprising given the significant population in Spring Hill and the fact that it is the largest city in Tennessee without its own hospital. An excessive number of obstetric patients out-migrate from the Spring Hill community to other areas. Only 16 percent of Spring Hill residents utilize a Maury County hospital to deliver their babies, which means 5 out of 6 obstetric patients leave Maury County for obstetric services. While many of these out-migrating patients travel to WMC, nearly one-third travel even further primarily to Davidson County. Approximately two-thirds of Columbia (38401) residents deliver locally, and one-third out-migrate. Furthermore, nearly one-half of Thompson's Station residents travel to Davidson County. The migration patterns are shown in response to **Attachment 1N, Acute** and **Question 4N** in the CON Form.

To demonstrate how egregious the travel times are for expectant Spring Hill mothers to access hospitals for deliveries, we undertook an analysis of deliveries in the area, including Maury, Williamson, Davidson and surrounding counties. For each zip code in these counties, we analyzed deliveries based on the past three years. 24 of these zip codes had greater than 400 deliveries. For each zip code with 400+ deliveries, we then identified the closest hospital and used google maps to identify the actual travel miles from the zip code to the closest hospital.

The zip codes were arrayed in descending order by travel miles to the closest hospital. Distinguishing Spring Hill from every zip code that met the defining characteristics for analysis, Spring Hill is the furthest distance from the closest hospital with an obstetrics program. For this reason, Spring Hill is listed as the first hospital in the following table.

**Exhibit 1N, NICU - 5**

| Zip Code | CY 2020 | CY 2021 | CY 2022 | % Change, 2020 to 2022 | Closest Hospital | Distance (Miles) | Travel Miles |
|---|---|---|---|---|---|---|---|
| 37174 - Spring Hill | 519 | 594 | 650 | 25.2% | Williamson Medical Center | 16.0 | 10,400 |
| 37072 - Goodlettsville | 322 | 335 | 417 | 29.5% | TriStar Hendersonville Medical Center | 11.6 | 4,837 |
| 37221 - Nashville | 448 | 465 | 449 | 0.2% | TriStar Centennial Medical Center | 11.5 | 5,164 |
| 37209 - Nashville | 579 | 670 | 680 | 17.4% | TriStar Centennial Medical Center | 10.1 | 6,868 |
| 37064 - Franklin | 590 | 595 | 596 | 1.0% | Williamson Medical Center | 9.7 | 5,781 |
| 37130 - Murfreesboro | 685 | 733 | 709 | 3.5% | Ascension St Thomas Rutherford | 9.6 | 6,806 |
| 37122 - Mount Juliet | 636 | 693 | 742 | 16.7% | TriStar Summit Medical Center | 8.7 | 6,455 |
| 37013 - Antioch | 1,493 | 1,564 | 1,673 | 12.1% | TriStar Stonecrest Medical Center | 8.2 | 13,719 |
| 37211 - Nashville | 1,368 | 1,343 | 1,391 | 1.7% | Vanderbilt University Medical Center | 8.1 | 11,267 |
| 37115 - Madison | 520 | 551 | 568 | 9.2% | TriStar Hendersonville Medical Center | 7.9 | 4,487 |
| 37027 - Brentwood | 419 | 435 | 448 | 6.9% | Williamson Medical Center | 7.1 | 3,181 |
| 37217 - Nashville | 511 | 520 | 561 | 9.8% | TriStar Summit Medical Center | 7.0 | 3,927 |
| 37129 - Murfreesboro | 622 | 646 | 709 | 14.0% | Ascension St Thomas Rutherford | 6.8 | 4,821 |
| 37207 - Nashville | 640 | 602 | 612 | -4.4% | Ascension St Thomas Midtown | 6.7 | 4,100 |
| 37206 - Nashville | 459 | 483 | 416 | -9.4% | TriStar Centennial Medical Center | 6.4 | 2,662 |
| 37128 - Murfreesboro | 837 | 872 | 928 | 10.9% | Ascension St Thomas Rutherford | 5.8 | 5,382 |
| 37087 - Lebanon | 602 | 605 | 712 | 18.3% | Vanderbilt Wilson County Hospital | 5.8 | 4,130 |
| 38401 - Columbia | 742 | 744 | 680 | -8.4% | Maury Regional Hospital | 5.7 | 3,876 |
| 37086 - La Vergne | 546 | 587 | 615 | 12.6% | TriStar Stonecrest Medical Center | 5.7 | 3,506 |
| 37076 - Hermitage | 476 | 486 | 542 | 13.9% | TriStar Summit Medical Center | 3.8 | 2,060 |
| 37167 - Smyrna | 816 | 765 | 883 | 8.2% | TriStar Stonecrest Medical Center | 3.4 | 3,002 |
| 37075 - Hendersonville | 693 | 680 | 730 | 5.3% | TriStar Hendersonville Medical Center | 2.6 | 1,898 |
| 37066 - Gallatin | 644 | 695 | 671 | 4.2% | Sumner Regional Medical Center | 2.3 | 1,543 |

*Source: THA Discharges by year and zip code; deliveries only (not total obstetrics).*

*Note: 37160 Shelbyville with 526 deliveries (CY 2022) is excluded from the above table as there is an existing hospital in Shelbyville that chose to discontinue obstetrics services requiring Shelbyville residents to drive 18.5 miles to Vanderbilt Tullahoma Hospital. This access hardship was prompted by the community hospital action which is dissimilar to Spring Hill that has no hospital.*

**Exhibit 1N, NICU – 5** shows that Spring Hill also had the second greatest increase in deliveries in the CY 2020 through CY 2022 period at 25.2 percent. Spring Hill deliveries are expected to continue to increase, which means travel miles will correspondingly continue to increase more than in comparative locations throughout the region.

When computing total travel miles for expectant mothers accessing the 'closest' obstetrics program, Spring Hill had the third highest travel miles of any zip code in the region. Deliveries multiplied by distance for Spring Hill expectant mothers totaled 10,400 miles. If the actual location of where these out-migrating patients had their babies is analyzed, travel miles would be even greater because 55 percent of the deliveries that occurred during this three-year period did not occur at the closest hospital to 37174 (Spring Hill). Rather, residents traveled further distances to other hospitals including Davidson County hospitals, and its TriStar Centennial. There is clear evidence that a hospital with maternity services is needed in Spring Hill.

Since the hospital is needed, it is critical to incorporate a Level II nursery into its obstetrics program. Birthing moms prefer hospitals with available neonatal services in the event of unforeseen circumstances. The comfort of knowing one can deliver in a holistic nurturing environment that can also respond to an emergency is foundational to the TriStar Spring Hill / Diana Health partnership. Having such a resource closer to home is a consumer advantage. Level II nurseries provide care for stable or moderately ill infants born at >32 weeks gestation and weighing >1500 grams who have problems that are expected to resolve

rapidly and are not anticipated to need subspecialty services on an urgent basis. These units also resuscitate and stabilize preterm and/or ill infants before transfer to a facility at which newborn intensive care is provided.

A Level II NICU at TSHH will provide reasonable access to infants in addition to mothers and families. The mother's average length of stay (ALOS) is expected to be 2.35 days. On average, the neonate stays at the hospital five days longer than the mother. In those instances where the mother is already discharged and the child has to stay an additional 5+ days in the NICU, it would be a significant hardship on the mother and family who lives in Spring Hill to travel daily (multiple times per day) to Davidson County.

> *We just had a baby and needed to go all the way to Nashville at Vanderbilt because my wife was being treated at their birthing center and the baby came 3 weeks earlier. We were there for 5 days and my mother-in-law needed it to drive there everyday for almost an hour to help. If we were able to have the baby here in Spring Hill, it would have been easier and less stressful for everyone.*
>
> *Daniel Gomez, Spring Hill Resident*

With the approval of TSHH, travel time for Service Area mothers and families to TSHH rather than a hospital outside the county, will improve access to the benefit of the community.

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

**RESPONSE:**

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

The need for the Level II NICU is demonstrated by the live birth rate and the NICU being an integral component of the full-service maternity program at TSHH. The maternity program at TSHH will be different than existing providers based on the introduction of Diana Health's partnership with TSHH. No program exists in Spring Hill or Maury or Williamson Counties, further distinguishing the TSHH program from other resources. The relationship with Diana Health will form the foundation of TSHH's maternity program and its NICU. Diana Health's care model includes a 24/7 OB hospitalist program and midwifery-led laborist services within an integrated model of care. Having an obstetrician on campus 24/7 assures rapid response in case of emergency, enables the obstetrician to oversee the midwifery service and provides meaningful interaction with staff, patients and families.

Diana Health is a private OB practice that incorporates a full-scope model that brings wellness-focused care that women love together with a clinical redesign on labor and delivery that is delivered through its midwifery-led laborist service. It serves as an extension of the hospital's service line leadership, which sets it apart from other providers through a model that puts women at the center of decision-making and empowers them with the information and support they need to achieve their health and wellness goals.

Through integrated care teams, smart technology and a thoughtfully designed care experience, the proposed TSHH OB program will align incentives across patients and providers and set TSHH's obstetrics service up for sustainability and success. The availability of the OB hospitalist model not only benefits the Diana Health physicians but also community obstetricians who want to engage the OB hospitalists to cover their private practice during nights, weekends, vacations or other absences.

Diana Health's contribution to the TSHH maternity services includes:

- Wellness-Focused Care Program:
  - Full scope women health service
  - Personalized care plans
  - Engaging digital platform
  - Warm, welcoming spaces
- Elevated Experience in Labor & Delivery:
  - Midwifery-led 24/7 coverage model
  - Protocol and workflow adjustments to enable consistent delivery of supportive evidence-based care
- Data-driven Program Management:
  - Clinical leadership and medical direction
  - Structured program to drive continuous quality improvement
  - State-of-the-art technology platform for data collection and management

**A team of compassionate midwives and doctors** who actually have the time to talk though your questions – and to give you the info you need to make empowered choices.

**A dedicated care navigator** available across your full course of care to ensure you get what you need, when you need it.

**Treatment for the whole you,** with mental health therapy, health coaching, classes, and community events, to help you feel grounded, connected, and prepared.

**Convenient care, in your pocket** with a custom app and website that lets you schedule same- or next-day appointments, find educational material and classes, and connect with your providers.

**Birth and delivery the way you want it.** Change your mind? Need a new plan? From "low-intervention" to "I'll take everything" – we listen and deliver. You'll be in the driver's seat, co-creating your care plan with your care team, based on your preferences and goals.

Labor and Delivery at TSHH with the Diana Health team includes the following:

- An early familiarity with the obstetrics unit, including tour and meeting the staff.
- 24/7 support caring team in the hospital 24/7 and will be by a patient's side every step of the way.
- When admitted, a patient's entire Care Team will review the birth plan, and, should plans need to change, work with the patient to make collaborative decisions.

- Each patient will be in a spacious, private room during labor and postpartum, with remote monitoring devices available if you want to move around.
- The program will support a variety of birth choices and pain management options. From nitrous oxide to aromatherapy, to water therapy and calming music, the patient is in complete control of the birthing environment.
- After delivery, the patient will meet virtually with a Care Navigator and the patient's OB or Midwife 24, 48, and 72 hours post-discharge, and will also have access to support groups and classes to get the new mother off to a strong start.
- Patient can access immersion tubs, aromatherapy diffusers, luxurious blankets, swedish bars, rebozo technique, birth stool, birth balls, bassinets that snuggle up to the bed, and plush robes.

Diana Health is currently offered at TriStar StoneCrest Medical Center, Smyrna, Rutherford County.[4] In the two years since establishing the program at TriStar StoneCrest, deliveries have increased from 50 to 60 per month to more than 150 per month. Additionally, the OB hospitalist program has been well received with nearly one-third of Diana Health's obstetricians' monthly deliveries being patients of community obstetricians. Given its unique and holistic approach to maternity care, TriStar StoneCrest proudly serves women from the Spring Hill area who are seeking this unique program that is not offered at the other hospitals in Williamson and Maury Counties. Establishment of the Diana Health program at TSHH will decrease out-migration from the Service Area to Diana Health in Rutherford, birthing centers in Davidson County and other midwifery led programs in Middle Tennessee.

> *We are excited by TriStar Health's plan to bring this type of individualized, holistic maternity and women's healthcare program care to the community of Spring Hill, including the provision of 24/7 professional coverage on L&D. Today, women living in Spring Hill and the nearby city of Columbia have to drive 30 minutes or more to access high-quality maternity care. These communities are home to 7,800 births today and are growing at 3.88% annually.*
>
> *TriStar Spring Hill Hospital will help fill this access gap and provide high-quality, midwifery-led maternity care to countless women.*
>
> *Margaret Buxton CNM, DNP, VP Clinical Operations*
> *Christopher Sizemore DO, FACOG, ABOIM, Medical Director*
> *Diana Health*

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

A unique education program that will be incorporated into TSHH's operations is Rachel's Gift. Rachel's Gift is a non-profit organization that is partnered with TriStar Health which provides the hospital staff with

[4] Diana Health is also at TriStar NorthCrest Medical Center in Robertson County.

training on pregnancy and infant loss. The Rachel's Gift team helps TriStar provide resources to support grieving moms processing the loss of their baby, which is an amazing benefit to patients. TriStar StoneCrest participates in this program and the plan is to incorporate this program at TSHH.

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

In addition, TSHH will maintain both current NRP and S.T.A.B.L.E. provider status. Required ancillary services will also be maintained, including routine laboratory services, 24/7 laboratory services and blood bank services. Consultation and transfer services will also be properly maintained.

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

TSHH anticipates that most infants requiring transfer will be transferred to TriStar Centennial utilizing TriStar Centennial's experienced transport team. TriStar Centennial has an active neonatal transport program dating back to 1988. It currently transports approximately 220 neonates each year, with 30-minute mobilizations. The TriStar Centennial NICU transport program staff includes 23 neonatal nurse practitioners, 25 neonatal RNs and 17 neonatal respiratory therapists. Approximately 80 percent of transports are via ground and 20 percent via air (SkyLife). When a neonate is being transported by ground, a neonatal nurse practitioner, RN and respiratory therapist travel in the ambulance with the EMTs. When being transported by air, in addition to these three personnel, a SkyLife native crew member (flight nurse or flight paramedic) accompanies the team with a pilot. All NICU transport personnel undergo initial training to familiarize themselves with equipment and procedures specific to the transport environment. Those involved in NICU transport via air also undergo initial and annual training specific to the aviation environment. TriStar Centennial has three isolettes dedicated to transport, two are configured for ground transport, and one is configured for air. The IV pumps are also specific to the transport environment. Soft supplies and smaller equipment are configured and standardized in EMS-style bags for use in air and ground transport environments. TriStar Centennial's policy for Neonatal Transport Arrangements is provided in **Attachment 1N-1, NICU.**

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

**RESPONSE:**

**Exhibit 1N, NICU - 6[5]**

| Facility | County | 2022 Licensed Neonatal Beds | Bed Days Available | Patient Days | | | Licensed Occupancy | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 |
| Maury Regional Hospital | Maury | 9 | 3,285 | 1,846 | 1,601 | 1,467 | 56% | 49% | 45% |
| Williamson Medical Ctr | Williamson | 8 | 2,920 | 149 | 105 | 82 | 5% | 4% | 3% |
| **Total** | | **17** | 6,205 | **1,995** | **1,706** | **1,549** | 32% | 27% | 25% |

*Source: Joint Annual Reports for Hospitals*

A Level II NICU is an important feature in the continuum of care for mothers and neonates. In fact, each hospital in this two-county area has a Level II program. A Level II NICU is essentially the standard of care for residents of these counties, whether birthing locally or out-migrating. Achieving the NICU occupancy standard of 80 percent is not as critical in the development of a new access point in a large community. The standard of care at the existing obstetrics programs in Maury and Williamson County includes the availability of a Level II NICU. This standard is expected by families in the community and should take priority over an occupancy metric.

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

**RESPONSE:**

TriStar Health and all its resources stand behind the implementation and licensure of TSHH. See **Attachment 1N - 6, Acute** for the commitment letter signed by Wes Fountain, CFO TriStar Division, committing to develop and maintain the facility resources, equipment and staffing. Use this link to access HCA Healthcare's most recent Annual Report:

https://investor.hcahealthcare.com/financials/annual-reports/default.aspx

The Level II NICU at TSHH will comply with the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities. The proposed hospital will provide care for stable or moderately ill infants born at >32 weeks gestation and weighing >1500 grams who have problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. Its unit will resuscitate and stabilize preterm and/or ill infants before transfer to a facility at which newborn intensive care is provided. It will also provide mechanical ventilation for brief (<24 hrs) duration or continuous positive airway pressure, or both, until the infant's condition improves, or the infant can be transferred to a higher-level facility.[6] In addition, the unit is available to provide care for infants who are convalescing after intensive care.

[5] The extremely low utilization of the WMC NICU suggests this program focuses on well-baby deliveries, which may be a contributing factor as to high out-migration from Williamson County.

[6] American Academy of Pediatrics Levels of Neonatal Care, 2012

Adequate Staffing

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

Physicians

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

Nurses:

- Nurse Manager: The nurse manager (R.N.) will be responsible for all nursing activities in the nurseries. The nurse manager will have completed the Level II neonatal courses prescribed for staff nurses in the most recent edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, Level II, published by the Tennessee Department of Health.
- All staff nurses (R.N.) will be skilled in the observation and treatment of sick infants. They will have completed the Level II neonatal course for nurses outlined in the most recent edition of the Tennessee Perinatal Care System Educational Objectives for Nurses, published by the Tennessee

Department of Health. Nurses will maintain unit-specific competencies. In addition, all nurses will be current NRP and S.T.A.B.L.E. providers.[7],[8]

- Recommended nurse ratios will be maintained.

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

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

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

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

Adequate Facilities

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

- A platform scale, preferably with metric indicators.
- A controlled source of continuous and/or intermittent suction.
- Incubators and/or radiant warmers for adequate thermal support.
- Equipment for determination of blood glucose at the bedside.
- Ability to provide intensive phototherapy.
- A device for the external measurement of blood pressure from the infant's arm or thigh.
- Oxygen flow meters, tubing, binasal cannulas for short-term administration of oxygen.
- A headbox assembly (oxygen hood), an oxygen blending device, and warming nebulizer for short-term administration of oxygen.
- An oxygen analyzer that displays the ambient concentration of oxygen.

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

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

- A newborn pulse oximeter for non-invasive blood oxygen monitoring.
- An infusion pump that can deliver appropriate volumes of continuous fluids and/or medications for newborns.
- A fully equipped neonatal resuscitation cart.
- Positive pressure ventilation equipment and masks; endotracheal tubes in all the appropriate sizes for neonates.
- A laryngoscope with premature and infant size blades.
- A CO2 detector.
- Laryngeal mask airway (LMA, size 1)

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

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

TSHH's letter documenting its full commitment to develop and maintain the facility resources, equipment, and staffing to provide a continuum of neonatal nursery services is included in **Attachment 1N, Acute.**

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

**RESPONSE:**

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

Incorporating the Level II program within the obstetrics continuum of care will enable expectant mothers to deliver locally without concern for risk factors associated with birthing an infant who may require intermediate care. The Pediatrix neonatology group will cover the Level II NICU 24/7. This is the same group that covers the NICUs at other TriStar Health hospitals throughout Middle Tennessee, including the 5-star TriStar Centennial NICU that is comprised of 60 beds (intermediate and intensive care beds). TriStar Centennial also has neonatal consulting subspecialists who will be available as a resource for the neonatologists practicing in Spring Hill. Additionally, Pediatrix and Diana Health work collaboratively at TriStar StoneCrest for the health and welfare of both mom and baby. This same collaboration will be developed at TSHH.

The Perinatal Advisory Committee's mission[9] is to assist the Department of Health in its oversight of perinatal and neonatal care, including regional development, expansion and maintenance of newborn centers, development of systems of rapid transportation and referral to obstetrics and newborn centers, development of educational programs, and assist in regional development, expansion, and maintenance of specialty level II birthing centers in every health region with certified obstetricians and pediatricians available who are trained in the prevention, early diagnoses, treatment, and stabilization of complications of pregnancy and childbirth.

Spring Hill is the largest city in Tennessee without a hospital. The need for a full-service hospital including an active obstetrics program has been demonstrated. Since Level II programs operate in conjunction with obstetrics programs, the proposed Level II NICU should be approved. Establishing a TSHH Level II NICU meets the mission of the Perinatal Advisory Committee as it will be an additional program and access point for obstetricians and pediatricians who are trained in prevention, early diagnoses, treatment, and stabilization of complications of pregnancy and childbirth. It will be engaged with TriStar Centennial which operates a Level III NICU and neonatal transport team.[10] TSHH also plans to participate in the Tennessee Initiative for Perinatal Quality Care as do other TriStar Health affiliates in Middle Tennessee.

9. **An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. The applicant shall comply with the staffing guidelines and qualifications set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities.**

**RESPONSE:**

HCA Healthcare is the largest private employer in Williamson County with more than 2,300 employees residing in Williamson County and more than 450 employees residing in Maury County. Approximately 1,000 of these employees are in direct patient care positions at TriStar Health facilities.

The TSHH campus operates a freestanding emergency department, imaging services, lab services, GI suite and physician offices for independent physicians and affiliated physicians. There are currently 45 FTEs at TriStar Spring Hill ER. Accordingly, TSHH has a significant foundation of staff upon which it will build its employee and physician base to appropriately staff the proposed hospital.

Based on forecasted utilization, TSHH estimates a need for 283 FTEs in its initial year of operation. 2,750 HCA Healthcare employees currently reside in Maury and Williamson Counties, and approximately 1,000 of these employees are in direct care positions. Due to the existing FTE complement at the TSHH campus and the significant number of HCA Healthcare employees residing in Maury and Williamson Counties, TSHH is confident that it will successfully recruit necessary staff to safely and successfully operate.

Additionally, more than 600 TriStar Health providers reside in Maury and Williamson County, and 39 currently reside in the Service Area. TSHH will capitalize on the presence of these providers as it develops its medical staff plan for its future operations.

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

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

TriStar Health and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. In 2021, HCA Healthcare opened the Galen College of Nursing in Nashville, which now has campuses and programs in Tennessee, Kentucky, Ohio, Virginia, South Carolina, Florida and Texas. The Nashville campus offers a 3-year Bachelor of Science in Nursing, an Associate Degree in Nursing (ADN) and an LPN to ADN Bridge program. In its first couple of years of operation, the Galen College of Nursing graduated 45 nurses in 2023. Today, it currently enrolls 700 new students every year. Enrollment is expected to increase by approximately 5-10 percent each year. By 2025, the Galen College of Nursing expects around 250 annual graduates. Notably, 55 percent of the Galen College of Nursing graduates join an HCA hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Health including recruitment for the proposed TSHH.

The Thomas F. Frist, Jr. College of Medicine at Belmont University in Nashville, is a new medical school founded in alliance with HCA Healthcare to focus on training diverse physician leaders who embrace and value a whole-person approach to healing. The Thomas F. Frist, Jr. College of Medicine at Belmont University will be housed in a new building that had its ribbon cutting on April 29, 2024.[11] The nearly 200,000-square-foot building is located within a block of Belmont's Gordon E. Inman Center and McWhorter Hall, which house the University's well-known nursing, physical therapy, occupational therapy, social work and pharmacy programs. The College of Medicine has recruited a leadership team consisting of experts from across the country and is currently recruiting clinical faculty. The College also recently announced that it has achieved accrediting "candidate status" from the LCME accrediting body. Its first class is expected to commence fall 2024.

In Middle Tennessee, TriStar Health is integrally involved in graduate medical education (GME). It currently has 59 residents, with 31 at TriStar Centennial (internal medicine, psychiatry, and transitional year), 20 at TriStar Skyline (emergency medicine, neurology and physical medicine and rehabilitation) and 8 family medicine residents at TriStar Southern Hills. HCA Healthcare has more than 1,850 residents at its hospitals, making it one of the largest GME providers in the country. TriStar Health and HCA Healthcare look forward to working collaboratively with Belmont to support the supply of healthcare professionals entering and staying in the profession and to ensure that they have access to training.

In addition to these programs for nurses and physicians, TriStar is extensively engaged with other educational and training programs throughout Middle Tennessee. These relationships provide for internships and other training opportunities for students at TriStar facilities and also provide a pipeline for future qualified employees. Exhibit 68 in the CON Form provides a summary of programs that currently work with TriStar and the profession for which the students are matriculating and training.

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

[11] https://www.nashvillepost.com/business/health_care/belmont-opens-180m-medical-school-building/article_747f28e8-065e-11ef-a805-972db9b9e527.html

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

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

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

**RESPONSE:**

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

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

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

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

**RESPONSE:**

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

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

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

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

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

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

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

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

12. **Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of NICU usage.**

**RESPONSE:**

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

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

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

- **March of Dimes**
  - March of Dimes works to improve the health of all moms and babies. One of their goals is to end pre-term labor, which helps decrease NICU admissions.
  - HCA and TriStar provide monetary donations and participate in community events (i.e. March for Babies) to help fund research and provide patient support.
    - Most recently, we had a group of corporate, division and hospital employees attend the March for Babies event in Nashville on 4/13/24. At the event, we were able to hand out informational pamphlets about the services we offer at our Centennial Women's and Children's Hospital.
- **Rachel's Gift**
  - Infant loss and bereavement support *(see attached PowerPoint).*
  - Through educational courses and resources provided by Rachel's Gift, our partner hospitals are equipped to provide appropriate and compassionate care for moms who experience miscarriage, still-born birth and infant loss while in our care. The Rachel's Gift team also provides patients access to contiguous support beyond their hospital stay.
- **Dolly Parton's Imagination Library**
  - Offer sign-up sheets for Dolly's Imagination Library to parents. Once registered, the baby receives a book from Dolly every month until they are 5 years old.

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

**RESPONSE:**

TSHH agrees to provide the Department of Health and/or the Health Facilities Commission with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested.

14. **Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system.**

**RESPONSE:**

TSHH is a new hospital and therefore has no operational history. However, its existing TriStar Spring Hill ER is part of TriStar Centennial. It is not only Joint Commission accredited, but also the only 5-Star CMS hospital in the Nashville area. The quality and performance evident at the TriStar Spring Hill ER will convert to the proposed hospital upon licensure as described below.

TSHH will participate in data reporting, quality improvement and outcome and process monitoring consistent with all TriStar Health facilities. As a future hospital in the TriStar Health organization, TSHH will adopt the TriStar Health methods to ensure and maintain quality of care. This includes a collaborative

multidisciplinary team approach, which considers the unique knowledge, judgment, and skills of a variety of disciplines in achieving desired patient outcomes, serving as a foundation for quality.

TSHH will be committed to providing a seamless continuum of health care both for individuals including neonates and for the community, linking together a full range of health care providers and services. TSHH's goal will be to provide services which are measurably more accessible, affordable, and which are improving in quality on a continuous basis. The continuum of services may begin prior to admission, such as in an ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

TSHH will adhere to TriStar Health's plan for improving organizational performance, including planned performance assessment and improvement activities, initiating activities designed to follow-up on unusual occurrences or specific concerns/issues, which may include following policies and procedures for ensuring staff competency and follow-up as appropriate on patient/family complaints and patient questionnaire results. Input and feedback from patients, staff and physicians will guide the improvement process. TSHH will address methods to ensure and maintain patients' quality of care.

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

TSHH will be dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. It will maintain the highest standards and quality of care. It will provide a robust Quality Assurance and Performance Improvement ("QAPI") Plan framed by the following essential elements:

- Design and Scope that encompasses the full range of services and departments;
- Governance and Leadership that actively engage with system expectations and priorities;
- Feedback, Data Systems, and Monitoring to continuously assess a wide range of care and service;
- Performance Improvement Projects to improve care or services based on the data captured; and
- Systematic Analysis and Systematic Action to create real impact and long-lasting improvement.

Further, TSHH will provide a robust Utilization Review ("UR") program that provides ongoing concurrent reviews of patient care to determine whether treatments are medically necessary and, if not, to assist in placing patients in more appropriate care settings. Internal case management will play an important advisory purpose in enhancing and maintaining the quality of care provided. Systems will be in place to conduct prospective, concurrent, and retrospective utilization reviews to ensure quality of care and protect revenue integrity. For more details, see **Attachment 5C** for TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence.

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

**RESPONSE:**

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

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

Additionally, TriStar Hendersonville Medical Center and TriStar Summit Medical Center participate with TIPQC in its education and resources.

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

# 1N

# Cardiac Catheterization Standards and Criteria

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

**RESPONSE:**

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

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

**RESPONSE:**

TSHH is a new hospital and therefore has no operational history. However, its existing TriStar Spring Hill ER is part of TriStar Centennial. TriStar Centennial is not only Joint Commission accredited, but it is also the only 5-Star CMS hospital in the Nashville area. The quality and performance evident at the Spring Hill ER will convert to the proposed hospital upon licensure. TSHH will be licensed by the Department of Health and seek accreditation by The Joint Commission.

In addition, TSHH will seek certification or accreditation to be a STEMI receiving facility. TriStar Centennial is Chest Pain Certified by The Joint Commission, and TSHH will pursue similar certification from The Joint Commission.

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

**RESPONSE:**

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

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

- Notify the nursing supervisor;
- Report to the staff at the receiving facility, which should include: patient name, reason for transfer, vital signs, meds administered, ETA, admitting physician and necessary equipment that should be available, including support devices i.e. IABP/ IMPELLA;
- Prepare Cardiac Cath images and documentation to be transported with patient;
- Ensure the EMTALA transfer form is completed for all Observation and ER patients; and
- Ensure a copy of the EMTALA sheet is retained at the facility and a copy sent to the receiving facility.

- Procedure for cardiologist: The cardiologist should contact physician at the receiving facility, and fill out the physician part of the EMTALA form.
- Procedure for nursing supervisor: The nursing supervisor should:
  - Ensure the medical records are copied.
  - Notify ER to direct ambulance to CCL.
  - Explain the transfer process to the patient's family.
  - Ensure EMTALA form is completed.
- Transporting the Patient: The patient will be accompanied by an Advanced Cardiovascular Life Support ("ACLS") certified RN, or ALS crew if transport by private ambulance services, under the direction of the referring cardiologist. During transport, the patient will be reassessed continuously to ensure all equipment (i.e., IABP) is functioning properly. If necessary, the cardiologist will accompany the patient. In addition, the accompanying individual will be responsible for ensuring the entire patient record accompanies the patient to the receiving facility.

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

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

**RESPONSE:**

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

TSHH will be committed to providing a seamless continuum of health care both for individuals and for the community, linking together a full range of health care providers and services. TSHH's goal will be to provide services which are measurably more accessible, affordable, and focused on continuous quality improvement. The continuum of services may begin prior to admission, such as in an ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

Within this context, TSHH will adhere to TriStar Health's plan for improving organizational performance, including planned performance assessment and improvement activities, initiating activities designed to

follow-up on unusual occurrences or specific concerns/ issues, which may include following policies and procedures for ensuring staff competency and follow-up as appropriate on patient/family complaints and patient questionnaire results. Input and feedback from patients, staff and physicians will guide the improvement process. TSHH will address methods to ensure and maintain patients' quality of care. The proposed cardiac catheterization program will be incorporated into the overall quality plan summarized above and discussed in Question 5C of the CON Form.

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

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

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

**RESPONSE:**

TSHH agrees to provide the Department of Health and/or the Health Facilities Commission with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested.

6. **Clinical and Physical Environment Guidelines: Applicants should agree to document ongoing compliance with the latest clinical guidelines of the American College of Cardiology/Society for Cardiac Angiography and Interventions Clinical Expert Consensus Document on Cardiac Catheterization Laboratory Standards (ACC Guidelines). As of the adoption of these Standards and Criteria, the latest version (2001) may be found online at:**
   **http://www.acc.org/qualityandscience/clinical/consensus/angiography/dirIndex.html**
   **Where providers are not in compliance, they should maintain appropriate documentation stating the reasons for noncompliance and the steps the provider is taking to ensure quality. These guidelines include, but are not limited to, physical facility requirements, staffing, training, quality assurance, patient safety, screening patients for appropriate settings, and linkages with supporting emergency services.**

**RESPONSE:**

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

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

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

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

**RESPONSE:**

Currently practicing within the TriStar Spring Hill campus are three cardiology providers who are affiliated with Centennial Heart Cardiovascular Consultants ("Centennial Heart"). This physician group includes 45 non-invasive cardiologists, invasive cardiologists, interventional cardiologists and cardiac surgeons, most of whom are located in Middle Tennessee including Maury and Williamson Counties. Centennial Heart will be partnered with TSHH to oversee and provide the cardiologists to staff the proposed catheterization laboratory at TSHH. The expertise of Centennial Heart is widely recognized as they currently work throughout Middle Tennessee including at one of the busiest and most robust cardiology programs, TriStar Centennial which has 9 catheterization labs with approximately 7,000 catheterizations performed annually and 5 open heart surgery suites with 1,265 surgeries performed annually.[1]

Centennial Heart is engaged in the planning for TSHH's proposed cardiac catheterization program.

> *On behalf of Centennial Heart, I offer my full support for TriStar Spring Hill Hospital. We plan to design the most modern and advanced cardiac catheterization lab at this facility and help to staff it with our Centennial Heart physicians. This facility will certainly be high-quality and will benefit residents of the Spring Hill area by providing unprecedented access to care right in their own community.*
>
> *Thomas McRae, III, M.D., Centennial Heart Cardiovascular Consultants*

The plan for TSHH includes non-invasive cardiologists, invasive cardiologists, interventional cardiologists including EP physicians, and heart failure physician specialists supported by their extenders. Interventional cardiologists will staff the cardiac catheterization lab, while being supported by advance practice providers. In addition, TSHH and Centennial Heart will coordinate with TriStar Centennial for staffing and recruitment of additional providers as needed.

Current Centennial Heart physicians named at this early stage to be practicing at TSHH include Jeffrey Webber, MD and John Riddick, MD. An advanced practice provider will be selected to work with these

[1] 2023 volume per internal records, to be included in 2023 JAR.

physicians. In addition to those at TSHH, other Centennial Heart providers may be rotated among other TriStar Health hospitals and TSHH to provide for continuity and collaboration of cardiac catheterization services amongst the practitioners and hospitals.

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

**Exhibit 1N, Cardiac Cath – 1**
**Cardiac Diagnostic, Testing & Procedures Proposed for TriStar Spring Hill Hospital**

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

As the largest private employer in Williamson County, HCA Healthcare has approximately 2,300 employees residing in Williamson County and more than 450 employees residing in Maury County. The cardiac catheterization lab non-physician staff will be recruited through the TriStar Health network based on its current recruitment methods. Given its ability to staff its quality cardiac programs throughout Middle Tennessee, including at the only 5-star CMS rated hospital in the Nashville area, it is confident it will successfully recruit qualified personnel to staff the TSHH cardiac catheterization program.

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

**RESPONSE:**

TSHH's Service Area is defined by three zip codes: 37174 (Spring Hill), 38401 (Columbia), and 37179 (Thompson's Station). The City of Spring Hill has no hospital and therefore no cardiac catheterization laboratories. In this defined 3-zip code Service Area, there is 1 hospital – MRH – which operates two cardiac catheterization laboratories. The 3-zip code service area straddles 2 counties; there is another hospital located in the other county in which the Service Area sits: WMC.

MRH operates at greater than 70 percent capacity as reflected in the below exhibit. In fact, it operates at greater than 96 percent capacity and 137 percent of optimal utilization.[2]

**Exhibit 1N, Cardiac Cath – 2**
**Maury Regional Hospital Utilization, 2022**

| Procedure Type | Setting | Procedure Weight | # Labs | # Cases | Weighted Cases (Adult) | Pediatric | Weighted Cases (Pediatric) | Total Cases | Total Weighted Cases | Weighted Cases Per Lab | Utilization per 2,000 Cases (Full Capacity) | Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Diagnostic Cardiac Catheterization | Inpatient | 1.0 | 2 | 575 | 575 | 0 | 0 | 575 | 575 | 287.5 | | |
| | Outpatient | 1.0 | 2 | 640 | 640 | 0 | 0 | 640 | 640 | 320 | | |
| Therapeutic Cardiac Catheterization | Inpatient | 2.0 | 2 | 146 | 292 | 0 | 0 | 146 | 292 | 146 | | |
| | Outpatient | 2.0 | 2 | 100 | 200 | 0 | 0 | 100 | 200 | 100 | | |
| Diagnotic EP | Inpatient | 2.0 | 2 | 46 | 92 | 0 | 0 | 46 | 92 | 46 | | |
| | Outpatient | 2.0 | 2 | 87 | 174 | 0 | 0 | 87 | 174 | 87 | | |
| Therapeutic EP | Inpatient | 4.0 | 2 | 62 | 248 | 0 | 0 | 62 | 248 | 124 | | |
| | Outpatient | 4.0 | 2 | 97 | 388 | 0 | 0 | 97 | 388 | 194 | | |
| Diagnostic Peripheral Vascular | Inpatient | 1.5 | 2 | 97 | 146 | 0 | 0 | 97 | 146 | 72.75 | | |
| | Outpatient | 1.5 | 2 | 11 | 17 | 0 | 0 | 11 | 17 | 8.25 | | |
| Therapeutic Peripheral Vascular | Inpatient | 3.0 | 2 | 168 | 504 | 0 | 0 | 168 | 504 | 252 | | |
| | Outpatient | 3.0 | 2 | 18 | 54 | 0 | 0 | 18 | 54 | 27 | | |
| Thrombolytic Therapy | Inpatient | 3.0 | 2 | 146 | 438 | 0 | 0 | 146 | 438 | 219 | | |
| | Outpatient | 3.0 | 2 | 29 | 87 | 0 | 0 | 29 | 87 | 43.5 | | |
| Total | | | 2 | 2,222 | 3,854 | 0 | 0 | 2,222 | 3,854 | 1,927 | 96.35% | 137.64% |

*Source: Maury Regional JARs, 2022 and Cardiac Catheterization Standards and Criteria Weighting Table*

In addition to a single year period, the MRH cardiac catheterization utilization is provided below for the most recent three JAR years, years 2020 through 2022, as reported in its Joint Annual Reports. The following table provides a summary from the above chart with the first line providing the 2022 information, and the second line providing the average of the most recent three-year period. As shown below, MRH has been operating well above capacity for at least the past three years.

**Exhibit 1N, Cardiac Cath – 3**
**Maury Regional Hospital Utilization, 2022 and 3-Year Average (2020 – 2022)**

| Time Period | # Cath Labs | Avg. Weighted Diagnostic Catheterizations | Diagnostic Catheterizations per Lab | Avg. Weighted Therapeutic Catheterizations | Therapeutic Catheterizations per Lab | Avg. Weighted Diagnostic and Therapeutic Catheterizations | Utilization per 2,000 Cases (Full Capacity) | Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity) |
|---|---|---|---|---|---|---|---|---|
| 2022 Year | **2** | 1,643 | 822 | 2,211 | 1,106 | **3,854** | **96.35%** | **137.64%** |
| 2020 - 2022 3-Year Average | **2** | 1,640 | 820 | 2,084 | 1,042 | **3,724** | **93.11%** | **133.01%** |

Source: Tennessee Department of Health - Office of Informatics and Analytics. https://www.tn.gov/content/tn/health/health-program-areas/statistics.html

*Note: The HDDS report generated by the Department of Health provide 2019-2021 and appeared to be missing all catheterizations as counts did not comport with the JARS for each hospital. This table utilizes most recent three years JARS data (2020-2022) and applies the weighting factors by type of procedure.*

[2] While TSHH is not located in Williamson County, there is additional cardiac catheterization service available at WMC in Williamson County. WMC weighted utilization for 2022, 2020 through 2022 and its combination with MRH is provided on Exhibit 1N, Cardiac Cath – 15, page 16 of this 1N, Cardiac Catheterization Services.

Based on the stated 2022 capacity – and the three-year average 2020 through 2022 – as presented above, there is need for additional cardiac catheterization services as proposed by TSHH. Locating the additional capacity in the City of Spring Hill will improve access for Service Area residents as demonstrated throughout this CON Application.

Despite not being located within the proposed Service Area, the above charts with Williamson Medical Center utilization data are included on **Exhibit 1N, Cardiac Cath – 15**, on page 16 of this 1N.

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

   **Need. The projected need for a service will be demonstrated through need-based epidemiological evidence of the incidence and prevalence of conditions for which diagnostic and/or therapeutic catheterization is appropriate within the proposed service area.**
   **Demand. The projected demand for the service shall be determined by the following formula:**
   **A. Multiply the age group-specific historical state utilization rate by the number of residents in each age category for each county included in the proposed service area to produce the projected demand for each age category;**
   **B. Add each age group's projected demand to determine the total projected demand for cardiac catheterization procedures for the entire proposed service area.**

**RESPONSE:**

No hospital, and accordingly no cardiac catheterization laboratories, exist in the City of Spring Hill. The degree of heart muscle damage from a heart attack is associated with how long it takes from when heart attack symptoms start to when patients receive an artery-clearing procedure called percutaneous coronary intervention ("PCI"). The longer the time before PCI, called "symptom-to-balloon time", the more significant and damaging the heart attack. Symptom-to-balloon time directly correlates with the amount of time the myocardium/heart muscle undergoes inadequate blood supply. Shorter symptom-to-balloon times for individual patients is also associated with lower mortality at 30-days and at 1 year. Accordingly, reducing such time should reduce the degree of damage and ultimately improve patient outcomes.

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

Per the travel times presented in response to Question 4N in the CON Form, time to reach hospitals outside the City of Spring Hill requires between 14 to 45 minutes of additional travel time than accessing TSHH. The availability of TSHH and its proposed catheterization laboratories in Spring Hill would save these patients up to 45 minutes in the symptom-to-balloon time. Time is muscle, and these minutes could be critical in patient outcomes.

MRH is in Maury County. While MRH has two catheterization laboratories, the MRH program operates at 137 percent of optimal capacity dictating need for additional cardiac catheterization services in Maury

County. Regarding MRH patient origin, less than 3 in 10 of its cardiac catheterization patients are Maury County residents as shown below.

**Exhibit 1N, Cardiac Cath – 4**

| Maury Regional Hospital - Cardiac Cath Patient Origin | | | |
|---|---|---|---|
| **Patient Residence** | **2019** | **2020** | **2021** |
| Maury County | 564 | 517 | 642 |
| Total MRH from JARs | 3,987 | 2,238 | 2,223 |
| % Maury County | 14.1% | 23.1% | 28.9% |

*Source: Maury County totals from TDOH Data Request 26250625 and 26250626; total from hospital's JARs for respective year. Note the 2019 JARs appears to have two erroneous entries radically changing the total: 1,053 therapeutic EP which is likely 105 based on trend in this procedure and 1,371 diagnostic peripheral vascular which is likely 13 based on its trend. That would adjust total to 1,682 of which Maury County residents would comprise one-third.*

MRH's high capacity likely contributes to the low number of services for Maury County residents and the out-migration to access needed healthcare services detailed throughout this CON Application. Maury County's out-migration for cardiac catheterization services occurs at similar rates to the overall hospital migration, with more than half of Maury County resident inpatient and outpatient catheterizations being performed outside Maury County as shown in the next table.

**Exhibit 1N, Cardiac Cath – 5**

| Inpatient and Outpatient Cardiac Catheterization | | | | | | |
|---|---|---|---|---|---|---|
| | **CY 2020** | **CY 2021** | **CY 2022** | **CY 2020** | **CY 2021** | **CY 2022** |
| **Maury County Residents** | | | | | | |
| Number of Patients Who Out-Migrated | 948 | 1,109 | 982 | 54.5% | 54.2% | Masked |
| Number of Patients to TriStar Centennial | 223 | 247 | Masked | 12.8% | 12.1% | |
| Number of Patients to Tristar Other | 7 | 16 | | 0.4% | 0.8% | |
| Out-Migration to Other Providers | 718 | 846 | | 41.3% | 41.3% | |
| *Total and Percent of Out-Migration to TriStar* | 230 | 263 | 223 | 24.3% | 23.7% | 22.7% |

*Source: THA data for the respective years.*

An average of 1,000 Maury County residents each year out-migrate from Maury County. This confirms the lack of access in Maury County, which is likely compounded by the high utilization at MRH. Approximately 23 percent of those out-migrating out of the county have their catheterizations at TriStar Health facilities. This percentage not only exceeds the overall Maury County hospital out-migration but also indicative of the level of Maury County resident support for TriStar Health and its physician group, Centennial Heart which will staff the TSHH's cardiac catheterization laboratories.

While not in the proposed hospital county, WMC in Williamson County also has catheterization laboratories. WMC operates at 39 percent as shown on **Exhibit 1N, Cardiac Cath – 15** on page 16. Williamson County's out-migration far exceeds that of Maury County residents with approximately 70 percent of Williamson County residents seeking these cardiac services outside the county, primarily in Davidson County.

**Exhibit 1N, Cardiac Cath – 6**

| Inpatient and Outpatient Cardiac Catheterization | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2020 | CY 2021 | CY 2022 | CY 2020 | CY 2021 | CY 2022 |
| **Williamson County Residents** | | | | | | |
| Number of Patients Who Out-Migrated | 1,765 | 1,874 | 2,051 | 72.2% | 67.4% | Masked |
| Number of Patients to TriStar Centennial | 363 | 377 | Masked | 14.8% | 13.6% | |
| Number of Patients to Tristar Other | 106 | 136 | | 4.3% | 4.9% | |
| Out-Migration to Other Providers | 1,296 | 1,361 | | 53.0% | 48.9% | |
| *Total and Percent of Out-Migration to TriStar* | 469 | 513 | 486 | *26.6%* | *27.4%* | *23.7%* |

*Source: THA data for the respective years.*

More than 2,000 patients out-migrated from Williamson County during the past year. This is likely compounded by the fact that to date WMC did not perform any advanced procedures in its catheterization laboratories including peripheral vascular, EP or thrombolysis. Approximately 1 in 4 out-migrating Williamson County residents have their catheterizations at TriStar Health facilities.

In terms of the 3-zip code Service Area, out-migration parallels that of Maury County, with significant out-migration occurring from each zip code. Nearly 60 percent of 37174 (Spring Hill) residents leave both Maury and Williamson Counties; when just considering these Spring Hill residents leaving Maury County, more than 85 percent leave the County. 34 to 39 percent of 38401 (Columbia) residents leave Maury County, and approximately 55 percent of 37179 (Thompson's Station) residents leave Williamson County. This migration is presented in the following table.

**Exhibit 1N, Cardiac Cath – 7**

| Inpatient and Outpatient Cardiac Catheterization | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2020 | CY 2021 | CY 2022 | CY 2020 | CY 2021 | CY 2022 |
| **Spring Hill - 37174** | | | | | | |
| Number of Patients Who Out-Migrated from Maur | 372 | 478 | Masked | 94.7% | 87.4% | Masked |
| Number of Patients Who Out-Migrated from Maury and Williamson Counties *(see note)* | 232 | 320 | | 59.0% | 58.5% | |
| Number of Patients to TriStar Centennial | 96 | 95 | | 24.4% | 17.4% | |
| Number of Patients to Tristar Other | 17 | 33 | | 4.3% | 6.0% | |
| Out-Migration to Other Providers | 119 | 192 | | 30.3% | 35.1% | |
| *Percent of Out-Migration to TriStar* | 113 | 128 | 132 | *48.7%* | *40.0%* | *46.5%* |
| **Columbia - 38401** | | | | | | |
| Number of Patients Who Out-Migrated | 455 | 487 | Masked | 46.2% | 42.9% | Masked |
| Number of Patients to TriStar Centennial | 66 | 100 | | 6.7% | 8.8% | |
| Number of Patients to Tristar Other | 6 | 4 | | 0.6% | 0.4% | |
| Out-Migration to Other Providers | 383 | 383 | | 38.9% | 33.8% | |
| *Percent of Out-Migration to TriStar* | 72 | 104 | 74 | *15.8%* | *21.4%* | *17.3%* |
| **Thompson's Station - 37179** | | | | | | |
| Number of Patients Who Out-Migrated | 86 | 97 | Masked | 62.3% | 61.8% | Masked |
| Number of Patients to TriStar Centennial | 20 | 7 | | 14.5% | 4.5% | |
| Number of Patients to Tristar Other | 0 | 3 | | 0.0% | 1.9% | |
| Out-Migration to Other Providers | 66 | 87 | | 47.8% | 55.4% | |
| *Percent of Out-Migration to TriStar* | 20 | 10 | 22 | *23.3%* | *10.3%* | *18.0%* |

*Note: More than 80 percent of Spring Hill 37174 patients out-migrate from Maury County; given this zip code traverses the county line, net out-migration is from both Maury and Williamson Counties*

*Source: THA data for the respective years.*

Nearly half of the 37174 (Spring Hill) patients who out-migrate have their cardiac catheterizations performed at TriStar Health facilities. And 16 to 21 percent of those out-migrating from 38401 (Columbia) and 10 to 23 percent of those from 37179 (Thompson's Station) are similarly treated at TriStar Health. TSHH proposes to implement two cardiac catheterization laboratories at the hospital to meet the current and expected increasing needs of Service Area residents. This will improve access for Service Area residents and reduce the current high level of out-migration.

This criterion indicates applying the State Utilization rates to the Service Area if there are no existing cardiac catheterization programs in the Service Area. The State Utilization Rates provided by TDOH are provided in the following table.

**Exhibit 1N, Cardiac Cath -8**

**Cardiac Cath - State Utilization Rates**

**Data - 2019-2021**

| Diagnostic Cardiac Caths | | | |
|---|---|---|---|
| Age Grp | Diagnostic Cardiac Caths | TN Resident Population | Utilization Rate |
| Total | 72,166 | 6,897,024 | 0.010463310 |
| 0 - 17 | 1,459 | 1,515,640 | 0.000962432 |
| 18 - 29 | 562 | 1,110,586 | 0.000506309 |
| 30 - 39 | 1,682 | 906,550 | 0.001855056 |
| 40 - 44 | 2,303 | 422,410 | 0.005452759 |
| 45 - 49 | 4,037 | 429,752 | 0.009393790 |
| 50 - 54 | 6,224 | 439,296 | 0.014167441 |
| 55 - 59 | 8,721 | 460,955 | 0.018919404 |
| 60 - 64 | 10,267 | 442,083 | 0.023224824 |
| 65 - 69 | 11,273 | 384,454 | 0.029322909 |
| 70 - 74 | 10,589 | 320,394 | 0.033049966 |
| 75 - 79 | 8,061 | 213,234 | 0.037803540 |
| 80 - 84 | 4,666 | 132,624 | 0.035179820 |
| 85 + | 2,322 | 119,046 | 0.019502491 |

| Therapeutic Cardiac Caths | | | |
|---|---|---|---|
| Age Grp | Therapeutic Cardiac Caths | TN Resident Population | Utilization Rate |
| Total | 60,066 | 6,897,024 | 0.008709017 |
| 0 - 17 | 2,949 | 1,515,640 | 0.001945514 |
| 18 - 29 | 866 | 1,110,586 | 0.000779769 |
| 30 - 39 | 1,428 | 906,550 | 0.001574872 |
| 40 - 44 | 1,473 | 422,410 | 0.003486423 |
| 45 - 49 | 2,378 | 429,752 | 0.005533424 |
| 50 - 54 | 3,806 | 439,296 | 0.008663179 |
| 55 - 59 | 5,815 | 460,955 | 0.012615105 |
| 60 - 64 | 7,723 | 442,083 | 0.017470249 |
| 65 - 69 | 9,280 | 384,454 | 0.024138149 |
| 70 - 74 | 9,447 | 320,394 | 0.029485601 |
| 75 - 79 | 7,610 | 213,234 | 0.035689899 |
| 80 - 84 | 4,560 | 132,624 | 0.034385094 |
| 85 + | 2,732 | 119,046 | 0.022946528 |

*Source: TDOH Data Request 2750954.*

Given there is an existing program in the Service Area at MRH, and it operates above capacity, there is defined need for a program in the Service Area. It should be noted that applying the above rates to the Service Area population indicates a Service Area demand of 2,885 catheterizations in 2027 increasing to 3,046 in 2029.

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

**Exhibit 1N, Cardiac – 9**

| Inpatient and Outpatient Cardiac Catheterization | | | |
|---|---|---|---|
| | 2027 | 2028 | 2029 |
| **Service Area** | | | |
| Spring Hill - 37174 | 613 | 626 | 639 |
| Columbia - 38401 | 1,075 | 1,090 | 1,105 |
| Thompson's Station - 37179 | 230 | 234 | 239 |
| **Service Area Total** | **1,918** | **1,950** | **1,982** |

With more than half of Spring Hill residents leaving the area, 40+ percent of Columbia residents and 70 percent of Thompson's Station leaving, TSHH's cardiac catheterization laboratories will significantly improve access and mitigate out-migration. Based on evaluation of migration patterns and associated anticipated percent of patients to seek services at the proposed hospital, the following percent of patients are estimated to utilize the proposed cardiac catheterization laboratories at TSHH.

**Exhibit 1N, Cardiac Cath – 10**

| Estimated Percent of TriStar Spring Hill Hospital Patients | | | |
|---|---|---|---|
| | 2027 | 2028 | 2029 |
| **Service Area** | | | |
| Spring Hill - 37174 | 20.0% | 25.0% | 30.0% |
| Columbia - 38401 | 10.0% | 15.0% | 18.0% |
| Thompson's Station - 37179 | 10.0% | 15.0% | 18.0% |
| **Service Area Total** | 13.2% | 18.2% | 21.9% |

Applying the above rates to the forecasts accounts for 75 percent of the forecasted patient population. As discussed in the CON Form, the Service Area is defined as 75 percent of the hospital's utilization with the remaining 25 percent emanating from outside the Service Area. Accordingly, the next table provides forecasted utilization at TSHH.

**Exhibit 1N, Cardiac Cath – 11**

| Forecasted Cardiac Catheterizations at TriStar Spring Hill Hospital | | | |
|---|---|---|---|
| | 2027 | 2028 | 2029 |
| **Service Area** | | | |
| Spring Hill - 37174 | 123 | 156 | 192 |
| Columbia - 38401 | 108 | 163 | 199 |
| Thompson's Station - 37179 | 23 | 35 | 43 |
| **Service Area Total** | **253** | **355** | **433** |
| Out of Area (25%) | 84 | 118 | 144 |
| Total Utilization | **337** | **474** | **578** |

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

**Exhibit 1N, Cardiac Cath – 12**

| Diagnostic and Therapeutic Catheterization Distribution | | | |
|---|---|---|---|
| | 2027 | 2028 | 2029 |
| Diagnostic Catheterizations | 253 | 355 | 433 |
| Therapeutic Catheterizations | 84 | 118 | 144 |
| Total Catheterizations | 337 | 474 | 578 |

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

10. **Access: In light of Rule 0720-4-.01 (1), which lists the factors concerning need on which an application may be evaluated, the HSDA may decide to give special consideration to an applicant:**
    a. **Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;**
    b. **Who documents that the service area population experiences a prevalence, incidence and/or mortality from heart and cardiovascular diseases or other clinical conditions applicable to cardiac catheterization services that is substantially higher than the State of Tennessee average;**
    c. **Who is a "safety net hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program; or**
    d. **Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program.**

**RESPONSE:**

TriStar Health is currently contracted with three TennCare MCOs in all its Middle Tennessee facilities, including TriStar Spring Hill ER. TSHH herein provides its written commitment to contract with these TennCare MCOs and is therefore entitled to special consideration under this criterion. In addition, TSHH will seek Medicare certification upon licensure and will participate in the Medicare program.

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

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

**RESPONSE:**

As detailed in response to #9 above, TSHH forecasts performing 578 total cardiac catheterizations in its third year of operation, 144 of which will be therapeutic cardiac catheterizations. The following exhibit summarizes the forecasted TSHH annual activity and provides the average of year two and year three as requested.

**Exhibit 1N, Cardiac Cath – 13**
**Annual TSHH Cardiac Catheterization Forecast and Year Two/Three Average**

| Procedure | Yr. 1 (2027) | Yr. 2 (2028) | Yr. 3 (2029) | Total | Average of Year 2 and Year 3 |
|---|---|---|---|---|---|
| Diagnostic Cardiac Catheterizations | 253 | 355 | 433 | 1,042 | 394 |
| Therapeutic Cardiac Catheterizations | 84 | 118 | 144 | 347 | 131 |
| **TOTAL** | 337 | 474 | 578 | 1,389 | 526 |

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

**RESPONSE:**

Centennial Heart interventionalists currently triage high risk or unstable patients from other hospitals without open heart surgery availability to TriStar Centennial based on ACC guidelines. Centennial Heart will similarly triage high risk or unstable patients from TSHH per the ACC guidelines; catheterizations on these patients will not be performed at the proposed hospital. Furthermore, TSHH will maintain an emergency transfer protocol with TriStar Centennial to provide tertiary level care if an appropriate patient experiences an adverse event during a catheterization.

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

**RESPONSE:**

TSHH will operate its cardiac catheterization laboratory in conjunction with Centennial Heart. The initial physicians identified for the proposed hospital are Jeffrey Webber, MD and John Riddick, MD.[3] Their current CVs are included in Attachment 1N, Cardiac. **Exhibit 14** includes their historic procedure volume during the past five years confirming they performed more than 75 therapeutic procedures annually.

**Exhibit 1N, Cardiac – 14**

| Jeffrey Webber, MD | Yr. 1 (2019) | Yr. 2 (2020) | Yr. 3 (2021) | Yr. 4 (2022) | Yr. 5 (2023) | Total | 5 Year Average |
|---|---|---|---|---|---|---|---|
| Diagnostic Cardiac Catheterizations | 385 | 297 | 369 | 388 | 370 | 1,809 | 361.8 |
| Therapeutic Cardiac Catheterizations | 188 | 118 | 112 | 126 | 113 | 657 | 131.4 |
| TOTAL | 573 | 415 | 481 | 514 | 483 | 2,466 | 493.2 |
| | | | | | | | |
| **John Riddick, MD** | **Yr. 1 (2019)** | **Yr. 2 (2020)** | **Yr. 3 (2021)** | **Yr. 4 (2022)** | **Yr. 5 (2023)** | **Total** | **5 Year Average** |
| Diagnostic Cardiac Catheterizations | 252 | 218 | 277 | 302 | 329 | 1,378 | 275.6 |
| Therapeutic Cardiac Catheterizations | 123 | 90 | 72 | 101 | 87 | 473 | 94.6 |
| TOTAL | 375 | 308 | 349 | 403 | 416 | 1,851 | 370.2 |

*Source: Internal records.*

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

[3] These two physicians are those who are initially identified for TSHH. With TSHH opening in 2027, it is likely other physicians who meet the required qualifications will be recruited and perform procedures at TSHH.

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

**RESPONSE:**

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

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

**RESPONSE:**

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

**Criterion 19 through 24 are Not Applicable.**

## Exhibit 1N, Cardiac Cath – 15

| Hospitals | # Cath Labs | 2022 Avg. Weighted Diagnostic Catheterizations | Diagnostic Catheterizations per Lab | 2022 Avg. Weighted Therapeutic Catheterizations | Therapeutic Catheterizations per Lab | 2022 Avg. Weighted Diagnostic and Therapeutic Catheterizations | Utilization per 2,000 Cases (Full Capacity) | Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity) |
|---|---|---|---|---|---|---|---|---|
| Maury Regional Hospital | 2 | 1,643 | 821.5 | 2,211 | 1105.5 | 3,854 | 96.35% | 137.64% |
| Williamson Medical Center | 2 | 963 | 481.5 | 588 | 294 | 1,551 | 38.78% | 55.39% |
| TOTAL | 4 | 2,606 | 1,303 | 2,799 | 1,400 | 5,405 | 67.56% | 96.52% |

*Source: Tennessee Department of Health - Office of Informatics and Analytics. https://www.tn.gov/content/tn/health/health-program-areas/statistics.html*

*Note: Joint Annual Reports for the respective hospitals, 2022*

| Service Area County | # Cath Labs | 2020-2022 Avg. Weighted Diagnostic Catheterizations | Diagnostic Catheterizations per Lab | 2020-2022 Avg. Weighted Therapeutic Catheterizations | Therapeutic Catheterizations per Lab | 2020-2022 Avg. Weighted Diagnostic and Therapeutic Catheterizations | Utilization per 2,000 Cases (Full Capacity) | Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity) |
|---|---|---|---|---|---|---|---|---|
| Maury Regional Hospital | 2 | 1,640 | 820 | 2,084 | 1,042 | 3,724 | 93.11% | 133.01% |
| Williamson Medical Center | 2 | 870 | 435 | 261 | 131 | 1,132 | 28.29% | 40.42% |
| TOTAL | 4 | 2,510 | 1,255 | 2,346 | 1,173 | 4,856 | 60.70% | 86.71% |

*Source: Tennessee Department of Health - Office of Informatics and Analytics. https://www.tn.gov/content/tn/health/health-program-areas/statistics.html*

*Note: Joint Annual Reports for the respective hospitals and years*

| Facility Name | Procedure Type | Setting | Procedure Weight | # Labs | # Cases | Weighted Cases (Adult) | Pediatric | Weighted Cases (Pediatric) | Total Cases | Total Weighted Cases | Weighted Cases Per Lab | Utilization per 2,000 Cases (Full Capacity) | Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Williamson Medical Center | Diagnostic Cardiac Catheterization | Inpatient | 1.0 | 2 | 356 | 356 | 0 | 0 | 356 | 356 | 178 | | |
| | | Outpatient | 1.0 | 2 | 607 | 607 | 0 | 0 | 607 | 607 | 303.5 | | |
| | Therapeutic Cardiac Catheterization | Inpatient | 2.0 | 2 | 186 | 372 | 0 | 0 | 186 | 372 | 186 | | |
| | | Outpatient | 2.0 | 2 | 108 | 216 | 0 | 0 | 108 | 216 | 108 | | |
| | Diagnotic EP | Inpatient | 2.0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | Outpatient | 2.0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | Therapeutic EP | Inpatient | 4.0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | Outpatient | 4.0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | Diagnostic Peripheral Vascular | Inpatient | 1.5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | Outpatient | 1.5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | Therapeutic Peripheral Vascular | Inpatient | 3.0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | Outpatient | 3.0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | Thrombolytic Therapy | Inpatient | 3.0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | Outpatient | 3.0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | Total | | | 2 | 1,257 | 1,551 | 0 | 0 | 1,257 | 1,551 | 776 | 38.78% | 55.39% |

# 1N

# Magnetic Resonance Imaging

1. **Utilization Standards for non-Specialty MRI Units. An applicant proposing a new non-Specialty stationary MRI service should project a minimum of at least 2160 MRI procedures in the first year of service, building to a minimum of 2520 procedures per year by the second year of service, and building to a minimum of 2880 procedures per year by the third year of service and for every year thereafter.**

**RESPONSE:**

TriStar Spring Hill Hospital ("TSHH") needs an MRI unit to, among other things, assure proper diagnosis of patients who are treated at the hospital, provide quality care for the patient population and ensure development of proper treatment plans upon diagnosis. As demonstrated below in **Exhibit 1N, MRI – 4**, current utilization of MRI units in Maury County is at 92 percent and Williamson County is at 93 percent. Both are well above the 80 percent threshold resulting in numeric need for the additional TSHH MRI unit. Additionally, having the unit at TSHH will make it seamlessly accessible for TSHH inpatients and outpatients. Out-migration from Maury County for MRI procedures is significant, with nearly half of Maury County residents having MRIs outside that county. **Exhibit 1N, MRI – 1** provides the most recent three-year period of MRI migration patterns:

**Exhibit 1N, MRI – 1**

| Maury County Resident MRI Procedures | | | |
|---|---|---|---|
| **Location of Procedure** | **CY 2020** | **CY 2021** | **CY 2022** |
| In Maury County | 6,235 | 6,641 | 7,628 |
| Outside Maury County | 5,589 | 5,717 | 6,573 |
| Total | 11,824 | 12,358 | 14,201 |
| Percent Out-Migration | 47.3% | 46.3% | 46.3% |

*Source: MRI Patient Origin, 2020 - 2022, HFC Website*

Nearly half of Maury County residents leave Maury County for MRI Procedures. Considering out-migration and the high utilization of the existing MRIs in the county, establishing an MRI service at TSHH will enhance access for the Spring Hill area.

While TSHH is not in Williamson County, its patient migration pattern shows 57 to 60 percent out-migration, even greater than Maury County.

**Exhibit 1N, MRI – 2**

| Williamson County Resident MRI Procedures | | | |
|---|---|---|---|
| **Location of Procedure** | **CY 2020** | **CY 2021** | **CY 2022** |
| In Williamson County | 9,652 | 10,998 | 10,791 |
| Outside Williamson County | 12,707 | 14,442 | 16,746 |
| Total | 22,359 | 25,440 | 27,537 |
| Percent Out-Migration | 56.8% | 56.8% | 60.8% |

*Source: MRI Patient Origin, 2020 - 2022, HFC Website*

Forecasted utilization of the TSHH MRI unit for its first three years of operation are provided in **Exhibit 1N, MRI – 3**. Volumes comply with the minimum projections identified in this criterion.

**Exhibit 1N, MRI – 3**

| Forecasted TriStar Spring Hill Hospital MRI Procedures | | | |
|---|---|---|---|
| **Patient Type** | **Year 1** | **Year 2** | **Year 3** |
| Inpatient | 365 | 508 | 585 |
| Outpatient | 1,826 | 2,032 | 2,340 |
| Total | 2,192 | 2,540 | 2,925 |

Inpatient MRIs were estimated based on experience of MRI utilization by medical-surgical inpatients. Outpatient utilization was developed considering experience of ratios of inpatient to outpatient volumes in conjunction with the utilization and high out-migration identified above.

2. **Access to MRI Units. All applicants for any proposed new MRI Unit should document that the proposed location is accessible to approximately 75% of the Service Area's population. Applications that include non-Tennessee counties in their proposed Service Areas should provide evidence of the number of existing MRI units that service the non-Tennessee counties and the impact on MRI unit utilization in the non-Tennessee counties, including the specific location of those units located in the non-Tennessee counties, their utilization rates, and their capacity (if that data are available).**

**RESPONSE:**

The MRI unit will be accessible to the entirety of the Service Area population. The location of the MRI unit will be in the radiology department of the proposed TSHH, which is centrally located in the proposed Service Area. Travel time to TSHH from the centroid of each of the three Service Area zip codes is less than 20 minutes, which makes TSHH accessible to the majority of the patients it will treat.

3. **Economic Efficiencies. All applicants for any proposed new MRI Unit should document that alternate shared services and lower cost technology applications have been investigated and found less advantageous in terms of accessibility, availability, continuity, cost, and quality of care.**

**RESPONSE:**

TSHH is proposing to establish a 68-bed full-service, acute care community hospital. In today's standard of care, to operate such a facility necessitates the inclusion of an MRI unit to provide appropriate care for certain patients whose standard of care requires an MRI.[1] When an MRI is required for an inpatient or a patient presenting in the emergency room, a sharing arrangement with an off-site MRI is not feasible. Such alternative arrangements would not enhance accessibility, contribute to timely and effective

[1] The ACR Appropriateness Criteria® (AC) are evidence-based guidelines to assist referring physicians and other providers in making the most appropriate imaging or treatment decision for a specific clinical condition. An advantage of the MRI technology is its ability to produce high-resolution images of soft tissues such as the brain, spinal cord, and joints.

diagnosis and treatment, or improve quality of care. Rather, it would lead to patients, at a minimum, incurring additional costs to be transported from TSHH to the off-site MRI and then transported back to TSHH for treatment. Accordingly, to expeditiously treat a patient prescribed to have an MRI, the TSHH MRI will be available for its patients to assure timely access, available technology, continuity of treatment, cost effectiveness and meeting today's standard of care (quality).

4. **Need Standard for non-Specialty MRI Units. A need likely exists for one additional non-Specialty MRI unit in a Service Area when the combined average utilization of existing MRI service providers is at or above 80% of the total capacity of 3600 procedures, or 2880 procedures, during the most recent twelve¬month period reflected in the provider medical equipment report maintained by the HSDA. The total capacity per MRI unit is based upon the following formula: Stationary MRI Units: 1.20 procedures per hour x twelve hours per day x 5 days per week x 50 weeks per year = 3,600 procedures per year.**

**RESPONSE:**

The availability of the MRI unit at TSHH is necessary as the technology is integral to the diagnosis and treatment of the patients to be treated at the proposed hospital. Additionally, based on the non-specialty MRI need formula, there is computed need for an additional MRI in the Service Area. The following table, **Exhibit 1N, MRI – 4**, provides the MRI utilization for each MRI unit in the counties comprising the Service Area during the past three years. Utilization in Maury County has been above 80 percent for the past two years and meets the above requirement of being greater than 80 percent in the most recent year, when utilization was 92 percent. Utilization in Williamson County has been above 80 percent for the past three years.

**Exhibit 1N, MRI – 4**
**Maury County MRIs**

| Facility | Units | Procedures | | | Procedures per Unit | | | Utilization Rate | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 |
| Maury Regional Medical Center | 3 | 8,002 | 8,645 | 9,401 | 2,667 | 2,882 | 3,134 | 74.1% | 80.0% | 87.0% |
| Mid Tennessee Bone and Joint Clinic, PC | 1 | 2,072 | 2,572 | 2,653 | 2,072 | 2,572 | 2,653 | 57.6% | 71.4% | 73.7% |
| Spring Hill Imaging Center (Maury Regional Imaging Ctr | 1 | 3,242 | 3,388 | 4,510 | 3,242 | 3,388 | 4,510 | 90.1% | 94.1% | 125.3% |
| Total | 5 | 13,316 | 14,605 | 16,564 | 2,663 | 2,921 | 3,313 | 74.0% | 81.1% | 92.0% |

**Williamson County MRIs**

| Facility | Units | Procedures | | | Procedures per Unit | | | Utilization Rate | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 |
| Elite Sports Medicine & Orthopaedic Center-Franklin | 0/0/1 | 0 | 0 | 1,631 | -- | -- | 1,631 | -- | -- | 45.3% |
| Premier Radiology Cool Springs | 2 | 4,605 | 4,325 | 4,949 | 2,303 | 2,163 | 2,475 | 64.0% | 60.1% | 68.7% |
| Vanderbilt Bone and Joint | 1 | 1,423 | 1,768 | 2,044 | 1,423 | 1,768 | 2,044 | 39.5% | 49.1% | 56.8% |
| Vanderbilt Imaging Services - Cool Springs | 1 | 4,443 | 4,743 | 4,731 | 4,443 | 4,743 | 4,731 | 123.4% | 131.8% | 131.4% |
| Williamson Medical Center | 1 | 5,345 | 6,943 | 6,600 | 5,345 | 6,943 | 6,600 | 148.5% | 192.9% | 183.3% |
| Williamson Medical Center Outpatient Imaging | 1 | 2,744 | 3,432 | 3,605 | 2,744 | 3,432 | 3,605 | 76.2% | 95.3% | 100.1% |
| Total | 6/6/7 | 18,560 | 21,211 | 23,560 | 3,093 | 3,535 | 3,366 | 85.9% | 98.2% | 93.5% |

*Source: HFC, MRI Utilization Report, accessed March 2024.*

5. **Need Standards for Specialty MRI Units.** Not Applicable.

6. **Separate Inventories for Specialty MRI Units and non-Specialty MRI Units. If data availability permits, Breast, Extremity, and Multi-position MRI Units shall not be counted in the inventory of non-Specialty fixed or mobile MRI Units, and an inventory for each category of Specialty MRI Unit shall be counted and maintained separately. None of the Specialty MRI Units may be replaced with non-Specialty MRI fixed or mobile MRI Units and a Certificate of Need granted for any of these Specialty MRI Units shall have included on its face a statement to that effect. A non-Specialty fixed or mobile MRI Unit for which a CON is granted for Specialty MRI Unit purpose use-only shall be counted in the specific Specialty MRI Unit inventory and shall also have stated on the face of its Certificate of Need that it may not be used for non-Specialty MRI purposes.**

**RESPONSE:**

The proposed TSHH MRI will be a non-specialty MRI unit and, therefore, will not have any restrictions on the face of its Certificate of Need.

7. **Patient Safety and Quality of Care. The applicant shall provide evidence that any proposed MRI Unit is safe and effective for its proposed use.**
   a. **The United States Food and Drug Administration (FDA) must certify the proposed MRI Unit for clinical use.**
   b. **The applicant should demonstrate that the proposed MRI Procedures will be offered in a physical environment that conforms to applicable federal standards, manufacturer's specifications, and licensing agencies' requirements.**
   c. **The applicant should demonstrate how emergencies within the MRI Unit facility will be managed in conformity with accepted medical practice.**
   d. **The applicant should establish protocols that assure that all MRI Procedures performed are medically necessary and will not unnecessarily duplicate other services.**
   e. **An applicant proposing to acquire any MRI Unit or institute any MRI service, including Dedicated Breast and Extremity MRI Units, shall demonstrate that it meets or is prepared to meet the staffing recommendations and requirements set forth by the American College of Radiology, including staff education and training programs.**
   f. **All applicants shall commit to obtain accreditation from the Joint Commission, the American College of Radiology, or a comparable accreditation authority for MRI within two years following operation of the proposed MRI Unit.**
   g. **All applicants should seek and document emergency transfer agreements with local area hospitals, as appropriate. An applicant's arrangements with its physician medical director must specify that said physician be an active member of the subject transfer agreement hospital medical staff.**

**RESPONSE:**

The proposed MRI will be certified by the FDA. In addition, TSHH is constructing a new hospital that will be built to current codes, including applicable federal and state standards, manufacturer's specifications and TDOH requirements. Given TSHH is being implemented to meet consumer needs, the radiology department which will house the MRI, will be designed to promote consumer access, privacy, patient safety and satisfaction.

TSHH is proposing to implement the MRI unit within its hospital. Therefore, it does not require an emergency transfer agreement for patients within the MRI unit who require hospitalization or hospital services. Rather, the patient will be appropriately treated at TSHH in conformity with accepted medical practice, including for any emergencies that might arise. If a patient requires services which are unavailable at TSHH, the patient will be transferred in accordance with the hospital's transfer policies discussed elsewhere within this CON Application.

As with all TriStar facilities, TSHH will have protocols in place that assure MRI procedures performed are medically necessary and will not unnecessarily duplicate other services.

As part of its radiology department operations, TSHH will meet the staffing recommendations and requirements set forth by the American College of Radiology, including staff education and training programs.

Finally, TSHH commits to obtaining accreditation from the American College of Radiology within two years following operation of the proposed MRI Unit.

8. **The applicant should provide assurances that it will submit data in a timely fashion as requested by the HSDA to maintain the HSDA Equipment Registry.**

**RESPONSE:**

TSHH agrees to provide the Department of Health and/or the Health Facilities Commission with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested.

9. **In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:**
   **a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;**
   **b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program; or**
   **c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or**
   **d. Who is proposing to use the MRI unit for patients that typically require longer preparation and scanning times (e.g., pediatric, special needs, sedated, and contrast agent use patients). The applicant shall provide in its application information supporting the additional time required per scan and the impact on the need standard.**

**RESPONSE:**

TriStar Health currently contracts with three TennCare MCOs in all of its Middle Tennessee facilities, including TriStar Spring Hill ER. TSHH commits to contract with these TennCare MCOs and is therefore entitled to special consideration under this criterion. TSHH will seek Medicare certification upon licensure and will participate in the Medicare program and is entitled to special consideration for this criterion.

Attachment 1N-1, Acute

Spring Hill Hospital, Inc -1

HSDA Final Order Granting CON

**BEFORE THE TENNESSEE**
**HEALTH SERVICES AND DEVELOPMENT AGENCY**

**IN THE MATTER OF:**
**SPRING HILL HOSPITAL, INC.** **DOCKET NO: 25.OO-092967J**

## FINAL ORDER

This matter came to be heard on February 27, 2008, before the Health Services and Development Agency ("HSDA") for review of the Initial Order entered by Administrative Judge Leonard Pogue on October 12, 2007. Administrative Judge Thomas Stovall presided over the proceeding in an advisory capacity to the HSDA. Maury Regional Hospital ("MRH") was represented by Dan Elrod, G. Brian Jackson and Brian C. Witt of Nashville. Williamson Medical Center ("WMC") was represented by Warren L. Gooch and Charles E. Young of Knoxville. Spring Hill Hospital ("SHH") was represented by Jerry W. Taylor, D. Edward Harvey, and Kathryn A. Stephenson of Nashville. The state of Tennessee was represented by Reid Brogden and James B. Christoffersen.

On October 25, 2007, SHH filed a Petition for Review of Administrative Judge's Order Denying a CON for Spring Hill Hospital. On November 14, 2007, the HSDA heard arguments from both sides on whether the HSDA should exercise its discretion to review the Administrative Judge's Initial Order and the HSDA voted to so review the Order. The entire record below has been filed with the Agency and provided to each member. Briefs have been filed by all parties and this matter became ready for consideration on February 27, 2008.

The underlying contested case hearing was heard on April 11-24, 2007, before Judge Pogue, sitting for the HSDA. In his Initial Order dated October 12, 2007, Judge Pogue DENIED the Spring Hill Hospital CON.

The subject of this hearing is the Petition for Review filed by SHH of the denial of a certificate of need (CON) to SHH by Administrative Judge Leonard Pogue for the establishment of a 56 bed hospital in Spring Hill, Tennessee. After consideration of the record in this matter, deliberation by the members of the HSDA, a vote in favor of granting the CON by the margin of seven to one, it is determined that the Spring Hill Hospital CON be **GRANTED** and the Initial Order issued by Judge Pogue should be **OVERRULLED** and **MODIFIED** as set forth herein. This decision is based upon the following findings of fact and conclusions of law. The official transcript, which is incorporated herein, reflects the discussion by the members of the HSDA of how and why the findings of fact and conclusions of law in this Final Order differ from the Initial Order, as required by Tennessee Code Annotated § 4-5-316.

## FINDINGS OF FACT

### Procedural Background

1. In April 2006, Spring Hill Hospital, Inc. ("SHH") filed an application with the Agency for a CON to construct and operate a new 56 bed hospital in Spring Hill, Tennessee at a cost of approximately $110 million. SHH was projected to open in 2010. The Agency approved the CON application at its regular monthly meeting on July 26, 2006.

2. The CON application was opposed by both MRH and WMC. MRH and WMC subsequently initiated a contested case proceeding by timely filing Petitions for a Contested Case Hearing.

3. The proposed SHH would be located in Maury County (close to the Williamson County line), approximately 14 miles from MRH in Columbia and approximately 17 miles from WMC in Franklin.

### Existing Medical Facilities

4. MRH, a public non-profit facility, operates a 255-bed acute care hospital in Columbia, Tennessee. The hospital serves eight counties in southern Middle Tennessee. MRH operates a primary care clinic on its main campus that treats more than 40,000 patients annually, of whom more than 50% are TennCare patients or are uninsured. MRH is in the process of tripling the size of its emergency department at a cost of $15.5 million. MRH has planned capital projects over the next five years of $40 to $50 million.

5. MRH operates facilities and programs in Spring Hill to address the health care needs of area residents and has expanded its services over the years in Spring Hill.

MRH constructed a primary care facility in 1998 in Spring Hill and expanded that facility in 2004. However, the clinic is not open 24 hours a day. MRH opened a specialty care facility in 2005 providing ENT, Gastroenterology, Orthopedic, Cardiology, Obstetrics/Gynecology and Podiatry services and constructed an outpatient diagnostic imaging center in 2006. The Agency has concerns over this facility's ability to provide adequate access to quality healthcare. To date, MRH has invested more than $6.2 million in construction and expansion costs in bringing these medical services to Spring Hill.

6. A review for the possible need of a hospital in Spring Hill was done for MRH in 2005. This evaluation concluded that a full service hospital was not feasible in Spring Hill in the near or immediate term, but also concluded that the citizens of Spring Hill would fill 60 beds by 2015.

7. The Mayor of Spring Hill, Danny Leverette, testified that he had no reason to believe that MRH has ever failed to address the health care needs of the Spring Hill community. However, there was testimony in the record that citizens of Spring Hill in rush hour traffic took more than an hour to access the other facilities.

8. WMC is a publicly owned not for profit hospital located in Franklin, Tennessee. WMC recently completed $83 million in additions and renovations to its facilities, including the addition of 40 medical/surgical hospital beds (July 2007), which increased its beds from 145 to 185. WMC provides a full-time family physician for Williamson County Health Department patients in Franklin and a part-time physician for patients in Fairview.

9. In 2005, WMC evaluated the need for additional medical services in Spring Hill, including a hospital. WMC concluded that its planning for Spring Hill should involve outpatient services rather than inpatient beds.

10. The majority of Spring Hill residents live in Williamson County. However, Spring Hill officials have never approached WMC about providing different or additional medical services in Spring Hill. The Mayor of Spring Hill addressed this issue by stating that he would ask himself "many times why WMC or MRH would not approach the City of Spring Hill."

**Proposed SHH**

11. In 2004, HCA and Vanderbilt University Medical Center discussed the possibility of a joint venture in the area south of Nashville. HCA commissioned an assessment of the area's health care needs from Ed Stall, a health planning consultant regularly engaged by HCA, to analyze the need for new facilities and services. Mr. Stall's 2004 report, not intended to be a detailed analysis, did not address the need for a hospital in Spring Hill.

12. In the fall of 2005, a Spring Hill real estate developer and then Chairman of the Spring Hill Chamber of Commerce contacted HCA and invited its executives to a meeting in Spring Hill with local officials. At that meeting, held on November 1, 2005, city officials promoted the idea of HCA offering health care services in the city, including possibly a hospital. The Spring Hill city officials present at the meeting had no background or expertise in health care and had not conducted any research or retained or consulted with any health care expert to advise the city on whether a new hospital was

actually needed in Spring Hill. Neither WMC nor MRH was ever invited to a similar meeting with city officials.

13. In January 2006, HCA contacted Mr. Stall and asked for an update of his 2004 report. Mr. Stall performed a bed need analysis of the area and summarized his work in a second report. The second report made conservative assumptions and was not a comprehensive analysis. Mr. Stall's update of the 2004 report concluded that the bed need at current admit rates and a four-day ALOS resulted in a need of 42 (conservative) to 56 (target) beds, and that 2010 was probably a little too soon. He further concluded that accelerated growth not projected in his estimates would shorten his timeline.

14. HCA representatives also visited Spring Hill extensively in late 2005 and early 2006. They determined that there was community and physician support for a new hospital. Ultimately, HCA decided that Spring Hill could support a 56 bed hospital by the year 2010.

15. In early March 2006, HCA hired Dr. Ron Luke of Research Planning Consultants, Inc. (RPC) to produce a report projecting volumes at the proposed Spring Hill hospital. HCA never asked Dr. Luke to give an opinion on whether some other type of health care facility should be constructed or what size the project should be. Dr. Luke was retained at the suggestion of HCA's litigation counsel. HCA management had not relied on him in the past and was unfamiliar with his qualifications and expertise.

