



**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 Hendersonville Medical Center

Name

an unaddressed site on an approximate three (3) +/- acre tract of vacant land on the north side of TN-258/Raymond Hirsch Parkway, located approximately 650 +/- feet west of the intersection of Raymond Hirsch Parkway and Highway 31W

Robertson County

County

Street or Route

White House

Tennessee

37188

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

Justin Coury

Chief Executive Officer

Name

Title

TriStar Hendersonville Medical Center

Justin.Coury@hcahealthcare.com

Company Name

Email Address

355 New Shackle Island Road

Street or Route

Hendersonville

Tennessee

37075

City

State

Zip

Executive

615-338-1000

Association with Owner

Phone Number

3A. Proof of Publication

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

Date LOI was Submitted: 07/25/24

RESPONSE: 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)

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

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

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

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

- ☐ Hospital
- ☐ Ambulatory Surgical Treatment Center (ASTC) – Multi-Specialty
- ☐ 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 -

Freestanding Emergency Department

Hospital -

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

Hendersonville Hospital Corporation

Name

355 New Shackle Island Road

615-338-1000

Street or Route**Phone Number**

Hendersonville

Tennessee

37075

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: TriStar Hendersonville Medical Center ("TriStar Hendersonville") is owned by Hendersonville Hospital Corporation. TriStar Hendersonville is ultimately owned by HCA Healthcare, Inc. through several wholly owned subsidiary corporations. Please see Attachments 7A-1 and 7A-2 for TriStar Hendersonville's corporate status from the Tennessee Division of Business Services Department of State, Charter, Amended Charter, Assumed Name and Certificate, respectively. Attachment 7A-3 contains a copy of TriStar Hendersonville's organizational chart. Attachment 7A-4 contains a listing of TriStar Hendersonville'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: Please see Attachment 9A.

10A. Floor Plan

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

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

RESPONSE: See Attachment 10A for a copy of the floor plan of the single-story structure.

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: See Attachment 11A. The site is located approximately 650 +/- feet west of the intersection of TN-258 (Raymond Hirsch Parkway) and Highway 31W in White House. It is easily accessible by car, ambulance, and other ground transportation. There are no public bus routes in White House. The site is on TN-258 (Raymond Hirsch Parkway) less than half a mile from TN-76 and very close (0.2 miles) to the intersection with Highway 31W. It is also 1.2 miles from Interstate 65 Exit 108. In addition to local roads, each of these state and federal highways provide favorable access from the service area cities of Cross Plains and Greenbrier and the unincorporated community of Cottontown.

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 size of site is approximately 3 acres. Please see the plot plan included in Attachment 12A for the site relative to the entire parcel, location of the structure on the site, the location of the proposed construction, and the names of all 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:

TriStar Hendersonville, which is part of TriStar Health, seeks to establish a FSED to be operated as a satellite location of its Emergency Department (“ED”) in White House, TN (“TriStar White House FSED”). It will be a full-service hospital ED able to care for all acuity levels of ED patients. The ED will include 11 treatment rooms, including one trauma room, a lab, an imaging department, a nursing station, and support space. It will have isolation and behavioral health/holding capabilities. It will be located on TN-258 Raymond Hirsch Parkway, White House, Robertson County, TN 37188 to serve the service area defined by the zip codes of White House (37188), Greenbrier (37073), Cross Plains (37049) and Cottontown (37048). There are no EDs in the service area. Over 77% of service area patients currently choose a TriStar Health ED for their emergency care. TriStar Hendersonville cares for the most service area ED patient visits (27%) followed by TriStar NorthCrest in Springfield (23%) and TriStar Skyline in Nashville (13%). Accordingly, TriStar Health wants to improve the ability of its patients to access high quality emergency care by establishing a FSED in White House. TriStar Hendersonville is the largest provider of emergency services in the White House zip code, caring for 43.1% of the visits from that zip code in 2023. The FSED is needed to address:

- **Geographic Isolation:** The 155 square mile service area is geographically isolated from emergency services. This area is suburban in nature and includes a significant and growing base of ED patients. The service area has geographical barriers that effect travel dynamics. A steep ridge separates the service area from communities to the south (Hendersonville and Nashville). Today, most patients from this area (62%) drive south, 30 minutes or more, into Hendersonville or Nashville for emergency care. Some (23%) get their emergency care in Springfield. The TriStar White House FSED will be closer and more accessible than Hendersonville, Nashville, Springfield or Gallatin.
- **TriStar Hendersonville Capacity Constraints:** At 1,954 visits per treatment room in 2023, the TriStar Hendersonville ED is 41.5% over capacity using a mid-range application of the American College of Emergency Physicians (“ACEP”) standard of 1,381. (TriStar Hendersonville is 61.2% over capacity using the high range ACEP standard). TriStar Hendersonville’s utilization rate per treatment room continues to increase year over year. Expanding at TriStar Hendersonville is not a viable long-term solution. Establishing an ED closer to where many patients live who already prefer TriStar Health ED care will be advantageous to consumers. By putting this FSED in White House, in the center of an area where many TriStar Hendersonville ED patients already live, many of those emergency patients will likely choose to go to the TriStar White House FSED, freeing up capacity at the TriStar Hendersonville ED.
- **Population Growth:** The proposed service area is rapidly growing and includes an aging population, with its greatest population growth in the White House zip code area (37188), which has nearly doubled in size since 2000 and is projected to grow another 13.7% in the next five (5) years.
- **Access/Availability:** There is no ED in the service area today. Therefore, TriStar Hendersonville wants to make emergency care more accessible by establishing a FSED in White House, which is the largest city in the service area and is central to an area where patients have to travel far for emergency services today.

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- Ownership structure

RESPONSE: The TriStar White House FSED will be a satellite of TriStar Hendersonville, which is owned by Hendersonville Hospital Corporation and whose ultimate parent company is HCA Healthcare, Inc. TriStar Hendersonville is part of the TriStar Health network, which operates 5 FSEDs in Middle Tennessee and HCA Healthcare operates 130 FSEDs in 20 states.

- Service Area

RESPONSE: The service area is defined by the zip codes of White House (37188), Greenbrier (37073), Cross Plains (37049), and Cottontown (37048). Zip codes 37188 (White House), 37073 (Greenbrier), and 37049 (Cross Plains) are primarily in Robertson County, and Cottontown (37048) is primarily in Sumner County.

- Existing similar service providers

RESPONSE: There is no emergency care provider in the service area. TriStar Hendersonville's main campus ED is 12.6 driving miles from the proposed TriStar White House FSED. TriStar NorthCrest is 15 driving miles from the proposed FSED. TriStar Skyline is 20.5 miles from the proposed FSED site. The SRMC Sumner Station FSED is 13.7 driving miles from the proposed FSED site, and the SRMC ED is 17.7 driving miles from the proposed FSED site.

- Project Cost

RESPONSE: The estimated capital cost of the project is \$17,832,032.

- Staffing

RESPONSE: The TriStar White House FSED will be staffed by approximately 31.8 FTEs, consisting of physicians, RNs, EMT/Paramedics, radiology, and lab tech, and nonclinical support staff to meet all acuity levels of ED services.

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: The TriStar White House FSED is needed because it is in the center of a geographically isolated 155 square mile area from which access to emergency care is difficult. There is no emergency care provider in the service area. TriStar Hendersonville's main campus ED and its Portland FSED are the closest at 12.6 driving miles (20-25 minutes drive time and more with traffic) from the proposed FSED location in opposite directions. The White House community is growing rapidly and with the congestion associated with being in a suburban, commuter area, the service area needs better access to emergency care. In addition, because TriStar Hendersonville experiences severe capacity challenges at its ED, adding a TriStar FSED in White House will free up some ED treatment rooms to enable TriStar Hendersonville to provide better access to emergency care. Adding the TriStar White House FSED allows patients to get emergency care closer to where they live as well as help decompress TriStar Hendersonville's high volume emergency department.

- Quality Standards

RESPONSE: The TriStar White House FSED will serve all ED acuity levels and operate under the same high-quality standards as the TriStar Hendersonville main campus ED. The TriStar White House FSED will provide high quality care that is accessible for all patients in the service area. As part of TriStar Hendersonville, the FSED will be accredited by the Joint Commission. In addition, the FSED will be part of TriStar Hendersonville's robust Quality Assurance and Performance Improvement (QAPI) and Utilization Review Programs to maintain and ensure quality of care and patient safety. TriStar Hendersonville is an outstanding hospital with a Leapfrog hospital safety grade A rating for the last six (6) quarters, 4-Star CMS score and many other recognitions for its high quality.

- Consumer Advantage

- Choice

RESPONSE: The TriStar White House FSED will introduce an additional choice for emergency care for service area residents.

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

RESPONSE: The TriStar White House FSED will improve access by (1) providing emergency services where there is currently no provider; (2) helping to alleviate capacity challenges at TriStar Hendersonville's main campus ED; and (3) bringing ED services geographically closer to patients' homes where today over 77% choose a TriStar emergency facility for care. TriStar Hendersonville has been involved in providing healthcare in the White House community for decades. Over 21 years ago, TriStar Hendersonville recruited physicians to start a primary care practice in White House, which now serves thousands of White House community residents. Because many White House patients have established relationships with providers at TriStar Hendersonville, having a TriStar FSED in White House will contribute to providing continuity of care for patients with their existing providers

- Affordability

RESPONSE: The TriStar White House FSED will ensure financial access for all patients. TriStar is the largest TennCare provider in Tennessee and has the most generous charity care policy in the region. TriStar emergency departments care for all patients regardless of their ability to pay and regardless of whether they are in-network for all insurance products.

3E. Consent Calendar Justification

- ☐ Letter to Executive Director Requesting Consent Calendar (Attach Rationale that includes addressing the 3 criteria)
- ☒ Consent Calendar 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	\$460,000
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	\$150,000
3. Acquisition of Site	\$0
4. Preparation of Site	\$1,843,000
5. Total Construction Costs	\$7,764,000
6. Contingency Fund	\$239,000
7. Fixed Equipment (Not included in Construction Contract)	\$1,600,000
8. Moveable Equipment (List all equipment over \$50,000 as separate attachments)	\$1,900,000
9. Other (Specify): construction escalation, building fees, all other	\$686,000

B. Acquisition by gift, donation, or lease:

1. Facility (inclusive of building and land)	\$0
2. Building only	\$0
3. Land only	\$3,150,000
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)	\$17,792,000
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E. CON Filing Fee	\$40,032
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F. Total Estimated Project Cost (D+E)	\$17,832,032
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TOTAL

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:

See **Attachment 1N** for detailed responses to applicable criteria and standards applicable to the proposal in this application. As is shown in **Attachment 1N**, the proposed TriStar White House FSED meets all applicable state health plan criteria.

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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:

The proposed TriStar White House FSED is central to the defined four (4) zip code service area of 37188 (White House), 37073 (Greenbrier), 37048 (Cottontown), and 37049 (Cross Plains). There are no emergency rooms in the service area. This service area incorporates the communities north of Hendersonville, east of Springfield, west of Gallatin, and south of the rural community of Orlinda. This is a historically rural area that has become suburban in nature. Today, most patients from this area (62%) drive south, 30 minutes or more, into Hendersonville or Nashville for emergency care. Some (23%) get their emergency care in Springfield. Fewer still travel to Gallatin. This travel can be time consuming along either mostly narrow country roads or the often- congested Interstate 65. Moreover, traveling to Hendersonville and Nashville requires navigating off a ridge, which can be difficult in severe weather. Travel to Gallatin is even more complicated along a narrow two-lane road. Travel to Springfield is not convenient from White House, Cross Plains or Cottontown and for Greenbrier residents who live on the eastern side of Highway 41, travel to White House is more or less equivalent to traveling to Springfield. The travel time for most residents of the service area to an ED today is 20 minutes or more. The TriStar White House FSED will reduce travel times for service area residents dramatically and will be closer and more accessible than the existing EDs in Hendersonville, Nashville, Springfield or Gallatin.

Outside of the service area, but in Sumner and Robertson counties are:

- TriStar Hendersonville’s ED – 12.6 driving miles away in Sumner County, zip code 37075.
- TriStar Portland FSED in Portland – 12.6 miles away in Sumner County, zip code 37148.
- TriStar NorthCrest in Springfield – 15 driving miles away in Robertson County zip code 37172.
- Sumner Regional Medical Center (“SRMC”) in Gallatin – 17.7 driving miles away, zip code 37066, owned and operated by Highpoint Health System (“Highpoint”), a joint venture operated by LifePoint Health and Ascension Saint Thomas with LifePoint owning a majority of the interest in the joint venture.
- SRMC’s FSED in Gallatin 13.7 driving miles away in Sumner County, zip code 37066.

Service Area Definition

See **Attachment 2N** for the proposed county service area map. This CON application seeks to establish a FSED in White House due to the service area’s geographic isolation and to help alleviate capacity challenges at TriStar Hendersonville.

The location in White House was based on a series of factors, such as:

- The White House area and surrounding communities are geographically isolated. They are distant from the existing EDs outside of the service area and road congestion and geographic qualities of the area enhance the isolated nature of the area.
- The service area has a high concentration of patients who have sought emergency care from a TriStar ED. In 2023, 77% of all ED patients in the service area went to a TriStar ED.
- TriStar Hendersonville provides emergency care for the greatest number of ED patients in the service area (27%) and needs to alleviate some of the stress on its over-capacity main campus ED. Since a large number of TriStar Hendersonville’s ED patients come from White House and the other communities in the service area, White House is a logical place to establish this FSED.
- Neighboring Springfield, zip code 37172, is already served by TriStar NorthCrest Medical Center (“TriStar NorthCrest”), and its 18 treatment room emergency department.
- Economic and social factors show that the TriStar White House FSED will benefit patients in the service area.

Within the context of the above factors, the TriStar Hendersonville has identified the zip codes in **Exhibit 1** as the service area for the proposed TriStar White House FSED.

Exhibit 1 TriStar White House FSED Service Area

Zip Code	Community	Primary County
37188	White House	Robertson
37073	Greenbrier	Robertson
37048	Cottontown	Sumner
37049	Cross Plains	Robertson

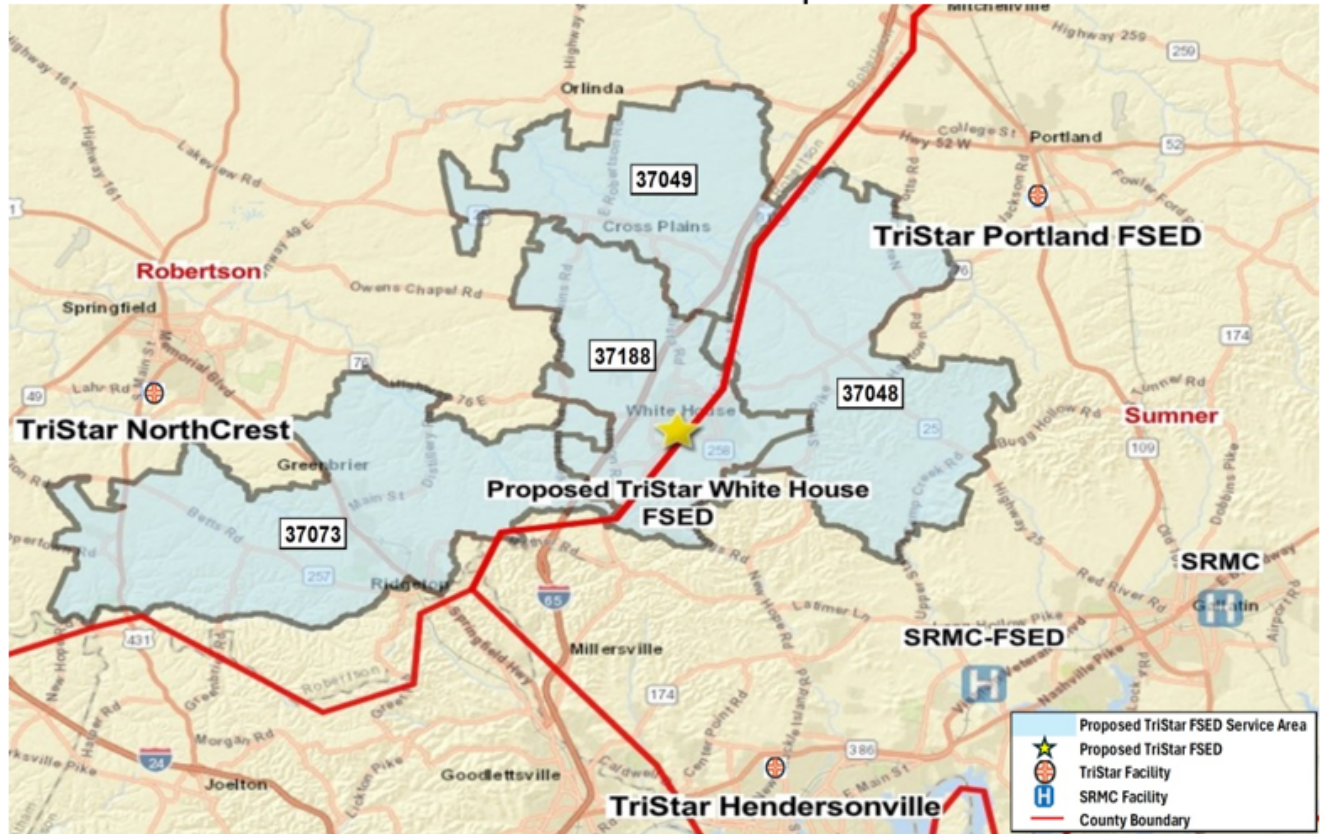
In addition to the factors considered to identify the location of the TriStar White House FSED, TriStar Hendersonville also considered the following factors in its determination of the proposed service area:

- TriStar Hendersonville’s historical patient origin by zip code;
- TriStar NorthCrest’s historical patient origin by zip code;
- TriStar Hendersonville’s and TriStar NorthCrest’s utilization by zip code;
- Travel time analysis from parts of the service area to the TriStar White House FSED site compared to the hospitals and EDs in Robertson and Sumner Counties;
- The location of existing EDs outside of the service area; and

- The fact that FSEDs often pull from a narrower service area than on-campus hospital EDs as evidenced by TriStar’s experience operating its five (5) FSEDs in Middle Tennessee.

Based on the aforementioned factors, the proposed service area is reasonable and justified. **Exhibit 2** provides a map of the service area zip codes. The map includes the existing hospitals and FSEDs outside of the service area, but located in Sumner or Robertson counties, and major roadways.

**Exhibit 2
Service Area Map**



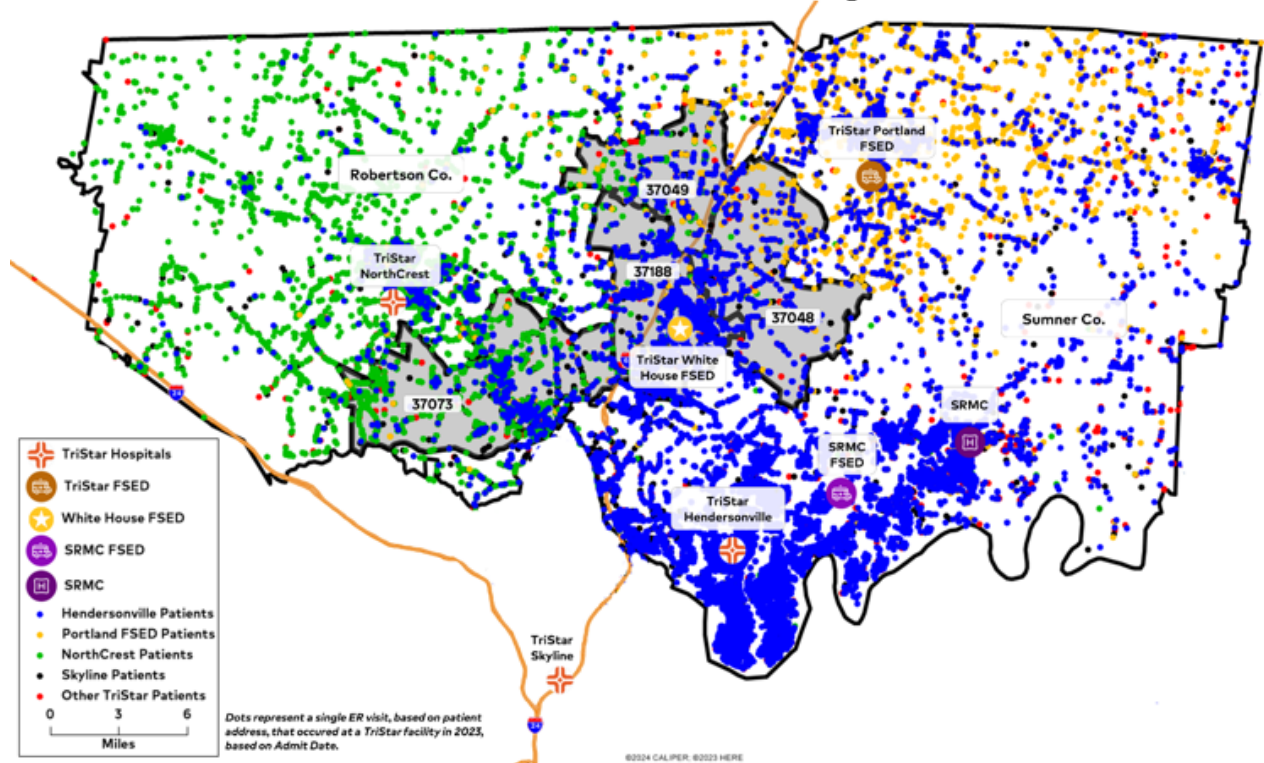
Please see additional detailed discussion of ED access for service area residents provided in **Attachment 1N**.

TriStar Hendersonville ED Used by Residents of the Proposed Service Area

As is described in **Attachment 1N**, TriStar Hendersonville’s ED has the highest number of visits by emergency patients from the service area. The TriStar Hendersonville ED is also highly utilized and experiencing significant capacity challenges. The TriStar Hendersonville on-campus ED cared for 39,089 patient visits in year 2023 and is on track to match that number in 2024. Emergency visits from patients in the service area in 2023 encompassed 11.4% of the patient visits at TriStar Hendersonville. Applicant projects that 3,215 of those patients will shift to the TriStar White House FSED in Year One, which should help relieve some of the burden on TriStar Hendersonville’s ED. See **Exhibit 16**.

The proposed service area is based on the geographic proximity of the zip codes surrounding the proposed TriStar White House FSED location and the patient origin of TriStar Health’s emergency patients in the two most proximate counties. **Exhibit 3** (below) provides a map of TriStar Health’s historical ED visits from the service area showing the area from which the patients came for care. In 2023, 4,466 of TriStar Hendersonville’s ED patient visits were from the service area. The TriStar White House FSED will allow TriStar Hendersonville to serve its emergency patients from the service area at another, more convenient location, which will also help alleviate some of TriStar Hendersonville’s capacity constraints at its main campus ED.

Exhibit 3 TriStar Health ED Patient Origin



Service Area Historical and Projected Utilization

The tables below provide the historical utilization from the service area at the existing TriStar Hendersonville ED as well as the total projected utilization at the TriStar White House FSED and the TriStar Hendersonville main ED. Note that some of the patients who currently choose TriStar NorthCrest are also likely to use the TriStar White House FSED and the projected impact on TriStar NorthCrest is also shown. Both tables include in-migration from outside of the proposed service area.

NOTE: this same Table appears in answer to Question 6N too.

Historical Utilization

Exhibit 4 provides the historical trend in ED visits from 2021 through 2023 for the TriStar Health EDs in Robertson and Sumner Counties.

Exhibit 4
TriStar Hendersonville Medical Center, TriStar Portland FSED and TriStar NorthCrest Historical ED
Visits for Service Area ZIP Codes and Total

Zip Code	Facility	2021 ED Visits	2022 ED Visits	2023 ED Visits
37188- White House	TriStar Hendersonville	2,328	2,618	2,474
37073- Greenbrier	TriStar Hendersonville	575	589	557
37049- Cross Plains	TriStar Hendersonville	266	382	316
37048- Cottontown	TriStar Hendersonville	643	714	635
All Other ZIPs	TriStar Hendersonville	31,661	33,704	35,107
Total	TriStar Hendersonville	35,473	38,007	39,089
37188- White House	TriStar Portland FSED	278	259	276
37073- Greenbrier	TriStar Portland FSED	46	38	40
37049- Cross Plains	TriStar Portland FSED	261	292	313
37048- Cottontown	TriStar Portland FSED	476	493	463
All Other ZIPs	TriStar Portland FSED	10,258	11,353	11,104
Total	TriStar Portland FSED	11,319	12,435	12,196
37188- White House	TriStar NorthCrest	615	461	501
37073- Greenbrier	TriStar NorthCrest	2,970	2,720	2,820
37049- Cross Plains	TriStar NorthCrest	537	453	432
37048- Cottontown	TriStar NorthCrest	54	45	54
All Other ZIPs	TriStar NorthCrest	19,971	20,587	21,170
Total	TriStar NorthCrest	24,147	24,266	24,977
37188- White House	All TriStar Facilities in Robertson/Sumner Counties	3,221	3,338	3,251
37073- Greenbrier	All TriStar Facilities in Robertson/Sumner Counties	3,591	3,347	3,417
37049- Cross Plains	All TriStar Facilities in Robertson/Sumner Counties	1,064	1,127	1,061
37048- Cottontown	All TriStar Facilities in Robertson/Sumner Counties	1,173	1,252	1,152
All Other ZIPs	All TriStar Facilities in Robertson/Sumner Counties	61,890	65,644	67,381
Total	All TriStar Facilities in Robertson/Sumner Counties	70,939	74,708	76,262

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

PROJECTED UTILIZATION

Unit Type: ☐ Procedures ☐ Cases ☐ Patients ☒ Other <u>ED Visits</u> _____		
Service Area Counties	Projected Utilization Recent Year 1 (Year = 2027)	% of Total
Robertson	3,741	38.57%
Robertson	1,134	11.69%
Other not primary/secondary county	1,940	20.00%
Sumner	1,246	12.85%
Robertson	1,637	16.88%
Total	9,698	100%

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

RESPONSE:

Population

Since the 2000 census, the service area population increased by over 16,000 residents (55%). White House, home to the FSED, doubled in size from 2000 to 2024 and the White House zip code is projected to increase by 13.7% between today and 2029.

Population estimates for 2024 through 2029 were obtained from Esri. The current population of the service area is 45,643. As shown in **Exhibit 5** below, the TriStar White House FSED's service area is projected to increase to 49,253 residents by 2029, representing 7.9% population growth in the service area as a whole and 13.7% growth in the White House zip code.

Exhibit 5
Population of Service Area

Zip Code	Zip City	2000	2010	2020	2024	% Change from 2000 to 2024	2029 (proj.)	2024-29 % Change
37188	White House	10,334	13,479	15,928	19,708	90.7%	22,412	13.7%
37073	Greenbrier	11,208	13,222	14,424	14,722	31.4%	15,210	3.3%
37049	Cross Plains	2,788	3,370	3,590	3,724	33.6%	3,850	3.4%
37048	Cottontown	5,156	6,161	7,104	7,489	45.2%	7,781	3.9%
TOTAL		29,486	36,232	41,046	45,643	54.8%	49,253	7.9%

Data Source: ESRI

Even though the service area is made up of the four zip codes, the Standards and Criteria ask for some of the data to be provided for any county in which the service area zip codes overlap. Accordingly, below is a population table showing the population of the two (2) counties in which the service area zip codes sit – as projected in the HDDS data out to 2029.

Exhibit 6
Population of the Counties in which the Service Area sits

	2020	2024	2029
Robertson County	72,275	75,475	79,113
Sumner County	195,561	208,192	223,103
Total Population of Both Counties	267,836	283,667	302,216

Source: Tennessee Department of Health Population Projections, Tennessee Counties and the State, 2020-2030

Service Area – Special Needs Populations – 65+

The elderly (65+) population in the service area is material and is projected to increase significantly. By 2029, the 65+ age group will be 19% of the service area population. See **Exhibit 7** below. In terms of growth rate, from 2024 to 2029, the 65

and older population is projected to grow by 21.7%. See **Exhibit 9** below. Because the over 65 age cohort typically accesses emergency room care more often than other patient groups, the dramatic growth in that age group in the service area further demonstrates the need for the TriStar White House FSED.

First, **Exhibit 7** shows the service area 65+ age group by zip code and projected to 2029.

Exhibit 7
Service Area 65+ age group by zip code

Zip Code Area	2024			2029		
	Age 65+	Total	% 65+	Age 65+	Total	% 65+
37188 (White House)	2,916	19,708	14.70%	3,776	22,412	16.8%
37073 (Greenbrier)	2,638	14,722	18.00%	3,119	15,210	20.5%
37049 (Cross Plains)	691	3,724	18.60%	761	3,850	19.8%
37048 (Cottontown)	1,457	7,489	18.60%	1,717	7,781	22.1%
Total	7,702	45,643	16.90%	9,373	49,253	19.0%

Source: ESRI, Age by Sex Profile (2024).

Exhibit 8
2024-2029 Service Area Population growth by Age Cohort – Projected to 2029

Zip Code Area	Age 0 - 18		Age 18-45		Age 45-65		Age 65+		Total	
	2024	2029	2024	2029	2024	2029	2024	2029	2024	2029
37188 (White House)	4,707	5,053	7,157	8,155	4,928	5,428	2,916	3,776	19,708	22,412
37073 (Greenbrier)	3,222	3,165	4,800	5,020	4,062	3,906	2,638	3,119	14,722	15,210
37049 (Cross Plains)	813	790	1,203	1,305	1,017	994	691	761	3,724	3,850
37048 (Cottontown)	1,589	1,612	2,292	2,396	2,151	2,056	1,457	1,717	7,489	7,781
Total	10,331	10,620	15,452	16,876	12,158	12,384	7,702	9,373	45,643	49,253

Source: ESRI, Age by Sex Profile (2024).

Exhibit 9
Population Growth by Age Cohort, 2024 to 2029

Zip Code Area	Age 0 - 18		Age 18-45		Age 45-65		Age 65+		Total	
	5-Yr Chg.	5-Yr % Chg.	5-Yr Chg.	5-Yr % Chg.	5-Yr Chg.	5-Yr % Chg.	5-Yr Chg.	5-Yr % Chg.	5-Yr Chg.	5-Yr % Chg.
37188 (White House)	346	7.4%	998	13.9%	500	10.1%	860	29.5%	2,704	13.7%
37073 (Greenbrier)	(57)	-1.8%	220	4.6%	(156)	-3.8%	481	18.2%	488	3.3%
37049 (Cross Plains)	(23)	-2.8%	102	8.5%	(23)	-2.3%	70	10.1%	126	3.4%
37048 (Cottontown)	23	1.4%	104	4.5%	(95)	-4.4%	260	17.8%	292	3.9%
Total	289	2.8%	1,424	9.2%	226	1.9%	1,671	21.7%	3,610	7.9%

Source: ESRI, Age by Sex Profile (2024).