16. In March 2006, HCA publicly announced its intent to build a 56-bed hospital in Spring Hill. On April 13, 2006, it filed its application for a CON with the Agency. HCA attached to its application a report created by Dr. Luke on April 12, 2006 (First RPC Report) projecting Spring Hill's population and setting forth other projections

and analyses about the proposed hospital. On April 26, 2006, Dr. Luke revised his report (Second RPC Report), which was attached to HCA's Second Supplemental Responses to the Agency.

17. SHH will be owned by Spring Hill Hospital, Inc., a subsidiary of HCA, Inc. It will be part of the local TriStar division of HCA, which currently consists of 19 hospitals.

18. The proposed hospital will have 56 beds and will provide a basic range of adult and pediatric acute care services, including an emergency department, 8 obstetric beds, 8 critical care beds, and 40 medical-surgical beds. The hospital will also provide diagnostic imaging services. The hospital will not provide tertiary care (more complex medical care). Such tertiary care would have to be handled at MRH, WMC, or the various tertiary care hospitals located in Nashville.

19. The proposed hospital's primary service area will consist of six ZIP codes encompassing and surrounding Spring Hill. The City of Spring Hill is contained within two of these ZIP codes. The service area is partly in Maury County and partly in Williamson County. WMC lies just outside the primary service area and the ZIP code encompassing MRH is included in the primary service area.

**Bed Need**

20. The Health Planning Act of 2002 directs the Tennessee Department of Health to review every CON application and to provide the Agency with a report that includes an analysis of whether the application complies with *Tennessee's Health Guidelines for Growth.* A bed need formula is incorporated into every certificate of need

application filed with the Agency. The bed need formula calculates the number of beds needed in a county.

21. The Department of Health report concluded that SHH did not satisfy the hospital bed need formula set forth in the *Guidelines* and did not meet the requirements to be excepted from the formula. The Department of Health determined that in 2010 there will actually be a surplus of 50 licensed beds in Maury County and a surplus of 81 licensed beds in Williamson County. Melanie Hill, Executive Director of the Agency, testified that the *Guidelines* are only guidelines and that Agency members consider the *Guidelines* along with other information brought to them by an applicant. The bed need guidelines have not been updated since the 1990s.

22. WMC's 40-bed CON application also did not satisfy the bed need formula in the *Guidelines*, but the application was granted. The StoneCrest Hospital (Smyrna) CON application too did not satisfy the bed need formula in the *Guidelines*, but the application was granted. After StoneCrest Hospital opened, utilization at StoneCrest was sufficient to support a bed expansion.

23. WMC's 40-bed CON application projected that the 40 new beds would be 80% to 84% occupied in fiscal years 2007 and 2008 and WMC projected that all of its beds would be 81.6% occupied in 2008. The WMC CON application further projected that in 2008, at 70% occupancy, Williamson County would need 210 beds. WMC's officials believed that the additional 40 beds would be sufficient to serve its population for several years after the beds open in 2007.

24. Before HCA filed the SHH CON application, MRH consultants prepared a series of reports that concluded, among other things, that the residents of Spring Hill will

need up to 60 additional beds (at 85% occupancy) by 2015. In November, 2005, WMC consultants performed an analysis that concluded, among other things, that Williamson County would need additional hospital beds by 2010, and that, in addition to the 40 beds to be opened in 2007, WMC should open 60 more beds in 2010 and more beds in phases thereafter, bringing WMC to 300 beds in 2020.

25. A bed-to-population ratio is used frequently in the health planning field to assist in determining bed need. MRH's and WMC's health care planning expert, Dr. Deborah Kolb, testified that she wouldn't necessarily consider a 1.8 bed-to-population ratio to be low and that bed ratio should not be the sole factor in determining need. Dr. Kolb has previously stated in a Florida CON application that 1.8 beds per 1,000 population is a low ratio. Combining SHH's beds and the high scenario population projections of MRH's and WMC's population and demographic expert Dr. David Swanson, there would be 1.9 beds per 1,000 population in 2010 in the two counties. With SHH's beds and Dr. Luke's population projections, there would be 1.75 beds per 1,000 population in 2010 in the two counties.

26. In Revised Figure 21 of the RPC Report attached to the CON application, HCA presented its bed need numbers to the Agency. Revised Figure 21 includes beds that will actually be located in Davidson County and any other county where residents from the SHH service area may go to seek medical services. The RPC Report never sets forth the number of beds actually needed to be physically located in Maury or Williamson Counties. This was explained by SHH in response to Supplemental Question 20 in the CON Application.

27. The occupancy rates set forth in Figure 22 of the RPC Report are similarly prepared. Although the Figure is labeled "Maury and Williamson County Combined Occupancy Rates," the calculation of the occupancy rates includes patients who will be treated in other counties. In other words, the numerator of the occupancy percentage equation includes patients who are being treated for tertiary and other services in Davidson County, while the denominator consists of the beds physically located in Maury and Williamson Counties.

28. In addition to out-migration for tertiary level services, a certain percentage of patients choose to seek medical treatment outside Maury and Williamson Counties for many other reasons. Patients may elect to seek treatment at facilities in Nashville because of commuting patterns or because patients may prefer to be treated at major medical centers. HCA's bed need calculations set forth in the RPC Reports accounted for this type of out-migration in its projected market shares which ranged from 5% to 35% in the service area. The number of patients out-migrating from Williamson and Maury Counties for non-tertiary level services in the six zip code PSA is 25.1% for Basic Med/Surg and 41% for OB.

**Population Projections**

29. Spring Hill is a rapidly growing city. In 2000, the U.S. Census found a Spring Hill population of 7,715. In 2005, the City conducted its own Special Census, which concluded that the population of Spring Hill was 17,325. This represents a 17.6% compound annual growth rate between 2000 and 2005. The Special Census was properly conducted. The State of Tennessee certified the Special Census after a detailed verification process.

30. MRH's and WMC's demographic expert, Dr. David Swanson, testified about several concerns he had about the Special Census that might have affected its accuracy, such as the effect of annexation in Spring Hill between 2000 and 2005 and that the documentation from the Special Census was insufficient to ensure that all residents counted were properly included. However, he did not undertake an investigation of any possible over-count and was unable to demonstrate any specific over-count. The impact of any potential over-count should be offset by the fact that 450 households did not respond to the Special Census, and those households were not included in the Special Census count.

31. Spring Hill City Manager, Ken York, testified that in April 2007, there were 9,251 active residential water accounts, an increase of 2,350 water accounts since 2005. Based on the water accounts and using an average number of persons per household between 2.51 and 3 (based on 2005 census), Spring Hill's 2007 population would be between 23,220 and 27,753 residents.

32. There are approximately 10,000 residential lots currently approved for development within the Spring Hill city limits. These lots have water lines and roads in place. Since 2006, Spring Hill has annexed several hundred acres of vacant farmland that can now be developed. There are 16,835 total acres within the city limits. Spring Hill's urban growth boundary contains an additional 39,600 acres.

33. Spring Hill's growth can be attributed to a number of factors, including the aggressive growth strategy adopted by local officials, the availability of relatively low-cost housing compared to elsewhere in Williamson County and the greater Nashville Metropolitan area, the availability of buildable land, the quality of schools, and the

proximity to commercial and employment centers made possible by major roadways such as 1-65 and State Highway 840. Limits on the potential for growth (such as topography, housing prices, and official anti-growth policies) in other areas surrounding Nashville also increase the potential for growth in the Spring Hill area. Since 2005, the growth rate in the Spring Hill area, especially in Maury County, has accelerated rather than leveled off. Edsel Charles, who provides growth forecasts relied upon by builders and lenders, predicts that the growth will continue for years.

34. The Spring Hill area is emerging as its own community, with its own retail and employment opportunities. Spring Hill has a Lowe's and a Home Depot, and will soon have a 400,000 square foot shopping center anchored by the largest Super Target store in Middle Tennessee.

35. SHH called Dr. Ron Luke as an expert in health care planning. Dr. Luke has limited experience in developing demographic models and is not a professional demographer. Nonetheless, it is also clear from both Dr. Luke's testimony and Dr. Kolb's testimony that population projections are an integral part of health care planning. Approximately 75% of Dr. Luke's personal working time and 75% of his firm's time is spent consulting on matters in litigation. In addition to CON cases, Dr. Luke has offered testimony as an expert witness in cases involving toxic torts, contracts, vehicle liability, employment discrimination, housing markets, statistical issues, water resources and antitrust. In the recent past, WMC retained Dr. Luke as a health planning and demographic expert.

36. Dr. Luke has little non-litigation experience or training in the field of population studies. His only contribution to the published literature on the subject of

population projections was an eight-page article authored 17 years ago. Dr. Luke has never attended a conference or professional meeting relating to population projections except for one conference in the 1970s. He has never taught a course or authored a textbook in population projections and had never designed, conducted or encountered a Special Census before his work on this case.

37. To prepare his population projections, Dr. Luke calculated Spring Hill's historical annual growth rate from 2000 to 2005. He then took the resulting rate of 17% and projected forward to the year 2014, compounding annually. As a result, Dr. Luke projects that the two ZIP codes encompassing Spring Hill will be home to 60,373 persons in 2010 and 116,763 persons in 2014. Dr. Luke testified that it is reasonable to project that Spring Hill will have a compound annual growth rate of 17% for a period of 14 years, from 2000 through 2014. Although Dr. Luke asserted that it was important to consider various factors such as zoning regulations and land use patterns when making population projections, he did not actually have any knowledge about such issues at the time he prepared his Spring Hill population projections. Spring Hill City Manager Ken York's testimony on the number of active residential water accounts as of April 2007 actually shows that Dr. Luke's projections thus far have been understated.

38. The projections Dr. Luke employed in the RPC report were prepared at Dr. Luke's direction by Robin Gage, an RPC employee. Ms. Gage has no formal training in population projections, has never taken a course about population projections and does not hold herself out to be an expert in projecting population.

39. MRH and WMC offered testimony from Dr. David Swanson, an expert in the field of demography and local population projections. Dr. Swanson derives a very

small percentage of his income from litigation-related work. Dr. Swanson, who is a professor at the University of Mississippi and Director of the Center for Population Studies there, has written dozens of articles about population projections in peer-reviewed journals. He has co-authored a textbook on the subject of projecting local populations and is the co-author of the current edition of a textbook on demography that is regularly consulted by Dr. Luke.

40. Dr. Swanson has had numerous experiences with population projections in both the public and private sectors: he has served as the state demographer of Alaska; he has performed population analyses for states, municipalities, private businesses and school districts. When Dr. Swanson was retained by MRH and WMC, he was not asked to reach any particular conclusions about the population of Spring Hill. Dr. Swanson testified that he approached the engagement not favoring any particular conclusion but merely applying the appropriate methodology and reporting his results, whether favorable or not.

41. The future population of Spring Hill, as projected by Dr. Swanson, is substantially lower than that submitted by Dr. Luke. Dr. Swanson looked at the land use patterns, growth potential, and types of industry but did not talk to city officials. He testified that, while Spring Hill has experienced and is likely to continue to experience substantial growth in the near future, the population growth projected by Dr. Luke is implausible and not likely to be achieved. The Health Services and Development Agency is troubled by some of the assumptions used by Dr. Swanson in his methodology.

42. Dr. Swanson analyzed the methodology used by Dr. Luke and the application of that methodology and found the application flawed. Although Dr.

Swanson testified that there was nothing inherently wrong with using a compound annual growth method, Dr. Luke's projection of a very high annual growth rate far into the future was unreasonable and generated unreliable results. Dr. Swanson has never seen any city or county sustain a 17% rate of growth for the time period projected by Dr. Luke. Dr. Luke's projected annual growth rate leads to the population of Spring Hill doubling every four years.

43. Dr. Swanson performed his own population projections for Spring Hill using the cohort-component method. He developed a low, medium and high projection, which is standard practice to account for the inherent uncertainty of future growth. His low scenario is based on the Claritas estimate of the 2005 population of the service area. The Claritas estimate was ultimately low and does not reflect the 2005 population of Spring Hill. Dr. Swanson's medium scenario is the average of his high and low scenarios. For his high scenario, Dr. Swanson accepted the population estimate from Spring Hill's 2005 Special Census, notwithstanding his concerns about its accuracy, and then grew that population forward to 2010 and 2015. The growth was based on assumptions about birth rates, mortality rates, and migration rates, but was not based on input from city planners in Spring Hill. Dr. Swanson's high scenario projections fall far below Dr. Luke's projections.

44. MRH and WMC offered testimony from Dr. Bill Fox, Director of the Center for Business and Economic Research and a professor of business at the University of Tennessee. Dr. Fox was tendered and accepted as an expert in economic and population forecasting in Tennessee.

45. Dr. Fox reviewed Dr. Luke's report and testified that its population projections were unreasonable and outside the range of an acceptable forecast. Dr. Fox testified that while Dr. Luke's methodology might be appropriate for the quick calculation of an estimate, it was not an acceptable method for projecting growth over long periods of time, particularly in a rapid growth area.

46. Dr. Fox also noted that the Dr. Luke analysis assumed that Spring Hill will continue to grow with no changes in outside influences. Dr. Fox stated that there were and would be changes in Spring Hill housing prices, employment growth, schools and health care that called this assumption into question. Dr. Fox also reviewed Dr. Swanson's projections and was of the opinion that Dr. Swanson had used a more appropriate methodology resulting in reasonable projections.

47. MRH's and WMC's expert Dr. Deborah Kolb, a health care planner with more than 20 years of experience in strategic planning, assessing the financial feasibility of health care projects and conducting financial impact analyses, including extensive experience with hospitals in general and even working for HCA, also testified that Dr. Luke's population projections were overstated and not credible. Dr. Kolb noted certain problems with RPC's population projections. For example, Dr. Luke took the growth rate from 2000 to 2005 from the Special Census and extended the growth projection beyond Spring Hill's city limits. Edsel Charles testified that adjacent Thompson's Station is not a high growth area like Spring Hill. However, Dr. Luke applied the 17% growth rate to both cities.

48. Although Dr. Luke's growth rate is criticized by Drs. Swanson, Fox and Kolb, the evidence demonstrates that the population growth in Spring Hill between 2005

and 2007 exceeded Dr. Luke's projection of 17.6% and therefore substantially exceeded Dr. Swanson's projection.

**SHH Utilization Projections**

49. Hospital utilization is a factor in projecting the need for additional health care services. A hospital utilization rate is calculated in terms of a ratio of the number of hospitalizations per one thousand people in a given area. Further, Dr. Kolb explained that population projections are crucial in accurately predicting utilization.

50. The utilization rate for SHH's six-zip code service area declined 4.2% from 2002 to 2005. Dr. Luke did not take into account in his report this declining use rate for hospital service. Dr. Luke testified that, based on his review of the data, he did not believe that the declining use rate was likely to continue. SHH's utilization rates do take into account the lower rate at which Spring Hill area residents (a young population) use hospital services. Dr. Kolb believed that use rates in Tennessee have been fairly stable overall. She had no opinion about when the current use rate would level off.

51. Dr. Luke lowered his utilization projections for the proposed SHH subsequent to submitting his original report that was attached to the CON application. The First RPC Report, dated April 12, 2006, projected a utilization rate for SHH of 10,296 per 100,000 people. RPC' s Third Report, dated February 12, 2007, projected a lower utilization for SHH, 9,605. The Third RPC Report lowered the overall volume projections at the proposed new hospital by changing the use rate.

52. Larry Kloess, president of HCA/TriStar, testified that no medical/surgical facility in HCA/TriStar's system of hospitals has enjoyed a 75% occupancy rate. SHH projects that it will have an occupancy rate of 82% by its fifth year of operation. Dr.

Kolb's report projects a lower occupancy rate based on the pro forma from HCA's application and the population projections from Dr. Swanson's high scenario. WMC, however, projected an 81.67% occupancy rate in 2008 when presenting its 40 bed expansion CON.

**Access**

53. Dr. Kolb believes that the function of the CON process is to balance accessibility and availability to needed healthcare services against cost effectiveness and cost efficiency.

54. In June 2006, Spring Hill resident Melissa Nesbitt twice spent an hour during morning rush hour trying to get to WMC while in severe pain with a kidney stone. However, Ms Nesbitt did not call an ambulance and was unaware that an urgent care center was located in Spring Hill. However, the urgent care center is only open from 8:00 a.m. to 8:00 p.m..

55. Spring Hill resident Angela Thompson's young son occasionally wakes up early in the morning with severely low blood sugar, when rush hour traffic can significantly slow the drive to health care in Franklin or Nashville. However, Ms. Thompson's emergency trips have not been by ambulance and on occasion were specifically to Vanderbilt University Medical Center. Ms. Thompson was unfamiliar with the Spring Hill urgent care center and would consider it for treatment if open at the time of need. However, the urgent care center is only open from 8:00 a.m. to 8:00 p.m.

56. In December 2006, Spring Hill resident Layla Thompson and her husband spent a confusing night searching for an emergency room for their severely ill baby. If

there had been a hospital in Spring Hill, they believe they would have been at an emergency room nine minutes after they left home.

57. MRH opened a primary care clinic in Spring Hill in 1998, a specialty clinic in 2005, an urgent care center in 2006, and a diagnostic center in 2006. None of these facilities is open 24 hours per day. Tim Scarvey, vice president of development for HCA, testified that the next step in Spring Hill is an emergency department, surgery services, and beds to place those patients.

58. Recruiting physicians and maintaining a good medical community is aided by having a good hospital. SHH would help attract physicians to the area. Spring Hill currently has fewer physicians per person than Franklin and the Franklin area needs more primary care physicians.

**Financial Projections**

59. HCA submitted five years of financial projections in support of its application. The pro forma in HCA's original application projected SHH would lose money until its fourth year of operation (2013). In the first three years, HCA's application projected losses ranging from $14.4 million (2010) to $3.9 million (2012).

60. After the appeal in this case was filed, Chris Taylor, HCA TriStar CFO, discovered and corrected an error in the SHH pro forma that had been filed with the CON application. To project the revenues and expenses at the proposed new hospital, it was necessary for HCA to project the number of Emergency Department (ED) visits at SHH each year. Mr. Taylor testified that an error relating to ED visits affected the financial projections in several respects. It caused errors in the gross revenue, deductions, net operating revenues, other expenses, total operating expenses, net operating income and

net operating income or loss less capital expenditures and interest expense. According to Mr. Taylor, the correction of the error flows through the income statement. Both before and after the correction, SHH showed a projected positive net income in the fourth year of operations.

61. The first three years of the project become more unprofitable under the revised pro forma. According to Mr. Taylor, his revised analysis using what he believed to be the correct ED visit numbers from RPC resulted in a negative change in the five-year projected net income (loss) less capital expenditures figures of between $2,000,000.00 and $2,500,000.00. In the year 2013, the first year in which a profit was projected for SHH, the net income or profit of $1,065,584 shown on the pro forma in fact should have been only $200,000 to $300,000.

62. While HCA's original application projected that the new hospital would lose approximately $25 million over its first five years of operation, HCA now expects to lose more than $29 million over that period of time. Projections for the facility's first year of profitability (2013) have declined from the $1,065,584 amount presented to the Agency to $179,000.

63. Mr. Taylor testified that a new hospital is expected to lose money in its initial years and that a new hospital is a long term investment. SHH is projected to generate positive net income in its fourth year of operations. Its net income should improve every year after its first year.

64. According to Mr. Taylor, HCA looks to cash flow, or EBITDA, when evaluating an investment. SHH is projected to generate positive cash flow in its second year of operations and will continue to improve thereafter.

65. To assist SHH expert Rick Knapp in preparing his expert report, Mr. Taylor prepared an updated spreadsheet, using both Dr. Luke's updated utilization projections and more recent revenues from the proxy hospitals that had supplied the underlying data for the original CON pro forma. This spreadsheet shows that SHH will generate positive net income in its fourth year of operations; its net income improves in every year after its first year; it will generate positive cash flow in its second year of operations; and EBITDA will improve in every year thereafter.

66. Dr. Kolb testified that if SHH's market share projections are correct then SHH cannot achieve financial viability. She further stated that either the hospital will have a much lower daily census than projected in the application, or the hospital, to achieve its financial goals, would have to attempt to capture more patients from MRH and WMC than is projected in SHH's application.

67. Dr. Kolb testified that if the assumptions contained in the CON application are applied to Dr. Luke's latest utilization projections, the proposed hospital will lose money for all of its first five years. Although her analysis used updated utilization projections from Dr. Luke's expert report, it did not use updated revenue projections from Mr. Knapp's expert report. If she had used the updated financial information as well as the updated utilization projections, her results would have been similar to Mr. Taylor's.

68. Mr. Knapp testified that if SHH does not reach the occupancy rates projected by Dr. Luke, and instead reaches a point mid-way between Dr. Luke's projections and Dr. Kolb's projections SHH will still have positive EBITDA in year two of operations and thereafter.

69. HCA indicated that it is fully prepared to support SHH financially.

**Impact**

70. If SHH is built, WMC and MRH will have less business than they will if they remain the only hospitals in Williamson and Maury Counties. No services will be offered at SHH that are not already offered at WMC and MRH.

71. The occupancy rates at MRH have been declining in recent years, averaging less than 60% in 2006. Discharges in its eight-county service area have declined every year since 2003. Fifty percent of MRH's discharges come from outside of Maury County. The farther people live north of MRH there is an inclination for those individuals to travel north for their medical care. MRH has a small market share of no more than 2% from the city of Spring Hill, which is on the northern border of the MRH service area.

72. WMC's occupancy rates have been higher than those of MRH, but to some extent this reflects the fact that WMC has been undergoing a major construction project which has at times reduced bed capacity and inflated occupancy rates. WMC's occupancy rates do not adequately reflect utilization of WMC's full licensed bed complement.

73. Based on his population and use projections, Dr. Luke projects that MRH will have 10% more discharges in 2010 than it had in 2005. This percentage will steadily grow through 2014 to a 30% increase.

74. Based on his population and use projections, Dr. Luke projects that WMC will have 11% more discharges in 2010 than it had in 2005. This percentage will steadily grow through 2014 to a 30% increase.

75. In her report, Dr. Kolb opines that assuming Dr. Swanson's population projections and steady use rates that SHH will prevent MRH from growing and limit WMC to marginal growth over a period of nine years. If use rates continue to decline, MRH and WMC would have significantly fewer discharges in 2014 than 2005.

76. Dr. Kolb believes that were SHH to achieve its projected utilization that there would be a significant adverse impact on MRH and WMC. Dr. Kolb testified that the minimal 5% non-tertiary out-migration experienced by the SHH service area is not sufficient to fill a 56-bed hospital in Spring Hill. Dr. Kolb's report, however, established a 25.1% outmigration for Basic Med/Surg and a 41% outmigration for OB.

77. As previously noted, MRH has planned capital projects over the next five years of $40 to $50 million. James Otwell, CEO of MRH testified that its debt-to-capitalization ratio and debt service coverage are stronger than its peers. In 2006 MRH's gross patient revenues increased, while its costs have decreased. Mr. Otwell testified that MRH has 30 days of cash reserves ($17-18 million) which he considered low compared to other hospitals. Its consultants believe it has the capacity to access $41 million in additional debt. The CFO of MRH testified that MRH is currently strong financially.

78. As previously noted, WMC is currently undertaking a number of capital expenditures either renovating existing facilities, or opening new services; many of these will bring state-of-the-art services to WMC. WMC has never had difficulty servicing its debt. WMC is financially healthy. Rodger Klein, COO of WMC, testified that WMC has cash reserves of $30 million.

79. Since 2002, WMC has applied for and received five Certificates of Need, the purpose of which was to expand WMC and its services. To assist WMC in funding

these expansion projects, Williamson County issued $30 million in revenue bonds and $20 million in general obligation bonds. WMC borrowed an additional $10 million on its own, and the remaining $23 million was taken from WMC's operations and cash reserves over the first four years of the projects. In addition to WMC's indebtedness related to the expansion projects, in fiscal year 2005-2006, WMC also had five outstanding loans for various capital projects such as the purchase of land and equipment. These additional loans amounted to approximately $25.5 million.

80. MRH offered testimony from Martin Brown, a Certified Public Accountant licensed in Tennessee and a member of the PYA firm. Mr. Brown testified regarding the financial impact SHH will have on MRH. PYA and Mr. Brown perform health care advisory and accounting services in Tennessee, serving approximately 60 hospitals in Tennessee since 2003.

81. Mr. Brown's analysis established that if SHH is built MRH will sustain cumulative financial losses over five years of approximately $40 million. Mr. Brown stated that such losses will reduce MRH's ability to provide for future fixed expenses and needs for capital expenses such as renovation and maintenance of all of its facilities. MRH faces capital requirements in the near future, including need for conversion of semi-private rooms to private rooms, electronic medical records and other technological improvements and similar capital requirements. Mr. Brown also responded to Mr. Knapp's testimony that WMC and MRH would not be injured financially because they would supposedly maintain the same number of discharges they had in 2005. Mr. Brown testified that having the same number of discharges today as a hospital had 10 years ago

would put that hospital in dire financial straits in light of factors such as increased expenses, increased capital spending and possible decreases in reimbursement by payers.

82. WMC offered testimony by Jeff Potter, a Certified Public Accountant licensed in Tennessee and a partner with LBMC, the largest Certified Public Accounting firm in Tennessee. Mr. Potter has worked in the health care industry for over 20 years and approximately 95% of his clients are hospital or health care related.

83. Mr. Potter's report illustrates the impact of patient volume shift from WMC to SHH and then converts that number to financial impact on WMC. Mr. Potter accepted SHH's estimates of inpatient and outpatient volumes for SHH at face value; determined how much profit or contribution margin WMC makes on the services SHH admits it will take from WMC; and then determined that WMC stands to suffer approximately $18 million in lost profits in the first five years of SHH's operation. For the past few years, WMC has averaged a profit of roughly $8.5 million a year. Thus, SHH threatens to cut WMC's profits almost in half.

84. If SHH is not built, discharges and revenues at the existing hospitals will increase due to the population increase. Neither Mr. Brown nor Mr. Potter made any effort to project the financial condition of MRH and WMC, with or without SHH.

85. SHH offered the testimony of Rick Knapp regarding the financial impact of SHH. Mr. Knapp testified that he is a Certified Public Accountant in Ohio and Georgia. However, in *voir dire* of Mr. Knapp, MRH and WMC established that he is not currently licensed in either state. It is determined that a CPA license is not required to testify about the financial aspects of health care planning.

86. Mr. Knapp's opinions, as to precise dollar amounts only, are essentially contingent upon Mr. Luke's projections being accurate.

87. Mr. Knapp estimated WMC stands to suffer $13,629,761.00 in lost profits in the first five years of SHH's operation. Mr. Knapp also estimated MRH's lost profits for the first five years of SHH's operation as $6,266,119.00.

88. Mr. Knapp was of the opinion that the population growth in Maury and Williamson Counties, and the resulting increase in overall discharges within those counties, will more than offset the financial impact caused by those patients who choose to go to SHH rather than to MRH and WMC.

89. As stated by Mr. Knapp, assuming Dr. Luke's projections and allocations of discharges in Williamson and Maury Counties, and assuming that Mr. Potter's per discharge revenue calculations for WMC are correct, WMC will enjoy $3.3 million more in operating income in 2010 than it did in 2006. By 2014, that increase is projected to grow to $8.7 million.

90. As stated by Mr. Knapp, assuming Dr. Luke's projections and allocation of discharges in Williamson and Maury Counties, and assuming that Mr. Brown's per discharge revenue calculations for MRH are correct, MRH will enjoy $15.7 million more in net income in 2010 than it did in 2006. By 2014, that increase is projected to grow to $21.3 million.

91. SHH offered proof regarding the opening of a new hospital and its impact on an existing hospital. In 2001, Middle Tennessee Medical Center (MTMC), located in Murfreesboro, Rutherford County, Tennessee, opposed a CON application filed by HCA for a new hospital (now StoneCrest Hospital) to be built in Smyrna, Rutherford County.

In opposing that application, MTMC predicted to the Agency that, if the new hospital was built, MTMC would suffer a 17-23% decline in admissions, resulting in a loss of some $16 million over two years. The CON application was granted, and StoneCrest Hospital opened in the fourth quarter of 2003.

92. In 2006 MTMC filed a CON application for a replacement facility. The application stated that "MTMC's current facility is already bed capacity constrained, despite the opening of StoneCrest Medical Center in 2003." The application showed that occupancy at MTMC was 73.8% in 2003, 78.2% in 2004, 76.3% in 2005, and 84.1% in 2006. The application's historical data chart and projected data chart also showed that MTMC was projected to significantly increase its bottom line financially in spite of the opening of StoneCrest. In her report, Dr. Kolb found the SHH comparisons to StoneCrest to be misleading. Dr. Kolb notes that Rutherford County and Smyrna are significantly more populous than Maury County or Spring Hill and the CON applications of SHH and StoneCrest are different in methodology and assumptions. It is also noted that Stonecrest opened with 75 beds, approximately 35% more than SHH.

93. MRH is located 14 miles from the site of the proposed SHH. MRH provides health care services in eight counties, some that have limited access to such services. Many of these services and facilities operate at a financial loss and depend upon MRH for financial support and for capital investment for upkeep, renovation and improvement.

94. MRH operates Marshall Medical Center in Lewisburg, Tennessee. Phyllis Brown, the CFO of that facility testified that before 1995, HCA and a variety of other private operators owned the hospital. In 1995, MRH assumed responsibility for operating

the facility. Marshall Medical Center serves as the only emergency care facility for the entire county. If the Marshall Medical Center ceased to exist, residents of Lewisburg would be required to travel to Columbia to receive emergency care. Marshall Medical Center has a payer mix of 42% Medicare, 22% Blue Cross, 15% TennCare, 10% commercial and 8% self pay/no insurance. Marshall Medical Center regularly incurs operating losses. Testimony of Bob Phillips, a pharmacist who is the Mayor of Lewisburg and a longtime member of the Marshall County Commission, also emphasized the important role MRH has played in supporting Marshall Medical Center and the difficulty the community experienced when the facility was repeatedly sold by various private owners.

95. MRH also operates the Lewis Ambulatory Care Center in Hohenwald, Tennessee. Hohenwald is the only town in Lewis County, with a population of approximately 3,800. The county as a whole has a population of approximately 12,000 people. The Lewis Ambulatory Care Center is the only urgent care center for Lewis County. If it did not exist, citizens of Hohenwald would have to travel either to Linden or to Columbia (which is 45 minutes away) for urgent care. The Lewis Ambulatory Care Center operates consistently at a loss of between $100,000 and $250,000 a year. The payer mix averages 25% Medicare, 25% TennCare, 25% Blue Cross and 25% self-pay/bad debt, managed care and other commercial insurance. Lewis County does not have the tax base to operate Lewis Ambulatory Care Center.

96. MRH operates Wayne Medical Center in Waynesboro, Tennessee. Byron Quinton, the Chief Executive Officer of Wayne Medical Center testified that MRH assumed the operation of that facility in 1995. Over the preceding 20 years the hospital

had been operated by several different private operators, including HCA. Each prior operator eventually divested itself of the facility. The payer mix of Wayne Medical Center is typically 70% Medicare and only 15 to 20% commercial insurance. The remainder of patients are TennCare or uninsured. Waynesboro is the primary town in Wayne County, with a population of approximately 2,500 people, and a county population of approximately 16,000. Wayne Medical Center is the only facility offering emergency services in the county. if it ceased to operate, citizens of the county would have to travel either 30 minutes to Savannah, Tennessee or 45 minutes to Florence, Alabama to receive emergency care. In addition, Wayne Medical Center transfers substantial funds to Wayne County each year. Wayne County does not have a sufficient tax base to operate Wayne Medical Center. Without MRH's financial support or the support of another outside entity, Wayne Medical Center would be forced to close.

97. MRH operates an Ambulatory Care Center in Columbia that provides medical care for area residents, including residents of the housing units operated by the Columbia Housing Authority. Many of those residents have no medical insurance or inadequate insurance.

## CONCLUSIONS OF LAW

1. The standard of review of an Initial Order by the HSDA is governed by TCA § 4-5-315(d), wherein the HSDA shall exercise all the decision-making powers that it would have had to render a Final Order had the HSDA presided over the contested case hearing. In the underlying contested case, the Administrative Law Judge sat without the Agency in the de novo hearing pursuant to Tenn. Code Ann. § 68-11-1610.

2. The party petitioning for the contested case hearing bears the burden of proof to establish, by a preponderance of the evidence, that the CON should be granted or denied. Tenn. Comp. R. & Regs. Rule No. 0720-13-.01(3). MRH and WMC had the burden of proof in the contested case hearing to establish that the SHH CON should be denied. On this review to the Health Services and Development Agency, SHH bears the burden of proof.

3. Tenn. Code Ann, § 68-1 1-1609(b) provides:

> No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services. In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. Until the state health plan is approved and adopted, the agency shall use as guidelines the current criteria and standards adopted by the state health planning and advisory board, and any changes implemented by the planning division pursuant to § 68-11-1625. Additional criteria for review of applications shall also be prescribed by rules of the agency.

Therefore, the CON can be approved only if it satisfies the three criteria set forth above.

4. Pursuant to T.C.A. § 68-1 1-1609(b) the Agency should use *"Tennessee's Health: Guidelines for Growth"* 2000 edition *(Guidelines)* as guidelines until such time as a comprehensive state health plan is prepared. The *Guidelines* sets forth a specific methodology for determining need for many types of health care services, including acute care hospital services. The *Guidelines* need formula for acute care hospital beds is calculated by county and takes into account patient migration patterns.

5. Rule 0720-ll-.01 of the Rules of the Tennessee Health Services and Development Agency sets forth additional criteria for review of CON applications as adopted by the Agency:

**GENERAL CRITERIA FOR CERTIFICATE OF NEED.** The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

(a) The relationship of the proposal to any existing applicable plans;

(b) The population served by the proposal;

(c) The existing or certified services or institutions in the area;

(d) The reasonableness of the service area;

(e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;

(f) Comparison of utilization/occupancy trends and services offered by other area providers;

(g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may he evaluated upon the following factors:

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition;

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;

(d) The quality of the proposed project in relation to applicable governmental or professional standards.

**NEED**

6. By a seven to one vote, the Health Services and Development Agency has determined that there is a need for a new hospital in Spring Hill. Based on population growth, commercial development, and approved subdivisions, the Health Services and Development Agency concludes the best way to meet the needs of the citizens of Spring Hill is with a new general hospital that provides a laboratory and medical technology, including x-ray, CT, MRI and ultrasound. Spring Hill's most significant need is more primary care physicians who make the area their home or the primary focus of their medical care. Primary care physicians will be attracted by a general hospital providing

these services. This need is not based solely on hospital beds. The bed need as calculated by the Department of Health is only a guideline and does not consider other immediate needs within Spring Hill; empty beds at MRH and WMC do not mean that there is an excess of medical care. The HSDA concludes that neither MRH nor WMC ever approached the administration of the City of Spring Hill with regard to opening an inpatient facility. The HSDA further concludes that neither MRH nor WMC has any plans to open an inpatient facility in Spring Hill in the foreseeable future. Based on population growth and traffic patterns, the HSDA sees the need for a hospital within the city limits of Spring Hill.

7. Prior to submitting the SHH CON application, HCA consulted Ed Stall, a hospital consultant it regularly engages, to update his 2004 report regarding the need for a hospital in Spring Hill. Although his report made conservative assumptions and was not a comprehensive analysis, his report is of some assistance in determining need. After a careful review of the record, the HSDA concludes that the 2004 report of Ed Stall did not make any recommendations about an inpatient facility in Spring Hill. Furthermore, the HSDA finds that Mr. Stall's updated 2006 report did conclude that a hospital of up to 55.7 beds would be needed in 2010. Additionally, Mr. Stall indicated that his report included conservative population projections. His report stated that accelerated population growth within the planning horizon would shorten the time frame in which beds would be needed in Spring Hill. Population growth in Spring Hill has in fact accelerated between 2005 and 2007. Prior to the SHH CON application, MRH consultants estimated that with 85% occupancy Spring Hill residents would need up to 60 beds by 2015 and WMC consultants estimated that WMC should open 60 more beds by

2010. It should be noted that 1) the MRH estimate calls for the beds in 2105, not 2010 and, 2) the additional beds called for at WMC are for the entire WMC service area not just Spring Hill. The HSDA further notes that Spring Hill is the fastest growing community in Williamson County, and therefore the 60 additional beds contemplated by WMC for 2010 would likely be most needed in the Spring Hill area.

8. The SHH CON application did not satisfy the *Guidelines* bed need formula. However, WMC's 40-bed CON application and Stonecrest's CON application each failed the formula but both were granted a CON by the Agency. Pursuant to Tenn. Code Ann. § 68-11-1609(b), the *Guidelines* are not mandatory but should be merely used as a guide. Additional evidence was presented and should be considered as to whether or not additional beds are needed in the Spring Hill area.

9. The Administrative Law Judge concluded that in determining bed need and occupancy rates, Dr. Luke failed to account for out-migration in his Report presented to the Agency. Some tertiary services are not currently available in Maury or Williamson Counties and are not expected to be available in the foreseeable future in those areas. Thus, even though out-migration for tertiary services will continue in the future, HCA's bed need analysis included such patients when calculating the bed need for the area. HCA's methodology has the effect of overstating bed need since SHH would not alter or reduce such tertiary out-migration since SHH would not offer tertiary care. Also, some patients seek treatment out of county for non-tertiary care and Dr. Luke also failed to account for this type of out-migration. Therefore, HCA's analysis of bed need does not show the number of hospital beds needed in Maury and Williamson Counties. Rather, it shows the number of beds needed by residents of Maury and Williamson Counties, even

if some of those beds would be located in Davidson County and other counties where residents obtain hospital services. The HSDA concludes that where a service area population needs beds, it is the role of the HSDA to determine where beds will be located. Furthermore, the HSDA concludes that out-migration was accounted for in the projected market shares of only 5% to 35% of the primary service area. This was fully disclosed and explained by SHH in the original Application.

10. The Administrative Law Judge concluded that the factor most driving bed need is population. Much of the evidence at this hearing related to and/or was dependent upon population projections for the proposed SHH service area. The essential question is whether there will be sufficient population in 2010 when SHH is projected to open and in subsequent years to support SHH as well as MRH and WMC. According to Dr. Luke, the two zip codes encompassing Spring Hill will have a population of 60,373 in 2010 and 116,371 in year 2014. Dr. Luke established this number by using a 17% growth rate and compounding annually. Dr. Swanson has never seen a city sustain a 17% rate of growth for the time period projected by Dr. Luke. SHH argues that Dr. Luke's predictions for the growth rate between 2005 and 2007 are already behind the population as established by the April 2007 city of Spring Hill water accounts. However, the population projections to establish the need for the hospital extend all the way to 2014. Dr. Luke's methodology leads to the population of Spring Hill doubling every four years until the growth stops (sometime after 2014). Dr. Swanson's population numbers were far below Dr. Luke's projections. Dr. Fox and Dr. Kolb felt that Dr. Swanson's methodology was more appropriate and resulted in reasonable projections. The HSDA concludes that the evidence of population growth between 2005 and 2007 establishes that Dr. Swanson's

"high" scenario falls far short of the growth rate that has been established to date. Moreover, no matter whose population projections are accepted, the evidence establishes that there will be a sufficient population in Spring Hill between the years 2010 and 2014 to support a 56 bed hospital.

11. The Administrative Law Judge concluded that residential lots approved for development, schools planned to be built, requested annexation and new businesses all demonstrate real growth in Spring Hill. Further, Spring Hill has available housing, land, residential lots, and infrastructure to accommodate much more additional growth, even than estimated by Dr. Luke. The HSDA concludes that there is no evidence in the record that the capacity of Spring Hill to grow is or will be limited between now and 2014.

12. The HSDA concludes that Dr. Luke's population projections are not outside the range of reason in light of the fact that the undisputed evidence in the record shows that Spring Hill has grown at a rate faster than either Dr. Luke or Dr. Swanson projected in the years 2005-2007. Furthermore, this accelerated growth rate establishes that Dr. Swanson's "high" scenario is actually at the low end of the range of reason.

13. The Administrative Law Judge concluded that Spring Hill officials and many of its residents support SHH. Several Spring Hill residents testified about lengthy trips for emergency care, though some were not familiar with the urgent care facility located in Spring Hill. Community support, though not the only criteria to determine whether a CON should be granted, was taken into consideration. The HSDA notes that the urgent care facility is open only from 8:00 a.m. to 8:00 p.m., and that health care needs are not limited to these hours.

14. When all of the above-cited factors are considered, MRH and WMC have failed to establish by a preponderance of the evidence that SHH is not "necessary to provide needed health care" to the proposed service area. The HSDA further concludes that SHH has established, by a preponderance of the evidence, that SHH is necessary to provide needed health care to the proposed service area.

**ECONOMIC FACTORS**

15. Although there was an error in the financial projections prepared in support of the SHH CON application, the subsequent corrected financial projections still show a positive net income in SHH's fourth year of operation. The anticipated profit decreased from approximately $1 million to approximately $250,000. With the correction, estimated losses increased from $25 million to $29 million. Even though the $4 million increase is not insignificant, it is not of such magnitude to be of concern since new hospitals are expected to lose money in initial years of operation. SHH's corrected and updated financial projections do not materially alter the CON application.

16. Significant to HCA is the cash flow or EBITDA of an investment. SHH is projected to have positive cash flow in year two of its operation and continue to improve every year thereafter.

17. SHH financial projections rely, in part, on Dr. Luke's population and use rates. Based on her review of Dr. Luke's and HCA projections, Dr. Kolb opined that SHH was not financially viable. However, occupancy rates at a mid-point between Dr. Luke's projections and Dr. Swanson's projections mean that SHH will still have positive EBITDA in year two.

18. Even if SHH does not obtain the occupancy rates projected by Dr. Luke within the projected time frame, HCA considers SHH a long term investment and has the financial ability to fund SHH.

19. When all of these factors are considered, MRH and WMC have failed to establish, by a preponderance of the evidence, that SHH cannot "be economically accomplished and maintained." The HSDA further concludes that SHH has established by a preponderance of the evidence that SHH can "be economically accomplished and maintained."

**CONTRIBUTION TO THE ORDERLY DEVEPMENT OF HEALTH CARE**

20. The HSDA concludes that Dr. Luke's projections are reasonable, and that Dr. Kolb's analysis was based on Dr. Swanson's population projections, which have been conclusively shown to be low. Her reliance on Dr. Swanson necessarily depresses her projections for admissions at MRH and WMC from 2010 through 2015. The Agency recognizes the fact that any new provider will take patients away from an existing provider. The CON process in Tennessee is not intended to protect hospitals from all competition, but rather to provide the public with reasonable access to healthcare while at the same time protecting existing facilities from unnecessary and duplicative competition that would threaten the ability of the existing facilities to continue to provide services in the community. The Agency therefore finds that while some patients and/or their physicians will choose SHH instead of MRH or WMC, there is no evidence that as a result either MRH or WMC will be unable to continue to provide their services to the community.

21. The HSDA concludes that, regardless of which expert's dollar amounts are accepted, the "losses" referred to by the experts for MRH and WMC were never netted by them against the increase in discharges that will result from the population growth that everyone agrees is occurring. Without any evidence of the net effect of these "losses," there is no evidence in this record of substantial financial harm that would prevent WMC or MRH from continuing to provide services to their communities.

22. The HSDA concludes that there is no evidence in the record that either MRH or WMC would likely be less able to provide for the health care needs of citizens in their service areas. The HSDA notes that WMC has projected capital expenditures for an additional 60 beds at WMC by 2010. If SHH becomes operational in 2010, the need for the additional 60 beds and the resulting capital expenditure might become unnecessary. On the other hand, if Dr. Luke's population projections prove accurate, the additional beds might be needed, but funds for the additional beds would also be available. The HSDA further concludes that, because MRH does not receive more than a 2% market share from the Spring Hill area, there is even less reason to believe that MRH will be adversely affected by SHH.

23. The HSDA concludes that the analogies between Stone Crest Medical Center and SHH are relevant. In resisting the StoneCrest CON application, MTMC made essentially the same predictions of adverse impact as WMC and MRH have made in this case. MTMC predicted that it would lose $16 Million over two years. Yet, MTMC filed a CON application for a replacement facility in 2006 that showed 2006 occupancy rates of 84.1%. The difference in population between Smyrna and Spring Hill is largely offset by the difference in sizes of StoneCrest and SHH.

24. The HSDA concludes that while MRH and WMC have made significant capital investments to serve the needs of their service areas, including Spring Hill, they have not shown a willingness to establish an inpatient facility in Spring Hill. As previously set forth in this Order, the Agency finds that there will be a sufficient population in the Spring Hill area by 2010 to support an inpatient facility. While SHH might have some impact on both MRH and WMC, neither hospital has demonstrated that it will be adversely impacted by SHH to the extent that they cannot continue to provide services to the citizens of their service area. Further, the improvements made by MRH and WMC will lessen the out-migration from those facilities to Davidson County or to other areas.

25. No evidence was presented that Marshall Medical Center will cease to exist if SHH were operational. No evidence was presented that Lewis Ambulatory Care Center would cease to exist if SHH were operational. No evidence was presented that Wayne Medical Center would cease to exist if SHH were operational. There was no evidence that services in the area would be significantly reduced or stopped if SHH were operational. The Health Services and Development Agency concludes that opening the new hospital will not result in the closing of other services.

26. There was evidence that HCA TriStar is a significant TennCare provider, with 20% of its patient mix being TennCare.

27. The Health Services and Development Agency concludes that establishing a hospital in Spring Hill will attract primary care physicians, provide comprehensive care to the citizens of Spring Hill, and provide referral sources to tertiary care hospitals in the region, thus contributing to the orderly development of healthcare.

28. When all of these factors are considered, MRH and WMC have not established, by a preponderance of the evidence, that SHH will not "contribute to the orderly development of adequate and effective health care facilities or services." The HSDA further concludes that SHH has established by a preponderance of the evidence that it will contribute to the orderly development of adequate and effective health care facilities and services.

## CONCLUSION

Maury Regional Hospital and Williamson Medical Center have not established by a preponderance of the evidence that the application for a Certificate of Need for Spring Hill Hospital fails to meet the statutory and regulatory criteria. Further, Spring Hill Hospital has established by a preponderance of the evidence that the application for a Certificate of Need for Spring Hill Hospital does meet the statutory and regulatory criteria.

THEREFORE, it is hereby **ORDERED** that the Certificate of Need filed for the Spring Hill Hospital be GRANTED and the Initial Order is modified as set forth herein.

It is further ORDERED, pursuant to Tenn. Code Annotated § 68-11-1610(i), that all of the costs in the contested case proceeding, including the Administrative Law Judge's costs, deposition costs, and expert witness fees are assessed to and shall be paid by MRH and WMC.

This Order entered this the 19th day of March, 2008.

Carl Ohm Koella, III,
Chairman, HSDA

Filed in the Administrative Procedures Division,

Office of the Secretary of State, this ____ day of _____, 2008.

By:

Attachment 1N-2, Acute

Spring Hill Hospital, Inc -1

Agreed Amendment to Final Order

**BEFORE THE TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY** 2008 APR 11 PM 2:36

| | | |
|---|---|---|
| IN THE MATTER OF: | ) | Docket No. 25.00-092967J |
| | ) | |
| SPRING HILL HOSPITAL, INC. | ) | CON No. CN0604-028 |
| | ) | |

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## AGREED AMENDMENT TO FINAL ORDER

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This matter came before the Health Services and Development Agency on April 23, 2008 for its consideration of the Motion for Reconsideration filed by Williamson Medical Center ("WMC") and Maury Regional Hospital ("MRH"). No opposition to the Motion has been filed.

The Motion for Reconsideration is GRANTED for the limited purpose requested in the Motion. Upon Motion by WMC and MRH, and upon agreement by WMC, MRH, Spring Hill Hospital, Inc., and counsel for the State, and after due consideration and deliberation by the HSDA in open meeting, the Final Order entered on March 25, 2008 (the "Final Order") is hereby AMENDED as follows.

1. The Findings of Fact, Conclusions of Law and the Final Order as a whole are adopted, re-affirmed and incorporated herein by reference, with the exception of one typographical error. In the first typewritten line of page 34 of the Final Order, in Conclusion of Law 7, the figure "2105" is amended to read "2015".

2. An additional Finding of Fact is adopted to provide as follows:

"98. In the CON application the applicant committed that when Spring Hill Hospital is licensed, the parent company, HCA, will de-license a corresponding number of hospital beds in its other Middle Tennessee

facilities, so that the region's total approved licensed bed complement will not increase as a result of Spring Hill Hospital (Tr. Ex. 27, p. 5). During the contested case hearing, Larry Kloess, President of Tri Star Health System, testified that HCA/Tri Star stood by that commitment, even though it did not appear on the face of the CON document that was originally issued by the HSDA. (Transcript, Vol. V, pp. 960-961). Mr. Kloess further testified that a decision as to which Tri Star facilities the 56 beds would be de-licensed from had not been made, and would be made at the time that the Spring Hill Hospital beds are licensed. (Transcript, Vol. V, pp. 693-695). During oral argument of this matter on February 26, 2008, counsel for Spring Hill Hospital again affirmed HCA/Tri Star's commitment to de-license the beds as stated in the CON application."

3. An additional Conclusion of Law is adopted to provide as follows:

"29. Although the Initial Order did not include a Conclusion of Law relating to the commitment to de-license beds, the Agency concludes that HCA/Tri-Star's continuing commitment to de-license 56 hospital beds upon the licensure of 56 beds at Spring Hill Hospital should be honored, and is consistent with the orderly development of healthcare services and facilities. HCA/Tri Star may choose the Tri Star facilities in Middle Tennessee from which the hospital beds will be de-licensed. The commitment to de-license beds shall only be effective upon licensure approval for the 56 beds at Spring Hill Hospital. The Certificate of Need will be modified to include a condition that is consistent with this Conclusion of Law."

4. The Final Order remains unchanged except as specifically amended herein.

Signed and adopted by the Health Services and Development Agency this ____ day of April, 2008.

Carl Ohm Koella, III,
Chairman, HSDA

AGREED TO AND APPROVED FOR ENTRY:

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Filed in the Administrative Procedures Division, Office of the Secretary of State, this ____ day of _____, 2008.

_____
Administrative Judge

Attachment 1N-3, Acute

Spring Hill Hospital, Inc -1

Chancery Court Ruling

724641

**IN THE CHANCERY COURT FOR THE STATE OF TENNESSEE**
**TWENTIETH JUDICIAL DISTRICT, DAVIDSON COUNTY**

| | | |
|---|---|---|
| MAURY REGIONAL HOSPITAL and WILLIAMSON MEDICAL CENTER, | ) | |
| Petitioners, | ) | |
| v. | ) | Case No. 08-1133-I |
| TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY, and SPRING HILL HOSPITAL, INC., | ) | |
| Respondents. | ) | |

F09, Ac(s)

FILED
2009 SEP -3 PM 4:33
DAVIDSON CO. CHANCERY CT.

**MEMORANDUM AND ORDER**

The Petitioners seek judicial review of an agency decision pursuant to Tenn. Code Ann. § 4-5-322, the agency's rules and regulations, and the Tennessee Health Services and Planning Act of 2002 at Tenn. Code Ann. § 68-11-1601, *et seq.* Contrary to objections posed by Petitioners Maury Regional Hospital and Williamson Medical Center, the Tennessee Health Services and Development Agency granted a certificate of need to Spring Hill Hospital, Inc. (SHH), a subsidiary of Hospital Corporation of America (HCA), to build a 56-bed hospital at a location between the two currently operating hospitals, the Petitioners. At the cost of $104 million to HCA, SHH would be located in Maury County (close to the Williamson County line) – 14 miles from Maury Regional Hospital in Columbia and 17 miles from the Williamson Medical Center in Franklin. The Petitioners ask the Court to take judicial notice of certain facts, or to remand the case to the Agency to present additional evidence about significant changes in

the economy of the Spring Hill area. If the motion is denied, the Petitioners seek judicial review and reversal of the Agency's decision to grant a certificate of need to SHH.

**Petitioners' Motion for the Court to Take Judicial Notice of Certain Facts or to Remand Case to the Agency for Additional Evidence**

On August 7, 2009, the Court heard the Petitioners' motion for judicial notice of certain facts or for remand of this case to the Agency for additional evidence. The Court took the motion under advisement for decision with the hearing on the merits.

At the motion hearing, counsel for all of the parties made thought-provoking arguments for their positions. It has been two years, say the Petitioners, since the trial of this case before the Administrative Law Judge (ALJ) and there have been unprecedented changes in the general economy, in the economy and tax structure of Spring Hill (including General Motors' plan to idle its Spring Hill plant indefinitely), and in hospital discharge data, that significantly alter the need for hospital services examined below. The Respondents counter with arguments about where the cycle of remand ends if the economy later improves. The Agency further contends that the State has a legitimate interest in the finality of administrative decisions and it is detrimental for State policy regarding a particular decision to stay in flux for extended periods of time. The Agency contends that the statutes governing the certificate of need process express a legislative intent to judge the facts at the time of the contested case hearing.

Section 4-5-322(c) of the APA gives this Court the discretion to remand a contested case to the deciding state agency under certain circumstances.[1] That statute provides:

[1] The Court notes that Tenn. Code Ann. § 68-11-1609(e) prohibits the Agency from reconsidering its decision regarding a certificate of need once it adjourns the meeting in which it considers the application.

> If, before the date set for hearing, application is made to the court for leave to present additional evidence, and it is shown to the satisfaction of the court that *the additional evidence is material and that there were good reasons for failure to present it in the proceeding before the agency*, the court *may* order that the additional evidence be taken before the agency upon conditions determined by the court. The agency may modify its findings and decision by reason of the additional evidence and shall file that evidence and any modifications, new findings or decisions with the reviewing court.

Tenn. Code Ann. § 4-5-322(e)(2005)(emphasis added).

The Court denies the motion to take judicial notice of certain facts without remand to the Agency because judicial review under the APA is just that – judicial review of the record below. This Court must consider the same facts considered by the Agency and any such additional facts presented under Tenn. Code Ann. §4-5-322(e) must first be presented to the Agency for its consideration. *See Phillips v. Tennessee Dep't of Transp.*, No. M2006-00912-COA-R3-CV, 2007 WL 1237695, at * 8 (Tenn. Ct. App. Apr. 26, 2007).

The Court also denies the alternative motion to remand. The Court finds that the evidence the Petitioners seek to present meets the requirements of Tenn. Code Ann. § 4-5-322(e) in that the evidence is material and that there was a good reason for not presenting such evidence below since it involves new, changed conditions. Yet, the Court exercises the discretion given by the statute to deny remand because State policy must become final at some point. While the changes in the economic conditions since the contested hearing are significant, economic conditions are always changing and the laws governing the Agency's process, which include strict timelines and a prohibition against reconsideration of decisions, indicate legislative intent to move the process forward.

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(fn 1 cont.) That statute, however, does not appear to prohibit remand under Tenn. Code Ann. § 4-5-322(e) because Tenn. Code Ann. § 68-11-1609(e) expressly does not limit application of the APA's contested case hearing provisions to this agency's decisions.

## Judicial Review of the Agency Final Order

The judicial review hearing took place on August 19, 2009 and this Court took its decision under advisement. The technical record is 23 volumes containing approximately 1000 pages each. The transcribed contested case hearing fills 10 additional volumes. Both sides of the controversy called several expert witnesses during the contested case hearing before the ALJ. The dispute about whether this hospital is needed was hard-fought and the expert witnesses' testimony contained some advocacy as well.

The proceedings below began with a ten-day contested case hearing, after which ALJ Leonard Pogue issued an order denying the certificate of need because two of the three statutory criteria for that certificate were not met. The ALJ found that there is no need for the new hospital in Spring Hill and that granting the certificate of need to this new hospital will not contribute to the orderly development of adequate and effective health care facilities or services.

The Agency met to review the initial order at the request of SHH. After brief deliberations, the Agency issued a final order, reversing the ALJ and granting the certificate of need to SHH. The parties then agreed, and the Agency ordered, that the certificate of need is conditioned upon HCA's elimination of a total of 56 beds from its other hospitals, somewhere in Middle Tennessee. This agreed order was not entered as a settlement, but rather to record SHH's commitment to this condition in its application for the certificate.

## Standard of Review

This Court reviews decisions of the Agency using the same standard of review applicable to the contested case decisions of other state boards, commissions, and

administrative agencies. Tenn. Code Ann. § 4-5-322(h)(2005). The Court reviews the Agency's "findings, inferences, conclusions or decisions" to determine whether they are:

> (1) In violation of constitutional or statutory provisions;
>
> (2) In excess of the statutory authority of the agency;
>
> (3) Made upon unlawful procedure;
>
> (4) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion; or
>
> (5) Unsupported by evidence which is both substantial and material in light of the entire record.

While on the Court of Appeals, Judge, now Justice Koch, elaborated on these standards of review and discussed how they do not always lend themselves to mechanical application:

> The standards of review in Tenn. Code Ann. § 4-5-322(h)(4) and Tenn. Code Ann. § 4-5-322(h)(5) are narrower than the standard of review normally applicable to other civil cases. They are also related but are not synonymous. Agency decisions not supported by substantial and material evidence are arbitrary and capricious. However, agency decisions with adequate evidentiary support may still be arbitrary and capricious if caused by a clear error in judgment.
>
> A reviewing court should not apply Tenn. Code Ann. § 4-5-322(h)(4)'s "arbitrary and capricious" standard of review mechanically. In its broadest sense, the standard requires the court to determine whether the administrative agency has made a clear error in judgment. An arbitrary decision is one that is not based on any course of reasoning or exercise of judgment, or one that disregards the facts or circumstances of the case without some basis that would lead a reasonable person to reach the same conclusion.
>
> Likewise, a reviewing court should not apply Tenn. Code Ann. § 4-5-322(h)(5)'s "substantial and material evidence" test mechanically. Instead, the court should review the record carefully to determine whether the administrative agency's decision is supported by "such relevant evidence as a rational mind might accept to support a rational conclusion." The court need not reweigh the evidence, and the agency's decision need not be supported by a preponderance of the evidence. The evidence will be

> sufficient if it furnishes a reasonably sound factual basis for the decision being reviewed.

*Jackson Mobilphone Co., Inc. v. Tennessee Pub. Serv. Comm'n*, 876 S.W.2d 106, 110-11, (Tenn. Ct. App. 1993)(citations omitted).

**Issues**

The Petitioners first contend that the Agency's decision was made upon unlawful procedure. They assert that the Agency had no reason to review the ALJ's detailed decision made after eight months of proceedings and two weeks of trial. They also argue that the Agency's review of the ALJ's initial order was procedurally defective because the Agency used an erroneous *de novo* standard of review, instead of the more deferential substantial and material evidence standard stated in Tenn. Code Ann. § 4-5-322(h). Next, the Petitioners assert that the Agency's decision is arbitrary and capricious because the Agency based its finding of need for SHH upon outlandish population projections for Spring Hill and other insubstantial and immaterial facts. Furthermore, they assert that there was no effort by the Agency to recognize planning for health care as it is required to do and the Agency ignored proof that a third hospital would disrupt and circumvent the orderly development of health care already provided in that area. Last, the Petitioners contend that this proposed hospital can only be economically accomplished and maintained with duplication of health services and the kind of competition that will threaten the Petitioners' ability to continue providing services in the community.

SHH contends that the Agency's decision was not arbitrary and capricious and is supported by substantial and material evidence since need for the third hospital is substantial. In particular, it contends the record shows that the new hospital will attract primary care doctors, reduce the burdensome driving time to emergency rooms, add

needed beds, and will generate greater health care use by the increasing population of Spring Hill. SHH asserts that the Petitioners do not show how badly SHH will damage their operations and that one of the Petitioners took the position that additional beds are needed in the same area of Tennessee when that Petitioner recently applied for a certificate of need to expand its facilities. SHH also asserts that the Agency appropriately substituted its judgment for that expressed in the Initial Order given that the review was *de novo* on the record as described in Tenn. Code Ann. § 4-5-315(d). Further, says SHH, the findings of fact in the Initial Order were largely accepted but the facts called for the different result reached by the Agency. Last, says SHH, the Tennessee Health Guidelines for Growth in the state health plan or those adopted by the state health planning and advisory board, may indicate there is no need for the hospital, but the Guidelines are only guidelines, and other certificates of need have been granted when hospital bed occupancy has not met the Guidelines.

The Agency filed its own brief to show there was no improper procedure. It made a forceful argument in support of its decision and procedures.

The Court must decide the following issues:

1. Did the Agency articulate and apply the proper standard of review of the Initial Order and was there other improper procedure which affected the merits?

2. Is there substantial and material evidence in the record that SHH is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or does this Agency conclusion lack a reasonably sound factual basis?

3. Was the decision to grant the certificate of need to SHH arbitrary and capricious because the Agency made a clear error in judgment?

## Summary of Decision

The Court reverses the Agency decision granting the certificate of need because the Agency made a clear error in judgment and came to its decision to grant the certificate to SHH without a reasonably sound factual basis. Respectfully, the Agency's decision is arbitrary and capricious and is unsupported in the record by substantial and material evidence.

## The Proceedings before the Agency

At a regular July, 2006 Agency meeting, the Agency granted SHH a certificate of need. The Petitioners filed an objection, a contested case hearing was set before ALJ Pogue, and a trial was held from April 11-24, 2007. In an Initial Order filed on October 12, 2007, the ALJ denied SHH's application, finding that the new hospital was "not necessary to provide needed health care to the proposed service area." In its Initial Order fact findings, the ALJ used the Tennessee Health Guidelines for Growth and the Certificate of Need Review by the Department of Health Division of Health Statistics.

The Department of Health Review and the State Health Guidelines provide that even with increased population in the Spring Hill area, there is still a surplus of hospital beds in that area and there will be continue to be a surplus in 2010. The ALJ concluded that the population projection methodology of SHH had the effect of overstating the bed need for the area and SHH did not show the number of hospital beds needed in Maury and Williamson counties. Based upon professional qualifications and testimony, the ALJ found the opinions of the Petitioners' expert witnesses about Maury and Williamson County population projections through 2010, were more credible than the opinions of the SHH experts.

Next, the ALJ found that SHH can be economically accomplished and maintained. He found that SHH should show positive net income in the fourth year of operation and HCA is prepared to make this long-term investment.

Third, the ALJ found that the Petitioners established, by a preponderance of the evidence, that SHH will not contribute to the orderly development of adequate and effective health care facilities or services because with SHH in the marketplace, the Petitioners stand to lose many millions over five years and the Petitioners will continue to experience declining use of their facilities. These losses will cause the reduction of health care services in the subject area because the Petitioners' technological improvements, debt payment and renovations will slow. This likely damage to the Petitioners from SHH's competition is not justified because there is no genuine need for services from SHH.

SHH requested review of the ALJ's decision, and the Agency decided to review the Initial Order. On February 27, 2008, the Agency members (functioning like a board or commission) met in person. The meeting is transcribed in the technical record at pages 000069 through 0000119. The parties' lawyers argued their positions and the members asked questions of the lawyers. The Agency deliberated for a brief time – transcribed on pages 00095 through 000097 – and voted, seven to one, to reject the ALJ's findings and conclusions.

Immediately before the vote, ALJ Tom Stovall advised the Agency that if the members rejected the ALJ's findings in the Initial Order, the Agency must craft a final order and articulate why the Agency reached the conclusions it reached. Thereafter, the Agency read aloud the SHH proposed final order and articulated findings which differed

from the SHH proposed final order. This SHH proposed final order text was largely taken from the ALJ's Initial Order but it was not identical. Because the Agency worked from the SHH proposal, the work of the Agency to identify differences between the Initial Order and its final order was confusing. Some Agency members stated they had read the entire massive record and the Agency members were, in general, familiar with the record. This background work was significant and the Agency members were determined to complete their decision.

One difference between the SHH proposed final order and the Initial Order which made its way into the Agency's Final Order was material and was not commented on, or perhaps even noticed, by the Agency as it crafted its own order:

> -- Paragraph 11 of the Initial Order stated that "Mr. Stall's 2004 report [expert for SHH], not intended to be a detailed analysis, concluded that the Spring Hill area *did not yet need* a hospital."
>
> -- The SHH proposed order replaced the last clause with the finding "*did not address the need* for a hospital in Spring Hill."

(emphasis added). Other changes from the ALJ findings were dictated into the record by the Agency:

> 1. The Petitioners' satellite clinic in Spring Hill does not necessarily address access to quality health care and the clinic is not open 24/7.
>
> 2. Some Spring Hill residents took over an hour to reach an emergency room during rush hour.
>
> 3. Mr. Stall's report indicates a bed need in 2010 from a conservative case of 42 beds, up to a target case of 55 beds will be needed in this area. The year 2010 is a little too soon. Mr. Stall further indicated that accelerated growth would shorten this timeline.
>
> 4. The acute hospital bed need methodology in the Guidelines has not been updated since the 1990's.

5. We do not know why some patients migrate from Maury and Williamson for health care at a hospital.

6. Dr. Luke's population projections have been understated so far.

7. Some assumptions used by Dr. Swanson and his methodology are troubling. Spring Hill will grow not from within but from people moving into Spring Hill. Dr. Swanson's population projections did not take the city planners' input into account.

8. Spring Hill's most significant need is for more primary care physicians who make this area their home. Based on population growth, commercial development and approved subdivisions, the Agency feels the best way to meet the needs of Spring Hill is with a new general hospital, with an emergency room, and inpatient care because this new hospital will attract primary care doctors.

9. The presence of hospital beds does not mean quality health care. Instead, more primary care physicians are needed.

10. The hospital bed need calculated by the Health Department is only a guideline. It is the role of the Agency to determine where hospital beds will be located.

11. Neither of the Petitioners has any plans to open an inpatient care facility in Spring Hill in the near future. Based on population growth and traffic patterns, the Agency sees a need for a hospital in Spring Hill.

12. No evidence was presented that Marshall Medical Center will close if SHH is operating and there is no proof that Lewis Ambulatory and Wayne Medical Center will cease to exist.

**Findings of Fact in Judicial Review**

The Court makes the following findings of fact in its judicial review: Maury Regional Hospital operates a 255-bed acute care hospital in Columbia, Tennessee. It serves eight counties in southern Middle Tennessee and also runs some satellite facilities such as a primary care facility in Spring Hill open from 8 a.m. to 8 p.m. Williamson Medical Center is a 185-bed acute care hospital in Franklin. It also provides one and one-half family physicians for the area.

SHH is a subsidiary of HCA. The proposed SHH would be located in Maury County (close to the Williamson County line), in Spring Hill, approximately 14 miles from Maury Regional Hospital and 17 miles from Williamson Medical Center. The majority of Spring Hill residents live in Williamson County. Spring Hill is a small city with its own mayor and government. SHH will add 56 acute care beds, including 8 critical beds, and 40 medical surgical beds, to serve six zip codes in and around Spring Hill. It will have an emergency department and its cost is $104 million.

The Health Planning Act of 2002 directs the Tennessee Department of Health to review every certificate of need application and provide the Agency with a report which analyzes whether the application of a new and proposed hospital complies with Tennessee Health Guidelines for Growth. These Tennessee Health Guidelines for Growth contain an acute bed need methodology and the Guidelines set out in detail when a certificate of need can be justified if there is no need for acute care beds.

Pursuant to Tenn. Code Ann. § 68-11-1608(a), the Department of Health reported upon the application filed by SHH. The Certificate of Need Review by the Department of Health Division of Health Statistics, trial exhibit 8 to the contested hearing, concluded that SHH did not satisfy the acute care hospital bed standard in the Guidelines and did not qualify for exception under the Guidelines' standard. The Guidelines set forth a specific methodology for determining need for many types of health services, including acute care hospital services. The Guidelines' need formula for acute care hospital beds is calculated by county and takes into account patient migration patterns, that is, how often and how many county residents leave the county for hospital services. As regards the Guidelines for acute care bed need, the Department of Health reported in trial exhibit 8:

*The applicant does not meet this* [sic] *criteria. The Division of Health Statistics' staff calculated the projected bed need as a surplus of 135 licensed beds and 65 staffed beds. The primary service area of Maury and Williamson counties has an actual bed count of 395 licensed beds and 370 staffed beds, with an additional 45 CON approved beds still to be introduced to the market place. If these 45 beds are implemented, the surplus will increase to 180 beds.*

The Certificate of Need Review by the Department of Health Division Of Health Statistics accurately states that Tennessee's Health Guidelines for Growth provide that when evaluating need for acute care beds, new hospital beds can be approved in excess of the need standard for a county if "all existing hospitals in the projected service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report. Occupancy should be based on the number of licensed beds that are staffed for two consecutive years." This certificate of need review by the Department of Health made further findings regarding whether SHH qualifies for the exception to the need standard:

*The applicant does not meet this criterion. The following table illustrates the service area hospitals and their occupancy rates for the last three years. Neither Maury Regional Hospital, nor Williamson Medical Center reached 80% occupancy rate in each of the last three years.*

**Service Area Hospital Utilization, 2003, 2004, and 2005 (Provisional)**

| *Facility* | *Licensed Beds* | *2003 Occupancy* | *2004 Occupancy* | *2005 Occupancy* |
|---|---|---|---|---|
| *Maury Regional Hospital* | *255* | *68.00%* | *61.20%* | *57.40%* |
| *Williamson Medical Center* | *140* | *50.10%* | *54.90%* | *55.00%* |

*Source: Joint Annual Report of Hospitals 2003, 2004, and 2005 (Provisional), Tennessee Department of Health Division of Health Statistics*

The Certificate of Need Review by the Department of Health Division of Health Statistics reported upon the population of Maury and Williamson Counties. From 2006 to 2010, the Department projects that Maury County's population will increase by 5.2 percent and Williamson County's population will increase by 9.9 percent.

The Petitioners called experts to project population through 2010. Their methodology and their projections were sharply attacked by SHH. Then SHH called its experts to project population through 2010. The Petitioners sharply attacked the SHH methodology and their projections. All agree that at the time of the contested hearing, it was reasonable to project an increase in population for the two counties and that Spring Hill's population, (located in Maury County) would increase. As found earlier in these facts, the Department of Health Division of Health Statistics also projected an increase through 2010 and it then determined, using that increase, that there is and will be a surplus of acute care beds in the two counties.

Additional factual findings are: The hospital service utilization rate for SHH's six zip code service area declined 4.2% from 2002 to 2005. No one can say for sure why hospital use in this region is decreasing. SHH plans to provide health care services which are already offered by the Petitioners. The Petitioners' experts testified that the Petitioners will lose significant profit to SHH while SHH's experts believe that increased population will generate a larger medical marketplace and cause all three hospitals to do well financially. SHH has a physician recruitment plan to attract a wide range of specialists for patient referral to SHH.

**Principles of Law**

The Tennessee Health Services and Development Agency was created by the legislature to administer the certificate of need program. Tenn. Code Ann. § 68-11-1602 (2006). A certificate of need means a permit granted by the Agency to any person for the establishment or modification of a health care institution, facility, or covered health

service, at a designated location. Tenn. Code Ann. § 68-11-1602(2)(2006). Agency policy is set by the Act:

> It is declared to be the public policy of this state that the establishment and modification of health care institutions, facilities and services shall be accomplished in a manner that is orderly, economical and consistent with the effective development of necessary and adequate means of providing for the health care of the people of Tennessee. To this end, the provisions of this section shall be equitably applied to all health care entities, regardless of ownership or type, except those owned and operated by the United States government.

Tenn. Code Ann. § 68-11-1603 (2006).

The Agency has among its duties, "to grant or deny certificates of need on the basis of the merits of such applications within the context of the local, regional and state health needs and plans, including, but not limited to, the state health plan developed pursuant to Tenn. Code Ann. § 68-11-1625." Tenn. Code Ann. § 68-11-1605(a)(2006). The Agency is to promulgate rules and regulations for the fulfillment of its duties and is to weigh and consider the health care needs of consumers, particularly women, minorities, and low income groups . . . when performing its duties. Tenn. Code Ann. § 68-11-1605(3), (5)(2006).

The Agency must not grant a certificate of need "unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services. In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan." Tenn. Code Ann. § 68-11-1609(b)(2006)(section since amended in 2007). The Tennessee Department of Health "shall review each application ...[a]t a minimum, the reports shall provide ...(4) [a]nalyses of the impact of

a proposed project on the utilization of existing providers...[and] (5) [s]pecific determinations as to whether a proposed project is consistent with the state health plan." Tenn. Code Ann. § 68-11-1608 (2006).

The General Assembly has directed that hospital beds and certain medical equipment shall be regulated through the certificate of need program. Tenn. Code Ann. § 68-11-1607(2006)(section amended in 2007). The Agency must review need and grant permission before any health care institution can increase its bed complement. *Id.* Permission must be granted in the form of a certificate of need if, for example, the health care institution will increase its licensed beds even if the increase is only one bed. *Id.* A certificate of need is also required if a health care institution will simply redistribute its beds from one facility to another or change a bed from acute care to long term. *Id.* There are exceptions to this rigid requirement, such as the one-year grace period enjoyed by hospitals with under 100 beds during which the hospital may add ten beds without seeking a certificate of need. *Id.* The analysis and regulation of hospital bed counts is a significant component of the Agency's duties. *Id.*

The General Assembly directs that the Department of Health will provide a review of certificate of need applications and the Department of Finance and Administration will provide guidelines in a state health plan which the Agency will use in making its decision. Tenn. Code Ann. §§ 68-11-1609; 68-11-1625 (2006).

"The agency shall determine whether a contested case shall be conducted by an administrative judge or hearing officer sitting alone or in the presence of members of the agency. Tenn. Code Ann. § 4-5-301(c)(2005). "[A]ll petitions for a contested case hearing shall be routinely referred to the Administrative Procedures Division, Department

of State for hearing by an administrative Judge sitting alone on behalf of the agency." Tenn. Comp. R. & Regs. 0720-13-.02(1)(Rules of the HSDA).

"The agency upon the agency's motion . . . or upon appeal by any party shall review an initial order . . ." Tenn. Code Ann. § 4-5-315(a)(2005). "A final order . . . under this section shall identify any difference between such order and the initial order, and shall include . . . all the matters required by Tenn. Code Ann. § 4-5-314(c)." Tenn. Code Ann. § 4-5-315(i)(2005).

"Courts defer to the decisions of Administrative Agencies when they are acting within their area of specialized knowledge." *Wayne County v. Tennessee Solid Disposal Ctrl. Bd.*, 756 S.W.2d 274, 279 (Tenn. Ct. App. 1988). Because an agency possesses its own fact-finding authority, it may make its own factual determinations, and it may substitute its judgment for that of the ALJ. *McEwen* v. *Tennessee Dep't of Safety*, 173 S.W. 3d 815, 822 (Tenn. Ct. App. 2003).

An agency, however, should not ignore the findings of fact contained in an initial order. *McEwen*, 173 S.W.3d at 823. "The initial order is a relevant and important part of the administrative record. While the reviewing court must focus its attention on the agency's final order, it may consider the initial order when determining whether the agency's final order has sufficient evidentiary support." *Id.* at 824.

An agency should expect closer scrutiny of its findings of fact when the agency disagrees with an ALJ's findings of fact. *Id.* The courts "may view the evidence supporting the agency's findings of fact as less substantial than it would otherwise be had the agency and the ALJ reached the same conclusion." *Id.* If the record contains

evidence sufficient to support conflicting findings, the agency's findings must be allowed to stand even if the court might have reached a different conclusion. *Id.* at 824.

Agency decisions with adequate evidentiary support may still be arbitrary and capricious if caused by clear error in judgment. *Jackson Mobilphone Co. Inc. v. Tennessee Pub. Serv. Comm'n.*, 876 S.W.2d at 110. An arbitrary decision is one that disregards the facts or circumstances of the case without some basis that would lead a reasonable person to reach the same conclusion. *Id.* at 111.

**Judicial Review of Claims of Improper Procedure**

The Petitioners complain that the Agency should apply the substantial and material standard of review when it evaluates the Initial Order instead of *de novo* review on the record which the Agency actually applied in this case. The Agency reviewed the record developed before the ALJ in compliance with the its rule, Tenn. Comp. R. & Regs. 0720-13-.03, which states that an agency's review of the initial order is strictly limited to the record which was developed before the administrative judge and the review proceeding is "in the nature of appellate review." It is this final phrase referencing the nature of appellate review that the Petitioners base their standard of review argument.

The Agency conducts reviews of initial orders in contested cases in accordance with the Uniform Administrative Procedures Act (APA). Tenn. Code Ann. § 68-11-1610(e)(2006). According to the APA, when an agency reviews an initial order, it must exercise "all the decision making power that the agency would have had to render a final order had the agency presided over the hearing." Tenn. Code Ann. § 4-5-315(d)(2005).

The Tennessee Court of Appeals in *McEwen* directly addressed the standard of review an agency should apply when it reviews an initial order. *McEwen*, 173 S.W.3d at

822-824. While the standard may differ in other states, the Court reiterated that a Tennessee agency has its own fact-finding authority and may substitute its judgment for that of the ALJ. *Id.* at 822. "Thus, when an agency reviews an initial order, it renders its own decision." *Id.* The *McEven* Court does warn that an agency should expect closer judicial scrutiny of its findings of fact when it disagrees with the ALJ's findings. *Id.* Yet, this difference does not change the standard of review of the ALJ's initial order when reviewed by the Agency. Consequently, the Agency was correct to review the record *de novo* instead of applying the substantial and material evidence standard for judicial review at Tenn. Code Ann. § 4-5-322.

The Petitioners also complain that the Agency abused its discretion when it decided to consider the appeal of SHH from the Initial Order. According to the Petitioners, the Agency should not second-guess the ALJ given the time and expertise devoted to the contested case hearing, and the Agency must have a compelling reason to review. The Petitioners do not direct the Court to a rule or law or even to common law for their position that the Agency abused its discretion in this regard. On the other hand, the Agency directs the Court to the language in both Tenn. Code Ann. § 68-11-1610(e) and Tenn. Code Ann. § 4-5-315(a) which together provide that the Agency has discretion in if, when, and how it grants review of an initial order. Accordingly, the Court finds that the Agency decision to review the Initial Order was not an improper procedure.

Last, the Petitioners claimed in the administrative proceedings, that the Agency's counsel erroneously referred to themselves as counsel for "the State", and they also wrongfully supported the overturn of the Initial Order. The Court does not closely examine this claim of improper procedure because staff counsel announced before the

February 27, 2008 Agency review of the Initial Order, that they would not take a position during the review. Consequently, the Court finds this claim of improper procedure is without merit.[2]

**Judicial Review of Substantive Claims**

Tenn. Code Ann. § 4-5-322 requires the courts to engage in a three-step analysis when reviewing a final order. First, the reviewing court will determine whether an agency has identified the appropriate legal principles applicable to the case. Then, the court will examine the agency's factual findings to determine whether they are supported by substantial and material evidence. Finally, the reviewing court will examine how the agency applied the law to the facts. This last task is a highly judgmental process involving mixed questions of law and fact, and great deference must be accorded to the agency. At this third point, the court must decide whether a reasoning mind could reasonably have reached the conclusion which the agency reached, consistent with a proper application of the controlling legal principles. *McEwen*, 173 S.W.3d at 820.

The Court first addresses the legal principles which the Agency must apply in the case. The Agency (formerly the Health Facilities Commission) is somewhat like a public service commission regulating public utilities, both as to initial entry and certification and as to expansion of services; public need under all the circumstances is the ultimate consideration, with the design of preventing costly inefficient development or duplication of services. *Humana of Tennessee v. Tennessee Health Facilities Comm'n.* 551 S.W.2d 664, 671 (Tenn. 1977).

[2] The Court notes that the Petitioners did not directly challenge the overall contested case scheme of the Agency (which is different from many other boards, agencies or commissions), but rather assert that the Agency's procedures, as applied, caused enough confusion to merit remand and/or for this Court to find reversible error.

This judicial review is about the need for a 56-bed hospital. Hospitalization is defined as "the reception and care of any person for a continuous period longer than twenty-four (24) hours, for the purpose of...diagnosis...or treatment bearing upon the physical health of such persons." Tenn. Code Ann. § 68-11-201(28)(2006)(since amended). The General Assembly has decided that the Agency will exert tight control over the allocation of hospital beds, a bed being necessary for a 24-hour stay. An increase of even one bed in a hospital bed count must be approved by the Agency with a grace period for the smaller hospitals. Consequently, although the Agency can evaluate various factors in deciding how additional hospital beds will impact needed health care in a location, the first and fundamental focus is whether additional hospital beds themselves have objective merit for the location to be served.

Unfortunately, although the General Assembly mandated that the Agency focus upon and use the Tennessee Health Guidelines for Growth (with its tools for planning health care needs), otherwise called the state health plan, the Agency disregarded the Guidelines without explaining why. The fact that the Guidelines' methodology and standards may not have been changed for some time, does not shed light on the Agency's reasoning without explanation. Further, the Agency ignored and disregarded the Certificate of Need Department of Health Review of hospital bed needs, even though this sister agency expends public monies to plan and evaluate population and health needs. Finally, the Agency left the decision of where 56 beds will be located up to SHH and HCA, contrary to the Agency's planning authority. According to the Agency, HCA may locate 56 beds in Spring Hill but must move 56 beds from another, undetermined, Middle Tennessee location. There was no discussion about the impact this removal of Middle

Tennessee hospital beds might have on overall acute hospital bed counts or upon pending certificate of need applications in Middle Tennessee, if any. Because the Agency failed to use the state health plan (Guidelines) and because the Agency did not focus upon the objective merit of increasing hospital beds, the Agency did not apply proper principles of substantive law.

The second task for the Court, is to review the factual findings, not for their weight, but to inquire whether the facts as found furnish a reasonably sound basis for the Agency's decision. Certain facts were determinative for the Agency: in setting out the differences between the ALJ's initial order and the Agency final order, the Agency found that SHH will attract primary care physicians necessary for good quality health care. The Initial Order did not mention primary care doctors and the proof in the record was that SHH will recruit specialists, with no mention of primary care physicians. It is probably not sound reasoning to build a $104 million dollar hospital without conditioning the certificate of need to assure satisfaction of the Agency's greatest concern -- the increase of primary care doctors in the location to be served. The Agency also found that some residents were not able to get to a hospital for emergency care in less than an hour. Three residents testified they had this trouble in rush hour. One of the residents was heading to Vanderbilt Children's' Hospital where her child's records were located but SHH does not claim that it will focus on pediatric care. The Court is concerned about these witnesses, but the testimony is hardly material to the Agency decision. There is little context for the stories and no proof that the experiences reflect systemic problems. These facts, as found by the Agency, do not furnish a reasonably sound basis for the

Agency's decision especially in light of the Initial Order which did not find these facts probative, material, or even relevant to the ALJ decision .