Even though the service area is made up of the four (4) zip codes, the Standards and Criteria ask for some of the data to be provided by county for all counties in which any of the service area zip codes sit. Accordingly, below **Exhibit 10** is an age cohort table showing the population of the two (2) counties in which the service area zip codes overlap by age cohort.

Exhibit 10
2024-2029 Robertson and Sumner County Population Growth by Age Cohort – Projected to 2029

	Age 18-64		Age 65+		Total	
County	2024	2029	2024	2029	2024	2029
Robertson	45,154	46,144	13,137	15,113	58,291	61,257
Sumner	123,595	130,051	37,499	43,070	161,094	173,121

Source: HDDS

The rapid growth and aging of the service area population will result in increased demand for healthcare services including emergency services. This is particularly true for the elderly population, which has been documented to have a higher incidence of emergency conditions than any other age cohort. See Ukkonen, M., Jämsen, E., Zeitlin, R., & Pauniah, S. L. Emergency department visits in older patients: a population-based survey. *BMC emergency medicine*, 19(1), 20. <https://doi.org/10.1186/s12873-019-0236-3> (2019).

Service Area Race and Ethnicity

The service area is four contiguous zip codes in eastern Robertson and western Sumner counties. In terms of racial and ethnic composition, as shown in **Exhibit 11**, the service area is approximately 87.8% white and 12.2% non-white (minority).

With the location of the proposed TriStar White House FSED in zip code 37188, the TriStar White House FSED will improve access to minority populations in two ways: 1) it will be located in the service area zip code with the greatest non-white population count and percentage; and 2) it will alleviate capacity constraints at TriStar Hendersonville, which provides 27% of the ED services in the service area.

Exhibit 11
2023 Racial and Ethnic Demographics - Service Area Population

	American Indian Alone	Asian Alone	Black Alone	Pacific Islander Alone	Some Other Race Alone	Two or More Races	White Alone	Total	Hispanic*
37188 (White House)	48	229	481	4	406	1,409	17,131	19,708	1,041
37073 (Greenbrier)	58	154	350	5	243	883	13,029	14,722	682
37049 (Cross Plains)	2	22	123	-	50	259	3,268	3,724	159
37048 (Cottontown)	17	57	111	2	90	390	6,822	7,489	263
Total	125	462	1,065	11	789	3,142	40,250	45,844	2,145
37188 (White House)	0.2%	1.2%	2.4%	0%	2.1%	7.1%	86.9%	100.0%	5.3%
37073 (Greenbrier)	0.4%	1.0%	2.4%	0%	1.7%	6.0%	88.5%	100.0%	4.6%
37049 (Cross Plains)	0.1%	0.6%	3.3%	0%	1.3%	7.0%	87.8%	100.0%	4.3%
37048 (Cottontown)	0.2%	0.8%	1.5%	0%	1.2%	5.2%	91.1%	100.0%	3.5%
Total	0.3%	1.0%	2.3%	0%	1.7%	6.9%	87.8%	100.0%	4.7%

Source: Esri.

Note: Hispanic designation is not a race, so those identifying as Hispanic may be in any of the other races or a combination (like two or more races).

Service Area Low Income and Uninsured Residents

An important benefit of the proposed project is increasing access to care for those with lower income. As shown in **Exhibit 12**, 5.6% of service area residents are below the poverty level according to the U.S. Census Bureau. While this is a lower below the poverty level percentage than the overall Sumner County or Robertson County rates, which are approximately 10.3% and 9.4%, respectively, addressing capacity challenges at the emergency room at TriStar Hendersonville by bringing ED capacity to White House will enhance access to the low income and underinsured residents of TriStar Hendersonville's overall patient base. Moreover, for residents of the service area that are low income or uninsured, access to healthcare services, including primary care, is often exacerbated by transportation issues. The development of the proposed FSED will bring emergency services closer to their homes, providing better access for all residents, particularly the low income and uninsured.

Research shows that individuals with lower incomes consistently experience worse health outcomes than individuals with higher incomes and those living in poverty. Individuals who live in low-income or high poverty neighborhoods are likely to experience poor health due to a combination of these socioeconomic factors, including limited access to proper nutrition and healthy foods, shelter, utilities, and other elements. <https://www.aafp.org/about/policies/all/poverty-health.html> By adding a new access point, the TriStar White House FSED will increase access to patients who are more likely to need emergent care.

Exhibit 12
Service Area Poverty Level

Area	% of Households below Federal Poverty Level
37188 (White House)	5.4%
37073 (Greenbrier)	6.5%
37049 (Cross Plains)	3.4%
37048 (Cottontown)	5.8%
Total Service Area	5.6%
37172 (Springfield)	15.2%
Robertson County	10.3%
Sumner County	9.4%
Tennessee	14.0%

Source: U.S. Census Bureau. "Poverty Status in the Past 12 Months." American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1701, 2022, <https://data.census.gov/table/ACSST5Y2022.S1701?t=Income and Poverty&q=860XX00US37048, 37049, 37073, 37188>. Accessed on July 23, 2024.

As a hospital emergency room operating under the TriStar Hendersonville license, the TriStar White House FSED will care for all who need emergency care. As previously established, the proposed TriStar White House FSED will be part of the larger TriStar Health 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. Moreover, 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. TriStar's Charity Care and Discount Policy is the best in Robertson County and Sumner County area because TriStar's charity discount provides assistance for patients up to 400% of the poverty level, while SRMC's policy only provides a discount up to 300% of the poverty level. See **Attachment 4N-1** for the Financial Assistance Policy for Uninsured Patients, Charity Financial Assistance Policy for Uninsured and Underinsured Patients and Discount Policy for Patients. Further, TriStar Hendersonville complies with the No Surprises

Act, which fully protects patients from any cost differential between services provided by in-network or out-of-network providers by holding the patients harmless from any such difference.

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:

Note that the Department of Health Statistics and TennCare do not provide data on a zip code level. TriStar Hendersonville has defined the proposed service area at a zip code level; however, the table below provides the population and demographic data at the county level (Robertson and Sumner) as each service area zip code is located in Robertson and Sumner Counties. This enables comparison between the service area and the entirety of Robertson and Sumner Counties.

Exhibit 13

Demographic Variable/ Geographic Area	Department of Health/Health Statistics							Census Bureau				TennCare	
	Total Population- Current Year 2024	Total Population- Projected Year 2027	Total Population-% Change	*Target Population- Current Year 2024	Target Population- Project Year 2027	Target Population-% Change	Target Population Projected Year as % of Total	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of Total	TennCare Enrollees	TennCare Enrollees as % of Total
Robertson County	75,475	76,975	2.0%	38,154	38,535	1.0%	50.1%	40.1	\$74,440	6,868	9.1%	13,470	17.8%
Sumner County	208,192	214,273	2.9%	7,489	8,537	14.0%	4.0%	39.9	\$81,883	15,614	7.5%	30,325	14.6%
TriStar White House FSED Service Area	45,844	46,545	1.5%	45,844	47,258	3.1%	101.5%	41.3	\$93,721	2,567	5.6%	*7,078	*15.4%
State of TN Total	7,125,908	7,231,338	1.5%	7,125,908	7,284,637	2.2%	100.7%	39.6	\$69,015	947,746	13.3%	1,434,654	20.1%

Source: Tennessee Department of Health; Census.gov Quick Facts; Esri. for service area population, median household income and median age; and Division TennCare.
* TennCare does not provide enrollees by zip code; TriStar estimated enrollees for the proposed FSED service area based on the service area population as a percent of the population of the two counties, and then applied that percentage to the TennCare enrollees for the two counties to estimate the service area TennCare enrollees.

- 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:

The TriStar White House FSED will ensure financial access for all patients. HCA Healthcare is the largest TennCare provider in Tennessee. Thus, the TriStar White House FSED will be part of network with vast experience caring for TennCare patients. TriStar Hendersonville projects that approximately 7,078 patients (15.4%) of the TriStar White House FSED service area population will be TennCare enrollees. Since the TriStar White House FSED will likely care for in excess of 50% of the TennCare patient ED visits from the service area, HCA Healthcare's experience taking care of TennCare patients will be a benefit to this segment of the likely patients who will come to the TriStar White House FSED for care.

In addition, the TriStar Health facilities have the most generous charity care policy in the region. All TriStar emergency departments care for all patients regardless of their ability to pay and regardless of whether they are in-network for all insurance products. Moreover, the proposed TriStar White House FSED will address the emergency care needs of the service area population. The service area is rapidly growing and aging. As the senior population has a higher incidence of emergent conditions, access to ED services is becoming increasingly critical to this community.

In accordance with TriStar Hendersonville's practice, and applicable Federal and State law, all patients presenting at the proposed TriStar White House FSED with emergency care needs will be served without regard to age, gender, race, ethnicity, income, or ability to pay – just as they are being served at the TriStar Hendersonville main hospital ED. As previously discussed, the TriStar White House FSED will be part of TriStar Health, which requires all facilities within it 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. Moreover, 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. <https://tristarhealth.com/patient-financial/charity-policy> See also **Attachment 4N-1** for the Financial Assistance Policy for Uninsured Patients, Charity Financial Assistance Policy for Uninsured and Underinsured Patients and Discount Policy for Patients. TriStar's policy provides discounts for all persons who have income at less than 400 percent of the poverty level. And for those who are below 200 percent of the poverty level, personal responsibilities are written off in their entirety.

The proposed TriStar White House FSED will not discriminate in its service to any patient. The proposed TriStar White House FSED will serve all patients regardless of race and ethnicity consistent with TriStar Hendersonville's policies and experience. The proposed service area is 12.2% minority (non-white) population. White House minority population exceeds that of the overall service area at 13.1%. Please see **Attachment 4N-2** for the Non-Discrimination Policy that will apply to the FSED.

TriStar Health has vast experience serving the service area patient population. As the provider of emergency care of over 77% of the emergency patient visits in 2023, TriStar Health is very active in the White House area through TriStar Hendersonville and TriStar NorthCrest due to relationships with primary care providers there. It will continue to develop additional relationships in the service area. See **Attachment 1N Question 18** for a list of TriStar Hendersonville's community linkages.

Since TriStar Hendersonville 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 Hendersonville and the Applicant. As a Tennessee provider, HCA Healthcare is the largest provider statewide of services to TennCare/Medicaid patients. Per **Exhibit 14**, HCA Healthcare, in 2022, admitted nearly 16% of TennCare/Medicaid patients, or 1 of 6 patients statewide. Regarding uninsured patients, the second highest statewide percentage of uninsured patients, 11 percent or 1 in 9 patients, were treated at a HCA Healthcare facility. This information is presented in the following table:

Exhibit 14
Percentage of TennCare/Medicaid by Health System in Tennessee

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: Hospital Joint Annual Report, 2022.

TriStar Hendersonville will continue the TriStar Health mission and serve all patients as indicated above. This will include providing services to underinsured, uninsured, and low-income populations, including TennCare.

These are just some of the ways in which TriStar Hendersonville addresses community need beyond just direct care to TennCare and low-income groups. The proposed TriStar White House FSED will serve all patients in the service area who present and will enhance access to care for the growing service area by adding a new access point for ED services, relieving capacity constraints for patients continuing to seek care at TriStar Hendersonville.

Patient Types

TriStar Hendersonville cannot control or predict the type of patients that will choose to present at the proposed FSED. The largest percentage of patients are expected to be walk-in patients who choose to visit the FSED to treat a variety of diagnoses for a variety of reasons whether it be proximity to home or the expectation of timely travel or timely access to care. It is expected that EMS patients will also utilize the facility, and the EMS provider will determine which patients are appropriate given the patient's condition, location, patient choice, and a variety of other factors.

TriStar Hendersonville expects that the types of patients that seek care at existing TriStar-affiliated FSEDs will also seek care at the proposed FSED. A review of the principal diagnosis of the FSED patient visits seen by TriStar affiliated FSEDs identifies over 5,000 different principal diagnoses. For this reason, it is very difficult to anticipate what types of patients will present to the proposed FSED.

Please see the discussion regarding care for time sensitive emergencies such as cardiac arrest, stroke, and sepsis in **Attachment 1N**.

TriStar Hendersonville's experience with the patient ED visits at its main ED and its FSED in Portland inform the following projection of the likely acuity level of patient visits at the TriStar White House FSED.

Exhibit 15
Projected White House Acuity Levels

Level of Care - CPT	TriStar Hendersonville (2023)	TriStar Portland FSED (2023)	TriStar White House FSED (Year 1)	Combined	Percent of Total
Level 1 - 99281	566	297	291	1,154	1.9%
Level 2 - 99282	1,410	692	825	2,927	4.8%
Level 3 - 99283	9,343	4,824	4,521	18,688	30.7%
Level 4 - 99284	18,123	5,206	3,317	26,646	43.7%
Level 5 - 99285	9,545	1,163	740	11,448	18.8%
Critical Care	68	14	5	87	0.1%
Total	39,055	12,196	9,698	60,949	100.0%

Source: Internal records for TriStar Hendersonville and TriStar Portland FSED CY 2023 ED Visits by Level of Care for TriStar Hendersonville and TriStar Portland FSED.

Note: CPT Code ED level, Level 5 and Critical Care are most acute, and Level 1 is least acute; Totals and shifted figures may not tie out due to rounding and will not foot with hand calculation.

- 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:

There are no emergency departments in the service area.

As for outside of the service area EDs in Sumner County and Robertson County:

There are four emergency care departments in Sumner County and one in Robertson County as follows:

- TriStar Hendersonville Medical Center (37075);
- SRMC (37066);
- SRMC FSED (37066);
- TriStar Portland FSED (37148); and
- TriStar NorthCrest (37172).

Trends in utilization for these providers are shown in detail in **Attachment 1N**. Also discussed is the level of utilization in relation to ACEP guidelines at area EDs. Despite capacity challenges, TriStar Hendersonville has ED wait times significantly below statewide and national averages.

Sumner County and Robertson County Emergency Department (non-service area) utilization trends are presented in **Exhibit 16**.

Exhibit 16
ED Visits by Robertson/Sumner County Emergency Department, 2020 through 2022

Hospital ED	Calendar Years		
	CY 2020	CY 2021	CY 2022
TriStar Hendersonville	29,860	35,519	37,932
TriStar Portland FSED	9,795	11,319	12,432
SRMC	29,903	28,774	26,678
SRMC FSED	7,921	10,649	12,695
Sumner County Total	77,479	86,261	89,737
TriStar NorthCrest	29,097	22,009	24,098
Robertson County Total	29,097	22,009	24,098
Sumner/Robertson Total ED Visits	106,576	108,270	113,835

Source: Hospital Joint Annual Report for the respective year.

As is shown above TriStar Hendersonville, TriStar Portland FSED, and SRMC's FSED grew in ED visits from 2020 through 2022, and TriStar NorthCrest and SRMC decreased in ED visits during that time.

While calendar year 2023 data is not publicly available as of this date, internal records show that TriStar Hendersonville ED and TriStar Portland ED visits continued to increase throughout 2023. This is presented in **Exhibit 17**.

Exhibit 17
TriStar Hendersonville, TriStar Portland, and TriStar NorthCrest ED Visits, 2020 through 2023

Hospital ED	CY 2020	CY 2021	CY 2022	CY 2023	Change 2020-2023	% Change 2020-2023
TriStar Hendersonville	29,860	35,519	37,932	39,089	9,229	27.0%
TriStar Portland FSED	9,795	11,319	12,432	12,196	2,401	26.9%
Total TriStar Hendersonville ED Visits	39,655	46,838	50,364	51,285	11,630	27.0%
TriStar NorthCrest	29,097	22,009	24,098	24,977	-4,120	-14.1%

Source: Hospital Joint Annual Report for the respective year. 2023 data TriStar internal data.

Historical service area utilization by zip code area and hospital facility are presented in **Exhibit 18**.

Exhibit 18
Service Area ED Visits by Year and Facility,
Calendar Year 2021 through 2023

Zip Code	Facility	2021 ED Visits	2022 ED Visits	2023 ED Visits
37188 (White House)	TriStar Hendersonville	2,368	2,660	2,768
37188 (White House)	TriStar Portland FSED	274	254	284
37188 (White House)	TriStar NorthCrest	563	453	509
37188 (White House)	Other TriStar Providers	1,428	1,328	1,263
37188 (White House)	Other Area Providers	1,401	1,406	1,603
37188 (White House)	Total	6,034	6,101	6,427
37073 (Greenbrier)	TriStar Hendersonville	583	607	607
37073 (Greenbrier)	TriStar Portland FSED	48	37	37
37073 (Greenbrier)	TriStar NorthCrest	2,986	2,748	2,855
37073 (Greenbrier)	Other TriStar Providers	1,441	1,484	1,405
37073 (Greenbrier)	Other Area Providers	1,026	1,023	1,049
37073 (Greenbrier)	Total	6,084	5,899	5,953
37049 (Cross Plains)	TriStar Hendersonville	267	411	349
37049 (Cross Plains)	TriStar Portland FSED	256	277	334
37049 (Cross Plains)	TriStar NorthCrest	485	453	434
37049 (Cross Plains)	Other TriStar Providers	341	356	333
37049 (Cross Plains)	Outside Area Providers	308	293	290
37049 (Cross Plains)	Total	1,657	1,790	1,740
37048 (Cottontown)	TriStar Hendersonville	680	758	742
37048 (Cottontown)	TriStar Portland FSED	457	472	487
37048 (Cottontown)	TriStar NorthCrest	42	42	53
37048 (Cottontown)	Other TriStar Providers	348	302	335
37048 (Cottontown)	Other Area Providers	833	838	891
37048 (Cottontown)	Total	2,360	2,412	2,508

Service Area	TriStar Hendersonville	3,898	4,436	4,466
Service Area	TriStar Portland FSED	1,035	1,040	1,142
Service Area	TriStar NorthCrest	4,076	3,696	3,851
Service Area	Other TriStar Providers	3,558	3,470	3,336
Service Area	Other Area Providers	3,568	3,560	3,833
Total		16,135	16,202	16,628

Source: THA Data

The data above indicates approximately 63.5% of service area patients are treated at the EDs in Robertson and Sumner Counties, and 36.5% outside these counties. ED visits from the service area have increased from 2021 through 2023 by 3.1%, while TriStar's facilities in Sumner and Robertson Counties have increased by a combined 5.0%. TriStar Hendersonville's ED Visits from the service area grew by 14.6% from CY 2021-CY2023 and TriStar Portland FSED grew by 10.3% over the same time period.

Urgent Care Providers Are Not An Alternative

Minor, non-emergent conditions are often served in an urgent care center ("UCC") or physician's office. It is important to note that UCCs are not equipped to provide emergency care and therefore are not a substitute for the proposed FSED for multiple reasons. UCCs are not licensed acute care facilities. They are not required to and do not care for all comers. They do not publicly report utilization. For medical emergencies, they are not acceptable alternatives to a hospital-operated emergency room. Moreover, UCCs are not open 24 hours a day. Another important distinction between a hospital affiliated FSED and a UCC relates to the obligation to serve all patients regardless of ability to pay and meet federal Emergency Medical Treatment and Labor Act ("EMTALA") requirements. A UCC has no obligation to do so. By contrast, hospital affiliated FSEDs are required to serve all patients regardless of ability to pay. Below is a list of urgent care centers and walk-in clinics in the proposed service area:

RHG-Crossroads Medical Main location	Primary Care	White House
RHG-Crossroads Urgent Care @ main location	Urgent Care	White House
Axis Medical - Dr. Paul Yim	Primary Care	White House
NP Clinic	Primary Care	White House
FAST PACE MEDICAL CLINIC, PLLC - White House	Urgent Care	White House
Little Clinic Urgent Care - Kroger White House	Urgent Care	White House
VIP Children's Clinic White House	Pediatrics	White House
FAST PACE MEDICAL CLINIC, PLLC - Greenbrier	Urgent Care	Greenbrier
RHG- Crossroads Urgent Care - Greenbrier location	Urgent Care	Greenbrier
Dr. Robert Holston	Primary Care	Cross Plains

UCCs only offer limited services. The below table compares services that are typically available in emergency rooms compared to those of UCCs. It is evident that UCCs do not provide emergency care and are therefore not effective alternatives to FSEDs. The following chart provides some examples of the types of patients that can appropriately be seen at an FSED that are inappropriate for a UCC. For these reasons, UCCs in the area are not an alternative and cannot address the access issues that service area patients face for emergency care.

Capabilities of the Emergency Department Compared to Typical Urgent Care Center			
Conditions	Urgent Care	TriStar Hendersonville Main Campus ED	Proposed TriStar White House FSED
Stroke	X	✓	✓
Severe Chest Pain	X	✓	✓
Traumatic Injuries	X	✓	✓
EMS Offload	X	✓	✓
Advanced Life Support	X	✓	✓
Deep Puncture Wounds	X	✓	✓
Complex Radiological Services	X	✓	✓
Patients in Labor	X	✓	✓
Complex Lab Services	X	✓	✓

The following photograph shows a typical TriStar Health FSED treatment room and some of the typical equipment available that clearly is not available in an urgent care center. Based on capability, equipment, facility design, and operational licensure requirements, a UCC is not an alternative for an FSED much less a hospital ED. With the same quality of care and accreditation standards as a hospital-based ED, FSEDs are able to see patients faster than traditional emergency rooms. This can mean the difference between life and death for someone experiencing a medical crisis.

Exhibit 19
TriStar FSED Treatment Room Example



- 1. Adult Resuscitation/Intubation Cart**
- 2. Pediatric Resuscitation/Intubation Cart**
- 3. Cardiac Monitor**
- 4. Rapid Blood Infuser**
- 5. Critical Equipment / Supplies**
 - a) Pediatric / Adult Ventilator
 - b) Cricothyrotomy Kit
 - c) Chest Tube Kit
 - d) Central Lines
 - e) Foley Catheters
- 6. Pyxis: Critical Medications**

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:

Historical Utilization

Exhibit 20 provides the historical trend in ED visits from 2021 through 2023 for the TriStar Health EDs in Robertson and Sumner Counties.

Exhibit 20
TriStar Hendersonville, TriStar Portland FSED, and TriStar NorthCrest Historical ED Visits for
Service Area Zip Codes and Total

Zip Code	Facility	2021 ED Visits	2022 ED Visits	2023 ED Visits
37188 (White House)	TriStar Hendersonville	2,328	2,618	2,474
37073 (Greenbrier)	TriStar Hendersonville	575	589	557
37049 (Cross Plains)	TriStar Hendersonville	266	382	316
37048 (Cottontown)	TriStar Hendersonville	643	714	635
All Other Zips	TriStar Hendersonville	31,661	33,704	35,107
Total	TriStar Hendersonville	35,473	38,007	39,089
37188 (White House)	TriStar Portland FSED	278	259	276
37073 (Greenbrier)	TriStar Portland FSED	46	38	40
37049 (Cross Plains)	TriStar Portland FSED	261	292	313
37048 (Cottontown)	TriStar Portland FSED	476	493	463
All Other Zips	TriStar Portland FSED	10,258	11,353	11,104
Total	TriStar Portland FSED	11,319	12,435	12,196
37188 (White House)	TriStar NorthCrest	615	461	501
37073 (Greenbrier)	TriStar NorthCrest	2,970	2,720	2,820
37049 (Cross Plains)	TriStar NorthCrest	537	453	432
37048 (Cottontown)	TriStar NorthCrest	54	45	54
All Other Zips	TriStar NorthCrest	19,971	20,587	21,170
Total	TriStar NorthCrest	24,147	24,266	24,977
37188 (White House)	All TriStar EDs in Robertson/Sumner Counties	3,221	3,338	3,251
37073 (Greenbrier)	All TriStar EDs in Robertson/Sumner Counties	3,591	3,347	3,417
37049 (Cross Plains)	All TriStar EDs in Robertson/Sumner Counties	1,064	1,127	1,061
37048 (Cottontown)	All TriStar EDs in Robertson/Sumner Counties	1,173	1,252	1,152
All Other Zips	All TriStar EDs in Robertson/Sumner Counties	61,890	65,644	67,381
Total	All TriStar EDs in Robertson/Sumner Counties	70,939	74,708	76,262

Source: TriStar Internal Data

From 2021 to 2023, TriStar Hendersonville experienced a combined 9.6% increase in emergency visits at both the host hospital ED and the Portland FSED (or an average annual growth rate of 4.7%) as presented in detail in **Exhibit 20** above.

Based on its ED activity, TriStar Hendersonville is operating well above capacity based on the ACEP standards for both high range and low range EDs (see **Table 1N-17** in **Attachment 1N**). Additionally, as noted in **Attachment 1N**, neither TriStar Hendersonville, TriStar Portland, nor TriStar NorthCrest present an opportunity to assist in decompressing TriStar Hendersonville's ED due to their distance from Hendersonville and the level of operations meeting or exceeding ACEP guidelines at those facilities. This information is summarized in **Exhibit 21**.

Exhibit 21
ED Visits per Treatment Room Trend, Calendar Year 2021 through 2023 and ACEP

	TriStar Hendersonville ED Visits per Treatment Room	TriStar Portland FSED Visits Treatment Room	TriStar NorthCrest ED Visits per Treatment Room
Number of Treatment Rooms	20	8	18
CY 2021	1,774	1,415	1,342
CY 2022	1,897	1,554	1,348
CY 2023	1,954	1,525	1,388
ACEP – High Range	1,212	909	1,250
ACEP - Mid Range	1,381	1,080	1,320
ACEP - Low Range	1,550	1,250	1,389
Using 2023 Visits			
# Greater than ACEP High Range	742	616	138
% Greater than ACEP High Range	61.2%	67.8%	11.0%
# Greater than ACEP Mid-Range	573	445	68
% Greater than ACEP Mid-Range	41.5%	41.2%	5.2%
# Greater than ACEP Low Range	404	275	NA
% Greater than ACEP Low Range	26.1%	22.0%	NA

Sources: 2021-22 Joint Annual Reports; 2023 Internal Data. American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 116-117; note that “low range” assumes a higher number of annual visits per room than the “high range.” Also, ACEP does not have a “mid-range.” Mid-range is the mid-point between low and high range.

It is obvious that TriStar Hendersonville's ED is highly utilized and experiencing increased demand for its ED services year over year. As is discussed in 1N, TriStar Hendersonville can be considered either in the ACEP High Range or Mid-Range. There is no designated ACEP Mid-Range. Rather, Mid-Range is simply an application of the mid-point between low range and high range. TriStar Hendersonville is at a minimum very close to being in the ACEP high range due to its visits per treatment room plus other factors. In any event, TriStar Hendersonville cared for 27% of the emergency visits from patients who live in the service area. As noted, overall 77% of the patient visits from residents of the service area were served by a TriStar ED. See **Table 1N-27** in **Attachment 1N**.

Projected Utilization

To project the utilization of the proposed FSED, the historical utilization by service area residents by zip code for period 2021 to 2023 was analyzed using internal TriStar Hendersonville and THA data. (Based on THA's data use policy, data for providers that are not affiliated with TriStar are masked/grouped.) Data for TriStar Hendersonville and affiliate facilities in the area and all other providers were also considered as shown below in **Exhibit 22**. The service area residents generated 16,628 ED visits in CY 2023.

Exhibit 22
CY 2023 Service Area ED Visits
ED Visits from Proposed Service Area, CY 2023- Includes IP and OP visits

	White House 37188	Greenbrier 37073	Cross Plains 37049	Cottontown 37048	TOTAL
TriStar Hendersonville	2,768	607	349	742	4,466
TriStar Skyline	834	935	218	185	2,172
TriStar NorthCrest	509	2,855	434	53	3,851
TriStar Portland FSED	284	37	334	487	1,142
Other TriStar	429	470	115	150	1,164
Total TriStar Visits	4,824	4,904	1,450	1,617	12,795
All Other Providers	1,603	1,049	290	891	3,833
Total Market ED Visits	6,427	5,953	1,740	2,508	16,628
% Service Area Visits at TriStar Affiliate	75.1%	82.4%	83.3%	64.5%	77.1%

Source: THA Data; Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

The above table summarizes the ED visits in CY 2023 and includes both patients admitted from the Emergency Department to Inpatient status and those discharged from the Emergency Department as Outpatients. As the proposed project is a freestanding emergency department not on a hospital campus, it was determined that only visits considered outpatient would be used for visit projections. The table below shows the ED visit volumes from the proposed service area reflecting this difference.

Exhibit 23
ED Visits from Proposed Service Area, CY 2023 - OP visits only

	White House 37188	Greenbrier 37073	Cross Plains 37049	Cottontown 37048	TOTAL
TriStar Hendersonville	2,352	503	278	573	3,706
TriStar Skyline	555	631	150	106	1,442
TriStar NorthCrest	453	2,502	374	50	3,379
TriStar Portland FSED	284	37	334	487	1,142
Other TriStar	321	363	87	121	892
Total TriStar Visits	3,965	4,036	1,223	1,337	10,561
All Other Providers	1,326	838	227	750	3,141
Total Service Area ED Visits	5,291	4,874	1,450	2,087	13,702
% Service Area Visits at TriStar Affiliate	74.9%	82.8%	84.3%	64.1%	77.1%

Source: THA Data; Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

The underlying ED utilization data and use rates were used to project the baseline ED visit volume for the service area as shown below based on the following assumptions:

- CY 2023 to Project Year One (2027) were projected based on the historical Compound Annual Growth Rate (CAGR) for OP ED Visit growth by zip code in the proposed service area as shown in Exhibit 14 which results in an average overall growth rate of 1.8%.
- Applying this growth to CY 2023 market visits results in 1,503 incremental visits from CY 2023 to Project Year One (2027), and an additional 652 by Project Year Two (2028).
- By Project Year 2028, the service area demand for ED visits is projected to increase to 16,120.

Projected ED Visits by service area zip code are presented in **Exhibit 24**.

Exhibit 24
Service Area Projected ED Visits Without TriStar White House FSED
Projected Year 1 (2027) Service Area Visits Projected Volumes by Facility

	White House 37188	Greenbrier 37073	Cross Plains 37049	Cottontown 37048	TOTAL	% of Total
TriStar Hendersonville	2,853	1,424	331	687	5,295	34.2%
TriStar Skyline	674	553	179	128	1,534	9.9%
TriStar Northcrest	549	1,298	445	60	2,352	15.2%
TriStar Portland	345	438	398	583	1,764	11.4%
Other TriStar	389	343	104	145	980	6.3%
Total TriStar Visits	4,809	4,056	1,457	1,602	11,925	77.1%
All Other Providers	1,429	1,172	385	557	3,543	22.9%
Total Market ED Visits	6,240	5,116	1,680	2,432	15,468	100.0%

Exhibit 25
Service Area Projected ED Visits Without TriStar White House FSED
Projected Year 2 (2028) Service Area Visits Projected Volumes by Facility

	White House 37188	Greenbrier 37073	Cross Plains 37049	Cottontown 37048	TOTAL	% of Total
TriStar Hendersonville	2,974	1,443	307	838	5,561	34.5%
TriStar Skyline	702	561	166	155	1,584	9.8%
TriStar Northcrest	573	1,315	413	73	2,373	14.7%
TriStar Portland	359	444	369	711	1,883	11.7%
Other TriStar	405	347	96	178	1,027	6.4%
Total TriStar Visits	5,013	4,110	1,350	1,955	12,428	77.1%
All Other Providers	1,490	1,221	401	580	3,692	22.9%
Total Market ED Visits	6,503	5,331	1,751	2,535	16,120	100.0%

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

Next, the base of patients that would shift from nearby TriStar Health facilities—and only TriStar facilities—to the proposed TriStar White House FSED by zip code was calculated based on the assumption that many patients closer to the proposed FSED would shift their use to the new TriStar White House FSED, particularly given the high utilization at TriStar's existing ED that currently serves these patients. These shift percentages consider the following:

- Three zip codes: White House (37188), Cross Plains (37049) and Cottontown (37048) are projected to shift approximately 80% of the patient ED volume currently cared for at a TriStar ED. Due to the geographic size of zip code 37073 (Greenbrier), and the western half of this zip code's proximity to an existing emergency department at TriStar NorthCrest, it is expected that only 40% of the TriStar patient visits from that zip code would likely shift to the proposed TriStar White House FSED; the census tracts in the eastern half of the

Greenbrier zip code (37073) (those east of Highway 41) comprise just over 50% of the total zip code population, which supports this assumption.

- It is assumed that all providers would keep their relative patient visit utilization percentages from 2023 throughout the projection time period.
- It is also estimated that approximately 20% of the ED visits occurring at the proposed project would originate from outside the proposed service area, because of the increased access to care in the service area that will be created through the development of the proposed TriStar White House FSED.

Based on these assumptions, **Exhibit 26** summarizes the resultant TriStar White House FSED projected patient utilization by zip code based on shifted volume of patient visits from TriStar Health affiliates. These utilization projections by zip code are reasonable and based on proximity to the proposed FSED.

Exhibit 26
Project Year 2 (2028) FSED Service Area Percentage Utilization
by Zip Code

Zip Code	TriStar White House FSED Utilization % Year Two (2028)
37188 (White House)	60.0%
37073 (Greenbrier)	30.2%
37049 (Cross Plains)	66.9%
37048 (Cottontown)	50.9%
TOTAL	61.8%

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

Exhibit 27 presents the total projected TriStar White House FSED utilization for the service area with in-migration from outside the area. This volume is also compared to the incremental growth in the demand projected for the service area.

Exhibit 27
Projected TriStar White House FSED Visits

Projected Utilization - TriStar White House Project Year 1 (2027) and Project Year 2 (2028)		
	Project Year One (2027)	Project Year Two (2028)
Visits Shifted from TriStar Hendersonville	3,215	3,303
Visits Shifted from TriStar Portland	1,047	1,075
Visits Shifted from TriStar NorthCrest	1,836	1,886
Visits Shifted from Other TriStar EDs	1,661	1,706
Total Service Area Patient Visits	7,758	7,970
Visits from Patients from OUTSIDE the Service Area	1,940	1,993
Total Projected Visits	9,698	9,963

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

To be conservative, any potential shifts of volumes were only calculated for TriStar affiliated sites and it was assumed that TriStar does not initially expect to capture additional market share within the service area; as such, no impact on non-TriStar affiliates is projected.

The total volume for TriStar Hendersonville and the proposed FSED was based on the baseline service area projection above, less the shift from TriStar Hendersonville and its affiliates to the FSED plus the incremental growth. Historically, TriStar Hendersonville and TriStar NorthCrest have had 50% of ED visits by service area patients.

Therefore, it is projected that most of the ED visits to the proposed TriStar White House FSED will come from the shift: patients choosing to go to the TriStar White House FSED because it is closer than TriStar Hendersonville (and TriStar NorthCrest). This will help alleviate some of the volume burden on the host hospital ED and even after the shift from NorthCrest, that hospital's ED will still have robust utilization. While impact on existing providers is no longer a criteria, the impact on SRMC should be negligible as its volume of ED patient utilization from the service area is negligible and no shift is projected from SRMC to the TriStar White House FSED. The total service area patients and total patients served by TriStar Hendersonville, TriStar NorthCrest and the TriStar White House FSED are summarized in **Exhibit 28**.

Exhibit 28
Projected Total ED Volume, TriStar White House FSED Service Area (Outpatient Visits Only)

	2023	2024	2025	2026	Project Year One (2027)	Project Year Two (2028)
TriStar Hendersonville Baseline Visits	3,706	3,777	3,852	4,015	803	899
TriStar NorthCrest Baseline Visits	3,379	3,444	3,512	3,660	2,196	2,310
TriStar Portland Baseline Visits	1,142	1,164	1,187	1,237	247	275
Other TriStar providers	2,334	2,379	2,426	2,528	948	1,033
Shift to TriStar White House FSED					7,758	7,970
Incremental ED Visits		263	278	600	625	652
Total Hendersonville, NorthCrest, Portland, and TriStar White House FSED Visits	10,561	11,027	11,256	12,040	12,577	13,139
Visits from Outside Service Area	3,141	2,938	2,987	2,803	2,891	2,981
Total Proposed Service Area Visits	13,702	13,965	14,243	14,843	15,468	16,120

Note: totals and shifted figures may not tie out due to rounding and will not foot with hand calculation.

**Includes 20% in-migration for the FSED. TriStar NorthCrest visit volumes in Project Year One and Two reflect smaller shift expected from the Greenbrier ZIP compared to other TriStar locations.*

HDDS Data Comparison

Typically it is expected that applicants use discharge data from Tennessee Department of Health's Inpatient and Outpatient Hospital Discharge Data System (HDDS). The preceding analysis was completed using the THA data available to the Applicant. When using the data provided to the Zip Code level, there are some challenges the applicant faces in confirming accurate discharge totals to estimate the market size. One particular limitation is that for zip codes with populations less than 20,000 residents, any discharge volume is aggregated to the Zip-3 level for patient anonymity. For example, the proposed FSED will be located in White House, TN, which is in 37188. Since this zip code – the most populous zip code in the TriStar White House service area – has a population of less than 20,000; the discharge data provided by HDDS is combined with any other zip code with less than 20,000 residents that begins with 371.

This complexity is shown in the following example of the official HDDS data:

Patient_Zip	2020	2021	2022
370	9,406	10,440	10,423
37066	27,073	30,199	31,421
37072	11,704	12,806	13,525
37075	22,338	24,984	25,658
371	7,217	8,364	8,621

As can be seen, patient visits from all zip codes of less than 20,000 population that start with 370 or 371 are “truncated” together. So, for this application, that means that using HDDS data, patients from Adams TN in the western part of Robertson County are counted in with those from White House on the eastern boundary of the county, when the likelihood of patients going from one of those ends of the county to the other for ED care (especially when there is an ED in the middle of the county in Springfield), is particularly unlikely. Yet, for HDDS data use purposes, those patients are lumped together.

Knowing this limitation, the Applicant reviewed the HDDS data and combined the zip codes presumed to be in Sumner and Robertson counties and established the discharge volume for those two counties. As some zip codes span more than one county there may be some overlap, the market size may be slightly larger than actual. **Exhibit 29** shows these market estimates using the required HDDS data.

Exhibit 29, ED Visits- Sumner and Robertson Counties: 2020- 2022

Patient Zip Code	Presumed Patient County*	2020	2021	2022	Chg. 2020-2022	2-yr CAGR
370	Sumner/Robertson	9,406	10,440	10,423	10.8%	5.3%
37066	Sumner	27,073	30,199	31,421	16.1%	7.7%
37072	Davidson/Robertson	11,704	12,806	13,525	15.6%	7.5%
37075	Sumner	22,338	24,984	25,658	14.9%	7.2%
371	Robertson/Davidson/Sumner	7,217	8,364	8,621	19.5%	9.3%
37148	Sumner	12,291	13,578	14,589	18.7%	8.9%
37172	Robertson	15,641	16,536	17,171	9.8%	4.8%
Total		105,670	116,907	121,408	14.9%	7.2%

Source: HDDS

Then, the Applicant summed the populations of Sumner and Robertson counties using data from The University of Tennessee Center for Business and Economic Research, 2021 Population Projection Data Files.

Exhibit 30, Population of Sumner and Robertson Counties: 2020-2022

Population of Sumner and Robertson Counties			
County	2020	2021	2022
Sumner	195,561	198,774	201,853
Robertson	72,275	73,098	73,907
Total	267,836	271,872	275,760

Source: The University of Tennessee Center for Business and Economic Research, 2021 Population Projection Data

Using the population data and the ED Visit data, the applicant calculated a use rate of Visits per 1,000 population below.

Exhibit 31
Estimated ED Use Rate-Sumner and Robertson
Counties: 2020-2022

2020	2021	2022
394.53	430.01	440.27

Source: HDDS data and UT Center for Business, 2021 Population Projection Data

The Applicant then applied the populations of the zip codes in the proposed service area, with the assumption that the proposed service area will utilize Emergency Department services at a similar rate as the rest of Sumner and Robertson Counties.

Exhibit 32, Estimated Market ED Visits by Zip Code: 2023 (Baseline)

Zip Code	Population 2023	ED Use Rate (2022)	ED Visits (2024)
37188 (White House)	19,708	440.27	8,677
37073 (Greenbrier)	14,722	440.27	6,482
37049 (Cross Plains)	3,724	440.27	1,640
37048 (Cottontown)	7,489	440.27	3,297
Total	45,643	440.27	20,095

Source: HDDS data and UT Center for Business, 2021 Population Projection Data

Using the calculated use rate and the 2024 population estimate for the zip codes in the proposed service area, the estimated market visits are 20,095. This total uses a use rate assumption applied at the county level and the underlying ED visits used to calculate the use rates may include zip codes not in the proposed service area due to HDDS truncating the data from zip codes smaller than 20,000 population. To maintain a more conservative growth rate and visit volume projection, the Applicant chose to use the lower estimated ED visits calculated using THA data to prevent an overestimation of the potential market size for the proposed project.

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:

TriStar Hendersonville does not have any other outstanding CON applications. TriStar Hendersonville's affiliates have several approved CONs as noted in the chart. The status of each is summarized below:

- CN1707-023 – The StoneCrest Surgery Center CON has 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.
- CN2205-027 – TriStar Centennial Medical Center was approved for a FSED CON for the Bellevue community on August 24, 2022. Construction commenced with an opening planned in October 2024.
- CN2302-006 – TriStar Skyline East Nashville FSED was approved on April 26, 2023. The CON has been issued and is valid through June 1, 2026. The project has been delayed by the inability to acquire the land for the project due to litigation between a tenant and the current owner. That litigation has been resolved and additional land has been acquired nearby, such that the land acquisition part of the process should be resolved in the near term.
- CN2304-010 – TriStar Southern Hills Nolensville FSED was approved 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.
- CN2308-020 – Chattanooga East Surgicenter was approved on October 25, 2023. It is currently in the development phase.
- CN2404-010A – TriStar Spring Hill Hospital was approved for a CON for a new hospital on June 26, 2024, and is waiting for issuance of the CON (the date of July 1, 2027, in the chart is a placeholder until we receive the actual CON). Vanderbilt University Medical Center and Williamson Medical Center commenced contested case proceedings on June 28, 2024.

CON Number	Project Name	Date Approved	Expiration Date
CN2304-010	TriStar Southern Hills Nolensville FSED	6/28/2023	8/1/2026
CN1707-023	TriStar StoneCrest Surgery Center	10/25/2017	5/31/2025
CN2205-027	TriStar Centennial Bellevue FSED	8/24/2022	10/1/2025
CN2302-006	TriStar Skyline East Nashville FSED	4/26/2023	6/1/2026
CN2308-020	Chattanooga East Surgicenter	10/25/2023	12/1/2025
CN2404-010	TriStar Spring Hill Hospital	6/26/2024	7/1/2027

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: Please see Attachment 1C-1, 1C-2, and 1C-3 for copies of TriStar Hendersonville transfer agreements, list of TriStar Hendersonville's community linkages and Annual Community Report.

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

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

RESPONSE: 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; and WellPoint. In addition, as an emergency department, the TriStar White House FSED will care for every presenting patient regardless of their commercial insurance or insured status as required by EMTALA. Like TriStar Hendersonville, the TriStar White House FSED will comply with the No Surprises Act, which fully protects patients from any cost differential between services provided by in-network or out-of-network providers by holding the patients harmless from any such difference.

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:

Positive Effects

The proposed TriStar White House FSED will have several positive effects including:

- Bringing a full-service Emergency Department to an area where no emergency care facility exists;
- Improving access for residents of the service area by providing ED care closer to their homes;
- Improving emergency outcomes by reducing travel times to emergency care facilities dramatically;
- Helping alleviate the capacity challenges at TriStar Hendersonville;
- Bringing TriStar ED care closer to where a substantial portion of TriStar Hendersonville's ED patients live;
- Planning for the growing service area need projected based on population growth and aging as well as residential commercial development as demonstrated by the substantial residential developments planned for White House;
- Providing consumers with enhanced family safety and peace of mind due to 77% of service area patients use TriStar their emergency care;
- Reducing the requirement for EMS resources to be out-of-county and unavailable for emergency response community; and
- Shortening EMS patient transport times and giving EMS quicker access to emergency facilities.

Decompressing TriStar Hendersonville is an additional consumer benefit of this project. Building a TriStar FSED in a service area in which TriStar Health already takes care of 77% of the patient visits and where TriStar Hendersonville serves approximately 27% of emergency patient visits will allow patients to have greater access to care and at the same time provide some relief for the TriStar Hendersonville's main campus ED, making it more accessible to patients in the service area.

Negative Effects

There are no material negative impacts for consumers. Quality ED services provided by TriStar Health will be made more readily available to service area residents with some reduction of the capacity challenges at TriStar Hendersonville too.

Opponents may claim some impact on other EDs' utilization, but the impact on other providers is no longer part of the Tennessee CON statute and in this instance, there should be little or no impact on those providers. SRMC has a minimal number of patient visits from the service area so the establishment of this FSED should have minimal impact on that hospital. The impact of TriStar Health patients being able to go to their preferred provider of ED care at a location closer to their homes will be positive for consumers.

Much of the FSED's volume will consist of patient visits from within the proposed service area – primarily White House – who have gone to TriStar Hendersonville's main campus ED and will likely choose to go to the TriStar White House FSED because of its proximity. TriStar Hendersonville does anticipate that with increased access a significant portion of TriStar service area patients will shift to the TriStar White House FSED from TriStar Hendersonville and other affiliated ED providers. If there is any impact on other providers, growth in demand should offset any such shift.

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

RESPONSE:

As previously discussed, TriStar Hendersonville, the Applicant, is part of TriStar Health and an affiliate of HCA Healthcare, one of the largest providers of healthcare and hospital services in the U.S. and U.K. With TriStar Hendersonville's local, statewide, and national affiliations, TriStar Hendersonville expects to be able to recruit highly qualified individuals with the appropriate licensure to staff and support the FSED. TriStar Hendersonville also has the benefit of a Nurse Residency Program to garner future nurses to meet the growing need for personnel across its service area. TriStar Hendersonville has had strong success integrating nurse residents into its existing ED and will utilize this

talent pool for recruitment at the future FSED. TriStar Hendersonville has in place the clinical and administrative leadership needed to develop and operate the proposed FSED. Please see **Attachment 4C-1** for a list of TriStar Hendersonville's clinical training affiliations.

TriStar Health and its HCA Healthcare affiliates are committed to addressing the ongoing challenges in recruiting and retaining healthcare professionals. To this extent HCA Healthcare has 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. This relationship will assist with ongoing recruitment of staff within TriStar Health as well as recruitment for the proposed FSED. TriStar Health is also committed to increasing its nursing residency programs. 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 TriStar White House FSED. 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 is currently under construction on Belmont's campus. The nearly 200,000-square-foot building will be 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. 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 emergency medicine.

In addition, 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.

HCA Healthcare is also the largest and most experienced operator of FSEDs in the U.S. HCA Healthcare has operated hospital affiliated FSEDs since 1985. Today, HCA Healthcare operates approximately 130 FSEDs in 20 states. HCA Healthcare operates its FSEDs as a department of a hospital and each FSED has all the essential characteristics of a hospital--based emergency department, including the following:

- Operate 24 hours a day/seven days a week as a licensed department of the hospital and provides the same emergency services and care for any condition as the on-campus emergency department.
- Provide on-site diagnostic imaging and clinical laboratory services also operated as part of the host hospital and maintain all required clinical certifications and accreditations as the host hospital.
- Staffed by board-certified emergency physicians that are on the hospital's medical staff and by experienced ACLS-trained emergency nursing staff.
- Accredited by The Joint Commission as part of the host hospital.
- Licensed by all required state agencies as part of the host hospital.
- Provide the same signage requirements as the main hospital's emergency department.
- Provide access to on-call specialty physicians for consultations.
- Operate in compliance with the federal Emergency Medical Treatment and Labor Act (EMTALA) regulations as well as appropriate state regulations (see **Attachment 4C-2** for TriStar Health's EMTALA Policies).
- Accept patients transported by EMS.
- Possess all required transfer agreements with local general acute care hospitals.
- Provide free and reduced cost care in alignment with the host hospital's financial assistance policies.
- When needed, provide rapid transfer to a hospital chosen by the patient or by the emergency department physician assessment of the best location for treatment.

As such, TriStar Hendersonville has all the appropriate resources and is familiar with, and meets, all human resource requirements of the Tennessee Board for Licensing Health Care Facilities and the Joint Commission. The Applicant is licensed and accredited by these bodies.

TriStar White House FSED Staffing

In terms of anticipated staffing for the TriStar White House FSED, there are no differences in the initial staff of a new FSED between the TriStar White House FSED and the other approved and new FSEDs operated by TriStar Hendersonville's affiliates. However, as the volume of an FSED increases additional staff will be added as needed. The staffing for the TriStar White House FSED is 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.

RESPONSE:

Licensure and Certifications

TriStar Hendersonville is licensed by the Tennessee Board for Licensing Health Care Facilities and the license is in good standing. TriStar Hendersonville is certified to participate in the Medicaid and Medicare programs and currently meets all requirements of certification. TriStar Hendersonville is accredited by The Joint Commission. See **Attachment 5C-1** and **Attachment 2Q** for TriStar Hendersonville's Hospital License and The Joint Commission Accreditation.

Clinical Leadership

Medical direction at the proposed TriStar White House FSED will be provided by Duane Harrison, MD. Currently, Dr. Harrison is the Medical Director for the TriStar Hendersonville ED. Dr. Tincher is the regional lead for the physician group that staffs the ED at TriStar Hendersonville and that will staff the proposed FSED. Dr. Harrison and Dr. Tincher are board certified by the American Board of Emergency Medicine, and they have collectively 50 years of experience in providing emergency care. See **Attachment 5C-2** for Dr. Harrison's and Dr. Tincher's CVs.

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.

Plan for Improvement of Organization Performance and Clinical Excellence

As a department of TriStar Hendersonville, TriStar White House FSED will be part of TriStar Hendersonville's existing methods to ensure and maintain quality of care. At TriStar Hendersonville, 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 Hendersonville 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. TriStar Hendersonville's goal is 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.

The TriStar White House FSED will be an extension of the Emergency Department at TriStar Hendersonville and a licensed department of TriStar Hendersonville and will therefore 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. TriStar Hendersonville addresses methods to ensure and maintain patients' quality of care.

TriStar Hendersonville is dedicated to ensuring quality care and patient safety through compliance with all applicable accreditation and certification standards. As a satellite ED to TriStar Hendersonville, the proposed TriStar White House FSED will maintain the highest standards and quality of care, consistent with the high standard that TriStar Hendersonville has sustained throughout its history of providing patient care. In this regard, TriStar Hendersonville provides a robust Quality Assurance and Performance Improvement ("QAPI") Plan which is 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, TriStar Hendersonville provides 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 serves an important advisory purpose in enhancing and maintaining the quality of care provided. To this extent, systems are 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-3** for TriStar Health's Plan for Improvement of Organizational Performance and Clinical Excellence.

Clinical Staff Training and Requirements

TriStar White House FSED will be operationally integrated with TriStar Hendersonville's main ED. As such, it will comply with all the specific State Health Plan standards for staffing planning and recruitment, training and competencies, supervision, the presence of at least one Board-certified Emergency Physician and RN at all times (24/7/365), staffing with RN's, operation under the same bylaws, hospital medical staff and nursing staff organizations, hospital standards of care, and written policies and procedures. The Medical Director of TriStar Hendersonville's emergency department is Dr. Harrison, who will serve as Medical Director of the FSED. Dr. Tincher will serve in a regional oversight role. Copies of Dr. Harrison's and Dr. Tincher's CVs, along with Letters of Support are attached as **Attachment 5C-2**.

In its dedication to enhance quality assurance and performance improvement, TriStar Hendersonville employees are 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, TriStar Hendersonville will continue to require all clinical staff members to attend continuing education programs, and receive annual in-services on HIPAA, Medicare Compliance, and OSHA. TriStar Hendersonville offers 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. See **Attachment 4N-2** and **Attachment 5C-4** for the Staff Education Policy. See **Attachment 4C-1** for List of Clinical Affiliations.

Proposed TriStar White House FSED

All equipment, including a CT, X-ray, and ultrasound as well as lab and pharmacy support equipment, will be available 24/7. See the major equipment listed provided in **Attachment 4E-1**.

HISTORICAL DATA CHART

- ☒ Total Facility
☐ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency.

	Year 1 2021	Year 2 2022	Year 3 2023
A. Utilization Data			
Specify Unit of Measure <u>Other : ED Visits</u>	46838	50364	51252
B. Revenue from Services to Patients			
1. Inpatient Services	\$614,260,006.00	\$665,859,123.00	\$707,129,018.00
2. Outpatient Services	\$800,011,676.00	\$955,297,037.00	\$1,014,592,396.00
3. Emergency Services	\$0.00	\$0.00	\$0.00
4. Other Operating Revenue (Specify) <u>Other</u>	\$3,737,151.00	\$11,724,397.00	\$14,638,537.00
Gross Operating Revenue	\$1,418,008,833.00	\$1,632,880,557.00	\$1,736,359,951.00
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	\$1,120,025,147.00	\$1,315,722,398.00	\$1,396,044,636.00
2. Provision for Charity Care	\$90,640,073.00	\$100,501,230.00	\$109,822,557.00
3. Provisions for Bad Debt	\$13,699,022.00	\$9,999,674.00	\$20,598,414.00
Total Deductions	\$1,224,364,242.00	\$1,426,223,302.00	\$1,526,465,607.00
NET OPERATING REVENUE	\$193,644,591.00	\$206,657,255.00	\$209,894,344.00

PROJECTED DATA CHART

- ☒ Project Only
☐ Total Facility

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

	Year 1 2027	Year 2 2028
A. Utilization Data		
Specify Unit of Measure <u>Other : ED Visits</u>	9698	9693
B. Revenue from Services to Patients		
1. Inpatient Services	\$0.00	\$0.00
2. Outpatient Services	\$98,976,174.53	\$101,680,720.44
3. Emergency Services	\$0.00	\$0.00
4. Other Operating Revenue (Specify) _____	\$0.00	\$0.00
Gross Operating Revenue	\$98,976,174.53	\$101,680,720.44
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	\$88,074,342.17	\$90,480,993.09
2. Provision for Charity Care	\$1,536,902.64	\$1,578,898.85
3. Provisions for Bad Debt	\$741,487.23	\$761,748.54
	\$90,352,732.04	\$92,821,640.48

	Total Deductions		
NET OPERATING REVENUE		<u>\$8,623,442.49</u>	<u>\$8,859,079.96</u>

- 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 (<i>Gross Operating Revenue/Utilization Data</i>)	\$0.00	\$0.00	\$10,205.83	\$10,490.12	0.00
Deduction from Revenue (<i>Total Deductions/Utilization Data</i>)	\$0.00	\$0.00	\$9,316.64	\$9,576.15	0.00
Average Net Charge (<i>Net Operating Revenue/Utilization Data</i>)	\$0.00	\$0.00	\$889.20	\$913.97	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:

The average Gross Charge per ED visit for the TriStar White House FSED are projected to be \$10,205.83 in the first and second years of operation. This is an all-inclusive average charge representing the visit along with any associated imaging, lab services, and pharmacy services required by the patient. The projected charges are based on and comparable to the ED charges already in place at TriStar Portland FSED. The proposed TriStar White House FSED is not expected to have any impact on the charges for ED services at TriStar Hendersonville or any affiliate.

- 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 of TriStar Hendersonville's ED, which are comparable throughout TriStar Health. It is difficult to compare the charges for ED services given the multiple levels of care and associated ancillary charges that varying types of ED patients experience.

Exhibit 33 provides a comparison of standard average gross charges by CPT Code for Codes 99281-99285 for the ED providers in Robertson and Sumner Counties.

Exhibit 33
Average of Standard Gross Charges by CPT Codes (Current)

Facility	99281	99282	99283	99284	99285
TriStar Hendersonville	\$ 883	\$ 1,291	\$ 2,075	\$ 3,622	\$ 5,017
TriStar Portland FSER	\$ 883	\$ 1,291	\$ 2,075	\$ 3,622	\$ 5,017
TriStar NorthCrest	\$ 876	\$ 1,215	\$ 1,745	\$ 2,669	\$ 4,267
SRMC	\$ 685	\$ 1,236	\$ 2,061	\$ 2,835	\$ 4,170
SRMC FSED	\$ 685	\$ 1,236	\$ 2,061	\$ 2,835	\$ 4,170

Source: Hospital Chargemasters, 2024 (SRMC FSED assumed to be same as SRMC).

It is important to consider several factors when reviewing these data:

- Comparison of CPT charges for ED services are not meaningful:
 - Gross charges do not reflect what either patients or payors pay for ED 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.
 - Charges for this single visit CPT code do not include associated ancillary charges that vary based on patient experience and acuity.
 - It is not possible to fully acuity-adjust ED patient charges for accurate comparison.
- 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 Hendersonville'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 these two counties area.

- 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	\$34,740,186.32	35.10	\$35,689,469.61	35.10
TennCare/Medicaid	\$15,104,979.63	15.26	\$15,517,726.54	15.26
Commercial/Other Managed Care	\$37,155,772.08	37.54	\$38,171,061.79	37.54
Self-Pay	\$8,359,137.24	8.45	\$8,587,552.52	8.45
Other(Specify)	\$3,616,099.26	3.65	\$3,714,909.98	3.65
Total	\$98,976,174.53	100%	\$101,680,720.44	100%
Charity Care	\$1,536,902.64		\$1,578,898.85	

**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: The TriStar White House FSED will participate in all state and federal programs, including Medicare and TennCare and will adhere to TriStar Health's financial assistance and charity care policies. As an ED, it will care for everyone regardless of status and comply with the No Surprises Act, which holds patients harmless from any cost differential. Financial relief is available to patients who receive non-elective care, do not qualify for assistance and cannot pay. TriStar provides discounts for all patients with income less than 400% of the poverty level. Personal responsibilities are written off for those with income below 200% of the poverty level. All self-pay patients receive a discount similar to managed care, which is available to patients with no third party payer source, who do not qualify for Medicaid/Charity/any other discount program. In CY 2023, TriStar Hendersonville and TriStar Portland FSED provided over \$109 million dollars in charity care. See Attachment 4N-1.

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.

☒ 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?

☒ Yes

☐ No

- Does the applicant commit to obtaining and maintaining all applicable state licenses in good 3standing?

☒ 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?

☒ Yes

☐ No

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

Credential	Agency	Status (Active or Will Apply)	Provider Number or Certification Type
Licensure	☒ Health Facilities Commission/Licensure Division ☐ Intellectual & Developmental Disabilities ☐ Mental Health & Substance Abuse Services	Active	0000000135
Certification	☒ Medicare ☒ TennCare/Medicaid ☐ Other _____	Active Active	44014 1000121
Accreditation(s)	TJC - The Joint Commission	Active	5174

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		
Nurses	0.00	11.50
Ultrasonographer	0.00	0.50
Radiology Tech	0.00	4.20
Lab Tech	0.00	5.20
Pharmacists	0.00	0.60
Total Direct Patient Care Positions	N/A	22

B. Non-Patient Care Positions		
Total Non-Patient Care Positions	N/A	0
Total Employees (A+B)	0	22

C. Contractual Staff		
Contractual Staff Position	0.00	9.80
Total Staff (A+B+C)	0	31.8

DEVELOPMENT SCHEDULE

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

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

PROJECT COMPLETION FORECAST CHART

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

Phase	Days Required	Anticipated Date (Month/Year)
1. Initial HFC Decision Date		09/27/24
2. Building Construction Commenced	370	10/01/25
3. Construction 100% Complete (Approval for Occupancy)	734	09/30/26
4. Issuance of License	824	12/29/26
5. Issuance of Service	884	02/27/27
6. Final Project Report Form Submitted (Form HR0055)	1004	06/27/27

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

Attachment 3A

Proof of Publication

THE TENNESSEAN

Public Notices

Originally published at tennessean.com on 07/30/2024

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 Hendersonville Medical Center, a/an Hospital owned by Hendersonville Hospital Corporation 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 the establishment of a freestanding emergency department (FSED) that will consist of approximately 13,087 square feet with 11 exam rooms, including 1 trauma room, a lab, imaging department, a nurse station, and associated support spaces located on a portion (Lot 8) of the property identified as Parcel 0741071 B 07700. The address of the project will be an unaddressed site on an approximate three (3) +/- acre tract of vacant land on the north side of TN-258/Raymond Hirsch Parkway, located approximately 650 +/- feet west of the intersection of Raymond Hirsch Parkway and Highway 31W, White House, Robertson County, Tennessee, 37188. The estimated project cost will be \$17,832,032.

The anticipated date of filing the application is 08/01/2024

The contact person for this project is CEO Justin Coury who may be reached at TriStar Hendersonville Medical Center - 355 New Shackle Island, Hendersonville, Tennessee 37075*Contact No. 615-338-1000.

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.

Publication Dates

L00000000



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 Hendersonville Medical Center, a/an Hospital owned by Hendersonville Hospital Corporation 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 the establishment of a freestanding emergency department (FSED) that will consist of approximately 13,087 square feet with 11 exam rooms, including 1 trauma room, a lab, imaging department, a nurse station, and associated support spaces located on a portion (Lot 8) of the property identified as Parcel 0741071 B 07700. The address of the project will be an unaddressed site on an approximate three (3) +/- acre tract of vacant land on the north side of TN-258/Raymond Hirsch Parkway, located approximately 650 +/- feet west of the intersection of Raymond Hirsch Parkway and Highway 31W, White House, Robertson County, Tennessee, 37188. The estimated project cost will be \$17,832,032.