The last task is connected to the first step in this particular case. The Agency did not apply the correct law to the facts since it did not use the state health plan guidelines or planning information from the Health Department Division of Health Statistics as required.

**Decision and Order**

The Court finds that the Agency came to its decision to grant the certificate to SHH without a reasonably sound factual basis and made a clear error in judgment. Thus, the Court must reverse the Agency decision as arbitrary and capricious and unsupported in the record by substantial and material evidence.

Costs are assessed jointly and severally to the Respondents.

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**RULE 58 CERTIFICATION**

A copy of this order has been served by U. S. Mail upon all parties or their counsel named above.

Deputy Clerk and Master
Chancery Court

9/3/09
Date

Attachment 1N-4, Acute

VRH -2 Final Order

**BEFORE THE TENNESSEE HEALTH FACILITIES COMMISSION**

| | |
|---|---|
| **IN THE MATTER OF:**<br><br>**SAINT THOMAS RUTHERFORD HOSPITAL,**<br>**TRISTAR STONECREST MEDICAL CENTER,**<br>**WILLIAMSON MEDICAL CENTER,**<br>***Petitioner,***<br><br>**v.**<br><br>**TENNESSEE HEALTH FACILITIES COMMISSION,**<br>***Respondent,***<br><br>**and**<br><br>**VANDERBILT UNIVERSITY MEDICAL CENTER d/b/a/ VANDERBILT RUTHERFORD HOSPITAL,**<br>***Intervenor.*** | **APD Case No. 25.00-220022J**<br>**CON No. CN2109-026** |



## FINAL ORDER

This contested case was heard *de novo* in Nashville, Tennessee, on December 5-9, 12, 15-16, and 19-20, 2022, before Administrative Judge Claudia Padfield, assigned by the Tennessee Secretary of State, Administrative Procedures Division (APD), to sit on behalf of the Tennessee Health Facilities Commission. The hearing addressed the allegations contained in the NOTICE OF HEARING filed on January 13, 2022, pertaining to the application for a certificate of need ("CON") filed by Vanderbilt University Medical Center d/b/a Vanderbilt Rutherford Hospital ("VRH") on October 1, 2021, which was approved by the Health Facilities Commission[1] ("HFC") on December 15, 2021. Petitioner, Saint Thomas Rutherford Hospital ("STRH"), was represented by attorneys

[1] Pursuant to Public Chapter 1119, the Tennessee Health Services and Development Agency was renamed as of July 1, 2022, to the Tennessee Health Facilities Commission. For consistency, the agency shall be referred to as the current name regardless of when the agency's action occurred.

Warren L. Gooch, John E. Winters, Betsy Beck, and Bryce E. Fitzgerald. Petitioner, TriStar StoneCrest Medical Center ("StoneCrest"), was represented by attorneys M. Clark Spoden, William Scales, Hilary Dennen, and Diamond Stewart. Petitioner, Williamson Medical Center ("WMC"), was represented by attorneys William West, Lindsay Ray, and Abby Nix. General Counsel James B. Christoffersen represented Respondent, HFC. Intervenor, VRH, was represented by attorneys Dan H. Elrod, G. Brian Jackson, Travis Swearingen, and C.E. Hunter Brush.

At the close of the hearing, multiple post-hearing deadlines were set for the filing of the following: the hearing transcript, counter designations of depositions, objections to the counter designations, redacted and condensed deposition transcripts, proposed findings of fact and conclusions of law, and post-hearing briefs. As such, the RECORD closed on April 11, 2023. On June 8, 2023, Administrative Judge Padfield entered an Initial Order reversing the HFC's approval of the VRH application. On July 27, 2023, VRH filed a Petition for Review of the Initial Order. On September 27, 2023, the HFC voted to accept review of the Initial Order.

After consideration of the entire record in this matter, including the findings of fact by the ALJ, briefing submitted by the parties, and oral argument by counsel on February 28, 2024, it is determined that the Initial Order should be **MODIFIED** as set forth herein, and that the CON application of VRH should be **GRANTED**.

## SUMMARY OF THE EVIDENCE

At the hearing, 25 witnesses provided live testimony. A video deposition of one witness was submitted in lieu of the live testimony by agreement of the parties. One hundred ninety-six exhibits were entered into evidence. Six documents were marked for identification purposes only as part of an offer of proof. Sixty-eight condensed and redacted deposition transcripts and four documents were entered as late-filed exhibits.

## FINDINGS OF FACT

1. In 2020, VRH applied with HFC for a CON application (No. CN2004-012) to establish a 48-bed full-service hospital in Murfreesboro, Rutherford County, Tennessee. The CON application also included six neonatal intensive care unit (NICU) bassinets.

2. HFC considered VRH's application at a Commission meeting held on August 26, 2020. Also considered by HFC, on that same date, was the CON application submitted by STRH to open a community hospital, Saint Thomas Rutherford Westlawn Hospital. HFC considered both CON applications simultaneously due to the nearly identical locations, overlapping services, overlapping service areas, and similar type of facilities.

3. At the August 26, 2020, meeting, by a 4-2 vote, VRH's CON application was denied by HFC. At the same meeting, HFC approved the Saint Thomas Westlawn Hospital's CON application.

4. VRH timely appealed HFC's denial of the application, which contested case was assigned a case number of 25.00-203133J by the Administrative Procedures Division. Per the ORDER GRANTING PETITIONS TO INTERVENE issued by Administrative Judge Rachel Waterhouse on November 4, 2020, WMC, StoneCrest, and STRH, along with two other Saint Thomas hospitals, were allowed to intervene.

5. VRH filed a notice of voluntary dismissal of APD Case. No. 25.00-203133J on October 7, 2021. An ORDER OF NONSUIT AND DISMISSAL was issued by Administrative Judge Waterhouse on October 8, 2021.

6. Administrative Judge Waterhouse issued both an ORDER GRANTING INTERVENOR'S MOTION FOR COSTS and an ORDER DENYING INTERVENORS' MOTION TO MODIFY AND EXTEND PROTECTIVE ORDER AND GRANTING

PETITIONER'S MOTION TO ENFORCE AGREED PROTECTIVE ORDER on December 3, 2021.

7. HFC filed a NOTICE OF PETITIONS FOR JUDICIAL REVIEW with APD on June 9, 2022. A certified technical record was provided by APD on June 15, 2022. To date, no further filings have been received by APD regarding that appeal.

8. The Tennessee Health Services and Planning Act of 2021 became effective after VRH's first CON was denied. Among other changes, the CON requirement for a hospital to add acute care beds to an existing facility was eliminated. Therefore, an existing hospital may add such beds without having to show a need for the same beds. The policy provision of the statute now requires that the establishment of healthcare facilities must promote access to necessary, high-quality, and cost-effective services. TENN. CODE ANN. § 68-11-1603.

9. While the first appeal was pending, VRH submitted a second application for a CON application (No. CN2109-026) on October 1, 2021. The second application was for a 42-bed hospital in Murfreesboro, Rutherford County, Tennessee, including diagnostic and therapeutic cardiac catheterization services.

10. HFC considered the second application at the Commission meeting held on December 15, 2021. At that same meeting, by a vote of 5-1, HFC approved VRH's CON No. CN2109-026.

11. VRH is owned by Vanderbilt University Medical Center (VUMC), in Nashville, Davidson County, Tennessee. VUMC's main campus consists of Vanderbilt University Hospital, Monroe Carell Jr. Children's Hospital Vanderbilt (MCJCHV), Vanderbilt Psychiatric Hospital,

and Vanderbilt Stallworth Rehabilitation Hospital. VUMC's main campus is a tertiary[2] and quaternary[3] medical center with 1,175 licensed beds for the relevant period. VUMC also owns Vanderbilt Wilson County Hospital, Vanderbilt Bedford Hospital, and Vanderbilt Tullahoma-Harton Hospital.

12. The proposed location for VUMC's VRH CON No. CN2109-026 is at the southeast intersection of Veterans Parkway and I-840, off I-24, on 80 acres of land. The site is approximately six miles from the Williamson County/Rutherford County border on the west side of Rutherford County. The proposed facility would be an acute care, community hospital and would include:

- 26 adult medical/surgical beds
- four intensive care unit beds
- six pediatric beds
- six obstetrical beds
- eight observation beds
- an emergency department
- a surgical suite with two major operating rooms
- four general purpose operating rooms
- two endoscopy procedure rooms
- a cardiac catheterization laboratory
- a physical and respiratory therapy room
- a reception and waiting area
- imaging services including magnetic resonance imaging, computerized tomography, ultrasound, and mammography
- laboratory and pharmacy services
- space for ancillary services and
- a helipad that can be accessed by VUMC LifeFlight aeromedical transport service.

13. STRH is an acute care hospital in Murfreesboro, Rutherford County, Tennessee. It sits on eight acres. STRH is approximately six miles from VRH's proposed location. At the time of the hearing, STRH had 376 licensed beds. Due to the change in Tennessee's CON law, STRH

[2] Tertiary care is highly specialized medical care. Tertiary care is typically provided over an extended period of time. It involves advanced and complex diagnostics, procedures, and treatments that are performed by medical personnel in facilities with highly specialized equipment.
[3] Quaternary care is an extension of tertiary care but is even more specialized.

does not need approval to add additional beds; at the time of the hearing, STRH was in the process of adding an additional 58 beds which were expected to open in Spring 2023.

14. STRH also has a community hospital in Murfreesboro, Rutherford County, Tennessee, Saint Thomas Rutherford Westlawn. Westlawn is across the street and less than one mile across Veterans Parkway from VRH's proposed location. Both sites are at the same intersection of I-840 and Veterans Parkway. Westlawn is a community hospital which has eight inpatient beds, eight emergency beds, outpatient services, imaging services, physician practices, and telemedicine services.[4]

15. StoneCrest is an acute care hospital in Smyrna, Rutherford County, Tennessee. StoneCrest is located approximately 12 miles northwest of VRH's proposed location off I-24. At the time of the hearing, StoneCrest had 119 licensed beds, 115 of which were staffed. Approximately 71% of StoneCrest's patients come from Rutherford County. StoneCrest last added beds in February 2020 when it added six intensive care unit beds. StoneCrest completed a major emergency department expansion in November 2019.

16. WMC is an acute care hospital in Franklin, Williamson County, Tennessee. It is located approximately 20 miles from the proposed site of VRH. WMC is approximately two miles from the Rutherford County/Williamson County border. WMC has 203 licensed beds, all of which were staffed during the relevant period.

17. VUMC has greatly expanded its geographic reach by purchasing three preexisting Middle Tennessee hospitals and also by establishing outpatient and walk-in clinics. VUMC operates more than 800 outpatient clinics across Middle Tennessee in 180 locations. In Rutherford

[4] Westlawn opened on March 16, 2023. As stated above in the facts, this hospital's CON application was approved prior to the filing of the current appeal but is relevant to the current appeal to provide a complete and accurate overview of hospital medical services in Rutherford County that had been approved at the time VRH filed the CON application under consideration.

County, VUMC operates retail health clinics in La Vergne, Smyrna, and Murfreesboro; comprehensive cardiology care; behavioral health; maternal medicine; ambulatory surgery; imaging; outpatient surgery; and other outpatient services.

18. For pediatric services in Rutherford County, VUMC's MCJCHV offers imaging, urgent care facilities, subspecialty clinics, and a pediatric outpatient surgery center. The subspecialty clinics include services for cardiology, diabetes, endocrinology, gastroenterology, nephrology, neurology, orthopedics and sports medicine, otolaryngology and audiology, plastic surgery, pulmonology, rheumatology, and urology. The magnetic resonance imaging service area at the Rutherford County location has an 18-county service area.

19. VUMC's Vanderbilt Wilson County Hospital has 245 licensed beds, 158 of which are staffed. VUMC's Vanderbilt Bedford Hospital has 49 licensed beds, 24 of which are staffed. VUMC's Vanderbilt Tullahoma-Harton Hospital has 135 licensed beds, 86 of which are staffed. VUMC's Vanderbilt Tullahoma-Harton Hospital is seeking a trauma designation which includes a service area of Rutherford and Williamson Counties.

20. The occupancy rates of VUMC's three existing community hospitals are between 13% and 37%.

21. VUMC, StoneCrest, STRH, and WMC all provide health care that meet appropriate quality standards.

22. The proposed service area of VRH is Rutherford County. Approximately 75% of VRH's patients are expected to originate in Rutherford County.

23. Rutherford County has had and continues to have rapid population growth. Rutherford County currently has a population of approximately 350,000. Rutherford County is projected to become the fourth most populated Tennessee county by 2026.

24. Despite the growth in population, Rutherford County residents have not had a significant increase in the level of utilization of inpatient services. This is consistent with the steady decline in length of hospitalization stays across the country and in Tennessee for general, non-tertiary care.

25. The COVID-19 pandemic caused hospitals across Rutherford County and throughout Tennessee to have occupancy rates that were skewed from typical years. The pandemic also caused various spikes in hospital utilization. The data from 2020-2022 is challenging to analyze when looking at daily average census and hospital utilization rates. As such, the data from 2020-2022 is not reliable and has been disregarded by healthcare planners.

26. The VRH CON application showed a surplus of 145 licensed beds in Rutherford County. Since the filing of the application, a new community hospital has opened, and STRH has added and is in the process of adding beds. Per the most recent data from the Tennessee Department of Health, the current surplus in Rutherford County is 67 licensed beds.

27. [redacted] There is no evidence that any patient treated in a hallway bed at any of the facilities involved led to a lower quality care for those patients.

28. [redacted] As such, area physicians have sometimes had difficulty admitting their patients to STRH.

29. STRH has an average inpatient occupancy rate of 80%. STRH has not enacted emergency medical services division.

30. At times, but especially during COVID-19 surges, all area hospitals have had to board patients in the emergency departments due to lack of available bed capacity in other hospital rooms. The wait time to transfer to an available inpatient bed in a hospital has varied greatly. The longer holds (24 or more hours) are typically due to psychiatric patients who are waiting to be transferred to an appropriate facility.

31. STRH offers a variety of services including orthopedic surgery, oncology, obstetrics, neuroscience, and cardiology. STRH has a NICU and is expanding that unit from 16 to 22 beds. STRH has increased the provided services to become a more of a tertiary referral center rather than a local community hospital.

32. StoneCrest offers inpatient services for women's health, obstetrics/gynecology, NICU, cardiology, orthopedics, pulmonology, critical care, diabetes, and oncology. StoneCrest also offers outpatient services such as imaging, physical therapy, emergency department services, and advanced wound care. StoneCrest has a dedicated pediatric emergency room.

33. StoneCrest has an average inpatient occupancy rate of less than 60%. While on occasion a patient has been placed in a hallway bed at StoneCrest, it is rare.

34. WMC has a partnership with MCJCHV whereby the eight-bed pediatric emergency department, eight-bed NICU, and 16-bed pediatric inpatient unit at WMC are staffed by Vanderbilt physicians. WMC provides the nurses for the pediatric units. Due to lack of need, WMC has plans to reduce the 16-bed pediatric inpatient unit to ten beds.

35. WMC's MCJCHV-run pediatric unit has an inpatient daily average census of two patients. The various pediatric units at WMC are underutilized and have capacity to admit all lower acuity pediatric patients from Rutherford County and adjacent counties.

36. VRH proposes to have six dedicated pediatric beds. This is a duplicative service to what MCJCHV pediatricians already offer at WMC.[5] VRH does not plan to offer a NICU, any pediatric inpatient surgery, or a pediatric emergency room.

37. STRH provides pediatric inpatient services. STRH does not have a separate pediatric unit. It has six pediatric beds with nurses who have pediatric advanced life support training certifications. STRH has had pediatric trained respiratory therapists.[6] STRH has an average daily census of pediatric patients of one. STRH has not had enough inpatient pediatric patients to sustain having full-time, designated pediatric nurses on staff.

38. The volume of non-critical care population at VUMC's MCJCHV has decreased 10-15% over the last five years. Most pediatric care is provided on an outpatient basis. Half of MCHCHV's subspecialties are offered in Rutherford County at the various locations as outlined above. The length of stay for non-critical care pediatric patients has declined both locally and nationally.

39. VRH projected a daily average census for its pediatric unit of two patients for the first year and 2.7 patients for the second year.

40. In the CON application, VRH represented to HFC that the average length of stay for a pediatric patient would be 4.6 days.

[5] Dr. Brent Rosser, a pediatrician at Murfreesboro Medical Clinic, reluctantly testified that the VRH facility would not offer any pediatric services that are not available at WMC.

[6] It was unclear from the testimony at the hearing whether STRH currently had pediatric trained respiratory therapists on staff.

41. Per Dr. Margaret Rush, President of MCJCHV, the actual anticipated average length of stay for a pediatric patient at VRH would be 2 to 2.5 days.

42. WMC is adding 15 emergency department beds due, in part, to an increase in the need for mental health services and the inability to transfer those patients from the emergency room to a mental health facility.

43. WMC has an average occupancy of 55%.

44. VRH proposes to offer the following services: general medical and surgical, cardiac catheterization, laboratory, and imaging. All of these services are offered at STRH, WMC, and StoneCrest. No tertiary level services are proposed.

45. The federal government requires not-for-profit hospitals to publish a Community Health Needs Assessment every three years to help justify their not-for-profit tax status. STRH and VUMC published a joint Rutherford County Health Needs Assessment in 2019. The report is based on data, interviews, and surveys. The top three needs in Rutherford County in 2019 were addressing affordable housing and homelessness; social factors including education levels, unemployment, crime, etc.; and health promotion and wellness. The need for an additional hospital was not mentioned anywhere in the report.

46. The cardiac catheterization CON criteria utilize a weighted formula to measure the existing capacity of cardiac catheterization labs in the proposed service area. Per the weighted formula as established in the guidelines, need is presumed to exist for additional cardiac catheterization lab capacity if the average current utilization of all existing providers is greater than 70%.

47. As one of its outpatient practices and clinics in Rutherford County, VUMC operates Vanderbilt Heart Murfreesboro. This consists of four cardiologists and two advanced practice

nurse practitioners. Additionally, a heart failure physician, a heart failure nurse practitioner, an electrophysiologist, and a lipid nurse practitioner rotate through the Vanderbilt Heart Murfreesboro Clinic. VRH's CON application includes a cardiac catheterization laboratory that would allow these practitioners to provide services at their own facility rather than having to coordinate the services at a current area hospital such as StoneCrest or STRH.

48. VRH would be staffed and maintained by at least one cardiologist who has performed 75 cases annually over the previous five years.

49. Dr. Fayaz Malik, the Chair of the Department of Cardiology at STRH, provided credible testimony that the practice of cardiology is changing due to emerging technology involving cardiac computed tomography (CT). While some patients are now able to avoid the more invasive procedure of a cardiac catheterization by having a cardiac CT performed, there are some patients who will need to have a cardiac catheterization based on the results of the cardiac CT.

50. Using the most recent reliable data (obtained prior to the pandemic), STRH's cardiac catheterization capacity was over 90%. StoneCrest's capacity was slightly less than 60%.

51. The cardiac catheterization capacity, per the weighted formula as established in the State Health Plan, at STRH and StoneCrest is over the required capacity threshold of 70%.

52. VUMC's cardiologists who practice in Rutherford County satisfy the minimum physician requirements to initiate these services per the guidelines.

53. Prices for services rendered at VRH would be based on the same community hospital charge structure as the three county-adjacent community hospitals: Vanderbilt Bedford Hospital, Vanderbilt Wilson County Hospital, and Vanderbilt Tullahoma-Harton Hospital.

54. VRH would accept Medicare and TennCare/Medicaid patients. VRH projected in the CON application that 61% of its patients would be Medicare and Medicaid patients. This is comparable to other area hospitals.

55. At least two of VUMC's community hospitals have not generated revenues in excess of their expenses. In 2021, Vanderbilt Bedford Hospital had a loss of $4,792,817; Vanderbilt Wilson County Hospital had a loss of $7,330,835.[7]

56. VRH has a projected charity care rate of 5%. This is a slightly lower rate than other area hospitals.

57. BlueCross/BlueShield of Tennessee (BCBST) is the largest commercial insurer in Tennessee. BCBST opposes the CON application due to unnecessary duplication of services that would inflate the cost of healthcare services.

58. VRH submitted a projected payor mix (the percentage of a facilities' revenue from private insurance versus self-paying patients versus public insurance programs such as Medicare and Medicaid) in the CON application. The payor mix listed Humana and Wellcare as part of its Medicare Advantage Payors list.

59. [redacted] In a press release to the public, VUMC asserted that a higher reimbursement rate was necessary to pay for inflationary costs of personnel, supplies,

[7] The record does not reflect the revenue compared to expenses of Vanderbilt Tullahoma-Harton Hospital.

equipment, and medications. VUMC announced on March 14, 2023, that an agreement to continue providing in-network care was reached with Humana. The increase in payments from Humana to VUMC was not announced. No agreement with WellCare was announced or provided.

60. There is a nursing shortage both in Tennessee and across the country. The shortage began before the outbreak of the COVID-19 pandemic and continues presently.

61. Due to staffing issues, hospitals have delayed services. Due to staffing issues, hospitals have temporarily closed certain services. This has created accessibility issues. Some of those delayed or closed services were due to staffing problems associated with the pandemic and are not ongoing issues.

62. None of the involved healthcare providers caused the nursing shortage. The involved healthcare hospitals have taken action to address the nursing shortage, such as offering residency programs for nursing graduates, programs to allow existing staff to take a more advanced clinical role, sponsorships of clinical workers to receive further education and more advanced training, and affiliation with nursing schools.

63. Hospitals, including all of the parties in this case, have resorted to hiring traveling or contract nurses in order to be adequately staffed. Traveling or contract nurses are paid at much higher rates than on-staff nurses.

64. VUMC represented to HFC, during the December 15, 2021, meeting, that staffing has not been an overwhelming challenge.

65. At the time of the hearing, VUMC had approximately [redacted] open nursing positions across its healthcare system.

66. VRH will require 114 nurses and 171 ancillary clinical personnel.

67. [redacted]

68. VUMC plans to staff VRH by having nurses transfer from other VUMC facilities to VRH as well as hiring new nurses.

69. The additional costs of labor to hospitals cannot be immediately passed directly to consumers due to the hospitals' contracts with the insurance companies or government. As indicative of the demands for a higher contract rate from VUMC to Humana and Wellcare, the additional costs can be a basis for requesting a higher reimbursement rate from insurance companies or the government as a continuation of accepting patients as in-network patients.

## APPLICABLE LAW

1. The Tennessee Health Facilities Commission is granted the authority to approve or deny certificate of need applications by TENN. CODE ANN. § 68-11-1609(a).

2. STRH, StoneCrest, and WMC are healthcare institutions that are located within a thirty-five-mile radius of the location of the action proposed. As such, the three entities had authorization to file written objections to appeal the approval of VRH's CON application. TENN. CODE ANN. § 68-11-1609(g).

3. Without opposition from Petitioners or Respondent, VRH moved to intervene in this case, which request was granted pursuant to TENN. CODE ANN. § 4-5-310 and TENN. COMP. R. & REGS. 0720-13-.01(4).

4. This contested case was presided over by an administrative law judge ("ALJ") sitting alone pursuant to TENN. CODE ANN. § 68-11-1610(c). As a proceeding convened by HFC, this contested case was a *de novo* hearing. *Big Fork Mining Company v. Tennessee Water Quality Control Board,* 602 S.W.2d. 515, 521 (TENN. CT. APP. 1981).

5. In a contested case hearing before HFC, Petitioners have the burden of proving, by a preponderance of the evidence, that a CON application should be denied. TENN. COMP. R. & REGS. 0720-13-.01(3).

6. Pursuant to TENN. CODE ANN. § 68-11-1609(b), "A certificate of need shall not be granted unless the action proposed in the application is necessary to provide needed health care in the area served, will provide health care that meets appropriate quality standards, and the effects attributed to competition or duplication would be positive for consumers. In making these determinations, the commission shall use as guidelines the goals, objectives, criteria, and standards adopted to guide the commission in issuing certificates of need. Until the commission adopts its own criteria and standards by rule, those in the state health plan apply. Additional criteria for review of applications must also be prescribed by the rules of the commission." The VRH proposal contains two covered CON services – the construction of a new community hospital containing acute care beds and the initiation of cardiac catheterization services. The Commission finds that the facts as found by the ALJ and as set forth in the entire record support the conclusion that VRH meets the statutory criteria and the HFC's general criteria necessary to obtain a Certificate of Need. *See* Tenn. Code Ann. § 68-11-1609(b). Specifically, the Commission finds that VRH is necessary to provide needed health care in the proposed service area, it will provide health care that meets appropriate quality standards, and the effects attributed to competition or duplication from the VRH project will be positive for consumers. *See id.*

7. The State Health Plan Certificate of Need Standards and Criteria sets forth the consideration given for applicants seeking to establish acute care beds for a new facility. The determination of need is established through a four step process "[u]sing utilization and patient origin data from the Joint Annual Report of Hospitals and the most current populations projection

series from the Department of Health, both by county, … ." State Health Plan, 2017-2018 Edition, p. 54. The need for hospital beds should be projected four years into the future. "New hospital beds can be approved in excess of the 'need standard for a county' if … [a]ll existing hospitals in the proposed service area have an occupancy level greater than or equal to 80 percent for the most recent Joint Annual Report." *Id.* at p. 56. This Commission has the discretion to approve new hospital beds even when not warranted under the State Health Plan criteria when there is a compelling reason to do so, and the Commission has done so when there was demonstrated need for additional health services in a particular community.

8. To determine whether there is a need for acute care beds in a new facility, the State Health Plan considers similar services in the service area, and trends in occupancy and utilization. Consideration is to be given to whether the increase in beds will result in unnecessary, costly duplication of services. *Id.* at p. 60. Under the 2021 revisions to the Tennessee CON law, the impact of a project on existing providers is no longer a criterion for consideration.

9. Other facts to consider when looking to add acute care beds are quality considerations, establishment of service area, services and relationship to high-need and underserved populations, access to serve equally all of the service area, adequate staffing, assurance of resources, data requirements, quality control and monitoring, licensure and quality considerations, and community linkage plan if applicable. *Id.* at pp. 61-62.

10. The State Health Plan provides criteria relating to cardiac catheterization services. State Health Plan, 2009 Edition, Appendix B. TENN. COMP. R. & REGS. 0720-11-.01(2)(h) (July 2022) provides the guidelines for evaluating quality standards for cardiac catheterization projects.

11. TENN. COMP. R. & REGS. 0720-11-.01 (July 2022) provides the general criteria that HFC will consider when determining if an application for a certificate of need should be granted.

Specifically applicable to the current appeal are the criteria for need and competition/duplication effects which are:

> (1) Need. The health care needed in the area to be served may be evaluated upon the following factors:
>
> (a) The relationship of the proposal to any existing applicable plans;
> (b) The population served by the proposal;
> (c) The existing or certified services or institutions in the area;
> (d) The reasonableness of the service area;
> (e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;
> (f) Comparison of utilization/occupancy trends and services offered by other area providers;
> (g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low-income patients will be served by the project.
>
> In determining whether this criteria is met, the Commission shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.
>
> ...
>
> (3) The effects attributed to competition or duplication would be positive for the consumers. Whether the effects attributed to competition would be positive for the consumers may be evaluated upon the following factors:
>
> (a) Access to high quality, cost-effective healthcare services;
> (b) The impact upon patient charges;
> (c) Participation in TennCare, Medicare and other federal and state reimbursement programs; participation in other insurance plans; and charity care;
> (d) Whether the applicant commits to maintaining an actual payor mix that is comparable to the pay mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent; and
> (e) The availability and accessibility of human resources required by the proposal, including those required by existing providers.

12. The commission has the authority to revoke a certificate of need if "[t]he decision to issue a certificate of need was based, in whole or in part, on information or data in the application which was false, incorrect, or misleading, whether intentional or not." TENN. CODE. ANN. § 68-11-1617(3). This authority is reserved to the Commission and is not vested in an ALJ sitting on

behalf of the Commission in a contested case proceeding pursuant to TENN. CODE. ANN. § 68-11-1610.

## ANALYSIS AND CONCLUSIONS OF LAW

The CON process plays an important role in ensuring access, sustainability, and safety in Tennessee's healthcare system. This includes ensuring appropriate and necessary services and facilities are available in communities across the state, and that patients are able to access those services in a safe and affordable manner. The CON process recognizes the unique needs and challenges of health care compared to other industries.

The written transcript of oral testimony provided at a hearing does not fully convey the evidence given or always provide a complete picture of the proof in a case.[8] Ginna Felts is the Vice President of Business Development at VUMC and prepared both of VRH's CON applications. Ms. Felts was unable to answer questions at the hearing that someone in her position should be expected to know, often stating that she did not recall when asked questions about the CON application or the process. In contrast, Ms. Felts provided one-word answers, such as "yes", "no", or "sure", when she was answering leading questions asked by VRH's counsel. Ms. Felts avoided answering questions directly if the answer would have been harmful to VRH. Ms. Felts' demeanor while providing live testimony was incredulity at the need to answer questions that would cast doubt on the CON application or VUMC. The veracity of Ms. Felts' testimony is questionable and is given little weight. Even if Ms. Felts' testimony is disregarded, the

[8] "A stenographic transcript correct in every detail fails to reproduce tones of voice and hesitations of speech that often make a sentence mean the reverse of what the words signify." *Broadcast Music v. Havana Madrid Restaurant Corp.*, 175 F.2d 77, 80 (2d. Cir. 1949). "It is true that the carriage, behavior, bearing, manner and appearance of a witness – in short, his 'demeanor' – is a part of the evidence." *Dyer v. MacDougall*, 201 F. 2d, 265, 268-268 (2d. Cir. 1952). "When credibility and weight to be given testimony are involved, considerable deference must be afforded to the trial court when the trial judge had the opportunity to observe the witnesses' demeanor and to hear in-court testimony." *Hughes v. Metropolitan Government of Nashville and Davidson County,* 340 S.W.3d 352, 360 (Tenn. 2011) (internal citations omitted).

Commission finds that there was ample other evidence presented supporting the need for VRH, including the occupancy levels of existing providers, [redacted], the lack of inpatient pediatric resources, and physician testimony. The burden of proof in this case was on the Petitioners, and the Commission finds that they did not meet their burden.

**Appropriate Quality Standards**

A CON applicant must prove that the facility will provide health care that meets appropriate quality standards. All four healthcare hospitals in this case offer health care at appropriate quality standards. There was no testimony or evidence that VRH would not be expected to offer the same quality of care at the proposed facility that is offered at other hospitals owned by Intervenor. Petitioners have failed to prove by a preponderance of the evidence that the CON application does not meet this portion of TENN. CODE ANN. § 68-11-1609(b).

**Need for Health Care in Area Served**

VRH and Petitioner hired expert witnesses to support their respective cases. All experts offered credible, well-reasoned testimony. The opinions reached, not surprisingly, by each expert was to the advantage of the expert's client. The experts used data and methodology to reach conclusions that benefitted their respective clients and discounted data that would have led to a different conclusion. While the testimony and opinions offered are not nullified in what was, essentially, a battle of the experts, VRH's experts relied upon statistics from the COVID-19 pandemic period. While the impact of COVID-19 should be considered when evaluating capacity at existing providers, and the use of such data is "challenging" (see FOF 23), the Commission must utilize available data to assess need, recognizing that the data may not perfectly predict future utilization. The long-term impact of COVID-19 on hospital utilization remains uncertain. VRH's expert witnesses did not consider the impact of the largest expansion in VUMC's history - an [redacted] expansion expected at the main, tertiary campus. A significant portion

of the justification for the need requirement in the CON application was the lack of available space at the Davidson County facilities. However, the construction of additional resources in Davidson County does not address the documented need for additional resources in Rutherford County.

In the CON application, VRH represented to HFC that the average length of stay for a pediatric patient would be 4.6 days. This contrasts with the testimony of Dr. Margaret Rush, President of MCJCHV, who provided credible testimony that the average length of stay at VRH is expected to be 2 to 2.5 days. Dr. Rush was not consulted or involved in planning any portion of the CON application. Whether the average length of stay would be 2.5 or 4.6 days is not dispositive. There are currently minimal inpatient resources for pediatric patients in Rutherford County. The fact that such services may be obtained by driving to another county does not make them reasonably accessible to the residents of Rutherford County. Even if the average length of stay is closer to the 2.5 days predicted by Dr. Rush, VRH will substantially improve the access of available inpatient care to pediatric patients in the Rutherford County community. A discrepancy in the projected average length of stay does not carry the Petitioners' burden, in the case of the significant lack of access to pediatric inpatient care that currently exists in Rutherford County.

The majority of VRH's anticipated patients will originate in Rutherford County. While VRH would have to draw patients from other counties to be viable and sustainable, the projected service area is reasonable under TENN. COMP. R. & REGS. 0720-11-.01(1)(d).

Some Rutherford County residents choose to travel to VUMC's tertiary campus to seek inpatient treatment that could be received at a hospital in Rutherford County. Due to a variety of factors such as convenience to tertiary services, if needed, or proximity to work, some Rutherford County residents would continue to go to VUMC even if VRH were built. This has proven to be true with the three community hospitals purchased by VUMC. For those Rutherford County

residents who choose to have Vanderbilt physicians as their healthcare providers, they may desire to have a Vanderbilt-owned hospital six miles from STRH or 10 miles from StoneCrest. The proposed VRH would provide a convenient option in Murfreesboro for VUMC patients with the appropriate level of acuity to access their preferred hospital closer to their homes. This will promote the general policy of advancing consumer choice by providing quality care that is reasonably accessible to residents of the community. The ALJ found that Rutherford County residents wanting to receive care from a Vanderbilt facility should continue to drive to Nashville or drive to Lebanon, Shelbyville, or Tullahoma to receive their care from a VUMC community hospital. But these alternatives are contrary to the CON criteria and the acknowledged advantages of receiving care close to where consumers live. The establishment of a new, state-of-the-art community hospital in Murfreesboro will significantly enhance patient accessibility and choice in Rutherford County.

The State Health plan gives special consideration to underserved population groups. The Rutherford County pediatric population is "underserved" in terms of reasonable access to inpatient services. Essentially any pediatric patient who requires hospitalization, even for relatively minor conditions, must drive to Nashville or Franklin. Forty-five minutes to an hour of travel for pediatric inpatient services does not constitute reasonable access for the residents of Rutherford County. The Commission finds that the addition of pediatric inpatient services to Rutherford County offered by VRH is appropriate for special consideration by the Commission and it is a substantial factor in favor of approval.

VRH hired a private firm to coordinate signatures to support the VRH CON application. As part of these efforts, VRH coordinated to have individuals submit affidavits in support of the project. VRH offered these affidavits in its CON application, and testimony at the HFC

commission hearing, in support of its application. While there is no evidence that VRH provided false or misleading information to the public, it does appear that some members of the public did not fully understand what the proposed hospital would entail. In support of VRH, affidavits from some community members spoke to being able to access non-routine or specialty care at the proposed hospital. This sentiment is included in the affidavits by individuals who believe that the new hospital would relieve them of having to go to a tertiary hospital to receive specialty care. As delineated above, VRH proposes to be a community hospital and does not propose any level of tertiary care.

Other affidavits supported VRH as a means of spreading medical services throughout Rutherford County. To the contrary, the services would not be spread throughout Rutherford County as VRH would be across the street from an existing hospital and emergency department at Westlawn. All proposed medical services at VRH are also available at StoneCrest and STRH which are not in the same location within Rutherford County.

Although members of the public may not have had a detailed understanding of the scope of the proposed hospital project, the record shows that there is strong community support for the application. The fact that a portion of the public support may not have fully understood the scope of the project does not prove a lack of need or lack of consumer advantage, which are the Petitioners' burden to establish. Community support is one factor to be weighed among others in consideration of an application, and in this case the community support weighs in favor of approval.

VRH coordinated with Murfreesboro Medical Clinic (MMC), a large physician group in Murfreesboro that rents office space to VUMC, to have MMC's physicians submit affidavits in support of the CON application. MMC physicians wrote in affidavits of the addition to the

community that could be offered through Vanderbilt's "incredible array of specialties." While VUMC has many specialty clinics in the Rutherford County area, VRH does not propose any specialties that are not available at the local area hospitals. Indeed, all specialty hospitalizations would continue to be admitted at VUMC's main tertiary campus – not at VRH.

The support of the local medical community weighs in favor of the application. The record shows that Saint Thomas Rutherford has been on [redacted] (FOF 26) This is consistent with the testimony of multiple physicians as to a lack of reasonable access. The factual findings of the ALJ do not justify disregarding the testimony of physicians. The Commission generally gives substantial weight to the testimony of physicians about the health care needs of the community. Although some of the physicians in this case may have misunderstood certain facts, the essence of their testimony—that additional inpatient resources are sorely needed in this community—is supported by the other evidence, including utilization of existing facilities, diversion, the use of hallway beds, and limited pediatric inpatient resources.

One indication of what is needed and desired in Rutherford County is the 2019 Community Health Needs Assessment. This report was not a result of a marketing tool by VRH to solicit opinions to support its goals but rather an objective assessment across all aspects and populations of Rutherford County as to what was needed. The need for an additional hospital was not mentioned in the report. However, this Commission does not consider the 2019 Community Health Needs Assessment to be dispositive on the issue of whether additional hospital beds are needed in Rutherford County.

The current CON law requires a new hospital to prove a need for additional hospital beds using the acute care bed standards and criteria in the State Health Plan. Any existing hospital can add acute care beds as budgets and space permit. While the State Health Plan's acute care bed

criteria do not suggest a need for additional hospital beds in Rutherford County, the Commission concludes from the Findings of Fact and the entire record, that there are compelling reasons to deviate from the State Health Plan with respect to this application. Specifically, the ALJ found and the Commission's review of the record shows that STRH has been on [redacted] (FOF 26). The ALJ further found that STRH has an average inpatient occupancy of 80% and that patients have sometimes been boarded in the Emergency Room. (FOF 27-28) These facts weigh heavily in favor of approving the VRH application.

The State Health Plan is a guideline and the Commission has the discretion to deviate from the guidelines for compelling reasons, and compelling reasons exist here.

Despite the acute care bed need formula showing a surplus of hospital beds in Rutherford County, STRH has continued to add hospital beds and anticipates opening even more in 2023. STRH has made efforts to become a tertiary center rather than a community hospital and is making the adjustments toward this goal. VUMC has begun construction on an approximately [redacted] project that would add roughly [redacted] at its tertiary hospitals, none of which need to be approved through the CON application process. This construction project – and the addition of a large number of beds – were not mentioned in the CON application or at the HFC hearing even though the project had been internally approved. While the plan has changed and will likely continue to evolve, VRH did not mention the largest expansion in VUMC's history to HFC. As noted above, the ALJ was not authorized to determine whether the Commission's initial approval of the application was based on "false, incorrect or misleading" information and her legal conclusions to that effect are rejected. Moreover, the addition of hospital beds in Davidson County will not address the identified need for more hospital resources in Rutherford County.

Petitioners have failed to establish, by the preponderance of the evidence, that the VRH project is not needed in the area to be served pursuant to Tenn. Code Ann. 68-11-1609(b) and Tenn. Comp. R. & Regs. 0720-11-.01(1)(f).

**Adequate Staffing**

A CON applicant must show, under the acute care need criteria, a plan for adequate staffing. There are a finite number of trained nurses. At the time of the hearing, VUMC had over [redacted] across its numerous clinics and hospitals. When HFC considered the CON application, VUMC had at least [redacted] unfilled nursing positions at its main campus, yet VUMC falsely presented that staffing had not been a problem. Having a nurse transfer from working at one of the downtown Nashville facilities to work at VRH does not "fill" the VRH position as it then opens a position elsewhere. If approved, VUMC would need to fully staff VRH in addition to [redacted] it is in the process of adding in Davidson County.

Marilyn Dubree, VUMC's Executive Chief Nursing Officer, provided credible testimony[9] as to the nursing shortages and challenges faced at VUMC over the course of her extensive career. At the time of the hearing, Ms. Dubree estimated that VUMC had [redacted] open nursing positions. VUMC has offered signing bonuses as [redacted] to fill specialized nursing positions. Ms. Dubree was not aware of any other hospital system that offered hiring bonuses at that level.

The parties' efforts to address the nursing shortage by helping to improve the availability of nursing and clinical staff are commendable. While providing hiring bonuses, moving expenses, and student loan forgiveness adds to the cost of a facility, these are costs that all healthcare providers are having to pay. Historically, no CON application has been denied on the basis of

[9] Due to unavailability at the close of the hearing, the parties agreed to submit Ms. Dubree's video deposition into the RECORD.

staffing. Petitioners have failed to prove by a preponderance of the evidence that the CON application fails to satisfy the staffing criterion under TENN. COMP. R. & REGS. 0720-11-.01(3)(e) in that there was no evidence and no finding of fact showing that the applicant will be unable to staff the proposed new facility or that the staffing of VRH will cause increased staffing difficulties for existing providers.

**Other Guidelines**

Several of the guidelines were uncontested: demonstration of an ability and willingness to serve all patients in the proposed service area; documentation that it will provide the resources necessary to properly support the applicable level of services; agreement to provide the Department of Health and/or HFC with all reasonably requested information and statistical data, identification for data reporting, quality improvement, and outcome and process monitoring system; and compliance with appropriate rules of the Department of Health as well as accreditation with the Joint Commission. As these factors were not contested, Petitioners have failed to prove that VRH's CON application does not satisfy these guidelines.

**Cardiac Catheterization Services**

The State Health Plan established extensive guidelines in 2009 for a CON application to establish cardiac catheterization services. Since the current guidelines were established more than 13 years ago, new cardiac technology has been created that may reduce the demand for diagnostic cardiac catheterizations. The applicable data support the weighted formula in the guidelines. Petitioners have failed to prove by a preponderance of the evidence that the CON application for cardiac catheterization criteria has not been met pursuant to TENN. COMP. R. & REGS. 0720-11-.01(2)(h).

**Effects for Consumers**

VRH's current CON application was filed after the CON application for the Westlawn hospital was approved. VRH is proposed to be in virtually the identical location as Westlawn. VRH's proposal is for the same type of facility, though larger, than Westlawn. VRH would cover the same service area as Westlawn thought it would extend into a larger area. Lastly, VRH would provide overlapping services to Westlawn in that both would have an emergency department and inpatient hospital services. Even though VRH will be near Westlawn, there is a significant difference between an 8-bed microhospital and a 42-bed general acute care hospital. The VRH facility will provide consumers in Rutherford County with needed access to pediatric care, as well as needed additional capacity for adult patients. Petitioners have failed to prove by a preponderance of the evidence the criteria under TENN. COMP. R. & REGS. 0720-11-.01(3)(a) have not been met.

The effects of competition or duplication are required to be positive for consumers. The Commission finds that the addition of additional inpatient resources, including pediatric resources, will be positive for consumers. Although adult inpatient hospital beds are available in the service area, the ALJ found that STRH has an average inpatient occupancy of 80% and patients are sometimes boarded in the Emergency Room. (FOF 27-28). As a policy matter the Commission aims for all Tennesseans to have access to health care in well-designed treatment spaces where they can be seen with dignity and privacy. The use of hallway beds by STRH is one factor weighing in favor of the need for VRH. The hospital has been on [redacted] (FOF 26) Significant diversion status is a strong indicator of the need for additional services. The Rutherford County pediatric population is "underserved" in terms of reasonable access to inpatient services. Essentially any pediatric patient who requires hospitalization, even for relatively minor conditions, must drive to Nashville or Franklin. Forty-

five minutes to an hour of travel for pediatric inpatient services does not constitute reasonable access for the residents of Rutherford County.

VRH has positioned itself as a low-cost provider of health care. After submitting the CON application and before the hearing began for one payor and during the hearing for the other payor, Intervenor chose to terminate contracts with Medicare Advantage Plans providers Humana and WellCare. VRH did not announce an adjustment to the projected payor mix or make HFC or the tribunal aware of the decision to stop accepting these Medicare Advantage plans despite VUMC asserting that the decision was made only after undertaking a careful analysis. While information has been provided to show that the contract with Humana was resolved, no such information was provided for WellCare. It is inevitable that healthcare providers and payors of care will have contractual discussions. There is also no guarantee that any healthcare provider will continue to accept every Medicare Advantage plan or any other payor. A minor dispute between VUMC and two insurance providers – especially a dispute that was resolved – is not an important consideration in evaluating the future costs at the new hospital or whether VRH will appropriately provide care to residents of the community regardless of their ability to pay.

VRH has asserted it will be a participant in TennCare, Medicare, and other federal and state reimbursement programs, similar to Intervenor's other facilities. VRH has presented that its payment model will be the same as VUMC's three existing community hospitals. Those hospitals have all lost money. According to Dr. Wright Pinson, the Deputy CEO and Chief Health System Office for VUMC, a healthcare system cannot undertake to complete a project unless it is financially feasible. From this record, the Commission does not conclude that the financial performance of the existing hospitals is predictive of the financial performance of VRH. Petitioners have failed to prove that the addition of another provider would have a material

negative impact on the cost of medical services in the community. Petitioners have failed to prove by a preponderance of the evidence that the effects attributed to competition or duplication of services would not be positive for consumers under TENN. COMP. R. & REGS. 0720-11-.01(3)(b), (c), and (d).

**Conclusion**

Based on the Findings of Fact and its review of the entire record, the Commission finds that the VRH application satisfies the criteria for a Certificate of Need set forth in Tenn. Code Ann. § 68–11–1609(b) and HFC Rules 0720-11-.01(1)-(3), and therefore should be GRANTED. STRH has experienced significant difficulties in managing its patient volumes. Local physicians testified that [redacted]. The Commission concludes that VRH would add much needed acute care capacity to Murfreesboro and Rutherford County and provide those residents with an additional hospital option. Further, the existing hospitals in Rutherford County offer only the most basic pediatric inpatient care and almost all children requiring hospitalization must travel to Nashville. VRH will offer a pediatric inpatient unit staffed by pediatric-trained providers. VRH will provide a needed healthcare option for one of the largest pediatric populations in the State, improving access, quality, and outcomes for the children of Rutherford County. Finally, VUMC currently treats a significant number of Rutherford County residents at its main campus in downtown Nashville. Vanderbilt Rutherford will provide a convenient option in Murfreesboro for VUMC patients to access their preferred hospital system closer to their homes.

2/29/2024
Chairman, Health Facilities Commission

## NOTICE OF APPEAL PROCEDURES

## REVIEW OF FINAL ORDER

1. **Petition for Reconsideration of the Final Order:** You may ask the Tennessee Health Facilities Commission ("Commission") to reconsider the decision by filing a Petition for Reconsideration with the Administrative Procedures Division (APD). A Petition for Reconsideration should include your name and the above APD case number and should state the specific reasons why you think the decision is incorrect. APD must **receive** your written Petition no later than 15 days after entry of the Final Order. The Commission has 20 days from receipt of your Petition to grant, deny, or take no action on your Petition for Reconsideration. If the Petition is granted, you will be notified about further proceedings, and the timeline for appealing (as discussed in paragraph (2), below) will be adjusted. If no action is taken within 20 days, the Petition is deemed denied. As discussed below, if the Petition is denied, you may file an appeal as discussed in paragraph 2.

2. **Review of a Final Order:** A person who is aggrieved by a Final Order in a contested case may seek judicial review of the Final Order by filing a Petition for Review "in the Chancery Court nearest to the place of residence of the person contesting the agency action or alternatively, at the person's discretion, in the chancery court nearest to the place where the cause of action arose, or in the Chancery Court of Davidson County," within 60 days of the date the Initial Order becomes a Final Order. *See* TENN. CODE ANN. § 4-5-322. The filing of a Petition for Reconsideration is not required before appealing. *See* TENN. CODE ANN. § 4-5-317.

3. **Petition for Stay:** In addition, you may file a Petition, with APD, asking the Commission for a stay that will delay the effectiveness of the Final Order. A Petition For Stay must be **received** by APD within 7 days of the date of entry of the Final Order. *See* TENN. CODE ANN. § 4-5-316. A reviewing court also may order a stay of the Order upon appropriate terms. *See* TENN. CODE ANN. §§ 4-5-322 and 4-5-317.

Attachment 1N-5, Acute

MRH Floor Plans from its Website

MAURY REGIONAL HEALTH

Print

# MAURY REGIONAL MEDICAL CENTER

## FLOOR OVERVIEW

### Ground Floor

Cafeteria
Emergency
Health Information Management
Outpatient Imaging
*(Use South Exterior Entrance)*
Private Dining Rooms
MOB Level 1
*(See MOB Directory)*
MOB Conference Room
Volunteer Services

### Floor 1

Admitting
ATM
Chapel
Conference Rooms
*(Auxiliary/First Floor)*
Gift Shop
Heart Center
Human Resources
Java Junction/Starbucks®
Outpatient Pharmacy
Patient Rooms 150-184
Patient Services
Security
Vendor Kiosk
Waiting Rooms
MOB Floor 2
(See MOB Directory)

### Floor 2

Infection Control
Patient Rooms 250-273
Same Day Surgery 218-245
Waiting Rooms

### Floor 3

Dialysis
Patient Rooms 338-397
Respiratory Care
Sleep Center
Waiting Room

### Floor 4

Labor & Delivery Rooms LDR 1-12
Mother/Baby Rooms 450-473
Neonatal Intensive Care Unit (NICU)
Waiting Room

*For Medical Office Building (MOB) and Pavilion information, please see the directory in the lobby of each facility.*

### Floor 5

Family Area with dedicated sleeping area
Patient Rooms 550-575

### Floor 6

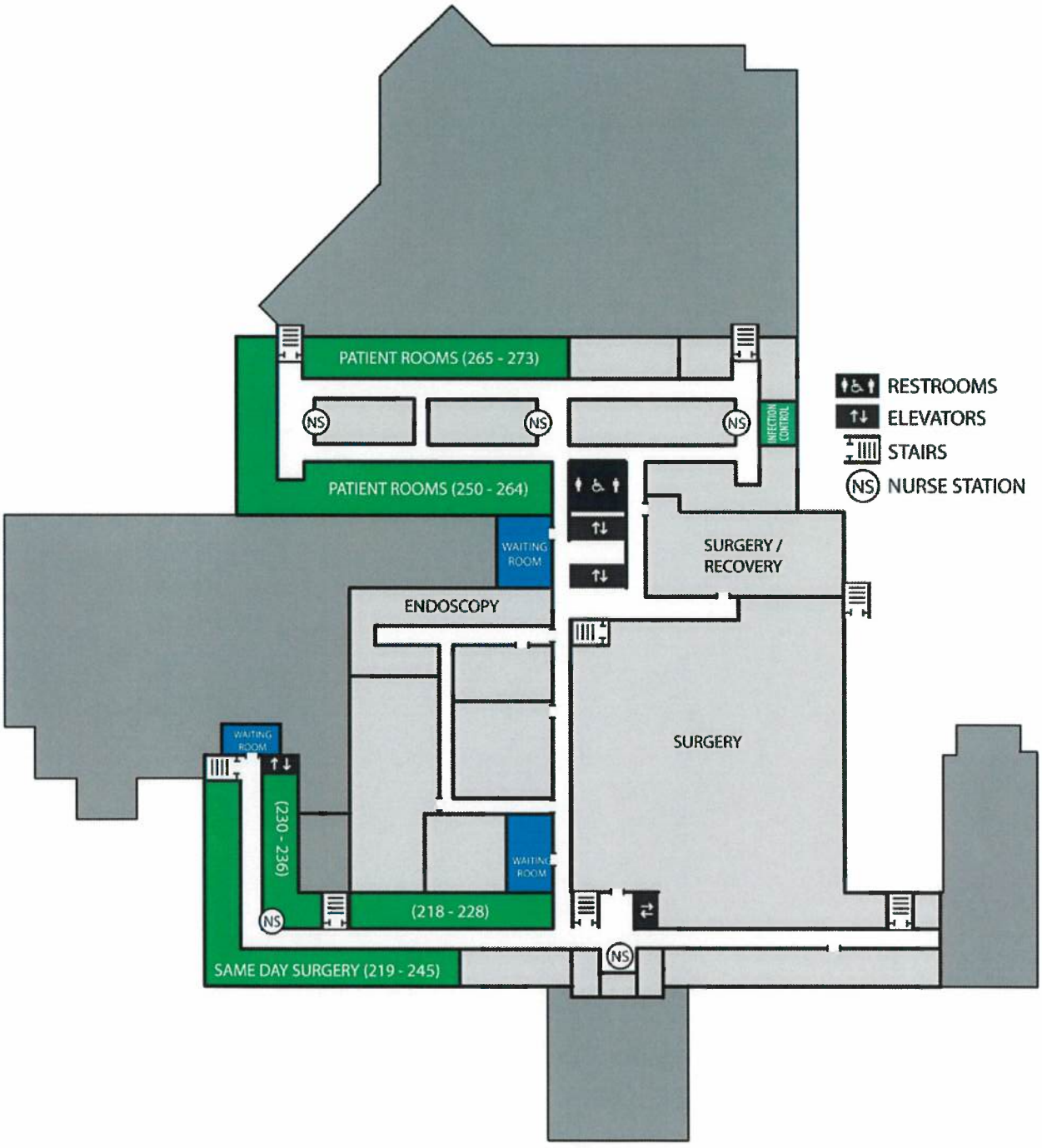
Orthopedics 652-671
Surgery 650-687

MAURY REGIONAL HEALTH

Print

# MAURY REGIONAL MEDICAL CENTER

## SECOND FLOOR MAP



MAURY REGIONAL HEALTH

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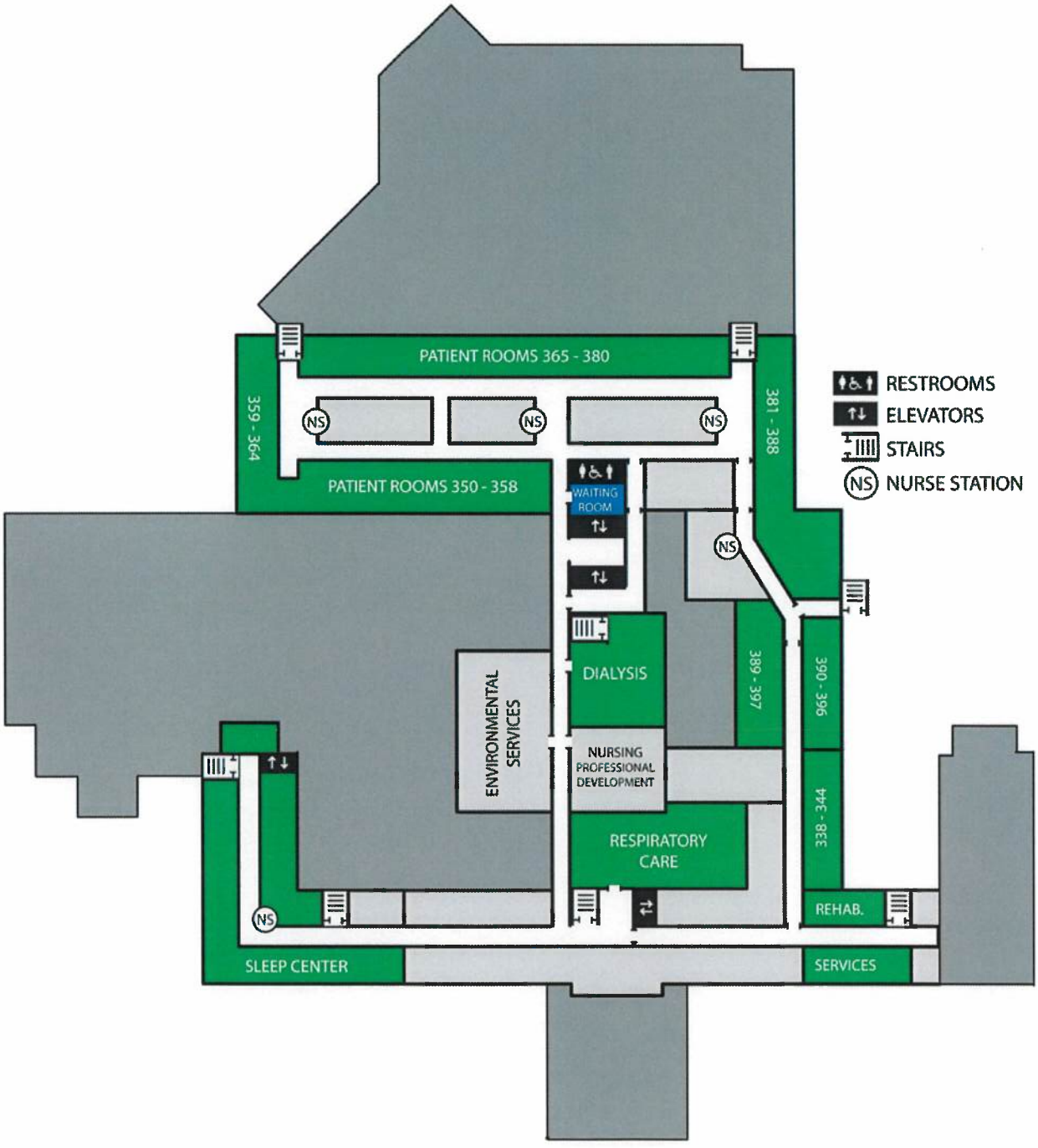
# MAURY REGIONAL MEDICAL CENTER

## THIRD FLOOR MAP



MAURY REGIONAL HEALTH

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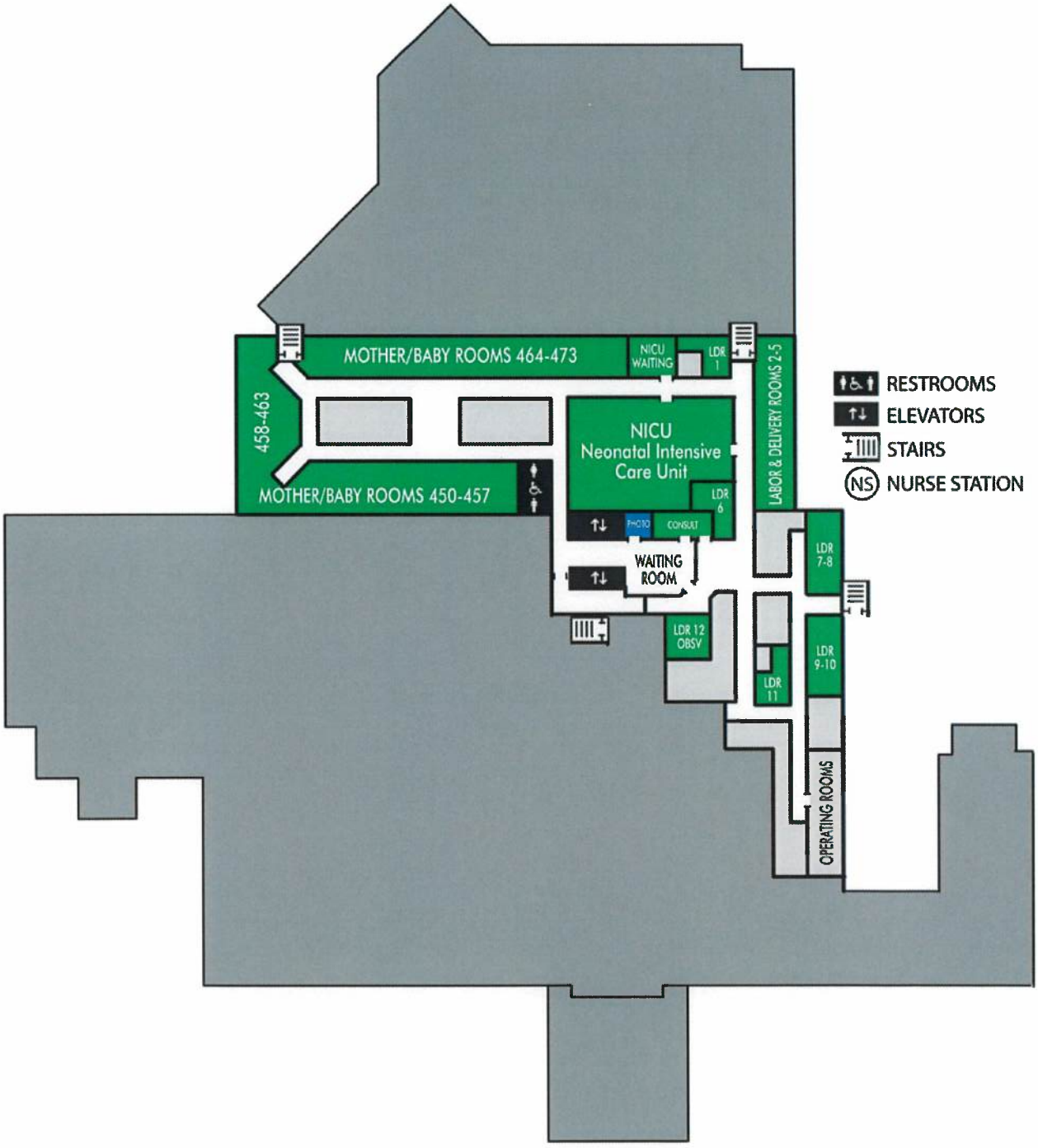
# MAURY REGIONAL MEDICAL CENTER

## FOURTH FLOOR MAP



MAURY REGIONAL HEALTH

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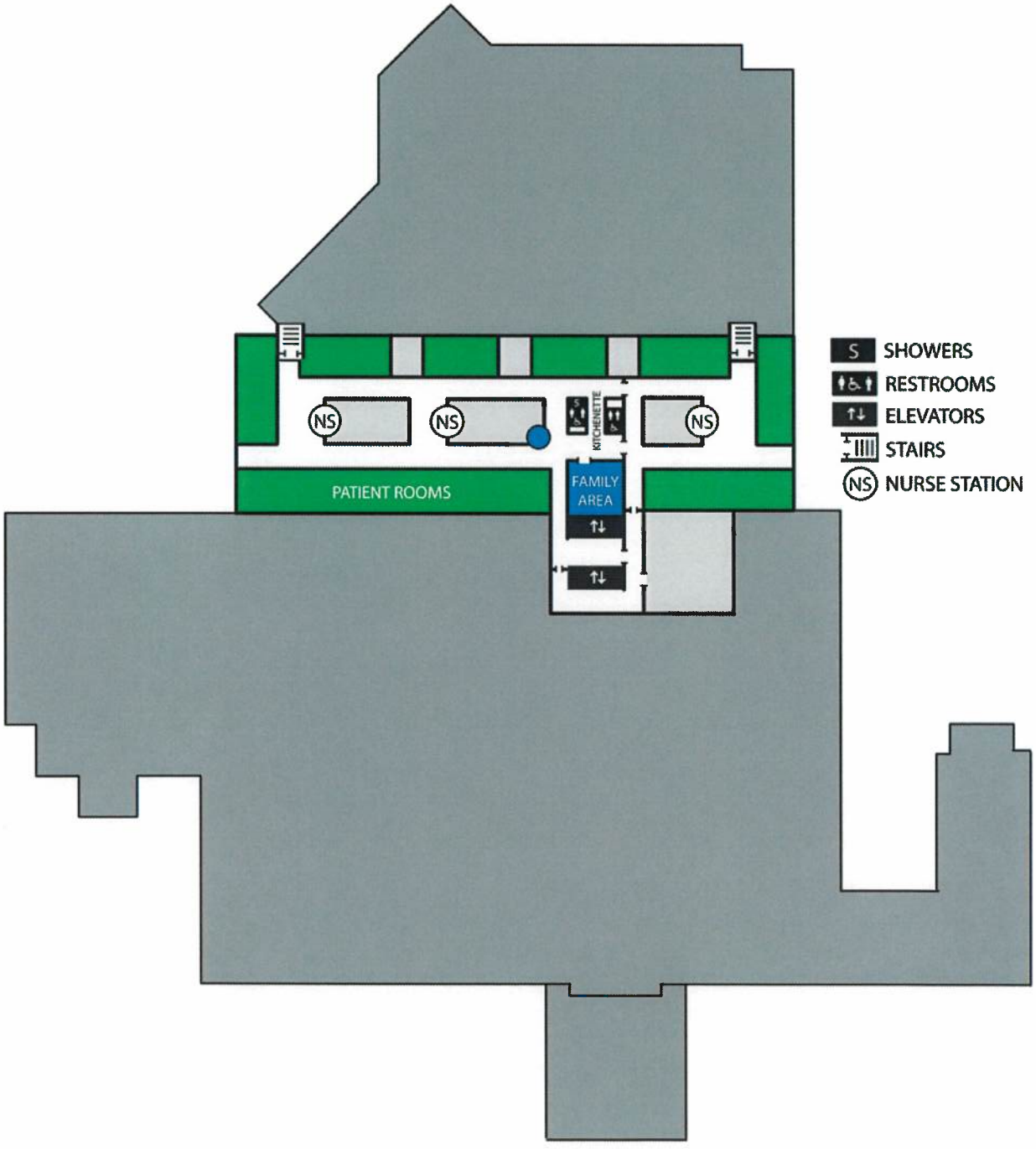
# MAURY REGIONAL MEDICAL CENTER

## FIFTH FLOOR MAP

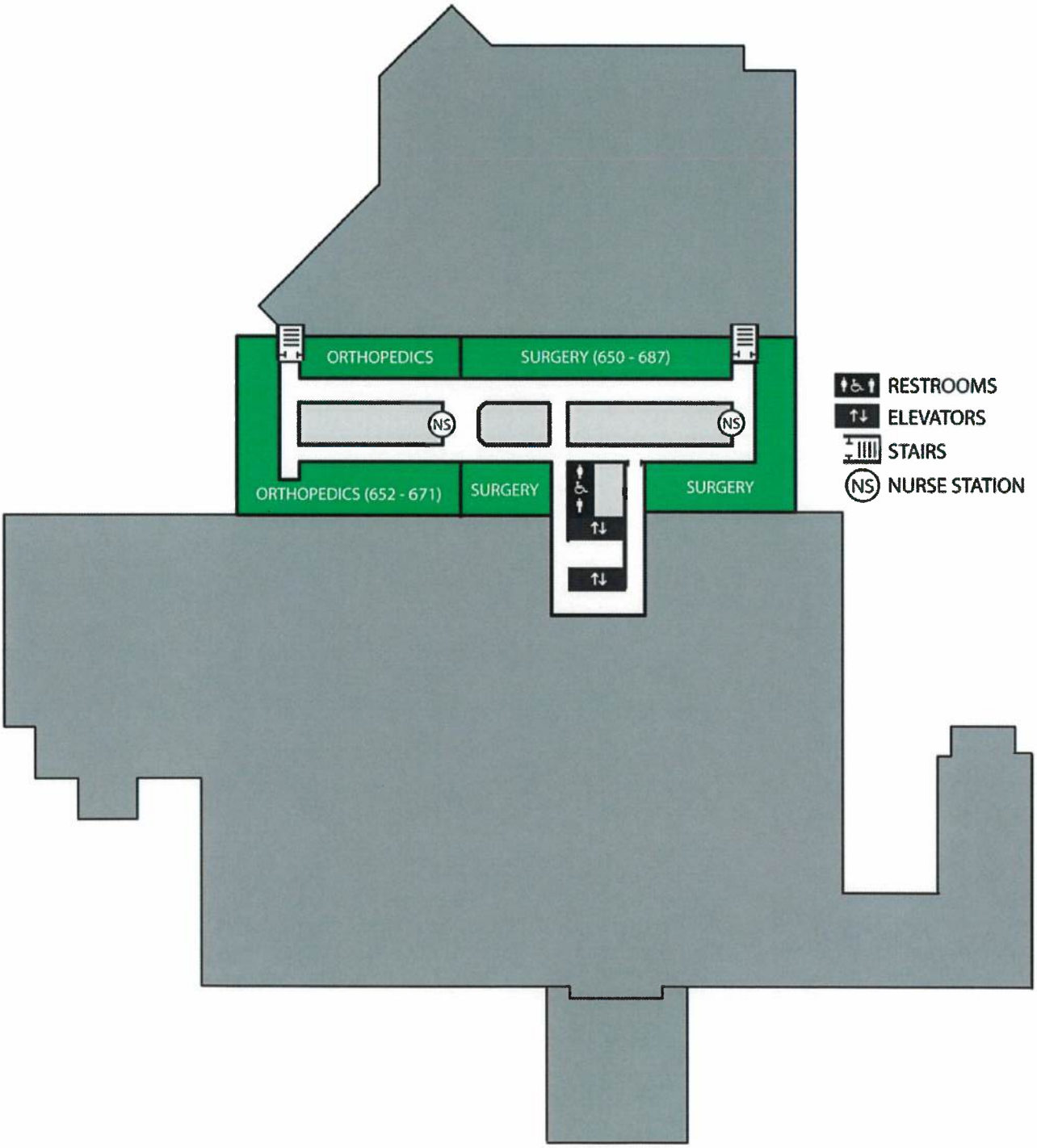


MAURY REGIONAL HEALTH

Print

# MAURY REGIONAL MEDICAL CENTER

## SIXTH FLOOR MAP



Attachment 1N-6, Acute and NICU

Applicant Commitment Letter

TriStar Health

April 22, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

**RE: TriStar Spring Hill Hospital Commitment Letter**

Dear Mr. Grant:

Spring Hill Hospital, Inc. d/b/a TriStar Spring Hill Hospital ("TSHH") is filing an application to establish a 68-bed hospital in Spring Hill, Maury County which will include acute care services, cardiac catheterization services, neonatal intensive care unit and MRI services. TSHH is part of the TriStar Health System in Middle Tennessee, and our system's hospitals are owned by HCA Healthcare, Inc. through wholly owned subsidiaries.

As Chief Financial Officer of Tristar Division, I am writing to confirm that HCA Healthcare, Inc. is committed to this project. Specifically, we are fully committed to developing and maintaining the facility resources, equipment, and staffing to provide the appropriate resources for all services to be provided, including acute care services, neonatal nursery services, cardiac catheterization services, and MRI services.

Please contact me if you have any questions regarding this information.

Sincerely,

Wes Fountain
Chief Financial Officer
TriStar Division

# Attachment 1N-1, NICU

# Transport Arrangements, Neonatal

Status **Active** PolicyStat ID **12087345**

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

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

# Transport Arrangements, Neonatal



## PURPOSE:

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

## POLICY:

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

# PROCEDURE:

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



# References:

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

Pre-PolicyStat Number: WH-NEO-139

## Approval Signatures

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

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

Attachment 1N-2, NICU

# Provision of Care Policy: Neonatal Intensive Care Unit

TriStar Centennial MEDICAL CENTER | TriStar Ashland City MEDICAL CENTER

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

# Provision of Care: Neonatal Intensive Care Unit

## Goal:

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

## Scope of Service:

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

## Department Description:

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

## Identification of Needs:

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

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

# Performance Improvement:

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

# Admission Criteria:

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

# Exclusionary Criteria:

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

# Transfer Criteria:

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

# Discharge Criteria:

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

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

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

C. The neonate will be gaining weight appropriatly.

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

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

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

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

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

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

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

K. Appropriate community resource referrals provided.

# Governance:

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

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

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

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

# Staffing:

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

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

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

# Process Used for Positive and Negative Variance:

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

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



# Support Systems:

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

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

## Attachments

No Attachments

## Approval Signatures

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



## Applicability

TriStar Centennial and Ashland City Policy Library

Attachment 1N - 1, Cardiac

Physician Bios

Jeffrey Webber, MD

Dr. Webber completed his internal medicine internship, residency and fellowship training at Vanderbilt University Medical Center where he served as the Chief Fellow in Cardiology. In 1995, he began practicing with Frist Cardiology at TriStar Centennial Medical Center while also serving as Medical Staff President and Chief of Cardiovascular Medicine. Before joining Centennial Heart in 2015, Dr. Webber conducted research for Sarah Cannon Research Institute, TriStar Centennial Medical Center, Vanderbilt University Medical Center and Cornell Medical Center. He has extensive experience researching treatment methods for patients with myocardial infarction (MI) and vascular restenosis. Dr. Webber has also published several medical journal articles about his research involving studies in arterial gene transfer, cryotherapy for acute MI and co-authored a chapter in the textbook, He is married with four children and three grandchildren. His outside interests include church service, Skiing, photography and motor sport racing.

**Procedures and Conditions Treated**

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

**Specialties**

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

**Affiliations**

- TriStar Centennial Medical Center
- TriStar Ashland City Medical Center

**Credentials and Education**

- **Vanderbilt University Medical Center**
  Internship , 1990
- **Vanderbilt University Medical Center**
  Fellowship , 1995
- **Cornell University - New York**
  Graduate Degree , 1989
- **Vanderbilt University Medical Center**
  Residency , 1992

## About John A. Riddick, MD

### Biography

This physician is accepting telehealth visits.

Dr. John Riddick is an interventional cardiologist with Centennial Heart Cardiovascular Consultants as well as the Medical Director for the Centennial Heart Center High Risk Valve Program. He is a graduate of Vanderbilt University School of Medicine where he also completed his residency in Internal Medicine. Dr. Riddick completed both a fellowship in cardiology as well as interventional cardiology at Emory University in Atlanta Georgia. Dr. Riddick has authored a number of abstracts on various cardiac subjects and is board certified in Internal Medicine, Cardiology, Interventional Cardiology and Nuclear Cardiology.

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### Procedures and Conditions Treated

- Cardiac (Medical) - Medical Cardiology
- Medical Cardiology

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### Specialties

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

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### Affiliations

- TriStar Centennial Medical Center
- TriStar Ashland City Medical Center

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### Credentials and Education

- Duke University
  Undergraduate Degree

- Vanderbilt University Medical Center
  Internship
  2001
- Emory University School of Medicine
  Fellowship

- Vanderbilt University School of Medicine
  Graduate Degree
  2001
- Vanderbilt University Medical Center
  Residency
  2004

Attachment 1N - 2, Cardiac

Cardiac Cath Lab to CMC Emergency Transfer

Status **Active** PolicyStat ID **10026041**

| | |
|---|---|
| Effective | 1/1/1996 |
| Last Reviewed | 9/11/2021 |
| Last Revised | 9/11/2021 |
| Next Review | 9/10/2024 |
| Owner | Brandon Ward: Dir Cardiac Cath Lab |
| Policy Area | Cardiovascular Services |
| Applicability | TriStar Southern Hills Medical Center |

# Cardiac Cath Lab to CMC Emergency Transfer



## PURPOSE:

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

## POLICY:

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

## PROCEDURE:

Cath Lab Staff should:

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

Cardiologist should:

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

Nursing Supervisor should:

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

Transporting the Patient:

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

## All Revision Dates

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



## Attachments

EMTALA Memorandum of Transfer Form ENGLISH.pdf

EMTALA Memorandum of Transfer Form Spanish.pdf

## Approval Signatures

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

## Applicability

TriStar Southern Hills Medical Center

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

**Service Area**

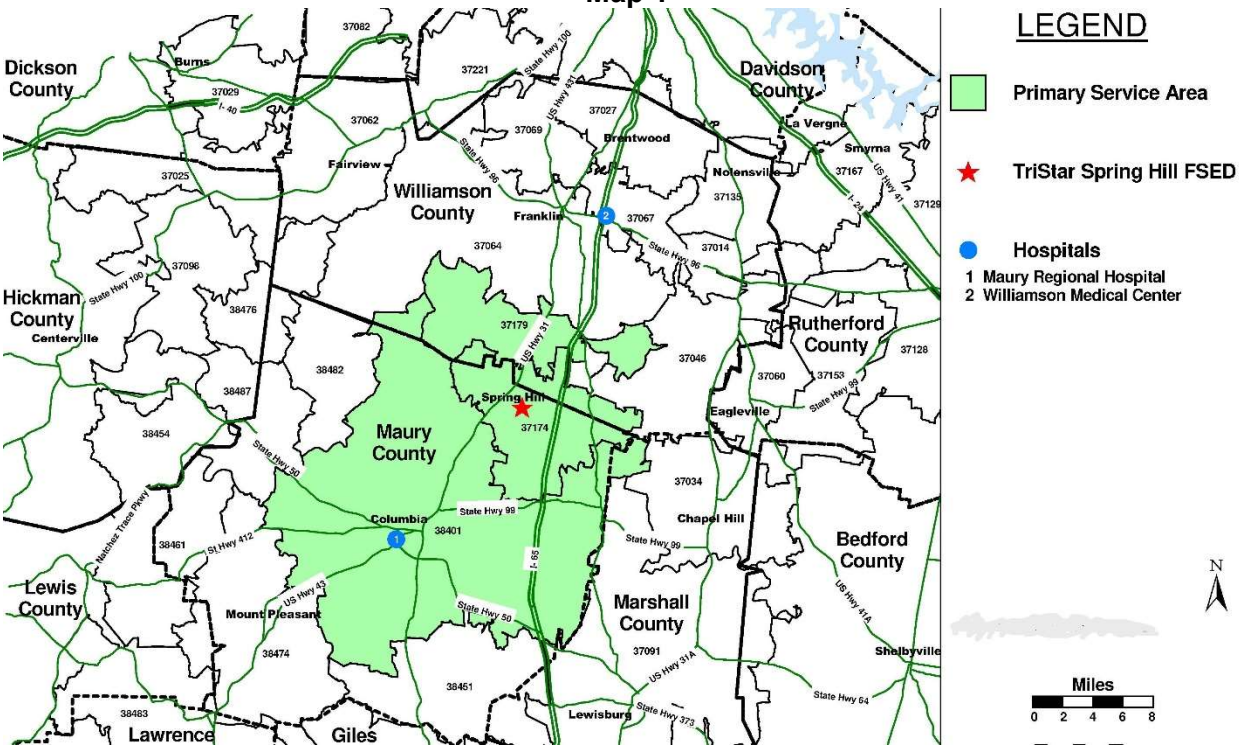
The proposed Service Area for TSHH is the following three zip codes:

- 37174 – Spring Hill;
- 37179 – Thompson's Station; and
- 38401 – Columbia

("Service Area"). Both 37174 and 38401 are assigned by the US Postal Service to Maury County; 37179 is assigned to Williamson County.

The following map presents the Service Area relative to Maury, Williamson and surrounding counties. As observed visually, a small portion of the Service Area is in southern Williamson County, while the majority is in northern Maury County. The dark bold line crossing the Service Area north of the TSHH red star is the county border.

**Map 1**

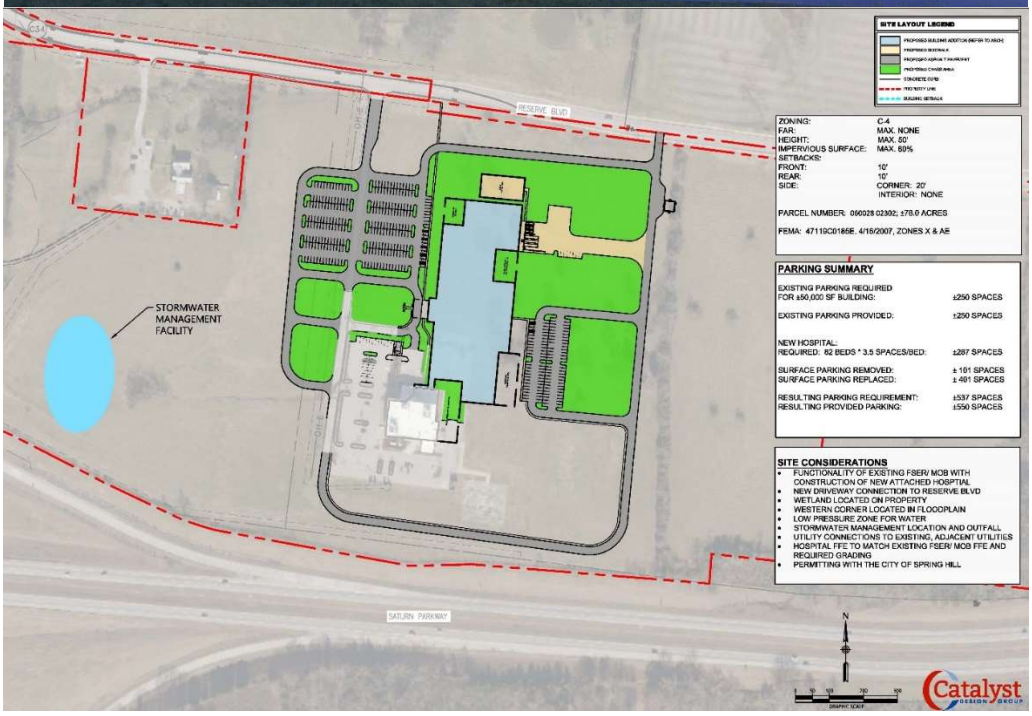



As discussed below, in determining the Service Area, the Applicant considered the proposed services, the current utilization of TriStar Spring Hill ER, and the location of providers in the Service Area.

**Overview of TriStar Spring Hill Hospital**

The proposed TSHH will be located at 3001 Reserve Boulevard, Spring Hill, Maury County, Tennessee, 37174, as an addition to the existing TriStar Spring Hill ER. Upon licensure of the hospital, the existing ER, which is currently a satellite of TriStar Centennial, will be incorporated into the new hospital license, operating as a significant access point to TSHH.

Below is a rendering of the hospital followed by a proposed site plan. The site plan shows the relationship of the existing building, proposed areas of construction to convert the freestanding emergency department to a full-service hospital, and site circulation from Reserve Boulevard.

The 68-bed hospital will be approximately 200,000 square feet, constructed as an addition to the existing TriStar Spring Hill ER. The addition will be adjacent to and connected with the existing 12 treatment room ER. At present, the ER occupies the first floor of the existing three-story TriStar Spring Hill Medical Park facility, which also includes imaging and laboratory services, adjacent to the ER on the first floor. The second and third floors of the existing TriStar Spring Hill Medical Park facility, include a GI suite (also currently a department of TriStar Centennial) and private physician office space. Physicians currently practicing in the building include two primary care providers, three cardiology providers, three orthopedic providers, two thoracic surgeons, a gynecologic oncologist, a gastroenterologist and a neurosurgeon.

The existing helipad, which facilitates quick transfers by TriStar's SkyLife Helicopter Service, will remain in its current location as it is easily accessible from the ER and the planned inpatient facilities. The helipad is also available for other air transport services.

The floor plans for the proposed three-story hospital are included in **Attachment 10A**. The first floor shows the connector from the existing ER. There is an expansion zone between the existing ER and the hospital labeled as imaging/ED expansion. This zone will be for future expansion as population increases and demand warrants such expansion. A description of the functions on each of the hospital floors is previously provided on page 4.

As noted, TSHH will be developed with the potential to expand as population increases and demand warrants such expansion. This will include the ability to add additional floors and beds above the proposed hospital plan identified herein, in addition to the expansion zones noted on the first, second and third floors. These potential additions will be available for future programming and services based on demand for services after initial licensure and years of operation.