The anticipated date of filing the application is 08/01/2024

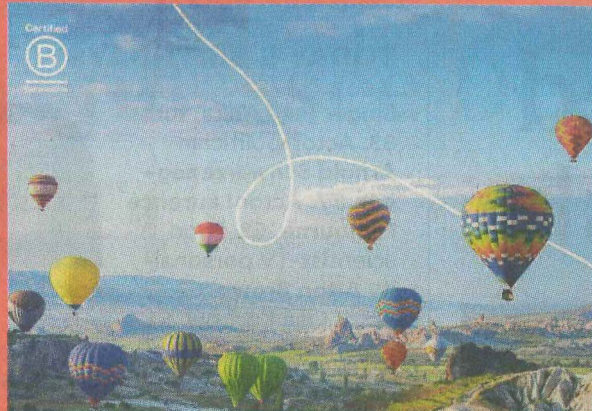
The contact person for this project is CEO Justin Coury who may be reached at TriStar Hendersonville Medical Center - 355 New Shackle Island, Hendersonville, Tennessee 37075 - Contact No. 615-338-1000.

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.

July 30 2024

LOKR0135592



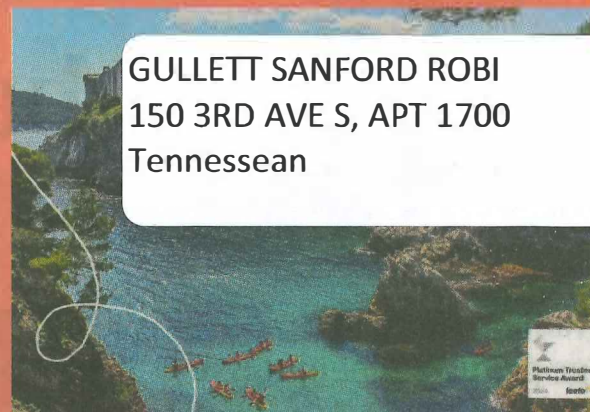
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THE TENNESSEAN

TUESDAY, JULY 30, 2024 | [TENNESSEAN.COM](https://tennessean.com)



PART OF THE USA TODAY NETWORK

ELECTION 2024



Mother: Judge has 'taken it too far'

Barrett 'livid' case
in son's death sealed

Evan Mealins

Nashville Tennessean

USA TODAY NETWORK - TENNESSEE

The mother of Dallas Barrett is livid that a Nashville judge has hidden court proceedings from public view in the criminal cases of seven men accused of killing her son in a downtown honky-tonk in 2021.

Tammy Barrett's 22-year-old son Dallas Barrett died from asphyxiation after a fight with security guards in Dierks Bentley's Whiskey Row on Aug. 16, 2021. Six security guards and one other man were indicted and charged with reckless homicide and aggravated assault in December of that year.

Judge Cheryl Blackburn sealed the

Black women get behind Harris run

But some worry about racist, sexist backlash during campaign

Deborah Barfield Berry, Melissa Brown and Terry Collins

USA TODAY

WASHINGTON – Glynda Carr's cellphone started buzzing and didn't stop on July 21. There was text after text heralding the growing likelihood that Kamala Harris would be the Democratic nominee for president.

Carr, whose organization she co-founded to support Black female candidates, wasn't surprised people would reach out as they heard the news.

But when she signed in to a Zoom call that evening to mobilize support for Harris, she was excited to learn there were tens of thousands of other Black women there as energized as she was.

More than 44,000 people, most of them women, joined a video call July 21, which lasted well past midnight and netted more than \$1.5 million for the Harris

campaign, organizers said. Some signed up to work in their communities and pledged to ramp up get-out-the-vote efforts.

But they're also bracing for attacks against the vice president, who would make history as the first woman of color to become a major party nominee.

"We celebrated (last night)," Carr said July 22, "but today we're going to protect defend, fight, organize and mobilize."

The audacity of hope

Last week, Tennessee state Sen. London Lamar choked up when reflecting on her own political path and the effect a Harris nomination, and a potential presidency, could have on other young Black women.

Lamar, chair of the Senate Democratic Caucus, recalled watching Barack Obama and his wife, Michelle Obama, take the stage after his nomination in 2008.

See WOMEN, Page 15A

not enter a public order announcing the seal or explaining why it was necessary until this month, an employee in the Davidson County Criminal Court Clerk's Office told The Tennessean. In her July 17 order, Blackburn states keeping the case out of the public eye is necessary to ensure the defendants get a fair trial due to "extensive pre-trial publicity."

The Nashville Banner first reported on Thursday that Blackburn sealed the

See SEALED CASE, Page 15A



Bill Callahan's list for fixing O-line

SPORTS, 1B

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Real Estate

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Govt Public Notices

Public Notice
Tennessee Department of Environment and Conservation (TDEC)
Division of Water Resources (DWR)
Notice Requesting Public Comments on Draft Permit Actions
FILE # NRS NRS24.121

The purpose of this notice is to advise the public of the following proposed permit action and solicit comments and information necessary to evaluate the potential impact of the proposed activities on the aquatic environment.

Pursuant to The Tennessee Water Quality Control Act of 1977, T.C.A. §69-3-108 and Tennessee Rules, Chapter 0400-40-07, the proposed activity described below has been submitted for approval under an Aquatic Resource Alteration Permit and Section 401 Water Quality Certification. Section 401 of the Clean Water Act

Real Estate

Rentals

PUBLISHER'S NOTICE

All real estate advertised herein is subject to the Federal Fair Housing Act, which makes it illegal to advertise any preference, limitation, or discrimination because of race, color, religion, sex, handicap, familial status, or national origin, or intention to make any such preference, limitation, or discrimination. "We will not knowingly accept any advertising for real estate which is in violation of the law. All persons are hereby informed that all dwellings advertised are available on an equal opportunity basis."



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Public Notices

10416796

Notice to Relocate the Branch of a Bank

Notice is hereby given, FirstBank, 1221 Broadway, Nashville, Tennessee, 37203 has made application to the Federal Deposit Insurance Corporation and the Tennessee Department of Financial Institutions for permission to relocate the branch of a bank to 401 Franklin Street, Huntsville, AL 35801, from its current location at 720 Gallatin Street, Southwest, Huntsville, AL 35801

Any person wishing to comment on this application is encouraged to submit comments through the FDIC's website at <https://www7.fdic.gov/CRA/>. Alternatively, comments may be filed in writing with the Regional Director of the Federal Deposit Insurance Corporation at its Regional Office at 600 North Pearl Street, Suite 700, Dallas, TX 75201. Comments must be submitted by August 15, 2024. Photocopies of information in the nonconfidential portion of the application file will be made available upon request.

Any person wishing to comment on or protest this application/notification or any person having information which may have a bearing on the fitness of any of the organizers or proponents of this application/notification may file comments with the Commissioner of Financial Institutions in the Tennessee Tower, 312 Rosa L. Parks Avenue, Nashville, Tennessee 37243, telephone the Department of Financial Institutions at 615-741-5018 or email comments to Debra.Grissom@tn.gov or William.Cook@tn.gov. Written or telephonic notice must be made to the Commissioner within fifteen (15) days of this publication.

Public Notices

10419782

Public Notice

Tennessee Department of Environment and Conservation (TDEC)
Division of Water Resources (DWR)
Notice Requesting Public Comments on Draft Permit Actions
FILE # NRS24.070

The purpose of this notice is to advise the public of the following proposed permit action and solicit comments and information necessary to evaluate the potential impact of the proposed activities on the aquatic environment.

Pursuant to The Tennessee Water Quality Control Act of 1977, T.C.A. §69-3-108 and Tennessee Rules, Chapter 0400-40-07, the proposed activity described below has been submitted for approval under an Aquatic Resource Alteration Permit and Section 401 Water Quality Certification. Section 401 of the Clean Water Act requires that an applicant obtain a water quality certification from the state when a federal permit is required. This notice is intended to inform interested parties of this permit application and draft permit and rationale, and to ask for comments and information necessary to determine possible impacts to water quality. At the conclusion of the public notice period a final determination will be made whether to issue or deny the permit.

PERMIT COORDINATOR

Scott Hall
Tennessee Department of Environment & Conservation
Division of Water Resources, Natural Resources Unit
Davy Crockett Tower
500 James Robertson Pkwy, 9th Floor
Nashville, TN 37243
615-590-4430
scott.hall@tn.gov

APPLICANT

Jay Tant - Assistant General Manager
Harpeth Valley Utility District
5838 River Road
Nashville, TN 37209

LOCATION

Unnamed Tributary to Harpeth River, Bellevue Road
Nashville, Davidson County
Latitude 36.034637, Longitude -86.555095

To view the proposed location of these impacts and the watershed condition, visit the Division's Map Viewer at <http://tdec.tn.gov/dwr/> and search on the permit number or coordinates listed in this Public Notice.

PROJECT DESCRIPTION / PURPOSE

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Public Notices

10391453

LEGAL NOTICE NOTICE OF PUBLICATION

Notification hereby is given that Wells Fargo Bank, National Association, 101 N. Phillips Avenue, Sioux Falls, South Dakota 57104, has filed an application on July 30, 2024 with the Comptroller of the Currency, as specified in 12 C.F.R. 5.30 of the Comptroller's regulations, for permission to establish a domestic branch to be known as West Nashville located at 5605 Charlotte Pike, Nashville, Davidson County, TN 37209.

Any person wishing to comment on this application may file comments in writing with Large Bank Licensing, Office of the Comptroller of the Currency, 7 Times Square, 10th Floor Mailroom, New York, NY 10036 within 30 days after the date of this publication. The public may find information about the filing in the OCC's Weekly Bulletin available at www.occ.gov. Additionally, the public portion of the filed application is available upon request.

Public Notices

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 Hendersonville Medical Center, a/an Hospital owned by Hendersonville Hospital Corporation 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 the establishment of a freestanding emergency department (FSED) that will consist of approximately 13,087 square feet with 11 exam rooms, including 1 trauma room, a lab, imaging department, a nurse station, and associated support spaces located on a portion (Lot 8) of the property identified as Parcel 0741071 B 07700. The address of the project will be an unaddressed site on an approximate three (3) +/- acre tract of vacant land on the north side of TN-258/Raymond Hirsch Parkway, located approximately 650 +/- feet west of the intersection of Raymond Hirsch Parkway and Highway 31W, White House, Robertson County, Tennessee, 37188. The estimated project cost will be \$17,832,032.

The anticipated date of filing the application is 08/01/2024

The contact person for this project is CEO Justin Coury who may be reached at TriStar Hendersonville Medical Center - 355 New Shackle Island, Hendersonville, Tennessee 37075 - Contact No. 615-338-1000.

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 hscd.staff@tn.gov.
July 30 2024
LOKR0135592

requires a permit to obtain a water quality certification from the state when a federal permit is required. This notice is intended to inform interested parties of this permit application and draft permit and rationale, and to ask for comments and information necessary to determine possible impacts to water quality. At the conclusion of the public notice period a final determination will be made whether to issue or deny the permit.

PERMIT COORDINATOR

Mike Lee
Tennessee Department of Environment & Conservation
Division of Water Resources,
Natural Resources Unit
Davy Crockett Tower
500 James Robertson
Parkway, 9th Floor
Nashville, Tennessee 37243

(615) 532-0712

Mike.

lee@tn.gov

APPLICANT Rob
Phipps, President
Phipps Construction Company
5711 Harding Pike
Nashville, TN 37209
(615) 714-7525

LOCATION: 116
Jackson Blvd., Nashville,
Davidson County
Latitude: 36.113405, Longitude: -86.961777

To view the proposed location of these impacts and the watershed condition, visit the Division's map viewer at <http://tdeonline.tn.gov/dwr/> and search on the permit number or coordinates listed in this Public Notice.

PROJECT DESCRIPTION / PURPOSE

Phipps Construction Company is proposing to repair existing stone walls totaling 564 feet along the banks of Richland Creek and an unnamed tributary to Richland Creek on a 6.81-acre residential property in Nashville, Davidson County. The site is located southeast of the intersection of Harding Pike and Clarendon Avenue, and north of Jackson Boulevard. The proposed impact will enhance the existing condition of the site and adjacent roadways by stabilizing sections of stone wall that have fallen into disrepair. All work will be accomplished from the land side and no work will occur in the stream.

ANTIDEGRADATION STATEMENT

In accordance with the Tennessee Antidegradation Statement (Rule 0400-40-03-.06), the Division has made a preliminary determination that the proposed activities will result in de minimis degradation of waters with

high quality, or impaired waters.

HOW TO COMMENT

TDEC is requesting public comment on this proposed permit action. Obtaining a broad range of facts and opinions on Agency actions is one of the best ways to ensure appropriate decisions. Persons wishing to comment on the proposal are invited to submit written comments to the Division. Written comments must be received within thirty days following distribution of the approved public notice materials (including signage and newspaper ad). Comments will become part of the record and will be considered in the final decision. The applicant's name and permit number should be referenced. Send all written comments to the Division's address listed below to the attention of the permit coordinator. You may also comment via email to water.permits@tn.gov.

After the Division makes a final permit determination, a permit appeal may be filed by the applicant or by any person who participated in the public comment period whose appeal is based on comments given to the Division in writing during the public comment period or in testimony at a formal public hearing. If it is hard for you to read, speak, or understand English, TDEC may be able to provide translation or interpretation services free of charge. Please contact Alisha Looper at 615-571-4470 or alisha.looper@tn.gov.

Si le resulta difícil leer, hablar o comprender inglés, TDEC puede proporcionarle servicios de traducción o interpretación sin cargo comunicándose con Alisha Looper al 615-571-4470 o alisha.looper@tn.gov.

FILE REVIEW

The permit application, supporting documentation, including detailed plans and maps, draft permit and rationale, and related comments are available for review on the internet at the Division's Water Resources Dataviewer: Report on Permits (tn.gov) by entering the permit file number listed in the title of this Public Notice. The file may be viewed and copied at the address listed below.
Tennessee Department of Environment & Conservation
Division of Water Resources
Natural Resources Unit
9th Floor David Crockett Tower
500 James Robertson Parkway
Nashville, Tennessee 37243-1102
July 30 2024
LOKR0135652

The applicant proposes open-cut stream crossings at five stream locations, decommissioning of a manhole in a wetland, and replacement of a manhole in a stream for the Birch Bark gravity sewer line upgrades. Impacts will include temporary water diversions (coffer dams and/or pump-arounds as needed) for work needed for installation of gravity sewer lines. All impacts are temporary and mitigation is not required.

ANTIDEGRADATION REVISIT ONCE LEE SEES PERMIT AND USE SAME TEXT

In accordance with the Tennessee Antidegradation Statement (Rule 0400-40-03-.06), the Division has made the preliminary determination that the proposed activities will not result in an appreciable permanent loss of resource values, and therefore will result in no more than de minimis degradation of resource value without mitigation.

For more information, please reference Tennessee's Antidegradation Statement which is found in Chapter 0400-40-03 of the Rules of the Tennessee Department of Environment and Conservation.

FACTORS CONSIDERED

In deciding whether to issue or deny this permit, the Division will consider all comments of record and the requirements of applicable federal and state laws. The division will consider the nature, scale and effects of proposed impacts. The Division will consider practicable alternatives to the alteration, loss of waters or habitat, diminishment in biological diversity, cumulative or secondary impacts to the water resource, and adverse impacts to unique, high quality, or impaired waters.

HOW TO COMMENT

TDEC is requesting public comment on this proposed permit action. Obtaining a broad range of facts and opinions on Agency actions is one of the best ways to ensure appropriate decisions. Persons wishing to comment on the proposal are invited to submit written comments to the Division. Written comments must be received within thirty days following distribution of the approved public notice materials (including signage and newspaper ad). Comments will become part of the record and will be considered in the final decision. The applicant's name and permit number should be referenced. Send all written comments to the Division's address listed below to the attention of the permit coordinator. You may also comment via email to water.permits@tn.gov.

After the Division makes a final permit determination, a permit appeal may be filed by the applicant or by any person who participated in the public comment period whose appeal is based on comments given to the Division in writing during the public comment period or in testimony at a formal public hearing. If it is hard for you to read, speak, or understand English, TDEC may be able to provide translation or interpretation services free of charge. Please contact Alisha Looper at 615-571-4470 or alisha.looper@tn.gov.

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PUBLIC HEARING

Interested persons may request in writing that the Division hold a public hearing on this application. The request must be received by the Division within the comment period, indicate the interest of the party requesting it, the reason(s) a hearing is warranted, and the water quality issues being raised. When there is sufficient public interest in water quality issues, the Division will hold a public hearing in accordance with 0400-40-07-.04(4) (f). Send all public hearing requests to the attention of the permit coordinator at the address listed below or via email to water.permits@tn.gov. Any scheduled public hearings will be advertised through a similar public notice process.

FILE REVIEW

The permit application, supporting documentation, including detailed plans and maps, draft permit and rationale, and related comments are available for review on the internet at the Division's data viewer at [Report on Permits \(tn.gov\)](http://Report on Permits (tn.gov)) by entering the permit file number listed in the title of this Public Notice. The file may be viewed and copied at the address listed below.

Tennessee Department of Environment & Conservation
Division of Water Resources, Natural Resources Unit
Davy Crockett Tower
500 James Robertson Pkwy, 9th Floor
Nashville, Tennessee 37243

Attachment 7A-1

Articles of Incorporation,
Amendment to Articles, and
TriStar Hendersonville Medical Assumed
Name Renewal

State of Tennessee



BOOK 7233 PAGE 101

Department of State

Certificate

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of

HENDERSONVILLE HOSPITAL CORPORATION,

was duly executed in accordance with the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.

Therefore, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on April 30th, 19 87.



Hentry Crowell
Secretary of State
by Carolee P. Pinner

MAIL ROOM

MAY 12 8 42 AM '87
FELIX L. WILSON, JR. REGISTER
DAVISON COUNTY, TN

IDENTIFY REFERENCE

24787

05/12 8:42 AM CHECK

FILED
SECRETARY OF STATE
1997 APR 30 AM 9:24

CHARTER
OF
HENDERSONVILLE HOSPITAL CORPORATION

The undersigned natural persons, having capacity of contract and acting as the incorporators of a corporation under the Tennessee General Corporation Act, adopt the following Charter for such corporation:

1. The name of the corporation is Hendersonville Hospital Corporation.

2. The duration of the corporation is perpetual.

3. The address of the principal office of the corporation in the State of Tennessee shall be One Park Plaza, Nashville, County of Davidson. BOOK 7233 PAGE 102

4. The corporation is for profit.

5. The purposes for which the corporation is organized are:

(a) To purchase, lease, or otherwise acquire, to operate, and to sell, lease, or otherwise dispose of hospitals, convalescent homes, nursing homes and other institutions for the medical care and treatment of patients; to purchase, manufacture, or prepare and to sell or otherwise deal in, as principal or as agent, medical equipment or supplies; to construct, or lease, and to operate restaurants, drug stores, gift shops, office buildings, and other facilities in connection with hospitals or other medical facilities owned or operated by it; to engage in any other act or acts which a corporation may perform for a lawful purpose or purposes.

(b) To consult with owners of hospitals and all other types of health care or medically-oriented facilities or managers thereof regarding any matters related to the construction, design, ownership, staffing or operation of such facilities.

FILED
SECRETARY OF STATE
1987 APR 30 AM 9:25

To provide consultation, advisory and management services to any business, whether corporation, trust, association, partnership, joint venture or proprietorship.

(d) To engage in any lawful businesses which are directly or indirectly related to the above purposes.

6. The maximum number of shares which the corporation shall have the authority to issue is One Thousand (1,000) shares of Common Stock, par value of \$1.00 per share.

7. The corporation will not commence business until the consideration of One Thousand Dollars (\$1,000) has been received for the issuance of shares. BOOK 7233 PAGE 103

8. (a) The shareholders of this corporation shall have none of the preemptive rights set forth in the Tennessee General Corporation Act.

(b) The initial bylaws of this corporation shall be adopted by the incorporations hereof, and thereafter, the bylaws of this corporation may be amended, repealed or adopted by a majority of the outstanding shares of capital stock.

(c) This corporation shall have the right and power to purchase and hold shares of its capital stock; provided, however, that such purchase, whether direct or indirect, shall be made only the extent of unreserved and unrestricted capital surplus.

Dated as of April 28, 1987


Bettye D. Daugherty


Vivian D. West

State of Tennessee



Department of State

Certificate

The undersigned, as Secretary of State of the State of Tennessee, hereby certifies that the attached document was received for filing on behalf of

HENDERSONVILLE HOSPITAL CORPORATION

was duly executed in accordance with the Tennessee General Corporation Act, was found to conform to law and was filed by the undersigned, as Secretary of State, on the date noted on the document.

Therefore, the undersigned, as Secretary of State, and by virtue of the authority vested in him by law, hereby issues this certificate and attaches hereto the document which was duly filed on November 19th, 1987.



Henry Crowell
Secretary of State
by Carole Rasm

FILED
SECRETARY OF STATE
1987 NOV 19 PM 2:22

7:12:4 13,76510

ARTICLES OF AMENDMENT TO THE CHARTER
OF
HENDERSONVILLE HOSPITAL CORPORATION

Pursuant to the provisions of Section 48-1-303 of the Tennessee General Corporation Act, the undersigned corporation adopts the following Articles of Amendment to its Charter:

1. The name of the corporation is Hendersonville Hospital Corporation.

2. The amendment adopted is:

The address of the corporation's principal office in the State of Tennessee is changed to 4525 Harding Road, Nashville, Tennessee 37205.

3. The amendment was duly adopted by the unanimous written consent of the Board of Directors on November 16, 1987.

4. This amendment will not effect issued shares.

5. This amendment is to be effective when these articles are filed by the Secretary of State.

Dated: November 16, 1987

HENDERSONVILLE HOSPITAL CORP-
ORATION

By: Charles R. Gaston
Charles R. Gaston,
Secretary



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

HENDERSONVILLE HOSPITAL CORPORATION
LEGAL DEPT
PO BOX 750
NASHVILLE, TN 37202-0750

April 12, 2022

Filing Acknowledgment

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

Control #: 188271 Status: Active

Filing Type: For-profit Corporation - Domestic

Document Receipt

Receipt #: 007159328

Filing Fee: \$20.00

Payment-Credit Card - State Payment Center - CC #: 3827375725

\$20.00

Amendment Type: Assumed Name Renewal

Image #: B1199-3692

Filed Date: 04/12/2022 8:01 AM

This will acknowledge the filing of the attached assumed name renewal. 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 effective date indicated above. You may renew the right to use this name within two (2) months preceding the expiration of such right, for a period of five (5) years, by filing an application with the Secretary of State.

Tre Hargett
Secretary of State

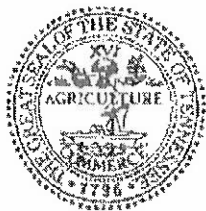
Processed By: Corp Web User

Field Name	Changed From	Changed To
Assumed Name	TriStar Hendersonville Medical Center	TriStar Hendersonville Medical Center
Expiration Date	04/19/2022	04/12/2027

006293034

APPLICATION FOR RENEWAL OF REGISTRATION OF ASSUMED NAME

SS-4488



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 # 006293034

Assumed Name: TriStar Hendersonville Medical Center

Date of Expiration: 04/19/2022

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, the undersigned submits this application.

Failure to file the required document within the two (2) months preceding the expiration of the registration of the assumed name will result in expiration of the assumed name.

1. The Secretary of State Control Number is: 000188271

and the true name of the business entity is:

HENDERSONVILLE HOSPITAL CORPORATION

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 Hendersonville Medical Center

The assumed name must satisfy the statutory requirements for that type of entity.

04/12/2022

Signature Date

Vice President & Asst. Secretary

Signer's Capacity

Electronic

Signature

John M. Franck II

Name (typed or printed)

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

Attachment 7A-2

Certificate of Corporate Existence



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

HILARY DENNEN
HILARY DENNEN
102 PIONEER COURT
HENDERSONVILLE, TN 37075

July 13, 2024

Request Type: Certificate of Existence/Authorization
Request #: 0591978

Issuance Date: 07/13/2024
Copies Requested: 1

Document Receipt

Receipt #: 009125514

Filing Fee: \$20.00

Payment-Credit Card - State Payment Center - CC #: 3877763682

\$20.00

Regarding: HENDERSONVILLE HOSPITAL CORPORATION

Filing Type: For-profit Corporation - Domestic

Control #: 188271

Formation/Qualification Date: 04/30/1987

Date Formed: 04/30/1987

Status: Active

Formation Locale: TENNESSEE

Duration Term: Perpetual

Inactive Date:

Business County: DAVIDSON COUNTY

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

HENDERSONVILLE HOSPITAL CORPORATION

- * 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.

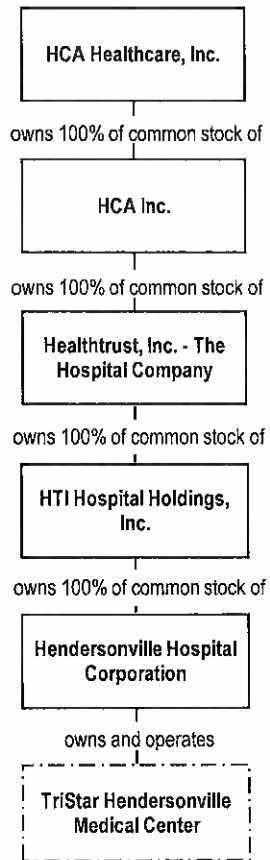
Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 068625623

Attachment 7A-3

Organizational Chart



Attachment 7A-4

TriStar Hendersonville Medical Center
Officers and Directors

May 1, 2024

**OFFICERS AND DIRECTORS
OF
HENDERSONVILLE HOSPITAL CORPORATION**

* Samuel N. Hazen	President	One Park Plaza Nashville, TN 37203
Mitch Edgeworth	Senior Vice President	1000 Health Park Drive, Ste 500 Brentwood, TN 37027
Jon M. Foster	Senior Vice President	One Park Plaza Nashville, TN 37203
John M. Hackett	Senior Vice President and Treasurer	One Park Plaza Nashville, TN 37203
Michael R. McAlevey	Senior Vice President	One Park Plaza Nashville, TN 37203
Tim McManus	Senior Vice President	One Park Plaza Nashville, TN 37203
Joseph A. Sowell, III	Senior Vice President	One Park Plaza Nashville, TN 37203
* Christopher F. Wyatt	Senior Vice President	One Park Plaza Nashville, TN 37203
Kevin A. Ball	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Mike T. Bray	Vice President	One Park Plaza Nashville, TN 37203
Monica Cintado	Vice President	One Park Plaza Nashville, TN 37203
Natalie H. Cline	Vice President and Secretary	One Park Plaza Nashville, TN 37203
Justin Coury	Vice President	355 New Shackle Island Road Hendersonville, TN 37075
Jaime DeRensis	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Wes Fountain	Vice President	1000 Health Park Drive, Ste 500 Brentwood, TN 37027
* John M. Franck II	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Ronald Lee Grubbs, Jr.	Vice President	One Park Plaza Nashville, TN 37203

Seth A. Killingbeck	Vice President and Assistant Secretary	One Park Plaza Nashville, TN 37203
Todd Maxwell	Vice President	One Park Plaza Nashville, TN 37203
Jeff McInturff	Vice President	One Park Plaza Nashville, TN 37203
T. Scott Noonan	Vice President	One Park Plaza Nashville, TN 37203
Peter Rossell	Vice President	One Park Plaza Nashville, TN 37203
Brad Spicer	Vice President	One Park Plaza Nashville, TN 37203
Russ Young	Vice President	One Park Plaza Nashville, TN 37203
Doug L. Downey	Assistant Secretary	One Park Plaza Nashville, TN 37203
Deborah H. Mullin	Assistant Secretary	One Park Plaza Nashville, TN 37203
Shirley Scharf-Cheatham	Assistant Secretary	One Park Plaza Nashville, TN 37203
John I. Starling	Assistant Secretary	One Park Plaza 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

Not Applicable

Attachment 9A

Option Agreement for Site

OPTION AGREEMENT

THIS OPTION AGREEMENT ("**Agreement**") is made and entered into effective as of the calendar date after the date the last of the Parties executes this Agreement ("**Effective Date**"), by and between FRANKLIN LAND ASSOCIATES, L.L.C., a Tennessee limited liability company ("**Seller**"), and HENDERSONVILLE HOSPITAL CORPORATION, a Tennessee corporation, its successors and assigns ("**Purchaser**"). Seller and Purchaser are sometimes referred to in this Agreement individually as a "**Party**" and collectively as the "**Parties**."

A. Seller has, or intends to have, a contract by and between Shrihare LLC, a Tennessee limited liability company, and Seller (as the same may be amended, collectively, the "**Purchase Agreement**"), to purchase approximately 3.6 acres, more or less, of vacant real property situated in Robertson County, Tennessee, located generally at the intersection of Hwy 31 W. and Raymond Hirsch Pkwy, White House, Tennessee, being a portion of a larger parcel, and being more particularly described in the Purchase Agreement (the "**Property**"). Seller desires to sell to Purchaser, and Purchaser desires to purchase from Seller, an option to assume the Purchase Agreement and acquire the Property pursuant to the Purchase Agreement ("**Option**").

IN CONSIDERATION of the Purchase Price, the agreements contained in this Agreement and other good and valuable consideration, the receipt and legal sufficiency of which are acknowledged, the Parties agree to the following:

1. GRANT OF OPTION. Seller grants to Purchaser the Option for the Option Term (defined below) pursuant to the terms and conditions of this Agreement.

2. PURCHASE PRICE. The purchase price ("**Purchase Price**") for the Option is \$50,000. Purchaser shall deliver the Purchase Price to Seller by check or federal wire transfer within five business days after the later of (i) the Effective Date, or (ii) the date on which Seller provides Seller's wire instructions ("**Wire Instructions**") to Purchaser.

3. OPTION TERM. The term of the option is the period commencing on the Effective Date and expiring on 11:59 PM local time where the Property is situated on the date that is five business days prior to the expiration of Seller's contingencies under the Purchase Agreement ("**Option Term**").

4. ASSIGNMENT FEE. The fee for the assignment of the Purchase Agreement from Seller to Purchaser ("**Assignment Fee**") is \$150,000.00.

5. EXERCISE OF OPTION. To effectively exercise the Option, Purchaser must deliver written notice to Seller, on or before the expiration of the Option Term, of Purchaser's election to exercise the Option ("**Exercise Notice**"). If Purchaser does not deliver the Exercise Notice to Seller, on or before the expiration of the Option Term, then Purchaser will be deemed to have elected to not exercise the Option and the Option and this Agreement will terminate upon the expiration of the Option Term. If Purchaser delivers the Exercise Notice to Seller, on or before the expiration of the Option Term, then Seller will execute the assignment instrument attached to this Agreement as Exhibit A ("**Assignment Instrument**"), and deliver the executed Assignment Instrument to Purchaser within two business days after Purchaser's delivery of the Exercise Notice to Seller. Purchaser will then deliver its executed counterpart to the Assignment Instrument and deliver the Assignment Fee to Seller (by check or pursuant to Seller's Wire Instructions) within two business days after receipt of the executed Assignment Instrument from Seller.

6. PRE-ASSUMPTION MATTERS. Throughout the Option Term, Seller: (i) shall not amend or modify the Purchase Agreement without the prior written consent of Purchaser, (ii) shall not enter into any agreement or grant any option or right to any person other than Purchaser with respect to the Purchase Agreement or the sale, transfer, conveyance, possession, use or occupancy of all or any portion of the Property without the prior consent of Purchaser. Seller acknowledges that no other contracts, agreements or other

documents signed or delivered or other acts or things done by Seller shall be binding upon Purchaser unless expressly approved or assumed in writing by Purchaser.

7. REPRESENTATIONS AND WARRANTIES – NON-REFERRAL SOURCE. Seller represents and warrants to Purchaser the following statements (A) and (B):

- (A) Seller is not a “Referral Source” (as hereinafter defined) and that no ownership or beneficial interest in Seller is owned or held by any Referral Source. For the purpose of this certification, “*Referral Source*” shall mean any of the following:
 - (i) a physician, an immediate family member or member of a physician’s immediate family, an entity owned in whole or in part by a physician or by an immediate family member or member of a physician’s immediate family;
 - (ii) any other “Person” (as hereinafter defined) who (a) makes, who is in a position to make, or who could influence the making of referrals of patients to any health care facility; (b) has a provider number issued by Medicare, Medicaid or any other government health care program; or (c) provides services to patients who have conditions that might need to be referred for clinical or medical care, and participates in any way in directing, recommending, arranging for or steering patients to any health care provider or facility; or
 - (iii) any Person or entity that is an “Affiliate” (as hereinafter defined) of any Person or other entity described in clause (i) or (ii) above.

“Immediate family member or member of a physician’s immediate family” means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

“Affiliate” means as to the Person in question, any Person that directly or indirectly controls or is controlled by or is under common control with such Person in question. For purposes of this definition, “control” (including the correlative meanings of the terms “controlled by” and “under common control with”), as used herein, shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such Person, through the ownership of voting securities, partnership interests or other equity interests.

“Person” means any one or more natural persons, corporations, partnerships, limited liability companies, firms, trusts, trustees, governments, governmental authorities or other entities.

- (B) The following is the sole member of Seller: George Tomlin.

8. DEFAULTS AND REMEDIES.

(a) Default by Seller. If Seller fails to timely perform any of its obligations, covenants or agreements contained in this Agreement or if any of the representations and warranties made in Section 7 above are untrue when made or become untrue during the Option Term due to the act or omission of Seller, then Purchaser, at its option and in addition to all other remedies available at law or in equity, may: (i) specifically enforce the provisions of this Agreement, and (ii) cancel and terminate this Agreement and receive a refund of the Purchase Price from Seller and retain all rights against Seller for damages arising out of such failure or untruthfulness, and (iii) without waiving Purchaser’s other remedies in this Section, forbear the exercise of such remedies as Purchaser deems reasonably necessary so as to allow an opportunity to cure such failure or untruthfulness in a manner satisfactory to Purchaser in Purchaser’s sole and absolute discretion.

(b) Default by Purchaser. If Purchaser fails to timely perform any of its obligations,

covenants or agreements contained in this Agreement, then Seller, as its sole and exclusive remedy, may terminate this Agreement and retain the Purchase Price and Seller waives all rights or claims of Seller against Purchaser by reason of such failure, and upon such termination the Parties will be released from any and all liability under this Agreement except for those liabilities which expressly survive the termination of this Agreement.

(c) Attorneys' Fees. In any action or litigation between Purchaser and Seller as a result of failure to perform or default under this Agreement, the prevailing Party will be entitled to recover its reasonable attorneys' fees and court costs from the non-prevailing Party.

9. ASSIGNMENT. Purchaser may assign this Agreement and its rights under this Agreement without the necessity of obtaining the prior consent, written or otherwise, of Seller.

10. BROKERS' COMMISSIONS. Purchaser represents and warrants to Seller that no third party broker or finder has been engaged or consulted by Purchaser or through Purchaser's actions is entitled to compensation as a consequence of this transaction. Seller represents and warrants to Purchaser that no third party broker or finder, other than GBT Realty Corporation, McBride Real Estate and HP Realty Partners as brokers to the Purchase Agreement for the Property (to whom any commissions will be paid by the seller of the Property under the Purchase Agreement), has been engaged or consulted by Seller or through Seller's actions is entitled to compensation as a consequence of this transaction (any compensation payable to the brokers above arising out of the Purchase Agreement and not this Agreement, the Purchase Price, or Assignment Fee). Each Party shall indemnify, defend and hold the other Party harmless against any and all claims of any other brokers, finders or the like, claiming any right to commission or compensation by or through acts of such Party or such Party's partners, agents or affiliates in connection with this Agreement.

11. NOTICES. Any notice, request, approval, demand, instruction or other communication to be given to either Party under this Agreement must be in writing, and all deliverables from one Party to the other will be conclusively deemed to be delivered when personally delivered or when (a) hand-delivered, or (b) deposited for prepaid overnight delivery with an overnight courier such as UPS or other national overnight courier service, and such notices are addressed to the addresses provided on the signature pages of this Agreement or to such other addresses as either Party may have furnished to the other from time to time, in writing, as a place for the service of notice. All notices will be effective upon being sent in the manner described in this Section 11. However, the time period in which a response to any such notice must be given will commence to run from the date of receipt by the addressee of such notice. Rejection or other refusal to accept or the inability to deliver because of changed address of which no notice was given, will be deemed to be receipt of the notice as of the date of such rejection, refusal, or inability to deliver.

12. MISCELLANEOUS. All of the recitals above and all exhibits attached to this Agreement are incorporated into this Agreement by this reference. The section headings of this Agreement are for convenience only and must not be considered in the interpretation of the terms and provisions of this Agreement. This Agreement is binding upon and inures to the benefit of the Parties and their respective successors and assigns. The word "person" as used in this Agreement, includes all individuals, partnerships, corporations, or any other entities whatsoever. If any provision of this Agreement is unenforceable or inapplicable, the other provisions of this Agreement will remain in full force and effect as if the unenforceable or inapplicable provision had never been contained in this Agreement. This Agreement may be executed in counterparts. Electronic signatures (including scanned signatures in .PDF format) sent via e-mail will have the same force and effect as executed originals. This Agreement must be governed by and construed in accordance with the laws of the state in which the Property is situated. This Agreement constitutes the entire agreement between the Parties. No subsequent alteration, amendment, change, deletion or addition to this Agreement will be binding upon the Parties unless in writing and signed by both Parties. Time is of the essence in the performance of the obligations of the Parties under this Agreement. If any date, time period or deadline under

this Agreement falls on a weekend, a state or federal holiday, or any other day on which Title Company or the governmental office for the recordation of deeds is not open for business, then such date will be extended to the next occurring business day. As used in this Agreement, "business day" means any day other than a Saturday, Sunday or state or federal holiday. THE PARTIES AND EACH PARTY'S COUNSEL HAVE NEGOTIATED AND REVIEWED THIS AGREEMENT (OR IF ANY PARTY'S COUNSEL HAS NOT NEGOTIATED OR REVIEWED THIS AGREEMENT, THEN SUCH PARTY ACKNOWLEDGES THAT IT HAS HAD AN OPPORTUNITY TO HAVE ITS COUNSEL NEGOTIATE AND REVIEW THIS AGREEMENT BUT HAS DECLINED TO DO SO), AND THIS AGREEMENT CONSTITUTES AN ARM'S LENGTH TRANSACTION BETWEEN A SOPHISTICATED PURCHASER AND SELLER OF REAL PROPERTY. Accordingly, this Agreement (and any amendments to this Agreement) shall be construed as having been prepared by the Parties and not by any one Party. Consequently, any rule of construction to the effect that any ambiguities be resolved against the drafting Party shall not be employed in the interpretation of this Agreement or any amendments to this Agreement.

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

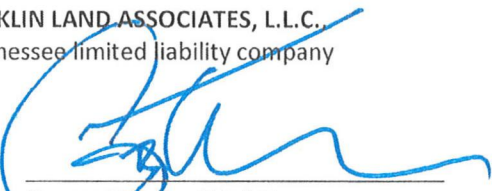
SELLER SIGNATURE PAGE TO REAL ESTATE PURCHASE AND SALE AGREEMENT

Seller has executed this Agreement effective as of the Effective Date.

SELLER:

FRANKLIN LAND ASSOCIATES, L.L.C.
a Tennessee limited liability company

By:


George Tomlin, Chief Manager

Date: July 25, 2024

Seller's Notice Address:

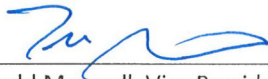
Franklin Land Associates, L.L.C.
Attn: George Tomlin
9010 Overlook Blvd.
Brentwood, TN 37027

PURCHASER SIGNATURE PAGE TO REAL ESTATE PURCHASE AND SALE AGREEMENT

Purchaser has executed this Agreement effective as of the Effective Date.

PURCHASER:

HENDERSONVILLE HOSPITAL CORPORATION,
a Tennessee corporation

By: 
Todd Maxwell, Vice President

Date: July 26, 2024

Purchaser's Notice Address:

Hendersonville Hospital Corporation
Attn: Clay Lehning, Real Estate Manager
2545 Park Plaza, 2nd Floor W.
Nashville, TN 37203

With a copy to:

Hendersonville Hospital Corporation
Attn: Andrew P. Gulotta, Esq.
2545 Park Plaza, 2nd Floor W.
Nashville, TN 37203

EXHIBIT A TO OPTION AGREEMENT

ASSIGNMENT AND ASSUMPTION OF PURCHASE AND SALE AGREEMENT

THIS ASSIGNMENT AND ASSUMPTION OF PURCHASE AND SALE AGREEMENT ("*Assignment*"), is made and entered into effective as of the Closing Date ("*Effective Date*"), by and between FRANKLIN LAND ASSOCIATES, L.L.C., a Tennessee limited liability company ("*Assignor*"), and HENDERSONVILLE HOSPITAL CORPORATION, a Tennessee corporation ("*Assignee*"). Assignor and Assignee are sometimes referred to in this Assignment collectively as the "*Parties*."

A. The Parties desire to assign and assume all of Assignor's right, title, interest and obligations in, to and under that certain contract by and between Shrihare LLC, a Tennessee limited liability company, and Assignor (as the same may be amended, collectively, the "*Purchase Agreement*"), to purchase approximately 3.6 acres, more or less, of vacant real property situated in Robertson County, Tennessee, located generally at the intersection of Hwy 31 W. and Raymond Hirsch Pkwy, White House, Tennessee, being a portion of a larger parcel, and being more particularly described in the Purchase Agreement, as provided in this Assignment.

IN CONSIDERATION of the agreements contained in this Assignment, and other good and valuable consideration, the receipt and legal sufficiency of which are acknowledged, the Parties agree to the following:

1. Assignment and Assumption. Assignor assigns, conveys, transfers, and sets over to Assignee, and Assignee accepts and assumes from Assignor, all of Assignor's right, title, interest and obligations in, to, and under the Purchase Agreement.

2. Indemnity. Assignor agrees to indemnify, defend and hold harmless Assignee from and against any and all claims and demands under the Purchase Agreement, based upon the acts or omissions of Assignor which first arise on or prior to the Effective Date. Assignee agrees to indemnify, defend and hold harmless Assignor from and against any and all claims and demands under the Purchase Agreement, based upon the acts or omissions of Assignee which first arise after the Effective Date.

3. Miscellaneous. All of the recitals above are incorporated into this Assignment by this reference. The section headings of this Assignment are for convenience only and must not be considered in the interpretation of the terms and provisions of this Assignment. This Assignment is binding upon and inures to the benefit of the Parties and their respective successors and assigns. If any provision of this Assignment is unenforceable or inapplicable, the other provisions of this Assignment will remain in full force and effect as if the unenforceable or inapplicable provision had never been contained in this Assignment. This Assignment may be executed in counterparts. Electronic signatures (including scanned signatures in .PDF format) sent via e-mail will have the same force and effect as executed originals.

The Parties have executed this Assignment effective as of the Effective Date.

ASSIGNOR:

FRANKLIN LAND ASSOCIATES, L.L.C.,
a Tennessee limited liability company

By: [EXHIBIT ONLY – DO NOT SIGN]
George Tomlin, Sole Member

ASSIGNEE:

HENDERSONVILLE HOSPITAL CORPORATION,
a Tennessee corporation

By: [EXHIBIT ONLY – DO NOT SIGN]
Joseph A. Sowell, III, Senior Vice President

REAL ESTATE PURCHASE CONTRACT

THIS REAL ESTATE PURCHASE CONTRACT (the "Agreement") is made and entered into as of the date of full execution of this Agreement (the "Effective Date") by and between SHRIHARE, L.L.C., a Tennessee limited liability company ("Seller") and FRANKLIN LAND ASSOCIATES, L.L.C., a Tennessee limited liability company ("Buyer").

WITNESSETH

For and in consideration of One Hundred Dollars (\$100.00), the agreements made herein, and other good and valuable considerations, the receipt and legal sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

1. Property. Seller hereby agrees to sell and Buyer hereby agrees to purchase, upon and subject to the terms and conditions herein set forth, that certain tract or parcel of land described as approximately 3 acres, more or less situated at 2929 Highway 31 W in White House, Robertson County, Tennessee being a portion (referred to as Lot 8) of the 18.4 acre property identified as Parcel 0741071 B 07700 (the "Property"), which is further depicted on **Exhibit "A"** which shall be presented by Seller and attached hereto within 10 days of Contract execution.

2. Earnest Money. \$25,000.00, to be deposited with Fidelity National Title, Nashville Office (hereinafter "Escrow Agent") within five (5) business days after the Effective Date, paid in accordance with the terms and provisions of this Agreement. All interest earned on the Earnest Money shall be the property of Buyer. Buyer and Seller shall indemnify and hold the Escrow Agent harmless from all damage, costs, claims and expenses arising from performance of its duties as Escrow Agent including reasonable attorneys' fees, except for those damages, costs, claims and expenses resulting from the gross negligence or willful misconduct of the Escrow Agent.

3. Purchase Price. \$3,150,000.00

4. Closing. Thirty (30) days after the end of the Inspection Period as extended (the "Closing Date"); provided however, Buyer at Buyer's sole discretion, may close sooner, but in any event no sooner than thirty (30) days after providing written notice of closing.

5. Obligations at Closing. At Closing, Seller shall deliver to Buyer, or Buyer's designee, a limited warranty deed conveying to Buyer or its designee good and marketable title in fee simple to the Property, subject only to exceptions acceptable pursuant to Paragraph 6 below, and all other documents required by the Escrow Agent for closing, pay for Seller's attorney's fees and all other cost incurred by Seller or required to be paid by Seller pursuant to any other provision of this Agreement, deliver improvements listed in Section 15 and in Exhibit B, and surrender the Property to Buyer. At Closing, Buyer shall pay the Purchase Price, as adjusted, pay for Buyer's attorney's fees, costs of recording the deed, transfer taxes, title, survey, and any costs associated with financing the purchase of the Property, and all other cost incurred by Buyer or required to be paid by Buyer pursuant to any other provision of this Agreement. Real property taxes will be prorated as of the Closing Date.

6. Inspection Period. Buyer shall be given 120 calendar days following contract execution for the completion of due diligence actions, environmental and geotechnical testing, the obtaining of all necessary permits and licenses, platting, and title investigation. In the event Buyer, at its sole discretion, determines after making such inspections that the Property or the transaction is undesirable, Buyer, at its sole option, upon written notice prior to the expiration of the Inspection Period or any extensions thereof, may declare the Contract terminated. In the event that Buyer does elect to terminate the Contract, neither Buyer nor Seller shall have any responsibilities to each other with regard to the Contract, and the Earnest Money shall be returned to the Buyer. Seller shall provide Buyer copies of all available materials pertaining to the Property to Buyer within ten (10) days after the Effective Date.

If Buyer terminates this Agreement before the end of the Inspection Period, all Earnest Money, except for \$100.00, which is paid as independent consideration to Seller, shall be returned to Buyer. If Buyer terminates this Agreement after the end of the Inspection Period, all Earnest Money shall be sent to Seller, unless Seller defaults under this Agreement, in which case the Earnest Money shall be returned to Buyer. Upon the termination of this Agreement pursuant to this subparagraph, the parties shall be relieved of any further obligations hereunder.

If Buyer intends to proceed with the Closing of its purchase of the Property, then Buyer shall, on or before the expiration of the Inspection Period, notify the Seller and/or Escrow Agent in writing as provided in this Agreement of Buyer's intent to proceed with the Closing of its purchase of the Property, subject to all of the other terms and conditions hereof.

Buyer may extend the Inspection Period for two (2) thirty (30) calendar day periods upon the payment to the Escrow Agent on or before the date of the expiration of the original time period of the Inspection Period, or extension thereof, of an amount of \$25,000.00 for the first extension period if required and \$50,000.00 for the second extension period if required, held in escrow per the terms and conditions described herein and shall be non-refundable except in the case of Seller default, but applicable to the Purchase Price at Closing.

6. Survey and Title. Buyer shall be responsible for obtaining an updated survey of the Property and a title policy commitment. Upon receipt of notice of any objections to title or survey, Seller shall have fifteen (15) days after receipt of such notice to satisfy or cure such objections to Buyer's satisfaction. If Seller fails or declines to satisfy the same within such period, the Buyer, at Buyer's option, may terminate the Agreement and all Earnest Money shall be returned to Buyer. Seller acknowledges that Seller is responsible for the removal of any tenant of the Property, and that any tenant must have vacated the property with sufficient notice under any applicable lease prior to the end of the Inspection Period, and Seller must provide Buyer with copies of all leases and all notices sent to tenants.

7. Commissions. Seller and Buyer warrant and represent to each other that they have not employed or dealt with any other real estate agent or broker relative to the sale and purchase of the Property, other than McBride Real Estate, HP Realty Partners, and GBT Realty Corporation whose Seven Percent (7%) commission and/or finder's fee shall be split 3% to McBride, 3% to HP Realty Partners, and 1% to GBT Realty Corporation to be paid by Seller at Closing. Each party hereby agrees to indemnify and hold harmless the other from and against any liability (including costs and reasonable attorneys' fees) incurred in the defense thereof to any other agents or brokers with whom such party may have dealt.

8. Representations and Warranties and Covenants of Seller. Seller warrants and represents and covenants to Buyer that there are no actions, suits or proceedings pending or threatened against, by or affecting Seller or the Property; Seller has the authority to convey the Property to Buyer without the joinder of any other person or entity; other than as disclosed to Buyer, there are no environmental hazards on the Property; on the Closing Date, Seller will not be indebted to any contractor, laborer, mechanic, materialmen, architect or engineer for work, labor or services performed or rendered, or for materials supplied or furnished, in connection with the Property for which any person could claim a lien against the Property; and the Property will be delivered to Buyer at Closing free and clear from any leases, contracts and tenants in possession. Each representation and warranty of Seller contained in this Agreement shall be true and accurate as of the date hereof and shall be deemed to have been made again at and as of Closing and shall be then true and accurate in all material respects.

9. Damage and Condemnation. Seller shall notify Buyer promptly upon the occurrence of any damage, destruction, taking or threat of taking affecting the Property.

10. Default. If Buyer defaults, Seller may terminate this Agreement by written notice to Buyer, whereupon the Earnest Money, and any other deposits, if any, hereunder shall be paid to Seller as full and complete liquidated damages for the default of Buyer as Seller's sole and exclusive remedy, in which event neither party shall have any further rights, obligations, or liabilities under this Agreement. If Seller defaults, Buyer may avail itself of the remedy of specific performance or terminate this Agreement by written notice to Seller, whereupon the

Earnest Money shall be refunded to Buyer as full and complete liquidated damages for such default and Seller shall reimburse Buyer for all out-of-pocket expenses.

11. Assignment. Buyer may at any time assign or transfer its interest in this Agreement, with notice to Seller. This Agreement shall be binding upon and enforceable against, and shall inure to the benefit of, the parties and their respective legal representatives, successors and assigns.

12. Applicable Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the state in which the Property is located.

13. Miscellaneous. Time shall be of essence in the performance of the terms and conditions of this Agreement. In the event any time period specified in this Agreement expires on a Saturday, Sunday or bank holiday on which national banks are closed for business, then the time period shall be extended so as to expire on the next business day immediately succeeding such Saturday, Sunday or bank holiday. For purposes of this Agreement, business days shall be Monday through Friday, excluding any Federal holidays. All captions, headings, paragraph and subparagraph numbers and letters and other reference numbers or letters are solely for the purpose of facilitating reference to this Agreement and shall not supplement, limit or otherwise vary in any respect the text of this Agreement. All references to particular paragraphs and subparagraphs by number refer to the paragraph or subparagraph so numbered in this Agreement. This Agreement supersedes all prior discussions and agreements between Seller and Buyer with respect to the purchase and sale of the Property. This Agreement contains the sole and entire understanding between Seller and Buyer with respect to the transactions contemplated by this Agreement, and all promise, inducements, offers, solicitations, agreements, representations and warranties heretofore made between the parties are merged into this Agreement. This Agreement shall not be modified or amended in any respect unless by a written Agreement executed by or on behalf of the parties to this Agreement in the same manner as this Agreement is executed. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which, collectively, shall be one and the same instrument. In addition, this Agreement may be transmitted between the parties via facsimile, and signatures transmitted by electronic mail shall be deemed originals and shall be binding upon the parties. Seller agrees that the terms of this Agreement shall be deemed confidential in nature and shall not be disclosed to any third parties by Seller without the prior written consent of Buyer. In the event of any litigation arising out of this Agreement, the party prevailing in obtaining the relief sought, in addition to all other sums that it may be entitled to recover, shall be entitled to recover from the other party its reasonable attorneys' fees and expenses incurred as a result of a litigation.

14. Notice. All notices shall be in writing and shall be deemed to have been duly given at the time and on the date when personally delivered, or upon being deposited with a nationally recognized commercial courier for next day delivery, to the addresses below, or upon delivery via pdf format sent by electronic mail. Rejection or other refusal to accept or inability to deliver because of changed address of which no notice was given shall be deemed to be in receipt of such communication. By giving prior notice to all other parties, any party may designate a different address for receiving notices.

15. Site Improvements. Seller is planning to complete the following site improvements before delivering the lot to Buyer: Seller intends to rough grade the site, stubbing utilities to the site, and creating an access road that benefits the entire 18.4 acre site by connecting Hwy 31 N with the portion of the site along Raymond Hirsch Parkway. Buyer's purchase price includes these improvements. Buyer shall be responsible for their own bioretention. The improvements listed above, schedule of completion, and what happens if Seller does not perform said improvements shall all be mutually agreed to via a Development Agreement which shall be attached to this Contract before the expiration of the Initial Inspection Period of The Contract as Exhibit B.

Buyer: Franklin Land Associates, L.L.C.
c/o GBT Realty Corporation
9010 Overlook Boulevard
Brentwood, TN 37027
Attn: Legal Dept.

Seller: Shrihare, L.L.C.
c/o Saumil Patel
Address: 1649 Foxland Blvd
Gallatin, TN 37066
Phone: (731)588-2690 731-514

SIGNATURES ON FOLLOWING PAGE

IN WITNESS WHEREOF, the parties have executed and sealed this Real Estate Purchase Contract, as of the day and year first above written.

BUYER:

FRANKLIN LAND ASSOCIATES, L.L.C.

By: 
Its: Authorized Agent
Date: 7/23/24

SELLER:

SHRIHARE, L.L.C.

By: 
Its: Member
Date: 7-23-2024

EXHIBIT A

To be replaced by Legal Description or Survey before Closing

Approximately 3 acres, more or less situated at 2929 Highway 31 W in White House, Robertson County, Tennessee being a portion(referred to as Lot 8) of the 18.4 acre property identified as Parcel 074107I B 07700

EXHIBIT B

To be replaced by mutually agreeable development agreement before the Expiration of the Initial Inspection Period

[SELLER AUTHORIZATION LETTER]

Franklin Land Associates, L.L.C.
c/o GBT Realty Corporation
9010 Overlook Boulevard
Brentwood, Tennessee 37027
Attention: Austin Rogers

Re: Authorization for Submittals in White House, TN, for real property located at Parcel # 0741071 B 07700 ("Property"), currently owned by SHRIHARE, L.L.C. ("Owner")

To whom it may concern:

As the current owner of real property described above, Owner hereby authorizes Franklin Land Associates, L.L.C., and its successors and assigns, to act on Owner's behalf to request and apply for all city, county, and state approvals necessary for the intended development of the Property, including, without limitation, submissions for rezoning, platting, and site, building, and utility permit applications.

Owner:

SHRIHARE, L.L.C.

By: V. A. Patel
Date: 7-23-24

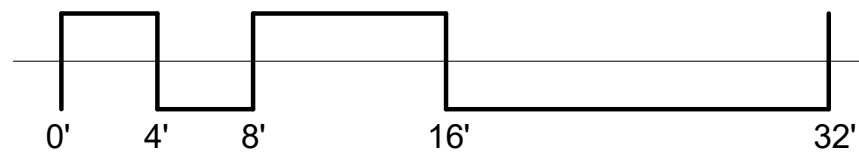
Attachment 10A

Floor Plan

7/18/2024 4:14:25 PM
THIS DRAWING IS THE PROPERTY OF HEREFORD DOOLEY ARCHITECTS. IT IS NOT TO BE REPRODUCED IN WHOLE OR IN PART. IT IS NOT TO BE USED ON ANY OTHER PROJECT. IT SHALL BE RETURNED UPON REQUEST. COPYRIGHT AS DATED HEREFORD DOOLEY ARCHITECTS. NOT VALID UNLESS SIGNED AND SEALED.



1 FLOOR PLAN
SCALE: 1/8" = 1'-0"



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F · 615 · 244 · 6697
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PROJECT
123456789