**TriStar Spring Hill ER**

TriStar Spring Hill ER is a full-service emergency department, open 24 hours a day, 7 days a week, 365 days a year. The TriStar Spring Hill campus is 77 acres.

TriStar Spring Hill ER has 12 ED beds and is staffed with board certified physicians and nurses who provide emergency care for all illnesses and injuries that present. Clinical support services include a full-service laboratory and imaging services inclusive of CT scan, ultrasound and x-ray. Patients who require admission to a hospital are transferred from TriStar Spring Hill ER to the patient's hospital of choice; most frequently patients are transferred to TriStar Centennial. If a service is not offered at the patient's selected hospital of choice, the patient is transferred to a higher level of care in accordance with the Emergency Medical Treatment and Labor Act ("EMTALA").

TriStar Spring Hill ER is the oldest continuously operating freestanding emergency department in the State. It became operational in February 2013 after many years of widespread community support to bring TriStar Health to Spring Hill. While the vision was initially for a full-service hospital, which was approved twice by the HSDA,[4] TriStar Spring Hill ER was implemented as a first phase. The initial plan always envisioned a full-service hospital, including when the freestanding ER was proposed as an alternative given the hospital's opposition at the time.

[4] Despite HSDA approval, the Chancery Court reversed issuance of the CON in a 2009 decision.

The high volume at this 12 bay ED has been the result of its highly regarded reputation for the quality of healthcare it provides and its ideal location and distance from other emergency rooms, improving patient access for the Spring Hill area and reducing out-migration. It is the only 24/7 healthcare facility in the City of Spring Hill. 37 percent of its patients are TennCare and an additional 16 percent are Medicare. TriStar Spring Hill ER's quality metrics are remarkable and include the following:

- Extremely low 'left prior to medical screening' at 0.6 percent;
- Less than 8 minutes from arrival to bed;
- 18.17 minutes from disposition to discharge; and
- Less than 5-minute EMS offload time.

As of 2024, TriStar Spring Hill ER has taken the initiative to incorporate Pediatric Readiness in its ER. Pediatric Readiness is a joint policy statement based on the American Academy of Pediatrics ("AAP"), American College of Emergency Physicians ("ACEP") and Emergency Nurses Association ("ENA"). This program includes administration and coordination of the ER for the care of children, healthcare providers who staff the ER have periodic pediatric-specific competency evaluations, the QAPI includes pediatric-specific indicators, and pediatric-specific issues incorporated into the policies, procedures, and protocols of the ER. Additionally, the emergency preparedness plan includes pediatric-specific needs. When TSHH incorporates the TriStar Spring Hill ER into its operations, TSHH will continue with the Pediatric Readiness program.

TriStar Spring Hill ER's historical utilization by zip code in the Service Area for the past five calendar years is presented in the following table.

**Exhibit 1**

| | TriStar Spring Hill ER Visits by Zip Code | | | | | 5-Year |
|---|---|---|---|---|---|---|
| **Zip Code** | **CY 2019** | **CY 2020** | **CY 2021** | **CY 2022** | **CY 2023** | **Total** |
| 37174 - Spring Hill | 5,451 | 4,747 | 5,635 | 5,784 | 5,911 | 27,528 |
| 38401 - Columbia | 5,585 | 4,181 | 4,834 | 5,559 | 5,426 | 25,585 |
| 37179 - Thompson's Station | 646 | 503 | 579 | 655 | 638 | 3,021 |
| Subtotal | 11,682 | 9,431 | 11,048 | 11,998 | 11,975 | 56,134 |
| All Other | 3,802 | 3,197 | 3,436 | 3,935 | 3,925 | 18,295 |
| Total | 15,484 | 12,628 | 14,484 | 15,933 | 15,900 | 74,429 |
| | | | | | | |
| | TriStar Spring Hill ER Percent of Total Visits | | | | | 5-Year |
| **Zip Code** | **CY 2019** | **CY 2020** | **CY 2021** | **CY 2022** | **CY 2023** | **Total** |
| 37174 - Spring Hill | 35.2% | 37.6% | 38.9% | 36.3% | 37.2% | 37.0% |
| 38401 - Columbia | 36.1% | 33.1% | 33.4% | 34.9% | 34.1% | 34.4% |
| 37179 - Thompson's Station | 4.2% | 4.0% | 4.0% | 4.1% | 4.0% | 4.1% |
| Subtotal | 75.4% | 74.7% | 76.3% | 75.3% | 75.3% | 75.4% |
| All Other | 24.6% | 25.3% | 23.7% | 24.7% | 24.7% | 24.6% |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

*Source: Internal records, CY 2019 through CY 2023.*
*CY 2020 was highly impacted by COVID-19; its visit reduction is an anomaly and volume has rebounded. Despite the volume reduction, the zip code origin of patients remained constant.*

Approximately 75 percent of the TriStar Spring Hill ER patients reside in three zip codes, 37174 (Spring Hill), 38401 (Columbia) and 37179 (Thompson's Station). This information, supported by the statistics showing where patients are treated, is the basis for defining the proposed Service Area for TriStar Spring Hill Hospital. Accordingly, it is from this defined Service Area that the proposed hospital anticipates treating 75 percent of its inpatients and outpatients, with the balance (25 percent) coming from outside the Service Area.

TriStar Spring Hill ER is also a significant source of patient transfers to inpatient community and specialized/tertiary care. The number of patient transfers out of Spring Hill by year has averaged between 100 and 140 per month. The following table provides these historical numbers (out-migration) by year from the TriStar Spring Hill ER to hospital facilities. This level of admissions shows a substantial baseline of patient activity which in and of itself supports an inpatient hospital in Spring Hill.

**Exhibit 2**

| | TriStar Spring Hill ER Visits and Transfers | | | | | 5-Year |
|---|---|---|---|---|---|---|
| **Factor** | **CY 2019** | **CY 2020** | **CY 2021** | **CY 2022** | **CY 2023** | **Total** |
| Total Patients Transferred to a Hospital | 1,643 | 1,581 | 1,151 | 1,204 | 1,118 | 6,697 |
| Total Visits at TriStar Spring Hill ER | 15,484 | 12,628 | 14,484 | 15,933 | 15,900 | 74,429 |
| Percent Transferred/Admitted | 10.6% | 12.5% | 7.9% | 7.6% | 7.0% | 9.0% |

*Source: Internal records, CY 2019 through CY 2023*

Approximately 70 percent of the above transfers are to TriStar Centennial with an additional 7 percent to other TriStar Health hospitals. All other remaining hospitals to which patients are transferred represent lower counts, ranging between 0.1 and 6.9 percent of total.

The above transfers were analyzed by service line, including tertiary versus non-tertiary, and other specialized care to estimate the level of clinically appropriate patients who could be retained with the establishment of TSHH. On average, during the past five years, between 86 and 90 percent of these patients could have been treated locally with the proposed services at TSHH as summarized in the next Exhibit.

**Exhibit 3**

| | Transfers from TriStar Spring Hill ER by Type | | | | | 5-Year |
|---|---|---|---|---|---|---|
| **Factor** | **CY 2019** | **CY 2020** | **CY 2021** | **CY 2022** | **CY 2023** | **Averge** |
| Community/Non-Tertiary | 1,442 | 1,362 | 988 | 1,084 | 976 | 1,170 |
| Tertiary/Specialized | 201 | 219 | 163 | 120 | 142 | 169 |
| Total Transfers | 1,643 | 1,581 | 1,151 | 1,204 | 1,118 | 1,339 |
| % Community Non-Tertiary | 87.8% | 86.1% | 85.8% | 90.0% | 87.3% | 87.4% |

*Source: Internal records, CY 2019 through CY 2023*

Specialized transfers include behavioral health patients being transferred to Pinewood Springs, TriStar's joint venture behavioral health hospital in Maury County with MRH. This 60-bed behavioral health hospital fulfills a crucial role in Maury County, with more than 50 percent of gross revenue being TennCare patients. Given Pinewood Springs' presence, while TSHH will

serve behavioral health patients in its ER, it will continue to transfer appropriate patients from its ER to Pinewood Springs.

In addition to direct transfers from TriStar Spring Hill ER, the data herein confirms the extent to which the Spring Hill ER is being bypassed by EMS despite having a local emergency room. During the past calendar year there were more than 1,900 EMS scene transports from within zip code 37174 that were not transported to TriStar Spring Hill ER.[5] The significance of scene transport volume substantiates consumers' stated need and demand for a local full-service community hospital to meet their healthcare needs.

As a substantial, and the only 24/7 acute emergency, provider in the City of Spring Hill, TriStar Spring Hill ER determined there is a critical need for the establishment of an acute care hospital in conjunction with its emergency room. This is based on various health planning metrics including no existing hospital in a city the size of Spring Hill, the rapidly growing Spring Hill area with increasing demand for acute care services, ER transfers out of the area, Service Area out-migration, EMS transfers out of the area, travel times to access needed inpatient services, opportunity to improve programmatic access and consumer support.

All underlying information and analysis supporting this proposed hospital are presented on the following pages, in response to Questions 2N through 6N. These demonstrate that TriStar Spring Hill ER's conversion into a full-service community hospital will fill a critical gap in access to care for Spring Hill and surrounding community members. This will also ensure residents and workers in this rapidly growing community can access a broad spectrum of comprehensive healthcare services closer to where they live, work and play.

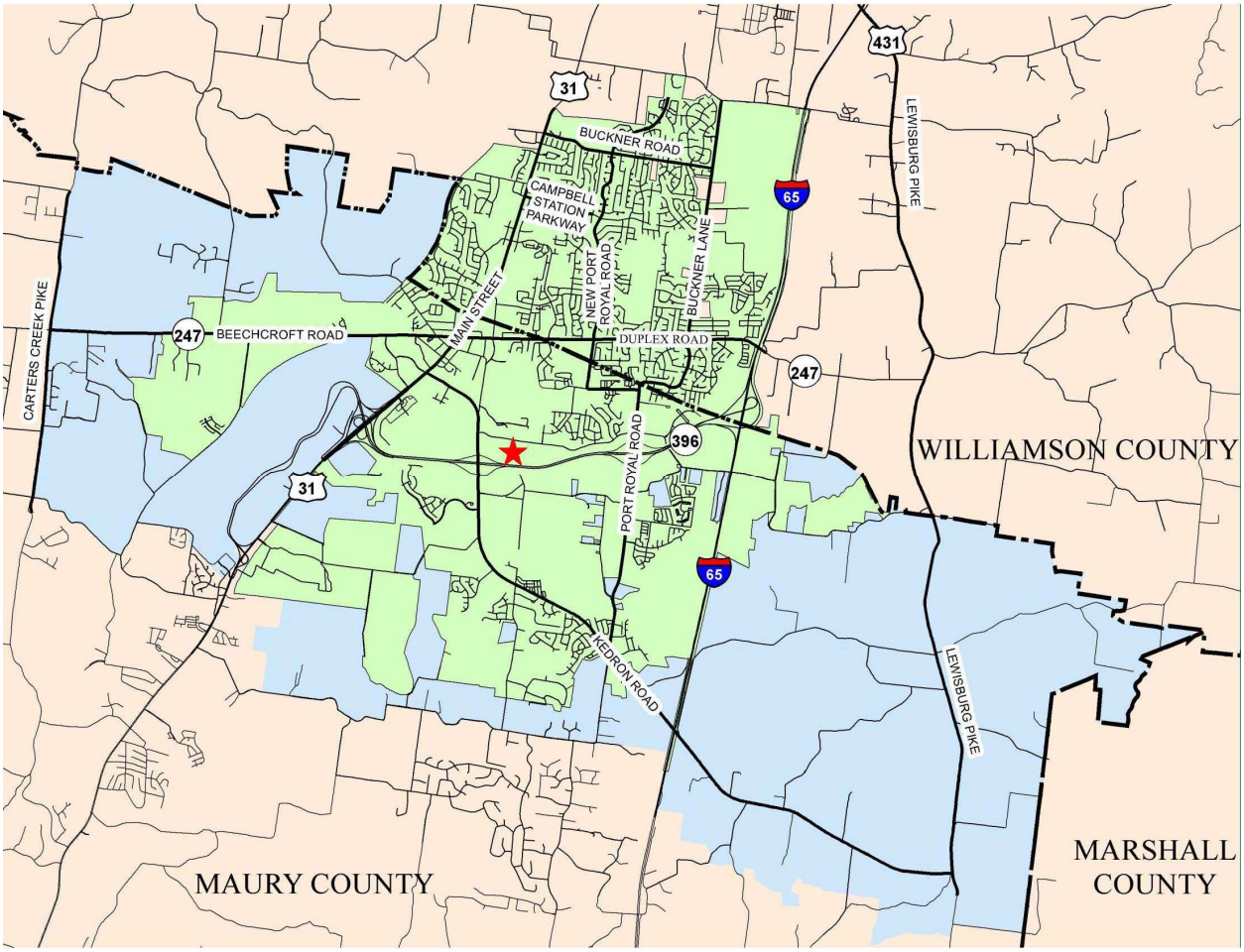
**Spring Hill**

The City of Spring Hill covers approximately 29 square miles and is located 35 miles south of Nashville, TN. The city is situated within two counties, Maury and Williamson Counties. The majority of the city lies in Maury County, denoted in the map's green shading below. The Williamson County portion of Spring Hill is fairly compact, due north of the TSHH campus and bounded by Interstate 65 on its east.

The City's future growth – referenced as the urban growth boundary[6] – is almost completely located within Maury County, denoted in the blue shading below. The City of Spring Hill and these growth areas are accessible to the TSHH campus via many roadways including Interstate 65, State Road 396 (Saturn Parkway), Beechcroft Road, U.S. 31, Kedron Road, Port Royal Road and Reserve Boulevard, among other area roadways.

[5] Biospatial data; see **Exhibit 24** for summary.

[6] The urban growth boundary is defined as the area into which the City of Spring Hill reserves the right to expand. The Maury growth area is estimated to be about 30 square miles to the east, west and south of the existing city limits; this area more than doubles the size of the city. The area includes many residential developments and the GM plant among other structures. *Map source: Spring Hill's Major Thoroughfare Plan 2021.* There are also two small areas within Williamson County that are identified for Spring Hill expansion but are not visible on this map.




*Note: The Red Star denotes the location of TriStar Spring Hill ER and the proposed TSHH*
*Source: City of Spring Hill Major Thoroughfare Plan, 2021 update. In addition to the Maury County UGB reflected in blue, the Williamson County UGB provides only two relatively small areas for Spring Hill's future growth.*

The City of Spring Hill has only one zip code, 37174.[7] As a result, the city and that zip code (37174) are fairly close in population counts although not fully aligned. Spring Hill is the 11th largest city in the State. More importantly, it is the largest city in Tennessee without an acute care hospital. The following chart presents all incorporated places in the State with 2023 population counts of approximately 40,000 or more.[8]

[7] Seventy-five percent of the zip code's geography is located in Maury County, while twenty-five percent is in Williamson County. It is therefore assigned by the US Postal Service to Maury County.
[8] 2023 Population Counts are from the State of Tennessee Comptroller's Office.

**Exhibit 4**

| City | # of Hospitals | # of Staffed Beds | 2023 Population | Size Based on 2023 Population |
|---|---|---|---|---|
| Nashville | 9 | 3,403 | 720,449 | 1 |
| Memphis | 8 | 2,213 | 623,978 | 2 |
| Knoxville | 5 | 1,561 | 195,609 | 3 |
| Chattanooga | 5 | 1,253 | 185,913 | 4 |
| Clarksville | 1 | 237 | 180,122 | 5 |
| Murfreesboro | 2 | 358 | 169,849 | 6 |
| Franklin | 1 | 203 | 90,181 | 7 |
| Johnson City | 2 | 514 | 72,509 | 8 |
| Jackson | 1 | 580 | 68,532 | 9 |
| Hendersonville | 1 | 123 | 64,761 | 10 |
| Spring Hill | 0 | 0 | 57,932 | 11 |
| Smyrna | 1 | 115 | 57,377 | 12 |
| Bartlett | 1 | 128 | 57,030 | 13 |
| Kingsport | 2 | 337 | 56,207 | 14 |
| Collierville | 1 | 79 | 51,032 | 15 |
| Gallatin | 1 | 112 | 50,965 | 16 |
| Cleveland | 1 | 152 | 49,497 | 17 |
| Brentwood | 0 | 0 | 47,651 | 18 |
| Lebanon | 1 | 147 | 44,815 | 19 |
| Columbia | 1 | 208 | 44,114 | 20 |
| Mt. Juliet | 0 | 0 | 43,304 | 21 |
| La Vergne | 0 | 0 | 40,760 | 22 |
| Germantown | 1 | 311 | 40,736 | 23 |

*Source: Joint Annual Reports, TN Licensing information, Office of Comptroller.*

There are 69 cities with hospitals in Tennessee that are smaller than Spring Hill. Similarly sized cities like Kingsport, Smyrna, Bartlett and Hendersonville each have at least one hospital; they range in size from 115 to 337 beds. (See Exhibit 4 above.) This contrasts with Spring Hill with no hospital and no beds.

There are 60 Tennessee cities with population less than 40,000 with hospitals. Detailed analysis of this information is provided in response to Question 4N. In addition, the closest hospitals to Spring Hill[9] are 13 to 18 miles away, requiring travel time of up to 45 minutes[10] which is also detailed in response to Question 4N.

Comparing Spring Hill with the other three cities identified above that also do not have a hospital provides some differentiation. Those three cities (a) are all smaller, and (b) have hospitals within 4 to 6 miles,[11] so their population has more immediate and timely access to one or more hospitals and as a result, are not as geographically isolated. This contrasts with residents of Spring Hill

[9] Measured from the zip code geographic centroid.
[10] Google maps Spring Hill, TN to WMC and MRH, time range throughout the day. See Question 4N, Spring Hill travel times.
[11] Distance is from geographic centroid of city to closest hospital outside the city as measured by google maps.

who are geographically isolated from a full-service hospital – separated by 13.4 to 17.2 miles to MRH to the south and 16.0 to 18.2 miles to WMC to the north.[12]

Accordingly, the Service Area is reasonable and supportable based on the following facts regarding the three zip codes:

- Individually, they generate the greatest number of emergency department visits at the existing TriStar Spring Hill ER.
- In the aggregate, they represent seventy-five percent of total ER visits at TriStar Spring Hill ER which from a health planning perspective is a reasonable and cohesive service area.
- Individually, they also generate the greatest number of outpatient visits (imaging, lab, etc.) at the other hospital based ancillary services located at TriStar Spring Hill Medical Park.
- 37174 is central to these three zip codes and generates the most ER visits at TriStar Spring Hill ER.

- **37174 (Spring Hill)**
  - TriStar Spring Hill ER has the greatest number of ER visits and patient utilization of any ER for residents of 37174. Between 40 and 44 percent of total resident ER visits each year during the past five years were to TriStar Spring Hill ER. Achieving this level of patient utilization without inpatient services is significant, and it is expected to increase further with a full-service community hospital able to provide surgery, catheterizations, and other procedures in addition to inpatient services.

- **38401 (Columbia)**
  - 38401 is to the south of and contiguous to the Spring Hill zip code.
  - TriStar Spring Hill ER accounts for the 2nd greatest number of ER visits and patient utilization of any ER for residents of 38401. During the past five years, between 17 and 18.3 percent of total resident ER visits each year were to TriStar Spring Hill ER.

- **37179 (Thompson's Station)**
  - 37179 is to the north of and contiguous to the Spring Hill zip code.
  - TriStar Spring Hill ER also has the 2nd greatest number ER visits and patient utilization of any ER for residents of 37179, ranging between 16.3 and 19.4 percent of total resident ER visits each year during the past five years.

**Location of Existing Hospitals**

TSHH has defined its Service Area – as is permitted – by zip code. In the defined 3-zip code Service Area, there is 1 hospital: MRH. The 3-zip code service area straddles 2 counties and there is another hospital in the other county in which the Service Area sits: WMC.

MRH is located in zip code 38401. However, 38401 is a geographically large zip code. As such, MRH is located more than 14 miles away from the proposed TSHH. Travel times from Spring Hill to MRH differ dramatically throughout the day and week based on travel and traffic patterns, taking up to 45 minutes to travel from Spring Hill to MRH.

[12] Range is measured from the geographic centroid of the city and the zip code. See Question 4N, Exhibit 15.

Moreover, while MRH serves the Columbia and Maury County area, less than half of Maury County resident inpatients were admitted to MRH, and only 62 percent of patients from Columbia (38401) were admitted to MRH.[13]

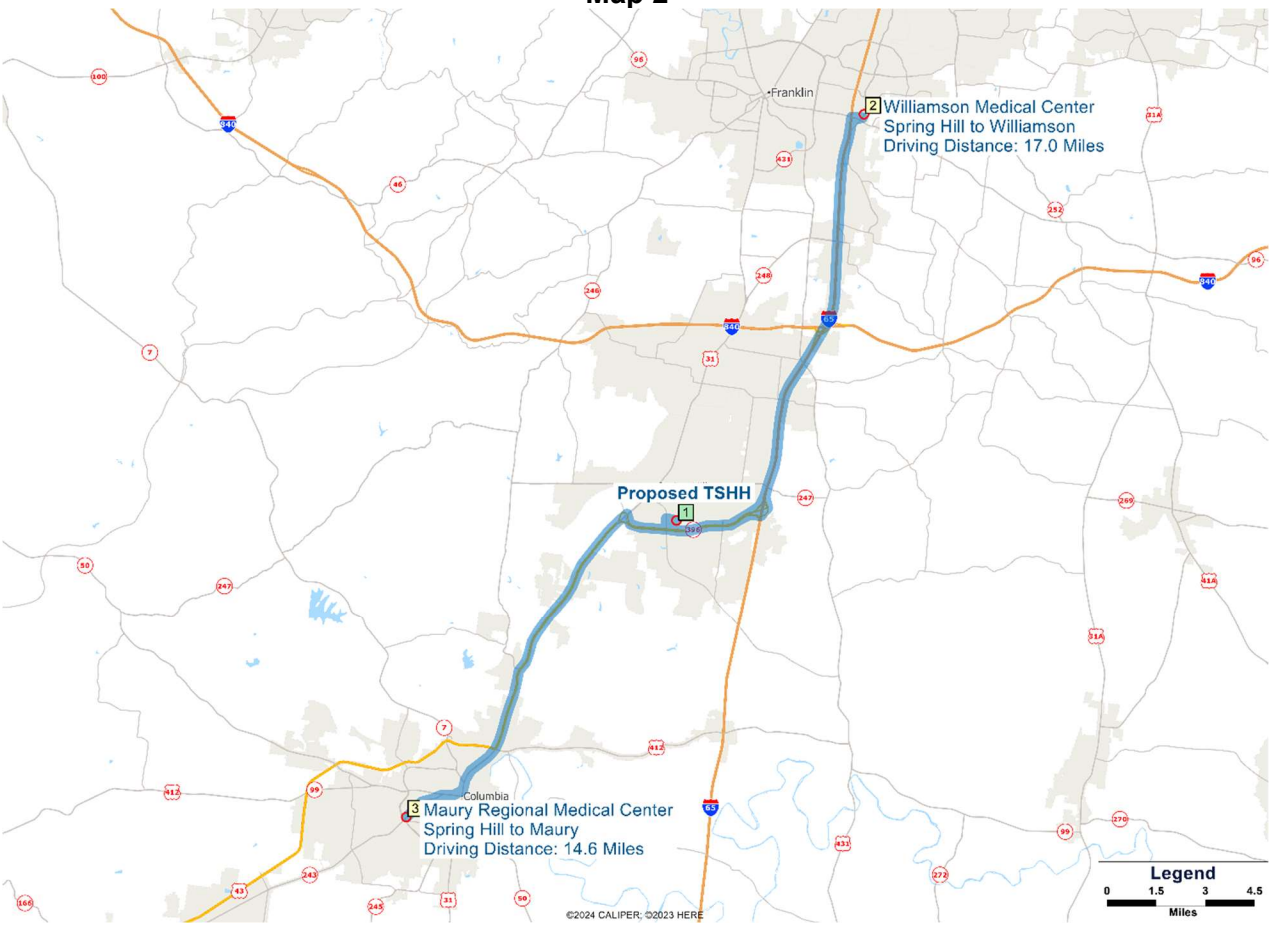
The Service Area includes Thompson's Station (37179), which is in Williamson County. 17.6 percent of Thompson's Station patients seeking ER services use the TriStar Spring Hill ER. This should translate into a similar baseline ratio of inpatients for TSHH. 54 percent of Thompson's Station inpatients seek care at hospitals outside of Williamson County.

WMC is located approximately 17 miles from the proposed TSHH. Travel times to this alternate hospital also differ dramatically throughout the day and week based on travel and traffic patterns. It takes between 22 and 45 minutes depending on the time of day and route to reach WMC from TSHH. WMC serves varying percentages of Service Area residents based on resident location and proximity to its hospital. Specifically, it admits less than 40 percent of total Williamson County residents admitted to a hospital.

MRH and WMC are 30 miles apart, resulting in a large community with tremendously increasing population that does not have reasonable access to a hospital. Map 2 shows the two existing hospitals and the TriStar Spring Hill ER.

[13] 2021 percent of zip code discharges.

**Map 2**




Visually observing the above map demonstrates the absence of any inpatient services across a large geographic area, the 30+ mile span throughout northern Maury County and southern Williamson County. Moreover, the area has a significant population base, and has experienced dramatic growth during the past 10 to 15 years.[14] Anticipated population increases using Claritas are near the highest in the State. (See Exhibit 6.) Both the current and forecasted population support need for a hospital.[15] Establishment of TSHH will enhance access for Service Area residents through the creation of a hospital access point designed to reduce geographic inaccessibility to serve the healthcare needs of this population.

[14] City leaders believe the current population of Spring Hill now exceeds 60,000; to confirm this the City is undertaking a Special Census (2024) to obtain a more accurate count. If the 2024 population is revised upward, that would have further implications for the forecasted population likely resulting in population in the upper 60,000s within five years. Forecasts throughout this CON Application conservatively use the Claritas population data presented in Question 3N.

[15] While Claritas forecasts currently estimate through 2029, in *its Major Thoroughfare Plan, 2021* the City of Spring Hill estimates a future (2040) population of 81,287 in Spring Hill (page 7 of its Future Conditions Report). In addition, in the City's UGB web page, it estimates a 2029 population ranging between 68,000 and 94,000. https://www.springhilltn.org/728/Urban-Growth-Boundaries-UGB

Please see additional detailed discussion of hospital access problems and extent of TriStar Health affiliate access for residents of the Service Area provided in **Attachment 1N** and **Questions 4N and 5N** herein.

**Service Area Historical and Projected Utilization – TriStar Spring Hill Hospital**

The Service Area definition is based on the geographic proximity of the zip codes surrounding the proposed location and the patient origin of TriStar Spring Hill ER patients. The tables below provide the historical utilization from the Service Area at the existing TriStar Spring Hill ER and the projected utilization at TSHH, including its ER. It is from this defined Service Area that the proposed community hospital anticipates treating 75 percent of its inpatients and outpatients, with the balance (25 percent) coming from outside the Service Area. Both tables include in-migration from outside of the proposed Service Area.

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

The proposed facility is a community hospital to serve the inpatient and outpatient needs of the Service Area population. There is no such facility in Spring Hill. The only 24/7 healthcare facility in Spring Hill is the TriStar Spring Hill ER, an affiliate of the Applicant. The historical utilization chart below for the most recent calendar year is provided for the TriStar Spring Hill ER to which the proposed hospital will be an extension.

| Unit Type: X Other: ED VISITS | | |
|---|---|---|
| **Zip Code** | **Historical Utilization Service Area Residents - TriStar Spring Hill ER - Most Recent Year - CY 2023** | **% of Total** |
| 37174 - Spring Hill | 5,911 | 37.2% |
| 38401 - Columbia | 5,426 | 34.1% |
| 37179 - Thompson's Station | 638 | 4.0% |
| **Service Area Subtotal** | 11,975 | 75.3% |
| All Other | 3,925 | 24.7% |
| **Total** | 15,900 | 100.0% |

*Source: Internal Records, CY 2023. TriStar Spring Hill ER is the only data included in the above table.*

The following charts provide forecasted utilization for TSHH for its first three years of operation. Provided are total discharges anticipated and total emergency room utilization including both outpatients and those who are expected to be admitted to the hospital.

| Unit Type: X - Patient Discharges and X - ED VISITS: Year 1 | | | | |
|---|---|---|---|---|
| Zip Code | Forecasted ER Utilization | % of Total | Forecasted Discharges | % of Total |
| 37174 - Spring Hill | 7,330 | 35.2% | 1,003 | 39.2% |
| 38401 - Columbia | 7,319 | 35.2% | 781 | 30.5% |
| 37179 - Thompson's Station | 950 | 4.6% | 136 | 5.3% |
| **Service Area Subtotal** | 15,599 | 75.0% | 1,921 | 75.0% |
| All Other | 5,200 | 25.0% | 640 | 25.0% |
| **Total** | 20,799 | 100.0% | 2,561 | 100.0% |
| *Discharges include medical/surgical, obstetrics and neonatology discharges* | | | | |

*Totals may not foot due to rounding.*

| Unit Type: X - Patient Discharges and X - ED VISITS: Year 2 | | | | |
|---|---|---|---|---|
| Zip Code | Forecasted ER Utilization | % of Total | Forecasted Discharges | % of Total |
| 37174 - Spring Hill | 8,203 | 35.4% | 1,309 | 39.7% |
| 38401 - Columbia | 8,108 | 35.0% | 985 | 29.9% |
| 37179 - Thompson's Station | 1,063 | 4.6% | 177 | 5.4% |
| **Service Area Subtotal** | 17,375 | 75.0% | 2,471 | 75.0% |
| All Other | 5,792 | 25.0% | 824 | 25.0% |
| **Total** | 23,167 | 100.0% | 3,294 | 100.0% |
| *Discharges include medical/surgical, obstetrics and neonatology discharges* | | | | |

*Totals may not foot due to rounding.*

| Unit Type: X - Patient Discharges and X - ED VISITS: Year 3 | | | | |
|---|---|---|---|---|
| Zip Code | Forecasted ER Utilization | % of Total | Forecasted Discharges | % of Total |
| 37174 - Spring Hill | 8,761 | 35.6% | 1,481 | 39.4% |
| 38401 - Columbia | 8,575 | 34.8% | 1,131 | 30.1% |
| 37179 - Thompson's Station | 1,136 | 4.6% | 206 | 5.5% |
| **Service Area Subtotal** | 18,471 | 75.0% | 2,818 | 75.0% |
| All Other | 6,157 | 25.0% | 939 | 25.0% |
| **Total** | 24,628 | 100.0% | 3,757 | 100.0% |
| *Discharges include medical/surgical, obstetrics and neonatology discharges* | | | | |

*Totals may not foot due to rounding.*

Please see the projected utilization by zip code assumptions provided in response to **Question 6N** below.

Attachment 2N

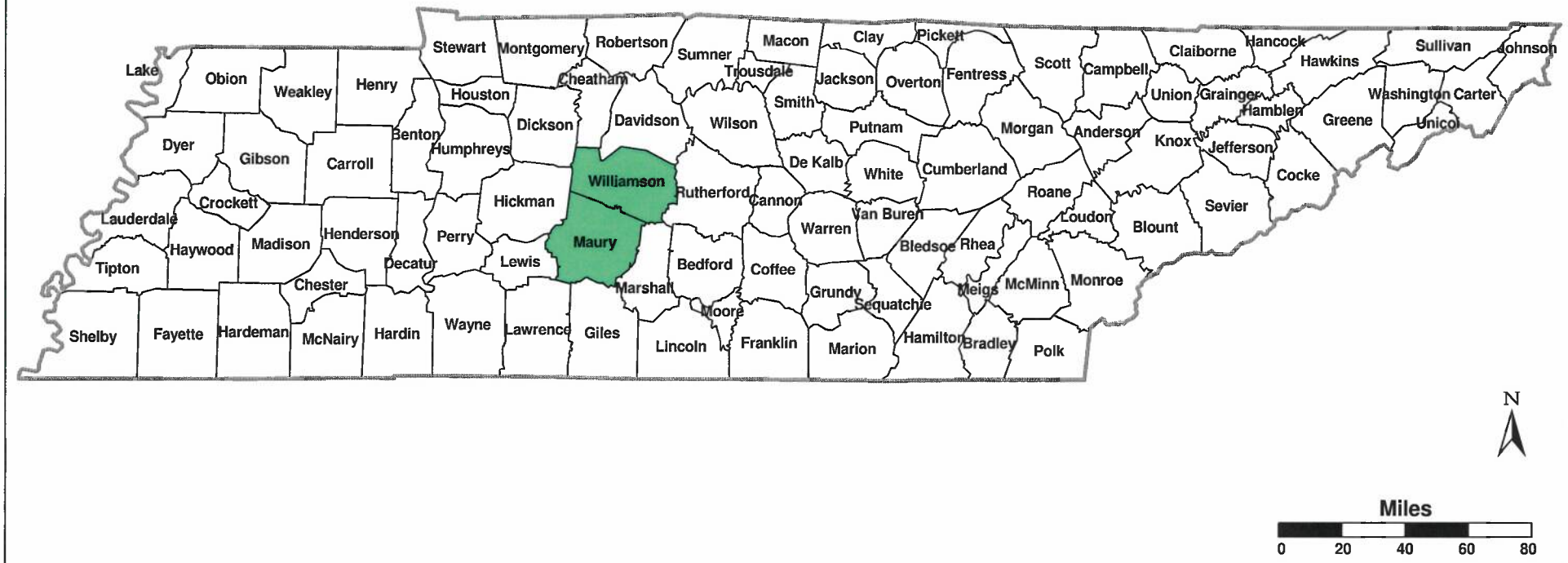
County Level Service Area Map

# TriStar Spring Hill Hospital

## Maury County

# TriStar Spring Hill Hospital

## Maury and Williamson Counties



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

The following section describes in detail the demographics of the population of the proposed service area.

**Population Trends**

Spring Hill is the largest city in the Service Area. Here is the Tennessee Controller's population estimates for the three cities in the Service Area:

| Service Area City | 2023 Population (TN Comptroller) |
|---|---|
| Spring Hill | 57,932 |
| Columbia | 44,144 |
| Thompson's Station | 8,996 |

Spring Hill is the 11th largest city in the State. Columbia is the 20th largest. Thompson's Station is 66th. Spring Hill's growth to the largest city in the Service Area has been dramatic. In 2005, the population of Spring Hill was 17,325. In the last 19 years, it has surpassed Columbia as the largest city in the Service Area by growing a 327 percent. This average annual growth rate of 17.2 percent per year is similar to the rate at which Spring Hill was growing when the first proposed Spring Hill hospital was considered.[16]

**Exhibit 5**

| Rank | Tennessee City | 2023 Population (TN Comptroller) |
|---|---|---|
| 1 | Nashville | 720,449 |
| 2 | Memphis | 623,978 |
| 3 | Knoxville | 195,609 |
| 4 | Chattanooga | 185,913 |
| 5 | Clarksville | 180,122 |
| 6 | Murfreesboro | 169,849 |
| 7 | Franklin | 90,181 |
| 8 | Johnson City | 72,509 |
| 9 | Jackson | 68,532 |
| 10 | Hendersonville | 64,761 |
| **11** | **Spring Hill** | **57,932** |
| 12 | Smyrna | 57,377 |
| 13 | Bartlett | 57,030 |
| 14 | Kingsport | 56,207 |

[16] In 2006, the HSDA found that "Spring Hill is a rapidly growing city. In 2000, the U.S. Census found a Spring Hill population of 7,715. In 2005, the City conducted its own Special Census, which concluded that the population of Spring Hill was 17,325. This represents a 17.6 percent compound annual growth rate between 2000 and 2005. The Special Census was properly conducted. The State of Tennessee certified the Special Census after a detailed verification process." HSDA Final Order, p. 10.

| Rank | Tennessee City | 2023 Population (TN Comptroller) |
|---|---|---|
| 15 | Collierville | 51,032 |
| 16 | Gallatin | 50,965 |
| 17 | Cleveland | 49,497 |
| 18 | Brentwood | 47,651 |
| 19 | Lebanon | 44,815 |
| **20** | **Columbia** | **44,114** |
| 21 | Mt. Juliet | 43,304 |
| 22 | La Vergne | 40,760 |
| 23 | Germantown | 40,736 |
| 24 | Cookeville | 35,942 |
| 25 | Maryville | 33,338 |
| 26 | Oak Ridge | 32,064 |
| 27 | Morristown | 30,548 |
| 28 | Bristol | 27,440 |
| 29 | Shelbyville | 24,191 |
| … | | |
| **66** | **Thompson's Station** | **8,996** |

*Source: TN Comptroller 2023. Cities 30 through 65 omitted from exhibit.*

When considering changes in population by city since 2000, Spring Hill is the second fastest growing in Tennessee and Thompson's Station is the third fastest at 651 and 601 percent, respectively.[17] Forecasted to 2028, Spring Hill total growth from 2000 is 730 percent taking over the first position in terms of population growth statewide. This information is reflected in the next exhibit.

**Exhibit 6**

| | Total Population | | | | | Percent Change | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| City | 2000 | 2010 | 2020 | 2023 | 2028 | 2000-2010 | 2010-2020 | 2020-2023 | 2000-2023 | 2000-2028 |
| Spring Hill | 7,715 | 29,036 | 50,005 | 57,932 | 64,034 | 276% | 72% | 16% | 651% | 730% |
| Columbia | 33,055 | 34,681 | 41,690 | 44,114 | 46,321 | 5% | 20% | 6% | 33% | 40% |
| Thompson's Station | 1,283 | 2,194 | 7,485 | 8,996 | 9,542 | 71% | 241% | 20% | 601% | 644% |

For purposes of Service Area definition, utilization analyses and forecasting, zip codes are utilized. Exhibit 7 provides the Service Area zip code population including the historical and forecasted changes.

[17] The Tennessee Controller reports that Spring Hill grew from 7,715 to 57,932 from 2000 to 2023, a 651% growth rate. The only city in the state that grew a greater percentage from 2000 to 2023 is Oakland, which grew from 1,279 to 8,728, a 653% growth rate. https://comptroller.tn.gov/maps/tennessee-city-profiles.html

**Exhibit 7**

| Zip Code | Geographic Name | Total Population | | | 2010 to 2024 | | 2024 to 2029 | |
|---|---|---|---|---|---|---|---|---|
| | | 2010 | 2024 | 2029 | Change % | Change # | Change % | Change # |
| 37174 | Spring Hill | 27,712 | 56,270 | 62,608 | 103.1% | 28,558 | 11.3% | 6,338 |
| 38401 | Columbia | 54,702 | 68,480 | 73,370 | 25.2% | 13,778 | 7.1% | 4,890 |
| 37179 | Thompson's Station | 10,466 | 19,114 | 21,068 | 82.6% | 8,648 | 10.2% | 1,954 |
| Service Area | | 92,880 | 143,864 | 157,046 | 54.9% | 50,984 | 9.2% | 13,182 |

*Source: Claritas Spotlight, January 2024.*

While the above analysis focuses on the change in population since 2010, the first Spring Hill CON application, twice approved by the HSDA, was filed in 2006, even prior to the 2010 census information presented. At that time (2005), Spring Hill's population was 17,325 persons, or less than 30 percent of today's population. Obviously, this change in population is dramatic and has an incredible impact on the need for supportive services including housing, education and healthcare.

During this time, the number of schools has almost doubled to keep up with population growth. Housing units increased more than 200 percent, also keeping up with population growth. Nursing homes have gone from 0 to 1. And assisted living facilities have increased from 0 to 5. Yet, there is still no hospital. This is despite the overwhelming and widespread support for the hospital nearly 20 years ago. The following table shows the dramatic growth observed in this nearly 20-year period.

**Exhibit 8**

| Health, Education and Housing Changes Since 2005 | | | | |
|---|---|---|---|---|
| **Spring Hill, TN** | **2005** | **2020** | **Current (2024)** | **Change 2005 to 2024** |
| Hospitals | 0 | 0 | 0 | n/a - still "0" |
| Nursing Homes | 0 | 1 | 1 | -- |
| Nursing Home Beds | 0 | 68 | 68 | -- |
| Assisted Living Facilities | 0 | 5 | 5 | -- |
| Assisted Living Beds | 0 | 330 | 330 | -- |
| Schools: | | | | |
| Williamson County, Spring Hill | 6 | 10 | 11 | 83% |
| Maury County, Spring Hill | 3 | 5 | 6 | 100% |
| Housing Units | 5,994 | 17,845 | 20,484 | 242% |
| Spring Hill (City) Population | 17,148 | 50,005 | 57,466 | 235% |

*Sources: Claritas Spotlight population and housing 2020 and 2024; City of Spring Hill website 2005 population; 2005 special city-wide census for 2005 housing units; Williamson County School various documents: additional schools opened include Longview (2007), Allendale (2010), Spring Station (2010), Summit (2011) and Amanda North (2022). Within Maury County, new facilities since 2005 include Battle Creek Elementary (2012), Battle Creek Middle (2018) and Battle Creek High (2024). Note, Maury County's Spring Hill High School has a Columbia address so not included in this table.*

*Note: The nursing home is in Maury County and all but one of the assisted living facilities are also located in Maury County.*

In addition to the schools identified above which have opened as of 2024, Williamson County Schools approved its latest five-year plan in November 2023, which includes the need for an additional elementary school, one high school and one early-childhood development facility, all to be in Spring Hill. In addition, Maury County has an additional elementary school under

construction, North Columbia Elementary, set to open next year just south of Spring Hill High School, also addressed in the northern part of the Columbia zip code.

In terms of senior living communities including assisted living and nursing home beds, further development is anticipated. In fact, on a 45-acre parcel adjacent to the TSHH campus, a retirement community has just received zoning approval. This campus will include 100 cottages (independent living) in conjunction with nearby The Reserve at Spring Hill.

The pace of residential and commercial growth in Spring Hill does not appear to be slowing. According to the Spring Hill planning department, there are more than 8,300 platted lots available or under development currently. An additional 116 lots and one commercial development were approved by the Planning Commission on March 8, 2024.

For example, a large-scale development is Spring Hill Crossings, a 213-acre proposed mixed-use development, just 2.1 miles from TSHH. The proposed site is planned to include 136,000 square feet of space, which would serve as a regional headquarters for the United States Tennis Association (USTA), 535,000 square feet of commercial development, about 1,000 hotel rooms and approximately 17 acres of recreational area. There will also be about 2,000 residential dwellings, as well as a parking garage associated with the site. Spring Hill Crossings would be poised on two parcels of land between U.S. 31 and Kedron Road.[18]

Additionally, there are currently 665 lots being developed in the southeast corner of Spring Hill between Port Royal Road and I-65, easily accessible to TSHH via Port Royal Road. Over 2,000 additional lots have been platted in this same area but construction has not begun. This area has easy access to the Saturn Parkway interchange with I-65. Another growth area is the west side of Spring Hill along Beechcroft Road, State Route 247. Over 1,700 lots are being developed or under construction to the north side of the highway. Growth is also occurring in the southwest quadrant of the city near the General Motors manufacturing plant. These areas are also easily accessible to TSHH via Beechcroft Road, U.S. 31 and Kedron Road.

Another large-scale development currently under way is the 775-acre mixed-use development called June Lake near the future I-65 exit at Buckner Road. The future interchange is projected to open to motorists in May 2024. This will become a significant gateway into Spring Hill, situated between I-840 and the existing Saturn Parkway exits of I-65. The next two decades are expected to see June Lake build up to 2,900 residential units, 3.9 million sq. ft. of class-A office space, nearly 1.3 million sq. ft. of retail and restaurant space and 400 hotel rooms. To date, construction on the infrastructure and actual building of 665 new homes is underway in two phases of the June Lake residential projects.

With the significant planned development approved and underway, Spring Hill's growth will likely exceed the Claritas population forecast by 2029. In fact, Spring Hill estimates on the city's Urban Growth Boundary ("UGB") web page, a 2029 population ranging between 68,000 and 94,000, compared to Claritas of 62,600.[19] Incremental population growth will put further stress on the existing infrastructure, including access and travel times, and provide additional support to approve a Spring Hill hospital.

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[18] https://www.columbiadailyherald.com/story/news/2022/11/20/crossings-213-acre-mixed-use-preliminary-plans-head-to-boma-favored-by-planners/69650755007/

[19] https://www.springhilltn.org/728/Urban-Growth-Boundaries-UGB

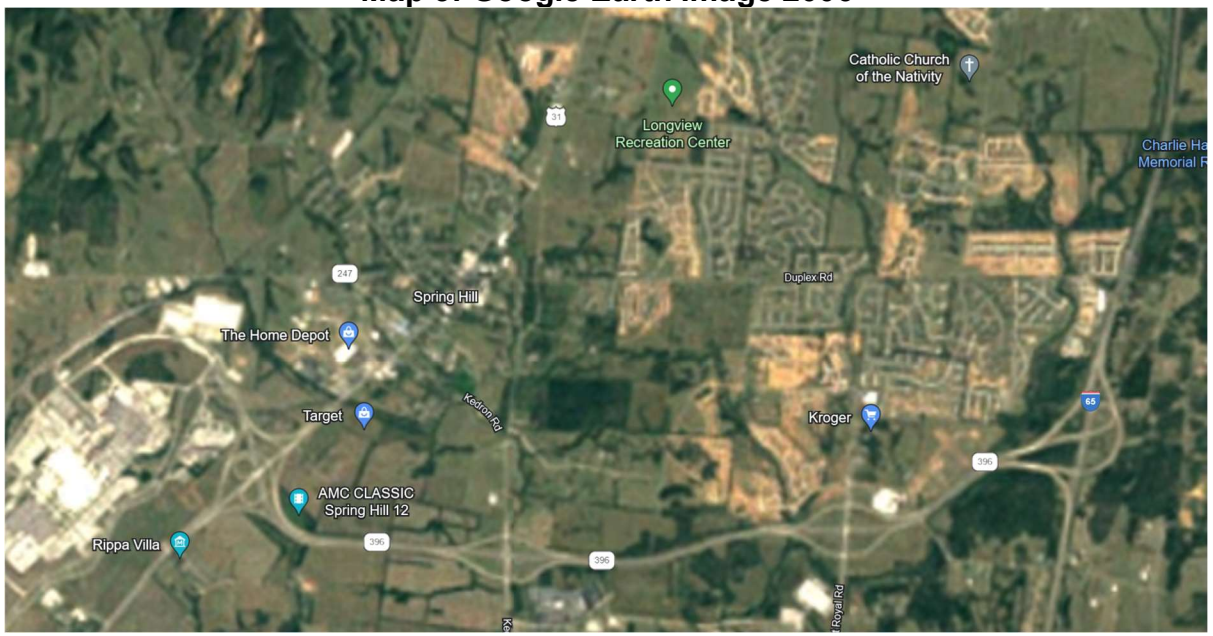
Presently, the City of Spring Hill covers over 29 square miles. The geography of future development favors the Maury County side of the Spring Hill city limits. The Spring Hill growth boundary in Maury County provides land area greater than 30 square miles to the east, west and south of the existing city limits.

The City of Columbia adjoins Spring Hill on the south and is also experiencing rapid residential growth. According to the City of Columbia, 9 residential developments containing 2,944 building units are presently under construction in the area adjoining Spring Hill. Additionally, another 990 residential units are in the review stage of the Columbia planning department.[20] The closest of these developments to Columbia is a 17-minute drive to MRH.

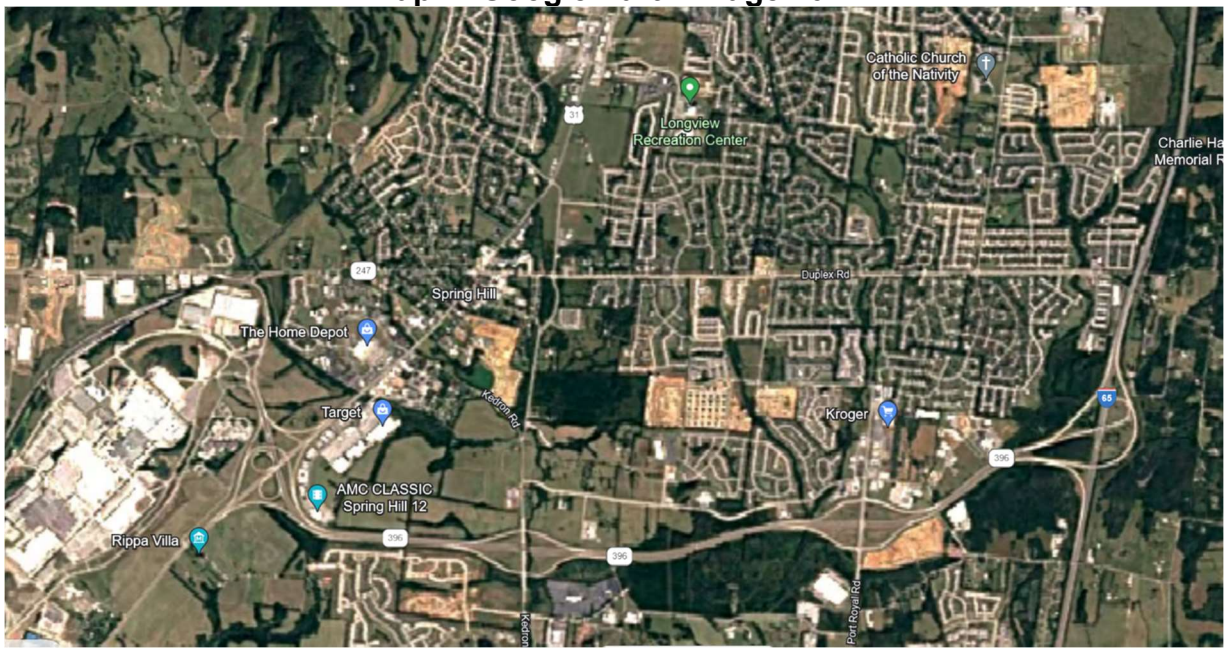
On the following page are two Google Earth images of Spring Hill, one from the 2006 period and the other from 2022. The images provide visual evidence of the tremendous, referenced growth in Spring Hill during the past two decades.

[20] https://columbiatn.maps.arcgis.com/apps/webappviewer/index.html?id=adbae9e266644e3e85adddc78b80f552

## Map 3: Google Earth Image 2006




## Map 4: Google Earth Image 2022



In terms of the Service Area population, when analyzing the details associated with each of the Service Area zip codes, Spring Hill and Thompson's Station have a younger population with approximately 30 percent under the age of 18 (2020). However, with the anticipated growth this percent decreases to approximately 26 percent by 2029. In contrast, the Columbia population under 18 approximates 22 percent of total population.

Service Area population age 18 to 64 was approximately 59 percent in 2020 and is projected to decrease only slightly by 2029. The elderly population (65 and older) has the most dramatic change. Overall, the elderly population will increase from 14 to 18 percent between 2020 and 2029, with 38401 (Columbia) nearly reaching 22 percent, 37174 (Spring Hill) at 14.2 percent and 37179 (Thompson's Station) at 14.7 percent. This impacts the need for TSHH as elderly are the most frequent users of hospital services. The following table provides 2020 census data, 2024 estimates and forecasted 2027 through 2029[21] population counts by age cohort and Service Area zip code.

**Exhibit 9**

| | Service Area Population by Age Cohort | | | | | Service Area Population Distribution by Age Cohort | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **2020** | **2024** | **2027** | **2028** | **2029** | **2020** | **2024** | **2027** | **2028** | **2029** |
| **37174 (Spring Hill, TN)** | | | | | | | | | | |
| <18 | 14,507 | 15,602 | 16,033 | 16,176 | 16,320 | 29.4% | 27.7% | 26.7% | 26.4% | 26.1% |
| 18-44 | 17,978 | 20,261 | 21,147 | 21,443 | 21,738 | 36.4% | 36.0% | 35.2% | 35.0% | 34.7% |
| 45-64 | 11,313 | 13,246 | 14,676 | 15,153 | 15,630 | 22.9% | 23.5% | 24.4% | 24.7% | 25.0% |
| 65-74 | 3,590 | 4,459 | 4,910 | 5,060 | 5,210 | 7.3% | 7.9% | 8.2% | 8.2% | 8.3% |
| 75-84 | 1,536 | 2,159 | 2,618 | 2,771 | 2,924 | 3.1% | 3.8% | 4.4% | 4.5% | 4.7% |
| 85+ | 444 | 543 | 689 | 737 | 786 | 0.9% | 1.0% | 1.1% | 1.2% | 1.3% |
| Total | 49,368 | 56,270 | 60,073 | 61,340 | 62,608 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | | | | | | | | | | |
| **38401 (Columbia, TN)** | | | | | | | | | | |
| <18 | 14,269 | 15,234 | 15,683 | 15,832 | 15,982 | 22.7% | 22.2% | 22.0% | 21.9% | 21.8% |
| 18-44 | 21,251 | 22,842 | 23,664 | 23,938 | 24,212 | 33.8% | 33.4% | 33.1% | 33.1% | 33.0% |
| 45-64 | 16,190 | 16,744 | 16,944 | 17,011 | 17,078 | 25.7% | 24.5% | 23.7% | 23.5% | 23.3% |
| 65-74 | 6,967 | 8,164 | 8,579 | 8,718 | 8,856 | 11.1% | 11.9% | 12.0% | 12.0% | 12.1% |
| 75-84 | 3,099 | 4,153 | 5,021 | 5,311 | 5,600 | 4.9% | 6.1% | 7.0% | 7.3% | 7.6% |
| 85+ | 1,114 | 1,343 | 1,522 | 1,582 | 1,642 | 1.8% | 2.0% | 2.1% | 2.2% | 2.2% |
| Total | 62,890 | 68,480 | 71,414 | 72,392 | 73,370 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | | | | | | | | | | |
| **37179 (Thompson's Station, TN)** | | | | | | | | | | |
| <18 | 5,237 | 5,382 | 5,380 | 5,380 | 5,379 | 30.7% | 28.2% | 26.5% | 26.0% | 25.5% |
| 18-44 | 5,569 | 6,265 | 6,594 | 6,704 | 6,814 | 32.6% | 32.8% | 32.5% | 32.4% | 32.3% |
| 45-64 | 4,455 | 5,106 | 5,513 | 5,648 | 5,784 | 26.1% | 26.7% | 27.2% | 27.3% | 27.5% |
| 65-74 | 1,275 | 1,581 | 1,807 | 1,882 | 1,957 | 7.5% | 8.3% | 8.9% | 9.1% | 9.3% |
| 75-84 | 431 | 655 | 831 | 890 | 949 | 2.5% | 3.4% | 4.1% | 4.3% | 4.5% |
| 85+ | 103 | 125 | 161 | 173 | 185 | 0.6% | 0.7% | 0.8% | 0.8% | 0.9% |
| Total | 17,070 | 19,114 | 20,286 | 20,677 | 21,068 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | | | | | | | | | | |
| **Service Area Total** | | | | | | | | | | |
| <18 | 34,013 | 36,218 | 37,096 | 37,388 | 37,681 | 26.3% | 25.2% | 24.4% | 24.2% | 24.0% |
| 18-44 | 44,798 | 49,368 | 51,406 | 52,085 | 52,764 | 34.6% | 34.3% | 33.9% | 33.7% | 33.6% |
| 45-64 | 31,958 | 35,096 | 37,134 | 37,813 | 38,492 | 24.7% | 24.4% | 24.5% | 24.5% | 24.5% |
| 65-74 | 11,832 | 14,204 | 15,295 | 15,659 | 16,023 | 9.1% | 9.9% | 10.1% | 10.1% | 10.2% |
| 75-84 | 5,066 | 6,967 | 8,471 | 8,972 | 9,473 | 3.9% | 4.8% | 5.6% | 5.8% | 6.0% |
| 85+ | 1,661 | 2,011 | 2,372 | 2,493 | 2,613 | 1.3% | 1.4% | 1.6% | 1.6% | 1.7% |
| Total | 129,328 | 143,864 | 151,773 | 154,410 | 157,046 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

*Source: Claritas Spotlight, January 2024.*

One-third of the population in each zip code is between the age of 18 and 44. This includes large numbers of families residing in and expected to move into the Service Area dictating the corresponding need for accessible maternal health services. Accordingly, TSHH will provide a

[21] 2027 through 2029 are expected to be the first three years of operation of TriStar Spring Hill Hospital.

meaningful and programmatically accessible women's health program at this new hospital with an OB unit of 10 beds and a Level II NICU with 8 beds.

The primary population utilizing an obstetrics service are women between the ages of 18 and 44. Following is the projected population for this sex and age cohort for the same years as presented above.

**Exhibit 10**

| | Service Area Female Population, Age 18 to 44 | | | | | | |
|---|---|---|---|---|---|---|---|
| **Female Population, 18 to 44** | **2020** | **2024** | **2027** | **2028** | **2029** | **% Change, 2020 to 2024** | **% Change, 2024 to 2029** |
| 37174 (Spring Hill, TN) | 9,278 | 10,425 | 10,811 | 10,940 | 11,069 | 12.4% | 6.6% |
| 38401 (Columbia, TN) | 10,731 | 11,488 | 11,909 | 12,050 | 12,190 | 7.1% | 5.4% |
| 37179 (Thompson's Station, TN) | 2,900 | 3,258 | 3,395 | 3,441 | 3,487 | 12.3% | 7.2% |
| Service Area Total | 22,909 | 25,171 | 26,116 | 26,431 | 26,746 | 9.9% | 6.1% |

*Source: Claritas Spotlight, January 2024.*

The female population increased approximately 10 percent in the past four years and is expected to increase an additional 6 percent during the next five years. Even more dramatic are the increases in 37174 (Spring Hill) and 37179 (Thompson's Station), with such increases exceeding 12 percent in the last four years and expected to increase 7 percent in the next five years.

The tremendous, anticipated growth surrounding the TriStar Spring Hill ER will only add to the high volume already presenting at this 12-bay emergency department. However, without inpatient beds, between 7 and 8 percent of the patients who present at this ER and require inpatient admission or observation will confront increasing challenges in obtaining timely inpatient/observation treatment. This is in addition to all Service Area patients who are directly transported by Spring Hill Emergency Medical Services (SHEMS) or another EMS service out of the Service Area, bypassing TriStar Spring Hill ER. Such transfers contribute to disparities in access which will be mitigated with the implementation of TSHH.

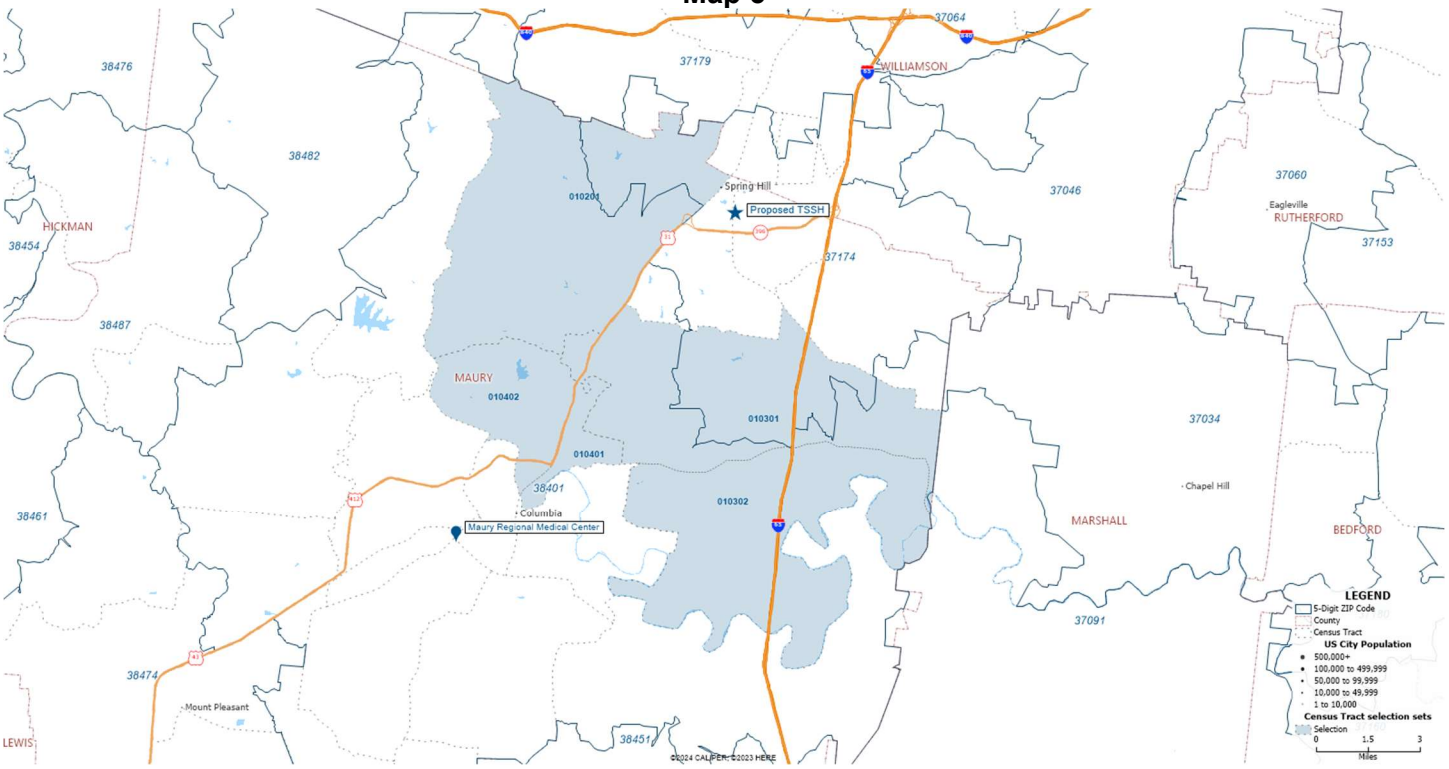
*Census Tract Information*

As noted, zip code 38401 (Columbia) is geographically very large, nearly 300 square miles.[22] With such a vast size, travel time between TSHH and MRH which is situated in the mid to southern part of the zip code can range between 20 and 45 minutes. The northern part of Columbia 38401 is closer to TSHH than MRH. There is also considerable development in this area as discussed above. Traditionally in health planning one considers zip code data due to the availability of demographic factors in addition to healthcare utilization, such as discharges. Healthcare utilization is not available on a census tract basis. While the detailed analysis herein uses the zip codes, census tract information can be informative relative to understanding the dynamic of the Columbia zip code, its size and understanding that nearly one in five emergency room patients are treated at TriStar Spring Hill ER.

The following map provides census tract information for the Maury County portion of the Service Area.

[22] https://www.zip-codes.com/city/tn-columbia.asp

**Map 5**




Observing the above map, census tracts 010201, 010301 and 010302 border Spring Hill; in fact 010301 is partially in Spring Hill. The other two census tracts which are in the northern part of Columbia, and north of State Road 412 are 010401 and 010402. The population counts associated with these census tracts are shown in the next exhibit.

**Exhibit 11**

| Census Tract | 2020 | 2024 | 2029 | % Change 2020 to 2024 | % Change 2024 to 2029 |
|---|---|---|---|---|---|
| 010201 | 8,425 | 9,885 | 11,056 | 17.3% | 11.8% |
| 010301 | 7,889 | 8,954 | 9,939 | 13.5% | 11.0% |
| 010302 | 2,884 | 3,058 | 3,205 | 6.0% | 4.8% |
| 010401 | 4,033 | 4,360 | 4,658 | 8.1% | 6.8% |
| 010402 | 2,674 | 3,075 | 3,452 | 15.0% | 12.3% |
| Total | 25,905 | 29,332 | 32,310 | 13.2% | 10.2% |

*Source: Claritas Spotlight, January 2024.*

The most northern census tracts are increasing at a rapid rate, faster than the Columbia zip code. In aggregate the above population represents 41 to 44 percent of the Columbia population count. With the general northward migration of patients demonstrated by the data presented throughout this CON Application, it is expected that TSHH will serve a greater portion of patients who reside in the northern half of zip code 38401 than the southern half of the zip code.

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

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

Note that the Department of Health Statistics and TennCare do not provide data at the zip code level. TSHH has defined the Service Area by zip code; however, the table below provides for the population and demographic data at the county level. Since the three-zip code Service Area crosses the Maury/Williamson County line, both counties are included in the chart. This is despite the hospital will be located in Maury County and that only a small portion of the Service Area is in Williamson County. Providing each of these metrics enables comparison between the Service Area and the counties in which the Service Area is located. Notably, the Service Area is growing 30+ percent faster than Maury County, and more than 2.5 times the State of Tennessee. TSHH is in zip code 37174 (Spring Hill), which is the fastest growing zip code within the Service Area, and 57 percent greater than 38401 (Columbia) and 10 percent greater than 37179 (Thompson's Station).

| Demographic Variable/Geographic Area | Department of Health/Health Statistics | | | | | | | Census Bureau | | | | TennCare | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total Population-Current Year 2024 | Total Population-Projected Year 2028 | Total Population-% Change 2024-2028 | *Target Population-All Ages Current Year 2024 | Target Population-All Ages Project Year 2028 | Target Population-% Change, 2024-2028 | 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 |
| 37174-Spring Hill | 56,270 | 61,340 | 9.0% | 56,270 | 61,340 | 9.0% | 100% | 36.0 | $99,209 | 1,350 | 2.4% | | |
| 38401-Columbia | 68,480 | 72,392 | 5.7% | 68,480 | 72,392 | 5.7% | 100% | 40.6 | $70,269 | 5,478 | 8.0% | | |
| 37179-Thompson's Station | 19,114 | 20,677 | 8.2% | 19,114 | 20,677 | 8.2% | 100% | 38.0 | $113,950 | 440 | 2.3% | | |
| **Service Area Total** | **143,864** | **154,409** | **7.3%** | **143,864** | **154,409** | **7.3%** | 100% | | | **7,268** | | | |
| Maury County | 106,039 | 112,011 | 5.6% | 106,039 | 112,011 | 5.6% | 100% | 39.7 | $71,500 | 11,028 | 10.4% | 21,831 | 20.6% |
| Williamson County | 270,313 | 295,116 | 9.2% | 270,313 | 295,116 | 9.2% | 100% | 40.5 | $125,943 | 11,083 | 4.1% | 15,849 | 5.9% |
| State of TN Total | 7,125,908 | 7,331,859 | 2.9% | 7,125,908 | 7,331,859 | 2.9% | 100% | 39.2 | $64,035 | 947,746 | 13.3% | 1,611,680 | 22.6% |

*Source: Tennessee Department of Health; Census.gov Quick Facts accessed March 2024; Claritas, Inc. for zip code/service area population, median household income, poverty level and median age; and Division TennCare, Enrollment as of January 2024 (latest available in March 2024).*
*https://data.census.gov/table/ACSST1Y2022.S0101?g=040XX00US47_050XX00US47119,47187*
*– TN, Maury County and Williamson County median age.*

"Target Population" is the population that the project will primarily serve, defined here as Total Population.
"Persons Below Poverty Level" computed from census.gov quick facts poverty level times Tennessee Department of Health current year population estimates for county and state; poverty level percent for zip code areas is from census.gov multiplied times current year population estimates for zip code area poverty counts.

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

**Summary of Need**

TriStar Spring Hill ER has been operational for more than ten years. It is an active participant in the Spring Hill community, meeting the 24/7 emergency care needs of 40+ percent of the population within 37174 (Spring Hill) and approximately 18 percent of the population in both 37179 (Thompson's Station) and 38401 (Columbia). TSHH is a natural extension of the care that residents of the Service Area receive via TriStar Spring Hill ER and TriStar Spring Hill Medical Park. More specifically, TSHH will address special needs of the Service Area, by:

- Providing access to unavailable services;
- Address population growth;
- Reduce travel time to services;
- Reduce patient out-migration; and
- Eliminate patient transfers and EMS bypass.

The underlying factors that support the need for the proposed hospital include the following:

*Largest City in Tennessee without a Hospital*

- The City of Spring Hill, a city of approximately 58,000 people, has no hospital. It is the most populated city in the state without one.
- On average, hospitals in the State serve smaller populations with the average population per hospital at approximately 41,000.
- In Tennessee, there is an average of 354 beds per 100,000 population. Spring Hill has no beds.
- Travel time for Spring Hill residents to reach hospital services is excessive with material access improvements to be realized with the licensure of TSHH.

*Existing Patient Base With No Hospital (2N)*

- There is an existing high volume freestanding emergency room on the proposed site, meeting a significant percentage of the emergent needs of the Service Area population; this includes between 40 and 44 percent of Spring Hill residents' emergency care needs.
- TriStar Spring Hill ER has provided 150,000 emergency visits since opening and currently provides emergency services to approximately 16,000 patients each year, which is substantial evidence of the vast support its 24/7 care has from the local community. However, if a patient requires non-emergency care or a higher level of care, they must be transported 30 minutes to an hour away, depending on traffic and patient preference.
- This ER will be incorporated into TSHH upon its licensure.

*Community Size and Population Dynamics (3N)*

- Population trends and dynamics place, and will continue to place, significant pressure on the healthcare infrastructure in the region. The Spring Hill zip code, alone, increased from 27,700

persons in 2010 to an estimated 56,200 in 2024.[23] This is a 103 percent increase between 2010 and 2024, and is the second fastest growth rate in the state.
- By 2029, the population is expected to exceed 62,600, a further 11 percent increase.[24]
- The City of Spring Hill is currently conducting a special census to determine the population more accurately as city officials estimate the population already exceeds 60,000.[25]

*Access Challenges and Excessive Travel Times*
- Of the cities in the state with populations greater than 24,000 without a hospital, Spring Hill residents have the poorest access to hospitals out of the area based on distance and resulting travel time.
- Given the distance from Spring Hill to out-of-area hospitals and the number of hospital discharges from Spring Hill, its residents collectively travel excessive miles to reach services resulting in some of the greatest aggregate travel miles to reach a hospital in the region.
- Residents of Spring Hill must travel significant distances to access inpatient care, with such travel times being exacerbated each year by the continued population increases.

*Out-Migration is Indicative of Access and Availability Challenges*
- Nearly 90 percent of Spring Hill residents leave Maury County to access inpatient acute care services; and a combined nearly 50 percent of Spring Hill residents leave both Maury and Williamson Counties for inpatient acute care services.[26]
- In addition, more than 50 percent of Maury County residents leave Maury County to access inpatient acute care services; this is significant outmigration indicative of an access problem.
- More than 60 percent of Williamson County residents leave Williamson County to access inpatient acute care services; this is significant outmigration also indicative of an access problem.
- The out-migration percentages and more importantly the number of patients who out-migrate confirm that effective healthcare planning is needed to mitigate these dramatic patient flows and improve access for Service Area patients.
- Of the combined out-migration from Maury and Williamson Counties, approximately 16.5 percent, or an average of 2,350 admissions per year, travel a significant distance to TriStar Centennial, evidence of its standing position in the Service Area.

*Travel Times Necessitate Access Improvement*
- The travel time study carried out by a traffic engineering firm found that in the morning, the average time saved to reach TSHH from the Service Area perimeter locations (furthest from TSHH) compared to WMC and MRH was 11 to 14 minutes; 48 minutes are saved reaching TriStar Centennial. With respect to the Spring Hill locations, the average time saved to reach TSHH is 20 minutes. Reaching TSHH took less than 10 minutes compared to an average of 30 minutes to reach either WMC or MRH. This demonstrates measurable access improvement for residents of the Service Area.

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[23] Claritas 2024. The City of Spring Hill's website estimates 2024 population between 57,604 and 66,071, which is approximately 1,400 to nearly 10,000 greater than Claritas estimates.

[24] Claritas 2024. The City of Spring Hill's website estimates 2029 population between 68,000 and 94,000, substantially more than Claritas forecasts. If the City's estimate is realized, this will result in increased pressure on infrastructure including healthcare services and further support the need for a hospital to be located in the City of Spring Hill.

[25] Spring Hill city's UGB report includes two alternate estimates of 2024 population, 57,604 and 66,071. The special census will confirm the 2024 estimate. https://www.springhilltn.org/728/Urban-Growth-Boundaries-UGB

[26] Zip code and county migration patterns from THA data are based on 2021 data; county data from the JARs are based on 2022 data.

- Like the morning travel analysis, the study found that in the late afternoon, access to hospital services was also improved with TSHH. At this time, the average time saved to reach TSHH from the Service Area perimeter locations compared to WMC and MRH was 10 to 15 minutes; 49 minutes are saved reaching TriStar Centennial. With respect to the Spring Hill locations, the average time saved to reach TSHH compared to WMC and MRH was 14 to 25 minutes. Reaching TSHH took less than 11 minutes compared to an average of 25 to 36 minutes to reach WMC and MRH, respectively.
- Travel miles (product of distance and frequency) to access both inpatient med/surg care and obstetrics services for Spring Hill residents is one of the greatest in the region.

*ER Transfers and EMS Bypass Verify Need*

- The level of patient activity at TriStar Spring Hill ER, number of transfers (87 percent non-tertiary)[27] for inpatient treatment and observation from this ER and their resulting impact on access to healthcare, cost and family hardship, collectively demonstrate the Service Area need for inpatient hospital beds on the TSHH campus.
- Based on its patient base, TriStar Spring Hill ER currently transfers an average of 100 patients per month to Nashville and elsewhere to access inpatient care thereby creating inadequate or delayed access to care. Prior to the past three years, and pre-pandemic, the number of transfers was approximately 140 per month. This difference enables quantification of Spring Hill ER bypasses that have increased during the past three years that could be treated in Spring Hill. In addition, there are additional EMS bypasses that have historically and continue to occur.
- In addition to the direct transfers from TriStar Spring Hill ER to TriStar Centennial, there are additional emergency transports from the Service Area to TriStar Centennial, totaling 84 in CY 2023.
- Local EMS providers currently mostly bypass TriStar Spring Hill ER, taking patients instead to ERs in hospitals and traveling distances to Franklin, Nashville or Columbia. When TSHH is in place, these same EMS transports will be to a much closer location in Spring Hill, keeping EMS vehicles in the community for prompter service to others. There were 2,341 documented transports from zip code 37174 (Spring Hill) with only 402 being transported to TriStar Spring Hill ER, indicating 1,939 were transported away from Spring Hill (CY 2023). There were also 7,000+ transports from 38401 (Columbia), including northern Columbia and 37179 (Thompson's Station), with only 61 being transported to TriStar Spring Hill ER. TSHH will positively impact the EMS services by being accessible and available more rapidly to meet local needs.
- Access for families will be enhanced as only 17 percent of EMS transports from 37174 are to TriStar Spring Hill ER. 69 percent are to WMC and MRH, and 14 percent are even further, to Nashville. When many of these patients are no longer diverted out of the area, families will have improved access and relative short travel times to be with their family and participate in any recovery.

*State Health Plan Criteria Are Met*

- The State Health Plan Standards and Criteria includes a Bed-Need Formula, however, the HFC "has the discretion to approve new hospital beds even when not warranted under the State Health Plan Criteria when there is a compelling reason to do so, and the Commission has done so when there was demonstrated need for additional health services in a particular

[27] Tertiary medical surgical cases are defined as transplants, trauma care, cardiac surgery, thoracic surgery, neurosurgery, burns, radiotherapy, neonatology and other complex interventions. Non-tertiary medical-surgical are the remaining inpatient services, excluding specialty services (behavioral health and medical rehabilitation). Obstetrics is also considered non-tertiary but is separately analyzed throughout this CON application.

community."[28] The need for a hospital in Spring Hill is detailed throughout this CON Application demonstrates compelling reasons for TSHH's approval. Most obviously, TSHH will improve access to inpatient hospital care for all citizens of Spring Hill because there is no hospital in Spring Hill. As noted before, Spring Hill is the largest city in Tennessee without a hospital. It is the 11th largest city in the State, and yet its citizens have to travel on congested roads to hospitals in other cities for inpatient care.

- Like many hospitals throughout Tennessee, MRH operates licensed semi-private rooms as private rooms. Furthermore, operational adjustments[29] to the published need tables indicate occupancy at the MRH meets occupancy metrics sufficient to support additional hospital beds in Maury County.[30]
- The bed need formula for Level II NICU beds confirms the need for additional Level II NICU beds in the Service Area.
- The cardiac catheterization services utilization formula confirms the need for additional cardiac catheterization laboratories in Maury County.
- The MRI services utilization formula confirms the need for an additional MRI in Maury County.
- TSHH will cure geographic isolation and inaccessibility through providing Service Area residents with an accessible and available inpatient hospital thereby enhancing access as demonstrated through health planning metrics and community support.
- Establishment of TSHH will foster quality of care and cost effectiveness through more rapid treatment of the thousands of patients currently being transferred from TriStar Spring Hill ER each year (and expected to increase), being transported from scenes each year to out of area facilities. Having TSHH in place will enable EMS to transport these patients to a hospital in Spring Hill, reducing the cost to the EMS system, and decreasing the costs to the Service Area residents. More rapid treatment leads to lives being saved.
- The economic impact to the Spring Hill community is meaningfully quantified in Question 3C below and demonstrates a Consumer Advantage based on its construction and the ongoing impact of its operations.
- Community leaders and residents alike have again raised their voices to state there is an overwhelming need for a hospital in Spring Hill and request TriStar Health implement the full-service hospital envisioned more than a decade ago. Their current impetus is based on the tremendous population growth, challenging traffic patterns extending travel time to service and the need for improved access to inpatient hospital services including obstetrics services.
- Consumer Advantage is meaningfully demonstrated by the community support for TSHH as expressed by city leaders, large community employers, business leaders, physicians, referral sources, elected officials, prior patients and others with personal knowledge and experiences in the Service Area.
- On February 29, 2024, the HFC issued its Final Order in the Vanderbilt Rutherford Hospital case and addressed the need requirement for a new community hospital. The analysis by the HFC is applicable to this CON Application. In that case, the HFC found that:
    - While the State Health Plan Standards and Criteria include a Bed-Need Formula, the HFC has the discretion to approve new hospital beds even when not warranted under the State Health Plan Criteria when there is a compelling reason to do so, and the Commission has done so when there was demonstrated need for additional health services in a particular community. I*n re Vanderbilt Rutherford Hospital*, Final Order, February 29, 2024, at p. 17.

[28] *In re Vanderbilt Rutherford Hospital,* Final Order, February 29, 2024, at p. 17.

[29] Inclusion of observation patient days and reduction in staffed beds based on floor plans published on the MRH website. See Exhibits 34 through 37.

[30] Expansion of beds at MRH while making beds 'available' does nothing to improve access for the Service Area population in need or reduce excess travel times.

- The HFC also specifically held that "Under the 2021 revisions to the Tennessee CON law, the impact of a project on existing providers is no longer a criterion for consideration." *Id.*
- The HFC found the hospital will "provide a convenient option in [city] for [provider] patients with the appropriate level of acuity to access their preferred hospital closer to their homes. This will promote the general policy of advancing consumer choice by providing quality care that is reasonably accessible to residents of the community."
- The HFC found alternatives out of the area are contrary to the CON criteria and the acknowledged advantages of receiving care close to where consumers live. The establishment of a new, state-of-the-art community hospital in [city] will significantly enhance patient accessibility and choice in the county. *Id.* at 22.
- "Forty-five minutes to an hour of travel for [pediatric] inpatient services does not constitute reasonable access for the residents of the [name] County." *Id.*
- The HFC found the level of public support significant. "[T]he record shows that there is strong community support for the application... Community support is one factor to be weighed among others in consideration of an application, and in this case the community support weighs in favor of approval." *Id.* at 23.
- The HFC specifically concluded that compelling reasons exist to deviate from the Bed-Need formula and that "The State Health Plan is a guideline and the Commission has the discretion to deviate from the guidelines for compelling reasons, and compelling reasons exist here." *Id.* at 25.

Each of the above underlying reasons to approve the proposed TriStar Spring Hill Hospital are discussed in response to Questions 2N and 3N (TriStar Spring Hill ER service to the community and population), on the following pages or in Attachment 1N, Acute Care Beds, as noted.

***TSHH Will Provide Much Needed Access to the Patients of the Service Area***

**Largest City in Tennessee without a Hospital**

Spring Hill is the largest city in Tennessee without a hospital. In fact, there are only four cities with more than 24,000 population without a hospital. There are also 54 cities with less than 24,000 population which have licensed hospitals (not shown below). Exhibit 12 below identifies those cities with 24,000+ population in descending order by size with number of hospitals and staffed beds, hospitals per capita and beds per 100,000 population.

**Exhibit 12**

| City | # of Hospitals | # of Staffed Beds | 2023 Population | Hospitals Per Capita (2023) | Beds per 100,000 Population (2023) | Size Based on 2023 Population |
|---|---|---|---|---|---|---|
| Nashville | 9 | 3,403 | 720,449 | 80,050 | 472 | 1 |
| Memphis | 8 | 2,213 | 623,978 | 77,997 | 355 | 2 |
| Knoxville | 5 | 1,561 | 195,609 | 39,122 | 798 | 3 |
| Chattanooga | 5 | 1,253 | 185,913 | 37,183 | 674 | 4 |
| Clarksville | 1 | 237 | 180,122 | 180,122 | 132 | 5 |
| Murfreesboro | 2 | 358 | 169,849 | 84,925 | 211 | 6 |
| Franklin | 1 | 203 | 90,181 | 90,181 | 225 | 7 |
| Johnson City | 2 | 514 | 72,509 | 36,255 | 709 | 8 |
| Jackson | 1 | 580 | 68,532 | 68,532 | 846 | 9 |
| Hendersonville | 1 | 123 | 64,761 | 64,761 | 190 | 10 |
| Spring Hill | 0 | 0 | 57,932 | 0 | 0 | 11 |
| Smyrna | 1 | 115 | 57,377 | 57,377 | 200 | 12 |
| Bartlett | 1 | 128 | 57,030 | 57,030 | 224 | 13 |
| Kingsport | 2 | 337 | 56,207 | 28,104 | 600 | 14 |
| Collierville | 1 | 79 | 51,032 | 51,032 | 155 | 15 |
| Gallatin | 1 | 112 | 50,965 | 50,965 | 220 | 16 |
| Cleveland | 1 | 152 | 49,497 | 49,497 | 307 | 17 |
| Brentwood | 0 | 0 | 47,651 | 0 | 0 | 18 |
| Lebanon | 1 | 147 | 44,815 | 44,815 | 328 | 19 |
| Columbia | 1 | 208 | 44,114 | 44,114 | 472 | 20 |
| Mt. Juliet | 0 | 0 | 43,304 | 0 | 0 | 21 |
| La Vergne | 0 | 0 | 40,760 | 0 | 0 | 22 |
| Germantown | 1 | 311 | 40,736 | 40,736 | 763 | 23 |
| Cookeville | 1 | 254 | 35,942 | 35,942 | 707 | 24 |
| Maryville | 1 | 146 | 33,338 | 33,338 | 438 | 25 |
| Oak Ridge | 1 | 176 | 32,064 | 32,064 | 549 | 26 |
| Morristown | 1 | 121 | 30,548 | 30,548 | 396 | 27 |
| Bristol | 1 | 269 | 27,440 | 27,440 | 980 | 28 |
| Shelbyville | 1 | 24 | 24,191 | 24,191 | 99 | 29 |
| | | | | | | |
| Tennessee | 105 | 15,267 | 4,307,690 | 41,026 | 354 | -- |

*Source: Joint Annual Reports, TN Licensing Information and Tennessee Comptroller's Office. Excludes pediatric, behavioral health, long term care and rehabilitation hospitals.*

Spring Hill is the 11th largest city in the State. There are 15 cities with a population between 24,000 and 57,000 with one or more hospitals and most with hospitals significantly larger than the TSHH 68-bed request in this CON Application. There are 54 additional cities with population less than 24,000 which also have hospitals.