CLIENT #123456789

WHITE HOUSE FSR

CON

AHCA #23/100226-16465

William E. Hereford, III
AR # 96247

07/18/2024



DATES OF ISSUANCE

TITLE

SCOPE PLAN

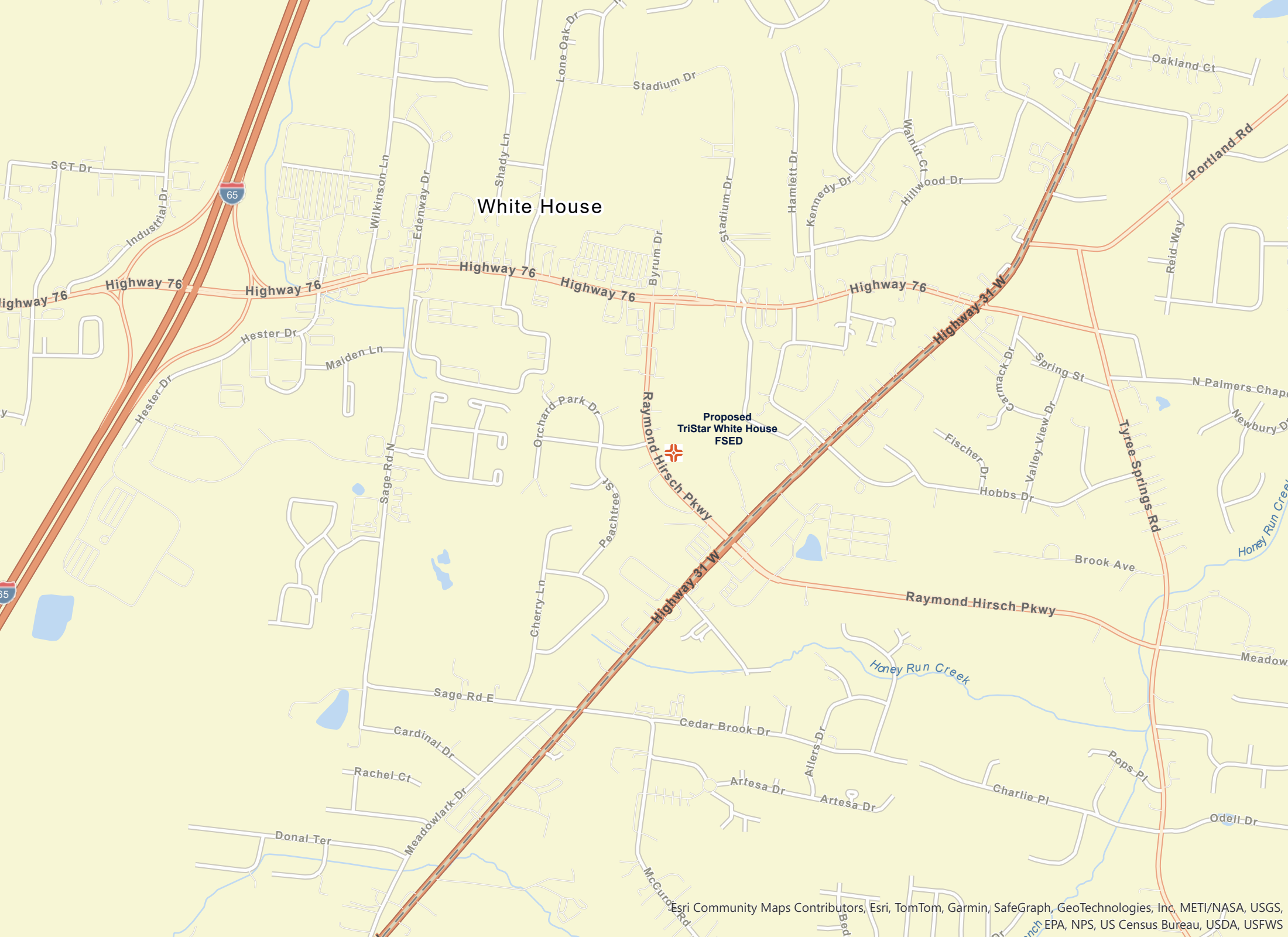
SHEET

A.2

Attachment 11A

Map of Major Roads in and around Service Area





White House

Proposed
TriStar White House
FSED

Raymond Hirsch Pkwy

Highway 31 W

Raymond Hirsch Pkwy

Highway 76

Highway 76

Highway 76

Highway 76

Highway 76

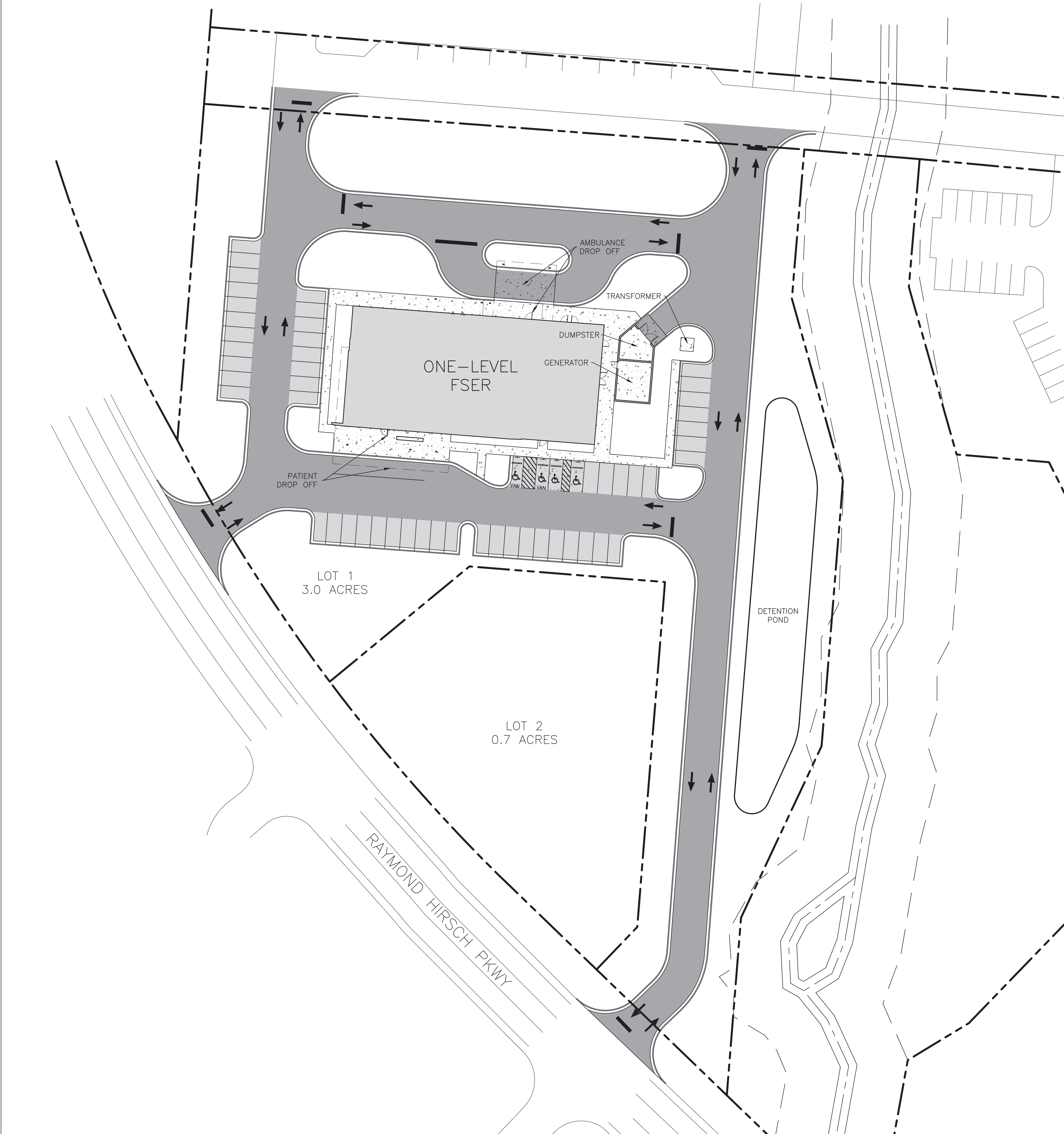
Highway 76

65

65

Attachment 12A

Site Plan



GENERAL SITE NOTES

- SITE LAYOUT FOR WHITE HOUSE FSER BY INGRAM CIVIL ENGINEERING GROUP, LLC.
- ORIGINAL TOPOGRAPHICAL INFORMATION IS BASED ON A PDF OF OF THE RAYMOND HIRSCH COMMERCIAL MIXED USE DEVELOPMENT BY KIMLEY HORN. THE ENGINEER, THE OWNER, OR ANY OF THE OWNERS CONSULTANTS SHALL NOT BE HELD RESPONSIBLE FOR THE ACCURACY OR COMPLETENESS OF THE INFORMATION.
- ALL CIVIL/SITE WORK ELEMENTS INDICATED TO BE CONSTRUCTED ON THE PLANS ARE TO BE BUILT IN STRICT ACCORDANCE WITH THE STANDARDS ADOPTED BY THE CITY OF WHITE HOUSE, UNLESS SPECIFICALLY NOTED OTHERWISE. ALL SITE WORK MUST ALSO COMPLY WITH THE CITY OF WHITE HOUSE ENVIRONMENTAL REQUIREMENTS AND FEDERAL EPA REQUIREMENTS.
- WRITTEN DIMENSIONS PREVAIL. DO NOT SCALE THESE DRAWINGS. PRINTED DIMENSIONS WHICH ARE OMITTED OR IN CONFLICT SHALL BE IMMEDIATELY REPORTED TO THE ENGINEER FOR REVIEW AND RESPONSE. DIMENSIONS ARE FROM FACE OF CURB / EDGE OF PAVEMENT AND FACE OF BUILDING, UNLESS NOTED OTHERWISE.
- DIMENSIONS LOCATING THE BUILDING IN RELATIONSHIP TO THE PROPERTY LINES HAVE BEEN PROVIDED FOR THE CONVENIENCE OF THE CONTRACTOR. WHERE POSSIBLE, COORDINATES CAN BE USED TO ESTABLISH PHYSICAL LENGTHS ALONG THE BUILDING PERIMETER. THE CONTRACTOR IS RESPONSIBLE FOR VERIFYING FROM STRUCTURAL AND ARCHITECTURAL DRAWINGS THE ACTUAL EXTENT OF THE BUILDING ON THE PROPERTY. BUILDING LAYOUT SHALL BE BASED SOLELY ON DIMENSIONAL INFORMATION PROVIDED ON STRUCTURAL AND ARCHITECTURAL DRAWINGS. DISCREPANCIES WHICH IMPACT SITE LAYOUT SHOULD BE IMMEDIATELY REPORTED TO THE ENGINEER.
- THE CONTRACTOR SHALL BE RESPONSIBLE FOR LOCATING ALL SITE FEATURES, (BUILDINGS, ROADS, PARKING, PADS, WALKS, ETC.) AND WILL EMPLOY A LAND SURVEYOR LICENSED TO PRACTICE IN THE PROJECT'S REGION OF CONSTRUCTION TO STAKE OUT AND MAINTAIN ALL REQUIRED CONTROL POINTS THROUGHOUT THE LIFE OF THE PROJECT. THE SURVEYOR SHALL CERTIFY TO THE ENGINEER, IN WRITING, THAT THE LAYOUT IN THE FIELD SUBSTANTIALLY CONFORMS TO THE LAYOUT INDICATED ON THE CONTRACT DOCUMENTS. LAYOUT DISCREPENCIES OR CHANGES SHOULD BE SO NOTED TO THE ENGINEER.
- THE CONTRACTOR SHALL BE HELD RESPONSIBLE FOR THE DAMAGE OR LOSS OF ANY REFERENCE POINTS, MONUMENTS, HUBS, AND STAKED LOT CORNERS DURING THE CONSTRUCTION OF THE WORK AND SHALL BEAR ANY COST ASSOCIATED WITH REPAIR.
- THE CONTRACTOR SHALL GIVE ALL NECESSARY NOTICES, OBTAIN ALL PERMITS, AND PAY ALL PERMIT FEES. THE CONTRACTOR SHALL CONFORM TO ALL STATE AND LOCAL CODES AND ORDINANCES AND RECEIVE APPROPRIATE APPROVALS WHERE REQUIRED PRIOR TO COMMENCEMENT OF THE WORK.
- MATERIALS AND PROCESSES OF CONSTRUCTION ARE THE SOLE RESPONSIBILITY OF THE CONTRACTOR. WHILE THE ENGINEER HAS PROVIDED, FOR THE CONVENIENCE OF THE CONTRACTOR, DRAWINGS OUTLINING CERTAIN REQUIRED OSHA MINIMUM SAFETY PRACTICES, THE ENGINEER DOES NOT ACCEPT RESPONSIBILITY FOR THE ACCURACY OF THE INFORMATION OR FOR VERIFYING THAT SUCH MEASURES ARE IMPLEMENTED ON SITE. MAINTAINING A SAFE ENVIRONMENT DURING THE PROMULGATION OF THE WORK IS THE RESPONSIBILITY OF THE CONTRACTOR. THE ENGINEER, THE OWNER AND OTHER CONSULTANTS, HAVE NO EXPERTISE, NOR ACCEPT ANY LIABILITY, IMPLIED OR OTHERWISE, FOR MATERIALS AND PROCESSES OF CONSTRUCTION.
- THE CONTRACTOR SHALL NOT COMMENCE ANY WORK WHICH IS NOT UNDER THE CONTROL OR OWNERSHIP OF THE OWNER WITHOUT WRITTEN PERMISSION FROM THE PROPERTY'S OWNER OR CONTROLLING INTEREST. WHERE CONTROLLING INTEREST IS A LOCAL, STATE, OR FEDERAL AGENCY, THEN APPROVAL FOR CONSTRUCTION SHALL CONSTITUTE AUTHORITY TO COMMENCE WORK.
- WHERE NOT SPECIFICALLY NOTED OTHERWISE, ALL CONCRETE FINISHES SHALL BE SLIP RESISTANT PER TECHNICAL SPECIFICATIONS.
- ALL ACCESSIBLE PARKING SPACES, INDICATED WITH THE GRAPHIC ACCESSIBLE SYMBOL, DENOTE ACCESSIBLE PARKING SPACES. THESE SPACES ARE DESIGNED TO CONFORM TO ADA AND XXX ACCESSIBILITY STANDARD SPECIFICATIONS. ALL INDICATED SPACES SHALL RECEIVE THE PAINTED SYMBOL AND APPROPRIATE IDENTIFICATION SIGNAGE. WHERE REQUIREMENTS ARE DIFFERENT OR IN EXCESS OF THESE, THE CONTRACTOR WILL ALLOW FOR THOSE ADDITIONAL REQUIREMENTS IN HIS PRICE AND PROMPTLY SUBMIT THEM TO THE ENGINEER.
- THE CONTRACTOR IS RESPONSIBLE FOR USING THE ONE-CALL SYSTEM OR OTHER MEANS TO CONTACT AND VERIFY LOCATIONS OF ALL UTILITIES. THE CONTRACTOR IS FULLY RESPONSIBLE FOR REPAIRS TO DAMAGED UTILITIES.
- THE CONTRACTOR IS TO CONTROL TRAFFIC FLOW DURING TIME OF CONSTRUCTION. ANY AND ALL TRAFFIC CONTROL IMPLEMENTED DURING THIS PROJECT SHALL CONFORM TO THE MANUAL OF UNIFORM TRAFFIC CONTROL DEVICES.
- ALL WORK WITHIN PUBLIC RIGHT-OF-WAY MUST BE IN ACCORDANCE WITH CITY OF WHITE HOUSE AND TENNESSEE D.O.T. REGULATIONS.

SITE NOTES

LEGEND: SITE

- PROPOSED HC ACCESSIBLE PARKING SPACE
- PROPOSED SIGN
- PROPOSED PRECAST WHEEL STOP
- PROPOSED TRAFFIC ARROW
- PROPOSED STOP BAR
- PROPOSED CROSS WALK MARKING
- PROPOSED HEAVY DUTY ASPHALT PAVEMENT
- PROPOSED LIGHT DUTY ASPHALT PAVEMENT
- PROPOSED HEAVY DUTY CONCRETE PAVEMENT
- PROPOSED LIGHT DUTY CONCRETE PAVEMENT
- PROPOSED CONCRETE WALK

Requirement	Variable No.	No. of Spaces
Medical Clinic		
2 spaces per exam room	11	22
Total Spaces Required =		22
Existing Spaces =		0
Demolished Spaces =		0
Proposed Spaces =		55
Total Provided Spaces =		55



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PROJECT # 123456789
CLIENT #123456789

WHITE HOUSE FSER

CON

AHCA #23/100226-16465



William E. Hereford, III
AR # 96247

07/18/2024



DATES OF ISSUANCE

SCOPE PLAN

TITLE SHEET

C200

Attachment 1N

Freestanding Emergency Department (FSED) Standards and Criteria

Freestanding Emergency Department (FSED) Standards and Criteria –Application Guide

As required, TriStar Hendersonville is using this document to address the Certificate of Need (CON) Criteria and Standards for Freestanding Emergency Departments (FSED).

1. Determination of Need in the Proposed Service Area

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

A. Geographic Isolation

Check the Box that Applies:



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



The applicant is not demonstrating geographic isolation for the proposed service area.

Data:

Utilizing the following table, provide the number of existing ED facilities in the proposed service area, as well as the distance of the proposed FSED from these facilities. This distance should be measured from the center of the county or zip code. If the proposed service area is comprised of contiguous Zip Codes, the applicant shall provide this information on all ED facilities located in the county or counties in which the service area Zip Codes are located. Add as many rows and/or columns to the table as necessary to adequately address this portion of the Determination of Need Standard.

The Project

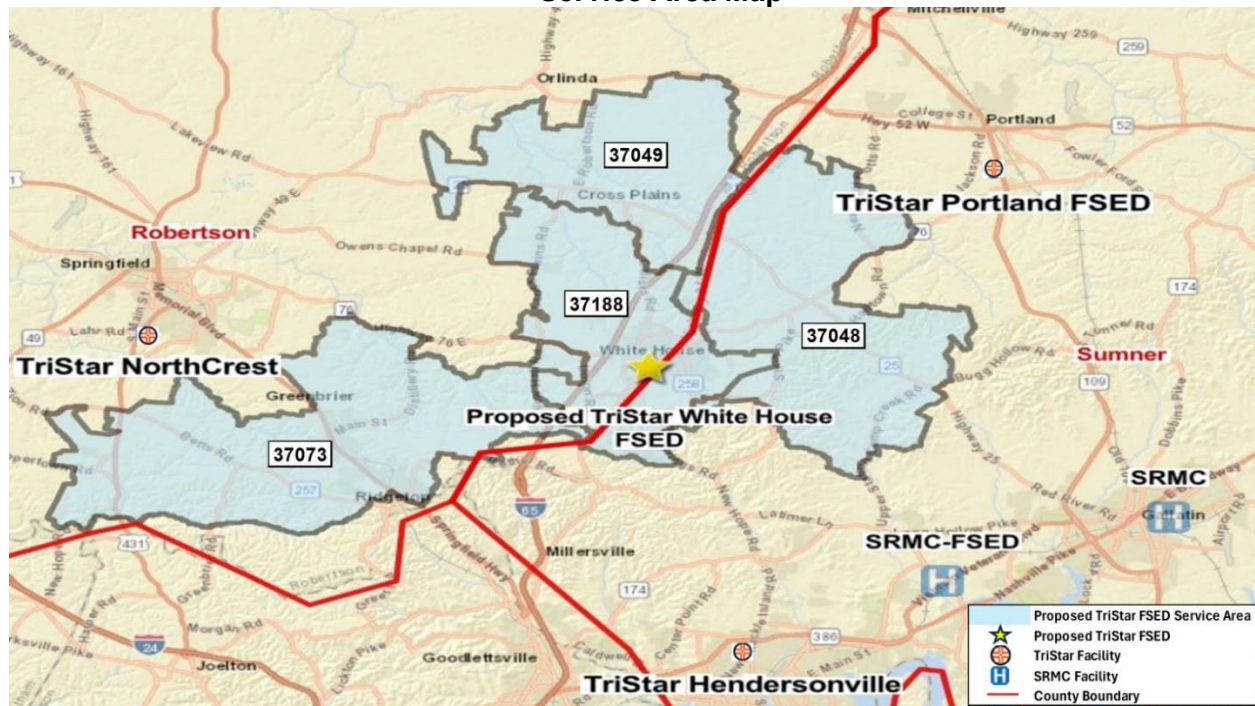
The Project is a freestanding emergency department (FSED) in White House, Robertson County, TN, that is approximately 13,087 square feet in size with 11 exam rooms, including 1 trauma room, a lab, imaging department, a nurse station, and associated support spaces.

The Service Area

The proposed TriStar White House FSED is central to the defined four (4) zip code service area of 37188 (White House), 37073 (Greenbrier), 37048 (Cottontown), and 37049 (Cross Plains). There are no existing emergency rooms in the service area. This service area incorporates the communities north of Hendersonville, east of Springfield, west of Gallatin, and south of the rural community of Orlinda. The White House (37188), Greenbrier (37073), and Cross Plains (37049) zip codes are primarily designated as Robertson County zip codes, and the Cottontown (37049) zip code is designated as a Sumner County zip code, but both the White House and Cottontown zip codes overlap both Robertson and Sumner

Counties. See Service Area Map below.

**Exhibit 1N-1
Service Area Map**



Source: ArcGIS

Interstate 65 and Highway 31 run north-south through the center of the service area and largely contribute to where emergency patients from the service area go. In 2023, over 50% of service area patient visits were to the south in Hendersonville or Nashville. The travel to Nashville or Hendersonville can be time consuming and unpredictable. Congestion along the interstate can force traffic onto two-lane roads through neighborhoods, commercial areas, and school zones. Moreover, traveling to Hendersonville and Nashville requires navigating off a steep ridge, which can be difficult in severe weather. The portion of TN-258 between White House and Hendersonville, “Tyree Springs Road,” is a heavily wooded and steep two-lane road that can cause travel times from White House to Hendersonville to take up to 40-45 minutes with commuter traffic, car accidents, and downed tree limbs after severe storms.

Travel to Springfield from White House, Cross Plains, and Cottontown is difficult. Travel from the service area to Gallatin is even more difficult. The roads going west or east are not as developed as the north-south highways, which must contribute to the low percentage of patient visits from the service area in Gallatin. The distances to existing EDs can be highly problematic when a patient is in need of emergency care for a life-threatening illness or injury.

TriStar is the preferred provider of emergency care for the patients residing in the service area, seeing over 77% of the emergency department patient visits from the service area in 2023. The Applicant, TriStar Hendersonville, cares for more emergency patient visits from the service area than any other provider (27%). The second greatest provider is the Applicant’s sister hospital’s ED at TriStar NorthCrest in Springfield (23%). TriStar Skyline in Nashville is third with 13%. In total, non-TriStar facilities serve just over 22% of the ED visits from this service area, including facilities in Sumner and Davidson Counties, despite being closer to parts of the service area than other facilities that are preferred by consumers.

Attachment 1N – FSED Criteria and Standards

TriStar Hendersonville's objective in this project is to shorten service area residents' travel time to emergency care, thereby reducing the isolation experienced by patients during a critical time when every minute is important for an emergency intervention. The proposed FSED will enhance geographic access to emergency services for patients in the service area and thus improve outcomes for patients with life threatening conditions. Geographic isolation is confirmed by community members.

"Roads from White House to Hendersonville or to the Portland ER are winding and 2 lane. If there is a wreck, you can be stuck for a bit . . . the interstate is backed up going north and south 60% of the time. 31W is 2 lane and winding in spots. Minutes matter. If there is snow or icy conditions, it is dangerous from White House to Hendersonville, Portland, Skyline, and NorthCrest."

– Teresa Sexton, White House Resident

"The addition of a TriStar Hendersonville freestanding ER to the White House area will offer a convenient and quick access option to residents who would typically travel to TriStar Hendersonville Medical Center for their ER services and, at times, can be more than a 45 minute drive."

– Representative Johnny Garrett

"We are in an isolated area surrounded by ridiculous traffic problems including the main roads through White House as well as the interstate 65 that leads to Nashville or Bowling Green . . . we truly just can't get there from here all too often."

– Jennifer Barton, White House Resident

"Due to the continuing population growth in the White House area and other nearby communities, the need for this type of high-quality emergency healthcare that WILL save lives is an immediate NEED. The busy I-65 corridor has frequent motor vehicle crashes, families have emergencies of all types, childhood illnesses, etc. would benefit from having a local-easy access TriStar ER in White House [that] will assist [with] more swift treatment."

– Darlene Allen, Cross Plains Resident

"When you are sick, you don't feel like driving a lot of miles to go get medical help. Plus there are a lot of winding roads between White House and Hendersonville and White House and Springfield."

– Penny Brown, Goodlettsville Resident

"A major interstate with constant construction going on would benefit from a close and local emergency room . . . I feel like quality hospital service is too far away from White House. People have to take long drives through backroads and crowded highways. The community is just too big for that to be the case anymore."

– Gavin Reeves, Greenbrier Resident

The Applicant

The Applicant is TriStar Hendersonville, a 159-bed acute care hospital located at 355 New Shackle Island Road, Hendersonville, Sumner County, Tennessee. It has been serving Sumner and Robertson County residents for nearly 45 years. The hospital is Joint Commission accredited and an accredited Chest Pain Center, certified Primary Stroke Center, Joint Commission Certified in Total Knee and Total Hip Replacement Surgery, and a Level III Trauma Center. It specializes in Minimally Invasive Robotic Surgical options which include Thoracic, Urologic, Gynecologic and General Surgery. The Birth Center at TriStar Hendersonville features private suites, breastfeeding support and the only Level II NICU north of downtown Nashville/Davidson County on the I-65 corridor.

TriStar Hendersonville provides the most inpatient and outpatient services in the Sumner-Robertson County region including cardiac catheterization, surgeries, and endoscopies. It is also the primary provider of Women's, Cardiac, Vascular, Gastroenterology ("GI") and Orthopedic services, among others, in Sumner and Robertson Counties. TriStar Hendersonville added/opened 4 incremental NICU beds, and will add a Med/Surg expansion of 24-beds at the end of this year. An additional 6 LDRPs are also underway and will be completed by the end of the year.

TriStar Hendersonville is one of the largest employers in Sumner County, with approximately 800 associates and a \$60 million payroll. The hospital is regularly recognized for its outstanding quality; please see Question 1N Criterion 22 below for a listing of TriStar Hendersonville's quality achievements.

Caring for the health of the White House community is not a new concept for TriStar Hendersonville. The hospital has been actively involved in White House for decades with a long-term vision for serving healthcare needs, demonstrating a commitment that offers a sense of security to the community. Over 21 years ago, TriStar Hendersonville recruited physicians to start a practice in White House, which now serves thousands of White House residents seeking healthcare close to home.

White House patients already prefer TriStar Hendersonville for their hospital services. Many White House patients have established relationships with providers at TriStar Hendersonville. In an emergency where a patient needs to be transferred to a hospital for additional care, it would be beneficial for the patient to see the physicians and specialists they know and trust. This is important for many reasons, including continuity of care with their existing providers.

The proposed TriStar Hendersonville White House FSED will be a much needed addition and a healthcare safety net in this community. For White House residents, it offers significant relief – the ability to receive care closer to home, eliminating the need for long drives to Hendersonville. This convenience is a key factor in improving patient experience and reducing stress during emergencies, providing a sense of reassurance in times of need.

Overview of the Area

The TriStar White House FSED service area comprises the four (4) zip codes east of Springfield, north of Hendersonville, west of Gallatin, and south of the rural community of Orlinda. These four zip codes collectively encompass the incorporated cities of White House, Greenbrier, and Cross Plains and the unincorporated community of Cottontown. This is a non-rural area as classified by Department of Health and Human Services that has become suburban in nature.

The service area population of 45,643 grew by 54.8% from 2000 to 2024 and is projected to grow nearly

Attachment 1N – FSED Criteria and Standards

another 8% from now through 2029. The White House zip code (37188) has grown most rapidly at a 91% pace between 2000 and 2020, with a projected 13.7% increase from now through 2029.

Exhibit 1N-2 below summarizes the population and growth rates for the service area zip codes:

Exhibit 1N-2
Population of Service Area

Zip Code	Zip City	2000	2010	2020	2024	% Change from 2000 to 2024	2029 (proj.)	2024-29 % Change
37188	White House	10,334	13,479	15,928	19,708	90.7%	22,412	13.7%
37073	Greenbrier	11,208	13,222	14,424	14,722	31.4%	15,210	3.3%
37049	Cross Plains	2,788	3,370	3,590	3,724	33.6%	3,850	3.4%
37048	Cottontown	5,156	6,161	7,104	7,489	45.2%	7,781	3.9%
TOTAL		29,486	36,232	41,046	45,643	54.8%	49,253	7.9%

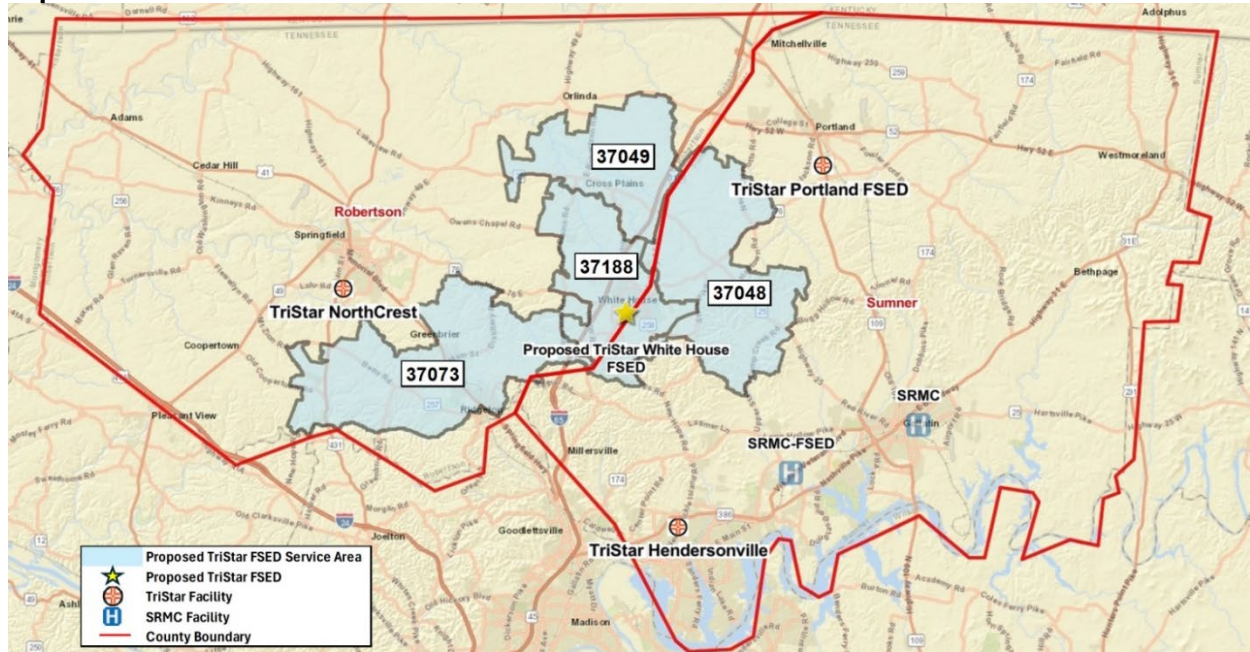
Source: ESRI

The City of White House is also experiencing growth in development with 8 industrial and commercial developments underway, and over 25 active residential projects that will bring more than 3,000 homes to White House.¹

The only EDs are outside of the service area. Having a FSED in White House will greatly diminish the distance service area residents must travel for emergency care.

Exhibit 1N-3 below presents a map that provides orientation to the EDs outside of the service area in Robertson and Sumner Counties.

Exhibit 1N-3
Map of Service Area and EDs Outside of the Service Area in Robertson & Sumner Counties



Source: Licensure facility search, Joint Annual Reports (JAR), ESRI/Google Maps.

¹ <https://whitehousetn.maps.arcgis.com/apps/dashboards/bb3cb00c54f9431da0c6630086036f8e>.

TriStar Hendersonville's ED is located in Hendersonville (37075). SRMC in Gallatin is owned and operated by HighPoint Health, a joint venture with LifePoint Health, which owns a majority of the interest, and Ascension St. Thomas, which owns a minority interest. Its main hospital ED is in the center of Gallatin (37066). It also operates the Sumner Station FSED on the border of the Gallatin/Hendersonville zip code line. In addition, TriStar Hendersonville operates a freestanding emergency room in Portland, Sumner County, the TriStar Portland FSED. This ED is also outside the service area.

TriStar NorthCrest is in Springfield and has an 18 treatment room ED. NorthCrest serves primarily Springfield and is also approaching capacity. This ED is outside the service area.

The TriStar White House FSED site is in Robertson County and is in zip code 37188. The Applicant estimates that 80% of the patient visits at the TriStar White House FSED will be patients from the four (4) service area zip codes, with the remaining 20% percent coming from outside the service area.

While the use of zip codes to define the service area is most conducive to analysis of population and ED utilization, TriStar Hendersonville expects that the proposed FSED in White House will serve the service area zip codes at essentially the same proportion, except for the eastern portion of 37073 (Greenbrier). Normal travel patterns for residents of the eastern side of the Greenbrier zip include travel to White House. Main Street in Greenbrier connects with State Route 76, which runs straight through the City of White House. As described in detail in 6N in the main application, while TriStar Hendersonville expects that most from the TriStar patient visits from the service area will shift to the TriStar White House FSED at an 80% rate, the projected shift from 37073 (Greenbrier) to the proposed TriStar White House FSED is anticipated at a reduced rate of 40% to account for the likelihood that most of the patient visits that come from the Greenbrier zip code will come from the eastern half of the zip code, closest to the proposed TriStar White House FSED.

The large service area of 155 square miles without local ED access is further highlighted by the distances and travel time from these communities to the existing EDs outside of the service area. **Exhibit 1N-5** presents the travel times between the relevant existing emergency facilities, none of which are in the service area. These distances range from almost 9 miles to over 30 miles; however, the drive times are most concerning. Travel times between these facilities can range from 20 minutes without traffic to 50 minutes with traffic. These travel times are far too long for a patient in need of emergency care, particularly for those experiencing a life-threatening condition such as a heart attack or stroke or injuries such as auto accident injuries. This analysis reveals a large geographic area that does not have timely access to care, which TriStar Hendersonville proposes to address.

As required by the FSED Guide, **Exhibit 1N-4** below reflects the travel distance (miles) from the center of each zip code in the service area and the centroid of each county to the nearest ED outside of the service area as well as the proposed TriStar White House FSED. Travel time (minutes) is presented in **Exhibit 1N-5** because travel time is the most important consideration when considering geographic isolation.

Exhibit 1N-4
Driving Distances from Zip Code and County Centroids to
Existing Emergency Departments and Proposed TriStar White House FSED

Emergency Department	Robertson County	Sumner County	37188 White House	37073 Greenbrier	37049 Cross Plains	37048 Cottontown	Distance in miles to Proposed TriStar White House FSED site
TriStar Hendersonville	25.2-25.8	16.0-18.7	14.8-19.1	18.4-18.8	21.6-25.2	13.7-17.1	12.9-14.8
SRMC	30.4-31.3	8.9-12.0	19.4-22.3	29.3-32.7	21.4-29.0	12.6-15.9	17.4-21.9
SRMC FSED	27.1-31.5	11.5-12.9	16.3-25.4	20.2-24.7	21.4-34.0	12.6-15.2	13.2-14.4
TriStar Portland FSED	25.8-28.7	8.6	14.3-17.7	27.5-28.2	15.2-16.2	7.4-8.0	12.2-17.3
TriStar NorthCrest	5.1	29.0-30.7	14.8-18.4	7.3-8.9	16.6-20.1	19.5-23.7	15.3-20.1
Proposed TriStar White House FSED	13.3-15.9	12.1-15.8	3.4-4.1	12.7-13.9	10.8-12.0	4.8	0.00

Source: Google Maps; National Bureau of Economic Research, ZIP Code Distance Database, "2022 centroid," <https://data.nber.org/distance/2022/>.

The State Health Plan Standards and Criteria for Freestanding Emergency Departments ("FSED Criteria and Standards") does not define "geographic isolation." It is up to the Applicant to determine what constitutes an isolated area or region. TriStar Hendersonville asserts that service area residents are geographically isolated due to the fact that there is a significant population base of over 45,000 residents in this area, which is growing and aging, without access to emergency services within a 15-minute drive. The closest provider is located more than 20 minutes away from most service area residents, and with the continued growth and aging of the population, as well as consistently increasing traffic congestion, residents need access to an emergency care provider in the service area.

Exhibit 1N-5 shows the mid-point of travel time estimates from the county and zip code centroids to the existing EDs outside of the service area and to the proposed TriStar White House FSED. The times that exceed 15 minutes are shown in bold.

Exhibit 1N-5
Travel Time in Minutes from Zip Code and County Centroids to
Existing Emergency Departments and Proposed TriStar White House FSED

Emergency Department	Robertson County	Sumner County	37188 White House	37073 Greenbrier	37049 Cross Plains	37048 Cottontown	Distance in minutes to Proposed TriStar White House FSED Site
TriStar Hendersonville	42	27	28	30	32	27	23

Attachment 1N – FSED Criteria and Standards

SRMC	50	17	37	45	35	13	33
SRMC FSED	44	20	30	35	31	23	24
TriStar Portland FSED	38	12	24	36	19	12	24
TriStar NorthCrest	13	46	27	15	29	34	31
Proposed TriStar White House FSED	22	24	7	21	14	10	0

Source: ESRI/ArcGIS Business Analyst, Midpoint of travel time estimates.

Travel times are critical when it comes to life threatening conditions such as heart attacks or strokes. With drive times to area hospitals ranging as high as 45 to 50 minutes with traffic, patients even when transported by EMS, can miss the “golden hour” when life saving and disability preventing treatment, such as Thrombolytics as well as other medications that can limit the damage done by a stroke or heart attack. It is important to remember that:

- In the United States, someone has a heart attack **every 40 seconds**.
- Every year, about 805,000 people in the United States have a heart attack.
- 1 in 6 people will have a stroke in their lifetime.
- There is **1 stroke every 40 seconds** in the United States.
- 1 in 10 people will have a seizure in their lifetime.

There is a common saying related to strokes that “Time is Brain.” The sooner a patient gets medical attention, the better their chances of surviving, recovery, and regaining their quality of life.

Residents of the service area lack timely access to emergency care. Since traffic can easily add 15 to 45 minutes to patient travel or transport to existing hospitals, this can significantly impact patient access to critical emergency care in a timely manner. Residents of the service area deserve to have more timely, local access to life saving care.

“Two years ago, while I was pregnant with my first child[,] my stepson experienced a reaction from a severe tree nut allergy that we were unaware of. Within minutes his throat began to swell, and he was covered in hives. Sumner Regional, TriStar Hendersonville, and TriStar NorthCrest are all an equal distance of 30 minutes from White House. We were faced with a toss-up decision when our child couldn’t breathe, a scenario that no parent should ever have to go through.”

– Helen Ankenbauer, Cottontown Resident

“My mother was bit on her face, in her sleep, by a brown recluse and had a severe allergic reaction. Anaphylaxis was a serious threat and we had to travel 40 minutes to Hendersonville Medical Center’s ER. In an event like that, time is of the essence and if we had a TriStar ER in White House we could have been there within 10-15 minutes. TriStar provides high quality throughout the region.”

– Tiffany Willis, Greenbrier Resident

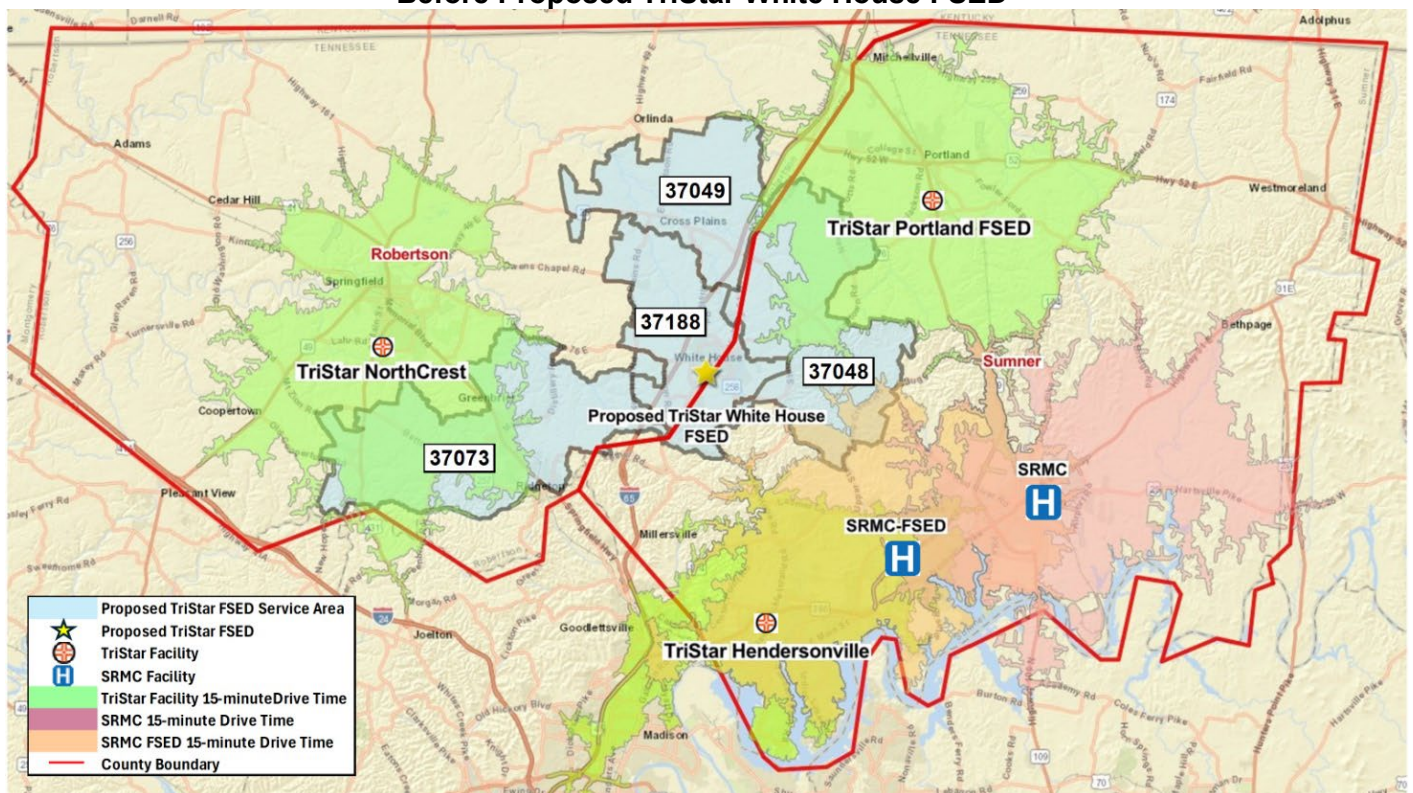
To address this geographic isolation, TriStar Hendersonville proposes to develop a FSED in White

Attachment 1N – FSED Criteria and Standards

House. **Exhibit 1N-6** presents a map of the service area existing EDs and the areas within the 15 minute drive time standard and **Exhibit 1N-7** shows the area within the 15 minute drive time for the proposed TriStar White House FSED location, and drive time contours around the proposed facility. While the FSED Criteria and Standards do not provide a recommended drive time, TriStar Hendersonville believes a 15 minute drive time is relevant given studies that show that patients drive an average of 8 miles and 17.3 minutes to access ED services.² As such, drive times that exceed these distances and times to access an ED indicate that patients experience less access and barriers to accessing care that exceed the average. While not every town, zip code or service area can support a FSED, TriStar Hendersonville believes that the data and analysis included in this application present compelling evidence that the TriStar White House service area has reached a critical mass of patients needing emergency services that can support a FSED—based solely on shifting patients from existing TriStar EDs that are the overwhelming choice of healthcare consumers in the service area today—while simultaneously decompressing TriStar’s existing EDs that are above or at ACEP capacity standards.

This map shows that the vast majority of the proposed service area—and the most highly populated portion—is currently outside the 15 minute driving time from existing facilities, particularly in the fastest growing part of the service area, 37188, the White House zip code.

Exhibit 1N-6
Service Area Map with Drive Time Contours
Before Proposed TriStar White House FSED



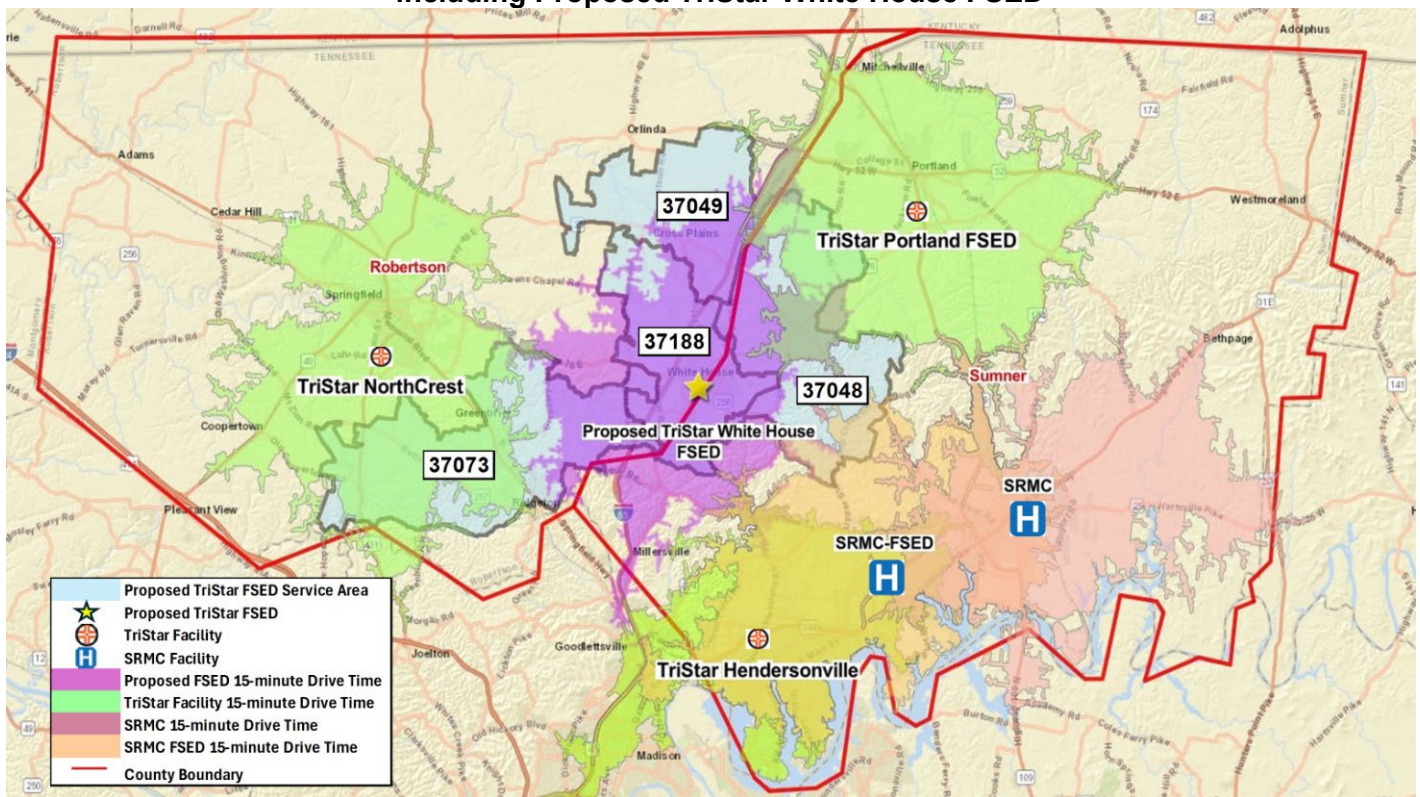
Source: Esri

² Tolpadi, A., Elliott, M.N., Waxman, D. *et al.*, National travel distances for emergency care. *BMC Health Serv Res* 22, 388 (2022). <https://doi.org/10.1186/s12913-022-07743-7>.

Attachment 1N – FSED Criteria and Standards

As shown in **Exhibit 1N-7**, the establishment of the proposed FSED in White House will not only ameliorate geographic isolation issues for the service area but also will provide an option for emergency services within 15 minutes for the most highly populated portion of the service area, White House, without significant overlap of the 15 minute drive time for existing facilities outside of the service area.

Exhibit 1N-7
Service Area Map with Drive Time Contours,
including Proposed TriStar White House FSED

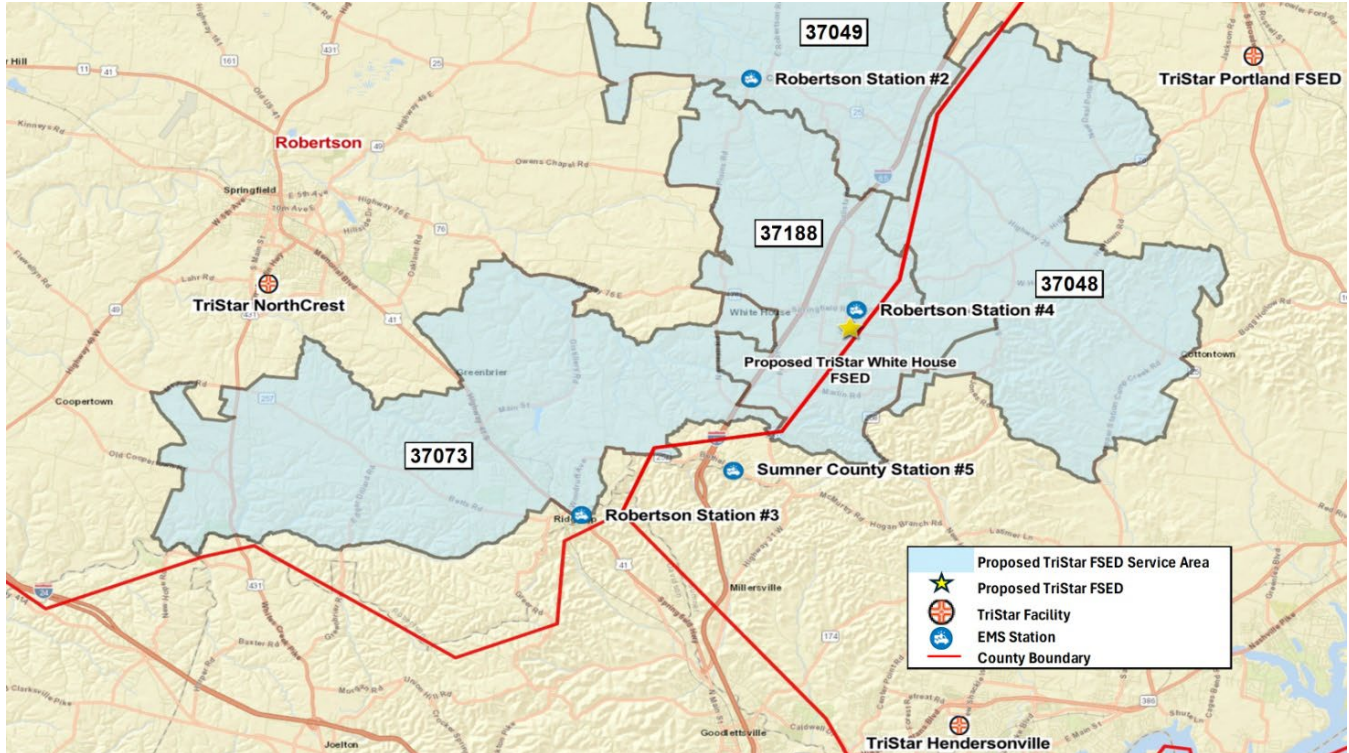


Source: Esri

EMS Access in the Service Area

Traffic congestion and EMS locations also impact emergency services for residents of the service area. Currently, there are 3 EMS stations in the service area. **Exhibit 1N-8** provides a map of the service area showing the location of EMS bases with advanced life support (“ALS”) and basic life support (“BLS”) transport capability.

Exhibit 1N-8 EMS Stations In and Around Service Area



As indicated below in **Exhibit 1N-9**, over 1,900 EMS drops from Robertson and Sumner EMS were to a TriStar facility in 2023, and TriStar Hendersonville and TriStar Portland FSED comprised over a third of the EMS drops from the service area zip codes. Additionally, as shown below in **Exhibit 1N-10**, patients from 37188 (White House) and 37073 (Greenbrier) generate a disproportionate share of all EMS drops from the service area (78.6%). For service area residents in need of emergency transport services, especially those in the White House zip code and the eastern side of the Greenbrier zip code, EMS providers must travel on often congested and unpredictable Interstate 65 or along two-lane roads through neighborhoods, commercial areas, and school zones to reach an existing ED, which can significantly delay access to care and increase the time EMS is occupied on medical transports. When an EMS ambulance run is outside of the service area, the vehicle is not available to carry other emergency patients who may need an ambulance, delaying access to care due to the unavailability of the EMS provider while it returns to base. The White House FSED will offer an alternative access point for EMS services and will significantly decrease EMS travel time for most service area residents.

"I live in Cottontown, Tennessee and I strongly support TriStar Hendersonville's application to put an emergency room in White House. I don't like having to drive 25 minutes to get to the nearest ER, it makes me uneasy thinking about having to travel all that time in an emergency health situation. Not to mention, they have to send an ambulance all the way out here and then it has to go all the way back, so that is double the time it would take to drive it. I know this firsthand because my uncle had a seizure due to alcohol withdrawals and it took them a long time for an ambulance to get to my house. Then, they had to turn right around and travel that same distance to get him to an emergency room. That is a lot of time that could have been saved if there was an

emergency room in White House. ”

– Kailey Anglea, Cottontown Resident

“Within the last year while herding up his cows, my stepfather was injured when he was thrown into a steel post by one of them. While EMS responded in less than 5 minutes when we called, they had to take him to Skyline which [is] over 30 [minutes] from our home. We had no idea if he had any major injuries at the time or not so the entire drive down there was so nerve wracking knowing all the things that could go wrong.”

– Jessica Morgan, White House Resident

**Exhibit 1N-9
EMS Drops by Destination ED**

Facility	Robertson County EMS	Sumner County EMS	Total Service Area EMS Drop	% SA EMS Drops
TriStar Hendersonville	394	253	647	33.6%
TriStar Skyline	461	129	590	30.7%
TriStar Portland FSED	18	38	56	2.9%
TriStar NorthCrest	577	2	579	30.1%
Other TriStar	42	10	52	2.7%
Total	1,492	432	1,924	100.0%

Source: TriStar 2023 Internal Data

**Exhibit 1N-10
EMS Drops by Pick-up Zip Code**

Zip	Robertson County EMS	Sumner County EMS	Total Service Area EMS Drop	% SA EMS Drops
37188 (White House)	618	196	814	42.3%
37073 (Greenbrier)	639	60	699	36.3%
37049 (Cross Plains)	189	26	215	11.2%
37048 (Cottontown)	46	150	196	10.2%
Total	1,492	432	1,924	100.0%

Source: TriStar 2023 Internal Data

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

Check the Box that Applies:



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



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

Data:

1. *Wait Times*

To demonstrate wait times in the proposed service area and demonstrate need, complete the below tables for each existing ED facilities in the proposed service area. For this analysis, service area is defined as including all of any county included in a ZIP Code area.

The Project

The proposed TriStar White House FSED is central to the defined four (4) zip code service area of 37188 (White House), 37073 (Greenbrier), 37048 (Cottontown), and 37049 (Cross Plains). There are no existing emergency rooms in the service area.

If one considers the whole of Robertson and Sumner Counties, however, which TriStar Hendersonville believes is inappropriate, there are four (4) EDs in Sumner County (TriStar Hendersonville in Hendersonville, SRMC in Gallatin, SRMC's Sumner Station FSED in Gallatin, and TriStar Portland ER in Portland, and one (1) in Robertson County, TriStar NorthCrest in Springfield. These EDs are outside of the service area for the proposed TriStar White House FSED. The geographic isolation of White House and the surrounding communities of Cross Plains, Cottontown and Greenbrier demonstrate the need for this Project.

The Applicant

TriStar Hendersonville is a 159-bed acute care hospital located in Hendersonville, Sumner County, Tennessee, and is part of the TriStar Division of HCA. In 2023, TriStar emergency departments cared for 77 % of the service area residents' emergency visits. TriStar Hendersonville treats the most service area patient visits at 27%. TriStar NorthCrest cares for 23% of service area patient visits. TriStar Skyline cares for 13% of service area ED patient visits. **Exhibit 1N-11** below shows the relative percentages of the ED patient visits where patients obtained emergency care in 2023. Non-TriStar providers are masked per THA data use policy.

**Exhibit 1N-11
% of ED Visits in Proposed TriStar White House FSED Service Area by Provider, 2023**

Hospital/ED	County	Visits	Service Area visits	%
TriStar Hendersonville	Sumner	4,466	16,628	26.9%
TriStar NorthCrest	Robertson	3,851	16,628	23.2%
TriStar Skyline	Davidson	2,172	16,628	13.1%
Other TriStar	Davidson & Others	1,164	16,628	7.0%

Attachment 1N – FSED Criteria and Standards

TriStar Portland FSED	Sumner	1,142	16,628	6.9%
Total TriStar	Sumner, Robertson, Davidson & Others	12,795	16,628	77.1%
Other EDs	Davidson & Others	3,833	16,628	23.0%
Total		16,628		100.00%

Source: THA Data 2023. Rounding causes totals to not foot.

TriStar Hendersonville's ED has 20 treatment rooms. Currently, TriStar Hendersonville is in the process of planning a 6 bed observation area (Critical Decision Unit ("CDU")) to help with patient flow in this very busy emergency department. However, such an area is not a long-term solution to the capacity constraints at the facility. In sum, TriStar Hendersonville's ED is highly utilized and experiencing significant capacity constraints.

Need for the Proposed TriStar White House FSED

As was demonstrated in the Geographic Isolation portion of this CON application, the primary need for this FSED is the geographic isolation of White House and its neighboring communities of Cross Plains, Cottontown, and a portion of the Greenbrier zip code. An additional reason for approving this CON is that it will relieve some of the capacity challenges at TriStar Hendersonville.

Much of the service area consists of residential neighborhoods – primarily in White House – with significant projected population growth. As shown in **Exhibit 1N-12**, the population of this service area is expected to grow by 7.9% from 2024 to 2029 (from 45,643 residents to 49,253 residents in 2029).

Exhibit 1N-12
Population of Service Area

Zip Code	Zip City	2000	2010	2020	2024	% Change from 2000 to 2024	2029 (proj.)	2024-29 % Change
37188	White House	10,334	13,479	15,928	19,708	90.7%	22,412	13.7%
37073	Greenbrier	11,208	13,222	14,424	14,722	31.4%	15,210	3.3%
37049	Cross Plains	2,788	3,370	3,590	3,724	33.6%	3,850	3.4%
37048	Cottontown	5,156	6,161	7,104	7,489	45.2%	7,781	3.9%
TOTAL		29,486	36,232	41,046	45,643	54.8%	49,253	7.9%

Data Source: ESRI

Exhibit 1N-13 below presents the service area population projected growth rate during the next five years by zip code area and overall.

Exhibit 1N-13
65+ Population as Percent of Total, 2024 to 2029

Zip Code Area	2024		2029		65+ Percent of Total	
	Age 65+	Total	Age 65+	Total	2024	2029
37188 (White House)	2,916	19,708	3,776	22,412	14.7%	16.8%
37073 (Greenbrier)	2,638	14,722	3,119	15,210	18.0%	20.5%

Attachment 1N – FSED Criteria and Standards

37049 (Cross Plains)	691	3,724	761	3,850	18.6%	19.8%
37048 (Cottontown)	1,457	7,489	1,717	7,781	18.6%	22.1%
Total	7,702	45,643	9,373	49,253	16.9%	19.0%

Source: ESRI, Age by Sex Profile, 2024-2029.

Older adults use emergency healthcare services at a higher rate than any other age group. The rapid growth and aging of the service area population will result in increased demand for healthcare services including emergency services. This is particularly true for the elderly population, which has been documented to have a higher incidence of emergency conditions than any other age cohort.³ In addition to published studies documenting that ED use rates increase as the population ages, analysis of use rates at the zip code level within the service area further confirms this.

Aging of the population is further demonstrated in **Exhibit 1N-13**. In 2024, the elderly comprised of approximately 17% of the service area population, which is similar to the State of Tennessee elderly population of 17.3%. This will increase to 19% in the next five years, with 37048 (Cottontown) and 37073 (Greenbrier) expected to exceed 20%. As the elderly population in the area continues to increase, new facilities are being built in White House to accommodate this growth. For example, Charter Senior Living of White House just recently opened in July 2024. The TriStar White House FSED will provide expanded access to residents of nursing home/assisted living facilities in the area that will reduce the need for travel into Hendersonville, Springfield, or Nashville, greatly reducing the burden faced by the patient, their families, and staff members.

“White House now has two senior living, skilled nursing and rehabilitation centers. If our senior citizens need help with emergent situations from their advanced cardiac and respiratory disease processes or injuries, falls, etc., it is very difficult for them to get out of the city and to a hospital.”

– Charles Roach, Springfield Resident

“The closest ER to me right now is 30 minutes away. It is something that weighs on my mind and I can only imagine that my elderly neighbors or the new parents in my community worry about it even more. Also, a TriStar ER is the best option for this community because those neighbors would not have to travel all the way to downtown for follow up care, instead they could just go to NorthCrest or Hendersonville if they need to once the situation isn’t an emergency.”

– Joseph Marlar, White House Resident

“Due to the aging population and influx of new residents, we need an emergency room in White House. Thankfully I have not had an emergency situation while living in White House, however, I have been taken by ambulance to Hendersonville Hospital following a fall, but it wasn’t a life-or-death situation. It would have been nicer to have treatment in my hometown and now that my husband and myself are in our 70’s – I think having an emergency room in White House would greatly benefit us should that need arise in the future.”

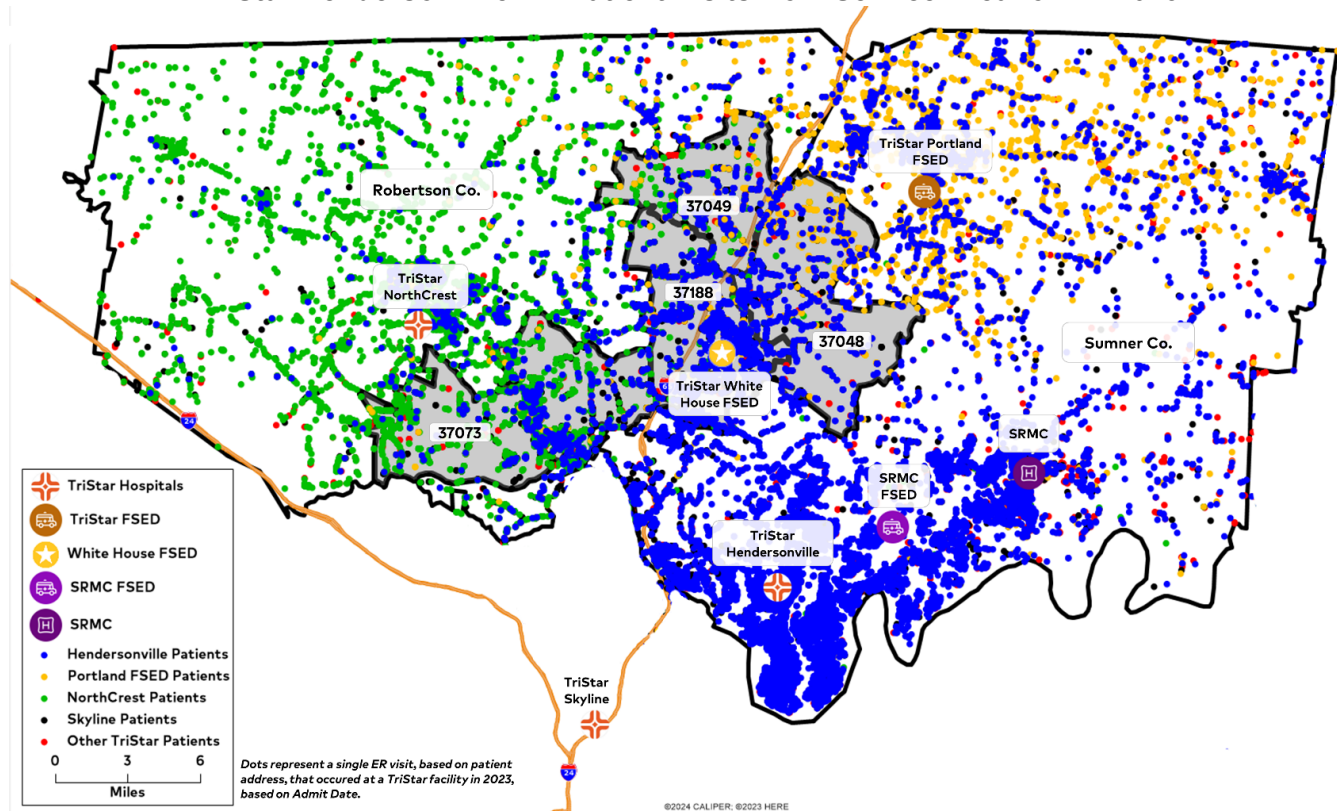
³ Ukkonen, M., Jämsen, E., Zeitlin, R., & Pauniahio, S. L. (2019). Emergency department visits in older patients: a population-based survey. BMC emergency medicine, 19(1), 20. <https://doi.org/10.1186/s12873-019-0236-3>

– Karen Fairbanks, White House Resident

The proposed TriStar White House FSED will provide expanded access for service area residents, including the elderly, upon its implementation. This is particularly important given the impending population growth in conjunction with the existing capacity constraints at the TriStar Hendersonville emergency room. The TriStar White House FSED will help ease capacity constraints at TriStar Hendersonville's emergency department.