On average, in the State of Tennessee, there is a hospital per 41,000 population and 354 beds per 100,000 population. Within the 10 cities larger than Spring Hill, there are a total of 35 hospitals and more than 10,000 beds, equating to 1 hospital per 67,700 persons and 440 beds per 100,000 population.

Notably Murfreesboro, which has two hospitals,[31] was just approved for a third hospital to provide convenience for its residents to access a nearby hospital and avoid traveling out of the area. Exhibit 13 presents the Spring Hill information with and without the proposed TSHH and compares it to Murfreesboro 'today' and inclusive of the recent Vanderbilt approval of its 42-bed hospital.

**Exhibit 13**

| City | # of Hospitals | # of Staffed Beds | 2023 Population | Hospitals Per Capita (2003) | Beds per 100,000 Population (2023) |
|---|---|---|---|---|---|
| Spring Hill Today | 0 | 0 | 57,932 | 0 | 0 |
| *Spring Hill Approved* | *1* | *68* | *57,932* | *57,932* | *117* |
| | | | | | |
| Murfreesboro Today | 2 | 358 | 169,849 | 84,925 | 211 |
| *Murfreesboro With VRH-2* | *3* | *400* | *169,849* | *56,616* | *236* |

*Source: Joint Annual Reports, TN Licensing Information, Tennessee Comptroller's Office and Final Order dated February 29, 2024 in the matter of CN2109-026.*

While the above counts confirm the Spring Hill community is currently devoid of any hospital services, and approval of this CON Application will enhance access and availability, a material difference between the two proposals does exist. Murfreesboro currently has two hospitals. In contrast, Spring Hill has no hospital, making it geographically isolated from inpatient services, requiring its residents to always (100 percent of the time) leave their city to access hospital services. Per the City of Spring Hill Mayor:

> *TriStar's proposal is a significant leap forward in our community's healthcare infrastructure. I am very excited about plans to expand the Spring Hill ER into a full-service hospital. Our growth demands that we evolve and adapt to meet the needs of our community members in a holistic and forward-thinking manner. This expansion is a testament to TriStar Health's ongoing investment in our health and wellness.*
>
> *This investment in our city holds profound significance for Spring Hill, not merely as a milestone but as a vital necessity. For too long, our city has been without a full-service hospital and is currently the largest city in the state without its own. And that means ensuring our residents have access to what they need. The TriStar Spring Hill Hospital will ensure accessible, high-quality healthcare right here in the heart of our city. With the addition of our own hospital, Spring* Hill takes a giant stride toward a brighter, healthier future for generations to come.
>
> *Jim Hagaman, Mayor, Spring Hill*

[31] Technically, Murfreesboro has 3 hospitals, Ascension Saint Thomas Rutherford Hospital, Ascension Saint Thomas Rutherford – Westlawn Hospital, and Trustpoint. Westlawn is not separately licensed from Ascension Saint Thomas Rutherford, but it represents an additional acute care location for city residents. In addition, while licensed as an acute care hospital, Trustpoint is primarily a behavioral health hospital and is thus excluded from this comparative analysis. Vanderbilt Rutherford Hospital will be a third acute care hospital in Murfreesboro that is focused on med-surg patients.

*Bed to Population Ratio*

The 354 beds per 100,000 population in Exhibit 12 equates to an average of 3.5 beds per 1,000 population. This contrasts with Spring Hill having 0 beds now, and 1.17 beds per 1,000 population (117 beds per 100,000) with TSHH approval as reflected in Exhibit 13. If approved, Spring Hill will have half the bed to population rate in Murfreesboro as shown above.

Other comparisons of bed to population ratio are also informative. Looking at cities of like size or nearby (Columbia and Franklin) reflects a range of staffed beds per 1,000 population of 2.3 to 9.8 beds.

**Exhibit 14**

| City | Hospitals | Licensed Beds | Staffed Beds | 2023 Population (est) | Licensed Beds available per 1,000 | # of Staffed Beds available per 1,000 persons |
|---|---|---|---|---|---|---|
| Spring Hill | 0 | 0 | 0 | 57,932 | 0.0 | 0.0 |
| Columbia | 1 | 255 | 208 | 44,144 | 5.8 | 4.7 |
| Franklin | 1 | 203 | 203 | 90,181 | 2.3 | 2.3 |
| Kingsport | 2 | 744 | 337 | 56,207 | 13.2 | 6.0 |
| Bristol (TN) | 1 | 312 | 269 | 27,440 | 11.4 | 9.8 |

*Source: City population from TN Comptroller's Office, hospitals, licensed and staff beds are JARs 2022.*
*Note: The City of Columbia's population is 44,144 which is significantly less than the population of zip code 38401 due to its vast geographic size. The City of Spring Hill and the Spring Hill zip code population counts are fairly similar.*

Approval of TSHH will provide for 1.17 beds per 1,000 population in the City of Spring Hill, half of the lowest value in Exhibit 14.

***TSHH Will Address the Rampant Population Growth Experienced by Spring Hill Residents***

As discussed in response to Question 3N, the population of the City of Spring Hill has tripled since 2005, more than doubled since 2010 and continues to be one of the fastest growing areas in the State of Tennessee. Claritas population is utilized throughout this CON Application for the Service Area analysis at the zip code level. However, the Spring Hill city government is currently conducting a special census to determine the population more accurately as city officials estimate the population has increased by 10,000 residents since the last U.S. Census in 2020.[32]

The increased population adds more traffic and stress to the local infrastructure, including roadways. Travel times vary throughout the day and week based on routine activities, travel to and from schools, employment or retail and commercial activities. To estimate the hospital access improvement that Spring Hill residents would realize with the establishment of TSHH, travel times from various locations throughout Spring Hill were calculated to identify the time it takes for Spring Hill residents to access the closest hospitals.

[32] The 2020 census identified a Spring Hill City population of 50,005; an increase to that in four years would indicate population exceeds 60,000. The City's website estimates by 2029 the city's population will increase to between 68,000 and 94,000.

Exhibit 15 shows travel time from three locations within Spring Hill to MRH, WMC and the proposed TSHH. The three locations include the geographic centroid of the City of Spring Hill, the geographic centroid of the Spring Hill zip code and the entrance to Del Webb's Southern Springs, 55+ community with more than 800 homes. The exhibit also includes the TSHH location to MRH and WMC to further demonstrate how this location is geographically isolated from those two hospitals.

**Exhibit 15**

| Travel Minutes from Spring Hill Locations to Hospital Facilities (Including Proposed) | | | |
|---|---|---|---|
| **Starting Point** | **Proposed TriStar Spring Hill Hospital** | **Maury Regional Hospital** | **Williamson Medical Center** |
| Spring Hill City (Centroid) | | | |
| *Distance (Mileage)* | *1.9* | *13.4* | *18.2* |
| 8AM | 4 - 6 | 18 - 35 | 24 - 40 |
| Midday | 5 | 22 | 25 |
| 5 PM | 4 - 7 | 20 - 40 | 22 - 35 |
| | | | |
| Spring Hill Zip Code 37174 (Centroid) | | | |
| *Distance (Mileage)* | *3.4* | *17.2* | *16.0* |
| 8AM | 7 - 12 | 24 - 40 | 22 - 40 |
| Midday | 7 | 27 | 23 |
| 5 PM | 7 - 12 | 26 - 45 | 22 - 35 |
| | | | |
| Del Webb Entrance | | | |
| *Distance (Mileage)* | *1.6* | *14.6* | *17.0* |
| 8AM | 4 | 20 - 35 | 26 - 45 |
| Midday | 4 | 24 | 25 |
| 5 PM | 4 | 22 - 40 | 20 - 26 |
| | | | |
| TriStar Spring Hill Hospital | | | |
| *Distance (Mileage)* | *0.0* | *14.6* | *16.0* |
| 8AM | 0 | 20 - 35 | 24 - 40 |
| Midday | 0 | 24 | 24 |
| 5 PM | 0 | 22 - 45 | 22 - 30 |

*Source: Google maps drive times, March 2024*

Depending on time of day and starting point, implementation of TSHH improves access by between 14 and 45 minutes to MRH and between 15 and 41 minutes to WMC. Approval of TSHH will not only be a convenience for residents of Spring Hill, but also materially improve access and reduce travel times for the area residents.

**TSHH Will Enhance Access as Expectant Mothers Experience Geographic Inaccessibility**

Spring Hill is a thriving and growing family community with one-third of the population between the ages of 18 and 44, also known as child-bearing ages. Given the population dynamics of Spring Hill and it being the largest city in Tennessee without its own hospital, women's health services and birthing locations are not easily accessible from Spring Hill.

To demonstrate how long the travel times are for expectant Spring Hill mothers to access hospitals for deliveries, the Applicant undertook an analysis of deliveries[33] throughout the area, including Maury, Williamson, Davidson and surrounding counties. For each zip code in these counties, deliveries were identified for the past three years. Of these zip codes, 24 had greater than 400 deliveries. For each zip code with 400+ deliveries, the Applicant identified the closest hospital and used Google maps to identify the actual travel miles from the zip code[34] to the closest hospital.

The zip codes were arrayed in descending order by miles from the zip code centroid to the closest hospital. Distinguishing Spring Hill from every zip code that met the defining characteristics for analysis, it has the greatest distance to the closest hospital with an obstetrics program. Accordingly, Spring Hill is listed first in the following exhibit.

**Exhibit 16**

| Zip Code | CY 2020 | CY 2021 | CY 2022 | % Change, 2020 to 2022 | Closest Hospital | Distance (Miles) | Travel Miles |
|---|---|---|---|---|---|---|---|
| 37174 - Spring Hill | 519 | 594 | 650 | 25.2% | Williamson Medical Center | 16.0 | 10,400 |
| 37072 - Goodlettsville | 322 | 335 | 417 | 29.5% | TriStar Hendersonville Medical Center | 11.6 | 4,837 |
| 37221 - Nashville | 448 | 465 | 449 | 0.2% | TriStar Centennial Medical Center | 11.5 | 5,164 |
| 37209 - Nashville | 579 | 670 | 680 | 17.4% | TriStar Centennial Medical Center | 10.1 | 6,868 |
| 37064 - Franklin | 590 | 595 | 596 | 1.0% | Williamson Medical Center | 9.7 | 5,781 |
| 37130 - Murfreesboro | 685 | 733 | 709 | 3.5% | Ascension St Thomas Rutherford | 9.6 | 6,806 |
| 37122 - Mount Juliet | 636 | 693 | 742 | 16.7% | TriStar Summit Medical Center | 8.7 | 6,455 |
| 37013 - Antioch | 1,493 | 1,564 | 1,673 | 12.1% | TriStar StoneCrest Medical Center | 8.2 | 13,719 |
| 37211 - Nashville | 1,368 | 1,343 | 1,391 | 1.7% | Vanderbilt University Medical Center | 8.1 | 11,267 |
| 37115 - Madison | 520 | 551 | 568 | 9.2% | TriStar Hendersonville Medical Center | 7.9 | 4,487 |
| 37027 - Brentwood | 419 | 435 | 448 | 6.9% | Williamson Medical Center | 7.1 | 3,181 |
| 37217 - Nashville | 511 | 520 | 561 | 9.8% | TriStar Summit Medical Center | 7.0 | 3,927 |
| 37129 - Murfreesboro | 622 | 646 | 709 | 14.0% | Ascension St Thomas Rutherford | 6.8 | 4,821 |
| 37207 - Nashville | 640 | 602 | 612 | -4.4% | Ascension St Thomas Midtown | 6.7 | 4,100 |
| 37206 - Nashville | 459 | 483 | 416 | -9.4% | TriStar Centennial Medical Center | 6.4 | 2,662 |
| 37128 - Murfreesboro | 837 | 872 | 928 | 10.9% | Ascension St Thomas Rutherford | 5.8 | 5,382 |
| 37087 - Lebanon | 602 | 605 | 712 | 18.3% | Vanderbilt Wilson County Hospital | 5.8 | 4,130 |
| 38401 - Columbia | 742 | 744 | 680 | -8.4% | Maury Regional Hospital | 5.7 | 3,876 |
| 37086 - La Vergne | 546 | 587 | 615 | 12.6% | TriStar Stonecrest Medical Center | 5.7 | 3,506 |
| 37076 - Hermitage | 476 | 486 | 542 | 13.9% | TriStar Summit Medical Center | 3.8 | 2,060 |
| 37167 - Smyrna | 816 | 765 | 883 | 8.2% | TriStar Stonecrest Medical Center | 3.4 | 3,002 |
| 37075 - Hendersonville | 693 | 680 | 730 | 5.3% | TriStar Hendersonville Medical Center | 2.6 | 1,898 |
| 37066 - Gallatin | 644 | 695 | 671 | 4.2% | Sumner Regional Medical Center | 2.3 | 1,543 |

*Source: THA Discharges by year and zip code; deliveries only (not total obstetrics).*

*Note: 37160 Shelbyville with 526 deliveries (CY 2022) is excluded from the above table as there is an existing hospital in Shelbyville that chose to discontinue obstetrics services requiring Shelbyville residents to drive 18.5 miles to Vanderbilt Tullahoma Hospital. This access hardship was prompted by the community hospital action which is dissimilar to Spring Hill that has no hospital.*

[33] Deliveries are defined by DRGs 768, 783-788, and 796-798 and are a subset of total Obstetrics Discharges presented elsewhere throughout this CON Application.

[34] Google maps uses the geographic centroid of the zip code when determining mileage from a zip code to a location. As shown on Exhibit 15 in the CON Form, WMC is closer than MRH to the centroid of 37174.

Reflected above, Spring Hill women also had the second greatest increase in deliveries in the CY 2020 through CY 2022 period at 25.2 percent. With continuing expected increases in Spring Hill deliveries, without TSHH travel miles for deliveries will continue to increase more than the comparative locations throughout the region.

When computing total travel miles for expectant mothers accessing the 'closest' obstetrics program, Spring Hill had the third highest travel miles[35] of any zip code in the region. Deliveries multiplied by travel miles for Spring Hill expectant mothers equaled 10,400 miles. If the actual location of where these out-migrating patients had their babies is analyzed, travel miles would be even greater because 55 percent of the deliveries that occurred during this three-year period did not occur at the closest hospital to Spring Hill. Rather, residents traveled further distances to other hospitals including to Nashville hospitals, and TriStar Centennial.

**TSHH Will Enhance Access as All Inpatients Face Inadequate Access**

Like the analysis conducted for expectant mothers by zip code throughout the region, we also identified total discharges by zip code throughout the area, including Maury, Williamson, Davidson and surrounding counties in the region. For each zip code in these counties, discharges were identified for the past three years. Of these zip codes, 25 had greater than 3,000 discharges. For each zip code with 3,000+ discharges, we then identified the closest hospital and used Google maps to identify the actual travel miles from the zip code[36] to the closest hospital.

The zip codes were arrayed in descending order by miles to the closest hospital. As with deliveries analyzed above, Spring Hill has the greatest distance to the closest acute care hospital for zip codes meeting the criteria for analysis. Accordingly, it is listed first in the following exhibit.

[35] Total Travel Miles is computed from CY 2022 deliveries times the travel miles to the closest hospital. Travel miles could far exceed this computation depending on the patient deliveries at the closest hospital. For example, in the Spring Hill zip code, less than ½ of the deliveries are at the closest hospital, yet travel miles compute as if 100 percent of the deliveries were at that hospital. The two zip codes with higher travel miles are based on the fact their deliveries were two to three times that of the Spring Hill deliveries in total, while distance was approximately half.

[36] Google maps uses the geographic centroid of the zip code when determining mileage from a zip code to a location.

## Exhibit 17

| Zip Code | 2020 | 2021 | 2022 | % Change 2020 to 2022 | Closest Hospital | Distance (Miles) | Travel Miles |
|---|---|---|---|---|---|---|---|
| 37174 - Spring Hill | 2,973 | 3,315 | 3,337 | 12.2% | Williamson Medical Center | 16.0 | 53,392 |
| 37160 - Shelbyville | 3,739 | 3,790 | 3,779 | 1.1% | Vanderbilt Bedford Hospital | 14.5 | 54,796 |
| 37072 - Goodlettsville | 3,520 | 3,584 | 3,543 | 0.7% | TriStar Skyline Medical Center | 11.2 | 39,682 |
| 37064 - Franklin | 4,060 | 4,456 | 4,404 | 8.5% | Williamson Medical Center | 9.7 | 42,719 |
| 37130 - Murfreesboro | 5,259 | 5,541 | 5,611 | 6.7% | Ascension St Thomas Rutherford | 9.6 | 53,866 |
| 37221 - Nashville | 3,100 | 3,224 | 3,336 | 7.6% | Ascension St Thomas West | 9.4 | 31,358 |
| 37209 - Nashville | 3,206 | 3,265 | 3,313 | 3.3% | Ascension St Thomas West | 8.8 | 29,154 |
| 37122 - Mount Juliet | 5,344 | 5,448 | 5,614 | 5.1% | TriStar Summit Medical Center | 8.7 | 48,842 |
| 37013 - Antioch | 7,517 | 7,893 | 8,011 | 6.6% | TriStar Southern Hills Medical Center | 7.8 | 62,486 |
| 37027 - Brentwood | 3,209 | 3,407 | 3,476 | 8.3% | Williamson Medical Center | 7.1 | 24,680 |
| 37217 - Nashville | 3,018 | 3,043 | 3,136 | 3.9% | TriStar Summit Medical Center | 7.0 | 21,952 |
| 37129 - Murfreesboro | 5,017 | 5,247 | 5,292 | 5.5% | Ascension St Thomas Rutherford | 6.8 | 35,986 |
| 37087 - Lebanon | 5,638 | 5,692 | 6,485 | 15.0% | Vanderbilt Wilson County Hospital | 5.8 | 37,613 |
| 37128 - Murfreesboro | 4,591 | 4,976 | 4,988 | 8.6% | Ascension St Thomas Rutherford | 5.8 | 28,930 |
| 38401 - Columbia | 6,172 | 6,222 | 6,080 | -1.5% | Maury Regional Hospital | 5.7 | 34,656 |
| 37086 - La Vergne | 3,172 | 3,255 | 3,262 | 2.8% | TriStar Stonecrest Medical Center | 5.7 | 18,593 |
| 37172 - Springfield | 3,426 | 3,258 | 3,462 | 1.1% | TriStar Northcrest Medical Center | 5.1 | 17,656 |
| 37115 - Madison | 5,328 | 5,638 | 5,348 | 0.4% | TriStar Skyline Medical Center | 4.3 | 22,996 |
| 37076 - Hermitage | 4,520 | 4,509 | 4,435 | -1.9% | TriStar Summit Medical Center | 3.8 | 16,853 |
| 37207 - Nashville | 5,589 | 5,764 | 5,868 | 5.0% | TriStar Skyline Medical Center | 3.6 | 21,125 |
| 37167 - Smyrna | 5,315 | 5,538 | 5,520 | 3.9% | TriStar Stonecrest Medical Center | 3.4 | 18,768 |
| 37075 - Hendersonville | 6,343 | 6,655 | 6,320 | -0.4% | TriStar Hendersonville Medical Center | 2.6 | 16,432 |
| 37066 - Gallatin | 6,509 | 6,844 | 6,845 | 5.2% | Sumner Regional Medical Center | 2.3 | 15,744 |
| 37203 - Nashville | 2,401 | 2,471 | 3,162 | 31.7% | Vanderbilt University Medical Center | 1.3 | 4,111 |
| 37211 - Nashville | 6,975 | 7,083 | 7,059 | 1.2% | TriStar Southern Hills Medical Center | 1.0 | 7,059 |
| *Source: THA Discharges by year and zip code.* | | | | | | | |

Reflected above, Spring Hill also had one of the largest increases in discharges (12.2 percent) in the CY 2020 through CY 2022 period. With continuing expected increases in Spring Hill discharges, travel miles will continue to increase more than the comparative locations throughout the region.

When computing total travel miles for acute patients accessing the 'closest' acute care hospital, Spring Hill had in excess of 53,000 miles.[37] Just one zip code had greater than 60,000 and three zip codes were in the 53,000 to 54,000 range. If actual location of Spring Hill discharges was computed, travel miles would be even greater as 60 percent of discharges during this three-year period did not occur at the closest hospital, with the majority of those traveling further, to Davidson County hospitals, including TriStar Centennial.

> *TriStar Health has extensive experience in Spring Hill, and I know that the existing ER has provided lifesaving, quality care for thousands of Spring Hill residents over the past decade…Spring Hill is the largest city in the state without a hospital. In order for patients to be cared for properly, that needs to change. When patients have to leave their communities to receive hospital care, it puts undue stress on patients and their families. By approving this hospital, you are providing them with the peace of mind that comes with accessible care.*
>
> *There is a need in Spring Hill for a full-service hospital. I treat patients from Spring Hill, and I can attest to the benefit that they would see by having a hospital nearby.*
>
> *Tammy Baxter, MD, Thoracic surgeon*

[37] Total Travel Miles is computed from CY 2022 discharges times the travel miles to the closest hospital. Travel miles could far exceed this computation depending on the patient discharges from the closest hospital. For example, in the Spring Hill zip code, less than ½ of the discharges are at the closest hospital, yet travel miles compute as if 100 percent of these discharges were at that hospital.

**Cardiac Patients Will Benefit from the Availability of TSHH**

No hospital and no cardiac catheterization laboratories exist in Spring Hill. The degree of heart muscle damage from a heart attack is associated with how long it takes from when heart attack symptoms start to when patients receive an artery-clearing procedure called percutaneous coronary intervention, or PCI. The longer the time before PCI, called symptom-to-balloon time, the more significant and damaging the heart attack. Symptom-to-balloon time directly correlates with the amount of time the myocardium/heart muscle undergoes inadequate blood supply. Reducing such time should reduce the degree of damage and ultimately improve patient outcomes. Shorter symptom to balloon times for individual patients is also associated with lower mortality at 30-days and at 1 year.

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

Per the travel times presented in response to Question 4N herein, time to reach hospitals outside of Spring Hill requires between 14 to 45 minutes additional time than accessing TSHH. The availability of TSHH and its proposed catheterization laboratories in Spring Hill would save these patients up to 45 minutes in the symptom to balloon time. Time is muscle, and these minutes could be critical in patient outcomes.

MRH has two catheterization laboratories. However, the MRH program operates at 137 percent of optimal capacity dictating need for additional cardiac catheterization services in Maury County. MRH's high capacity likely contributes to the low number of services for Maury County residents and the out-migration to access needed cardiac services. Maury County's out-migration for cardiac catheterization services is like overall hospital migration, with more than half of Maury County resident inpatient and outpatient catheterizations being performed outside Maury County as shown in the next exhibit.

**Exhibit 18**

| Inpatient and Outpatient Cardiac Catheterization | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2020 | CY 2021 | CY 2022 | CY 2020 | CY 2021 | CY 2022 |
| **Maury County Residents** | | | | | | |
| Number of Patients Who Out-Migrated | 948 | 1,109 | 982 | 54.5% | 54.2% | Masked |
| Number of Patients to TriStar Centennial | 223 | 247 | Masked | 12.8% | 12.1% | |
| Number of Patients to Tristar Other | 7 | 16 | | 0.4% | 0.8% | |
| Out-Migration to Other Providers | 718 | 846 | | 41.3% | 41.3% | |
| *Total and Percent of Out-Migration to TriStar* | 230 | 263 | 223 | 24.3% | 23.7% | 22.7% |

*Source: THA data for the respective years. 2022 data is thus masked per the THA data use policy.*

An average of 1,000 Maury County residents each year out-migrate from Maury County. This confirms the lack of access in Maury County likely compounded by the high utilization at MRH. Approximately 23 percent of those out-migrating out of the county have their catheterizations at TriStar Health facilities. This percentage exceeds that of the total inpatient hospital migration but is indicative of the level of Maury County support for TriStar Health and its physician group, Centennial Heart which will staff TSHH's cardiac catheterization laboratories.

WMC in Williamson County also has catheterization laboratories. Williamson County's outmigration far exceeds that of Maury County residents with approximately 70 percent of Williamson County residents seeking these cardiac services outside the county, primarily in Davidson County.

**Exhibit 19**

| Inpatient and Outpatient Cardiac Catheterization | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2020 | CY 2021 | CY 2022 | CY 2020 | CY 2021 | CY 2022 |
| **Williamson County Residents** | | | | | | |
| Number of Patients Who Out-Migrated | 1,765 | 1,874 | 2,051 | 72.2% | 67.4% | Masked |
| Number of Patients to TriStar Centennial | 363 | 377 | Masked | 14.8% | 13.6% | |
| Number of Patients to Tristar Other | 106 | 136 | | 4.3% | 4.9% | |
| Out-Migration to Other Providers | 1,296 | 1,361 | | 53.0% | 48.9% | |
| *Total and Percent of Out-Migration to TriStar* | 469 | 513 | 486 | *26.6%* | *27.4%* | *23.7%* |

*Source: THA data for the respective years. 2022 data is masked per the THA data use policy.*

More than 2,000 patients out-migrated from Williamson County during the past year. This is likely compounded by the fact that to date WMC did not perform any advanced procedures in its catheterization laboratories including peripheral vascular, EP or thrombolysis. Approximately one in four out-migrating Williamson County residents have their catheterizations at TriStar Health facilities.

In terms of the 3 zip code Service Area, out-migration parallels that of Maury County, with significant out-migration occurring from each zip code. More than half of 37174 (Spring Hill) residents leave both Maury and Williamson Counties; when just considering these Spring Hill residents leaving Maury County, more than 80 percent leave the County. More than four in ten 38401 (Columbia) residents leave Maury County, and approximately 60 percent of 37179 (Thompson's Station) residents leave Williamson County.

> *On behalf of Centennial Heart, I offer my full support for TriStar Spring Hill Hospital. We plan to design the most modern and advanced cardiac catheterization lab at this facility and help to staff it with our Centennial Heart physicians. This facility will certainly be high-quality and will benefit residents of the Spring Hill area by providing unprecedented access to care right in their own community.*
>
> *Thomas McRae, III, M.D., Centennial Heart Cardiovascular Consultants*

**TSHH Will Reduce Outmigration from the Service Area.**

*County Out-Migration*

The out-migration from Maury and Williamson Counties is significant and alarming. Overall Maury County residents leave Maury County for inpatient acute hospital services more than 50 percent of the time. This represents total hospital utilization including tertiary, non-tertiary, obstetrics, neonatology and other specialized services. Most of those out-migrating travel past the City of Spring Hill to hospitals to the north of Maury County. Even more drastic is that Williamson County residents leave Williamson County for inpatient acute hospital services on average 63 percent of the time during the past three years. A summary of this out-migration is presented in the following exhibit.

**Exhibit 20**

| Hospital Admissions by County of Residence - Migration Patterns | | | |
|---|---|---|---|
| | **FY 2020** | **FY 2021** | **FY 2022** |
| **Maury County Resident Admissions** | | | |
| To Maury County Hospitals | 5,254 | 5,236 | 4,976 |
| Outmigration from Maury County | 5,481 | 5,315 | 5,291 |
| Total Maury County Resident Admissions | 10,735 | 10,551 | 10,267 |
| Percent Outmigration from Maury County | 51.1% | 50.4% | 51.5% |
| | | | |
| **Williamson County Resident Admissions** | | | |
| To Williamson County Hospitals | 4,888 | 5,115 | 5,446 |
| Outmigration from Williamson County | 8,679 | 8,961 | 9,181 |
| Total Williamson County Resident Admissions | 13,567 | 14,076 | 14,627 |
| Percent Outmigration from Williamson County | 64.0% | 63.7% | 62.8% |
| *Source: Joint Annual Report Hospital Summary, 2020 through 2022* | | | |

Notably of those out-migrating from the above two counties, on average 1 of 6 patients (16.5 percent) are being admitted to TriStar Centennial. While some of those patients are intra-facility transports from TriStar Spring Hill ER, the majority are either transports from a scene or walk ins. This significant patient draw from these counties to Patterson Street, Davidson County demonstrates that TriStar Health is a significant provider in these counties. As a result, TriStar Health will be even more effective in reducing out-migration with the establishment of TSHH. From The Surgical Clinic with more than 40 surgeons:

> *Some of our members intend to apply for privileges and provide services at this hospital. I am confident that residents of Spring Hill will benefit from access to general surgery within their own community.*
>
> *We currently staff general and vascular surgical services at Maury Regional Medical Center. We intend to continue and expand our service to Columbia and this excellent institution. It has been our general experience that most of our surgical patients from the Spring Hill community are cared for by our Nashville based offices and surgeons. We see fewer Spring Hill patients at our Columbia location. We believe that those Spring Hill patients would likely stay in Spring Hill if a hospital was available in that community.*
>
> *This proposal aligns with The Surgical Clinic's effort to give patients access to surgical procedures close to home. Our surgeons look forward to providing services at this hospital when it is built. Please grant TriStar Health the certificate of need to bring this facility to Spring Hill.*
>
> *John Boskind, M.D., FACS, President of The Surgical Clinic*

*Service Area Out-Migration, Non-Tertiary Med-Surg Patients*

The Spring Hill zip code has more than 56,000 residents and is expected to increase to more than 62,000 during the next five years.[38] City leaders also expect further growth this decade, expected to reach between 68,000 and 94,000 residents by 2029.[39] Notwithstanding this significant population base, there is no hospital in Spring Hill.

From a hospital admission perspective, a significant number of patients leave the service area for in-patient services in other cities. Embedded within the data is that 100 percent of Spring Hill residents out-migrate to other cities because Spring Hill has no hospital.

A primary reason for patients leaving the area for hospital services is the unavailability of these services. MRH is the only hospital in the Service Area and it is over 14 miles from Spring Hill on often congested roadways. Spring Hill and Thompson's Station have no hospital in their communities. As the largest city in the Service Area, Spring Hill residents have very limited access to hospital services because there is no hospital in Spring Hill. Accordingly, implementation of TSHH will improve healthcare access for most of the Service Area population.

Of patients out-migrating from the Service Area, on average 17 percent are being admitted to TriStar Centennial. An additional 3 percent are admitted to other TriStar Health facilities. This significant patient draw from the Service Area demonstrates that TriStar Health is a significant provider of inpatient care to Service Area residents even though it has no hospital in the Service area. As a result, the establishment of TSHH will reduce out-migration to TriStar Health hospitals because most of the community hospital patients who would have gone to TriStar Centennial or other TriStar hospitals can receive the same TriStar quality care at TSHH.

TSHH will be a full-service community hospital primarily serving the inpatient acute care needs of non-tertiary and obstetrics patients. Therefore, the migration analysis presented herein is separated into non-tertiary medical surgical and obstetrics migration patterns.[40]

37174 (Spring Hill) resident out-migration from Maury County is around 90 percent. Spring Hill residents leaving both Maury and Williamson County approximated 45 percent, a 2-point decrease from total med-surg cases, confirming the significant out-migration is not attributable to the acuity of the patient. Exhibit 21 below presents the non-tertiary medical surgical patients of the Service Area zip codes and their respective migration patterns.

[38] City leaders believe the current population now exceeds 60,000; to confirm this the city is now undertaking a special census (2024) to obtain a more accurate count. If the 2024 population is revised upward, that would have further implications for the forecasted population likely resulting in population in the upper 60,000's within five years. Forecasts throughout this CON Application conservatively use the Claritas counts.

[39] Major Thoroughfare Plan, 2021, page 7 of its Future Conditions Report indicates 81,000 by 2040. This estimate is roughly in the middle of the UGB forecast for 2029 of 68,000 to 94,000 but 11 years later. The special census results will be informative relative to these future projections.

[40] Tertiary medical surgical cases are defined as transplants, trauma care, cardiac surgery, thoracic surgery, neurosurgery, burns, neonatology and other complex interventions. Non-tertiary medical-surgical are the remaining inpatient services, excluding specialty services (behavioral health and medical rehabilitation). Obstetrics is also considered non-tertiary but is separately analyzed throughout this CON application.

**Exhibit 21**

| Non-Tertiary Med Surg Hospital Admissions by Zip Code of Residence - Migration Patterns | | | |
|---|---|---|---|
| | **CY 2020** | **CY 2021** | **CY 2022** |
| **37174 - Spring Hill Resident Admissions** | | | |
| To Maury County Hospitals | 171 | 230 | Masked |
| Outmigration from Maury County | 1,666 | 1,756 | |
| Total 37174 Resident Admissions | 1,837 | 1,986 | 1,991 |
| Percent Outmigration from Maury County | 90.7% | 88.4% | Masked |
| *Because 37174 Crosses County Line, Add:* | | | |
| *To Williamson County Hospitals* | *724* | *835* | *Masked* |
| *Percent Outmigration from Maury and Williamson Counties* | *51.3%* | *46.4%* | *44.9%* |
| | | | |
| **38401 - Columbia Resident Admissions** | | | |
| To Maury County Hospitals | 2,766 | 2,761 | Masked |
| Outmigration from Maury County | 1,477 | 1,527 | |
| Total 38401 Resident Admissions | 4,243 | 4,288 | |
| Percent Outmigration from Maury County | 34.8% | 35.6% | |
| | | | |
| **37179 - Thompson's Station Resident Admissions** | | | |
| To Williamson County Hospitals | 288 | 276 | Masked |
| Outmigration from Williamson County | 345 | 293 | |
| Total 37179 Resident Admissions | 633 | 569 | |
| Percent Outmigration from Williamson County | 54.5% | 51.5% | |
| *Source: THA data, CY 2020 through CY 2022, excludes obstetrics* | | | |

Non-tertiary Thompson's Station out-migration from Williamson County approximates 53 percent, also significant. Similarly, Columbia out-migration from Maury County is approximately 35 percent. This information confirms that the out-migration from the TSHH Service Area is not only excessive but also results in non-tertiary patients traveling lengthy distances to access available community hospital services elsewhere. TSHH will mitigate out-migration, improve access and provide available community hospital services in Spring Hill. From the largest orthopaedic surgery group in Tennessee:

> *This project is needed to provide greater access to hospital services for Maury and Williamson Counties, and especially the city of Spring Hill which is split between both counties. I applaud TriStar Health for its foresight in planning for greater access to high-quality hospital services in the service area.*
>
> *TOA intends to apply for privileges and provide services at this hospital. We are confident that TriStar Health will provide excellent care for both patients receiving care and providers offering inpatient services at this facility. We are excited to fully support this project to increase healthcare access for the greater Spring Hill community.*
>
> *Rob Simmons, CEO, Tennessee Orthopaedic Alliance*

*Service Area Out-Migration, Obstetrics Patients*

Obstetrics patients are defined as those being categorized within major diagnostic category ("MDC") 14,[41] Pregnancy, Childbirth & the Puerperium. Most obstetrics cases are deliveries of infants. In addition, there are admissions for false labor, antepartum complications and other conditions associated with a pregnancy. Like total acute hospital patients and those with non-tertiary diagnoses, obstetrics patients experience significant out-migration from their home area for services.

**Exhibit 22**

| Obstetrics Hospital Admissions by Zip Code of Residence - Migration Patterns | | | |
|---|---|---|---|
| | **CY 2020** | **CY 2021** | **CY 2022** |
| **37174 - Spring Hill Resident Admissions** | | | |
| To Maury County Hospitals | 74 | 93 | Masked |
| Outmigration from Maury County | 481 | 533 | |
| Total 37174 Resident Admissions | 555 | 626 | 681 |
| Percent Outmigration from Maury County | 86.7% | 85.1% | Masked |
| *Because 37174 Crosses County Line, Add:* | | | |
| *To Williamson County Hospitals* | *251* | *271* | *Masked* |
| *Percent Outmigration from Maury and Williamson Counties* | *41.4%* | *41.9%* | *37.0%* |
| Total Outmigration | 230 | 262 | 252 |
| | | | |
| **38401 - Columbia Resident Admissions** | | | |
| To Maury County Hospitals | 532 | 530 | Masked |
| Outmigration from Maury County | 263 | 259 | |
| Total 38401 Resident Admissions | 795 | 789 | |
| Percent Outmigration from Maury County | 33.1% | 32.8% | |
| | | | |
| **37179 - Thompson's Station Resident Admissions** | | | |
| To Williamson County Hospitals | 100 | 117 | Masked |
| Outmigration from Williamson County | 104 | 104 | |
| Total 37179 Resident Admissions | 204 | 221 | |
| Percent Outmigration from Williamson County | 51.0% | 47.1% | |
| *Source: THA data, CY 2020 through CY 2022* | | | |

As with med/surg cases, a primary reason for obstetrics patients leaving the area for care is the lack of availability of services. TSHH will not only provide OB services that are currently unavailable to the residents of Spring Hill, TSHH will be distinguishable from existing services in the Service Area as it will incorporate 24/7 OB hospitalist services, midwifery, doula, water immersion and other specialty programming to reduce out of area travel to access specialized obstetrics services. Additionally, based on the Level II NICU bed need formula, there is a computed need for the Level II NICU beds proposed for TSHH. From Diana Health, TSHH's maternity services partner:

[41] DRGs in MDC 14 include 768, 769, 770, 783-788, 796-798, and 817-819.

*We are excited by TriStar Health's plan to bring this type of individualized, holistic maternity and women's healthcare program care to the community of Spring Hill, including the provision of 24/7 professional coverage on L&D. Today, women living in Spring Hill and the nearby city of Columbia have to drive 30 minutes or more to access high-quality maternity care. These communities are home to 7,800 births today and are growing at 3.88% annually.*

*TriStar Spring Hill Hospital will help fill this access gap and provide high-quality, midwifery-led maternity care to countless women.*

*Margaret Buxton CNM, DNP, VP Clinical Operations*
*Christopher Sizemore DO, FACOG, ABOIM, Medical Director*
*Diana Health*

**TSHH Will Reduce Spring Hill Emergency Medical Services (EMS) Transports Out of the Area**

*Emergency Transports from the Field*

Biospatial is a proprietary vendor with which TriStar contracted for EMS data analytics. [42] Biospatial combines EMS electronic patient care reports (ePCR) from its network of thousands of Emergency Medical Services (EMS) providers with other electronic healthcare data sources using proprietary artificial intelligence (AI) to support the missions of public sector and commercial healthcare entities. The data available from biospatial includes EMS transport data collected from jurisdictions and providers. Data collection includes EMS transports by counties and zip codes, transport destination facility, patient condition and other variables. It is essentially a claims data base that access is contracted by healthcare providers and others to utilize the data as a tool to assess various market dynamics.[43]

As part of its analysis of the Spring Hill Service Area, TSHH acquired this described biospatial EMS data by zip code and county to identify the level of transports from Spring Hill, and surrounding areas. The following exhibit provides the EMS transports counts from each of the Service Area zip codes.

[42] WMC currently provides the EMS transports out of the Spring Hill community under a contract with Spring Hill and Applicant was unable to obtain that data from either WMC or the City of Spring Hill. In order to provide some reliable information to the HFC, Applicant acquired EMS transport data from biospatial, a vendor with access to a proprietary database.

[43] Biospatial was founded to commercialize a research and development program sponsored by the Department of Homeland Security and managed by the University of North Carolina at Chapel Hill (UNC). The National Collaborative for Bio-Preparedness (NCBP) focused on identifying health-related data sources that could provide early warning of biological weapon attacks and infectious disease outbreaks. The NCBP program discovered that while many relevant health-related data sources exist, electronic Patient Care Reports (ePCR) collected by Emergency Medical Services (EMS) are the ideal foundational data source to support early warning of threats from chemical, biological, radiological, and nuclear (CBRN) agents.

**Exhibit 23**

| EMS Transports by Service Area Zip Code | | | |
|---|---|---|---|
| **Zip Code of EMS Call** | **CY 2021** | **CY 2022** | **CY 2023** |
| 37174, Spring Hill | 1,831 | 2,242 | 2,341 |
| 38401, Columbia | 5,953 | 6,145 | 6,533 |
| 37179, Thompson's Station | 378 | 412 | 520 |
| Total | 8,162 | 8,799 | 9,394 |

*Source: biospatial proprietary database, March 2024.*
*Note: the above data was generated from the report by EMS agency; when EMS agency sort is deselected, total transports increase by 126 as certain transports are suppressed for various reasons.*

Biospatial advises that its data is not 100 percent reported. It therefore estimates by county the percentage of transports in its database that it represents of the total using its proprietary algorithm. For Williamson and Maury Counties, its algorithms suggest the above transports represent between 70 and 90 percent of total transports. As a result, the Service Area transports above (and in its database) are the minimum occurring and could conceivably be 10 to 30 percent greater.

As with travel time and distance, those transports emanating from 37174 (Spring Hill) have the longest distance to travel to reach a hospital for treatment. Exhibit 24 provides more detail on the 37174 (Spring Hill) transports by year, including hospitals which accepted the patient.

**Exhibit 24**

| Spring Hill Zip Code 37174 EMS Transports | | | |
|---|---|---|---|
| **EMS Service/Destination** | **CY 2021** | **CY 2022** | **CY 2023** |
| **Maury County EMS** | | | |
| Maury Regional Hospital | 125 | 144 | 167 |
| TriStar Spring Hill ER | 91 | 83 | 59 |
| TriStar Centennial | 0 | 0 | 6 |
| Williamson Medical Center | 113 | 128 | 116 |
| Total | 329 | 355 | 348 |
| | | | |
| **Williamson County EMS** | | | |
| Ascension St Thomas West | 0 | 25 | 36 |
| Maury Regional Hospital | 142 | 197 | 244 |
| TriStar Spring Hill ER | 236 | 403 | 343 |
| TriStar Centennial | 46 | 58 | 50 |
| VA Medical Center | 0 | 0 | 17 |
| Vanderbilt University Medical Center | 93 | 77 | 105 |
| Monroe Carell Children's Hospital | 76 | 131 | 115 |
| Williamson Medical Center | 906 | 994 | 1,083 |
| Total | 1,499 | 1,885 | 1,993 |
| | | | |
| All Other | 3 | 2 | 0 |
| | | | |
| Total | 1,831 | 2,242 | 2,341 |

*Source: biospatial proprietary database, March 2024*

Of the 2,341 EMS transports in CY 2023, only 402 were transported to TriStar Spring Hill ER; 1,939 were transported out of the City of Spring Hill. Collectively, during the last three years, 81 percent of Spring Hill EMS patients were transported to emergency rooms out of Spring Hill. The next exhibit summarizes the above data for the two closest destination hospitals (MRH and WMC) and TriStar Spring Hill ER.

**Exhibit 25**

| Spring Hill Zip Code 37174 EMS Transports | | | |
|---|---|---|---|
| **Destination** | **CY 2021** | **CY 2022** | **CY 2023** |
| Transports to WMC | 1,019 | 1,122 | 1,199 |
| Transports to MRH | 267 | 341 | 411 |
| Total | 1,286 | 1,463 | 1,610 |
| Percent to WMC/MRH | 70.2% | 65.3% | 68.8% |
| | | | |
| TriStar Spring Hill ER | 327 | 486 | 402 |
| Percent to TriStar Spring Hill ER | 17.9% | 21.7% | 17.2% |

*Source: biospatial proprietary database, March 2024*

Based on the travel time, TSHH will be the closest hospital for transport within zip code 37174. As a result, based on Tennessee EMS guidelines, one would expect that a substantial portion of the 37174 transports would be re-directed to TSHH once it becomes licensed as a full-service community hospital.

In CY 2023 there were a minimum of 2,341 transports from 37174 (Spring Hill) to emergency rooms. Just 402 were transported to TriStar Spring Hill ER, resulting in 1,939 being taken out of Spring Hill. These transports are for both inpatient and outpatient diagnosis and treatment. With the establishment of TSHH, Spring Hill residents will be afforded the opportunity to receive services at their local community hospital resulting in reduced out-migration and geographic access improvement for patients and families. Spring Hill residents will be provided with a hospital where they live, work and play. The community will also benefit as EMS will be able to remain in the community thus reducing costs for transport out of the area and enabling EMS to be available locally for the next call.

With respect to zip code 38401 (Columbia), as discussed, it is very large geographically. One would expect transports from the northern part of Columbia (previously discussed based on census tract data), are closer to TSHH. EMS transport data, like hospital utilization data, is not available at the census tract level. Accordingly, the below exhibit provides the data for the entire zip code.

**Exhibit 26**

| Columbia Zip Code 38401 EMS Transports | | | |
|---|---|---|---|
| **EMS Service** | **CY 2021** | **CY 2022** | **CY 2023** |
| **Maury County EMS** | | | |
| Ascension St Thomas Midtown | 11 | 0 | 12 |
| Ascension St Thomas West | 12 | 21 | 0 |
| Maury Regional Hospital | 5,400 | 5,592 | 6,010 |
| TriStar Spring Hill ER | 103 | 76 | 27 |
| TriStar Centennial | 14 | 16 | 18 |
| TriStar Skyline | 4 | 0 | 0 |
| Vanderbilt University Medical Center | 115 | 110 | 112 |
| Monroe Carell Children's Hospital | 31 | 40 | 56 |
| Williamson Medical Center | 225 | 229 | 262 |
| Total | 5,915 | 6,084 | 6,497 |
| **Vanderbilt LifeFlight** | | | |
| Ascension St Thomas West | 0 | 1 | 0 |
| Vanderbilt University Medical Center | 38 | 44 | 36 |
| Total | 38 | 45 | 36 |
| | | | |
| All Other | 0 | 16 | 0 |
| | | | |
| Total | 5,953 | 6,145 | 6,533 |

*Source: biospatial proprietary database, March 2024.*
*biospatial estimates that the data collected within Maury County represents approximately 92 percent of total transports during this three-year period.*

Given the geography of 38401, population growth in northern Columbia and current travel patterns, one would expect a portion of the above EMS transports being redirected to TriStar Spring Hill ER to provide the emergency patient with access to the closest hospital with the available services the patient requires.

With respect to 37179 (Thompson's Station) transports would also be closer to TSHH as demonstrated by the Travel Time Study. Accordingly, one would expect a portion of the transports presented in the next exhibit would also be re-directed to TSHH once it is a full-service hospital.

**Exhibit 27**

| Thompson's Station Zip Code 37179 EMS Transports | | | |
|---|---|---|---|
| **EMS Service** | **CY 2021** | **CY 2022** | **CY 2023** |
| **Williamson County EMS** | | | |
| Maury Regional Hospital | 11 | 14 | 11 |
| TriStar Spring Hill ER | 24 | 34 | 34 |
| TriStar Centennial | 6 | 3 | 10 |
| Vanderbilt University Medical Center | 38 | 36 | 40 |
| TriStar Southern Hills | 0 | 0 | 2 |
| TriStar Summit | 0 | 0 | 1 |
| Monroe Carell Children's Hospital | 36 | 44 | 65 |
| Williamson Medical Center | 263 | 281 | 357 |
| Total | 378 | 412 | 520 |

*Source: biospatial proprietary database, March 2024*
*Note: biospatial estimates that the above data collected within Williamson County represents approximately 69 percent of total transports during this three year period.*

Collectively, this data demonstrates there is a substantial time and economic burden on local EMS services to transport thousands of patients annually out of the proposed Spring Hill Service Area. TSHH will enable a measurable portion of these residents to be diagnosed and treated where they reside which is a distinct consumer advantage. It will also result in reduced out-migration and geographic access improvement for patients and families.

*Transports from TriStar Spring Hill ER*

Prior to 2021, a greater number of clinically appropriate patients with conditions appropriate for TriStar Spring Hill ER were transported to TriStar Spring Hill ER. However, when the SHEMS vendor was changed from AMR to WMC, many other patients were also diverted in the field by SHEMS. Transporting patients out of the area when they could be appropriately treated locally impairs access for this patient population who were diverted, and their families.

Historical analysis of transferred patients both pre and post change in EMS vendor delineates this situation. In the three years prior to change in vendor from AMR to WMC, the percentage of ER visits at TriStar Spring Hill ER averaged 11.4 percent and were at its peak of 12.5 percent in 2020. Since the change in vendor, the transfer rate has decreased to between 7 and 8 percent. Exhibit 28 identifies TriStar Spring Hill ER visits by disposition (discharge or transfer) and the transfer rate for the past six years.

**Exhibit 28**

| Factor | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | Change, 2018 to 2023 |
|---|---|---|---|---|---|---|---|
| Discharged Patients | 13,364 | 13,841 | 11,047 | 13,333 | 14,729 | 14,782 | 10.6% |
| Transferred Patients | 1,703 | 1,643 | 1,581 | 1,151 | 1,204 | 1,118 | -34.4% |
| Total Patients | 15,067 | 15,484 | 12,628 | 14,484 | 15,933 | 15,900 | 5.5% |
| Percent Transferred/Admitted | 11.3% | 10.6% | 12.5% | 7.9% | 7.6% | 7.0% | |
| *Source: Internal records* | | | | | | | |

Patients transferred decreased 34 percent between 2018 and 2023, while at the same time discharged patients increased nearly 11 percent. This is confirmed by the acuity of the patients at TriStar Spring Hill ER during this same time frame which shows a decrease in acuity. The decrease in transfer rate suggests there are increasing patient transports out of the area posing potential patient, family and EMS hardships relative to access and travel times.

Had the prior experience and EMS transport patterns not been altered with the new SHEMS vendor, an estimated 12.5 percent of ER visits would require transfer for more comprehensive or specialized care. This would have increased overall ER visits at TriStar Spring Hill ER during the past three years. To estimate the number of bypassed ER patients based on this change in transport patterns, a 12.5 percent transfer rate was applied to total ER visits in 2021 through 2023. The computation is presented in the below table, estimating between 662 and 873 bypassed visits during the past three years.

**Exhibit 29**

| | CY 2020 | CY 2021 | CY 2022 | CY 2023 |
|---|---|---|---|---|
| Total Patients | 12,628 | 14,484 | 15,933 | 15,900 |
| Bypassed Patients Since 2020: | | | | |
| At 2020 Rate | 1,581 | 1,813 | 1,995 | 1,991 |
| Less Actual | 1,581 | 1,151 | 1,204 | 1,118 |
| *Bypass Estimate* | *0* | *662* | *791* | *873* |

Had these patients, who are estimated to have bypassed TriStar Spring Hill ER, been delivered by EMS to that ER, the ER would have been responsible for any subsequent transfer of the patient. This would have left the SHEMS ambulance in service in Spring Hill for its next emergency call. From a physician who currently practices at the TSHH campus:

> *TriStar Health has been a part of the Spring Hill community for over a decade, providing patients with quality emergency care in the freestanding ER. In that time, the population of Spring Hill grew steadily as people from all across the country settled down to start families. The rapid growth that the community has experienced has outpaced the growth of healthcare services. A hospital in Spring Hill would allow residents of the community to be cared for without having to travel far from home. The proposed hospital will address many of the gaps in care that Spring Hill faces. Services for expecting mothers are practically non-existent in Spring Hill, and the birthing suites and NICU that will be available will give mothers the care that they need. I serve many patients from Spring Hill, and I welcome the opportunity to care for them in their own community.*
>
> *Another important benefit of a hospital in Spring Hill is continuity of care. Patients at the ER who are transferred to hospitals in Franklin, Columbia, and Nashville will be able to*

*stay within the same system and in the same city. This makes it easier for their doctors to see them and it makes it easier for their loved ones to visit them. The peace of mind that patients will get from this cannot be understated.*

*Dr. Michael Numnum, MD, GYN Oncologist*

**Most TriStar Spring Hill ER Transfers Will Now be Treated at TSHH**

Most transfers from TriStar Spring Hill ER could be treated at TSHH if it were a full-service hospital. Patient transfers were analyzed based on the receiving service line and hospital. This analysis concluded that during the past five years, an average of 87 percent of patient transfers for inpatient, observation or specialized care could remain at TSHH. This is significant retention, reduction in out-migration, and avoidance of patient and family hardship due to what is ultimately unnecessary transfers out of the area.

By receiving hospital, more than 5,100 of the nearly 6,700 transfers during the past five years were to TriStar Health hospitals. This equates to 77 percent of transfers to TriStar Health facilities, with the majority of those being to TriStar Centennial. This information is presented in Exhibit 30 below.

**Exhibit 30**

**Transfers from TriStar Spring Hill ER by Receiving Facility**

| Hospital | CY 2019 | CY 2020 | CY 2021 | CY 2022 | CY 2023 | 5-Year Total | 5-Year Distribution |
|---|---|---|---|---|---|---|---|
| TriStar - Centennial Medical Center | 1,182 | 1,158 | 763 | 765 | 800 | 4,668 | 69.7% |
| TriStar - All Other | 82 | 113 | 128 | 78 | 71 | 472 | 7.0% |
| Maury Regional Hospital | 86 | 91 | 75 | 141 | 58 | 451 | 6.7% |
| Williamson Medical Center | 126 | 82 | 78 | 81 | 97 | 464 | 6.9% |
| Vanderbilt Univ Medical Center | 82 | 76 | 57 | 73 | 59 | 347 | 5.2% |
| Ascension Saint Thomas Hospital West | 0 | 0 | 0 | 3 | 9 | 12 | 0.2% |
| Ascension Saint Thomas Hospital Midtown | 0 | 0 | 0 | 1 | 8 | 9 | 0.1% |
| All Other | 85 | 61 | 50 | 62 | 16 | 274 | 4.1% |
| Total | 1,643 | 1,581 | 1,151 | 1,204 | 1,118 | 6,697 | 100.0% |
| *Percent TriStar Health* | *76.9%* | *80.4%* | *77.4%* | *70.0%* | *77.9%* | *76.8%* | *76.8%* |
| *Source: Internal records* | | | | | | | |

Building the TSHH on the same site as the TriStar Spring Hill ER will result in most of these transfers being rendered obsolete based on the planned services. Nearly 9 in 10 of these patients are non-tertiary patients who could be treated at TSHH once implemented.

*Since the ER opened in 2013, I've been one of the physician providers here and been lucky to work with the great staff, great nurses, great radiology group and it, it's been a real honor. But one of the biggest questions that I get when I'm treating patients is when are we gonna open, build a hospital here in Spring Hill.*

*Just one little story to tell, I was at one of the local restaurants here just last week and I'd went in after I worked a night with my scrubs on and struck up a conversation with an 85-year-old gentleman who had moved over here to the Del Webb community. And he had moved here to be closer to his children and grandchildren. And he told me about an unfortunate event with his wife who had a health issue who came into the ER and, and had to be treated, treated. He was very complimentary of our care and was complimentary*

*about our facilities. But he closed our conversation, the statement he closed our conversation with was we need a hospital in Spring Hill.*

*Scott Jobe, MD, Emergency Physician, TriStar Spring Hill ER*

*Patients that live in rural areas of Tennessee have seen a dramatic decrease in access to quality healthcare services over the last several years. Having a hospital in Spring Hill will provide local care for the residents and also access to more complex care if needed. That is why I support TriStar in their application to build a hospital in Spring Hill.*

*Matthew Beuter, MD*
*Chief Medical Officer*
*Physician Services Group, TriStar Division*

Not only will there be a considerable reduction in EMS scene transports out of the area but also the majority of the above transfers will also be avoided with the licensure of TSHH. Accordingly, the reductions in transfers and direct transports means that residents of Spring Hill can avoid transfers outside of the area where they live. This includes people like Spring Hill residents, Leanne Smith and Katie Chilton.

Leanne Smith writes:

*About 5 years ago my 70+ year old husband had a heart attack. Thank God for the ER. He was transported to Centennial. Therefore I (also 70+) had to drive to Centennial every day. How much easier for senior citizens to have a hospital within a few minutes.*

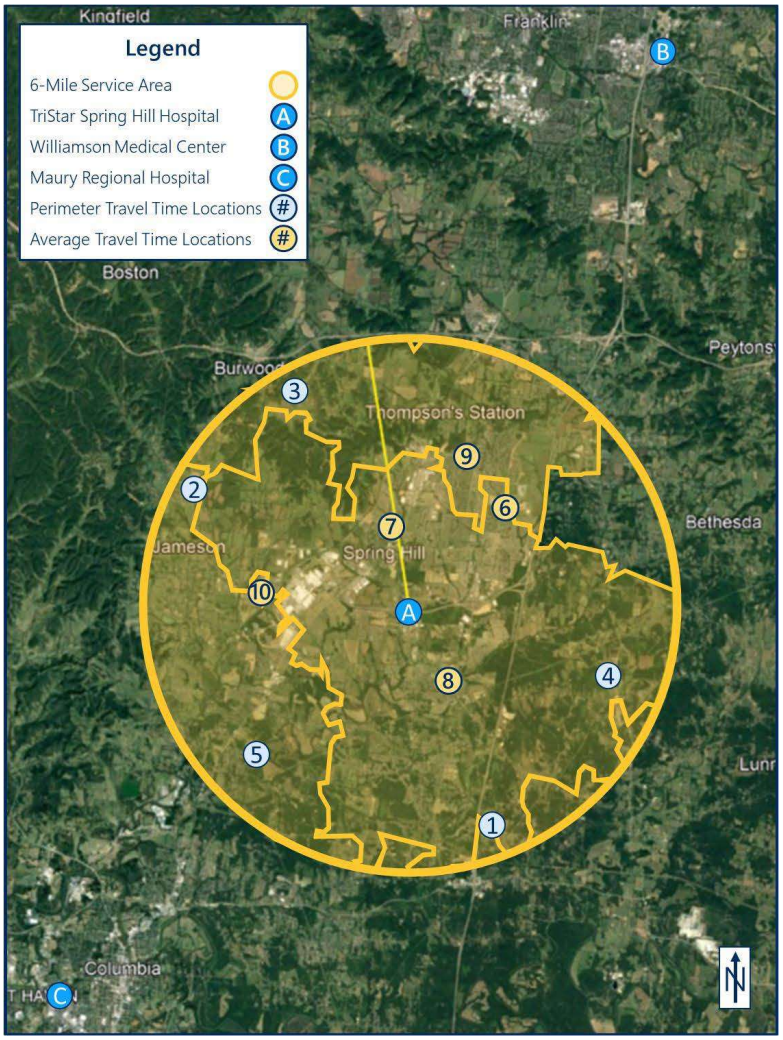
Katie Chilton writes:

*In 2016 I experienced a CVA while I was an employee of Tristar at that time and the ER that is currently there was wonderful in treating me. I needed a higher level of care ASAP and that required transport. Time is everything during a stroke. Thanks to the quick action of Dr. Jobe and staff, I am still a fully functioning mother, wife, and nurse with only mild post event side effects. My life was saved and my dignity intact, but I shudder to think of what if and mainly just due to my access to the level of care needed at the time. Tristar is known for quality care. The Spring Hill community needs this!*

Letters from which these quotes were excerpted are included in Attachment 4N.

**Travel Times are Indicative of Geographic Inaccessibility**

KCI Technologies, Inc., a professional traffic engineering firm, was commissioned to conduct a traffic study for a possible CON to establish a new hospital in Spring Hill (the “Study”). The Study identified ten locations dispersed throughout the Service Area, five were near a six-mile perimeter including outer reaches of Spring Hill, Thompson’s Station and northern Columbia. These five locations were intended to represent the longest travel times residents would experience reaching TSHH. The other five were selected from within Spring Hill near prominent subdivisions to represent travel times that Spring Hill residents should experience. The ten locations are shown in the following map, with those defined as outer perimeter numbered 1 through 5 and those within Spring Hill numbered 6 to 10.




By location, the Study identified the distance from each of the ten locations to TSHH, WMC, MRH and TriStar Centennial. Exhibit 31 identifies the specific location by map key from above and the mileage from that location to each hospital location.

**Exhibit 31**

| Distance to Hospital (Miles) | | | | | |
|---|---|---|---|---|---|
| **Map Key** | **Location** | **TriStar Spring Hill** | **WMC** | **MRH** | **TriStar Centennial** |
| 1 | Bear Creek Pike and Barker Road | 11.2 | 20.4 | 11.5 | 39.4 |
| 2 | Carters Creek Pike and Les Robinson Road | 8.1 | 18.5 | 14.1 | 37.5 |
| 3 | Thompson's Station Road Westand Cayce Springs Road | 10.2 | 17.4 | 19.9 | 36.4 |
| 4 | Franklin Pike and Flat Creek Road | 8.6 | 16.5 | 19.6 | 35.5 |
| 5 | Nashville Highway and Honey Farm Way | 6.5 | 21.6 | 8.1 | 40.6 |
| 6 | Buckner Lane and Wilkerson Pike | 4.7 | 13.4 | 17.0 | 32.6 |
| 7 | Miles Johnson Parkway and Columbia Pike | 2.1 | 14.9 | 14.2 | 34.0 |
| 8 | Golf View Way and Kedron Road 3.3 17.3 15.0 36.4 | 3.3 | 17.3 | 15.0 | 36.4 |
| 9 | New Port Royal Road and Buckner Road | 4.8 | 13.8 | 16.8 | 32.9 |
| 10 | Harvest Point Boulevard and Cleburne Road | 4.9 | 21.6 | 12.3 | 40.3 |

*Source: KCI Technologies, Inc. Travel Time Study*

The Study measured travel times from these ten locations to TSHH, WMC, MRH and TriStar Centennial. The times of day included were morning (AM), midday and late afternoon (PM) peak hours. Both field travel times and Google maps data were gathered with the field travel times used to validate the Google maps travel times. The Study found that in the morning, the average time saved to reach TSHH from the perimeter locations (1 through 5) compared to WMC and MRH was 11 to 14 minutes; 48 minutes are saved reaching TriStar Centennial. With respect to the Spring Hill locations, the average time saved to reach TSHH is 20 minutes. Reaching TSHH took less than 10 minutes compared to an average of 30 minutes to reach either WMC or MRH. This demonstrates measurable access improvement for residents of the Service Area. The time to TriStar Centennial was nearly an hour longer. These times are shown in Exhibit 32.

**Exhibit 32**

| AM Travel Times from Location to Hospitals (Minutes) | | | | |
|---|---|---|---|---|
| Location | TriStar Spring Hill | WMC | MRH | TriStar Centennial |
| 1 | 14.0 | 29.5 | 22.0 | 65.0 |
| 2 | 18.0 | 26.0 | 24.0 | 60.0 |
| 3 | 18.0 | 24.0 | 34.0 | 57.5 |
| 4 | 14.0 | 28.5 | 33.0 | 60.0 |
| 5 | 10.0 | 33.0 | 16.0 | 67.5 |
| AVERAGE | 14.8 | 28.2 | 25.8 | 62.0 |
| | | | | |
| 6 | 10.5 | 27.5 | 33.0 | 65.0 |
| 7 | 5.5 | 31.0 | 27.5 | 70.0 |
| 8 | 7.5 | 32.0 | 29.5 | 70.0 |
| 9 | 13.0 | 27.5 | 35.5 | 65.0 |
| 10 | 12.0 | 33.0 | 24.0 | 72.5 |
| AVERAGE | 9.7 | 30.2 | 29.9 | 68.5 |

*Source: KCI Technologies, Inc. Travel Time Study*

Like the morning travel analysis, the Study found that in the late afternoon, access to hospital services was also improved with TSHH. At this time, the average time saved to reach TSHH from the perimeter locations (1 through 5) compared to WMC and MRH was 10 to 15 minutes; 49 minutes are saved reaching TriStar Centennial. With respect to the Spring Hill locations, the average time saved to reach TSHH compared to WMC and MRH was 14 to 25 minutes. Reaching TSHH took less than 11 minutes compared to an average of 25 to 36 minutes to reach WMC and MRH, respectively. The time to TriStar Centennial was 44 minutes longer. These times are shown in Exhibit 33.

**Exhibit 33**

| PM Travel Times from Locations to Hospitals (Minutes) | | | | |
|---|---|---|---|---|
| Location | TriStar Spring Hill | WMC | MRH | TriStar Centennial |
| 1 | 14.0 | 26.0 | 26.5 | 55.0. |
| 2 | 15.0 | 24.0 | 29.5 | 55.0 |
| 3 | 19.0 | 23.0 | 40.0 | 55.0 |
| 4 | 20.0 | 24.0 | 35.5 | 55.0 |
| 5 | 11.5 | 29.5 | 21.0 | 60.0 |
| AVERAGE | 15.9 | 25.3 | 30.5 | 56.3 |
| | | | | |
| 6 | 12.5 | 22.0 | 41.5 | 57.5 |
| 7 | 6.5 | 27.5 | 37.0 | 60.0 |
| 8 | 7.0 | 24.0 | 32.0 | 57.5 |
| 9 | 17.0 | 20.0 | 44.0 | 45.0 |
| 10 | 12.0 | 30.5 | 27.5 | 55.0 |
| AVERAGE | 11.0 | 24.8 | 36.4 | 55.0 |

*Source: KCI Technologies, Inc. Travel Time Study*

Overall, the Study confirms that access for residents of Spring Hill will be greatly improved with the availability of TSHH. Consumer sentiments in letters of support show the excessive time to reach today's available alternatives and also confirm the need for a Spring Hill hospital to improve access. For example,

*Tammy Colletti, a Spring Hill resident writes:*

> *My son has epilepsy and experiences grand mal seizures that come in clusters. Unfortunately, we are unable to get the seizures to stop with home rescue meds prescribed by our doctor. Our son always needs to visit the ER to receive IV meds to stop the seizures from coming. This happened once again in January of 2024. The ambulance drivers were wonderful to us and did the best job they could to get our son as quickly as possible to the hospital in Franklin, but traffic on 65 caused our commute to be almost an hour. Thankfully, God protected our son, and we made it in time to get him the meds he desperately needed. I can't help but think that an hour commute might be too long on a different day.*

Janet Hart, another resident of Spring Hill, writes:

> *The length of time to drive to either hospital is a concern due to all the traffic and congestion, even though we live halfway between Williamson Medical and Maury Regional Hospitals. The traffic in years to come will only get worse….We seldom drive to either Columbia or Franklin because it is no longer a 15-minute drive. It is a minimum of 30 minutes on a good day, and in several cases, it can be 45 minutes to an hour or more; especially if it is raining or there is an accident. We need a local hospital to avoid the stress of the drive to our current hospital choices.... If one my family members were to be hospitalized for several days, just the thought of a daily drive to Maury Regional or Williamson for visitation provokes stress.*

Kathleen Crump, a Spring Hill Resident writes:

> *I have lupus and many times I have just sat at home and prayed that I was going to feel better because I'm a widow and I'm alone and I'm just too frightened to drive 20 or 30 minutes to ER.*

Letters from which these quotes were excerpted are included in Attachment 4N.

**Maury County Does Not Have Enough Acute Care Hospital Beds**

As noted, MRH is the only hospital within Maury County, the county in which TSHH will be located. MRH is licensed for 255 beds and reports in its Joint Annual Report that it has 208 staffed beds. However, on its website, MRH shows that it has only 172 staffed beds.

MRH publishes its floor plans and identifies patient rooms by program, which appear to be staffed beds; the remainder of the licensed beds do not appear to be available. These floor plans are included in Attachment 1N, Acute. MRH is not unlike other hospitals in Tennessee who operate patient rooms licensed for two beds as private rooms thereby effectively reducing its bed capacity based on its operations.

Review of the floor plans indicates that rather than having 60 step-down beds on its second floor, it only has 24 beds on its second floor. This reduces the number of staffed beds from 208 to 172 staffed beds. This delta in staffed beds is presented in the following table.

**Exhibit 34**

| Staffed Beds by Type | JARS | Floor Plans | Floor (Location) |
|---|---|---|---|
| Intensive Care | 26 | 26 | 5 |
| Stepdown | 60 | 24 | 2 |
| NICU | 8 | 9 | 4 |
| Orthopedic | 21 | 21 | 6 |
| Medical (*) | 52 | 52 | 3 |
| Surgical | 16 | 16 | 6 |
| Obstetrics / OBGYN | 25 | 24 | 4 |
| Pediatric | 0 | 0 | -- |
| Total | 208 | 172 | |
| *(*) Floor plans indicates 55 rooms; per JARs, 52 beds. Change could be result of some rooms used for ancillary or office spaces and not patient beds.* | | | |

Utilizing actual 2022 MRH patient days and including observation days as reported in its JARs, the MRH 2022 staffed occupancy rate if it operates 208 staffed beds is 76 percent. When considering the staffed beds identified on its floor plans showing only 172 staffed beds, MRH's occupancy increases to 92 percent. These computations are shown in the following table.

**Exhibit 35**

| | | | | Patient + Observation Days | | | Staffed Occupancy | | |
|---|---|---|---|---|---|---|---|---|---|
| **Hospital** | | **Staffed Beds** | **Bed Days** | **2020** | **2021** | **2022** | **2020** | **2021** | **2022** |
| Maury Regional Hospital | Maury | 208 | 75,920 | 52,005 | 56,782 | 57,610 | 68% | 75% | 76% |
| **Staffed Beds per Website Floor Plans** | | | | **Patient + Observation Days** | | | **Staffed Occupancy** | | |
| Maury Regional Hospital | Maury | 172 | 62,780 | 52,005 | 56,782 | 57,610 | 83% | 90% | 92% |
| *Source: Joint Annual Reports for Hospitals and Maury Regional website* | | | | | | | | | |

Taking into account the above staffed beds, and forecasted utilization based on population changes, there is a computed need for additional beds in Maury County. Utilizing the Tennessee Department of Health most recent published acute care bed need by county and its square root

formula to estimate the need for beds (SQRT*2.33, the Poisson formula), and adding in observation patient days as observation patients occupy the staffed beds, results in a bed need of 36 beds in CY 2028, the second year of operation of the proposed hospital. This computation is reflected in the first table on the following page (Exhibit 37). The inpatient days are derived from the Schedule G, Patient Origin as used in TDOH's presentation. This excludes patient days for persons residing outside the state. The total patient days increase to 50,731 on Schedule G, Payor and Age reports. Factoring in total patient days, including in-migration, increases the bed need from 36 to 39 beds as shown in the second table.

While the first two tables compute a bed need based on the square root formula, the alternate tables use a 75 percent factor against total patient days including observation days. If the 75 percent occupancy factor is substituted in place of the current HFC acute bed need formula in the first two tables, the computed need is 53 to 57 beds as presented the third and fourth tables on the following page. The deviation is based on patient days from the Patient Origin vs Payor charts in MRH's 2022 JAR.

All of these computations when factoring for observation days and actual staffed beds demonstrate actual need for additional beds in Maury County.

In addition, there are numerous compelling health planning factors described throughout this needs assessment that warrant approval of this CON Application. These include no other hospital in the community (geographic isolation), population dynamics, travel time to access hospital facilities (poor access), inadequate programmatic access (travel time to obstetrics programs), state of the art obstetrics program with 24/7 OB hospitalists, LDRPs and other desired features, level of out-migration for med/surg, obstetrics, cardiac catheterization services and MRI procedures, transfer and transport time to out of area facilities, volume of EMS transports from Spring Hill to other cities, and consumer advantage including providing hospital services closer to where patients live.

With respect to cardiac catheterization services, there is a computed need for additional cardiac catheterization laboratories in Maury County. The computed need is demonstrated by the weighting formula incorporated within the criteria and standards for these services. Exhibit 36 provides the computation for Maury County and its only hospital, MRH.

**Exhibit 36**

| Service Area Hospital | Cath Labs | Diagnostic Cardiac Caths | Diagnostic Peripheral Vascular Caths | Therapeutic Cardiac Caths | Therapeutic Vascular Caths | Diagnostic EP's | Therapeutic EP's | Thrombolitic Therapeutic | Total / Weighted Cases | Case Capacity |
|---|---|---|---|---|---|---|---|---|---|---|
| Maury Regional Hospital | 2 | 1,215 | 108 | 246 | 186 | 133 | 159 | 175 | 2,222 | -- |
| Weighting | | 1 | 1.5 | 2 | 3 | 2 | 4 | 3 | -- | -- |
| MRH Weighted Totals | 2 | 1,215 | 162 | 492 | 558 | 266 | 636 | 525 | 3,854 | 96.4% |

*Source: Joint Annual Report, 2022 and HFC weighting.*

## Exhibit 37

### Forecasted 2028 Bed Need Applying the Existing HFC Bed Need Formula, Patient Origin Patient Days

| COUNTY | 2022 | | CURRENT | SERVICE AREA POPULATION | | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | DAYS | ADC | NEED | 2022 | 2024 | 2028 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury IP Days | 49,667 | 136 | 163 | 102,878 | 106,039 | 112,011 | 148 | 177 | 255 | 172 | -78 | 5 |
| Add observation | 6,879 | 19 | 29 | 102,878 | 106,039 | 112,011 | 21 | 31 | 0 | 0 | 31 | 31 |
| Total Days | 56,546 | 155 | 192 | 102,878 | 106,039 | 112,011 | 169 | 208 | 255 | 172 | -47 | 36 |
| *Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Population Corrected from TDOH file.* | | | | | | | | | | | | |
| *Hospital Data from Final JAR-Hospitals Schedules F and G, Patient Origin.* | | | | | | | | | | | | *9/23/2023* |

### Forecasted 2028 Bed Need Applying the Existing HFC Bed Need Formula, Payor Patient Days

| COUNTY | 2022 | | CURRENT | SERVICE AREA POPULATION | | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | DAYS | ADC | NEED | 2022 | 2024 | 2028 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury IP Days | 50,731 | 139 | 166 | 102,878 | 106,039 | 112,011 | 151 | 180 | 255 | 172 | -75 | 8 |
| Add observation | 6,879 | 19 | 29 | 102,878 | 106,039 | 112,011 | 21 | 31 | 0 | 0 | 31 | 31 |
| Total Days | 57,610 | 158 | 195 | 102,878 | 106,039 | 112,011 | 172 | 211 | 255 | 172 | -44 | 39 |
| *Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Population Corrected from TDOH file.* | | | | | | | | | | | | |
| *Hospital Data from Final JAR-Hospitals Schedules F and G, Payor.* | | | | | | | | | | | | *9/23/2023* |

### Forecasted 2028 Bed Need Applying the Proposed Acute Care Occupancy Standards (75%), Patient Origin Patient Days

| COUNTY | 2022 | | CURRENT | SERVICE AREA POPULATION | | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | DAYS | ADC | NEED | 2022 | 2024 | 2028 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury IP Days | 49,667 | 136 | 181 | 102,878 | 106,039 | 112,011 | 148 | 198 | 255 | 172 | -57 | 26 |
| Add observation | 6,879 | 19 | 25 | 102,878 | 106,039 | 112,011 | 21 | 27 | 0 | 0 | 27 | 27 |
| Total Days | 56,546 | 155 | 207 | 102,878 | 106,039 | 112,011 | 169 | 225 | 255 | 172 | -30 | 53 |
| *Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Population Corrected from TDOH file.* | | | | | | | | | | | | |
| *Hospital Data from Final JAR-Hospitals Schedules F and G, Patient Origin.* | | | | | | | | | | | | *9/23/2023* |

### Forecasted 2028 Bed Need Applying the Proposed Acute Care Occupancy Standards (75%) & Patient Days from Schedule G, Payor

| COUNTY | 2022 | | CURRENT | SERVICE AREA POPULATION | | | PROJECTED 2028 | | 2022 ACTUAL BEDS | | SHORTAGE/SURPLUS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | DAYS | ADC | NEED | 2022 | 2024 | 2028 | ADC-2028 | NEED 2028 | LICENSED | STAFFED | LICENSED | STAFFED |
| Maury IP Days | 50,731 | 139 | 185 | 102,878 | 106,039 | 112,011 | 151 | 202 | 255 | 172 | -53 | 30 |
| Add observation | 6,879 | 19 | 25 | 102,878 | 106,039 | 112,011 | 21 | 27 | 0 | 0 | 27 | 27 |
| Total Days | 57,610 | 158 | 210 | 102,878 | 106,039 | 112,011 | 172 | 229 | 255 | 172 | -26 | 57 |
| *Source: Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics. Population Corrected from TDOH file.* | | | | | | | | | | | | |
| *Hospital Data from Final JAR-Hospitals Schedules F and G, Payor.* | | | | | | | | | | | | *9/23/2023* |

MRH operates at greater than 137 percent of optimal utilization, in its cardiac catheterization laboratories as reflected above. This confirms the need for additional cardiac catheterization services in Maury County given its utilization exceeds 70 percent capacity. Given the time and distance for the Spring Hill community to access such services, the additional laboratories should be in Spring Hill to most effectively reduce travel time and out-migration and improve access for this community.[44]

With respect to Level II NICU beds, based on Maury County live births, there is a computed need for 4 additional NICU beds in Maury County. There is also a need for 17 additional NICU beds in Williamson County.

Regarding MRI utilization, there is 46 percent out-migration from Maury County. Its utilization was 74 percent in 2020, 81 percent in 2021 and 92 percent in 2022. With respect to Williamson County, its out-migration is even greater at 61 percent; its utilization has been greater than 80 percent for the last three years. Utilization and out-migration confirm the need for the TSHH proposed MRI.

[44] Any additional cardiac catheterization laboratories added to MRH might be effective in reducing its 96 percent capacity but would not improve access for Spring Hill residents who only minimally utilize these services at MRH.

Attachment 4N

Letters of Support

Physicians

Christian N. Anderson, M.D.
Christopher P. Ashley, M.D.
Matthew O. Barrett, M.D.
W. Cooper Beazley, M.D.
Michael C. Bowman, D.O.
Alexander M. Brown, M.D.
S. R. Brown, M.D.
Daniel S. Burrus, M.D.
Lucas J. Burton, M.D.
Daniel J. Burval, M.D.
J.W. Thomas Byrd, M.D.
William E. Carpenter, M.D.
Peter M. Casey, M.D.
Matthew J. Cavallero, M.D.
Robert E. Clendenin III, M.D.
Philip G. Coogan, M.D.
W. Chase Corn, M.D.
Paul D. Crook, M.D.
William H. DeVries, M.D.
Keith C. Douglas, M.D.
C. Robinson Dyer, M.D.
W. Blake Garside, Jr., M.D.
Martha P. George, M.D.
R. Edward Glenn, Jr., M.D.
Robert C. Greenberg, M.D.
Paul W. Grutter, M.D.
Jeffrey L. Herring, M.D.
Michael R. Jordan, M.D.
Kyle S. Joyner, M.D.
Philip A. G. Karpos, M.D.
Brian E. Koch, M.D.
Kurtis L. Kowalski, M.D.
William B. Kurtz II, M.D.
Justin W. Langan, M.D.
Bryan W. Lapinski, M.D.
Jeffrey P. Lawrence, M.D.
Robert W. Lowe III, M.D.
Edward S. Mackey, M.D.
R. Trigg McClellan, M.D.
J. Bartley McGehee III, M.D.
Russell C. McKissick, M.D.
Scott M. Miller, M.D.
Damon H. Petty, M.D.
S. Matthew Rose, M.D.
Lucas K. Routh, M.D.
James H. Rubright, M.D.
James L. Rungee, M.D.
William A. Shell, Jr., M.D.
Nicholas A. Shepard, M.D.
Juris Shibayama, M.D.
Jane M. Siegel, M.D.
Christopher J. Siodlarz, D.O.
Stuart E. Smith, M.D.
Ryan D. Snowden, M.D.
S. Tyler Staelin, M.D.
Timothy J. Steinagle, D.O.
Lucas G. Teske, M.D.
Robert L. Thompson, M.D.
R. David Todd, M.D.
Roderick A. Vaughan, M.D.
Justin W. West, MD
Lydia A. White, M.D.
Richard I. Williams, M.D.
James R. Yu, M.D.

# TOA

TENNESSEE ORTHOPAEDIC ALLIANCE

April 23, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Spring Hill Hospital CON Application**

Mr. Grant,

My name is Rob Simmons, and I serve as the Chief Executive Officer of Tennessee Orthopaedic Alliance (TOA), Tennessee's largest orthopaedic surgery group. I am writing to express my strong support for TriStar Health's certificate of need (CON) application to develop TriStar Spring Hill Hospital in Spring Hill, Tennessee. This project is needed to provide greater access to hospital services for Maury and Williamson Counties, and especially the city of Spring Hill which is split between both counties. I applaud TriStar Health for its foresight in planning for greater access to high-quality hospital services in the service area.

TOA intends to apply for privileges and provide services at this hospital. We are confident that TriStar Health will provide excellent care for both patients receiving care and providers offering inpatient services at this facility. We are excited to fully support this project to increase healthcare access for the greater Spring Hill community.

I fully support the proposed CON application and would appreciate your consideration and approval of TriStar Health's proposed TriStar Spring Hill Medical Center.

Sincerely,

Rob Simmons
CEO, Tennessee Orthopaedic Alliance (TOA)

THE SURGICAL CLINIC

Julia M. Boll, MD
Roger A. Bonau, MD
John A. Boskind, MD
Chris Braxton, MD
Timothy W. Bush, DPM
Tod Bushman, DPM
Mariana Chavez, MD
Mark E. Cooper, MD
Jeffery B. Dattilo, MD
Patrick T. Davis, MD
JimBob Faulk, MD
Alex Brent Fruin, MD
Andrew W. Garrett, MD
Robert F. Garza, MD
Bassam N. Helou, MD
Mark S. Hinson, MD
John B. Kendrick, MD
Billy J. Kim, MD
Allen P. Lee, MD
E. Dwayne Lett, MD
George B. Lynch, MD
Clinton A. Marlar, MD
James G. McDowell, Jr., MD
Willie Melvin III, MD
Chad M. Moss, MD
M. Caroline Nally, MD
Gregory E. Neal, MD
David Oxley, MD
William H. Polk, Jr., MD
Drew H. Reynolds, MD
Adam A. Richter, MD
Marc E. Rosen, DO
Mark W. Shelton, MD
Joshua T. Taylor MD
K. Tyson Thomas, MD
John D. Valentine, MD
J. Tyler Watson, MD
Todd Wilkens, MD
Patrick S. Wolf, MD
Mae Lee K. Yang, MD
Patrick C. Yu, MD

Administration Office

410 42ND Avenue N. | Ste. 400
Nashville, TN 37209
TEL 615.346.6200
FAX: 615-346-6201

*TSCLINIC.COM*

April 29, 2024

**Executive Director Grant**

**Tennessee Health Facilities Commission**

**RE: TriStar Spring Hill Hospital CON App.**

Mr. Grant:

My name is John Boskind, M.D. and I am the president of The Surgical Clinic. I am writing to you to strongly express my support for TriStar Health's proposed full-service hospital in Spring Hill.

The Surgical Clinic was founded in 1997 by a group of surgeons to develop patient-focused, conveniently located surgical care close to home. We are the largest private general and vascular surgery group in Middle Tennessee. We have over 40 surgeons providing surgical care in our communities. These services include a broad array of general, laparoscopic, robotic, surgical oncology, bariatrics, thyroid, breast, endovascular, plastics and podiatry procedures. Some of our members intend to apply for privileges and provide services at this hospital. I am confident that residents of Spring Hill will benefit from access to general surgery within their own community.

We currently staff general and vascular surgical services at Maury Regional Medical Center. We intend to continue and expand our service to Columbia and this excellent institution. It has been our general experience that most of our surgical patients from the Spring Hill community are cared for by our Nashville based offices and surgeons. We see fewer Spring Hill patients at our Columbia location. We believe that those Spring Hill patients would likely stay in Spring Hill if a hospital was available in that community.

This proposal aligns with The Surgical Clinic's effort to give patients access to surgical procedures close to home. Our surgeons look forward to providing services at this hospital when it is built. Please grant TriStar Health the certificate of need to bring this facility to Spring Hill. Your support is crucial to advancing the healthcare access for residents of Spring Hill.

Sincerely,

John Boskind, MD, FACS
The Surgical Clinic

Centennial Heart

April 29, 2024

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

**Re: CON Application for a full-service hospital in Spring Hill by TriStar Health**

Mr. Grant:

My name is Tom McRae, and I am an advanced heart failure specialist with Centennial Heart. I am affiliated with TriStar Centennial Medical Center and am writing to express my strong support for TriStar Health's certificate of need application to develop a full-service hospital in Spring Hill, Tennessee. This project is needed to provide access to hospital-based care and services to Spring Hill and the surrounding region.

The Centennial Heart Cardiovascular Consultants treat arrhythmia, heart attack, heart failure, heart valve disorders, high blood pressure and vascular disorders. With more than 30,000 patients and over 30 clinic locations across Middle Tennessee, Chattanooga, and Southern Kentucky, we are committed to cardiac excellence and improving quality of life. At Centennial Heart, our team of experienced cardiologists are leaders in cardiac care and offer the latest advancements in cardiology and electrophysiology.

On behalf of Centennial Heart, I offer my full support for TriStar Spring Hill Hospital. We plan to design the most modern and advanced cardiac catheterization lab at this facility and help to staff it with our Centennial Heart physicians. This facility will certainly be high-quality and will benefit residents of the Spring Hill area by providing unprecedented access to care right in their own community.

I respectfully ask that you grant TriStar Health the required Certificate of Need to build TriStar Spring Hill Hospital.

Thank you,

Thomas McRae III MD

Dr. Thomas McRae III, MD

Centennial Heart Cardiovascular Consultants
2400 Patterson Street, Suite 502
Nashville, TN 37203

Diana Health

April 23, 2024

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

***TriStar Spring Hill Hospital CON Application***

Executive Director Grant,

I am excited to write to you on behalf of Diana Health in support of TriStar Health's application to build a full-service hospital in Spring Hill.

Diana Health's mission is to set a new standard of women's health care that inspires, empowers, and supports women to live the lives they deserve. We believe that care that is personalized, connected, comprehensive, and easily accessible produces the best outcomes for women and their families.

Through our work we have seen the tremendous clinical impact that this type of programming can have on perinatal outcomes and on the experience of women and families entering parenthood.

We are excited by TriStar Health's plan to bring this type of individualized, holistic maternity and women's healthcare program care to the community of Spring Hill, including the provision of 24/7 professional coverage on L&D.

Today, women living in Spring Hill and the nearby city of Columbia have to drive 30 minutes or more to access high-quality maternity care. These communities are home to 7,800 births today and are growing at 3.88% annually. TriStar Spring Hill Hospital will help fill this access gap and provide high-quality, midwifery-led maternity care to countless women.

Thank you,

Margaret Buxton CNM, DNP
VP Clinical Operations

Christopher Sizemore DO, FACOG, ABOIM
Medical Director

Diana Health
300 StoneCrest Blvd, Suite 310
Smyrna, TN 37167

GYNECOLOGIC ONCOLOGY
OF MIDDLE TENNESSEE

April 17, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Health's Spring Hill Hospital CON Application**

Dear Mr. Grant,

My name is Mike Numnum, I specialize in gynecologic oncology, and I am writing to you today in support of TriStar Health's Certificate of Need application for a hospital in Spring Hill.

TriStar Health has been a part of the Spring Hill community for over a decade, providing patients with quality emergency care in the freestanding ER. In that time, the population of Spring Hill grew steadily as people from all across the country settled down to start families. The rapid growth that the community has experienced has outpaced the growth of healthcare services. A hospital in Spring Hill would allow residents of the community to be cared for without having to travel far from home.

The proposed hospital will address many of the gaps in care that Spring Hill faces. Services for expecting mothers are practically non-existent in Spring Hill, and the birthing suites and NICU that will be available will give mothers the care that they need. I serve many patients from Spring Hill, and I welcome the opportunity to care for them in their own community.

Another important benefit of a hospital in Spring Hill is continuity of care. Patients at the ER who are transferred to hospitals in Franklin, Columbia, and Nashville will be able to stay within the same system and in the same city. This makes it easier for their doctors to see them and it makes it easier for their loved ones to visit them. The peace of mind that patients will get from this cannot be understated.

This hospital will address the needs of Spring Hill by providing high-quality services that Spring Hill currently lacks. For this reason, I support this project and urge you to award TriStar Health the required Certificate of Need.

Thank you,

Dr. Michael Numnum
Gynecologic Oncologist
TriStar Health
330 23rd Ave Ste 600
Nashville, TN 37203

TRISTAR MEDICAL GROUP
Centennial Thoracic
Surgical Associates

April 17, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Health's Spring Hill Hospital CON Application**

Dear Mr. Grant,

My name is Tammy Baxter, I practice at TriStar Centennial Medical Center, and I am a thoracic surgeon. I urge you to support TriStar Health's application to develop the existing Spring Hill ER into a full-service hospital because it will benefit patients in the community and provide the services that Spring Hill needs as it continues to grow.

TriStar Health has extensive experience in Spring Hill, and I know that the existing ER has provided lifesaving, quality care for thousands of Spring Hill residents over the past decade. However, this community has rapidly grown, emphasizing the need for a full-service hospital as opposed to just a freestanding ED. TriStar Health first applied to build a hospital in Spring Hill in 2006, and since then, the need for a hospital has only grown. Spring Hill is the largest city in the state without a hospital. In order for patients to be cared for properly, that needs to change. When patients have to leave their communities to receive hospital care, it puts undue stress on patients and their families. By approving this hospital, you are providing them with the peace of mind that comes with accessible care.

There is a need in Spring Hill for a full-service hospital. I treat patients from Spring Hill, and I can attest to the benefit that they would see by having a hospital nearby. Please grant TriStar Health the required Certificate of Need to bring this hospital to Spring Hill.

Sincerely,

Dr. Tammy Baxter
Thoracic Surgeon – TriStar Centennial Medical Center
2400 Patterson St. Ste 215
Nashville, TN 37203

April 16, 2024

Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

**TriStar Health's Spring Hill Hospital CON Application**

Logan Grant,

Patients that live in rural areas of Tennessee have seen a dramatic decrease in access to quality healthcare services over the last several years. Having a hospital in Spring Hill will provide local care for the residents and also access to more complex care if needed. That is why I support TriStar in their application to build a hospital in Spring Hill.

The population is growing, therefore access to high-quality local healthcare should grow in parallel. Spring Hill has seen a dramatic increase in the number of people moving there. Many of these people moving to Spring Hill are families. They deserve to have healthcare for themselves and their children. That is what this hospital will provide, and it will make the community happier knowing that healthcare is nearby.

This is why I support the hospital and why it will be beneficial for Spring Hill residents, I hope to see it approved.

Thank you,

Matthew Beuter, MD
Chief Medical Officer – Physician Services Group, TriStar Division
3501 Wimbledon Rd.
Nashville, TN 37215

Excerpt from Transcription of TSHH Announcement Event
April 15, 2024

Dr. Scott Jobe, Emergency Room Physician:

*I first moved to Spring Hill in 2004 to partner with HCA to open a primary care clinic, and at that time we could see that there was a need for, an apparent need for a hospital. With the growth that's occurred over the past 20 years including the addition of nursing homes, assisted living facilities, and even the 55 and over community that need is more apparent now.*

*Since the ER opened in 2013, I've been one of the physician providers here and been lucky to work with the great staff, great nurses, great radiology group and it, it's been a real honor. But one of the biggest questions that I get when I'm treating patients is when are we gonna open, build a hospital here in Spring Hill.*

*Just one little story to tell, I was at one of the local restaurants here just last week and I'd went in after I worked a night with my scrubs on and struck up a conversation with an 85-year-old gentleman who had moved over here to the Del Webb community, and he had moved here to be closer to his children and grandchildren. And he told me about an unfortunate event with his wife who had a health issue who came into the ER and, and had to be treated, treated. He was very complimentary of our care and was complimentary about our facilities. But he closed our conversation, the statement he closed our conversation with was we need a hospital in Spring Hill.*

City of
SPRING HILL
TENNESSEE

April 17, 2024

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

**Spring Hill Hospital CON Application**

Good day Mr. Grant:

As the Mayor of Spring Hill, I fully support the full-service Spring Hill Hospital. Our city needs, wants, and deserves access to local care. The economic impact of the proposed hospital in the first five years of operation will result in nearly $870 million and more than 3,000 new jobs for Spring Hill. This is the right move at the right time for our city.

TriStar's proposal is a significant leap forward in our community's healthcare infrastructure. I am very excited about plans to expand the Spring Hill ER into a full-service hospital. Our growth demands that we evolve and adapt to meet the needs of our community members in a holistic and forward-thinking manner. This expansion is a testament to TriStar Health's ongoing investment in our health and wellness.

This investment in our city holds profound significance for Spring Hill, not merely as a milestone but as a vital necessity. For too long, our city has been without a full-service hospital and is currently the largest city in the state without its own. And that means ensuring our residents have access to what they need. The TriStar Spring Hill Hospital will ensure accessible, high-quality healthcare right here in the heart of our city. With the addition of our own hospital, Spring Hill takes a giant stride toward a brighter, healthier future for generations to come.

This hospital is about more than economic development. It's about fostering wellbeing and a sense of security for every parent, every family, and every community member, knowing that expert medical care is just moments away.

Thank you, sir, for your consideration. I respectfully ask that you help us to ensure that the future of Spring Hill shines brighter than ever before.

Sincerely,

Jim Hagaman

CITY OF SPRING HILL TENNESSEE

**OFFICE OF THE MAYOR**

199 Town Center Parkway • Spring Hill, Tennessee 37174

931-486-2252 ext 216

**www.springhilltn.org**

4/17/2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Spring Hill Hospital CON Application**

Dear Mr. Grant,

In Spring Hill, the closest hospitals are 28 min away and we are in constant growing. Just my community at Harvest point has over 500 houses mostly family with kids. We need more healthcare to go along with the growth and provide services to the city of Spring Hill.

We just had a baby and needed to go all the way to Nashville at Vanderbilt because my wife was being treated at their birthing center and the baby came 3 weeks earlier. We were there for 5 days and my mother-in-law needed it to drive there everyday for almost an hour to help. If we were able to have the baby here in Spring Hill, it would have been easier and less stressful for everyone.

The growth has made it necessary that we have our own hospital and don't have to drive and wait in other communities. That is why TriStar should be allowed to build a hospital here in Spring Hill.

Thank you,

Donald Gomez
1063 Ewell farm circle
Spring Hill, TN 37174

April 21, 2024

Logan Grant
Executive Director, Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
TriStar Spring Hill Hospital CON Application

Mr. Grant,

I have lived in Spring Hill for 23 years. The population and traffic has exploded. If there is a need for a hospital visit the traffic between SH and Columbia and/or Franklin is impossible. The ER is a blessing, but it certainly doesn't take the place of a full-service hospital.

About 5 years ago my 70+ year old husband had a heart attack. Thank God for the ER. He was transported to Centennial. Therefore I (also 70+) had to drive to Centennial every day. How much easier for senior citizens to have a hospital within a few minutes.

There are many reasons why Spring Hill needs a hospital, but the biggest is population growth. The community has exploded in terms of population. That has brought traffic and a greater need for care. This hospital should help take care of all of the new residents of Spring Hill, as well as those who have lived here for decades.

Thank you,

Leanne Smith
4515 Tom Lunn Road
Spring Hill, TN 37174

April 16, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Health's Spring Hill Hospital CON Application**

Dear Mr. Grant,

I am writing to you today in support of TriStar Spring Hill Hospital. It is now a necessity because of the growth that has occurred in Spring Hill and the community health needs.

I can personally attest to medical services being too far for Spring Hill residents. In 2016 I experienced a CVA while I was an employee of Tristar at that time and the ER that is currently there was wonderful in treating me. I needed a higher level of care ASAP and that required transport. Time is everything during a stroke. Thanks to the quick action of Dr. Jobe and staff, I am still a fully functioning mother, wife, and nurse with only mild post event side effects. My life was saved and my dignity intact, but I shudder to think of what if and mainly just due to my access to the level of care needed at the time. Tristar is known for quality care. The Spring Hill community needs this!

Spring Hill is a wonderful community with many young families and many who share experiences like mine. They deserve access to high quality care. Please approve this hospital!

Thank you,

Katie Chilton
271 Canvasback Ct.
Spring Hill, TN 37174

April 22, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Spring Hill Hospital CON Application**

Dear Mr. Grant,

Traffic conditions can make the commute to the hospitals in Franklin or Columbia too long. That is why Spring Hill needs to have its own hospital.

My son has epilepsy and experiences grand mal seizures that come in clusters. Unfortunately, we are unable to get the seizures to stop with home rescue meds prescribed by our doctor. Our son always needs to visit the ER to receive IV meds to stop the seizures from coming. This happened once again in January of 2024. The ambulance drivers were wonderful to us and did the best job they could to get our son as quickly as possible to the hospital in Franklin, but traffic on 65 caused our commute to be almost an hour. Thankfully, God protected our son, and we made it in time to get him the meds he desperately needed. I can't help but think that an hour commute might be too long on a different day. I am very much in support of a hospital in Spring Hill and believe it is desperately needed for my son and all of the great residents of our community who may require prompt medical care.

Traffic conditions prevent patients from receiving prompt care. If there were a hospital in Spring Hill, patients would be able to get the services they need in a timely manner.

Thank you for taking the time to hear our story.

Tammy Colletti
3020 Shandor Street
Spring Hill, TN 37174

**April 23, 2024**

Executive Director Logan Grant
Tennessee Health Facilities Commission
Nashville, Tennessee 37243
TriStar's Spring Hill Hospital Application

Mr. Grant,

It's time for Spring Hill to get its own hospital. The population and traffic warrant it. The proposed hospital is good for the city and provides a local more convenient option for the residents when there is a need.

Thankfully, we haven't had an emergency or immediate need but as we get older, quick accessibility will be important. The length of time to drive to either hospital is a concern due to all the traffic and congestion, even though we live halfway between Williamson Medical and Maury Regional Hospitals. The traffic in years to come will only get worse. In the event our family needs hospital care, we definitely prefer to stay local which is not an option right now. We seldom drive to either Columbia or Franklin because it is no longer a 15-minute drive. It is a minimum of 30 minutes on a good day, and in several cases, it can be 45 minutes to an hour or more; especially if it is raining or there is an accident. We need a local hospital to avoid the stress of the drive to our current hospital choices. As a matter of fact, we use the Vanderbilt Walk-in Clinic for most of our unexpected healthcare needs versus a drive to the hospital. As our Franklin and Brentwood physicians and dentists retire, we seek local Spring Hill physicians and dentists to avoid the commute. If one my family members were to be hospitalized for several days, just the thought of a daily drive to Maury Regional or Williamson for visitation provokes stress.

It is time for the city of Spring Hill to get their own hospital. As you are aware, Tennessee is experiencing a population explosion. There is certainly enough population and expected continued growth in Williamson, Maury and surrounding counties to warrant a new hospital. It would anger us even more, if the proposed hospital isn't approved; forcing us into the horrible commute for urgent care, and then having a lengthy wait to be seen because the current hospitals can't support the increased population. The future is here, and the Spring Hill community needs this hospital.

Thank you,

Janet M. Hart

Janet Hart
623 Vaughans Gap Rd
Spring Hill, TN 37174

4/17/2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Spring Hill Hospital CON Application**

Dear Mr. Grant,

Because of the population explosion in this area and the traffic it's difficult to have to drive 20 or 30 minutes each way and an emergency. I'm a senior and I'm terribly uncomfortable driving outside of the city. Yet I have several health problems that need to be addressed. I'd rather have a hospital right down the street, having to sit it out at home and hoping that I'm going to feel better.

I have lupus and many times I have just sat at home and prayed that I was going to feel better because I'm a widow and I'm alone and I'm just too frightened to drive 20 or 30 minutes to ER.

Spring Hill Hospital is in the best interest of the community given the population growth in the last 10 years. This is a no-brainer.

Thank you,

*Kathleen Crump*

Kathleen Crump
2143 Deer Valley Dr
Spring Hill, TN 37174

April 16, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Health's Spring Hill Hospital CON Application**

Dear Mr. Grant,

With our community growing so much the proposed hospital will benefit many and it will avoid having to drive downtown to see loved ones. Lots of people have parents and friends that will need to stay in the hospital. This will make it easier for them to visit and help the patient and their family.

Personally, I have had to deal with this issue. I have had numerous hospital stays at Centennial hospital and the drive alone has hindered loved ones from visiting and providing support. I would have liked to have been at a hospital nearby so that my loved ones could have had an easier time coming to see me.

This community needs this hospital. HCA is a fabulous health care system, and I am confident that they will serve Spring Hill well.

Thank you,

**Cheryl Keegan**
**2409 Adelaide Dr.**
**Thompson's Station, TN 37179**

April 16, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Health's Spring Hill Hospital CON Application**

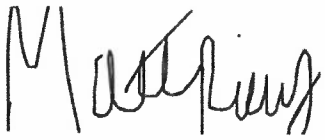
Dear Mr. Grant,

My name is Matt Rigelsky, and I am a resident of Spring Hill. I am writing to you in support of TriStar's request to build a hospital in Spring Hill. Proximity and overcrowding at other locations and long waits have made this a necessity.

Our daughter was born at 24 weeks. Once we brought her home on oxygen and other health issues, our biggest concern was the closest hospital was 20 plus minutes away. Spring Hill has over 50,000 residents, many of whom are families with similar concerns. This hospital would greatly benefit them.

This is needed. I hope that you will see that and give Spring Hill the hospital it needs and deserves.

Thank you,



Matt Rigelsky
1123 Brixworth Dr.
Spring Hill, TN 37174

April 21, 2024

Executive Director Logan Grant
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
Nashville, Tennessee 37243
*Re: TriStar Spring Hill Hospital CON Application*

Executive Director Grant,

We have 50 % MORE people than Columbia, and we have no full-sized hospital! Spring Hill deserves to have healthcare and residents shouldn't have to drive to other communities when they could get that care here.

Many residents of our community have encountered situations where they needed access to hospital care and had to leave our city to get care in Columbia, Franklin or Nashville. Thankfully, this has not happened to my family, but we would really like to know that if we needed it there was a hospital in Spring Hill.

We are the largest city south of Nashville without a full serve hospital. It's time for Spring Hill to get the care it needs.

Thank you,

Steven Yankowski
2243 Clara Mathis Rd.
Spring Hill, TN 37174

April 16, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
**Re: TriStar Health's Spring Hill Hospital CON Application**

Dear Mr. Grant,

I live in a community of 803 homes that were built for adults 55 and over who are always in need of good healthcare. We currently have to drive at least 25 minutes in either direction for a hospital. Given the traffic on the 65 northbound, it can be very critical at times. Sometimes I think of one of my friends being in the hospital and how convenient it would be for me to visit them five minutes away, and how beneficial that would be for the healing of that person that people could visit them. That is why I support TriStar bringing a hospital to Spring Hill.

A town our size without a hospital is a travesty! Spring Hill is the largest city in the state without a hospital, and we are continuing to grow. When people move here, the healthcare needs to be able to keep up with and accommodate for the growing needs of residents. If we do not do this now, we could be looking at a dire situation when Franklin, Spring Hill, and Columbia grow even more.

This hospital will be an investment in Spring Hill and a resource for residents. Please vote for its approval.

Thank you,

Kathy Beck

Kathy Beck
860 Clay Place
Spring Hill, TN 37174

Excerpt from Transcription of Media Interview
April 15, 2024

Mayor Jim Hagaman, Spring Hill:

*I would just say that Spring Hill does need a hospital. I've done a lot of research. I used to work at a hospital at Vanderbilt and Nashville General Hospital. And there's so much that goes on at a hospital and I was also a former firefighter and medic and seconds matter. So, when you're in the back of an ambulance or you're facilitating your own ride to a hospital, the fact that we have one so close in our own backyard in Spring Hill I believe strongly that it will save lives and as a person that represents quality the citizens of Spring Hill deserve this hospital. It's the right time and the right place.*

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

In the defined 3-zip code Service Area, there is 1 hospital: MRH. The 3-zip code service area straddles 2 counties and there is another hospital in the other county in which the Service Area sits: WMC. There are no hospitals in Spring Hill, a city of 58,000 persons and more than 14 miles from MRH.[45]

Travel time to MRH from the TSHH location in Spring Hill with no traffic is 26 minutes and much longer during congested times.[46] Travel time from the center of the Spring Hill zip code is between 24 and 45 minutes depending on the day and time of the day. MRH has not expanded in at least 20 years and is staffing 83 fewer beds than it is licensed to operate. This is despite opposing the first proposed Spring Hill Hospital 19 years ago.

While travel time is an important factor when addressing geographic access, patient migration patterns should also factor into this analysis. The data shows that less than 11 percent of Spring Hill residents travel from Spring Hill to seek services at MRH. This demonstrates that MRH is not geographically or programmatically available or accessible to Spring Hill residents. Additionally, given the vast size of zip code 38401 (Columbia), only 60 percent of 38401 (Columbia) residents seek inpatient services at MRH; 4 out of 10 leave the county traveling past Spring Hill to other providers. TSHH will be more accessible to this population and reduce out-migration, all of which benefit the healthcare system, community and patients.

In terms of utilization, MRH is operating at near full occupancy based on 2022 data. Accounting for actual 2022 MRH patient days including observation days as reported in its JARs equates to a 2022 staffed occupancy rate of 76 percent using what it shows on its JAR as staffed beds. The actual occupancy using the actual staffed beds is 92 percent. This is without accounting for forecasted growth in the next four years.

Furthermore, when considering the staffed beds identified on its floor plans,[47] staffed occupancy increases to 92 percent due to the 36-bed reduction. (See Exhibit 35).

In response to the instructions for this question, the below charts populate the 5N charts as provided by HFC and present historical utilization for each hospital in Maury and Williamson Counties for acute services, Level II NICU and cardiac catheterization services. While WMC is not located in Maury County or in the proposed hospital's Service Area, it is provided for informational purposes only.

[45] Measured from the zip code centroid.
[46] Random travel time taken using Bing maps at 4:35 p.m. on April 27, 2024.
[47] Discussed in response to Question 4N.

## Exhibit 38
## Acute Care Hospital Historical Utilization, 2020 through 2022

| Facility | County | 2022 Staffed Beds | Bed Days Available | Patient Days | | | Staffed Occupancy | | | % Change in Patient Days 2020-2022 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | |
| Maury Regional Hospital | Maury | 208 | 75,920 | 47,162 | 51,372 | 50,731 | 62% | 68% | 67% | 8% |
| Williamson Medical Center | Williamson | 203 | 74,095 | 32,398 | 35,205 | 38,739 | 44% | 48% | 52% | 20% |
| **TOTAL** | | 411 | 150,015 | 79,560 | 86,577 | 89,470 | 53% | 58% | 60% | 12% |
| | | | | | | | | | | |
| **Patient Days Including Observation Days in Staffed Beds** | | | | **Patient + Observation Days** | | | **Staffed Occupancy** | | | |
| Maury Regional Hospital | Maury | 208 | 75,920 | 52,005 | 56,782 | 57,610 | 68% | 75% | 76% | 11% |
| Williamson Medical Center | Williamson | 203 | 74,095 | 37,319 | 38,693 | 43,209 | 50% | 52% | 58% | 16% |
| **MRH Adjusted for Staffed Beds per Website Floor Plans** | | | | **Patient + Observation Days** | | | **Staffed Occupancy** | | | |
| Maury Regional Hospital | Maury | 172 | 62,780 | 52,005 | 56,782 | 57,610 | 83% | 90% | 92% | 11% |

*Source: Joint Annual Report for Hospitals for respective hospital and years*

## Exhibit 39
## Level II NICU Historical Utilization, 2020 through 2022

| Facility | County | 2022 Licensed Beds (Neonatal Unit) | Bed Days Available | Patient Days | | | Licensed Occupancy | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 |
| Maury Regional Hospital | Maury | 9 | 3,285 | 1,846 | 1,601 | 1,467 | 56% | 49% | 45% |
| Williamson Medical Ctr | Williamson | 8 | 2,920 | 149 | 105 | 82 | 5% | 4% | 3% |
| **Total** | | 17 | 6,205 | 1,995 | 1,706 | 1,549 | 32% | 27% | 25% |

*Source: Joint Annual Reports for Hospitals*

## Exhibit 40
## Cardiac Catheterization Lab Historical Utilization, 2020 through 2022

| Hospital | Cath Labs | Procedure | CY 2020 | | | CY 2021 | | | CY 2022 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Inpatient | Outpatient | Total | Inpatient | Outpatient | Total | Inpatient | Outpatient | Total |
| Maury Regional Hospital | 2 | Diagnostic Cath | 558 | 707 | 1,265 | 674 | 740 | 1,414 | 575 | 640 | 1,215 |
| | | Therapeutic Cath | 149 | 225 | 374 | 64 | 228 | 292 | 146 | 100 | 246 |
| | | Diagnostic EP | 49 | 85 | 134 | 0 | 102 | 102 | 46 | 87 | 133 |
| | | Therapuetic EP | 59 | 98 | 157 | 53 | 112 | 165 | 62 | 97 | 159 |
| | | Diagnostic PV | 76 | 8 | 84 | 0 | 0 | 0 | 97 | 11 | 108 |
| | | Therapeutic PV | 76 | 15 | 91 | 87 | 26 | 113 | 168 | 18 | 186 |
| | | Thrombolitic Ther | 80 | 53 | 133 | 99 | 38 | 137 | 146 | 29 | 175 |
| | | Total | 1,047 | 1,191 | 2,238 | 977 | 1,246 | 2,223 | 1,240 | 982 | 2,222 |
| | | | | | | | | | | | |
| Williamson Medical Center | 2 | Diagnostic Cath | 267 | 446 | 713 | 323 | 610 | 933 | 356 | 607 | 963 |
| | | Therapeutic Cath | 118 | 91 | 209 | 183 | 98 | 281 | 186 | 108 | 294 |
| | | Diagnostic EP | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Therapuetic EP | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Diagnostic PV | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 0 | 0 |
| | | Therapeutic PV | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Thrombolitic Ther | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Total | 386 | 537 | 923 | 507 | 708 | 1,215 | 542 | 715 | 1,257 |
| | | | | | | | | | | | |
| Total | 4 | Diagnostic Cath | 825 | 1,153 | 1,978 | 997 | 1,350 | 2,347 | 931 | 1,247 | 2,178 |
| | | Therapeutic Cath | 267 | 316 | 583 | 247 | 326 | 573 | 332 | 208 | 540 |
| | | Diagnostic EP | 49 | 85 | 134 | 0 | 102 | 102 | 46 | 87 | 133 |
| | | Therapuetic EP | 59 | 98 | 157 | 53 | 112 | 165 | 62 | 97 | 159 |
| | | Diagnostic PV | 77 | 8 | 85 | 1 | 0 | 1 | 97 | 11 | 108 |
| | | Therapeutic PV | 76 | 15 | 91 | 87 | 26 | 113 | 168 | 18 | 186 |
| | | Thrombolitic Ther | 80 | 53 | 133 | 99 | 38 | 137 | 146 | 29 | 175 |
| | | Total | 1,433 | 1,728 | 3,161 | 1,484 | 1,954 | 3,438 | 1,782 | 1,697 | 3,479 |

*Source: Joint Annual Report, Schedule D, Page 15*

The above data is not weighted but actual utilization as reported in the Joint Annual Reports. The next exhibits utilize the above historical utilization and applies the HFC cardiac catheterization weighting factors by type of procedures. In Exhibit 41, the most recent year and the 3-year average for MRH are provided.

**Exhibit 41**
**MRH Weighted Cardiac Catheterization Utilization**

| Time Period | # Cath Labs | Avg. Weighted Diagnostic Catheterizations | Diagnostic Catheterizations per Lab | Avg. Weighted Therapeutic Catheterizations | Therapeutic Catheterizations per Lab | Avg. Weighted Diagnostic and Therapeutic Catheterizations | Utilization per 2,000 Cases (Full Capacity) | Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity) |
|---|---|---|---|---|---|---|---|---|
| 2022 Year | 2 | 1,643 | 822 | 2,211 | 1,106 | 3,854 | 96.35% | 137.64% |
| 2020 - 2022 3-Year Average | 2 | 1,640 | 820 | 2,084 | 1,042 | 3,724 | 93.11% | 133.01% |

Source: Tennessee Department of Health - Office of Informatics and Analytics. https://www.tn.gov/content/tn/health/health-program-areas/statistics.html

*Note: The HDDS report generated by the Department of Health provide 2019-2021 and appeared to be missing all catheterizations as counts did not comport with the JARS for each hospital. This table utilizes most recent three years JARS data (2020-2022) and applies the weighting factors by type of procedure.*

The above exhibit is most relevant as TSHH will be located in Maury County, in Spring Hill, which has the fastest growing Service Area population and has no cardiac catheterization laboratories. TSHH will fill a community void in a county which has excess utilization.

For informational purposes, the next exhibit provides the most recent year for both MRH and WMC weighted cardiac catheterizations. WMC is underutilized, however WMC does not provide all advanced procedures. As the data previously presented indicates WMC is either being bypassed by Williamson County residents or referred out for advanced cardiac procedures, both to Davidson County cardiology programs. Despite such low utilization at WMC, the average of the two programs is nearing the 70 percent threshold in 2022. With population growth, it is likely that the two programs now exceed the 70 percent threshold combined.

**Exhibit 42**
**MRH and WMC Weighted Cardiac Catheterization Utilization, 2022**

| Hospitals | # Cath Labs | 2022 Avg. Weighted Diagnostic Catheterizations | Diagnostic Catheterizations per Lab | 2022 Avg. Weighted Therapeutic Catheterizations | Therapeutic Catheterizations per Lab | 2022 Avg. Weighted Diagnostic and Therapeutic Catheterizations | Utilization per 2,000 Cases (Full Capacity) | Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity) |
|---|---|---|---|---|---|---|---|---|
| Maury Regional Hospital | 2 | 1,643 | 821.5 | 2,211 | 1105.5 | 3,854 | 96.35% | 137.64% |
| Williamson Medical Center | 2 | 963 | 481.5 | 588 | 294 | 1,551 | 38.78% | 55.39% |
| TOTAL | 4 | 2,606 | 1,303 | 2,799 | 1,400 | 5,405 | 67.56% | 96.52% |

*Source: Tennessee Department of Health - Office of Informatics and Analytics. https://www.tn.gov/content/tn/health/health-program-areas/statistics.html*

*Note: Joint Annual Reports for the respective hospitals, 2022*

Lastly relative to cardiac catheterization services, the next exhibit provides the three year averages for both MRH and WMC for 2020 through 2022.

**Exhibit 43**
**MRH and WMC Weighted Cardiac Catheterization Utilization, 2020 – 2022 Average**

| Service Area County | # Cath Labs | 2020-2022 Avg. Weighted Diagnostic Catheterizations | Diagnostic Catheterizations per Lab | 2020-2022 Avg. Weighted Therapeutic Catheterizations | Therapeutic Catheterizations per Lab | 2020-2022 Avg. Weighted Diagnostic and Therapeutic Catheterizations | Utilization per 2,000 Cases (Full Capacity) | Utilization (per 70% of Full Capacity) - 1,400 Cases (Optimum Capacity) |
|---|---|---|---|---|---|---|---|---|
| Maury Regional Hospital | 2 | 1,640 | 820 | 2,084 | 1,042 | 3,724 | 93.11% | 133.01% |
| Williamson Medical Center | 2 | 870 | 435 | 261 | 131 | 1,132 | 28.29% | 40.42% |
| TOTAL | 4 | 2,510 | 1,255 | 2,346 | 1,173 | 4,856 | 60.70% | 86.71% |

*Source: Tennessee Department of Health - Office of Informatics and Analytics. https://www.tn.gov/content/tn/health/health-program-areas/statistics.html*

*Note: Joint Annual Reports for the respective hospitals and years*

Regarding MRI services, Exhibit 44 provides 3-year historical utilization of MRI services in Maury County. These MRIs have exceeded 80 percent utilization for each of the past two years.

**Exhibit 44**
**Maury County MRI Utilization, 2020 to 2022**

| Facility | Units | Procedures | | | Procedures per Unit | | | Utilization Rate | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 |
| Maury Regional Medical Center | 3 | 8,002 | 8,645 | 9,401 | 2,667 | 2,882 | 3,134 | 74.1% | 80.0% | 87.0% |
| Mid Tennessee Bone and Joint Clinic, PC | 1 | 2,072 | 2,572 | 2,653 | 2,072 | 2,572 | 2,653 | 57.6% | 71.4% | 73.7% |
| Spring Hill Imaging Center (Maury Regional Imaging Ctr) | 1 | 3,242 | 3,388 | 4,510 | 3,242 | 3,388 | 4,510 | 90.1% | 94.1% | 125.3% |
| Total | 5 | 13,316 | 14,605 | 16,564 | 2,663 | 2,921 | 3,313 | 74.0% | 81.1% | 92.0% |

*Source: HFC, MRI Utilization report, accessed March 2024.*

Exhibit 45 provides 3-year historical utilization of MRI services at the 6 MRI units, which expanded to 7 in 2022, in Williamson County. These MRIs have exceeded 80 percent utilization in each year.

**Exhibit 45**
**Williamson County MRI Utilization, 2020 to 2022**

| Facility | Units | Procedures | | | Procedures per Unit | | | Utilization Rate | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 | 2020 | 2021 | 2022 |
| Elite Sports Medicine & Orthopaedic Center-Franklin | 0/0/1 | 0 | 0 | 1,631 | -- | -- | 1,631 | -- | -- | 45.3% |
| Premier Radiology Cool Springs | 2 | 4,605 | 4,325 | 4,949 | 2,303 | 2,163 | 2,475 | 64.0% | 60.1% | 68.7% |
| Vanderbilt Bone and Joint | 1 | 1,423 | 1,768 | 2,044 | 1,423 | 1,768 | 2,044 | 39.5% | 49.1% | 56.8% |
| Vanderbilt Imaging Services - Cool Springs | 1 | 4,443 | 4,743 | 4,731 | 4,443 | 4,743 | 4,731 | 123.4% | 131.8% | 131.4% |
| Williamson Medical Center | 1 | 5,345 | 6,943 | 6,600 | 5,345 | 6,943 | 6,600 | 148.5% | 192.9% | 183.3% |
| Williamson Medical Center Outpatient Imaging | 1 | 2,744 | 3,432 | 3,605 | 2,744 | 3,432 | 3,605 | 76.2% | 95.3% | 100.1% |
| Total | 6/6/7 | 18,560 | 21,211 | 23,560 | 3,093 | 3,535 | 3,366 | 85.9% | 98.2% | 93.5% |

*Source: HFC, MRI Utilization report, accessed March 2024.*

A particularly vulnerable population is one with mental health issues. The existing TriStar Spring Hill ER accepts behavioral health patients given its expertise and ability to properly transfer to a behavioral health facility. TSHH's ER will continue this practice. It has been determined that incorporating a behavioral health program at TSHH is not warranted because TSHH has an affiliate, Pinewood Springs, a 60-bed joint venture behavioral health hospital locally operated by TriStar Health and MRH in Columbia. This hospital provides a broad range of inpatient and outpatient behavioral health services within a supportive and therapeutic environment. This collaboration combines MRH and the expertise of TriStar in a way that benefits the community.

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

**Historical and Forecasted Service Area Utilization**

The proposed project is for a new acute care community hospital, so it does not have historical utilization and occupancy statistics. The existing Spring Hill ER currently treats patients and will become a department of TSHH once TSHH opens. Its historical utilization is included in Exhibit 1. The Applicant's projected annual utilization for three years following completion is summarized in Exhibit 46 and detailed with assumptions throughout this section.

**Exhibit 46**

| TriStar Spring Hill Hospital<br>Forecasted Utilization Discharges and Patient Days<br>2027 through 2029 | | | |
|---|---|---|---|
| | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **Med-Surg Discharges** | | | |
| Total Med-Surg Discharges | 2,197 | 2,764 | 3,109 |
| Average Length of Stay | | 3.80 | |
| Med-Surg Patient Days | 8,350 | 10,502 | 11,813 |
| Med-Surg Average Daily Census | 22.9 | 28.7 | 32.4 |
| | | | |
| **Obstetrics Discharges** | | | |
| Total OB Discharges | 334 | 487 | 595 |
| Average Length of Stay | | 2.35 | |
| OB Patient Days | 785 | 1,144 | 1,398 |
| OB Average Daily Census | 2.1 | 3.1 | 3.8 |
| | | | |
| **Level II NICU Discharges** | | | |
| Total Level II NICU Discharges | 30 | 44 | 54 |
| Average Length of Stay | 4.00 | 6.00 | 8.00 |
| NICU Patient Days | 120 | 263 | 428 |
| NICU Average Daily Census | 0.3 | 0.7 | 1.2 |
| | | | |
| **Total Discharges** | | | |
| Total Discharges | 2,561 | 3,294 | 3,757 |
| Total Patient Days | 9,255 | 11,909 | 13,640 |
| Total Average Daily Census | 25.4 | 32.5 | 37.4 |

To forecast volume for the proposed hospital, the Applicant assessed historical tertiary and non-tertiary inpatient utilization by zip code and age cohort.

**Service Area Historical and Forecasted Utilization**

The Service Area emergency room, non-tertiary and obstetrics utilization were analyzed and based on use rates and future population were forecasted to the first 3 years of TSHH operation, 2027 through 2029. The Service Area historical and forecasted utilization are presented in the next series of exhibits.

*Historical and Forecasted Service Area Emergency Room Utilization*

In calendar year 2022, there were 48,360 emergency room visits made by residents of the Service Area. Utilization of all ERs was down in 2020 due to the impact of COVID by more than 20 percent from prior years. As of 2022, Service Area utilization of ERs had almost fully rebounded. Use of ERs by residents of the Spring Hill zip code, 37174, increased by 21 percent during this five-year period; it only experienced a 13 percent decrease during COVID and has more than fully rebounded with a 31 percent increase since 2020. Similarly, use of ERs by residents of the Thompson's Station zip code, 37179, increased 5 percent during this five-year period and has fully rebounded since COVID, with a 25 percent increase since 2020. Residents of the Columbia zip code, 38401, have not fully returned to their pre-COVID ER use rate, but are only 1.2 percent below the pre-COVID rate.

To forecast future year ER visits, the actual CY 2022 emergency room visit rate per 1,000 population at the zip code and age cohort level was computed. Spring Hill and Thompson's Station rates had rebounded from COVID and were used for future year computations. While Columbia had not rebounded to pre-COVID levels, it is this lower CY 2022 rate that was also applied to future Columbia ER utilization. These 2022 use rates were applied to future year population estimates by zip code area and age cohort to conclude on expected annual ER visits by zip code.

Exhibit 47 presents historical emergency room encounters by Service Area residents by zip code for CY 2018 through CY 2022 and that which is forecasted for each of the three planning years.

**Exhibit 47**

**TriStar Spring Hill Hospital Service Area**
**Historical and Forecasted Emergency Room Encounters**
**Historical CY 2018 through 2022 and Forecasted 2027 through 2029**

| | Historical | | | | | | Forecasted | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Zip Code | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 | % Change, '18-'22 | 2027 (Year 1) | 2028 (Year 2) | 2029 (Year 3) | % Change '27 to '29 |
| 37174 – Spring Hill | 11,840 | 12,536 | 10,935 | 13,499 | 14,304 | 20.8% | 16,660 | 17,091 | 17,521 | 5.2% |
| 38401 – Columbia | 33,569 | 32,780 | 24,346 | 28,346 | 30,338 | -9.6% | 33,270 | 33,785 | 34,299 | 3.1% |
| 37179 – Thompson's Station | 3,543 | 3,721 | 2,983 | 3,555 | 3,718 | 4.9% | 4,316 | 4,430 | 4,543 | 5.2% |
| Total Service Area | 48,952 | 49,037 | 38,264 | 45,400 | 48,360 | -1.2% | 54,246 | 55,305 | 56,363 | 3.9% |

*Source: Historical represents THA data for the respective years.*

The future estimates of ER utilization by Service Area zip code and year incorporate the anticipated significant population increase and associated aging in Service Area population. The growth in Spring Hill exceeds the rest of the Service Area. By 2029 it will account for 31 percent of the Service Area encounters.

*Historical and Forecasted Service Area Non-Tertiary Hospital Utilization*

During the most recent year for which utilization data is available (CY 2022), there were a total of 7,144 med-surg discharges of Service Area residents of which 6,615 were non-tertiary. The Applicant's non-tertiary definition is appropriate for a community hospital and excludes behavioral

health, neonatology, burns, trauma, transplants, neurosurgery, radiotherapy, burns, cardiac surgery, other complex interventions and comprehensive medical rehabilitation.[48] Additionally, obstetrics is separately analyzed so not included in the non-tertiary analysis. For both total and non-tertiary cases, approximately 53 percent were 65 and older. The proposed hospital will significantly improve seniors' safety as well as provide them with an easier, less congested route to navigate compared to travel to existing hospitals.

Discharges of patients from 37174 (Spring Hill) have increased between 14 and 15 percent during the past five years. This is of particular importance in this analysis given Spring Hill is home to the Spring Hill ER and is the largest city in the state without a hospital. It is obvious that Spring Hill residents prefer the Spring Hill ER as their emergency care provider of choice because between 40 and 44 percent of Spring Hill residents needing emergency care use the Spring Hill ER. This utilization rate is expected to increase to greater than 50 percent with the conversion into a full-service community hospital.

Historical discharge use rates are much higher in the older age cohorts compared to the younger cohorts. With respect to the Service Area, they are higher in 38401 (Columbia) than the other two zip codes, indicative of the Spring Hill and Thompson's Station population having a younger population. The most recently available 2022 use rates by age cohort and zip code were applied to forecasted population resulting in the forecasted Service Area non-tertiary utilization in the planning years presented above.

Based on anticipated population growth and aging of the population, coupled with historical discharge use rates per 1,000 population for both total medical-surgical and non-tertiary medical-surgical discharges, it is expected that there will be 7,856 non-tertiary medical-surgical discharges originating from the Service Area in 2027. This represents an increase of more than 1,200 non-tertiary med-surg discharges during the next five years. This increase is largely driven by the population dynamics in Spring Hill. The next exhibit presents historical non-tertiary med-surg discharges by Service Area residents by zip code for CY 2018 through CY 2022 and the forecasts for each of the three planning years.

**Exhibit 48**

**TriStar Spring Hill Hospital Service Area**
**Historical and Forecasted Non-Tertiary Discharges**
**Historical CY 2018 through 2022 and Forecasted 2027 through 2029**

| | Historical | | | | | | Forecasted | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Zip Code** | **CY 2018** | **CY 2019** | **CY 2020** | **CY 2021** | **CY 2022** | **% Change, '18-'22** | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** | **% Change '27 to '29** |
| **Non-Tertiary Discharges** | | | | | | | | | | |
| 37174 – Spring Hill | 1,742 | 1,770 | 1,837 | 1,986 | 1,991 | 14.3% | 2,472 | 2,566 | 2,661 | 7.7% |
| 38401 – Columbia | 4,582 | 4,809 | 4,243 | 4,288 | 4,023 | -12.2% | 4,635 | 4,748 | 4,861 | 4.9% |
| 37179 – Thompson's Station | 578 | 635 | 633 | 569 | 601 | 4.0% | 749 | 779 | 810 | 8.0% |
| Total Service Area | 6,902 | 7,214 | 6,713 | 6,843 | 6,615 | -4.2% | 7,856 | 8,094 | 8,332 | 6.1% |

*Source: Historical Data Source: THA.*
*Note: Non-tertiary excludes obstetrics, newborns, behavioral health, burns, trauma, transplants, neurosurgery, cardiac surgery and comprehensive medical rehabilitation. Also excludes long-term care hospitals and comprehensive medical rehabilitation hospitals.*

[48] Obstetrics is excluded from the non-tertiary med-surg presentation as it is separately analyzed given its distinct programming. Therefore, it is also excluded from the computation of non-tertiary as a percent of total med-surg discharges.

Overall Service Area increases in Spring Hill and Thompson's Station again exceed that of Columbia, and the overall Service Area average. The non-tertiary med-surg discharges are utilized to estimate future utilization at TSHH.

*Historical and Forecasted Service Area Obstetrics Utilization*

Obstetrics discharges include both delivery and non-delivery discharges within MDC 14. Of the three Service Area zip codes, Spring Hill experienced a 12 percent growth during the past five years. Both Columbia and Thompson's Station were fairly constant with Columbia decreasing by 9 discharges and Thompson's Station increasing by 2 discharges. A similar approach to forecasting Service Area obstetrics discharges was taken. The obstetrics use rate applied to females age 18 to 44 was analyzed on a historical basis. Exhibit 49 presents historical obstetrics discharges by Service Area zip code for CY 2018 through CY 2022 and those forecasted for years 2027 through 2029.

**Exhibit 49**

**TriStar Spring Hill Hospital Service Area**
**Forecasted Obstetrics Discharges**
**Historical CY 2018 through 2022 and Forecasted 2027 through 2029**

| | Historical | | | | | | Forecasted | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Zip Code | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 | % Change, '18-'22 | 2027 (Year 1) | 2028 (Year 2) | 2029 (Year 3) | % Change '27 to '29 |
| 37174 – Spring Hill | 608 | 557 | 555 | 626 | 681 | 12.0% | 747 | 756 | 765 | 2.4% |
| 38401 – Columbia | 746 | 755 | 795 | 789 | 737 | -1.2% | 790 | 799 | 809 | 2.4% |
| 37179 – Thompson's Station | 197 | 177 | 204 | 221 | 199 | 1.0% | 219 | 222 | 225 | 2.7% |
| Total Service Area | 1,551 | 1,489 | 1,554 | 1,636 | 1,617 | 4.3% | 1,757 | 1,778 | 1,799 | 2.4% |

*Source: Historical Data Source: THA.*

The obstetrics discharges are utilized to estimate future utilization at TSHH based on its anticipated patient utilization rate.

**Forecasted TriStar Spring Hill Hospital Utilization**

Need for the project is substantiated by the compelling reasons presented throughout this CON Application and TSHH meeting the Acute Care, NICU, Cardiac Catheterization Service and MRI Criteria and Standards as presented throughout this CON Application. The facts substantiate individually and collectively, that when weighing and balancing these criteria, TSHH should be approved. The Service Area, and particularly the Spring Hill community, needs accessible and available acute care beds in a new access point to alleviate issues of interfacility transports, geographic accessibility, excessive drive times, senior driving issues, ER bypass, provide relief to SHEMS and meet the growing community's needs well into the future.

In forecasting percent of Service Area patient utilization for the proposed hospital, the Applicant evaluated historical inpatient migration patterns and historical percent of patient utilization by zip code of its emergency department visits. Other factors considered in forecasting percent of Service Area patients to utilize the proposed hospital was population dynamics by zip code, current and expected travel times, community request for an accessible hospital in Spring Hill, each zip code's geographic proximity to the closest existing acute care hospital, EMS transports from the area and the significant out-migration of Service Area residents. The following discussion provides insight into TriStar Spring Hill ER's historical patient utilization in the defined Service Area.

*TriStar Spring Hill ER Historical and Forecasted Patient Utilization*

TriStar Spring Hill ER's percent of patients treated from the Service Area demonstrates that it is the preferred provider of ER services in Spring Hill. Because ER utilization is commonly indicative of likely inpatient hospital utilization, the Applicant relies heavily on its historical ER utilization by Service Area patients. As previously discussed, the ER treats more Spring Hill emergency patients than any other provider. And it treats the second highest number of patients residing in the Columbia and Thompson's Station zip codes. From a utilization perspective, it treats more than 40 percent of patients who reside in Spring Hill and approximately 18 percent of those who reside in the other two Service Area zip codes. Notably, it treats this high proportion of patients despite being bypassed by EMS and others due to not having a full-service hospital on site. TriStar Spring Hill ER's percent of patients it treated during the past five years by zip code is summarized in Exhibit 50:

**Exhibit 50**

| TriStar Spring Hill ER<br>Percent of Total ER Patients By Zip Code It Treats by Year<br>CY 2018 through CY 2022 | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2018 | CY 2019 | CY 2020 | CY 2021 | CY 2022 | 5-Year Average |
| 37174 - Spring Hill | 42.7% | 43.5% | 43.4% | 41.7% | 40.4% | 42.3% |
| 38401 - Columbia | 17.1% | 17.0% | 17.2% | 17.1% | 18.3% | 17.3% |
| 37179 - Thompson's Station | 19.4% | 17.4% | 16.9% | 16.3% | 17.6% | 17.5% |
| Service Area Total | 23.5% | 23.8% | 24.6% | 24.3% | 24.8% | 24.2% |

Approximately 25 percent of all ER encounters of patients residing in the Service Area were treated at TriStar Spring Hill ER. This is despite not having surgical facilities, cath lab and other diagnostic and treatment services which are typically available at a full service community hospital and utilized by some ER patients. Accordingly, once TSHH is licensed and operational, the above percentage of patients being treated at TriStar Spring Hill is expected to increase due to both reduction of EMS bypass and self-selection by the community who are demanding access to a Spring Hill hospital.

Exhibit 51 presents the forecasted percentage of ER visits that are expected to present at TriStar Spring Hill ER during the first three years after licensure of the full-service hospital.

**Exhibit 51**

| TriStar Spring Hill Hospital Service Area<br>Actual CY 2022 and Forecasted Percent Patient Utilization by Service Area Zip Code<br>2027 through 2029 | | | | |
|---|---|---|---|---|
| Zip Code | CY 2022 | 2027 (Year 1) | 2028 (Year 2) | 2029 (Year 3) |
| 37174 – Spring Hill | 40.4% | 44.0% | 48.0% | 50.0% |
| 38401 – Columbia | 18.3% | 22.0% | 24.0% | 25.0% |
| 37179 – Thompson's Station | 17.6% | 22.0% | 24.0% | 25.0% |
| Total Service Area | 24.8% | 28.8% | 31.4% | 32.8% |

Applying the above percentage of patients to be treated at the TSHH emergency room to forecasted Service Area emergency room utilization results in the following expected ER visits at TSHH once it becomes a hospital.

**Exhibit 52**

| TriStar Spring Hill Hospital<br>Forecasted TriStar Spring Hill ER Encounters by Service Area Zip Code<br>2027 through 2029 | | | |
|---|---|---|---|
| | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| 37174 – Spring Hill | 7,330 | 8,203 | 8,761 |
| 38401 – Columbia | 7,319 | 8,108 | 8,575 |
| 37179 – Thompson's Station | 950 | 1,063 | 1,136 |
| Total Service Area | 15,599 | 17,375 | 18,471 |
| Out of Area (25%) | 5,200 | 5,792 | 6,157 |
| Total ER Visits | 20,799 | 23,167 | 24,628 |

One of the compelling reasons for approval of the proposed hospital is the level of ER bypass experienced by the Spring Hill community. Area residents are forced to leave Spring Hill for hospital services not available in their community. As a result, once licensed as a hospital a significant portion of the inpatient admissions will be patients who present at its emergency room. Currently, that percentage ranges between 7 and 8 percent of ER encounters. Pre-change in SHEMS vendor, the rate was 12.5 percent. The 12.5 percent rate is generally a community hospital reasonable benchmark for the percentage of ER visits admitted to a community hospital. To be conservative, it was estimated that the TriStar Spring Hill ER visit volume would increase to the 12.5 percent rate by the third year of licensure (rather than immediately upon licensure). As a result, the estimate of ER patients requiring inpatient care are identified in the next Exhibit.

**Exhibit 53**

| TriStar Spring Hill Hospital<br>Forecasted TriStar Spring Hill ER Encounters by Service Area Zip Code<br>2027 through 2029 | | | |
|---|---|---|---|
| | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **Emergency Room Visits** | | | |
| Total ER Visits | 20,799 | 23,167 | 24,628 |
| | | | |
| **ER Patients Requiring Inpatient and Specialized Services** | | | |
| Percent | 8.9% | 10.7% | 12.5% |
| Number | 1,841 | 2,473 | 3,079 |

Based on TriStar Spring Hill ER's percent of patients historically being transferred who were treated for tertiary or specialty services (i.e. behavioral health), an estimate of 13 percent of the above patients are expected to continue to be transferred to a higher or specialized level of care. Importantly, however, 87 percent of these patients will be admitted and treated at TSHH, quantified below.

**Exhibit 54**

| TriStar Spring Hill Hospital<br>Forecasted TriStar Spring Hill ER Encounters by Service Area Zip Code<br>2027 through 2029 | | | |
|---|---|---|---|
| | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **ER Patients Requiring Inpatient and Specialized Services** | | | |
| Number | 1,841 | 2,473 | 3,079 |
| | | | |
| **ER Patients Who Will No Longer Need to be Transferred Out of Spring** | | | |
| Percent | 87.0% | 87.0% | 87.0% |
| Patient Count, Avoiding Transfer | 1,602 | 2,152 | 2,678 |

Avoiding transfer of thousands of patients annually is an important health planning factor to consider in the approval of this CON Application. It is also this patient quantification that is foundational to the need to implement TSHH to meet the Spring Hill community's acute care inpatient hospitalization needs.

*TriStar Spring Hill Non-Tertiary Projected Utilization*

In addition to the TriStar Spring Hill ER patient counts by zip code area and resulting level of ER utilization identified above, other factors incorporated into the forecasted non-tertiary patient utilization rate include historical utilization by provider in Maury, Williamson and Davidson counties, out-migration by county and zip code, excessive travel times to reach existing providers, level of EMS transports out of the area, and consumer support for TSHH.

Another consideration in this analysis was the number of interfacility transports for inpatient services originating at TriStar Spring Hill ER previously presented. This includes both historical and that which is projected. Of the annual transports, 87 percent were determined to be appropriate for admission to TSHH based on its proposed service profile. It is this level of forecasted ER interfacility transports that would be eliminated with the licensure of TSHH, totaling more than 2,600 in the third year of operation.

Based on the above considerations, the Applicant's forecasted non-tertiary med/surg patient utilization by Service Area zip code for each of the first three years of operation are presented blow in Exhibit 55.

**Exhibit 55**

| TriStar Spring Hill Hospital<br>Forecasted Percent Patient Utilization by Service Area Zip Code<br>2027 through 2029 | | | |
|---|---|---|---|
| **Zip Code** | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **Percent of Non-Tertiary** | | | |
| 37174 – Spring Hill | 34.0% | 42.0% | 45.0% |
| 38401 – Columbia | 15.0% | 18.0% | 20.0% |
| 37179 – Thompson's Station | 15.0% | 18.0% | 20.0% |
| Total Service Area | 21.0% | 25.6% | 28.0% |

The above non-tertiary patient utilization estimates are reasonable and achievable given the existing and forecasted patient utilization at TriStar Spring Hill ER, level of out-migration, level of interfacility transports, and community need for a full-service hospital. In the next exhibit, the Service Area non-tertiary patient utilization to be expected at TSHH is shown relative to its ER patient utilization and how the above rates equate to total med/surg discharges expected for the Service Area.

**Exhibit 56**

| TriStar Spring Hill Hospital<br>Forecasted Program Percent Patient Utilization Summary<br>2027 through 2029 | | | |
|---|---|---|---|
| | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **Percent of ER Visits (from Prior Section)** | | | |
| Total Service Area | 28.8% | 31.4% | 32.8% |
| | | | |
| **Percent of Non-Tertiary (from Above)** | | | |
| Total Service Area | 21.0% | 25.6% | 28.0% |
| | | | |
| **Non-Tertiary as a Subset of Tertiary** | | | |
| Effective Percent of Total Tertiary (*) | 19.4% | 23.7% | 25.9% |
| *(*) Computed by taking forecasted non-tertiary discharges based on non-tertiary market share and dividing the non-tertiary discharges by total med/surg (including tertiary) discharges.* | | | |

Considering that the TriStar Spring Hill ER currently treats 25 percent of Service Area patients with no full-service hospital in Spring Hill, it is reasonable that it will increase that level of community services to nearly 33 percent in the emergency room and 26 percent of total med/surg discharges in the Service Area.

The non-tertiary patient utilization rates presented above were applied to the forecasted non-tertiary med-surg discharges previously presented resulting in the following forecasted TSHH med/surg discharges for the first three years of operation:

**Exhibit 57**

| TriStar Spring Hill Hospital<br>Forecasted Discharges by Service Area Zip Code<br>2027 through 2029 | | | |
|---|---|---|---|
| **Zip Code** | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **Non-Tertiary Med/Surg** | | | |
| 37174 – Spring Hill | 840 | 1,078 | 1,197 |
| 38401 – Columbia | 695 | 855 | 972 |
| 37179 – Thompson's Station | 112 | 140 | 162 |
| Total Service Area | 1,648 | 2,073 | 2,332 |
| Out of Area (25%) | 549 | 691 | 777 |
| Total Discharges | 2,197 | 2,764 | 3,109 |

The above forecasted med-surg discharges are reasonable particularly when considering that more than 70 percent of the total are expected to be 'avoided transfers' from the Spring Hill ER.

*TriStar Spring Hill Obstetrics Projected Utilization*

Obstetrics utilization was considered separately from med-surg utilization in the analysis. Developing a distinguishable obstetrics program at TSHH is a significant objective. However, given the normal gestation period associated with pregnancy, achieving a stabilized patient utilization rate is expected to take somewhat longer than medical-surgical rate.

The TSHH maternity program will be different than existing providers based on the introduction of Diana Health's partnership with TSHH. The relationship with Diana Health will form the foundation of TSHH's maternity program and its NICU. Diana Health's care model includes a 24/7 OB hospitalist program and midwifery-led laborist services within an integrated model of care. There is no such program in Spring Hill or Maury or Williamson Counties, further distinguishing the TSHH program from other resources. Having an obstetrician on campus 24/7 assures rapid response in case of emergency, enables the obstetrician to oversee the midwifery service and provides meaningful interaction with staff, patients and families.

Diana Health is a private OB practice that incorporates a full-scope model that brings wellness-focused care that women love together with a clinical redesign on labor and delivery that is delivered through its midwifery-led laborist service. It serves as an extension of the hospital's service line leadership, which sets it apart from other providers through a model that puts women at the center of decision-making and empowers them with the information and support they need to achieve their health and wellness goals.

Through integrated care teams, smart technology and a thoughtfully designed care experience, the proposed TSHH OB program will align incentives across patients and providers and set TSHH's obstetrics service up for sustainability and success. The availability of the OB hospitalist model not only benefits the Diana Health physicians but also community obstetricians who want to engage the OB hospitalists to cover their private practice during nights, weekends, vacations or other absences.

Diana Health's contribution to the TSHH maternity services includes:

- Wellness-Focused Care Program:
    - Full scope women health service
    - Personalized care plans
    - Engaging digital platform
    - Warm, welcoming spaces
- Elevated Experience in Labor & Delivery:
    - Midwifery-led 24/7 coverage model
    - Protocol and workflow adjustments to enable consistent delivery of supportive evidence-based care
- Data-driven Program Management:
    - Clinical leadership and medical direction
    - Structured program to drive continuous quality improvement
    - State-of-the-art technology platform for data collection and management

The Certified Nursing Midwife Qualifications will include the following:

- Licensed in the State of Tennessee as a Registered Nurse and Advanced Practice RN;
- Successful completion of a nurse midwifery program accredited by the American Commission for Midwifery Education;
- Current active certification by the American Midwifery Certification Board;

- Possess a current DEA certificate of registration with a Tennessee address [if applicable to privileges requested]; and
- Provide documentation of a Collaborative Practice Agreement with OB/GYN physicians who have OBGYN clinical privileges at the hospital.

A visual of the various program elements to be included in the TSHH and Diana Health program are provided in the following graphic:

**A team of compassionate midwives and doctors** who actually have the time to talk though your questions – and to give you the info you need to make empowered choices.

**A dedicated care navigator** available across your full course of care to ensure you get what you need, when you need it.

**Treatment for the whole you,** with mental health therapy, health coaching, classes, and community events, to help you feel grounded, connected, and prepared.

**Convenient care, in your pocket** with a custom app and website that lets you schedule same- or next-day appointments, find educational material and classes, and connect with your providers.

**Birth and delivery the way you want it.** Change your mind? Need a new plan? From "low-intervention" to "I'll take everything" – we listen and deliver. You'll be in the driver's seat, co-creating your care plan with your care team, based on your preferences and goals.

Labor and Delivery at TSHH with the Diana Health team will include the following:

- An early familiarity with the obstetrics unit, including tour and meeting the staff;
- 24/7 Support caring team in the hospital 24/7 and will be by a patient's side every step of the way;
- When admitted, a patient's entire Care Team will review the birth plan, and, should plans need to change, work with the patient to make collaborative decisions;
- Each patient will be in a spacious, private room during labor and postpartum, with remote monitoring devices available if you want to move around;
- The program will support a variety of birth choices and pain management options. From nitrous oxide to aromatherapy, to water therapy and calming music, the patient is in complete control of the birthing environment;
- After delivery, the patient will meet virtually with a Care Navigator and the patient's OB or Midwife 24, 48, and 72 hours post-discharge, and will also have access to support groups and classes to get the new mother off to a strong start; and
- Each patient can access immersion tubs, aromatherapy diffusers, luxurious blankets, swedish bars, rebozo technique, birth stool, birth balls, bassinets that snuggles up to bed, and plush robes.

The Diana Health program is currently offered at TriStar StoneCrest Medical Center located in Smyrna, Rutherford County.[49] In the two years since establishing the program at TriStar StoneCrest, deliveries increased from 50 to 60 per month to 150+ per month. Additionally, the OB hospitalist program has been well-received with nearly one-third of Diana Health's obstetricians' monthly deliveries being patients of community obstetricians. Given its unique and holistic approach to maternity care, TriStar StoneCrest proudly serves women from the Spring Hill area who are seeking this program, which is different from the other hospitals in Williamson and Maury Counties. Establishment of the Diana Health program at TSHH will decrease out-migration from the Service Area to reach Diana Health in Rutherford, birthing centers in Davidson County, and other midwifery led programs in Middle Tennessee.

Based on the above considerations, the Applicant's forecasted obstetrics utilization by Service Area zip code for each of the first three years of operation are presented in the following exhibit.

**Exhibit 58**

| TriStar Spring Hill Hospital<br>Forecasted Percent Patient Utilization by Service Area Zip Code<br>2027 through 2029 | | | |
|---|---|---|---|
| **Zip Code** | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **Percent of Obstetrics** | | | |
| 37174 – Spring Hill | 20.0% | 28.0% | 34.0% |
| 38401 – Columbia | 10.0% | 15.0% | 18.0% |
| 37179 – Thompson's Station | 10.0% | 15.0% | 18.0% |
| Total Service Area | 14.3% | 20.5% | 24.8% |

The above obstetrics patient utilization estimates are reasonable and achievable given the community support and anticipated distinguishable programming at TSHH. The obstetrics utilization rates presented above were applied to the forecasted obstetrics discharges previously presented resulting in the following forecasted TSHH OB discharges for the first three years of operation:

**Exhibit 59**

| TriStar Spring Hill Hospital<br>Forecasted Discharges by Service Area Zip Code<br>2027 through 2029 | | | |
|---|---|---|---|
| **Zip Code** | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **Obstetrics** | | | |
| 37174 – Spring Hill | 149 | 212 | 260 |
| 38401 – Columbia | 79 | 120 | 146 |
| 37179 – Thompson's Station | 22 | 33 | 41 |
| Total Service Area | 250 | 365 | 446 |
| Out of Area (25%) | 83 | 122 | 149 |
| Total Obstetrics Discharges | 334 | 487 | 595 |

[49] Diana Health is also at TriStar NorthCrest Medical Center in Robertson County.

The above forecasted OB discharges are reasonable particularly when considering the proposed programming planned for the hospital, community support to establish this unique service in Spring Hill and the level of out-migration experienced by the Spring Hill community.

Total obstetrics discharges were used to estimate the number of Level II neonatal intensive care babies to be admitted to TSHH. Based on evaluation of the experience of other area hospitals as well as that of Diana Health and Pediatrix, the neonatologists who will manage the NICU, it is estimated that 9 percent of the obstetrics utilization will result in Level II NICU admissions at the proposed hospital. This is presented in the following exhibit.

**Exhibit 60**

| TriStar Spring Hill Hospital<br>Forecasted Utilization<br>2027 through 2029 | | | |
|---|---|---|---|
| | 2027<br>(Year 1) | 2028<br>(Year 2) | 2029<br>(Year 3) |
| **Obstetrics** | | | |
| Total Obstetrics Discharges | 334 | 487 | 595 |
| | | | |
| **Level II NICU** | | | |
| Level II NICU Discharges | 30 | 44 | 54 |

Given the anticipated planning and programming for this women's health service at TSHH, these forecasts are reasonable and consistent with the program to be implemented.

*TriStar Spring Hill Project Cardiac Catheterization Services*

TSHH proposes to implement two cardiac catheterization laboratories at the hospital to meet the current and expected increasing needs of Service Area residents. This will improve access for Service Area residents and reduce the current high level of out-migration. Nearly half of the patients in 37174 (Spring Hill) who out-migrate have their cardiac catheterizations performed at TriStar Health facilities. And 17 to 18 percent of those out-migrating from 38401 (Columbia) and 37179 (Thompson's Station) are similarly treated at TriStar Health.

Currently practicing within the TriStar Spring Hill campus are three cardiology providers who are affiliated with Centennial Heart Cardiovascular Consultants ("Centennial Heart"). This physician group includes 45 non-invasive cardiologists, invasive cardiologists, interventional cardiologists and cardiac surgeons, most of whom are located in Middle Tennessee including Maury and Williamson Counties. Centennial Heart will be partnered with TSHH to oversee and provide the cardiologists to staff the proposed catheterization laboratory at TSHH. The expertise of Centennial Heart is widely recognized as they currently work throughout Middle Tennessee including at one of the busiest and most robust cardiology programs, TriStar Centennial which has 9 catheterization labs with approximately 7,000 catheterizations performed annually and 5 open heart surgery suites with 1,265 surgeries performed annually.[50]

The plan for TSHH includes non-invasive cardiologists, invasive cardiologists, interventional cardiologists including EP physicians, and heart failure physician specialists supported by their extenders. Interventional cardiologists will staff the cardiac catheterization lab, while being supported

[50] 2023 volume per internal records, to be included in 2023 JAR.

by advance practice providers. In addition, TSHH and Centennial Heart will coordinate with TriStar Centennial for staffing and recruitment of additional providers as needed.

Current Centennial Heart physicians named at this early stage to be practicing at TSHH include Jeffrey Webber, MD and John Riddick, MD. An advanced practice provider will be selected to work with these physicians. In addition to those at TriStar Spring Hill, other Centennial Heart providers may be rotated among other TriStar hospitals and TSHH to provide for continuity and collaboration of cardiac catheterization services amongst the practitioners and hospitals.

Based on evaluation of migration patterns and associated anticipated percent of patients to seek services at the proposed hospital, the following percent of patients are estimated to utilize the proposed cardiac catheterization laboratories at TSHH.

**Exhibit 61**

| Estimated Percent of TriStar Spring Hill Hospital Patients | | | |
|---|---|---|---|
| | **2027** | **2028** | **2029** |
| **Cardiac Catheterizations** | | | |
| Spring Hill - 37174 | 20.0% | 25.0% | 30.0% |
| Columbia - 38401 | 10.0% | 15.0% | 18.0% |
| Thompson's Station - 37179 | 10.0% | 15.0% | 18.0% |
| **Service Area Total** | 13.2% | 18.2% | 21.9% |

Applying the above rates to the forecasts accounts for 75 percent of the forecasted patient population, with the remaining 25 percent emanating from outside the Service Area. Exhibit 62 provides forecasted utilization at TSHH.

**Exhibit 62**

| Forecasted Cardiac Catheterizations at TriStar Spring Hill Hospital | | | |
|---|---|---|---|
| | **2027** | **2028** | **2029** |
| **Service Area** | | | |
| Spring Hill - 37174 | 123 | 156 | 192 |
| Columbia - 38401 | 108 | 163 | 199 |
| Thompson's Station - 37179 | 23 | 35 | 43 |
| **Service Area Total** | **253** | **355** | **433** |
| Out of Area (25%) | 84 | 118 | 144 |
| Total Utilization | **337** | **474** | **578** |

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

**Exhibit 63**

| Diagnostic and Therapeutic Catheterization Distribution | | | |
|---|---|---|---|
| | **2027** | **2028** | **2029** |
| Diagnostic Catheterizations | 253 | 355 | 433 |
| Therapeutic Catheterizations | 84 | 118 | 144 |
| Total Catheterizations | 337 | 474 | 578 |

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

*TriStar Spring Hill Project Magnetic Resonance Imaging Services*

Forecasted utilization of the TSHH MRI unit for its first three years of operation are provided in Exhibit 65. Inpatient MRIs were estimated based on experience of MRI utilization by medical surgical inpatients. Outpatient utilization was developed considering experience of ratios of inpatient to outpatient volumes in conjunction with the utilization and high out-migration identified above.

**Exhibit 64**

| Forecasted TriStar Spring Hill Hospital MRI Procedures | | | |
|---|---|---|---|
| **Patient Type** | **Year 1** | **Year 2** | **Year 3** |
| Inpatient | 365 | 508 | 585 |
| Outpatient | 1,826 | 2,032 | 2,340 |
| Total | 2,192 | 2,540 | 2,925 |

The underlying utilization discussion and migration patterns were previously presented in 1N, MRI attached to this CON Application.

## Summary of TriStar Spring Hill Hospital Inpatient Utilization

The above discharges by program were utilized to estimate total patient days and census at TSHH. Applied to the discharges is the anticipated average length of stay (ALOS) by program. The anticipated ALOS is based upon the ALOS for the Service Area patients, ALOS experienced by WMC and MRH, ALOS of previously transported patients and programmatic discussions with physicians.

**Exhibit 65**

| TriStar Spring Hill Hospital<br>Forecasted Utilization Discharges and Patient Days<br>2027 through 2029 | | | |
|---|---|---|---|
| | **2027 (Year 1)** | **2028 (Year 2)** | **2029 (Year 3)** |
| **Med-Surg Discharges** | | | |
| Total Med-Surg Discharges | 2,197 | 2,764 | 3,109 |
| Average Length of Stay | | 3.80 | |
| Med-Surg Patient Days | 8,350 | 10,502 | 11,813 |
| Med-Surg Average Daily Census | 22.9 | 28.7 | 32.4 |
| | | | |
| **Obstetrics Discharges** | | | |
| Total OB Discharges | 334 | 487 | 595 |
| Average Length of Stay | | 2.35 | |
| OB Patient Days | 785 | 1,144 | 1,398 |
| OB Average Daily Census | 2.1 | 3.1 | 3.8 |
| | | | |
| **Level II NICU Discharges** | | | |
| Total Level II NICU Discharges | 30 | 44 | 54 |
| Average Length of Stay | 4.00 | 6.00 | 8.00 |
| NICU Patient Days | 120 | 263 | 428 |
| NICU Average Daily Census | 0.3 | 0.7 | 1.2 |
| | | | |
| **Total Discharges** | | | |
| Total Discharges | 2,561 | 3,294 | 3,757 |
| Total Patient Days | 9,255 | 11,909 | 13,640 |
| Total Average Daily Census | 25.4 | 32.5 | 37.4 |

The average daily census by program in the above chart was utilized to estimate the number of needed beds to accommodate the TSHH patients. With continuing population growth, the above daily census will continue to increase. As it increases, additional beds will be added in the defined expansion zones to meet the future Service Area needs.

## Bed Need Computation

To compute the number of needed beds by program, the formula included in the Acute Care Beds Standard and Criteria is applied to the average daily census. That formula is the projected average daily census +2.33 X square root of projected ADC. This formula is incorporated into the next exhibit.

**Exhibit 66**

| TriStar Spring Hill Hospital<br>Utilization Summary and Bed Need (HFC Formula) | | | | |
|---|---|---|---|---|
| **Year 3 Utilization** | **Medical/Surgical** | **Obstetrics** | **Level II NICU** | **Total** |
| Admissions | 3,109 | 595 | 54 | 3,757 |
| Patient Days | 11,813 | 1,398 | 428 | 13,640 |
| Average Daily Census | 32.4 | 3.8 | 1.2 | 37.4 |
| Computed Beds Needed | 45.6 | 8.4 | 3.7 | 57.7 |
| | | | | |
| *Proposed Beds* | *50* | *10* | *8* | *68* |

As demonstrated in the above table, the medical/surgical beds needed to support the proposed census in year three totals 58 beds, which is the current programming. The med/surg beds require a total of 46 beds; 50 are programmed since by year 5, the need is 51 beds. The OB beds result in 8.4 beds in year three. By year five, the OB beds needed increases to nine beds. Accordingly planning for 50 med-surg beds and a 10-bed OB program are reasonable given the anticipated utilization.

With respect to the Level II NICU, the number of needed beds computes to 4 NICU beds. Given the bed need in the Service Area based on live births, the Applicant is seeking approval for 8 beds at this time. However, the Applicant intends on staging the licensure and opening of the beds with seeking to license the first four beds at initial licensure and expanding the Level II NICU as demand warrants.

# Attachment 1C

# Sample Transfer Agreement

**FACILITY TRANSFER AGREEMENT** (Revised 04-2011)

This Transfer Agreement (the "Agreement") is made as of this __ day of _____, 20____, by and between: _____, doing business as _____ and _____, each individually referred to herein as "facility," or "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

**W I T N E S S E T H:**

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

**WHEREAS**, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities;

**NOW, THEREFORE**, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. **Transfer of Patients.** In the event any patient of either facility is deemed by that facility (the "Transferring Facility") as requiring the services of the other facility (the "Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. **Responsibilities of the Transferring Facility.** The Transferring Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer;

(B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;

(C) Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;

(D) Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;

(E) Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

(F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

(G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

(H) Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and with respect to a patient with an emergency medical condition that has not been stabilized, a copy of the patient's informed consent to the transfer or physician certification that the medical benefits of the transfer outweigh the risk of transfer. If all necessary and relevant medical records are not available at the time the patient is transferred, then the records will be forwarded by the Transferring Facility as soon as possible;

(I) Transfer the patient's personal effects, including, but not limited to, money and valuables, and information related to those items;

(J) Notify the Receiving Facility of the estimated time of arrival of the patient;

(K) Provide for the completion of a certification statement, summarizing the risk and benefits of the transfer of a patient with an emergency condition that has not been stabilized, by the transferring physician or other qualified personnel if the physician is not physically present at the facility at the time of transfer;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Recognize the right of a patient to request to transfer into the care of a physician and facility of the patient's choosing;

(N) Recognize the right of a patient to refuse consent to treatment or transfer;

(O) Complete, execute, and forward a memorandum of transfer form to the Receiving Facility for every patient who is transferred;

(P) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's medical records in accordance with applicable state and federal law, and (ii) for the inventory and safekeeping of any patient valuables sent with the patient to the Receiving Facility; and,

(Q) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

3. **Responsibilities of the Receiving Facility.** The Receiving Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, as promptly as possible, confirmation to the Transferring Facility regarding the availability of bed(s), appropriate facilities, services, and staff necessary to treat the patient and confirmation that the Receiving Facility has agreed to accept transfer of the patient. The Receiving Facility shall respond to the Transferring Facility within _____ minutes after receipt of the request to transfer a patient with an emergency medical condition or in active labor;

(B) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the receiving physician with the receipt and treatment of the patient transferred and maintain a call roster of physicians at the Receiving Facility;

(C) Reserve beds, facilities, and services as appropriate for patients being transferred from the Transferring Facility who have been accepted by the Receiving Facility and a receiving physician, if deemed necessary by a transferring physician unless such are needed by the Receiving Facility for an emergency;

(D) Designate a person who has authority to represent and coordinate the transfer and receipt of patients into the facility;

(E) When appropriate and within its capabilities, assist with the transportation of the patient as determined appropriate by the transferring or receiving physician;

(F) Provide the Transferring Facility with a copy of the patient's clinical or medical records, including any record generated in the emergency department;

(G) Maintain the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law;

(H) Establish a policy and/or protocols (i) for maintaining the confidentiality of the patient's clinical or medical records in accordance with applicable state and federal law, (ii) for the receipt of the patient into the facility, and (iii) for the acknowledgment and inventory of any patient valuables transported with the patient;

(I) Provide for the return transfer of patients to the Transferring Facility when requested by the patient or the Transferring Facility and ordered by the patient's attending/transferring physician, if the Transferring Facility has a statutory or regulatory obligation to provide health care assistance to the patient, and if transferred back to the Transferring Facility, provide the items and services specified in Section 2 of this Agreement;

(J) Provide the Transferring Facility any information available about the patient's coverage or eligibility under a third party coverage plan, Medicare or Medicaid, or a healthcare assistance program established by a county, public hospital, or hospital district;

(K) Upon request, provide current information concerning its eligibility standards and payment practices to the Transferring Facility and patient;

(L) Acknowledge any contractual obligations and comply with any statutory or regulatory obligations that might exist between a patient and a designated provider;

(M) Complete, execute, and return the memorandum of transfer form to the Transferring Facility; and,

(N) Recognize and comply with the requirements of any state law and regulations or local ordinances that apply to the care and transfer of patients.

4. **Billing.** All claims or charges incurred with respect to any services performed by either facility for patients received from the other facility pursuant to this Agreement shall be billed and collected by the facility providing such services directly from the patient, third party payer, Medicare or Medicaid, or other sources appropriately billed by that facility, unless applicable law and regulations require that one facility bill the other facility for such services. *In those cases in which the regulations apply, the facilities shall bill in accordance to the regulations that apply to skilled nursing facility prospective payment system ("SNF PPS") and consolidated billing. In those cases in which payment rates are consistent with SNF PPS regulations and have been negotiated, such payment shall be made at _____% of charges or in accordance with the payment fee schedule, labeled as Exhibit _____, attached hereto and incorporated herein by this reference.* In addition, it is understood that professional fees will be billed by those physicians or other professional providers who actually participate in the care and treatment of the patient and who are entitled to bill for their professional services at usual and customary rates. Each facility agrees to provide information in its possession to the other facility and such physicians or professional providers sufficient to enable them to bill the patient, responsible party, or appropriate third party payer.

5. **Transfer Back; Discharge; Policies.** At such time as the patient is ready for transfer back to the Transferring Facility or another health care facility or discharge from the Receiving Facility, in accordance with the direction from the Transferring Facility and with the proper notification of the patient's family or guardian, the patient will be transferred to the agreed upon location. If the patient is to be transferred back to the Transferring Facility, the Receiving Facility will be responsible for the care of the patient up until the time the patient is re-admitted to the Transferring Facility. Such transfers shall be conducted in accordance with HCA Healthcare Corporation Ethics and Compliance Policies and Procedures (*e.g., Discharge Planning and Referrals of Patients to Post Discharge Providers Policy, LL.HH.016 and EMTALA – Transfer Policy, EM.001*).

6. **Compliance with Law.** Both facilities shall comply with all applicable federal and state laws, rules and regulations, including, without limitation, those laws and regulations governing the maintenance of clinical or medical records and confidentiality of patient information as well as with all standards promulgated by any relevant accrediting agency.

7. **Indemnification; Insurance.** The facilities shall each be responsible for their own acts and omissions in the performance of their duties hereunder, and the acts and omissions of their own employees and agents, and shall indemnify and hold harmless the other party from and against any and all claims, liabilities, causes of action, losses, costs, damages and expenses (including reasonable attorney's fees) incurred by the other party as a result of such acts and omissions. In addition, each party shall maintain, throughout the term of this Agreement, comprehensive general and professional liability insurance and property damage insurance coverage in amounts reasonably acceptable to the other party, and shall provide evidence of such coverage upon request.

8. **Term; Termination.** The term of this Agreement shall be a minimum of one (1) year, commencing on the ____ day of _____, 20____, and ending on the ____ day of _____, 20____, unless sooner terminated as provided herein. Either party may terminate this Agreement without cause upon thirty (30) days advance written notice to the other party. Either party may terminate this Agreement upon breach by the other party of any material provision of this Agreement, provided such breach continues for five (5) days after receipt by the breaching party of written notice of such breach from the non-breaching party. In addition, this Agreement may be terminated immediately upon the occurrence of any of the following events:

(A) Either facility closes or discontinues operation to such an extent that patient care cannot be carried out adequately, or

(B) Either facility loses its license, or Medicare certification.

This Agreement may be renewed for subsequent one (1) year terms upon the mutual written consent of the parties.

9. **Arbitration.** Any dispute or controversy arising under, out of or in connection with, or in relation to this Agreement, or any amendment hereof, or the breach hereof shall be determined and settled by arbitration in _____, _____, in accordance with the rules of the American Health Lawyers Association Alternative Dispute Resolution Services and applying the laws of the state specified in section 11 below. Any award rendered by the arbitrator shall be final and binding upon each of the parties, and judgment thereof may be entered in any court having jurisdiction thereof. The costs shall be borne equally by both parties. During the pendency of any such arbitration and until final judgment thereon has been entered, this Agreement shall remain in full force and effect unless otherwise terminated provided hereunder.

10. **Entire Agreement; Modification.** This Agreement contains the entire understanding of the parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties relating to such subject matter. This Agreement may not be amended or modified except by mutual written agreement.

11. **Governing Law.** This Agreement shall be construed in accordance with the laws of the State of _____ in which the facility affiliated with HCA is located.

12. **Partial Invalidity.** If any provision of this Agreement is prohibited by law or court decree of any jurisdiction, said prohibition shall not invalidate or affect the remaining provisions of this Agreement.

13. **Notices.** All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by overnight courier, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to: _____
_____
_____
Attention: Chief Executive Officer

Copy to: One Park Plaza, P.O. Box 550
Nashville, Tennessee 37202-0550
Attention: _____, Operations Counsel

If to: _____
_____
_____
Attention: Chief Executive Officer

or to such other persons or places as either party may from time to time designate by written notice to the other.

14. **Waiver.** A waiver by either party of a breach or failure to perform hereunder shall not constitute a waiver of any subsequent breach or failure.

15. **Assignment; Binding Effect.** Each facility shall not assign or transfer, in whole or in part, this Agreement or any of its rights, duties or obligations under this Agreement without the prior written consent of the other Facility, and any assignment or transfer by either Facility without such consent shall be null and void. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective heirs, representatives, successors and permitted assigns.

16. **Change in Law.** Notwithstanding any other provision of this Agreement, if the governmental agencies (or their representatives) which administer Medicare, any other payer, or any other federal, state or local government or agency passes, issues or promulgates any law, rule, regulation, standard or interpretation, or if any court of competent jurisdiction renders any decision or issues any order, at any time while this Agreement is in effect, which prohibits, restricts, limits or in any way substantially changes the method or amount of reimbursement or payment for services rendered under this Agreement, or which otherwise significantly affects either party's rights or obligations hereunder, either party may give the other notice of intent to amend this Agreement to the satisfaction of both parties, to compensate for such prohibition, restriction, limitation or change. If this Agreement is not so amended in writing within thirty (30) days after said notice was given, this Agreement shall terminate as of midnight on the thirtieth (30th) day after said notice was given.

17. **Warranty of Non-Exclusion.** Each party represents and warrants to the other that the party, its officers, directors and employees (i) are not currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. §1320a-7b(f) (the "federal healthcare programs"), (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services but have not yet been excluded, debarred, or otherwise declared ineligible to participate in the federal healthcare programs, and (iii) are not, to the best of its knowledge, under investigation or otherwise aware of any circumstances which may result in the party or any such individual being excluded from participation in the federal healthcare programs. This shall be an ongoing representation and warranty during the term of this Agreement and each party shall immediately notify the other of any change in the status of the representations and warranty set forth in this section. Any breach of this section shall give the other party the right to terminate this Agreement immediately for cause.

18. **HIPAA Compliance Requirements.** To the extent applicable to this Agreement, Contractor agrees to comply with the Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), the

Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 USC § 1320d through d-8 ("HIPAA") and any current and future regulations promulgated under either the HITECH Act or HIPAA, including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162 and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transactions Regulations"), all as may be amended from time to time, and all collectively referred to herein as "HIPAA Requirements." Contractor agrees to enter into any further agreements as necessary to facilitate compliance with HIPAA Requirements.

19. **Access To Records.** Pursuant to the requirements of 42 CFR §420.300 et seq., each party agrees to make available to the Secretary of Health and Human Services ("HHS"), the Comptroller General of the Government Accounting Office ("GAO") or their authorized representatives, all contracts, books, documents and records relating to the nature and extent of costs hereunder for a period of four (4) years after the furnishing of Services hereunder for any and all Services furnished under this Agreement. In addition, each party hereby agrees to require by contract that each subcontractor makes available to the HHS and GAO, or their authorized representative, all contracts, books, documents and records relating to the nature and extent of the costs thereunder for a period of four (4) years after the furnishing of Services thereunder.

20. **Execution of Agreement.** This Agreement shall not become effective or in force until all of the below named parties have fully executed this Agreement.

**IN WITNESS WHEREOF**, the parties hereto have executed this Agreement as of the day and year first above written.

_____
_____
_____

By:_____
Its:_____

_____
_____
_____

By:_____
Its:_____

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

Consumer advantage weighs heavily in support of TSHH. Indeed, TSHH will have an overwhelmingly positive effect on the healthcare landscape in the Spring Hill area, including:

- Establishing a hospital in the City of Spring Hill, where no such facility exists, which will provide an option close to where citizens live, work, and play;
- Reducing travel time for patients and families;
- Improving access for patient and families with shorter time to reach services and to visit with patients who are not diverted out of the area;
- Providing cardiac catheterization services where none exist in Spring Hill. This, in turn, will save heart muscle by reducing the symptom to balloon time for patients needing intervention in a cath lab;
- Improving the time for birthing mothers to reach a hospital;
- Providing 24/7 OB coverage, mid-wifery led laborist services and a state-of-the-art LDRP facility with program enhancements such as immersion tubs, doulas and other desired features;
- Establishing a Level II NICU where no NICU currently exists in Spring Hill;
- Reducing travel time for a discharged mother to be with her Level II NICU baby while s/he remains hospitalized;
- Decreasing out-migration to access hospital services.
- Reducing ER to hospital transports for TriStar Spring Hill ER patients requiring inpatient or specialized care;
- Decreasing EMS transports from scenes to hospitals in other cities, which will reduce the time for EMS transports to reach a hospital and reduce the time that the EMS providers are out of service; and
- Reducing travel time for staff.

As a general principal, consumers benefit from having choices for their healthcare. This is especially true when it comes to hospital services. The HFC has recently recognized that patient choice is a valuable consumer benefit, especially when there is no such service available in a community. Here, there is no hospital in Spring Hill so consumers will benefit from the competition of having a hospital in their community rather that – as required currently – having to leave Spring Hill for hospitals in other cities.

As is fairly obvious, there is no material duplication of services from putting a hospital in the largest city in Tennessee that does not have one. The only "duplication" will be claimed by MRH. But MRH is 14.6 miles away, in another city, and on the other side of that city. Residents of the Spring Hill area regularly complain about the travel challenges that they face and requiring them to travel out of their city to Columbia is simply unfair to them. Spring Hill is the 11$^{th}$ largest city in the state. Spring Hill at 57,932 in population is considerably larger than Columbia at only 44,114 in population. The Spring Hill community deserves to have as good of access to hospital services as the community of Columbia.

Moreover, as discussed more fully in context with Exhibit 68, the charges at TSHH will be comparable to the charges at MRH. Accordingly, the cost and inconvenience of traveling to another city for inpatient hospital care will be greatly reduced by approving TSHH.

TSHH will bring other needed services to the Spring Hill community that are not there today, including cardiac catheterization, an ICU, hospital operating rooms, and a maternity center, including a Level II NICU. These additional benefits to consumers flow from the approval of TSHH.

Finally, as evidenced by the Letters of Support, the community, as it did in 2006, is begging for a hospital.

> *I have had numerous hospital stays at Centennial hospital and the drive alone has hindered loved ones from visiting and providing support. I would have liked to have been at a hospital nearby so that my loved ones could have had an easier time coming to see me.*
>
> *Cheryl Keegan, Thompson's Station Resident*

> *Our daughter was born at 24 weeks. Once we brought her home on oxygen and other health issues, our biggest concern was the closest hospital was 20 plus minutes away. Spring Hill has over 50,000 residents, many of whom are families with similar concerns. This hospital would greatly benefit them.*
>
> *This is needed. I hope that you will see that and give Spring Hill the hospital it needs and deserves.*
>
> *Matt Rigelsky, Spring Hill Resident*

> *We have 50 % MORE people than Columbia, and we have no full-sized hospital! Spring Hill deserves to have healthcare and residents shouldn't have to drive to other communities when they could get that care here.*
>
> *Steven Yankowski, Spring Hill Resident*

> *I live in a community of 803 homes that were built for adults 55 and over who are always in need of good healthcare. We currently have to drive at least 25 minutes in either direction for a hospital. Given the traffic on the 65 northbound, it can be very critical at times…A town our size without a hospital is a travesty! Spring Hill is the largest city in the state without a hospital, and we are continuing to grow. When people move here, the healthcare needs to be able to keep up with and accommodate for the growing needs of residents. If we do not do this now, we could be looking at a dire situation when Franklin, Spring Hill, and Columbia grow even more.*
>
> *Kathy Beck, Spring Hill Resident*

> *I would just say that Spring Hill does need a hospital. I've done a lot of research. I used to work at a hospital at Vanderbilt and Nashville General Hospital. And there's so much that goes on at a hospital and I was also a former firefighter and medic and seconds matter. So, when you're in the back of an ambulance or you're facilitating your own ride to a hospital, the fact that we have one so close in our own backyard in Spring Hill I believe strongly that it will save lives and as a person that represents quality, the citizens of Spring Hill deserve this hospital. It's the right time and the right place.*
>
> *Jim Hagaman, Mayor, Spring Hill*
> *April 15th, 2024 Media Interview*

The letters from which the above were extracted are included in Attachment 4N.

Respectfully, there are no negative impacts for consumers.

*Favorable Impact of TriStar Spring Hill Hospital on the Local Economy*

In addition, TSHH will benefit all residents of the Service Area, not only those who require inpatient and outpatient services via the direct, indirect and induced impact the hospital's implementation will have on the local economy, both short term and long term. This includes creating a significant long-term employment base in an area which is known for its commuting population and limited employment opportunities, positive impact on local taxes to enable Spring Hill to redeploy these

revenues into its community commitments, indirect impact benefiting local businesses and induced impact resulting from employees spending their wages on consumer-related services such as retail, restaurants, and other activities.

During the multi-year construction process, it will also generate significant employment in the construction industry, taxes from material, equipment, systems and other related purchases, indirect impact relative to local businesses supporting the construction and equipping activities and induced impact with workers spending locally.

The Economic Impact Study prepared by Chmura Economics & Analytics quantified the following impact on the local economy:

- Hospital construction is expected to have a $288.2 million local economic impact with 1,145 cumulative jobs:
    - $220.1 million in direct construction and related spending supporting 727 jobs;
    - $22.1 million in indirect spending supporting 70 jobs benefitting local businesses; and
    - $45.9 million and 348 cumulative jobs in induced impact as direct workers spend their wages at various businesses in the region.

- During its first five years of operation, the hospital is expected to have an $868.1 million local economic impact with 3,164 cumulative jobs, including:
    - $638 million in direct hospital operations with 1,869 jobs, measured based on total hospital revenue for five years and total hospital employment for five years;
    - $111.2 million in indirect spending supporting 512 jobs benefitting local businesses;
    - $119 million and 783 cumulative jobs in induced impact as hospital employees spend their wages at various businesses in the region; and
    - Local workforce employment will also reduce commuter traffic to access employment in other cities.

- The construction and operation of the proposed hospital will also generate significant tax revenue for the State and local government:
    - Corporate tax: Estimated at $800,000 during construction and $2.1 million during the first five years of operation.
    - Franchise tax: Estimated at $5.7 million during the first five years of operation.
    - Real estate tax: Estimated at $12.3 million during the first five years of operation.

TSHH will have a significant economic impact on the Spring Hill community which is a direct Consumer Advantage.

**4C. Discuss the availability of and accessibility to human resources required by the proposal, including clinicalleadership and adequate professional staff, as per the State of Tennessee licensing requirements, CMS,and/or accrediting agencies requirements, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.**

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

HCA's healthcare facilities in Tennessee and Kentucky, are organized with its TriStar Division, and within the TriStar Division, TriStar Health manages 11 hospitals, 5 freestanding EDs, 6 surgery centers, 20 urgent care centers, and 116 physician practices, with a continuum of services for residents of Middle Tennessee and Southern Kentucky. With TriStar Health's local, statewide, and national affiliations, TSHH expects to be able to recruit highly qualified individuals with the appropriate licensure to staff and support the hospital.

HCA Healthcare is the largest private employer in Williamson County and has approximately 2,300 employees residing in Williamson County and more than 450 employees residing in Maury County. At the TriStar Spring Hill campus, it operates a freestanding emergency department, imaging services, lab services, GI suite and provides physician offices to both independent physicians and affiliated physicians. TriStar employees at Spring Hill currently total 45 FTEs, giving TSHH a significant foundation of staff upon which it will build its employee and physician base to staff the proposed hospital appropriately.

Based on forecasted utilization, TriStar Spring Hill estimates a need for 283 FTEs in its initial year of operations. With the 2,750 HCA Healthcare employees residing in Maury and Williamson Counties, of which approximately 1,000 are direct care positions, and the existing FTE complement at the TriStar Spring Hill campus, the Applicant is confident it will successfully recruit the needed complement to staff the hospital with minimal impact on existing providers.

TriStar Health also has a significant representation of its providers (physicians and extenders) who reside in Maury and Williamson County. More than 600 providers reside in these two counties, with 39 currently residing in the Service Area. TSHH will capitalize on the presence of these providers as it develops its medical staff plan for its future operations.

TriStar Health and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. In 2021, HCA Healthcare opened the Galen College of Nursing in Nashville, which now has campuses and programs in Tennessee, Kentucky, Ohio, Virginia, South Carolina, Florida and Texas. The Nashville campus offers a 3-year Bachelor of Science in Nursing, an Associate Degree in Nursing (ADN) and an LPN to ADN Bridge program. It graduated 45 nurses in 2023, and is currently enrolling 700 new students each year. It expects estimated enrollment to increase of 5 to 10 percent each year. Accordingly, by 2025, Galen College of Nursing expects to graduate approximately 250 graduates each year. It is HCA's experience that 55 percent of the graduates join an HCA hospital for future employment. This relationship will assist with ongoing recruitment of staff within TriStar Health including recruitment for the proposed TSHH. TriStar Health is also committed to increasing its nursing residency programs.

The Thomas F. Frist, Jr. College of Medicine at Belmont University in Nashville, is a new medical school founded in alliance with HCA Healthcare to focus on training diverse physician leaders who embrace and value a whole-person approach to healing. The Thomas F. Frist, Jr. College of Medicine

at Belmont University will be housed in a new building that had its ribbon cutting on April 29, 2024.[51] The nearly 200,000-square-foot building is located within a block of Belmont's Gordon E. Inman Center and McWhorter Hall, which house the University's well-known nursing, physical therapy, occupational therapy, social work and pharmacy programs. The College of Medicine has recruited a leadership team consisting of experts from across the country and is currently recruiting clinical faculty. The College also recently announced that it has achieved accrediting "candidate status" from the LCME accrediting body. Its first class is expected to commence fall 2024.

In Middle Tennessee, TriStar Health is integrally involved in graduate medical education (GME). It currently has 59 residents, with 31 at TriStar Centennial (internal medicine, psychiatry, and transitional year), 20 at TriStar Skyline Medical Center (emergency medicine, neurology and physical medicine and rehabilitation) and 8 family medicine residents at TriStar Southern Hills Medical Center. HCA Healthcare has more than 1,850 residents at its hospitals, making it one of the largest GME providers in the country. TriStar Health and HCA Healthcare look forward to working collaboratively with Belmont to support the supply of healthcare professionals entering and staying in the profession and to ensure that they have access to training.

In addition to these programs for nurses and physicians, TriStar Health is extensively engaged with other educational and training programs throughout Middle Tennessee. These relationships provide for internships and other training opportunities for students at TriStar facilities and also provide a pipeline for future qualified employees. Exhibit 67 below provides a summary of programs that currently work with TriStar and the profession for which the students are matriculating and training.

**Exhibit 67**

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

[51] https://www.nashvillepost.com/business/health_care/belmont-opens-180m-medical-school-building/article_747f28e8-065e-11ef-a805-972db9b9e527.html

TSHH will:

- Be licensed by all required state agencies;
- Be accredited by The Joint Commission;
- Provide on-site diagnostic imaging and clinical laboratory services meeting all required clinical certifications and accreditations;
- Be staffed by credentialed physicians; and
- Provide access to on-call specialty physicians for consultations.

The Applicant will have all appropriate resources and be familiar with and meet all human resource requirements of the Tennessee Board for Licensing Health Care Facilities and the Joint Commission. In addition, the Applicant will be licensed and accredited by these bodies.

**TriStar Spring Hill Hospital Staffing**

More specific staffing estimates for TSHH are provided in response to **Question 8Q**.

**5C. Document the category of license/certification that is applicable to the project and why. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.**

Licensure and Certification

TSHH will seek licensure by the Tennessee Board for Licensing Health Care Facilities. The existing and currently licensed TriStar Spring Hill ER will be incorporated into the TSHH license and operate as its emergency room. TSHH will also apply to become certified to participate in the Medicaid and Medicare programs and meet all requirements of certification. TSHH will also plan to be accredited by The Joint Commission as are all TriStar Health hospitals.

Plan for Improvement of Organization Performance and Clinical Excellence

As part of TriStar Health, TSHH will be part of TriStar Health's methods to ensure and maintain quality of care. At TriStar Health, a collaborative multidisciplinary team approach, which considers the unique knowledge, judgment, and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for quality. TriStar Health is committed to providing a seamless continuum of health care both for individuals and for the community, linking together a full range of health care providers and services. TSHH's goal will be to provide services which are measurably more accessible, affordable, and are focused on continuous quality improvement. The continuum of services may begin prior to admission, such as in an ER visit, and continue throughout the hospital stay and post discharge phase to ensure appropriate patient assessment, reassessment, problem solving, and follow-up care as needed.

TSHH, as part of TriStar Health, will adhere to TriStar Health's plan for improving organizational performance, including planned performance assessment and improvement activities, initiating activities designed to follow-up on unusual occurrences or specific concerns/ issues, which may include following policies and procedures for ensuring staff competency and follow-up as appropriate on patient/family complaints and patient questionnaire results. Input and feedback from patients, staff and physicians guide the improvement process. TSHH will address methods to ensure and maintain patients' quality of care.

TSHH will be dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. It will maintain the highest standards and quality of care, consistent with the high standard that TriStar Centennial (its existing host which is 5-star CMS rated) has sustained throughout its history of providing patient care. In this regard, TSHH will incorporate a robust Quality Assurance and Performance Improvement ("QAPI") Plan, which will be framed by the following essential elements:

- Design and Scope that encompasses the full range of services and departments;
- Governance and Leadership that actively engage with system expectations and priorities;
- Feedback, Data Systems, and Monitoring to continuously assess a wide range of care and service;
- Performance Improvement Projects to improve care or services based on the data captured; and
- Systematic Analysis and Systematic Action to create real impact and long-lasting improvement.

Further, TSHH will provide a robust Utilization Review ("UR") program that provides ongoing concurrent reviews of patient care to determine whether treatments are medically necessary and, if not, to assist in placing patients in more appropriate care settings. Internal case management will

serve an important advisory purpose in enhancing and maintaining the quality of care provided. To this extent, systems will be in place to conduct prospective, concurrent, and retrospective utilization reviews to ensure quality of care and protect revenue integrity. For more details, see Attachment 5C for TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence.

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

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

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

Clinical Leadership

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

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

TSHH will be actively engaged in developing its leadership, establishing a performance improvement culture and empowering staff in their delivery of quality care in the Spring Hill community.

Clinical Staff Training and Requirements

In its dedication to enhance quality assurance and performance improvement, TSHH employees will be held to the highest standards and are expected to adhere to policies created by the Administration. These policies are developed in compliance with The Joint Commission guidelines for education, competency, and continuing education. Appropriate clinical licenses and certifications are required and documented. Moreover, during the recruitment process, employees are thoroughly vetted to ensure they meet the requirements identified in the job description. Upon hiring, employees are obligated to attend system-wide and department-specific orientation. New hires complete an initial skills checklist and competency assessment and undergo annual performance evaluation to appraise technical competency thereafter.

Furthermore, TSHH will require all clinical staff members to attend continuing education programs, and receive annual in-services on HIPAA, Medicare compliance, and OSHA. TSHH will offer an array of programs and resources to support employees in learning new skills and advancing their careers. For example, employees may take classes or workshops in the areas of computer technology skills, career and work-specific skills, and leadership and management skills.

Attachment 4C

EMTALA Policies

## EMTALA – MODEL Facility Policy

**POLICY NAME:** Tennessee EMTALA – Transfer Policy

**DATE:** (facility to insert date here)

**NUMBER:** (facility to insert number here)

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This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

**PURPOSE**: To establish guidelines for either accepting an appropriate transfer from another facility or providing an appropriate transfer to another facility of an individual with an emergency medical condition ("EMC"), who requests or requires a transfer for further medical care and follow-up to a receiving facility as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

**POLICY**: Any transfer of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf or by a physician order with the appropriate physician certification as required under EMTALA. EMTALA obligations regarding the appropriate transfer of an individual determined to have an EMC apply to any emergency department ("ED") or dedicated emergency department ("DED") of a hospital whether located on or off the hospital campus and all other departments of the hospital located on hospital property.

A hospital with specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) shall accept from a transferring hospital an appropriate transfer of an individual with an EMC who requires specialized capabilities if the receiving hospital has the capacity to treat the individual. The transferring hospital must be within the boundaries of the United States.

The transfer of an individual shall not consider age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law, except to the extent that pre-existing medical condition

or physical or mental handicap is significant to the provision of appropriate medical care to the individual.

The CEO must designate in writing an administrative designee by title responsible for accepting transfers in conjunction with a receiving physician. The CEO designee in conjunction with the ED physician has authority to accept the transfer if the hospital has the capability and capacity to treat the individual.

Note: Movement of an individual to another part of the same hospital is not considered a transfer for EMTALA purposes.

1. **Transfer of Individuals Who Have Not Been Stabilized**

   a. If an individual who has come to the emergency department has an EMC that has not been stabilized, the hospital may transfer the individual only if the transfer is an appropriate transfer and meets the following conditions:
      i. The individual or a legally responsible person acting on the individual's behalf requests the transfer, after being informed of the hospital's obligations under EMTALA and of the risks and benefits of such transfer. The individual must have received complete and accurate information about matters pertaining to the transfer decision, including: medical necessity of the movement; availability of appropriate services at both the transferring and receiving hospitals; the availability of indigent care at the hospital initiating the transfer and the facility's legal obligations to provide medical services without regard to the patient's ability to pay; and any obligation of the hospital through its participation in government medical assistance programs to accept such program's reimbursement as payment in full for needed medical care. The request must be in writing and indicate the reasons for the request as well as indicate that the individual is aware of the risks and benefits of transfer; or
      ii. A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of the woman in labor, to the woman or the unborn child, from being transferred. The certificate must contain a written summary of the risks and benefits upon which it is based; or
      iii. If a physician is not physically present in the DED at the time the individual is transferred, a qualified medical person ("QMP") has signed a certification after a physician in consultation with the QMP, agrees with the certification and subsequently countersigns the certification. The certification must contain a written summary of the risks and benefits upon which it is based.
      Note: The date and time of the physician or QMP certification should match the date and time of the transfer.

b. A transfer will be an appropriate transfer if:
   i. The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
   ii. The receiving facility has available space and qualified personnel for the treatment of the individual and a physician at the receiving facility has agreed to accept the transfer and to provide appropriate medical treatment;
   iii. The transferring hospital sends the receiving hospital copies of all medical records related to the EMC for which the individual presented that are available at the time of transfer as well as the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
   iv. The transfer is effected through qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transport.

   Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized EMCs that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the necessary capability and capacity to care for the unstabilized EMC.

c. Higher Level of Care. A higher level of care should be the more likely reason to transfer an individual with an EMC that has not been stabilized. The following are examples of a higher level of care:
   i. A receiving hospital with **specialized capabilities or facilities** that are not available at the transferring hospital (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) must accept an appropriate transfer of an individual with an EMC who requires specialized capabilities or facilities if the hospital has the capacity to treat the individual.
   ii. If there is a local, regional or state plan for hospital care for designated populations such as individuals with psychiatric disorders or high risk neonates, the transferring hospital must still provide an MSE and stabilizing treatment prior to transferring to the hospital so designated by the plan.

2. **Additional Transfer-Related Situations**

a. Diagnostic Facility. If an individual is moved to a diagnostic facility located at another hospital for diagnostic procedures not available at the transferring hospital and the hospitals arrange to return the individual to the transferring hospital, the transfer requirements must still be met by the sending hospital. The receiving hospital is not obligated to meet the EMTALA transfer requirements when implementing an appropriate transfer back to the transferring hospital. The recipient hospital will send or communicate the results of the tests performed to the transferring hospital.

b. Off-Campus hospital-based facilities to nonaffiliated hospital. A transfer from a hospital-based facility located off-campus to a nonaffiliated hospital must still comply with the requirements of an appropriate transfer as defined by EMTALA. A Memorandum of Transfer must be used in such situations.

> Note: Off-Campus Provider-based EDs or DED. A movement of a patient from an off-campus provider-based ED or DED to the main hospital ED is a movement and not a transfer.

c. Pre-Existing Transfer Agreements. Appropriate transfer agreements should be in place and in writing between the hospital, including any outpatient or other off-campus departments where care is provided and other hospitals in the area where the outpatient or off-campus departments are located. Even if there are pre-existing transfer agreements between transferring and receiving hospitals, a physician certification is required for any medically indicated transfer for an unstable individual. Transfer Agreements shall not include financial provisions for transfer but may include reciprocal provisions for transferring the individual back to the original transferring hospital when the higher level of care is no longer required.

d. Transfers for High Risk Deliveries. A hospital that is not capable of handling the delivery of a high-risk woman in labor must still provide an MSE and any necessary stabilizing treatment as well as meet the requirements of an appropriate transfer even if a transfer agreement is in place. In addition, a physician certification that the benefits of transfer outweigh the risks of transfer is required for the transfer of the woman in labor.

e. Diversion/Exceeded Capacity. If the transferring hospital has the capability but lacks the capacity to treat the individual, then the individual would likely benefit from the transfer and it would be permissible if all other conditions of an appropriate transfer are met. In addition, the hospital may transfer an individual due to bed shortage or overcrowding, if it has exhausted all its capabilities, even if the individual does not require any specialized capabilities of the receiving hospital. The receiving hospital must accept the transfer of the individual if it has the capacity and capability to do so. In communities with a community-wide emergency services system, the receiving hospital must accept the individual being transferred from a hospital on diversionary status if it has the capacity and capability. After acceptance, the receiving hospital may attempt to validate that the transferring hospital has, in fact, exhausted all its capabilities prior to transfer.

f. Lateral Transfers. Transfers between hospitals of comparable resources and capabilities are not permitted unless the receiving facility would offer enhanced care benefits to the patient that would outweigh the risks of the transfer. Examples of such situations include a mechanical failure of equipment or no ICU beds available.

g. Women in Labor. For a woman in labor, a transfer may be made only if the woman in labor or her representative requests the transfer, or if a physician signs a certification that the benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual or the unborn child. A hospital cannot cite State law or practice as the basis for transfer. A woman in labor who requests transfer to another facility may not be discharged against medical advice to go to the other facility. The risks associated with such a disposition must be thoroughly explained to the patient and documented. If the patient still insists on leaving to go to another facility, the facility should take all reasonable steps to obtain the patient's request in writing and take all reasonable steps to have the patient transported using qualified personnel and transportation equipment. Transporting a woman in labor by privately-owned vehicle is not an appropriate form of transportation.

h. Observation Status. An individual who has been placed in observation status is not an inpatient, even if the individual occupies a bed overnight. Therefore, an individual placed in an observation status who came to the hospital's DED for example, does not terminate the EMTALA obligations of that hospital or a recipient hospital toward an individual who remains in unstable condition at the time of transfer. The EMTALA obligation does not end until the patient has been stabilized, appropriately transferred, or discharged. Therefore, any transfer of a patient in observation status who initially presented to a DED must meet all the requirements of an EMTALA transfer.

## 3. Authority to Decline a Transfer Request

The ED physician, working in conjunction with the CEO, Administrator-on-Call (AOC), or a hospital leader who routinely takes administrative call has the authority to decline a transfer request based on a determination that the facility does not have the capability and/or capacity to accept such transfer. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor, or other similarly titled position is not considered to be an equivalent of the AOC.

## 4. Authority to Conduct a Transfer

The transferring physician is responsible for determining the appropriate mode of transportation, equipment and attendants for the transfer in such a manner as to be able to effectively manage any reasonably foreseeable complication of the individual's condition that could arise during the transfer. Only qualified personnel, transportation and equipment, including those life support measures that may be required during transfer shall be employed in the transfer of an individual with an unstabilized EMC. If the individual refuses the appropriate form of transportation determined by the transferring physician and decides to be transported by another method, the transferring physician is to document that the individual was informed of the risks associated with this type of transport and the individual should sign a form indicating the risks have been

explained and the individual acknowledges and accepts the risks. All additional requirements of an appropriate transfer are to be followed by the transferring hospital.

5. **Transfer Center Use**

Hospitals may utilize a Transfer Center to facilitate the transfer of any individual from or to the Emergency Department of the transferring facility to the receiving facility. The transferring physician, after discussion with the individual patient or his or her legally authorized representative, determines the appropriate receiving facility for providing the care necessary to stabilize and treat the individual's emergent condition. The Transfer Center then facilitates the transfer from the transferring facility to the facility selected by the transferring physician and/or the patient. Transfer Centers do not: 1) diagnose or determine treatment for medical conditions; 2) make independent decisions regarding the feasibility of transfer; 3) make independent decisions as to where the individual will be transferred; or 4) determine how a transfer shall be effected.

At the ED Physician's request, the Transfer Center must facilitate a discussion between the ED Physician and the on-call physician of the receiving facility. The on-call physician does not have the authority to refuse an appropriate transfer on behalf of the facility.

The Transfer Center may, at the transferring ED Physician's request, provide a list of the receiving facilities with capability and capacity for accepting the individual in need of transfer. The list should include geographic distances and specific capabilities of the receiving facilities. The ED Physician and the individual to be transferred then make the decision on the receiving facility.

The Transfer Center may, at the request of the transferring facility, provide information on the availability of EMS or transport options for transfer of an individual. However, the Transfer Center does NOT select the level of care provided by the transferring facility. The transfer acceptance cannot be predicated upon the transferring facility using a mode of transportation chosen by the receiving facility or a Transfer Center.

6. **Bed Management/Transfer Center Facility**

If the Transfer Center has real time access to necessary data elements documenting capability and capacity, the facility, the ED physician, and the Transfer Center representatives may develop criteria and algorithms for allowing the Transfer Center to accept a transfer request on behalf of the facility and the ED physician in order to expedite the transfer process. Such documents allowing a Transfer Center to accept a patient on behalf of a facility shall be in writing in the ED and on file in the Transfer Center. However, prior to completing the transfer process, the Transfer Center should validate the acceptance with the receiving ED and notify the facility of the transfer to ensure that the capability and capacity status has not changed and that the on-call physician is available when needed. A Transfer Center may not make any independent decisions

to refuse a transfer request, except that a bed management Transfer Center may refuse a request with respect to capacity.

**PROCEDURES:**

1. **Transfers of Individuals Who Are Not Medically Stable**

   **Requirements Prior to Transfer.** After the hospital has provided medical treatment within its capability to minimize the risks to the health of an individual with an EMC who is not medically stable, the hospital may arrange an appropriate transfer for the individual to another more appropriate or specialized facility. Evaluation and treatment shall be performed and transfer shall be carried out as quickly as possible for an individual with an EMC which has not been stabilized or when stabilization of the individual's vital signs is not possible because the hospital does not have the appropriate equipment or personnel to correct the underlying process. The following requirements must be met for any transfer of an individual with an EMC that has not been stabilized:

   a. Minimize the Risk. Before any transfer may occur, the transferring hospital must first provide, within its capacity and capability, medical treatment to minimize the risks to the health of the individual or unborn child.

   b. Individual's Request or Physician's Order. Any transfer to another medical facility of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf or by a physician order with the appropriate physician or QMP and Physician certification as required under EMTALA. Any written request for a transfer to another medical facility from an individual with an EMC or the legally responsible person acting on the individual's behalf shall indicate the reasons for the request and that he or she is aware of the risks and benefits of the transfer. The individual must have received complete and accurate information about matters pertaining to the transfer decision, including: medical necessecity of the movement; availability of appropriate services at both the transferring and receiving hospitals; the availability of indigent care at the hospital initiating the transfer and the facility's legal obligations to provide medical services without regard to the patient's ability to pay; and any obligation of the hospital through its participation in government medical assistance programs to accept such program's reimbursement as payment in full for needed medical care.

   c. Request To Transfer Made to Receiving Facility. The transferring hospital must call the receiving hospital or the Transfer Center if the facility is part of a Transfer Center network to verify the receiving hospital has available space and qualified personnel for the treatment of the individual. A physician at the receiving hospital must agree to accept the transfer and provide appropriate treatment. The transferring hospital must obtain permission from the receiving hospital to transfer an individual. This may be facilitated by a Transfer Center. Such permission should be documented on the medical record by

the transferring hospital, including the date and time of the request and the name and title of the person accepting transfer. The transferring physician shall ensure that a receiving hospital has appropriate services and has accepted responsibility for the individual being transferred. If utilizing the services of a Transfer Center, the Transfer Center may assist in determining whether the receiving hospital has the appropriate services.

d. Document the Request. The transferring hospital must document its communication with the receiving hospital, including the request date and time and the name of the person accepting the transfer.

e. Send Medical Records. The transferring hospital must send to the receiving hospital copies of all medical records available at the time of transfer related to the EMC and continuing care of the individual. The transferring hospital may provide the Face Sheet with the appropriate information to the Transfer Center to assist Transfer Center in facilitating the transfer. But, the Transfer Center generally may not provide any information to, or respond to questions from, to the receiving facility or physician at the receiving facility, from the Face Sheet regarding whether or not the patient has insurance, or the type of insurance, or other information regarding the patient's ability to pay for services prior to acceptance of the patient except as required by a state or local plan for providing care to certain patient populations where insurance coverage is a determining factor in where the patient may receive care. Documentation sent to the receiving hospital must include:

- Copies of the available history, all records related to the individual's EMC, observations of signs or symptoms, patient's condition at the time of transfer, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests, monitoring and assessment data, any other pertinent information, and the informed written consent for transfer of the individual or the certification of a physician or QMP.
- The name and address of any on-call practitioner who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and
- The individual's vital signs which should be taken immediately prior to transfer and documented on the Memorandum of Transfer Form.
- Copies of available records must accompany the individual; and
- Copies of other records not available at the time of transfer must be sent to the receiving hospital as soon as practical after the transfer.

Medical and other records related to individuals transferred to or from the hospital must be retained in their original or legally reproduced form in hard copy, microfilm, or electronic media for a period of five years from the date of transfer.

f. Physician Certification of Risks and Benefits. A physician must sign an express written certification that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a

woman in labor, to the unborn child, from being transferred. The certification should meet the following requirements:

- The certification must state the reason for transfer. The narrative rationale need not be a lengthy discussion of the individual's medical condition as this can be found in the medical record but should be specific to the condition of the patient upon transfer.
- The certification must contain a complete picture of the benefits to be expected from appropriate care at the receiving facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer.
- The date and time of the physician certification should closely match the date and time of the transfer.
- Certifications may not be backdated.

g. QMP Certification. If a physician is not physically present at the time of the transfer, a QMP may sign the certification, after consultation with a physician, and transfer the individual as long as the medical benefits expected from transfer outweigh the risks. If a QMP signs the certification, a physician shall countersign it within 24 hours or a reasonable time period specified by the hospital bylaws, rules or regulations.

h. Send Memorandum of Transfer. A Memorandum of Transfer must be completed for every patient who is transferred to another separately licensed hospital. The Memorandum of Transfer and the patient's medical record must be sent with the patient at the time of the transfer. A copy of the Memorandum of Transfer shall be retained by the transferring hospital and incorporated into the patient's medical record.

2. **Transfers that are requested by the individual but not medically indicated**

If a medically unstable individual, or the legally responsible person, requests a transfer to another hospital that is not medically indicated, the individual or the legally responsible person must first be fully informed of the risks of the transfer; the alternatives (if any) to the transfer; and the hospital's obligations to provide further examination and treatment sufficient to stabilize the individual's EMC.

Components of the Individual's Request for Transfer. The transfer is appropriate only when the request meets all of the following requirements:

- is in writing and indicates the reasons for the request;
- contains a statement of the hospital's obligations under EMTALA and the benefits and risks that were outlined to the person signing the request;
- indicates the individual is aware of the availability of appropriate services at both the transferring and receiving hospitals, the availability of indigent care at the transferring

hospital, and any obligation of the hospital to accept government medical assistance program reimbursement as payment in full;

- indicates that the individual is aware of the risks and benefits of the transfer;
- is made part of the individual's medical record, and a copy of the request should be sent to the receiving facility when the individual is transferred; and
- is not made through coercion or by misrepresenting the hospital's obligations to provide an MSE and treatment for an EMC or labor.

Note: Once the transfer is accepted, the Memorandum of Transfer and the patient's medical record must be sent with the patient.

3. **Refusal to Consent to Transfer**

If an individual, or the legally responsible person acting on the individual's behalf, refuses to consent to the hospital's offer to transfer the individual to another facility for services the hospital does not provide and informs the individual, or the legally responsible person, of the risks and benefits to the individual of the transfer, all reasonable steps must be taken to secure a written refusal from the individual or the person acting on the individual's behalf. The individual's medical record must contain a description of the proposed transfer that was refused by the individual or the person acting on the patient's behalf, a statement that the individual was informed of the risks and benefits and the reason for the individual's refusal to consent to the transfer.

4. **Transfer of Individuals Who Are Medically Stable**

EMTALA does not apply to an individual who has been medically stabilized. The hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized or who has been admitted as an inpatient.

a. Any individual who has been medically stabilized may be transferred upon request or pursuant to a physician's order via a pre-arranged transfer or treatment plan according to hospital policy.

b. **Document Stable Condition**. The stability of the individual is determined by the ED physician or QMP in consultation with the physician. After it is determined that the individual is medically stable, the physician or QMP must accurately and thoroughly document the parameters of such stability.

   i. A woman who is in labor is considered to be stabilized only after she has been delivered of the child and the placenta.

   ii. An individual presenting with psychiatric symptoms is considered to be stabilized when he/she is protected and prevented from harming self or others.

iii. If there is a disagreement between the treating physician and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual is stable for transfer, the medical judgment of the physician who is treating the individual at the transferring facility DED takes precedence over that of the off-site physician.

5. **Recipient Hospital Responsibilities**

a. A participating hospital that has specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) may not refuse to accept an appropriate transfer from a transferring hospital within the boundaries of the United States, of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

b. The requirement to accept an appropriate EMTALA transfer applies to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a DED. All licensed hospitals in Tennessee are required to accept appropiate transfers from other hospitals if the receiving hospital has space and capability, without regard to the patient's source of payment or ability to pay.

c. The recipient hospital's EMTALA obligations do not extend to individuals who are inpatients at another hospital.

d. If an individual arrives through the DED as a transfer from another hospital or health care facility, the hospital has a duty to have a physician or QMP, not a triage nurse, perform an appropriate MSE to determine whether the patient's condition deteriorated during the transport. The MSE must be documented in the medical record.

e. A recipient hospital with specialized capabilities that delays the treatment of an individual with an EMC who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances of the delay.

f. An individual on an EMS stretcher in the DED must be provided an MSE without delay. EMTALA regulations apply as soon as the individual arrives on the facility's campus even if the EMS service has not formally turned the individual over to the DED care providers.

g. The receiving hospital may handle the receipt and subsequent assessment of the transferred emergency patient in a number of ways, including:
   i. For example, the transferring facility may contact the individual or department designated by the CEO as the coordinator for transfers such as the House Supervisor or the Transfer Center. After the receiving hospital's designated transfer coordinator is contacted, this individual or Transfer Center will then coordinate any transfer

requests with the Administrator On-Call and the ED Physician as necessary. Once it has been determined that the receiving facility has agreed to accept the patient, the patient may be transferred directly to a designated specialty unit such as a SICU, PICU, Cardiac Catheterization Lab, Burn Center, or other Specialty Unit if there is capacity and a physician with the appropriate specialty credentials is available to assess the patient within a reasonable timeframe (generally, within 30 minutes). Upon acceptance into the specialty unit as an inpatient, the Conditions of Participation govern the patient's care, including the history and physical and establishment of a plan of care.

ii. If the receiving facility participates in a community wide cardiac or stroke alert system inclusive of pre-hospital patient management by EMS Services under the direction of a qualified physician that allows for diagnosis of an emergent medical condition prior to arrival at the receiving facility, the EMS service may take the patient directly to the Interventional Radiology Suite or the Cardiac Catheterization Lab if the stroke or cardiac alert team, including the appropriately credentialed physician, is present upon arrival of the patient. The awaiting physician in the Unit would perform the additional evaluation and treatment and document such findings in the medical record. The Interventional Radiology Suite or Cardiac Cath Lab would be responsible for ensuring the registration as an emergency patient thus ensuring the patient appears on the Central/EMTALA log.

iii. If a facility's transfer coordinator receives a request from a transferring hospital and no specialty bed is available but the DED has capacity and capability to further treat and stabilize the individual and an on-call physician is available, the receiving facility should accept the transfer as an ED to ED transfer. If the Emergency Department of the receiving hospital has exceeded its capacity and capability with individuals waiting to be seen and patients being held on stretchers in the hallways because no beds are available, then the receiving ED can refuse the transfer based upon no capacity and capability if that has been their practice in the past based on the same capacity.

iv. Each specialty unit shall be responsible for entering the transferred patient's name and pertinent data into the appropriate log as per hospital policy.

## 6. Review Process for Any Refused Transfers

For those situations in which the hospital refuses to accept a transfer from another facility, the hospital and Transfer Center must have in place a procedure to review potential refusals and/or to monitor any refusals of transfer from other facilities.

## 7. Reporting Potential EMTALA Violations

Each Transfer Center employee working with the DED, medical staff member, house staff member, hospital employee, or contracted individual who works in the DED or other area where EMTALA requirements are applicable and who has reason to believe that a potential violation of the law has resulted in an inappropriate transfer to the hospital as a receiving hospital or from the hospital as a transferring hospital must report the incident to the CEO or CEO's designee such as the Risk Manager or the ECO immediately for investigation.

a. **Receiving Hospitals**. Receiving hospitals have a duty to report any inappropriate transfer received from a transferring institution. A hospital that suspects it may have received an improperly transferred individual (transfer of an unstable individual with an EMC who was not provided an appropriate transfer according to 42 C.F.R. § 489.24(e)(2)), is required to promptly report the incident to the Centers for Medicare & Medicaid Services ("CMS") or the state agency within 72 hours of the occurrence. Failure to report within 72 hours may result in an EMTALA violation by the receiving facility.

b. **Transferring Hospitals**. A participating hospital may not penalize or take adverse action against a physician or a QMP because the physician or QMP refuses to authorize the transfer of an individual with an EMC that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of the EMTALA obligations.

## 8. Declared Emergencies

Sanctions under EMTALA for an inappropriate transfer during a national emergency do not apply to a hospital with a DED located in an area that has been declared a national emergency area. Please review the requirements for transfers during a National Emergency contained in the EMTALA – Definitions and General Requirements Policy, LL.EM.001, and consult with the hospital's Disaster and Emergency Preparedness Plan as well as Operations Counsel for additional guidance.

a. **Waiver of Sanctions**. Sanctions under EMTALA for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site for the MSE during a national emergency do not apply to a hospital with a DED located in an emergency area if the following conditions are met:
   i. the transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period;
   ii. the direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency ("PHE") that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan;

iii. the hospital does not discriminate on the basis of an individual's source of payment or ability to pay;
iv. the hospital is located in an emergency area during an emergency period; and
v. there has been a determination that a waiver of sanctions is necessary.

b. **Waiver Limitations**.

i. An EMTALA waiver can be issued for a hospital only if:
   - the President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act;
   - the Secretary of HHS has declared a PHE; and
   - the Secretary of HHS invokes his or her waiver authority including notifying Congress at least 48 hours in advance.

ii. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.

iii. In addition, in order for an EMTALA waiver to apply to the hospital and for sanctions not to apply: (i) the hospital must activate its disaster protocol; and (ii) the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan.

iv. Even when a waiver is in effect, there is still the expectation that everyone who comes to the DED will receive an appropriate MSE, if not in the DED, then at the alternate care site to which they are redirected or relocated.

v. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that if a PHE involves a pandemic infectious disease, the waiver will continue in effect until the termination of the application decision of a PHE or a limitation by CMS. However, the waiver may be limited to a date prior to the termination of the PHE declaration, as determined by CMS. If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital is located prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date. Likewise, if the hospital deactivates its disaster protocol prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date.

vi. All other EMTALA-related requirements continue to apply, as do similar State law requirements, even when a hospital is operating under an EMTALA waiver. For example, a hospital's obligation to accept an appropriate transfer of an individual under EMTALA cannot be waived if the hospital has the capabilities and capacity to accept such transfer (as discussed in this Policy).

PHYSICIAN

**Emergency Medical Condition (EMC) Identified:** (Mark appropriate box; have physician certify if **I.c** or **I.d** selected and then go to Section II.)

I. **MEDICAL CONDITION:** **Diagnosis:**_____

a. ☐ **No Emergency Medical Condition Identified:** This patient has been examined and an EMC has not been identified.
**Screening Physician Signature:**_____ *Date:* ____/____/____ *Time:*_____ *AM/PM*

b. ☐ **Unstable Patient, Request for Transfer:** The patient has been examined and an EMC has been identified and the patient is not stable. The hospital has the capability and capacity to provide the care needed but the patient has specifically requested to be transferred to another facility after being notified that the hospital can and is willing to provide the care needed to stabilize and treat the EMC.

c. ☐ **Patient Stable For Transfer:** The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

d. ☐ **Patient Unstable:** The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

**I.c and I.d Physician Certification:** *I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.*
**Physician Signature:**_____ *Date:* ____/____/____ *Time:*_____ *AM/PM*
**Signature applies to any checked boxes.**

II. **REASON FOR TRANSFER:**
☐ Medically Indicated ☐ Patient Requested (see patient request documentation: Section VII)
☐ On-call physician refused or failed to respond within a reasonable period of time
On-Call Physician Name: _____ Address _____

III. **RISKS AND BENEFITS FOR TRANSFER:**

| **Medical Benefits:** | **Medical Risks :** |
|---|---|
| ☐ Obtain level of care/ service unavailable at this facility. | ☐ Deterioration of condition in route |
| Service: _____ | ☐ Worsening of condition or death if you stay here. |
| ☐ Medical Benefits outweigh the risks. | ☐ Risk of traffic delay/accident resulting in condition deterioration or death. |
| ☐ Other _____ | ☐ Other _____ |

IV. **MODE/SUPPORT DURING TRANSFER AS DETERMINED BY PHYSICIAN:**
**Mode of transportation for transfer:** ☐ BLS ☐ ALS ☐ Helicopter ☐ Neonatal Unit ☐Other_____
Agency: _____ Name/Title of accompanying hospital employee if required: _____
**Support/Treatment during transfer:** ☐ Cardiac Monitor ☐ Oxygen: _____ ☐ IV Pump
☐ IV Fluid: _____Rate: _____ ☐ Restraints – Type: _____ ☐ Other: _____ ☐ None

Transferring Physician Signature if different from Certifying Physician:_____ Date: ___/___/___ Time: ____ AM/PM
If no physician immediately available, transfer authorized by Qualified Medical Provider per Dr. _____
QMP Signature _____ Date: ___/___/___ Time: ____ AM/PM
Authorizing Physician Signature _____ Date: ___/___/___ Time: ____ AM/PM

NURSING

V. **RECEIVING FACILITY AND INDIVIDUAL:** The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility: _____Person accepting TXFR: _____ Date: ___/___/___Time:____ AM/PM

Receiving MD_____ Date: ___/___/___Time:____ AM/PM

Questions regarding Medication Reconciliation Information may be directed to _____or Transferring Physician.

VI. **ACCOMPANYING DOCUMENTATION** sent via: ☐ Patient/Responsible Party ☐ Fax ☐ Transporter
Documentation includes: ☐ Copy of Medical Record ☐ Lab/ EKG/ X-Ray ☐ Copy of Transfer Form
☐Medication Reconciliation Information ☐ Advanced Directive ☐ Other _____

Report given to: (Person/title): _____
Time of Transfer: _____ Date: _____ Nurse Signature: _____Transferring Unit:_____
Vital Signs Just Prior to Transfer: Temp: _____ Pulse_____ R_____ BP_____ spO2%_____ FHT_____ Time:____ AM/PM

PATIENT

VII. **PATIENT CONSENT TO MEDICALLY INDICATED TRANSFER or PATIENT REQUEST FOR TRANSFER (Mark appropriate box a. or b.):**

a. ☐ I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits of this transfer.

b. ☐ I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's EMTALA responsibilities that have been explained to me, the availability of appropriate care, the medical risks and benefits of transfer and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician or anyone associated with the hospital. I agree to accept the risks associated with my decision.

The reason I request transfer is: _____

Signature of: ☐ Patient ☐ Responsible Person_____ Relationship to patient_____

Witness_____ Title _____ Date: ___/___/___Time:____ AM/PM

PATIENT LABEL

## EMTALA - MODEL Facility Policy

**POLICY NAME:** Tennessee EMTALA – Medical Screening Examination and Stabilization Policy

**DATE:** (facility to insert date here)

**NUMBER:** (facility to insert number here)

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This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

**Purpose:** To establish guidelines for providing appropriate medical screening examinations ("MSE") and any necessary stabilizing treatment or an appropriate transfer for the individual as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

**Policy:** An EMTALA obligation is triggered when an individual comes to a dedicated emergency department ("DED") and:

1. the individual or a representative acting on the individual's behalf requests an examination or treatment for a medical condition; or
2. a prudent layperson observer would conclude from the individual's appearance or behavior that the individual needs an examination or treatment of a medical condition.

Such obligation is further extended to those individuals presenting elsewhere on hospital property requesting examination or treatment for an emergency medical condition ("EMC"). Further, if a prudent layperson observer would believe that the individual is experiencing an EMC, then an appropriate MSE, within the capabilities of the hospital's DED (including ancillary services routinely available and the availability of on-call physicians), shall be performed. The MSE must be completed by an individual (i) qualified to perform such an examination to determine whether an EMC exists, or (ii) with respect to a pregnant woman having contractions, whether the woman is in labor and whether the treatment requested is explicitly for an EMC. If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as defined by and required by EMTALA. Stabilization treatment shall be applied in a non-discriminatory manner (*e.g.*, no different level of care because of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law).

**Procedure:**

1. **When an MSE is Required**

A hospital must provide an appropriate MSE within the capability of the hospital's emergency department, including ancillary services routinely available to the DED, to determine whether or not an EMC exists: (i) to any individual, including a pregnant woman having contractions, who requests such an examination; (ii) an individual who has such a request made on his or her behalf; or (iii) an individual whom a prudent layperson observer would conclude from the individual's appearance or behavior needs an MSE. An MSE shall be provided to determine whether or not the individual is experiencing an EMC or a pregnant woman is in labor. An MSE is required when:

a. The individual ***comes to a DED*** of a hospital and a request is made by the individual or on the individual's behalf for examination or treatment for a medical condition, including where:
   i. The individual requests medication to resolve or provide stabilizing treatment for a medical condition.
   ii. The individual arrives as a transfer from another hospital or health care facility. Upon arrival of a transfer, a physician or qualified medical person ("QMP") must perform an appropriate MSE. The physician or QMP shall provide any additional screening and treatment required to stabilize the EMC. The MSE of the individual must be documented. This type of screening cannot be performed by the triage nurse. If an EMC is determined to exist and the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under EMTALA ceases.

   **Note:** The MSE and other emergency services need not be provided in a location specifically identified as a DED. The hospital may use areas to deliver emergency services that are also used for other inpatient or outpatient services. MSEs or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the DED.

b. The individual arrives on the ***hospital property other than a DED*** and makes a request or another makes a request on the individual's behalf for examination or treatment for an EMC.
   i. Screening where the individual presented: If an individual is initially screened in a department or location on-campus other than the DED, the individual may be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being a transfer. The hospital shall not move the individual to an off-campus facility or department (such as an urgent care center or satellite clinic) for an MSE.
   ii. Transporting to the DED: The hospital may determine that movement of an individual to the hospital's DED may be necessary for screening. However, common sense and individual judgment should prevail. When determining how best to transport the individual to the DED (means of transport, accompanying qualified personnel, equipment, etc.), the following factors should be taken into account but shall not be determinative:
      - Whether the hospital DED has the personnel and resources necessary to render adequate medical treatment to all existing patients in the DED,
      - Whether responding to the emergency could send hospital personnel into harm's way or unreasonably endanger or jeopardize the lives or health of such personnel, and

- Whether non-hospital paramedics, emergency medical technicians, or other qualified personnel are more appropriate to respond.

iii. Transporting to other hospital property: The facility may direct individuals to other hospital-based facilities that are on hospital property and operated under the hospital's provider number. However, the hospital should not move an individual to a hospital-based facility located off-campus, such as a rural health clinic or physician office, for an MSE or other emergency services. Individuals should only be moved to the hospital-based on-campus facility when the following conditions are met:

- all persons with the same medical condition are moved to this location regardless of their ability to pay for treatment,
- there is a bona fide medical reason to move the individual, and
- QMP accompany the individual.

**Note:** Unless outpatient testing is associated with an individual presenting to the DED with a request for an emergency medical screening, it should not be performed in the emergency department. Individuals presenting for outpatient testing should be registered as outpatients and not as emergency patients.

**Note:** Anyone may make the request for an MSE or treatment described in both a. and b. above. Specifically,

- A minor (child) can request an examination or treatment for an EMC. Hospital personnel should not delay the MSE by waiting for parental consent. If, after screening the minor, it is determined that no EMC is present, the staff may wait for parental consent before proceeding with further examination and treatment. **Note:** For additional information regarding treatment of minors, please consult your operations counsel.
- Emergency Medical Services (EMS) personnel may request an evaluation or treatment on an individual's behalf.

**Example:** If an individual is on a gurney or stretcher or in an ambulance or on a helipad at the hospital and EMS personnel, the individual, or a legally responsible person acting on the individual's behalf, requests examination or treatment of an EMC from hospital staff, an MSE must be provided.

c. The individual arrives ***on the hospital property***, either in the DED or property other than the DED, ***and no request is made*** for evaluation or treatment, but the appearance or behavior of the individual would cause a prudent layperson observer to believe that the individual needed such examination or treatment.

d. An individual is in a ***ground or air ambulance*** for purposes of examination and treatment for a medical condition at a hospital's DED, and the ambulance is either:
   i. *owned and operated by the hospital,* even if the ambulance is not on hospital grounds, or
   ii. neither owned nor operated by the hospital, but *on hospital property.*

e. A ***community-wide plan*** exists for specific hospitals to treat certain EMCs (*e.g.*, psychiatric, trauma, physical or sexual abuse). Prior to transferring the individual to the community plan hospital, an MSE must be performed and any necessary stabilizing treatment rendered.

f. If a ***law enforcement official*** requests hospital emergency personnel to provide ***medical clearance*** for incarceration, the Hospital has an EMTALA obligation to provide an MSE to determine if an EMC exists. If an EMC is found to exist and is stabilized, the Hospital has met its EMTALA obligations and additional requests for assessment or testing are not required. All facilities must remain in compliance with federal and state HIPAA regulations.

g. If a ***law enforcement official*** brings a person who is exhibiting behavior that suggests that he or she is intoxicated to the DED for ***drawing of the blood alcohol*** and asks for an MSE, or if a prudent layperson observer would believe that the individual needed examination or treatment for a possible EMC, then an MSE must be performed. This is required because some medical conditions could present behaviors similar to those of an inebriated individual.

h. If an individual presents to a facility which does not have the capability to perform a rape kit when one is needed, the hospital's obligation is to provide an appropriate MSE without disturbing the evidence and transfer the individual to a hospital that has the capability to gather the evidence. Transfer must occur only in compliance with hospital policies and procedures that are Medicare Hospital Conditions of Participation (CoP) and licensure compliant.

i. ***Born Alive Infant.*** When an infant is born alive in the DED, if a request is made on the infant's behalf for screening for a medical condition or if a prudent layperson would conclude based on the infant's appearance or behavior that the infant needed examination or treatment for a medical condition, the hospital and physician must provide an MSE. If the infant is born alive elsewhere on the hospital's campus and a prudent layperson observer would conclude based on the born alive infant's appearance or behavior that the infant was suffering from an EMC, the hospital and medical staff must perform an MSE to determine whether or not an EMC exists. If an EMC exists, the hospital must provide for stabilizing treatment or an appropriate transfer.

j. ***Off-Campus Provider-Based Emergency Department.*** **An off-campus provider based-emergency department is a department of the hospital, located no more than 35 miles from the main hospital, that meets all the provider-based requirements, holds the same Medicare provider number as the main hospital and either is (i) licensed by the state as an Emergency Department, (ii) is advertised as providing care for emergency medical conditions on an urgent basis without appointment, or (iii) provides at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring previously scheduled appointments.** If an individual presents to an off-campus provider-based emergency department (should not be referred to as a "free-standing" emergency department), he or she must be provided an appropriate MSE just as he or she would if the presentation was at the main campus emergency department. Should the individual require additional screening for stabilizing care by a physician specialist, he or she will be moved to the main campus or another non-HCA facility for the additional care required. Such movement would be via an appropriate transport vehicle as designated by the ED Physician with appropriate equipment and personnel as determined by the ED Physician.

2. **When an MSE is NOT Required**

a. If an individual **presents to a DED** in the following circumstances only, **no MSE is required by EMTALA:**

i. ***The individual requests services that are NOT examination or treatment for an EMC,*** *such as preventive care services or drugs that are not required to stabilize or resolve an EMC;*

**Example**: An individual presents to the DED and tells the clerk that he needs a flu shot because it is now flu season. The hospital is not obligated to provide an MSE under EMTALA because the request for a flu vaccine is a preventive care service.

ii. ***The individual requests services that are NOT for an EMC such as gathering of evidence for criminal law cases*** (sexual assault, blood alcohol). When the request made is only to collect evidence, not to analyze the results or otherwise examine or treat the individual, no EMTALA obligation exists;

iii. ***When an individual appears for non-emergency tests*** or pursuant to a previously scheduled visit. The hospital must ensure and document that no EMC was present or that no request was made to examine or treat the individual for an EMC.

a) When an individual presents to the DED for medical care that is, by its nature, clearly unlikely to involve an EMC, the individual's statement that he or she is not seeking emergency care, together with brief questioning by QMP, is sufficient to establish that there is no EMC.

b) A QMP is not required to question or examine the individual if the individual presents to the DED solely to fill a physician's order for a non-emergency test. The QMP should, however, question the individual to confirm that no EMC exists if the individual requests treatment for a non-emergency condition unrelated to the physician's order.

**Example:** A physician refers an individual to the emergency department for occupational medicine testing.

b. If the individual is in a ***ground or air ambulance*** which is:

i. *owned and operated* by the hospital and *operated under community-wide EMS protocols or EMS protocols "mandated by State law" that direct it to transport* the individual to a hospital other than the hospital that owns the ambulance (i.e., to the closest appropriate facility). In this case, the individual is considered to have "come to the emergency department of the hospital" to which the individual is transported, at the time the individual is brought onto hospital property; or

ii. *not owned by the hospital and not on the hospital's property* even if the ambulance personnel contact the hospital by telephone or telemetry communications and inform the hospital that they want to transport the individual to the hospital for examination and treatment; or

iii. *owned but not operated by the hospital* as where a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance directs its operation and the ambulance is not on hospital property.

**Note**: A hospital may deny access to individuals when it is in "official diversionary" status because it does not have the capability or capacity to accept any additional emergency

individuals at the time. The hospital shall develop and adopt written criteria that describe the conditions under which any or all of the hospital's emergency services are deemed to be at maximum capacity.

**Caution:** If the ambulance staff disregards the hospital's instructions and brings the individual on to hospital property, the individual has come to the emergency department and the hospital must perform an appropriate MSE. Should a hospital which is not in official diversionary status fail to accept a telephone or radio request for transfer or admission, the refusal could represent a violation of other Federal or State regulations.

**Note**: The hospital shall maintain written records documenting the date and time of the start and end of each period of diversionary status.

c. ***Use of hospital-owned helipad on hospital property for patient transport.*** No MSE is required for individuals being transported by local ambulance services or other hospitals to tertiary hospitals throughout the state through use of a ***hospital-owned helipad on the hospital's property*** by local ambulance services or other hospitals as long as the sending hospital conducted the MSE prior to transporting the individual to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an EMC exists and implementing stabilizing treatment or conducting an appropriate transfer.

**Caution:** If the individual's condition deteriorates while being transported to the helipad or while at the helipad, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity if requested by medical personnel accompanying the individual.

If, as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital with the helipad does not have an EMTALA obligation if they are not the recipient hospital, unless a request is made by EMS personnel, the individual, or a legally responsible person acting on the individual's behalf for the examination or treatment of an EMC.

d. ***Off campus, non-DED.*** If an individual requests emergency care in a hospital department off the hospital's main campus that does not meet the definition of a DED, EMTALA does not apply and the hospital department is not obligated to perform an MSE. However, the off-campus department must have policies and procedures in place as to how to handle patients in need of immediate care.

3. **Extent of the MSE**

a. **Determine if an EMC exists.** The hospital must perform an MSE to determine if an EMC exists. It is not appropriate to merely "log in" or triage an individual with a medical condition and not provide an MSE. Triage is not equivalent to an MSE. Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital in order to prioritize when the individual will be screened by a physician or other QMP.

b. **Definition of MSE.** An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. It is not an isolated event. The MSE must be appropriate to the individual's presenting signs and symptoms and the capability and capacity of the hospital.

c. **An on-going process.** The individual shall be continuously monitored according to the individual's needs until it is determined whether or not the individual has an EMC, and if he or she does, until he or she is stabilized or appropriately admitted or transferred. The medical record shall reflect the amount and extent of monitoring that was provided prior to the completion of the MSE and until discharge or transfer.

d. **Judgment of physician or QMP.** The extent of the necessary examination to determine whether an EMC exists is generally within the judgment and discretion of the physician or other QMP performing the examination function according to algorithms or protocols established and approved by the medical staff and governing board.

e. **Extent of MSE varies by presenting symptoms.** The MSE may vary depending on the individual's signs and symptoms:
   i. Depending on the individual's presenting symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans and other diagnostic tests and procedures.
   i. *Pregnant Women:* The medical records should show evidence that the screening examination includes, at a minimum, on-going evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of membranes (*i.e.,* ruptured, leaking and intact), to document whether or not the woman is in labor. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife or other QMP acting within his or her scope of practice as defined by the hospital's medical staff bylaws and State medical practice acts, certifies in writing that after a reasonable time of observation, the woman is in false labor. The recommended timeframe for such physician certification of the QMP's determination of false labor should be within 24 hours of the MSE, however, the medical staff bylaws, rules and regulations can provide guidance on the timeframe.
   ii. *Individuals with psychiatric or behavioral symptoms:* The medical records should indicate both medical and psychiatric or behavioral components of the MSE. The MSE for psychiatric purposes is to determine if the psychiatric symptoms have a physiologic etiology. The psychiatric MSE includes an assessment of suicidal or homicidal thoughts or gestures that indicates danger to self or others.

**Non-discrimination.** The hospital must provide an MSE and necessary stabilizing treatment to any individual regardless of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law.

4. **Who May Perform the MSE**

a. Only the following individuals may perform an MSE:
   i. A qualified physician with appropriate privileges;
   ii. Other qualified licensed independent practitioner (LIP) with appropriate competencies and privileges; or
   iii. A qualified staff member who:
      - is qualified to conduct such an examination through appropriate privileging and demonstrated competencies;
      - is functioning within the scope of his or her license and in compliance with state law and applicable practice acts (*e.g.*, Medical or Nurse Practice Acts);
      - is performing the screening examination based on medical staff approved guidelines, protocols or algorithms; and
      - is approved by the facility's governing board as set forth in a document such as the hospital bylaws or medical staff rules and regulations, which document has been approved by the facility's governing body and medical staff. It is not acceptable for the facility to allow informal personnel appointments that could change frequently.

b. **Qualified Medical Personnel.** QMPs may perform an MSE if licensed and certified, approved by the hospital's governing board through the hospital's bylaws, and only if the scope of the EMC is within the individual's scope of practice.

   i. The designation of QMP is set forth in a document approved by the governing body of the hospital. Each individual QMP approved to provide an MSE under EMTALA must be appropriately credentialed and must meet the requirements for annual evaluations set forth in the protocol agreements with physicians and the State's medical practice act, nurse practice act or other similar practice acts established to govern health care practitioners. Only appropriately credentialed APRNs, PAs and physicians may perform MSEs in the DED.

   ii. **Psychiatric QMP.** The ED physician shall consult the QMP providing the behavioral assessment for psychiatric purposes but shall remain the primary decision-maker with regard to transfer and discharge of the individual presenting to the DED with psychiatric or behavioral emergencies. Should an individual with a psychiatric or behavioral emergency present to a behavioral department of a hospital that meets the requirements of a DED, that department is responsible for ensuring that the individual has the appropriate MSE, including any behavioral examination, and providing necessary stabilizing treatment.

   iii. **Labor and Delivery QMP.** QMPs in the labor and delivery DED may be appropriately-approved RNs and must communicate their findings as to whether or not a woman is in labor to the obstetrician on call, the laborist, or the ED physician.

   iv. **Limitations.** The hospital has established a process to ensure that:
      a) a physician examines all individuals whose conditions or symptoms require physician examination;
      b) an ED physician on duty is responsible for the general care of all individuals presenting themselves to the emergency department; and

c) the responsibility remains with the ED physician until the individual's private physician or an on-call specialist assumes that responsibility, or the individual is discharged.

5. **No Delay in Medical Screening or Examination**

a. **Reasonable Registration Process.** An MSE, stabilizing treatment, or appropriate transfer will not be delayed to inquire about the individual's method of payment or insurance status, or conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered. The facility may follow reasonable registration processes for individuals for whom examination or treatment is required. Reasonable registration processes may include asking whether the individual is insured, and if so, what that insurance is, as long as these procedures do not delay screening or treatment or unduly discourage individuals from remaining for further evaluation. The hospital may seek non-payment information from the individual's health plan about the individual, such as medical history. In the case of an individual with an EMC, once the hospital has conducted the MSE and has initiated stabilizing treatment, it may seek authorization for all services from the plan as long as doing so does not delay completion of the stabilizing treatment.

b. **Managed Care.** For individuals who are enrolled in a managed care plan, prior authorization from the plan shall NOT be required or requested before providing an appropriate MSE and initiating any further medical examination and necessary stabilizing treatment.

c. **EMS.** A hospital has an obligation to see the individual once the individual presents to the DED whether by EMS or otherwise. A hospital that delays the MSE or stabilizing treatment of any individual who arrives via transfer from another facility, by not allowing EMS to leave the individual, could be in violation EMTALA and the Hospital CoP for Emergency Services. Even if the hospital cannot immediately complete an appropriate MSE, the hospital must assess the individual's condition upon arrival of the EMS service to ensure that the individual is appropriately prioritized based on his or her presenting signs and symptoms to be seen for completion of the MSE.

d. **Contacting the individual's physician.** An ED physician or non-physician practitioner may contact the individual's personal physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to medical treatment and screening of the individual, so long as this consultation does not inappropriately delay services.

e. **Financial Responsibility Forms.** The performance of the MSE and the provision of stabilizing treatment will NOT be conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered.

f. **Financial Inquiries.** Individuals who inquire about financial responsibility for emergency care should receive a response by a staff member who has been well trained to provide information regarding potential financial liability. The staff member who provides information on potential financial liability should clearly inform the individual that the hospital will provide an MSE and

any necessary stabilizing treatment, regardless of his or her ability to pay. Individuals who believe that they have an EMC should be encouraged to remain for the MSE.

Note: There is no delay in the provision of an MSE or stabilizing treatment if: (i) there is not an open bed in the DED; (ii) there are not sufficient caregivers present to render the MSE and/or stabilizing treatment; and (iii) the individual's condition does not warrant immediate screening and treatment by a physician or QMP.

6. **Refusal to Consent to Treatment**

   a. **Written Refusal – Partial Refusal of Care or Against Medical Advice.** If a physician or QMP has begun the MSE or any stabilizing treatment and an individual refuses to consent to a test, examination or treatment or refuses any further care and is determined to leave against medical advice, after being informed of the risks and benefits and the hospital's obligations under EMTALA, reasonable attempts shall be made to obtain a written refusal to consent to examination or treatment using the form provided for that purpose or document the individuals refusal to sign the Partial Refusal of Care or the Against Medical Advice Form (see Partial Refusal of Care or Against Medical Advice Form previous). The medical record must contain a description of the screening and the examination, treatment, or both if applicable, that was refused by or on behalf of the individual.

   b. **Waiver of Right to Medical Screening Examination.** If an individual refuses to consent to examination or treatment and indicates his or her intention to leave prior to triage or prior to receiving an MSE or if the individual withdrew the initial request for an MSE, facility personnel must request that the individual sign the Waiver of Right to Medical Screening Examination Form that is part of the Sign-In Sheet or document on the Sign-In Sheet the individual's refusal to sign the Waiver of Right to Medical Screening Examination Form previous.

   c. **Documentation of Information.** If an individual refuses to sign a consent form, the physician or nurse must document that the individual has been informed of the risks and benefits of the examination and/or treatment but refused to sign the form.

   d. **Documentation of Unannounced Leave.** If an individual leaves the facility without notifying facility personnel, this must be documented upon discovery. The documentation must reflect that the individual had been at the facility and the time the individual was discovered to have left the premises. Triage notes and additional records must be retained. If the individual leaves prior to transfer or leaves prior to an MSE, the information should be documented on the individual's medical record. If an individual has not completed a Sign-In Sheet, an ED staff member should complete a sheet and if the individual's name is not known a description of the individual leaving should be entered on the form. All individuals presenting for evaluation or treatment must be entered into the Central Log.

7. **Stabilizing Treatment Within Hospital Capability**

The determination of whether an individual is stable is not based on the clinical outcome of the individual's medical condition. An individual has been provided sufficient stabilizing treatment

when the physician treating the individual in the DED has determined, within reasonable clinical confidence, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an EMC of a woman in labor, that the woman has delivered the child and placenta; or in the case of an individual with a psychiatric or behavioral condition, that the individual is protected and prevented from injuring himself/ herself or others. For those individuals who are administered chemical or physical restraints for purposes of transfer from one facility to another, stabilization may occur for a period of time and remove the immediate EMC, but the underlying medical condition may persist and, if not treated for longevity, the individual may experience exacerbation of the EMC. Therefore, the treating physician should use great care when determining if the EMC is in fact stable after administering chemical or physical restraints.

a. **Stable.** The physician or QMP providing the medical screening and treating the emergency has determined within reasonable clinical confidence, that the EMC that caused the individual to seek care in the DED has been resolved although the underlying medical condition may persist. Once the individual is stable, EMTALA no longer applies. (The individual may still be transferred; however, the "appropriate transfer" requirement under EMTALA does not apply.)

b. **Stabilizing Treatment Within Hospital Capability and Transfer.** Once the hospital has provided an appropriate MSE and stabilizing treatment within its capability, an appropriate transfer may be effected by following the appropriate transfer provisions. (See Transfer Policy.) If there is a disagreement between the physician providing emergency care and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual has been provided sufficient stabilized treatment to effect a transfer, the medical judgment of the transferring physician takes precedence over that of the off-site physician.

   Refer to the hospital's Transfer Policy for additional directions regarding transfers of those individuals who are not medically stable. If a hospital has exhausted all its capabilities and is unable to stabilize an individual, an appropriate transfer should be implemented by the transferring physician.

c. **Stabilizing Treatment and Individuals Whose EMCs Are Resolved.** An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his or her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions. The EMC that caused the individual to present to the DED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.

8. **When EMTALA Obligations End**

The hospital's EMTALA obligation ends when a physician or QMP has made a decision:

a. That no EMC exists (even though the underlying medical condition may persist);
b. That an EMC exists and the individual is appropriately transferred to another facility; or
c. That an EMC exists and the individual is admitted to the hospital for further stabilizing treatment; or
d. That an EMC exists and the individual is stabilized and discharged.

**Note**: A hospital's EMTALA obligation ends when the individual has been admitted in good faith as an inpatient, whether or not the individual has been stabilized.* An individual is considered to be an inpatient when the individual is formally admitted to the hospital by a physician's order. A hospital continues to have a responsibility to meet the patient's emergency needs in accordance with hospital CoPs. A patient in observation status is not considered admitted as an inpatient, therefore, EMTALA obligations continue.

*Case law provides that EMTALA does apply to inpatients who have not been stabilized in Kentucky, Tennessee, Ohio and Michigan. *Moses v. Providence Hospital and Medical Centers, Inc. and Paul Lessem, 6th Circuit Court of Appeals, April 6, 2009.*

k. ***EMTALA Waivers and Requirements During Pandemics and Other Declared Emergencies.***
   a. Alternative Screening Sites on Campus for Screening during a Pandemic (No Waiver Required.) For the screening of influenza like illnesses, the hospital may establish an alternative screening site(s) on campus. Individuals may be redirected to these sites AFTER being logged in. The redirection and logging can take place outside the entrance to the DED. However, the person doing the directing must be qualified (*e.g.*, an RN or QMP) to recognize individuals who are obviously in need of immediate treatment in the DED. The MSEs must be conducted by qualified personnel.
   b. Alternative Screening Site Off-Campus (No Waiver Required.) The hospital may encourage the public to go to an off-campus hospital-controlled site for the screening of influenza like illness. However, the hospital may NOT tell an individual who has already come to the DED to go to the off-site location for the MSE. The off-campus site for influenza like illnesses should not be held out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis.
   c. EMTALA Waivers.
      i. A hospital operating under an EMTALA waiver will not be sanctioned for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site, for the MSE if the following conditions are met:
         1. The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period (as those terms are defined in the hospital's EMTALA Transfer Policy);
         2. The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan

or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan;
3. The hospital does not discriminate on the basis of an individual's source of payment or ability to pay;
4. The hospital is located in an emergency area during an emergency period; and
5. There has been a determination that a waiver of sanctions is necessary.

ii. An EMTALA waiver can be issued for a hospital only if:
1. The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act; and
2. The Secretary of HHS has declared a Public Health Emergency (PHE); and
3. The Secretary invokes his or her waiver authority including notifying Congress at least 48 hours in advance; and
4. The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.

c. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.

d. In addition, in order for an EMTALA waiver to apply to the hospital and for sanctions not to apply, (i) the hospital must activate its disaster protocol, and (ii) the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan.

e. Even when a waiver is in effect, there is still the expectation that everyone who comes to the DED will receive an appropriate MSE, if not in the DED, then at the alternate care site to which they are redirected or relocated.

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's disaster protocol. In the case of a PHE involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, the waiver may be limited to a date prior to the termination of the PHE declaration, as determined by CMS. If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital is located prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date. Likewise, if the hospital deactivates its disaster protocol prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date.

## EMTALA - MODEL Facility Policy

**POLICY NAME:** EMTALA – Provision of On-Call Coverage Policy

**DATE:** (facility to insert date here)

**NUMBER:** (facility to insert number here)

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This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be easily identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

**PURPOSE:** To establish guidelines for the hospital, including a specialty hospital, and its personnel to be prospectively aware of which physicians, including specialists and sub-specialists, are available to provide additional medical evaluation and treatment necessary to stabilize individuals with emergency medical conditions ("EMCs") in accordance with the resources available to the hospital as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal and State regulations and interpretive guidelines promulgated thereunder.

**POLICY:** The hospital must maintain a list of physicians on its medical staff who have privileges at the hospital or, if it participates in a community call plan, a list of all physicians who participate in such plan. Physicians on the list must be available after the initial examination to provide treatment necessary to stabilize individuals with EMCs who are receiving services in accordance with the resources available to the hospital. The cooperation of the hospital's medical staff members with this policy is vital to the hospital's success in complying with the on-call provisions of EMTALA. The hospital should make its privileged physicians aware of their legal obligations as reflected in this policy and the Medical Staff Bylaws and should take all necessary steps to ensure that physicians perform their obligations as set forth herein and in each document.

**PROCEDURE:**

**Develop an On-Call Schedule.** The facility's governing board must require that the medical staff be responsible for developing an on-call rotation schedule that includes the name and direct telephone number or direct pager of each physician who is required to fulfill on-call duties. Practice group names and general office numbers are not acceptable for contacting the on-call physician. Individual physician names with accurate contact information, including the direct telephone number or direct pager where the physician can be reached, are to be put on the on-call list. The hospital MUST be able to contact the on-call physician with the number provided on the list. If the on-call physician decides to list an answering service number as the preferred method of contact, his/her mobile phone number must be

provided to the hospital as a backup number to reach the on-call physician. The backup number will be used by hospital and Transfer Center personnel when the On-Call Physician does not respond to calls in a timely manner. Each physician is responsible for updating his or her contact information as necessary. Each hospital shall provide a copy of the daily on-call schedule to the Transfer Center.

The on-call schedule may be by specialty or sub-specialty (*e.g.*, general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the hospital and implemented by the relevant department chairpersons. The Medical Executive Committee ("MEC") shall review the on-call schedule and make recommendations to the CEO when formal changes are to be made or when legal and/or operational issues arise.

The hospital shall keep local Emergency Medical Services advised of the times during which certain specialties are unavailable.

Only physicians that are available to physically come to the ER may be included on the on-call list. A physician available via telemedicine does not satisfy the on-call requirements under EMTALA.

**Specialty Hospital Call.** A specialty hospital such as a psychiatric, orthopedic, or heart hospital that does not operate an emergency department is still subject to EMTALA requirements, and must maintain an on-call list and accept appropriate transfers when requested to do so.

**Records.** The hospital must keep a record of all physicians on-call and on-call schedules for at least five years. Any on-call list must reflect any and all substitutions from the time of first posting of the list. These records may be in electronic or hardcopy format.

**Maintain a List.** Each hospital must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The Medical Staff Bylaws or appropriate policy and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with an EMC. Factors to consider in developing the on-call list include: the level of trauma and emergency care afforded by the hospital; number of physicians on the medical staff who are holding the privileges of the specialty; other demands on the physicians; frequency with which the physician's services are required; and the provisions the hospital has made for situations where the on-call physician is not available or not able to respond due to circumstances beyond his or her control. The hospital is expected to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available.

In addition, the on-call list requirement applies to any hospital with specialized capabilities that is participating in the Medicare program regardless of whether the hospital has a DED. Specialty Hospitals must have appropriate on-call specialists available for receiving those individuals transferred pursuant to EMTALA. Hospitals should verify that the privileges of each on-call physician are current as to the procedures that each on-call physician is able to perform and the services that each on-call physician may provide.

The on-call list maintained for the main hospital Emergency Department shall be the on-call list for the hospital, including any Off-Campus Provider-based Emergency Departments.

**Physician's Responsibility.** The hospital has a process to ensure that when a physician is identified as being "on-call" to the DED for a given specialty, it shall be that physician's duty and responsibility to assure the following:

1. Immediate availability, at least by telephone, to the ED physician for his or her scheduled "on-call" period, or to secure a qualified alternate who has privileges at the hospital if appropriate.
2. If a Transfer Center is being utilized to contact the on-call physician, the on-call physician must respond to the Transfer Center within a reasonable timeframe (generally, within 30 minutes).
3. Arrival or response to the DED within a reasonable timeframe (generally, response by the physician is expected within 30 minutes). The ED physician, in consultation with the on-call physician, shall determine whether the individual's condition requires the on-call physician to see the individual immediately. The determination of the ED physician or other practitioner who has personally examined the individual and is currently treating the individual shall be controlling in this regard.
4. The on-call physician has a responsibility to provide specialty care services as needed to any individual who comes to the Emergency Department either as an initial presentation or upon transfer from another facility.
5. The on-call physician has a responsibility to notify the Medical Staff Office of changes to the on-call schedule.

**Authority to Decline Transfers.** The on-call physician does not have the authority to refuse an appropriate transfer on behalf of the facility.

Only the CEO, Administrator-on-Call ("AOC"), or a hospital leader who routinely takes administrative call has the authority to verify that the facility does not have the capability and capacity to accept a transfer. Any transfer request which may be declined must first be reviewed with this individual before a final decision to refuse acceptance is made. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor or other similarly titled position is not considered to be an equivalent of the AOC.

**Financial Inquiries.** Medical Staff Members who are on-call and who are called to provide treatment necessary to stabilize an individual with an EMC may not inquire about the individual's ability to pay or source of payment before coming to the DED and no facility employee, including Transfer Center employees, may provide such information to a physician on the phone.

**Physician Appearance Requirements.** If a physician on the on-call list is called by the hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable timeframe, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Social Security Act. If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person within a reasonable amount of time. For those physicians who do not respond within a reasonable amount of time, the Chain of Command Policy should be initiated.

Note: Each facility should define a reasonable timeframe – generally that timeframe should not be greater than 30 minutes.

If, as a result of the on-call physician's failure to respond to an on-call request, the hospital must transfer the individual to another facility for care, the hospital must document on the transfer form the name and address of the physician who refused or failed to appear.

**Call by Non-Physician Practitioners.** The ED physician must be able to first confer with the on-call physician. Midlevel practitioners (usually physician assistants or advanced practice registered nurses) who are employed by and have protocol agreements with the on-call physician, may appear at the hospital and provide further assessment or stabilizing treatment to the individual only after the on-call physician and ED physician confer and the on-call physician so directs the licensed non-physician practitioner to appear at the hospital. The individual's medical needs and capabilities of the hospital, along with the State scope of practice laws, hospital bylaws, and rules and regulations, must be thoroughly reviewed prior to implementing this process. The designated on-call physician remains ultimately responsible for providing the necessary services to the individual in the DED regardless of who makes the first in-person visit. If the ED physician does not believe that the non-physician practitioner is the appropriate practitioner to respond and requests the on-call physician to appear, the on-call physician must come to the hospital to see the individual.

**Selective Call and Avoiding Responsibility.** Medical Staff Members may not relinquish specific clinical privileges for the purpose of avoiding on-call responsibility. The Board of Trustees is responsible for assuring adequate on-call coverage of specialty services in a manner that meets the needs of the community in accordance with the resources available to the hospital. Exemptions for certain medical staff members (*e.g.*, senior physicians) would not per se violate EMTALA-related Medicare provider agreement requirements. However, if a hospital permits physicians to selectively take call ONLY for their own established patients who present to the DED for evaluation, then the hospital must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement.

**Providing Elective Surgeries or Other Therapeutic or Diagnostic Procedures While On-Call.** The hospital shall have in place policies and procedures to ensure that specialty services are available to meet the needs of any individual with an EMC if the hospital permits on-call physicians to schedule elective surgeries during the time that they are on-call. An on-call physician who undertakes an elective surgery while on-call must arrange for an appropriate physician with comparable hospital privileges to serve as back-up to provide on-call coverage and notify the facility of such determination. The facility will ensure that the DED is familiar with the back-up arrangement for any physician performing elective procedures.

**Simultaneous Call.** Physicians are permitted to have simultaneous call at more than one hospital in the geographic area; however, the physician must provide the hospital with the physician's on-call schedule so that the hospital can have a plan in place to meet its EMTALA obligation to the community. This plan could include back-up call by an additional physician or the implementation of an appropriate transfer. An on-call physician may not choose the hospital in which to treat a patient purely for the physician's convenience (*e.g.*, if a physician is on-call for both Hospitals A and B, is at Hospital B, but

is requested to come to Hospital A by the Hospital A ED physician, the on-call physician is obligated to treat the patient at Hospital A).

**Back-up Plans and Transfers.** The hospital shall have in place a written plan for transfer and/or back-up call coverage by a physician of the same specialty or subspecialty for situations in which a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond the physician's control. The ED physician shall determine whether to attempt to contact another such specialist or immediately arrange for a transfer. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.

Appropriate transfer agreements shall be in place for those occasions when an on-call specialist is not available within a reasonable period of time to provide care for those individuals who require specialty or subspecialty physician care and a transfer is necessary. A list of facilities with which the hospital has transfer arrangements and the specialties represented shall be available to the individual or Transfer Center responsible for facilitating the transfer. The transfer agreements shall not include financial provisions for EMTALA transfers.

**Transfer to Physician's Office.** When a physician who is on-call is in his or her office, the hospital may NOT refer individuals receiving treatment for an EMC to the physician's office for examination and treatment. The physician must come to the hospital to examine the individual if requested by the treating physician.

**Community Call Plan.** A community call plan is designed to meet the needs of the communities served utilizing the resources within the region. A community call plan facilitates appropriate transfers to the hospital providing the specialty on-call services pursuant to the plan, but does not relieve any hospital of any EMTALA obligations with respect to transfer. Even though a hospital may participate in a community call plan, the hospital must still accept appropriate transfers from non-participating hospitals.

Any community call plan must be approved by Operations Counsel and meet all applicable federal and state regulations and guidelines.

## EMTALA - MODEL Facility Policy

**POLICY NAME:** Tennessee EMTALA – Central Log Policy

**DATE:** (facility to insert date here)

**NUMBER:** (facility to insert number here)

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This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

**Purpose:** To establish guidelines for tracking the care provided to each individual seeking care in a dedicated emergency department ("DED") for a medical condition or seeking care in areas on hospital property other than a DED for an emergency medical condition ("EMC") as required of any hospital with an emergency department by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

**Policy:** The hospital will maintain a Central Log containing information on each individual who comes on the hospital campus requesting assistance or whose appearance or behavior would cause a prudent layperson observer to believe the individual needed examination or treatment, whether he or she left before a medical screening examination ("MSE") could be performed, whether he or she refused treatment, whether he or she was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged.

The Central Log includes the patient logs from the traditional ED and, either by direct or indirect reference, patient logs from any other areas of the hospital that may be considered DEDs or where an individual may present for emergency services or receive an MSE, such as Labor and Delivery.

**Procedure:**

1. All hospitals must maintain the Central Log in an electronic format. An electronic template that includes all federal requirements for EMTALA is available on Meditech for each market or division to customize.

2. All ancillary logs maintained by all hospital departments, including the DEDs, labor & delivery, behavioral health, pediatric EDs, and catheterization labs, are incorporated by reference and become part of the facility's EMTALA Central Log.

3. The Central Log, including all additional logs incorporated into the Central Log by reference, shall be maintained in the same manner and with the same central core of information. The logs must contain at a minimum, the name of the individual, the date and time of arrival, the record number, and whether the individual:

   - refused treatment,
   - was refused treatment,
   - was transferred,
   - was admitted and treated,
   - was stabilized and transferred,
   - was discharged, or
   - expired.

4. A log entry for all individuals who have come to the hospital seeking medical attention or who appear to need medical attention must be made by the appropriate individual. Further, in non-DED departments of the hospital where an individual may present with an EMC, the department will provide the necessary information from the point of contact to the DED for logging purposes.

5. The Central Log of individuals who have come to the hospital seeking medical attention or who appear to need medical attention will be available within a reasonable amount of time for surveyor review and must be retained for a minimum of five years from the date of disposition of the individual.

6. Duplicate accounts created for the same patient who visits the hospital on more than one occasion must be consolidated so that only one medical record number per patient exists in the Central Log.

## EMTALA – MODEL Facility Policy

**POLICY NAME:** Tennessee EMTALA – Signage Policy

**DATE:** (facility to insert date here)

**NUMBER:** (facility to insert number here)

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This policy reflects guidance under the Emergency Medical Treatment and Labor Act ("EMTALA") and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be clearly identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

**Purpose:** To establish guidelines for providing all individuals with the opportunity to be aware of and view their right to medical screening examination ("MSE") and stabilization for an emergency medical condition ("EMC") as required of any hospital with an emergency department by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated thereunder.

**Policy:** All emergency departments and any other place likely to be noticed by all individuals entering the emergency department and those individuals waiting for examination and treatment in areas of the hospital other than the traditional emergency department such as the entrance area, admitting areas, waiting rooms, and treatment areas located on hospital property must post conspicuously, appropriate signage notifying individuals of their right to an MSE and stabilization or treatment for an EMC and required services for women in labor as specified under EMTALA as well as information indicating whether or not the hospital participates in the Medicaid program. The entrance to the emergency department shall be clearly marked.

**Procedure:** All hospitals must post signage that, at a minimum, meets the following requirements:

- signage must be conspicuously posted in any place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than the traditional emergency department (*e.g.*, entrance, admitting area, waiting room, labor and delivery, and other treatment areas located on hospital property):
    - signage must be readable from anywhere in the area
    - wording on signage must be clear and in simple terms in a language(s) that is (are) understandable by the population the hospital serves

The contents of the signage must:

- indicate whether or not the hospital participates in a Medicaid program approved under a State plan under Title XIX;
- specify the rights of individuals with EMCs to receive an MSE and necessary stabilization and treatment for any EMC regardless of the ability to pay; and
- specify the rights of women in labor who come to the emergency department for health care services.

The signage content must include the following language:

IT'S THE LAW!

If you have a medical emergency or are in labor, even if you cannot pay or do not have medical insurance or you are not entitled to Medicare or Medicaid, you have the right to receive, within the capabilities of this hospital's staff and facilities:

- An appropriate medical screening examination;
- Necessary stabilizing treatment (including treatment for an unborn child); and
- If necessary, an appropriate transfer to another facility.

This hospital (does/does not) participate in the Medicaid program.

# INFORMED REFUSAL FOR PARTIAL REFUSAL OF CARE AND AMA

The sections below for **Partial Refusal of Care** and for **Against Medical Advice** are only applicable for those individuals who have been triaged and an ED physician or QMP has begun a Medical Screening Examination or any stabilizing treatment. NOT APPLICABLE FOR INDIVIDUALS WHO LPT OR LPMSE. Pregnant women in labor who are transferred to another facility should be transferred using a MOT and Physician certification.

## ☐ *PARTIAL REFUSAL OF CARE*

I acknowledge that I have begun receiving a medical screening examination and have decided that I do not want the tests, exams or treatments listed below. I acknowledge that I have been informed and do understand that the risks associated with my refusal of the test(s), examination(s) and/or treatment(s) or my withdrawal of consent to this test(s), examination(s) and/or treatment(s) may seriously harm my health or life, and if I am pregnant, the health and life of my unborn child.

I acknowledge that treatment options; the risk of refusal of the test(s), examination(s) and/or treatment(s) listed below; and the purpose and benefit of the test(s), examination(s) and/or treatment(s listed below were all explained to me,

I asked the questions I wanted to ask and that I still refuse the test(s), examination(s) and/or treatment(s) as follows:

| | Test, Exam or Treatment Refused | Risk of such Refusal of Care |
|---|---|---|
| A. | | |
| B. | | |
| C. | | |

## ☐ *AGAINST MEDICAL ADVICE*

**INFORMED REFUSAL OF CARE**

A Physician, other Qualified Medical Provider and/or an appropriate Clinical Staff Member of the ED has explained the risks to me of my leaving **Against Medical Advice** and my refusal of the care offered. I understand that if I am pregnant, this informed refusal of care applies to both me and my unborn child.

I understand the risks that were discussed with me and further understand that my refusal of further examination and/or treatment or my withdrawal of consent to a medical screening examination and/or treatment and leaving **Against Medical Advice** may result in serious harm to my body functions or serious harm to any organ or body part or may place my health or life in serious danger. Knowing these serious risks, knowing and understanding the treatment options explained to me and the risks and benefits of the treatment options, I still elect to leave **Against Medical Advice**,

I accept full responsibility for the refusal of further examination and/or selected medical treatment or tests (or this withdrawal of consent to permit further medical examination and/or treatment) for my medical condition. Because I am leaving **Against Medical Advice**, I hereby release and hold harmless, the hospital, its personnel, the physician(s), and any other persons participating in my care from any responsibility whatsoever for unfavorable or adverse results which I understand may occur as a consequence of my refusing any further examination or treatment offered and leaving against medical advice.

I also understand that **I may return** to this Hospital at any time in the event that I change my mind or if my condition worsens.

Describe examination or specific treatment modalities recommended by Physician or QMP and refused by individual:

A. _____
B. _____
C. _____

I acknowledge that I understand that my Refusal of further recommended Examination and/or Treatment or my refusal to Consent to recommended Examination/Treatment by the Emergency Physician and/or Specialists may result in injury to me, including death or severe and permanent disability or deformity as otherwise specified below:

A. _____
B. _____
C. _____

I acknowledge that I understand that the Benefits of Examination/Treatment Offered could include completion of a medical screening examination, further diagnostic evaluation and treatment for the condition for which I presented to the hospital, stabilizing and other medical and/or surgical treatment, and as otherwise specified below:

A. _____
B. _____
C. _____

**INDIVIDUAL or LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE:**

| | |
|---|---|
| Individual or Legally Authorized Representative | Relationship to Individual |
| Witness | Date Time AM / PM |

**CLINICAL SIGNATURES:**

The signature of the Physician certifies that the patient or the individual acting on the patient's behalf has the mental capacity to understand the risks and benefits of a partial refusal of care and/or leaving against medical advice and that the patient or caregiver has had an opportunity to ask questions about the benefits or risk of the refusal of care and/or leaving against medical advice.

| | |
|---|---|
| Physician | Date Time AM / PM |
| Health Care Personnel | Date Time AM / PM |

**CERTIFICATION OF INTERPRETATION:**

I certify that I have read the foregoing to the signor hereof in the _____ language.

_____
Interpreter

_____
Date Time AM / PM

PATIENT

## PART A – PATIENT INFORMATION – PLEASE COMPLETE PART A AND PART B

Today's Date: ___/___/___ Have you received care at this Facility before? ❑Yes ❑No

I came to the Emergency Department today because: _____

_____

TIME STAMP (Facility Use Only)

Last Name: _____ First Name: _____ Middle Initial: ____ Check one: ❑Male ❑Female

Address: _____ _____ _____ _____

(Number/Street) (City) (State) (Zip) Date of Birth: ___/___/___

Phone: (___)_____ Soc Sec Number: _____-_____-_____ Family Physician: _____

**FOR FEMALE PATIENTS ONLY:** Are you pregnant? ❑ Yes ❑ No

Last menstrual period: ___/___/___ Have you had a baby within the past 6 weeks? ❑ Yes ❑ No

Form completed by: ❑ Self ❑ Other: _____ Relationship: _____

## PART B – CURRENT SYMPTOMS

**Please check any of the following symptoms you currently have:**

- ❑ Persistent cough greater than 3 weeks
- ❑ Fever greater than 100.4°F
- ❑ Night Sweats
- ❑ Cough with blood production
- ❑ Fatigue
- ❑ History of TB or Positive TB Skin Test
- ❑ Close contact with person who has TB
- ❑ Sore Throat
- ❑ Body aches
- ❑ Cough (not related to allergies or COPD)
- ❑ Rash
- ❑ Nasal congestion (not related to allergies or sinus infections)
- ❑ Close contact with person who has influenza-like illness
- ❑ Unexplained weight loss

FACILITY

## PART C - TRIAGE INFORMATION (For Facility Use Only)

| 1st Call for Triage at: | 2nd Call for Triage at: | 3rd Call for Triage at: | 4th Call for Triage at: |
|---|---|---|---|
| ____:____ AM PM | ____:____ AM PM | ____:____ AM PM | ____:____ AM PM |

Triage Nurse Notes:

## PART D – RAPID (INITIAL) TRIAGE (For Facility Use Only)

**Time:** _____ **First Point of Contact Screening Positive:** Y N **Patient requested to mask?** Y N

**AIRWAY:** ❑ Patent ❑ Impaired **BREATHING – Respiratory Distress:** ❑ None ❑ Mild ❑ Moderate ❑ Severe

**CIRCULATION:** ❑ Warm/Dry/Normal Color ❑ Pale ❑ Diaphoretic

**Pulse Rate:** ❑ WNL ❑ Rapid **Capillary Refill:** ❑ < 2 seconds ❑ > 2 seconds

**DEFORMITY/DISABILITY – Loss of Consciousness:** ❑ Yes ❑ No ❑ No Neuro Deficits ❑ Neuro Changes

**Extremity:** Neurovascular Integrity Intact: ❑ Yes ❑ No ❑ N/A

**CHIEF COMPLAINT:** _____

| TRIAGE ACUITY: | 1 Resuscitation | 2 Emergent | 3 Urgent | 4 Semi Urgent | 5 Non Urgent |
|---|---|---|---|---|---|

**DISPOSITION:** ❑ Immediate Bed ❑ Stable – To Waiting Area after Instructions

**Comments:** _____

_____ Triage Nurse Signature: _____

# Sign-in Sheet for Emergency Services

*Patient Identification Label*

## ☐ *WAIVER OF RIGHT TO MEDICAL SCREENING EXAMINATION*

SECTION 1: This section is only applicable for those individuals who leave prior to Triage (LPT) or who leave prior to Medical Screening Examination (LPMSE). Check either LPT to LPMSE to indicate the individual's status at the time the individual leaves the ED.

◯ Patient LPT ◯ Patient LPMSE

I, _____, came to the Emergency Department (ED) at (Facility Name to be inserted here) asking for examination and treatment for a medical problem, but I have now decided against being examined or treated and waive my right to receive a medical screening examination.

I understand that if I am pregnant, the waiver of my right to a medical screening examination and any necessary stabilizing treatment applies to both me and my unborn child.

I understand that a medical screening examination would benefit me and let me know whether or not I have an emergency medical condition and that a determination as to the seriousness of any medical problem I may be experiencing cannot be made if I do not have a medical screening examination.

I understand that if I have an emergency medical condition and do not receive a medical screening examination, my health, or the health of my unborn child, may get worse which could cause serious harm to my body, organs or even result in my death.

I know that I have a right to receive a medical screening examination to determine if I have an emergency medical condition and necessary stabilizing treatment regardless of my ability to pay for it.

I also understand that I may come back to the hospital at any time if I change my mind.

If this form was provided to me by a non-clinical staff member I acknowledge that I was provided the opportunity to discuss the risks and benefits related to my decision with a clinical staff member.

Finally, I am aware of the possible risks of waiving my right to a medical screening and any necessary stabilizing treatment. I accept these risks, accept the responsibility of my decision and release the hospital, its personnel, physicians and others who would participate in my care, from any responsibility whatsoever should I experience a bad outcome related to these risks.

SIGNATURE OF INDIVIDUAL Waiving a medical screening examination and treatment:

| | | |
|---|---|---|
| Individual | Date | Time AM / PM |
| Witness | Date | Time AM / PM |

CLINICAL SIGNATURES:

| | | |
|---|---|---|
| Health Care Personnel or Registration Personnel | Date | Time AM / PM |
| Physician *(if applicable)* | Date | Time AM / PM |

**CERTIFICATION OF INTERPRETATION:**

I certify that I have read the foregoing to the signor hereof in the _____ language.

_____
Interpreter

_____
Date Time AM / PM

Attachment 5C

2023 QAPI Plan

TriStar Centennial MEDICAL CENTER | TriStar Ashland City MEDICAL CENTER

| | |
|---|---|
| **Origination:** | *01/2016* |
| **Last Approved:** | *09/2023* |
| **Last Revised:** | *09/2023* |
| **Next Review:** | *09/2024* |
| **Owner:** | *Lisa Moore: VP Quality/Risk Mgmt* |
| **Policy Area:** | *Hospital Plans* |
| **Locations:** | *TriStar Centennial & Ashland City Medical Centers* |
| **Applicability:** | *TriStar Centennial and Ashland City Policy Library* |

# 2023 Plan for Improvement of Organizational Performance and Patient Safety

## SECTION I.MISSION AND VALUES

**Mission**:Above all else, we are committed to the care and improvement of human life by caring for those we serve with integrity, compassion, a positive attitude, respect and exceptional quality.

In pursuit of our mission, we believe the following value statements are essential and timeless:

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
- We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect and dignity.
- We display the ICARE philosophy with all internal and external customers.

## SECTION II.PHILOSOPHY/OBJECTIVES/SCOPE OF SERVICES

A. PHILOSOPHY

The Performance Improvement/ Patient Safety Program's underlying philosophy:

- Utilizes a planned, systematic, hospital-wide approach to design, measurement, assessment and improvement in performance and processes.
- Offers facility leaders, medical staff, and facility staff objective information, which they can use for purposes of review, patient management, and quality measurement.
- Facilitates activities that are collaborative and interdisciplinary in order to respond to the needs of the patient, physician, staff and community.
- Promotes integration and communication between hospital departments, medical staff, and Senior Leadership to continuously improve processes which affect patient care.

B. OBJECTIVES

The objectives of this plan are to preserve/improve the quality of patient care, enhance appropriate utilization of resources, and to reduce or eliminate unnecessary risks and hazards within the facility by promoting:

1. The employment of qualified, competent, and effectively supervised personnel for patient care,

utilizing clear channels of supervision, responsibility, and accountability.

2. Patient care, which is appropriate to the ages and needs of patients, is delivered as follows:
   - in a safe and timely manner
   - within the range of available resources
   - in a cost-efficient manner as possible
   - consistent with achievable goals
   - properly documented to facilitate evaluation and effective communication
   - continuously evaluated and improved
3. A system in which the same level of care is provided to all patients and is subject to periodic review (prospective or concurrent) with the use of pre-established objective indicators and documentation of findings.
4. A system in which the findings of patient care monitoring and evaluation are utilized by the hospital in concrete ways to fulfill the objectives of the Performance Improvement/ Patient Safety Program.
5. The maintenance of a continuing education program utilizing, in part, results of patient care monitoring and evaluation.
6. Continuous evaluation and improvement of customer satisfaction (patients/family/community, physicians, employees).

C. SCOPE OF SERVICES

The scope of this plan includes monitoring and evaluation activities which address patients of all ages served by the hospital and all services and settings owned by the hospital.

**SECTION III.LEADERSHIP'S ROLE AND RESPONSIBILITY FOR IMPROVEMENT OF ORGANIZATIONAL PERFORMANCE AND PATIENT SAFETY**

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

Leaders are responsible for establishing a policy and procedure for serious safety events, educating staff on serious safety events events, and responding appropriately when they occur. The policy shall include a process for conducting a timely serious event analysis that focuses on processes and systems, and the development of risk reduction strategies and an action plan that includes evaluating the effectiveness of the actions taken.

Leaders set a positive Performance Improvement/Patient Safety culture in the organization through planning, education in tools, approaches, methods), providing support, such as time and resources (staff, information systems, etc), and empowering staff as appropriate. Leaders also actively participate in interdisciplinary PI and patient safety activities, as appropriate.

The Performance Improvement/ Patient Safety Program is the shared responsibility of the Board of Trustees,

the Medical Staff, and the Senior Leadership of the hospital with specific areas of the program delegated to each. The program involves the Board, medical and other professional staff, administrative, technical and all support services, and includes education concerning the approaches and methods of Performance Improvement.

A. BOARD OF TRUSTEES

The Board shall require specific review and evaluation of activities to assess and improve the overall quality, safety and efficiency of patient care in the hospital. While maintaining overall responsibility, the Board delegates operational authority to the Medical Staff and Senior Leadership. In exercising its supervisory responsibility, the Board will:

- Receive, review and accept or reject periodic reports on findings, conclusions, recommendations, actions and results of program activities.
- Assess the program's effectiveness and efficiency and require modification in organizational structure and systems where necessary to improve program performance.
- Provide for resources and support systems for Performance Improvement and functions related to patient care and safety.
- Verify that the overall goal of patient care enhancement is being achieved.
- Require a process designed to assure that all individuals responsible for the assessment, treatment or care of patients are competent.

B. MEDICAL EXECUTIVE COMMITTEE

1. The Medical Executive Committee of the Medical Staff is accountable to the Board of Trustees for oversight of the monitoring and evaluation functions to determine that the same level of medical care is rendered to all patients in the hospital through Performance Improvement monitoring, actions taken when indicated, and by reporting these activities to the Board of Trustees.
2. The Medical Executive Committee shares the responsibility for the operations of the monitoring and evaluation functions with the Medical Staff, Quality Council and the appropriate Medical Staff Committees. The Credentials Committee is delegated the responsibility for evaluation of the results of monitoring and evaluation functions at the time of reappointment to the Medical Staff.

C. SENIOR LEADERSHIP

Senior Leadership, through the Chief Executive Officer (CEO) and the Quality Council, is accountable to the Board of Trustees for the quality of care provided and patient safety. The CEO will:

- Promote the participation of the appropriate members of professionals and technical staffs and departments in the program through interdisciplinary monitoring and evaluation of patient care and patient safety activities through the Quality Council.
- Establish and maintain operational linkages between Risk Management, Patient Safety, and Performance Improvements functions.
- Assure that sufficient resources and personnel are provided to support Patient Safety and Performance Improvement activities and that staff are provided adequate time to participate in Performance Improvement and Patient Safety activities.

D. QUALITY MANAGEMENT DEPARTMENT

Senior Leadership will provide adequate resources to conduct Quality, Performance Improvement and Patient Safety functions. These resources will be directed through the Quality/Risk Management Department. This department will provide at least the following services and functions:

1. Orientation and training on programs, functions and tools related to Performance Improvement and Patient Safety.
2. Reports of changes in regulations, laws, and accreditation standards to Senior Leadership, the Medical Staff Leaders and Employees.
3. Conduct data retrieval functions.
4. Aggregate Performance Improvement findings for presentation to Leadership, Medical Staff, and hospital staff.
5. The Vice President of Quality/Risk will be responsible for ensuring that appropriate actions are implemented within established time frames.
6. The Vice President of Quality/Risk or other Quality Management Department Staff will be a member of Medical Staff Committees, Medical Executive Committee, Quality Council, Infection Prevention , Environment of Care Committees, and Board of Trustees.

**SECTION IV: PLAN**

TriStar Centennial Medical Center participates in collaborative, interdisciplinary monitoring of patient care activity processes and outcomes. Performance improvement activities include how the hospital designs, measures, assesses, and improves important processes and outcomes. All Performance Improvement activities are incorporated into a collaborative, interdisciplinary approach through interdisciplinary monitoring and Performance Improvement Teams.



A. Performance Improvement MODEL
TriStar Centennial Medical Center will utilize proven Performance Improvement tools and methodologies in its improvement efforts. Our primary Improvement Model will be Focus PDSA.
**F**ind a process to improve
**O**rganize a team that knows the process
**C**larify the current knowledge of the process
**U**nderstand the causes of process variation
**S**elect the process improvement
**P**lan the improvement and continued data collections
**D**o the improvement, data collection and analysis
**S**tudy and check the results
**A**ct to hold the gain and to continue to improve the process
Leadership supports the use of data driven, scientific approaches to process improvement and the necessary hospital wide planning and prioritization of resources required to achieve and sustain desired results. A variety of improvement tools are utilized. Opportunities involving large scale and complex inter-departmental processes are reviewed, prioritized and resourced through the Quality Council with representatives from Clinical Operations, Quality, Risk, Medical Staff and Senior Leadership.

B. HOSPITAL-WIDE PRIORITIES
Priorities for hospital-wide Performance Improvement activities at TriStar Centennial Medical Center will be designed to improve processes and patient outcomes. These priorities will be developed by the Quality Council, with participation of all hospital disciplines, and approved by the Medical Executive Committee and Board of Trustees. High priority will be given to processes/outcomes which are:

1. High risk (including patient safety issues)
2. High volume/Low volume

3. Problem prone

**2023 Patient Safety/Quality Improvement/Risk Management Priorities:**

In addition to the ongoing improvement efforts outlined by the quality improvement/patient safety indicators, the organization has identified Patient Safety and Quality Improvement operational strategies. These strategic initiatives were developed from trends of quality improvement data, current industry literature, and proactive initiatives derived from our mission and values statements. Priority focus areas will include (1) reduction in Hospital Acquired Infections, (2) evaluation and maintenance of safety for behavioral health patients, (3) Improving overall outcomes (mortality and complications) for patients (4) a review of all Sentinel Events to evaluate ongoing sustainability of corrective action plans (5) in-house pressure ulcer .

| | Area of Focus | 2023 Goals | Goal Source |
|---|---|---|---|
| Eliminate Harm & Mitigate Organizational Risk | CMS CLABSI | goal 0.485 | CMS Hospital Compare |
| | CMS CAUTI | goal 0.342 | |
| | MRSA HO LabID | goal 0.559 | |
| | CDIFF LabID | goal 0.210 | |
| | SSI HYST | goal 0.250 | |
| | SSI COLO | goal 0.327 | |
| | TOTAL HAIs | TOTAL HAIs | |
| Optimize Care Effectiveness & Efficiency | Stoke DTN | goal 80% | CMS Hospital Compare |
| | NTSV C-Section Rate | goal 23.68% | |
| | SEP-1 | goal 69% | |
| | 1 Hour Bundle | goal 65% | |
| | 3 Hour Bundle | goal 75% | |
| | Mortality Index | goal 0.72% | |
| | PCI Mortality | goal 2.12% | |
| Elevate Care Experience & Care Team Engagement | ER Satisfaction | goal 66.3% | Press Ganey |
| | HCAHPS Inpatient Overall rating | goal 69.8% | |

**Reprioritizing:** The priorities may be reprioritized periodically in response to unusual or urgent events such as those identified through Performance Improvement monitoring and evaluation, changing regulatory requirements, significant patient/staff needs, changes in patient population, changes in the environment of care, changes in the community, or in response to sentinel events.

**SECTION V: DESIGN**

When a need or opportunity to establish new services, extend product lines, occupy a new facility, or significantly change existing functions or processes, the following factors will be considered:

A. The process meets the needs of individuals served, staff, and others.

B. It will incorporate the results of performance improvement activities, when available.

C. It will incorporate available information to minimize potential risks to patients affected by the new or redesigned process, function, or service.

D. Design or redesign of the service will be based on current knowledge and relevant information from literature and/or clinical guidelines.

E. Information about sentinel events will be considered, when available and relevant.

F. Testing/Analysis will be done to determine if the proposed design/redesign is an improvement.

G. Leaders will collaborate with staff and appropriate stakeholders to design services.

H. The process will be consistent with the hospital's mission, vision, values, goals and plans.

Consideration of these factors will provide basic performance expectations that can be measured, assessed, and improved over time. All disciplines which will be involved in the new service, product line, function, or process will be included in the design.

**SECTION VI. MEASURE**

Measurement is the basis for determining the level of performance of existing processes and the outcomes resulting from these processes. Continuous and ongoing measurement activities will include:

A. Measurement of both processes and outcomes

B. Measurement of patient safety issues incorporated into the monitors

C. Measurement of high volume, high risk, and problem prone processes/outcomes

D. Measurement of areas identified for focused or targeted data collection

E. Establishment of a performance baseline

F. Comparison of outcomes to external databases, when available, as appropriate

G. Measurement will focus on sustaining improvement

**MEDICAL STAFF MONITORING AND EVALUATION**

A. The Medical Staff is responsible for participating in interdisciplinary ongoing physician practice evaluation and focused physician practice evaluation. Medical staff responsibilities include, but are not limited to:

   1. Participate in identification of interdisciplinary indicators, collection of data for each indicator, reaching conclusions, making recommendations and initiating actions.
   2. Communicate findings, conclusions, recommendations and actions, effectiveness of actions taken to department members and Medical Executive Committee.
   3. Assess the effectiveness of actions and document improvement in patient care.
   4. Make recommendations to the Credentials Committee for clinical privileges.
   5. Participate on Performance Improvement Teams.
   6. Work collaboratively to review and evaluate the Performance Improvement findings.

B. All Performance Improvement activities will be reported to the Medical Staff, as appropriate, and the Medical Executive Committee. The Medical Executive Committee is responsible for participating in and evaluation of Performance Improvement activities. All Performance Improvement activities are reported to the Board of Trustees.

**SECTION VII. AGGREGATE AND ANALYZE**

1. AGGREGATE AND ANALYZE PROCESS

Aggregating and analyzing data allows the organization to use information to draw conclusions about the

stability of a process or the predictability of an outcome in relation to performance expectations. Accumulated data are analyzed in such a way that current performance levels, patterns, or trends can be identified. This is supported by the following data use principles:

- Collected data are aggregated and analyzed
- Data are aggregated at the frequency appropriate to the activity or process being studied.
- Statistical tools and techniques are used to analyze and display data
- Data are analyzed and compared internally overtime and externally with other sources of information when available (benchmarking)
- Comparative data are used to determine if there is excessive variability or unacceptable levels of performance when available.

**B.Intensive Analysis**

Intensive analysis will be conducted when the following factors are identified:

1.Important single events, performance, and patterns or trends vary significantly from expectations
2.Performance varies significantly and undesirably from other hospitals
3.Performance varies significantly and undesirably from recognized standards
4.When a sentinel event has occurred
5.Confirmed transfusion reactions
6.Significant adverse drug reactions
7.Significant medication errors and hazardous conditions
8.Major discrepancies between pre and post-operative diagnoses in pathology reports
9.Adverse events during anesthesia, moderate or deep sedation
10Staffing effectiveness issues
11Core measures data which identify the hospital as a negative outlier for three or more consecutive quarters

**C.Analysis Findings Relevant to Individual Performance**

When the findings of the analysis process are relevant to an individual's performance, the following process will be followed:

1. **Credentialed Practitioners/Medical Staff Members:** Peer review process will be utilized for individual Medical Staff/Credentialed practitioner performance. The case will be referred to the appropriate Professional Practice Evaluation Committee and reviewed by a peer, as defined by the peer review policy and an improvement strategy, such as education, letter , etc., determined as necessary. Any recommended action on privileges and/or membership will be referred to the MEC for recommendations to the Board of Trustees. Peer Practice Evaluation Committee findings are maintained in individual Medical Staff Quality Files by the Quality Risk Management staff.
2. **Hospital Staff:** The Department Leadership will review information relevant to individual staff performance and an improvement strategy determined as necessary. Documentation of this action will be maintained in individual employee files and utilized in the performance evaluation process, as appropriate.

**D.Use of Dimensions of Performance and Scientific Tools**

The following definitions of dimensions of performance will be utilized in assessing how performance was improved:

| DIMENSIONS OF PERFORMANCE |
| --- |
| I. **Doing the Right Thing** |

- The **efficacy** of the procedure or treatment in relation to the patient's condition. Efficacy is the degree to which the care/intervention for the patient has been shown to accomplish the desired/ projected outcome (s).
- The **appropriateness** of a specific test, procedure, or service to meet a patient's needs. Appropriateness is the degree to which the care/intervention provided is relevant to the patient's clinical needs, given the current state of knowledge.

**II.Doing the Right Thing Well**

- The **availability** of a needed test, procedure, treatment, or service to the patient who needs it. Availability is the degree to which appropriate care/intervention is available to meet the patient's needs.
- The **timeliness** with which a needed test, procedure, treatment, or service is provided to the patient. Timeliness is the degree to which the care/intervention is provided to the patient at the most beneficial or necessary time.
- The **effectiveness** with which tests, procedures, treatment, or service is provided to the patient. Effectiveness is the degree to which care/intervention is provided in the correct manner, given the current state of knowledge, in order to achieve the desired/projected outcome for the patient.
- The **continuity** of the services provided to a patient with respect to other services, practitioners, and providers, and over time. Continuity is the degree to which care/intervention for the patient is coordinated among practitioners, among organizations, and over time.
- The **safety** of the patient (and others) to whom the services are provided. Safety is the degree to which the risk of an intervention and risk in the care environment are reduced for the patient and others, including the health care provider.
- The **efficiency** with which services are provided. Efficiency is the relationship between the outcomes (results of care) and the resources used to deliver patient care.
- The **respect and caring** with which services are provided. Respect and caring is reflected by the degree to which the patient or a designee is involved in his/her own care decisions and to which those providing services do so with sensitivity and respect for patients' needs, expectations, and individual differences.

Various scientific tools may be used to assist in assessment, including flowcharts, Pareto charts (bar graphs), histograms, cause-and-effect diagrams (fishbone diagram), and run charts.

**E.Reference Databases**

The hospital will utilize state and national patient outcome database reports (including CMS reports) to compare the hospital's performance with other facilities. In addition, the hospital provides data to external databases for comparative patient outcome studies comparing our hospital to other peer hospitals and national rates. This information will be utilized to determine areas for improvement.

Comparative databases used by TriStar Centennial Medical Center include but are not limited to:

- NHSN national databank with the CDC
- Q-Source, Inc.
- American College of Cardiology – Cath/PCI and ICD
- Getting with the Guidelines
- HCAHPS- Patient Satisfaction
- ORYX
- COMET – outcomes measurement for core measures
- American College of Radiology

- American College of Pathology
- American Association of Blood Banks
- Leapfrog
- Institute of Healthcare Improvement
- National Quality Forum
- Vermont Oxford Network
- Society of Thoracic Surgeons
- Agency for Healthcare Research and Quality
- Centers for Medicare and Medicaid Services

**SECTION VIII. IMPROVE**

Monitoring activities identify a variety of opportunities for improvement. These include improving existing processes, designing new processes, and/or reducing variation or eliminating undesirable variation in processes or outcomes. Improved changes which are made will be implemented into standard operating procedures and monitored for sustained improvement. Staff will be educated about redesigned processes or changes. The following reporting structure is utilized for Performance Improvement reporting:

A. DECISIONS FOR IMPROVEMENTS
Decisions for making improvements are made by the Quality Council based on the following factors:

1. Opportunities to improve processes within the important functions.
2. Results of autopsies, risk management activities, and performance improvement activities.
3. Resources needed to improve, such as staffing, facilities, training, equipment, etc.
4. Organization's mission and priorities.
   Opportunities to improve care may be referred to the Quality Council from the following sources:
   - Patients/ Families/Community Members
   - Board of Trustees
   - Medical Staff/ Credentialed Practitioners
   - Employees/Volunteers/Students/Vendors
   - Senior Leadership
   - Committees
   - Corporate or Divisional Office
   - Risk Management Activities

B. ACTIONS FOR IMPROVEMENT
Once results have been evaluated and the decision is made that improvement is necessary, the Quality Council will determine actions to be implemented for the improvement. When action is taken to improve a process:

1. The action may be tested on a trial basis
2. The action's effectiveness is evaluated using the dimensions of performance
3. When the initial action is not effective, a new action will be taken and may include the formation of a PI Team, if appropriate.
4. Successful actions are implemented

C. QUALITY COUNCIL REPORTING

Reports of findings, conclusions, recommendations and actions will be reported to the Medical Executive Committee and the Board of Trustees, as well as back to other Medical Staff/hospital committees and departments as appropriate.

D. PERFORMANCE IMPROVEMENT TEAMS

The hospital may utilize Performance Improvement teams to study processes which occur in the hospital, design new processes, and to make improvements. The processes may be studied because a problem was determined or because the process can be improved even if a problem has not been identified. The Performance Improvement Teams are interdisciplinary and include members from all involved departments and Medical Staff members, as necessary.

The following factors will be utilized in determining when to use a team:

| TEAM DECISION | INDIVIDUAL MANAGER'S DECISION |
|---|---|
| • The need exists to combine old and new information - requires brainstorming, data-gathering, and innovation<br>• The situation doesn't require an immediate solution<br>• Consensus is needed to make the solution work<br>• When the problem is a process problem<br>• When the process crosses departmental boundaries<br>• When the process seems to be very complex | • No need for extensive data-gathering<br>• Quick decision is required<br>• Consensus is not needed<br>• When the problem is a people or performance problem |

The Performance Improvement Teams are groups of people who work together for a common objective. The teams identify processes or problems needing improvement, and, then study the processes methodically to improve them by eliminating root causes of problems. Team meetings will be conducted as often as determined necessary by the team to work on the process. Each team will have a team leader/facilitator. Department Managers will encourage employees to serve on Performance Improvement Teams as needed for Performance Improvement functions.

## SECTION IX. SENTINEL EVENTS

Leaders of the organization will be responsible for defining the policy and procedure for responding to a sentinel event. If a sentinel event occurs, a serious event analysis will be conducted in accordance with current policy and procedure. Once the serious event analysis has been conducted, the team will develop an appropriate action plan to address any variations identified and establish measures for any changes made. Once resolved, Performance Improvement indicators may be continued to ensure that the problem remains corrected.

### *Proactive Risk Reduction*

Annually at least one acute care high-risk process is selected to perform a proactive risk assessment. The process is then reviewed using a Failure Mode and Effects Analysis (FMEA). The FMEA process includes:

- Identification of steps that could fail in a process and how
- Identification of possible effects a process could have on patients
- Prioritization of the potential process failures by severity
- Determination of why priority failures could occur through the completion of a serious event analysis
- Redesign of the process/system to manage the risk of effects on patients
- Testing and implementation of the redesigned process

- Monitoring the effectiveness of the redesigned process

**SECTION X. MANAGEMENT OF INFORMATION**

A. INFORMATION SYSTEMS

The hospital utilizes a number of systems to assist in the management of information for the Performance Improvement/ Patient Safety Program. Performance improvement data and reports will only be accessible to those participating in the performance improvement program and by those agencies responsible for ascertaining the existence of an ongoing and effective performance improvement program. All medical staff quality files and measurement/assessment data will be secured in the Quality Department.

**SECTION XI. INTEGRATION OF RISK MANAGEMENT and PATIENT SAFETY**

A. **RISK MANAGEMENT**

In order for this Plan to be effective, it is essential that Risk Management functions be integrated with the Performance Improvement functions. Integration of Risk Management functions will be accomplished through the following:

1. Risk Management reports will be presented to the Quality Council at least quarterly.
2. Life Safety Data trends will be reviewed by the EOC Committee as appropriate.

B. **PATIENT SAFETY**

The Director Patient Safety is also the Patient Safety Officer. The purpose of the hospital Patient Safety program, which is an integral part of Performance Improvement monitoring, is as follows:

- Promote a patient-safe environment that identifies mechanisms that contribute to patient safety, such as review of high-risk patient care processes, collection and analysis of adverse patient incident data, and routine investigation of significant adverse events
- Implement the TJC National Patient Safety Goals and recommendations from the Sentinel Event Alerts.
- Develop proactive patient safety risk reduction strategies for minimizing the occurrence of medical/health care errors using TJC sentinel event information and other published information related to medical/health care errors
- Aggregate patient safety related data and information to improve professional and organizational performance
- Learn about actual and potential medical and healthcare errors and utilize that knowledge to improve patient safety

Patient Safety monitoring will be incorporated into ongoing Performance Improvement monitors, including TJC National Patient Safety Goals and other published information. These will be monitored on an ongoing basis and reported to the Quality Council, Medical Executive Committee and Board of Trustees.

**SECTION XII. CONFLICT OF INTEREST AND CONFIDENTIALITY**

A. CONFLICT OF INTEREST

No physician will participate in the review of any case in which he/she or his/her partners have been directly or indirectly involved in the provision of care to the patient.

B. CONFIDENTIALITY

Confidentiality shall be maintained, based on full respect of the patient's right to privacy and keeping with hospital policy and state and federal laws/regulations. All employees of TriStar Centennial Medical Center and

outside agencies that are involved in the review process will be made aware of the responsibility. All data shall be considered the property of TriStar Centennial Medical Center and the hospital shall ensure the maximum protection of all confidential data, including any findings, and recommendations or actions.

The Plan for Improvement of Organizational Performance and Patient Safety of TriStar Centennial Medical Center is established based on the facilities professional review function and is designed to comply with TJC standards, applicable federal and state laws, including HIPPA regulations, Tennessee Peer Review Statute and the Healthcare Quality Improvement Act.

In order to safeguard the privacy of our patients and the rights of health care providers practicing within the facility, all information relative to the Plan for Improvement of Organizational Performance and Patient Safety is considered confidential and will be treated as such. Information which identifies individual patients or practitioners will be shared only with those who have a direct responsibility for measuring the performance or services provided by the individuals involved or who can take direct action to resolve identified opportunities for improvement. All other communication regarding quality of services will contain only information which is pertinent to the maintenance of a general awareness of quality issues, the prevention of quality issues in the future and the identification of opportunities to improve patient care and prevent adverse outcomes.

**SECTION XIII. ANNUAL APPRAISAL**

The Plan for Improvement of Organizational Performance and Patient Safety is evaluated annually to determine the effectiveness of the plan in meeting the objectives. A report of the evaluation is provided to the Medical Executive Committee and the Board of Trustees. The plan is revised when evaluation indicates need for revision, patient and/or staff expectation indicate a need for revision, performance improvement or patient safety indicates a need for revision or if there is a major change to the scope of services, patient population, change in technology or any factor that would have a direct impact on patient care services for which measurement of a process and outcomes would be required.

On an annual basis leadership measures and assesses the effectiveness of their contribution to improving performance and patient safety by setting measurable objectives, assessing effectiveness and evaluating performance in support of sustained improvements.

**Definitions:**

**Action Plan**: The product of the serious event analysis is an action plan that identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

**Adverse Outcome Distinction**: A distinction is made between an adverse outcome that is primarily related to the natural course of the patient's illness or underlying condition (not reviewed by this policy) and a death or major permanent loss of function that is associated with the treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient's illness or underlying condition. In indeterminate cases, the event will be presumed reviewable and the organization's response will be reviewed under this policy according to the prescribed procedure and timeframes without delay for additional information, such as autopsy results.

**Failure Mode and Effects Analysis (FMEA):** A technique used to identify potential failures in a system or process. The process once flow-charted can be dissected at each step to be reviewed for severity and probability of failure. Each step is then reviewed to determine weakness and detectability. Identified failures are scored and prioritized for determination of the more severe and most probable steps to design appropriate

actions to be taken to prevent failures. The actions are then implemented and tested to assure risk reduction.

**Near-Miss**: A near-miss is any process variation which did not affect the outcome.

**Peer Practice Evaluation** : Professional Practice Evaluation is the concurrent or retrospective review of an individual's qualifications and competence, including thorough clinical professional review activities. Peer review or professional review activity is conducted to determine whether an individual may have Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges. Peer review is more completely defined by the Tennessee Peer Review law of 1967 (TCA 63-6-219). A peer is an individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications. An effective peer review process is consistent, timely, defensible, balanced, useful, and ongoing.

**Provider**: Any person furnishing medical or health care services.

**Serious Event Analysis**: A process for identifying the basic or causal factors that underling variation in performance, including the occurrence or possible occurrence of a sentinel event. A serious event analysis (SEA) focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and systems that would tend to decrease the likelihood of such events in the future or determines, after analysis that no such improvement opportunities exist.

**Sentinel Event**: A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: 1) death, 2) permanent harm, or 3) severe temporary harm. Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/ monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition

**Significant Medical Error**: An unexpected occurrence, within the control of the provider, involving the death or serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function.

**Definitions of Dimensions of Quality:**

**DOING THE RIGHT THINGS RIGHT:**

| | |
|---|---|
| **Efficacy:** | The degree to which the care or intervention for the patient has been shown to accomplish the desired or projected outcome. |
| **Appropriateness:** | The degree to which the care or intervention provided is relevant to the patient's clinical needs, given the current state of the art. |

**DOING THE RIGHT THINGS WELL:**

| | |
|---|---|
| **Availability:** | The degree to which appropriate care or intervention is available to meet the patients needs. |
| **Effectiveness:** | The degree to which the care or intervention is provided in the correct manner, given the current state of the art, in order to achieve the desired or projected outcome for the patient. |
| **Timeliness:** | The degree to which the care or intervention is provided to the patient at the most beneficial or necessary time. |

| | |
|---|---|
| **Safety:** | The degree to which the risk of an intervention and risk in care environment are reduced for the patient and health care provider. |
| **Efficiency:** | The ratio of the outcomes (results of care) for a patient to the resources used to deliver the care. |
| **Continuity:** | The degree to which the care or intervention for the patient is coordinated among practitioners, among organizations and across time. |
| **Respect and Caring:** | The degree to which the patient, or designee, is involved in his or her own care decisions, and to which those providing services do so with sensitivity and respect for his or her needs, expectations, and individual differences. |

**Definitions of Quality Improvement Tools and Techniques:**

**Problem Solving/Problem Statements:** Structured processes for acquiring and analyzing data in a way that will identify the root causes of quality problems and remove or reduce those causes. Problem statements are a description in specific/measurable terms of how a particular deficiency affects the quality of an organization. Problem statements never give any pre-conceived indication of what the root cause might be; never state or imply a particular type of solution; and never affix blame for the problem.

**Brainstorming**: Brainstorming is a group technique for generating new, useful ideas; it uses a few simple rules for discussion that increase the chances for originality and innovation.

**Multi-voting**: A method by which a group or combination of groups determine the relative importance of a quality improvement need; focuses on proposed solutions.

**Consensus**: A technique by which quality improvement group members discuss proposed actions and agree upon a direction/solution to the area of identified concern.

**Cause and Effect Diagrams**: A way to organize theories about the causes of a problem.

**Flow Diagrams**: Graphic representations of the sequence of steps needed to produce some output.

**Control Charts**: Graphic representation of data which includes an expected standard of quality.

**Histograms**: Graphic summary of the variation in a set of data.

**Pareto Charts**: A graphic display in ranked comparison of factors related to a quality problem which separates the vital few from the useful many.

**Scatter Diagrams**: A graphic representation of the observed relationship between two variables

**Trend Charts**: A graphic representation of quality over time.

**Storyboarding**: A visual display of the activities and results achieved by a quality improvement team.

## Attachments

No Attachments

## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Executive Committee | Lisa Moore: VP Quality/Risk Mgmt | 09/2023 |
| Policy Review Committee | Brittany Owen: Dir Performance Improv/Quality | 08/2023 |
| Policy Owner | Lisa Moore: VP Quality/Risk Mgmt | 08/2023 |

## Applicability

TriStar Centennial and Ashland City Policy Library

Attachment 10C

Financial Assistance Policies

PARALLON®

| DEPARTMENT: Operations Support | POLICY DESCRIPTION: Financial Assistance Policy for Uninsured Patients |
|---|---|
| PAGE: 1 of 13 | REPLACES POLICY DATED: 11/01/2017, 11/04/2021 |
| APPROVED: 06/17/2022 | EFFECTIVE DATE: 06/17/2022 |
| ANNUAL REVIEW DATE: 11/04/2022 | REFERENCE NUMBER: PARA.PP.OPS.015 |

**SCOPE:**
All Self-Pay patient accounts, excluding elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients will be given an Uninsured Discount.

The following also qualify for the Uninsured Discount::

- Accounts where insurance benefits have been exhausted or terminated
- Medicare outpatient self-administered drugs

NOTE: If a Parallon Client chooses to participate in the uninsured discount process and the processes are different a client specific policy should be developed using this policy as the guideline and making changes as applicable. Use the reference number identifying the client as defined in the Policy and Procedure Development policy PARA.PP.GEN.001.

**PURPOSE:**
To define the process for selecting the appropriate Self-Pay IPLAN, providing patients with information regarding available discounts and processing discounts for patients assigned one of the Uninsured Discount IPLANS.

**POLICY:**
All Self-Pay patient accounts will receive an uninsured discount, with the exception of elective cosmetic procedures; facility designated self-pay flat rate procedures, scheduled/discounted procedures for International patients and accounts meeting the charity guidelines. Uninsured discounts will also be applied to accounts where insurance benefits have been exhausted or terminated. Medicare outpatient self-administered drugs will also receive the uninsured discount. Accounts will be assigned one of the following Uninsured Discount IPLANS.

| IPLAN | IPLAN Description | LOG ID | IP Proc Code | OP Proc Code |
|---|---|---|---|---|
| 099-40 | Uninsured Discount Plan | UINS | 920970 | 920980 |
| 099-41 | Uninsured Discount Plan – Burn Unit | UINB | 920971 | 920981 |
| 099-42 | Uninsured Discount Plan – Transplant | UINT | 920972 | 920982 |
| 099-44 | Uninsured State Specific | (local) | (local) | (local) |
| 099-45 | Uninsured ESP – Left or Ref | (local) | (local) | (local) |

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|---|---|---|---|---|
| 099-46 | Uninsured ESP - Treated | (local) | (local) | (local) |
| 099-47 | Uninsured Discount Plan – Patient Non-Compliance | UINS | 920970 | 920980 |
| 099-49 | Uninsured – Partially Exhausted Benefits | N/A | (local) | (local) |
| N/A | Uninsured – Medicare Self-Administered Drugs | N/A | N/A | 957983 |

The discount amounts will be provided to each facility in a formal rate schedule document. The patient will receive the Uninsured Discount unless the patient qualifies for a Charity Discount as outlined in the existing Charity Financial Assistance Policy for Uninsured and Underinsured Patients (PARA.PP.OPS.016).

Refer to Uninsured Discount FAQ for more information.

**Patient Notification at the time of Registration:**
If it is determined the patient is uninsured at the time of registration, the patient/responsible party will be presented with an Uninsured Patient Information document (PARA.FT.OPS.015) that provides information on the Uninsured Discount Policy and other available discounts and payment options. This document will outline the process for uninsured discounts and inform the patient of additional account resolution options (i.e. monthly payments). The patient/responsible party will be asked to sign and date the document. The document will then be scanned into the imaging system and be placed in the imaging Patient Folder document type, as a validation that information regarding discounts has been communicated to all uninsured patients.

**Patient Access Responsibilities at the Time of Registration:**
Patient Access will be responsible for determining the appropriate IPLAN assignment from the table above and for presenting the Uninsured Patient Information Document (PARA.FT.OPS.015) to the patient/responsible party. Patient Access will explain the process as documented, answering questions related to the document and obtaining a signature from the patient/responsible party documenting that the information regarding available discounts was provided.

All requests for payment will be based on total estimated charges less the uninsured discount.

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Patient Access will be responsible for requesting from the patient/responsible party the expected patient liability amount by using a facility specific deposit schedule which has been updated to reflect the Uninsured Discount.

Patient Access will be responsible for asking the patient/responsible party for payment in full or monthly payment arrangements on the patient liability amount.

**Inpatient and Outpatient self-pay patients who are able to make payment in full or monthly payment arrangements.**

- Assign the appropriate Uninsured Discount IPLAN
- The Uninsured Discount IPLAN should reflect proration of 100% of the total charges for the patient
- A facility/SSC specific prompt pay discount may be applied in addition to the Uninsured Discount as set forth in the PARA.PP.SS.035 Discount Policy for Patients

**Inpatient self-pay patients who are not able to make payment in full or monthly payment arrangements and Outpatient self-pay patients will be considered for Medicaid eligibility.**

- Assign the facility designated Pending Medicaid IPLAN as the primary payer
  - The Pending Medicaid IPLAN should reflect proration of 100% of the total charges for the patient
- Assign the Pending Charity IPLAN (099-50) as the secondary payer
  - Present the patient with a Financial Assistance Application for Charity consideration; (Note: Patients who are elective will not qualify for Charity, so the Pending Charity I-plan does not need to be added)
- Assign the appropriate Uninsured Discount IPLAN as the tertiary payer

**Outpatient self-pay patients who are not able to make payment in full or monthly payment arrangements and do not meet the Medicaid eligibility threshold.**

- Assign the Pending Charity IPLAN (099-50) as the primary payer
  - The Pending Charity IPLAN should reflect proration of 100% of the total charges for the patient
  - Present the patient with a Financial Assistance Application for Charity consideration; (Note: Patients who are elective will not qualify for Charity, so the Pending Charity I-plan does not need to be added)
- Assign the appropriate Uninsured Discount IPLAN as the secondary payer

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**All Inpatient and Outpatient self-pay patients registered for elective cosmetic procedures, facility designated self-pay flat rate procedures and scheduled/discounted procedures for International patients.**

- Assign the facility/SSC designated IPLAN for the discounted/flat rate procedure

**Emergency Department self-pay patients who opt out to an ESP process will be assigned an Uninsured ESP IPLAN.**

- Assign the Uninsured ESP –Left or Referred IPLAN (099-45) as the primary payer if the patient elects to Leave or be Referred during the ESP process
- Assign the Uninsured ESP – Treated IPLAN (099-46) as the primary payer if the patient receives treatment via the ESP process

The default of Self-Pay IPLAN 000-00, due to the absence of an IPLAN, should be avoided once this policy is implemented. All accounts that are not assigned an IPLAN and systematically assigned Self-Pay 000-00 should be reviewed and moved to the appropriate IPLAN. All accounts excluding Client/Industrial accounts must be registered with an appropriate IPLAN for the third party payer, Medicaid Pending, Charity Pending, elective cosmetic/facility designated flat rate plan or an Uninsured Discount Plan. A Business Objects script has been developed to assist in identifying accounts without an IPLAN assignment.

**Financial Counselor/ CSO/Collector Responsibilities:**
If at any time it is determined that the patient is covered for these services by a health plan, the Uninsured Discount IPLAN should be removed and the Uninsured Discount reversed. The Uninsured Discount is limited to patients who have no third party payer source of payment. The IPLAN assignment of the third party payer should be assigned to the account in place of the Uninsured Discount IPLAN.

**Retroactive consideration for Medicaid eligibility or Charity Discount:**
Uninsured Discount Plan patients that retroactively are considered for Medicaid eligibility or Charity discounts will have the appropriate Pending Medicaid eligibility and Pending Charity IPLANS assigned as outlined in the Patient Access process above. The Uninsured Discount will be reversed until determination of Medicaid eligibility and Charity can be ruled out.

**Insurance Denials for Partially Exhausted Benefits:**
Accounts where a denial is applied due to partially exhausted benefits, the Uninsured – Partially Exhausted Benefits IPLAN (099-49) should be applied to the secondary position, after the payer with

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partially exhausted benefits. A manual p-line must be performed to adjust the exhausted benefit portion of the account by the facility Uninsured Discount percentage.

Guidelines to determine if an uninsured discount qualifies based on Partially Exhausted Benefits (All three guidelines must be met):

- The remit indicates a Final Denial, or verbiage used on the remit such as "Exhausted Benefits" or "Maximum Coverage Exceeded" and
- The patient was considered for Charity for the remaining balance and not approved and
- Days being considered for the uninsured discount were not covered by insurer; Also, no insurance payment or contractual adjustment was received or posted for a portion of the day's charges

**Medicare Outpatient Accounts containing Self-administered Drugs:**
Self-administered drugs (SADs) provided to Medicare outpatients are considered a non-covered service by Medicare. SADs will not be tracked using an IPLAN. Charges for SADs will be uniformly discounted 100% for all HCA facilities. Non-HCA will be discounted based on facility Uninsured Discount percentage. A manual p-line using procedure code 957983 must be performed to adjust the SAD portion of the account. Click here for more information.

**Insurance Denials for no coverage including pre-existing:**
Accounts where the insurance remits a denial of coverage including pre-existing conditions and there are no other insurance coverage's on file will be considered self-pay accounts. The IPLAN for the insurance denial should be removed and the Pending Medicaid IPLAN added as primary (if the account meets local screening guidelines), Pending Charity IPLAN assigned as secondary and the Uninsured Discount IPLAN assigned as tertiary. A Financial Assistance Application will need to be forwarded to the patient/responsible party.

**Patient Statements:**
Statements should not be sent out until the uninsured discount has been posted. Letters to a Self-Pay patient/responsible party should not include the account balance until the Uninsured Discount has been posted. If you use letters in your Medicaid Pending or Charity Pending process, you will need to remove the account balance reflected on them.

**Late Charges:**
Accounts with the Uninsured Discount IPLAN as the primary payer should not have late charges posted. If late credits are posted to the account, the Uninsured Discount should be recalculated to

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reflect the correct patient liability. The Bill Code master file on Patient Accounting should be modified to reflect no posting of late charges. Late charges after the Late Charge Days have elapsed should be NPST (not posted) from the Late Charge Report.

**State Specific requirements**
Each SSC should evaluate whether this policy complies with the applicable State regulations regarding Uninsured Discounts, and if it does not, clearly document exceptions to this policy in either a State specific policy or an addendum to this policy.

**HCA Trauma Facilities**
After all efforts to identify funding for Uninsured patients have been exhausted, the trauma activation charge will be discounted at 100% and then the standard uninsured discount will be applied to the remainder of the account. The discount will be applied automatically when the uninsured IPLAN is applied.

**PROCEDURE:**

| Responsible Party | Action |
|---|---|
| **Self-Pay – Inpatient and Outpatient (able to pay)** | |
| Patient Access | Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient. |
| | Determines the patient <u>can</u> make payment or establish arrangements for payment. |
| | Assigns the Uninsured IPLAN as the primary payer. |
| | Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party. |
| | Calculates deposit from facility deposit schedule. |
| | Collects deposit and documents account. |

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| **Self-Pay – Inpatient (unable to pay)** | |
| Patient Access | Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient.<br><br>Determines the patient cannot make payment or establish arrangements for payment.<br><br>Assigns the Medicaid Pending IPLAN as the primary payer.<br><br>Assigns the Charity Pending IPLAN as the secondary payer.<br><br>Assigns the Charity Pending IPLAN as the secondary payer.<br><br>Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.<br>Presents the Financial Assistance Application to the patient or responsible party.<br><br>Documents account. |
| **Self-Pay – Inpatient and Outpatients for an Elective Cosmetic Procedure, Facility Flat Rate or a scheduled/discounted International Patients** | |
| Patient Access | Assigns the facility/SSC designated IPLAN for the elective cosmetic procedure, facility flat rate procedure or scheduled/discounted International Patient procedure.<br>Collects payment for elective cosmetic or facility flat rate procedure.<br><br>Documents account. |
| **Self-Pay – Non Inpatient (unable to pay and for services that exceed the facility Medicaid Eligibility threshold)** | |
| Patient Access | Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient.<br><br>Determines the patient cannot make payment or arrangements for payment. |

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| | Determines the charges will be over the Medicaid eligibility threshold.<br><br>Assigns the Medicaid Pending IPLAN as the primary payer.<br><br>Assigns the Charity Pending IPLAN as the secondary payer.<br><br>Assigns the Uninsured Discount IPLAN as the tertiary payer.<br><br>Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.<br><br>Presents the Financial Assistance Application to the patient or responsible party.<br><br>Documents account. |
| **Self-Pay – Non Inpatient (unable to pay and charges for services that may not exceed Medicaid eligibility threshold)** | |
| Patient Access | Determines the patient is not seeking services for elective cosmetic, a flat rate procedure or is a scheduled/discounted International Patient.<br><br>Determines the patient cannot make payment or arrangements for payment.<br><br>Determines the complete charges for services cannot be made at time of registration or<br>Determines the charges will not be over the Medicaid eligibility threshold.<br><br>Assigns the Charity Pending IPLAN as the primary payer.<br><br>Assigns the Uninsured Discount IPLAN as the secondary payer. |

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| | Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.<br><br>Presents the Financial Assistance Application to the patient or responsible party.<br><br>Documents account. |
| **Self-Pay – Emergency Department Registrations** | |
| Patient Access | EMTALA guidelines must be adhered to for all ED patients.<br><br>Assign the Charity Pending IPLAN as the primary payer.<br><br>Assign the Uninsured Discount IPLAN as the secondary payer.<br><br>Documents account accordingly. |
| **Self-Pay – Emergency Department Departures (able to pay)** | |
| Patient Access | Determines the patient <u>can</u> make payment or arrangements for payment.<br><br>Removes the Charity Pending IPLAN (if assigned at time of registration)<br><br>Assigns the Uninsured IPLAN as the primary payer. If the patient opts out for the ESP process, assign the appropriate ESP IPLAN.<br><br>Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.<br><br>Calculates deposit from facility deposit schedule.<br><br>Collects deposit and documents account. |
| **Self-Pay – Emergency Department Departures (unable to pay)** | |

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| Patient Access | Determines the patient cannot make payment or arrangements for payment.<br><br>Ensures the Charity Pending IPLAN is the primary payer<br><br>Ensures the Uninsured IPLAN is the secondary payer.<br><br>Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.<br><br>Documents account. |
| **Monitoring Inpatient and Outpatient Uninsured Discounts** | |
| **Operations Support** | Reviews Self-Pay accounts with the Uninsured Discount Plan as the primary payer for appropriate posted discount.<br><br>Notifies Payment Compliance of accounts with Uninsured Discount Plan as the primary payer that are final billed and do not reflect an Uninsured Discount.<br><br>Ensures that all Statements are held until the Uninsured Discount is posted for patients who have the Uninsured Discount Plan as the primary payer.<br><br>Ensures that all Letters to a Self-Pay patient/responsible party do not include the account balance until the Uninsured Discount has been posted |
| **Self-Pay - Medicaid Eligibility Denied** | |
| **Operations Support** staff | Determines the patient IS NOT eligible for Medicaid Coverage. |

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| | Deletes the Medicaid Pending IPLAN and the system will automatically move the Charity Discount IPLAN to the primary position and the Uninsured Discount IPLAN to the secondary position.<br><br>Considers the patient for a Charity Discount based on PARA.PP.OPS.016 Discount Charity Policy for Patients. |
| **Self-Pay – Charity Discount Denied** | |
| **Operations Support Staff** | Determines the patient IS NOT eligible for a Charity Discount<br><br>Deletes the Charity Pending IPLAN and the system will automatically move the Uninsured Discount Plan to the primary position<br><br>Non-Concuity facilities processes an IZ transaction to ensure that the Uninsured Discount IPLAN Log ID performs discount calculation |
| **Insurance Denials – No Coverage or Pre-existing** | |
| Collections and/or CSO | Third Party payer denies coverage due to no coverage or pre-existing.<br><br>Remove Third Party IPLAN from account.<br>Add Pending Medicaid as primary payer and Charity Pending 099-50 as secondary payer.<br>Send Financial Assistance Application to patient/RP |
| **Insurance Denials – Partially Exhausted Benefits** | |

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| Collections and/or CSO | Third Party Payer denies for partially exhausted benefits.<br>Adds the Uninsured – Partially Exhausted Benefits IPLAN (099-49) into the secondary position following the partially exhausted benefits payer IPLAN.<br><br>Processes a manual p-line for the facility approved Uninsured Discount on the portion of the account partially denied due to exhausted benefits and re-prorates to patient liability. |
| **Medicare - Self-administered Drugs** | |
| MSC Process | Will identify billed claims from the billing database that require a SADs uninsured discount. Charges for SADs will be uniformly discounted 100% for all HCA facilities. Non-HCA will be discounted based on facility Uninsured Discount percentage. A p-line using procedure code 957983 will be entered in eTran. The p-line follows the standard approval process defined in eTran. Once the uninsured discount is posted to the account; the accounts follow the normal MSC collection process. Click here for more information.<br><br>**NOTE: Encounters reaching a zero balance will be moved to zero balance status and will not require an uninsured discount.** |

**REFERENCE:**

PARA.FT.OPS.015 Uninsured Patient Information Document
Facility Specific Uninsured Discount Plan Deposit Schedule
Facility Specific Cosmetic Procedure Plan Policy and Procedure
PARA.PP.SS.035 Discount Policy for Patient
PARA.PP.OPS.016 Discount Charity Policy for Patients
PARA.PP.GEN.001 Policy and Procedure Development
PARA.PP.COLL.053 Non-Compliant COB Policy
Self-Administered Drug Discount effective 04/01/2016

Self-Administered Drugs 04012016.doc

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QHP- denial code 8X addendum

QHP denial code 8X specific to collectior

Uninsured Discount FAQ 04/01/2016

Uninsured Discount Plan FAQ 04012016.c

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**SCOPE:**

All SSC and Facility areas responsible for requesting and evaluating Financial Assistance Applications ("FAA") for the purposes of processing a charity write-off for certain patients receiving services at HCA-affiliated, non-partnership, acute-care hospitals ("Hospitals").

**PURPOSE:**

To define the policy for providing partial or full financial relief to patients who (i) have received emergency services, (ii) meet certain income requirements, (iii) do not qualify for state or federal assistance for the date of service, (iv) are uninsured or underinsured, and (v) are unable to make partial or full payment on outstanding balances. In addition, with respect to the FAA and income validation, to establish protocols and supporting documentation requirements.

**POLICY:**

The following types of patients may qualify for a charity write-off based on the patient's total household income, supporting income verification documentation or processes, as required, and the amount of the patient liability:

1) To be eligible for a charity write-off review, a patient must have incurred emergent, non-elective services.

2) To be eligible for a charity write-off, a patient must be (a) uninsured or underinsured and (b) have an out-of-pocket patient responsibility of $1,500 or more for an individual account. Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than $1,500 may be reviewed and a charity write-off applied if Federal Poverty Guidelines/Level ("FPL") thresholds are met as set forth in Section 9, below.

3) For purposes of this policy, an uninsured patient is one (i) with no third party payer coverage for emergent health care services, (ii) who provides documentation that the patient is unable to pay for some or all of the provided non-elective hospital services and (iii) who satisfies the financial eligibility criteria set forth herein.

4) For purposes of this policy, an underinsured patient is one with some form of third party payer coverage for health care services, but such coverage is insufficient to pay the current bill such that the patient retains a patient liability that they are unable to pay.

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5) A validation will be completed, as required in this Policy, to ensure that if any portion of the patient's medical services can be paid by any federal or state governmental health care program (e.g., Medicare, Medicaid, Tricare, Medicare secondary payer), private insurance company, or other private, non-governmental third-party payer, that the payment has been received and posted to the account. No charity write-off can be applied to any account with any outstanding payer liability.

6) Supporting Income Verification Documentation & Review:

A. Medicare Accounts

i. All Medicare patients (i.e., inpatients and/or outpatients) must submit supporting income verification documentation. Electronic validation of patient income, e.g., Experian, alone is not sufficient. Medicare requires independent income and resource verification for a charity care determination with respect to Medicare beneficiaries (PRM-I § 312).

ii. In addition to the FAA, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide two pieces of supporting documentation from the following list to meet this income verification requirement:

- State Income Tax Return for the most current year
- Supporting W-2
- Supporting 1099's
- Copies of all bank statements for last 3 months
- Most recent bank and broker statements listed in the Federal Tax Return
- Current credit report

iii. Dual-Eligible Beneficiaries: A Medicare beneficiary who also qualifies for Medicaid (dual-eligible beneficiary) may be deemed indigent as long as the "Must Bill" requirements are met. That these requirements are met must be supported by a State Medicaid remittance advice. When claiming an amount as Medicare Bad Debt for a dual-eligible beneficiary, Medicaid must be billed. In addition, the remittance advice showing non-payment must be maintained as supporting documentation for the Medicare Bad Debt adjustment. Charity write-offs for Medicaid Exhausted beneficiaries may be less than $1,500.

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iv. Patients who qualify for a Medicare Savings Program (Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), Qualified Disabled and Working Individuals (QDWI)) will be eligible for a full charity write-off. Charity write-offs for Medicare Savings Program qualified patients may be less than $1,500.

B. Non-Medicare Accounts

i. Generally, for all non-Medicare Accounts, the following will be acceptable supporting documentation: (i) the documentation listed in A. above, (ii) or any one of the following:

- Most Recent Employer Pay Stubs
- Written documentation from income sources
- Proof of Medicaid Eligibility
- Electronic validation of patient income and family size, such as Experian

ii. Supporting income verification documentation through an electronic validation of patient information/income, such as Experian, shall be obtained where no other income verification is obtained.

iii. To the extent required by state law, a complete FAA shall be obtained for any dollars reported as charity to the state.

iv. Review of assets may take place during the application process where required by state law or regulation.

C. Patients/Responsible Party Deemed Eligible.

The patient/responsible party may be deemed to meet the charity guidelines if:

- the patient/responsible party is determined to be eligible by a local clinic under poverty and income guidelines similar to the ones in this policy; or
- the patient/responsible party presents with Medicaid, and Medicaid does not pay.

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D. Charity Processing Based on Extenuating Circumstances, i.e., Potential Charity Write-off Absent Full Documentation.

There may be extenuating circumstances where resource testing cannot be completed because the patient/responsible party does not/cannot (i) complete the FAA, or (ii) provide supporting documentation listed in A or B, above. In those circumstances, a manager may waive the required documentation and extend a charity care write-off, consistent with this Policy. The following may be considered by the manager to be extenuating circumstances:

i. *Patients identified as an undocumented residents or homeless through*:

- Medicaid Eligibility screening
- Registration process
- Discharge to a shelter
- Clinical or Case Management documentation
- Absence of a credit report

*ii. Patients that expire* - if it is determined through family contact and/or courthouse records that an estate does not exist, it may be considered for a charity write-off (even if the patient had a spouse) upon documentation and with the manager's review and approval of a policy exception.

*iii. Medically Indigent* – In addition to the above, if a patient/responsible party meets the medically indigent status based upon state guidelines or requirements, a charity write-off may be applied after the manager completes a resource testing process for the patient/responsible party.

7) Pending Medicaid Effect on Charity Write-off:

The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Pending Charity.

8) Health Insurance Marketplace for Qualified Health Plans:

Pending qualification in the Health Insurance Marketplace may take place concurrently with the Pending Charity process. The QHP enrollment is not retroactive. Rather, the coverage

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becomes effective for future dates of service. Therefore, it is necessary to continue with the Pending Charity process for visits occurring prior to QHP effective dates.

9) Charity Processing based on Federal Poverty Guidelines:

A. Patients with individual or household incomes of between 0-200% of Federal Poverty Guidelines:

Patients with more than a $1,500 patient liability that fall within 0-200% of the FPL will have the entire patient balance processed as charity write-off. Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than $1,500 may be reviewed and a charity write-off applied.

B. Patients with individual or household incomes of between 201- 400% of Federal Poverty Guidelines:

Patients with incomes between 201% and 400% of FPL will have their balances capped at a percentage of their income according to the table below. This percentage will be determined using the patient's FPL.

- 201% - 300% - balances capped at 3% of annual household income
- 301% - 400% - balances capped at 4% of annual household income

Upon request by a patient and, if there are extenuating circumstances, accounts with out-of-pocket responsibility balances of less than $1,500 may be reviewed and a charity write-off applied.

C. Insured Accounts with emergency services only: Additional financial relief will be available for insured patients with emergent services only. These patients will be identified by having one of the following emergency Evaluation and Management (E/M) codes on their account: 99281,99282,99283,99284,99285, or 99291, and NOT in inpatient status.

After all managed care payments, contractuals and/or discounts have been applied, patients will have their balance capped to a fixed amount depending on their income and corresponding FPL. The patient balance caps are as follows:

PARALLON

| DEPARTMENT: Vendor Collections Management | POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients |
|---|---|
| PAGE: 6 of 6 | REPLACES POLICY DATED: 11/01/2017 |
| APPROVED: 09/29/2020 | EFFECTIVE DATE: 10/1/2020 |
| ANNUAL REVIEW DATE: | REFERENCE NUMBER: PARA.PP.VCM.016 |
| RETIRED DATE: | |

**E/M Levels 1-3**
201% - 300% - balance capped at $1500
301% - 400% - balanced capped at $1750

**E/M Levels 4 +**
201% - 300% - balance capped at $2500
301% - 400% - balanced capped at $2750

In the event that **Section 9A** or B above provides more relief to the patient, then Section 9)A or B will be used to determine patient responsibility.

10) Patients Who Are Uninsured:

Notwithstanding 9)A. and B. above, patients who are uninsured and who provide the supporting income verification documentation and otherwise meet the requirements of this Policy, will have their patient balance capped at the lesser of the amount calculated under 9)A. or 9)B. above, or the amount calculated pursuant to the uninsured discount model.

Balances from multiple accounts for the same patient may be considered together to determine out-of-pocket responsibility minimums and for calculating the cap.

The write-off will be applied to the entire outstanding patient balance.

11) Refunds on Charity Accounts:

The general expectation is that all patients pay for services rendered if they are not fully covered by a third party. Therefore, any amount paid by the patient (even if the patient subsequently meets the charity write-off guidelines for their balance due), will be retained. Only amounts paid by the patient that exceed the amount that patient would have paid had they received the uninsured discount, or that exceed their out of pocket responsibility per their insurance, will be refunded. For those patients that do meet the charity write-off criteria and have made a partial payment, the charity write-off will be posted on the remaining patient balance.

PARALLON

| DEPARTMENT: Vendor Collections Management | POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients |
|---|---|
| PAGE: 7 of 6 | REPLACES POLICY DATED: 11/01/2017 |
| APPROVED: 09/29/2020 | EFFECTIVE DATE: 10/1/2020 |
| ANNUAL REVIEW DATE: | REFERENCE NUMBER: PARA.PP.VCM.016 |
| RETIRED DATE: | |

12) Patient Dispute Process:

In the event a patient wishes to file a dispute and appeal their eligibility for a Charity write-off under this policy, the patient may seek review from the Vendor Collections Management Director, Hospital Chief Financial Officer or an SSC Executive as defined in the Charity Review Appeal Process policy (PARA.PP.VCM.020).

13) Compliance with State regulations:

Each SSC should evaluate whether this Policy complies with the applicable state law and regulations regarding charity care, e.g., California, Florida. If this Policy does not comply with state law and regulations, each SSC must clearly document exceptions to this policy in either a State specific policy or an addendum to this Policy.

14) Liens:

Under no circumstances will liens be considered on properties less than $300,000 in value.

**REFERENCE:**

- **PARA.FT.VCM.606 Federal Charity Guidelines**
- **PARA.FT.VCM.638 Financial Assistance Application**
- **PARA.MF.VCM.804 Collection Charity Letters**
- **PARA.PARS.PP.009 Medicare Bad Debt and Recovery Logs Policy**
- **PARA.PP.VCM.019 Utilizing the Artiva Charity Process**

PARALLON
HCA Healthcare

| | |
|---|---|
| **DEPARTMENT:** Support Services | **POLICY DESCRIPTION:** Discount Policy for Patients |
| **PAGE:** 1 | **REPLACES POLICY DATED:** 01/01/2015 |
| **APPROVED:** | **RETIRED:** |
| **EFFECTIVE DATE:** 05/26/2016 | **REFERENCE NUMBER: PARA.PP.GEN.043** |

**SCOPE:**
All SSC (including Specialty Services) and Facility areas responsible for offering discounts at the time of service, or settlements after services are rendered, for the sole purpose of expediting collection efforts.

**PURPOSE:**
To define the policy for providing discounts and/or settlement offers to patients with outstanding patient liable amounts for the purposes of liquidating receivables. All discounts will be offered in an effort to liquidate receivables and not to induce incremental volume.

**POLICY:**
Discounts as defined below may be provided to uninsured and insured patients receiving non-elective and elective care based on the patient liable amount as courtesy type discounts. Discounts cannot be considered for Medicare Bad Debt and should not be included in the Medicare Bad Debt Log. Discounts cannot be advertised and are to be offered only in an effort to liquidate receivables. The following outlines the associated discount types:

**Uninsured Patients**

- **Prompt Pay** – Prompt pay discounts may be offered at the time of service. The discount should be offered contingent on payment of the remaining balance. The maximum prompt payment discount should be no more than 20%.
- **Settlement Offers** – Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the collection process to settle a delinquent account.

**Insured Patients**

- **Prompt Pay** – Prompt pay discounts may be offered at the time of service provided the patient liable portion has been determined and, provided that the prompt pay discount is in accordance with payer contract provisions and state law. The maximum prompt payment discount should be no more than 20%. A written notification that the provider may have offered a prompt payment discount to the patient liable portion will be included in the remarks section of the UB claim form in FL-80.
- **Out of Network Discounts** – Out of Network discounts may be applied provided the Payer has been notified in advance that the facility intends to waive the out-of-network penalty.
- **Out of Network Medicare and Medicaid PPO/HMO** - Waiving the difference between out-of-network charges and in-network charges for beneficiaries is prohibited. For example, a facility cannot tell a physician that the facility will accept the in-network charge of $300 instead of the out-of-network charge of $700, when the facility is an out-of-network provider. Refer to Compliance Alert #15 (attached) for information regarding permissible waivers.
- **Out of Network PPO/HMO with Medicare as Secondary/Tertiary Payer-** Discounts may not be offered to reduce or waive an Out Of Network penalty when Medicare is also listed as a payer on the account. For example, if the account lists an OON Payer as primary and Medicare as secondary, you may not offer a discount to offset the primary payer's penalty.

PARALLON
HCA Healthcare

| | |
|---|---|
| **DEPARTMENT:** Support Services | **POLICY DESCRIPTION:** Discount Policy for Patients |
| **PAGE:** 2 | **REPLACES POLICY DATED:** 01/01/2015 |
| **APPROVED:** | **RETIRED:** |
| **EFFECTIVE DATE:** 05/26/2016 | **REFERENCE NUMBER: PARA.PP.GEN.043** |

- **Settlement Offers** – Settlement offers may be extended to the patient/responsible party as part of ongoing collection efforts at any time during the patient liability collection process to settle a delinquent account.

The Division and SSC management teams will work together to establish the allowable discount percent for their respective facilities. The maximum prompt payment discount should be no more than 20%.

**PROCEDURE:**

| Responsible Party | Action |
|---|---|
| Registrar/Financial Counselor/Collection and Support Services Staff | Identifies that the patient/responsible party collection efforts could be shortened if a discount would be provided. |
| Registrar/Financial Counselor/Collection and Support Services Staff | Determines the appropriate type of discount to offer in accordance with the list of discounts previously approved by the facility, Division and SSC. |
| Registrar/Financial Counselor/Collection and Support Services Staff | Offers discount to patient/responsible party. If patient/responsible party is contacted by phone, the Verification of Requestors policy should be followed. (SSD.PP.PRI.103) |
| Registrar/Financial Counselor/Collection and Support Services Staff | Documents the account. |

**REFERENCE:**
**Compliance Alert #15: Beneficiary Inducement Prohibition (updated 06/01/2012)**
http://atlas2.medcity.net/portal/site/ethics
Select Compliance Alerts and choose Alert #15
**Attachment Q**

Attachment Q
01072015.doc

**The below appends the 'check marks' in the HFC portal for responses to question 7Q.**

**7Q. Respond to all of the following and for such occurrences, identify, explain, and provide documentation if occurred in last five (5) years.**

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

The Applicant made a good faith effort to respond to this question regarding the entities identified in the organizational chart for direct upstream ownership of Spring Hill Hospital, Inc., to the best of its knowledge, information, and belief. Due to the breadth of the question and lack of definition of key terms, the Applicant cannot represent these responses are totally comprehensive, but no responsive information is being intentionally withheld. Because there is no central repository for the information sought, and because the length of time some of the entities have been in existence, the Applicant's responses are limited to the past 5 years as a reasonable look-back period, unless the applicable question specifically calls for a different time period.

**Been subject to any of the following:**

- **Final Order or Judgement in a state licensure action:**
  The Applicant assumes for the purpose of this question that "state licensure action" refers to facility licensure. TriStar Spring Hill Hospital and Spring Hill Hospital, Inc. have not been the subject of a Final Order or Judgment in a state licensure action. The other entities in the chain of ownership do not hold a hospital license.

- **Criminal fines in cases involving a Federal or State health care offense:**
  None.

- **Civil monetary penalties in cases involving a Federal or State health care offense:**
  None. The Applicant is not aware that any of its entities upstream have been involved in civil litigation whereby a judgement or settlement was entered in payment of civil monetary penalties.

- **Administrative monetary penalties in cases involving a Federal or State health care offense:**
  None. The Applicant is not aware that any of its entities upstream have been involved whereby a judgment or settlement was entered into resulting in payment of administrative monetary penalties.

- **Agreement to pay civil or administrative monetary penalties to the federal government or any state incases involving claims related to the provision of health care items and services:**
  Please see the responses to the two statements above.

- **Suspension or termination of participation in Medicare or TennCare/Medicaid programs:**
  None.

- **Is presently subject of/to an investigation, or party in any regulatory or criminal action of which you are aware:**
  In light of the breadth and scope of services provided and the business conducted by the entities upstream from the Applicant, it is likely that at any given time one or more are involved, in some capacity, in some type of investigation or regulatory action. However, neither TriStar Spring Hill Hospital, Spring Hill Hospital, Inc. nor any of its upstream entities are the subject of criminal action.

Although Tristar Centennial (owned by HCA Health Services of Tennessee, Inc.) and Spring Hill Hospital, Inc. (owned by HTI Hospital Holdings, Inc.) are not owned by the same entity. On December 29, 2021, TriStar Centennial entered into a settlement agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services ("OIG"). This settlement was in connection with a 2017 CMS survey that resulted in certain alleged EMTALA claims, which were disputed by TriStar Centennial. The OIG and TriStar Centennial agreed to the settlement pursuant to which TriStar Centennial paid the U.S. Department of Health and Human Services $725,000 without any admission of wrongdoing by TriStar Centennial or any concession as to the lack of merit of the allegations by the OIG.

## Attachment – Bed Complement Data

| | *Current Licensed* | *Beds Staffed* | *Beds Proposed* | **Beds Approved* | ***Beds Exempted* | *TOTAL Beds at Completion* |
|---|---|---|---|---|---|---|
| 1) Medical/Surgical | | | *42* | | | *42* |
| 2) Surgical | | | | | | |
| 3) ICU/CCU | | | *8* | | | *8* |
| 4) Obstetrical | | | *10* | | | *10* |
| 5) NICU | | | *8* | | | *8* |
| 6) Pediatric | | | | | | |
| 7) Adult Psychiatric | | | | | | |
| 8) Geriatric Psychiatric | | | | | | |
| 9) Child/Adolescent Psychiatric | | | | | | |
| 10) Rehabilitation | | | | | | |
| 11) Adult Chemical Dependency | | | | | | |
| 12) Child/Adolescent Chemical Dependency | | | | | | |
| 13) Long-Term Care Hospital | | | | | | |
| 14) Swing Beds | | | | | | |
| 15) Nursing Home – SNF (Medicare only) | | | | | | |
| 16) Nursing Home – NF (Medicaid only) | | | | | | |
| 17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid) | | | | | | |
| 18) Nursing Home – Licensed (non-certified) | | | | | | |
| 19) ICF/IID | | | | | | |
| 20) Residential Hospice | | | | | | |
| **TOTAL** | | | *68* | | | *68* |

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