Exhibit 1N-14 is a map showing the four (4) zip code service area and the areas from which TriStar's ED patient visits originated in 2023. The yellow star is the proposed location of the TriStar White House FSED. The blue dots represent the area from which TriStar Hendersonville patient visits were generated in 2023.

Exhibit 1N-14
TriStar Hendersonville ED Patient Visits from Service Area for CY 2023



Source: CY 2023 Internal Data.

Exhibit 1N-14 demonstrates that virtually all of TriStar Hendersonville emergency patient visits by service area patients in 2023 originated from an area closer to the proposed TriStar White House FSED than to TriStar Hendersonville.⁴ For TriStar Hendersonville's emergency patients, access to emergency care will be greatly enhanced. As service area patients choose the TriStar White House FSED over TriStar Hendersonville for their emergency care needs, much needed additional capacity will be created in the

⁴ Analysis of the data and given address indicates that less than one percent (1%) of TriStar Hendersonville's ED visits in 2023 from service area zip codes originated closer to TriStar Hendersonville than to the proposed site of the TriStar White House FSED.

main TriStar Hendersonville ED. This will result in reduction of some patients going to TriStar Hendersonville's ED, easing some of the capacity challenges at the main campus ED. **Exhibit 1N-14** also confirms that most emergency patient originating from the service area will be closer to the proposed TriStar White House FSED than to any existing emergency department.

Well over 95% service area emergency visits that originated from the service area who were cared for at the TriStar Hendersonville ED will be closer to the TriStar White House FSED. This highlights the easing of the geographic isolation of the residents of the service area by the placement of the TriStar FSED in White House.

Economic and Residential Development in the Service Area

The proposed FSED is needed to address the existing geographic isolation. As the service area grows the complications of suburban traffic in a rural road system will exacerbate the need for the TriStar White House FSED.

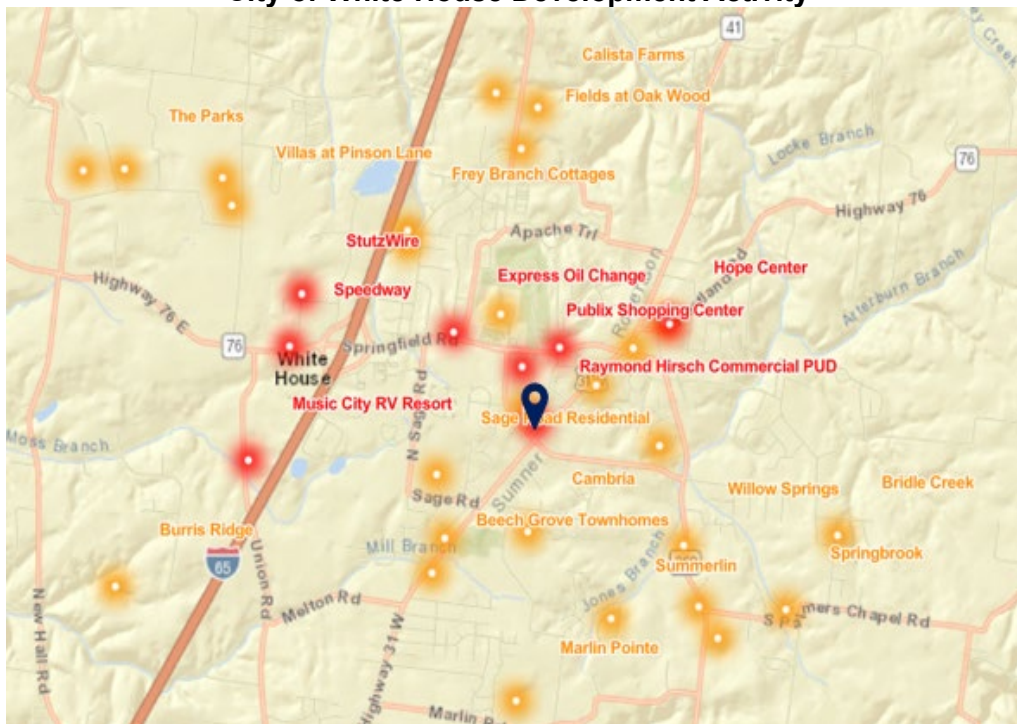
As discussed in response to Question 3N in the main application, there is significant expected population growth in the White House area during the next five years. That growth will put additional stress on the already over capacity ED at TriStar Hendersonville. With 11 ED treatment rooms in White House, the current and projected service area population will benefit from having ED care in its community with much shorter travel times to ED care.

The White House zip code 37188 has nearly doubled in size from 2000 to 2024 and increased nearly 44.6% from 2010 to 2024. Population counts are expected to continue to increase based on population forecasts, nearly 13.7% between 2024 and 2029.

The City of White House's significant pipeline of planned developments including both residential and commercial projects indicate that the forecasted population increase of 13.7% over four (4) years is likely understated. Currently, the City of White House⁵ has 27 active residential projects underway, ranging from preliminary approvals to those under construction. These projects include a variety of residential developments from single family homes to townhomes to multi-family residential buildings. The non-residential projects include 8 approved industrial/commercial developments, including a shopping center, convenience store, RV resort, and other commercial developments. **Exhibit 1N-15** is a graphic depiction of the White House city development activity, which will put additional stress on existing traffic infrastructure. Each red and yellow circle represents one of the projects underway in the city of White House.

⁵ The boundaries of the White House zip code, 37188, extend beyond the boundaries of the City of White House.

Exhibit 1N-15
City of White House Development Activity



Source: City of White House, circles represent projects as of July 2024.

Of the 27 active residential projects, 25 are currently under construction. Since 2020, over 2,700 single family homes have been approved or are in the approval process and 680 multifamily units have been approved. This total over 3,380 new residential units in line for development since 2020. Once all the projects are completed, there will be more than 3,000 additional units/homes in the City of White House. With more than 3,000 additional residential units in the aggregate, the future population of 37188 (White House) will exceed the 13.7% (3,780 person) increase predicted by ESRI in that zip code which has been incorporated into this CON application and presented in **Exhibit 1N-11** above. Using the average for residents per household for Robertson and Sumner Counties of 2.7,⁶ three thousand (3,000) new residences equals 8,100 additional residents (more than double the prediction model).

“White House has grown tremendously in the past 7 years and the only ER facility that we have access to is either the free standing TriStar ER in Portland, TN. There’s also the ER at TriStar Hendersonville hospital. Both are excellent, but to have something closer will be fantastic.”

– Kelly Parcher, Cottontown Resident

“White House is rapidly growing. This facility would save lives. I live in this community and my family and friends would benefit from a stabilizing location when minutes matter most. HCA would be welcomed in this community.”

⁶ Tennessee Average household size by County (indexmundi.com).

– Jodi Cunningham, White House Resident

“White House needs an ER because it will greatly reduce the time it takes to get lifesaving care . . . due to population growth, it is an urgently needed addition. Population is continuing to grow, with many thousands more people that have moved in since 2022.”

– Michael McDaniel, White House Resident

Population Growth and Development Impact Timeliness of ED Services

There is no doubt that the area development and anticipated population increases in the White House area will contribute to the isolation of this area from emergency services.

When it comes to life threatening conditions such as heart attacks or strokes, time is of the essence, and every minute counts. As population continues to increase in the area, patients, even when transported by EMS, can miss the “golden hour” for life-saving and disability preventing treatment, such as thrombolytics and other medications that can limit the damage done by a stroke or heart attack. It is important because:

- In the United States, someone has a heart attack every 40 seconds.
- Every year, about 805,000 people in the United States have a heart attack.
- 1 in 6 people will have a stroke in their lifetime.
- There is 1 stroke every 40 seconds in the United States.
- 1 in 10 people will have a seizure in their lifetime.

Reduced travel and transport times to ED services are directly linked to improved outcomes including lives saved. For example:

Condition	Clinical Outcomes⁷	# of TriStar FSED Patients in 2023
Cardiac Arrest	Survival Rates: 22% at 0 Minutes 8% at 10 Minutes 3% at 20 Minutes	103
Stroke	1.9 million neurons die every minute a stroke goes untreated	122
Sepsis	1-year mortality risk increases 10% for every hour delay in antibiotic administration	517

⁷ Cardiac: Yoshikazu, Goto. *Relationship Between the Duration of Cardiopulmonary Resuscitation and Favorable Neurological Outcomes After Out-of-Hospital Cardiac Arrest: A Prospective, Nationwide, Population-Based Cohort Study.* *Journal of the American Heart Association*, 2006 March; 115.002819; Stroke: Saver JL. *Time is brain--quantified.* *Stroke.* 2006 Jan;37(1):263-6; Sepsis: Peltan et al. *ED Door-to-Antibiotic Time and Long-term Mortality in Sepsis.* *Chest.* 2019 May;155(5):938-946.

Attachment 1N – FSED Criteria and Standards

Confirmed in the above chart, the sooner a patient gets medical attention, the better their chances of surviving, recovery, and regaining their quality of life. This proposed FSED will offer a vital access point to emergency care for residents of the service area in an easily accessible location.

The proposed FSED is designed primarily to better serve TriStar Hendersonville's existing patient base by providing a more convenient access point closer to where these patients reside. By patient choice, it will result in a shifting of TriStar patient visits from the service area to the TriStar White House ED. This will help ease capacity constraints at the host hospital while benefiting consumers through enhanced access.

Wait Times

There are no EDs in the service area. Despite the four (4) zip code service area, the FSED Standards and Criteria require that the data provided include the entirety of Robertson and Sumner Counties. TriStar Hendersonville submits that including these entire counties is not appropriate in this circumstance where the area to be served is very limited, only 4 of 19 zip codes in the two counties. FSEDs tend to draw emergency patients from a geographic area close to the FSED. Considering data from all 19 zip codes covering all of both Sumner and Robertson counties is simply unreasonable.

Nevertheless, because the Criteria require it, the identity of all EDs in the two counties follows.

Within the counties in which a portion of the service area sits, there are three hospitals, TriStar Hendersonville and SRMC in Hendersonville and Gallatin respectively, and TriStar NorthCrest in Springfield. There are also two FSEDs in Sumner County, in Portland and in Gallatin. The Centers for Medicare and Medicaid Services (CMS) does not separately report wait time for the FSEDs as their data is encompassed under the host hospital's single provider number. Therefore, only the data of the three hospitals in Sumner County and Robertson County, although all fully outside the service area, is presented in this wait time analysis as required by the Standards and Criteria – with the FSED data encompassed within the individual hospital's data.

Exhibit 1N-16

Measure: OP-18 Median Time from ED Arrival to ED Departure for Discharged Patients

Emergency Department	Volume	Timeframe	ED Time/Score	TN Average	National Average
TriStar Hendersonville	High	7/1/22 - 6/30/23	162	195	212
SRMC	High	7/1/22 - 6/30/23	155	195	212
NorthCrest	Low	7/1/22 - 6/30/23	148	132	125

Source: CMS Medicare Compare, updated June 30, 2024.

As documented throughout the CON application, TriStar Hendersonville's ED is extremely busy and faces significant capacity constraints. As the CMS data presented in the Quality section of this Attachment 1N evidences, TriStar Hendersonville's wait time performance is obviously being affected by the volume of patient visits it has. TriStar Hendersonville wants to reduce its wait times.

Exhibit 1N-17 demonstrates the visits per treatment room for the EDs outside the service area, but within the two counties in which the service area is located.

Exhibit 1N-17
Visits per Treatment Room

Emergency Department	Total Visits 2022	# of Rooms 2022	# Visits per Room	ACEP Low Range	ACEP Mid-Range	ACEP High Range
Exceeded ACEP Range						
TriStar Hendersonville	37,932	20	1,897	1,522	1,386	1,250
TriStar Portland FSED	12,432	8	1,554	1,250	1,080	909
SRMC FSED	12,165	8	1,521	1,250	1,080	909
Within ACEP Range						
TriStar NorthCrest	24,098	18	1,339	1,389	1,320	1,250
Below ACEP Range						
SRMC	26,678	26	1,026	1,389	1,320	1,250

Source: Hospital Joint Annual Reports, Search site <https://apps.health.tn.gov/PublicJARS/Default.aspx> American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 116-117; mid range is calculated as the average of low and high ranges

As shown, the TriStar Hendersonville ED, the TriStar Portland FSED and the SRMC FSED exceed the ACEP ranges, with TriStar Hendersonville—the facility from which the largest number of ED patient visits are expected to shift to the proposed FSED— well-above the highest number of visits per room in the ACEP ranges. In addition, TriStar NorthCrest is above the mid-range and approaching the low range guideline. SRMC is the only facility in the two counties that is below all ACEP ranges.

By establishing an access point in White House, many of TriStar Hendersonville's patients who reside closer to the TriStar White House FSED will likely choose the closer more convenient option. This will result in a shift of ED volume from TriStar Hendersonville's main campus ED to the proposed TriStar White House FSED, optimizing patient flow at both locations and reducing the frequency of volume surges at TriStar Hendersonville.

There will likely be a shift in ED patient visits from other TriStar facilities too, such as TriStar NorthCrest and TriStar Skyline.

The median time from ED arrival to ED departure compiled by CMS for TriStar Hendersonville is shown by CMS to be 162 minutes. See **Exhibit 1N-16** above. CMS also designates each hospital as high volume, medium volume or low volume and then identifies the average time for hospitals within each volume grouping to calculate the average by state and national for comparative purposes to a defined peer group. TriStar Hendersonville's median wait time is significantly below its comparable Tennessee (195 minutes) and National times (212 minutes), but it is higher than TriStar Hendersonville would like, which underscores the need for establishment of a FSED in White House to provide care to some of the patients who would otherwise choose to go to TriStar Hendersonville for their care.

TriStar Hendersonville is well above the ACEP standards for ED visits per room. At the same time, it is well below Tennessee and National average wait times regardless of its visits per room. This is due to the benchmark expectations of all TriStar facilities and HCA's focus nationally on improving the timeliness of care offered by its EDs.

Likewise, as shown on the OP-23 table (**Question 6**), TriStar Hendersonville is well below the Tennessee and National measure of Left Without Treatment (“LWOT”) percentages. This is also due to the emphasis in TriStar ED operations on ensuring patients are seen by a provider quickly, so they do not get discouraged by the wait time and leave.

Data:

2. Visits per Treatment Room

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

Visits per Treatment Room

There are no emergency rooms in the service area. The service area zip codes are in Robertson and Sumner Counties. TriStar Hendersonville, the host hospital for this project, has the highest number of visits per room of all emergency providers. Visits per treatment room for outside the service area providers in Robertson and Sumner County EDs are presented in **Exhibit 1N-18**.

Exhibit 1N-18
Visits per Treatment Room in Existing ED Facilities in Robertson and Sumner Counties

Emergency Department	Year	Total Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP High Range
TriStar Hendersonville	CY 2022	37,932	20	1,897	1,550	1,212
TriStar Portland FSED	CY 2022	12,432	8	1,554	1,250	909
SRMC	CY 2022	26,678	26	1,026	1,389	1,250
SRMC FSED	CY 2022	12,695	8	1,587	1,250	909
TriStar NorthCrest	CY 2022	24,098	18	1,339	1,389	1,250
Total / Average	CY 2022	113,835	80	1,423	1,366	1,106

Sources: 2022 Hospital Joint Annual Reports for each hospital and American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 116-117.

TriStar Hendersonville significantly exceeds ACEP benchmark ED capacity levels for both low-range and high-range EDs, providing 37,932 ED visits in 20 rooms in 2022. SRMC FSED also exceeds its ACEP benchmarks while SRMC is below the ACEP range; however, this shows that SRMC has the capacity to accommodate future volume growth at its ED.

Given the further increase in ED volume at TriStar Hendersonville since 2022, there is even more compelling reason for implementation of the TriStar White House FSED. **Exhibit 1N-19** below is the

three-year trend of ED visits at TriStar Hendersonville.

Exhibit 1N-19
TriStar Hendersonville ED
Visits per Treatment Room, Calendar Years 2021 through 2023

Timeframe	Total Visits	# of Rooms	# Visits per Room	ACEP Low Range	ACEP High Range
CY 2021	35,487	20	1,774	1,522	1,250
CY 2022	37,932	20	1,897	1,550	1,300
CY 2023	39,089	20	1,954	1,600	1,212

Sources: 2021-2022 Hospital Joint Annual Reports, 2023 Internal Data; American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 116-117.

As shown above in **Exhibit 1N-19**, TriStar Hendersonville visits per room in calendar year 2022 reached 1,897, a 7% increase from 1,774 in 2021, increasing again to 1,954 visits per room in 2023 using internal data. This confirms TriStar Hendersonville is facing significant capacity constraints, which ultimately limit access to care. TriStar Hendersonville visits per room statistics applied to ACEP planning guidelines as presented in **Exhibit 1N-18** and **1N-19** above confirm the need for TriStar Hendersonville to increase its ED capacity. Thus, establishing the TriStar FSED in White House will both provide access to a geographically isolated area and will help decompress some of the volume at the TriStar Hendersonville main campus ED.

The FSED Standards and Criteria ask for utilization data at ED facilities in the service area. There are none. As for the counties in which the service area sits, **Exhibit 1N-20** shows that data.

Exhibit 1N-20
CY 2020-2022 ED Visits in Sumner and Robertson County EDs

Hospital ED	CY 2020	CY 2021	CY 2022
TriStar Hendersonville (Out of Service Area)	29,830	35,487	37,932
SRMC (Out of Service Area)	29,974	29,185	26,678
SRMC FSED (Out of Service Area)	7,921	10,649	12,165
TriStar Portland FSED (Out of Service Area)	9,794	11,318	12,432
Total ED Visits in Sumner County	77,519	86,639	89,207
TriStar NorthCrest Medical Center (Out of Service Area)	29,097	22,009	24,098
Total ED Visits in Robertson County	29,097	22,009	24,098
Total ED Visits Robertson/Sumner Counties	106,616	108,648	113,305

Source: Hospital Joint Annual Report for the respective year; note TriStar Hendersonville report for 2020 and 2021 included TriStar Portland utilization which was also separately reported in its own Joint Annual Reports for those two years. Above information was adjusted to separate TriStar Portland from the TriStar Hendersonville data.

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

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

Check the Box that Applies:

- ☐ The applicant is demonstrating low quality of emergency care in the proposed service area. If this box is checked the applicant must provide the information below.
- ☒ The applicant is *not* demonstrating low quality of emergency care in the proposed service area.

Data:

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

Not applicable. The Applicant is not applying under a Low Quality of Care at Existing Emergency Department in the Service Area criteria.

Quality of Care Provided at Existing ED Facilities in the Proposed Service Area: Tables 1C (1-8)

Measure: OP-1 Median Time to Fibrinolysis						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-2 Fibrinolytic Therapy Received Within 30 Minutes						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-4 Aspirin at Arrival						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						

Measure: OP-5 Median Time to ECG						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
Measure: OP-20: Door to Diagnostic Evaluation by a Qualified Medical Personnel						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-21 ED-Median Time to Pain Management for Long Bone Fracture						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						
Measure: OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or HemorrhagicStroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
ED 1						
ED 2						
ED 3						

D. Other Applicable Data Related to Need and Capacity

Check the Box that Applies:



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



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

Data:

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

Utilization Factors Impacting Upon Capacity Constraints

Exhibit 1N-21 below provides the percentage of behavioral health and high acuity ED patient visits treated by TriStar’s ED providers in Sumner and Robertson Counties. The statewide average data in the table are based on Hospital Discharge Data System (“HDDS”) for 2021, as it is the most current data available to the Applicant at this time.

**Exhibit 1N-21
Additional Data to Demonstrate Need in the Proposed Service Area**

Emergency Department	% of Behavioral Health	Statewide Average 2021	% of Level I or II	Statewide Average 2021	% of Ages 65+	Statewide Average 2021
TriStar Hendersonville	2.80%	1.8%	68.0%	57.3%	25.6%	21.2%
TriStar Portland FSED	2.60%		52.6%		13.9%	
TriStar NorthCrest	3.70%		57.2%		23.9%	

*Sources: 2023 Internal data for TriStar facilities; HDDS data for 2021 for statewide averages
For Percentage Level I or II, Emergency Department cases identified by CPT codes 99281, 99282, 99283, 99284, 99285 - Outpatient Only.
Level I and II cases identified by CPT codes 99285, 99284 - Outpatient Only.
For Behavioral Health and Percent Elderly, ER Flag utilized, and thus includes both inpatient and outpatient ED visits.*

Exhibit 1N-21 above shows that:

- According to 2023 internal data, 2.8% of TriStar Hendersonville’s ED visits and 2.6% of TriStar Portland were behavioral health visits. Additionally, the percentage of ED visits for behavioral health at TriStar Hendersonville’s sister facility, TriStar NorthCrest, was 3.7%.⁸

⁸ In order to determine the percentage of behavioral health visits for CY2023, the Applicant looked at internal data for inpatient and outpatient ED visits that were categorized using “behavioral health” as the service line. This service line takes “behavioral health” and “medical psychiatry” DRG codes into consideration, as well as other primary indicators, including the primary CPT code, where necessary.

- The percentage of Level I or II patient visits served in the ED varies significantly from a low of 52.6% at TriStar Portland FSED to the high of 68% at TriStar Hendersonville.

A high percentage of medically complex patients and behavioral health patients can contribute to capacity constraints for EDs. The TriStar White House FSED will have a behavioral health room to help address demand. TriStar Hendersonville with high percentages of elderly and high acuity patient visits displays indicators consistent with a high-range ED as defined by ACEP, resulting in longer treatment time and a lower number of visits per ED treatment room.

TriStar Hendersonville’s Capacity is Impacted by High Acuity Patients

TriStar Hendersonville’s ER receives a large amount of EMS trauma transports within Sumner County, has 24/7 GI coverage, coverage for neonatal and maternal fetal medicine and includes a Level III Trauma Center, an Accredited Chest Pain Center, and a Certified Primary Stroke Center. With these services and designations, TriStar Hendersonville has experienced an increase in the acuity and complexity of its ED patients over time. This change in its program has resulted in an influx of more complicated, higher acuity patients into the ED. **Exhibit 1N-22** shows that from 2021 through 2023, TriStar Hendersonville’s ED experienced a significant number of inpatient admissions and high acuity patients as a percentage of total ED visits. TriStar Hendersonville’s high acuity of patients has stayed over 70% from 2021 through 2023. Higher acuity patients impact the time required in the ED and resource needs for each patient.

Exhibit 1N-22
Host Hospital Trend in IP Admissions and High Acuity Patients
as Percent of Total ED Visits

TriStar Hendersonville ED	2021	2022	2023
% ED Patients Admitted	16.2%	15.3%	15.6%
% ED High Acuity Patients*	72.9%	71.1%	70.8%

Source: Internal Data; TriStar Hendersonville main campus only, excludes TriStar Portland FSED data. () ER Critical, ER Level 4 and ER Level 5 (CPT Code ED Level 99284 and 99285)*

TriStar Hendersonville’s ED treats a significant number of complex, highly acute patients, which impacts capacity, and is not considered fully in the visits per treatment space analysis set forth in the ACEP Guidelines. Such medically complex patients require a longer length of stay in the ED.

To accommodate current and projected demand, additional capacity will help TriStar Hendersonville ED operational efficiency. The proposed FSED will capture a portion of TriStar Hendersonville’s current ED volume, projected to shift more than 3,000 visits from TriStar Hendersonville and will thus help alleviate some of TriStar Hendersonville’s capacity constraints, further increasing access to emergency care at TriStar Hendersonville.

2. Expansion of Existing Emergency Department Facility

Applicants seeking expansion of the existing host hospital ED through the establishment of a FSED to decompress patient volumes should demonstrate the existing ED of the host hospital is operating at or above capacity.

Check the Box that Applies:



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



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

A. Visits per Treatment Room

Data:

The applicant should provide data on the number of visits per treatment room per year at the relevant existing ED facility. This number should be compared to the ACEP guidelines found in **Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, Figure 5.1, pages 116-117. Complete the following two tables to demonstrate host hospital ED capacity. In order to determine if the host hospital is a low, medium, or high range hospital, utilize Table 5.2, pages 109- 112 in the ACEP Guidelines. The results for the majority of the factors in the first table determine the range selected for the second table. See Exhibit 1N-23 below.**

Capacity Constraints at TriStar Hendersonville are Fully Evident

The ACEP Guidelines set out 16 factors by which one may categorize an ED as low, mid, or high range in terms of the number of rooms needed for a given range of annual visits. **Exhibit 1N-23** on the following page summarizes the measures and how the applicant fits into the ACEP scheme. While TriStar Hendersonville's results vary from low to high range, the hospital ED falls into mid-range as its median point in the measures (i.e., 6 low-range results, 6 mid-range results, and 4 high-range results).

Exhibit 1N-23

Factor	Result/Range	Metric
% Emergency Department Patients Admitted as Inpatients	Mid-Range	12% to 20% is mid-range Applicant was between 15.3% (2022) and 15.6% (2023).
Length of Stay (Hours) in ED	Mid-Range	Mid-Range is 2.5 to 3.75 hours Applicant is 2.7 hours.
% of ED Patients seen in Private Rooms	Mid-Range	Due to capacity constraints, not all patients may be seen in the 20 private rooms; ~25% of patients seen in group areas for throughput

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% of patients that will be moved from patient rooms to inner waiting or results waiting areas	Mid-Range	Limited use of inner waiting/results waiting and only when ED is at capacity (~10%-20%).
% of observation and extended stay patient remaining in ED	Mid-Range	Limited capacity for extended stay patients, CDU or observation patients will be accommodated in ED; additional observation space available on patient floors; 51% of these patients remain in ED.
# Average Minutes an ED patient admitted as an inpatient remains in ED	High-Range	ED patients who are admitted will remain in the department for over 150 minutes after order to admit; Applicant was 185 minutes.
Average turnaround time (minutes) for results for lab and imaging studies	Mid-Range	Mid-Range average turn time is 60 minutes; lab turn time ranges between 34 and 70 depending on test and imaging is 76 to 79.
% of behavioral health ED patients	Low-Range	Low is <3% Applicant's visits were 2.9% (2022) and 2.8% (2023).
% of ED patients either ESI 4 or 5 (Percent of Non-Urgent Patients)	High-Range	High is < 25%; applicant was 5.1% for two levels least acute (ESI level 4 and 5).
% of ED patients Age 65+	High-Range	High is >20% elderly; Applicant's patient visits were 25.6%, (2023)
% of imaging studies performed in ED	High-Range	Multiple imaging rooms, CT, mammography, and potential MRI; 100% of applicant ED imaging performed in ED.
Provisions in ED for family consult/grieving rooms	Low-Range	No provisions for additional family consult rooms, family nourishment areas and so on.
Availability of geriatric specialty area	Low-Range	No designated geriatric area.
Availability of pediatric specialty area	Low-Range	No designated pediatric area.
Availability of prisoner/detention patient specialty area	Low-Range	No designated prisoner spaces.
Availability of administrative/teaching specialty area	Low-Range	No designated administrative/teaching area.
The Range Where Majority of Above Factors Fall, i.e. Low, Mid or High range	Mid-Range	

TriStar Hendersonville characteristics are almost equally split between low, mid and high range ACEP standards. With its median score in the mid-range, TriStar Hendersonville is over capacity treating an average of 1,897 ED visits per bed in 2022 versus a mid-range ACEP standard of approximately 1,400 visits per bed.

Exhibit 1N-24
Host Hospital ED Visits per Treatment Room and ACEP Ranges

Facility/Standard	Annual Visits 2023	Dept. Gross Area (Square Footage)	Bed Quantities		
			Bed Quantity	Visits/Beds	Area/Bed
Host Hospital	39,089	10,650	20	1,954	533
ACEP Standard - Mid Range	35,000	22,250	26	1,386	838
ACEP Standard - Mid Range	40,000	24,438	29	1,406	838

Source: Internal records, most recent year (2023) and includes all ED Visits (IP/OP); American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 109-112; mid-range is midpoint between low and high range tables.

The visits per bed in **Exhibit 1N-24** at the host hospital (1,954) are more than 40 percent greater than the 35,000 annual visit ACEP guideline (1,386) for a mid-range ED. The capacity constraints at TriStar Hendersonville are evident when one considers this information.

The ACEP standards for both 35,000 and 40,000 annual visits are presented in **Exhibit 1N-24** above. With a 2022 visit count of nearly 38,000 and over 39,000 ED visits in 2023, see **Exhibit 1N-25**, TriStar Hendersonville is on track to be measured by the 40,000 visit metric during calendar year 2024.

TriStar NorthCrest is Not an Alternative to Decompress TriStar Hendersonville's ED

TriStar NorthCrest is approximately 15 miles from White House and approximately 24 miles from TriStar Hendersonville. Drive time is approximately 30 minutes between TriStar NorthCrest and the proposed TriStar White House FSED and 45 minutes from TriStar Hendersonville with no traffic. The TriStar NorthCrest ED has 18 treatment rooms and is highly utilized.

Given both proximity and actual utilization trends at the TriStar NorthCrest ED of patients residing in the service area, it is not an alternative for decompression. **Exhibit 1N-14** above is a graphic depiction of the areas where TriStar NorthCrest ED patients reside. As was shown there, most of TriStar NorthCrest ED's patients reside closer to TriStar NorthCrest than to the new TriStar FSED in White House or to TriStar Hendersonville.

"NorthCrest isn't easily accessible because it is on the opposite side of Springfield from White House. To get to NorthCrest, patients have to go down Highway 76 which is known for having bad wrecks all of the time, and then you have to go through the City of Springfield . . . It can take my patients up to 45 minutes, maybe longer depending on the time of day to get from White House to NorthCrest."

– Carmen Roach, Home Health Registered Nurse

Exhibit 1N-25 shows the utilization trend for the TriStar EDs in Robertson and Sumner Counties in the last 3 years. Overall, ED volumes have increased approximately 7.5% since 2021, with a compounded annual growth rate (“CAGR”) of 3.7%.

Exhibit 1N-25
TriStar Facility ED Visits by Year

Calendar Year	TriStar Hendersonville ED Visits	TriStar Portland FSED Visits	TriStar NorthCrest ED Visits	Total TriStar ED Visits
CY 2021	35,473	11,319	24,147	70,939
CY 2022	38,007	12,435	24,266	74,708
CY 2023	39,089	12,196	24,977	76,262
% Change 2021 to 2023	10.2%	7.7%	3.4%	7.5%
CAGR, 2021-2023	5.0%	3.8%	1.7%	3.7%

Source: Internal Data, includes admitted and non-admitted ED Visits

As concluded in **Exhibit 1N-23**, TriStar Hendersonville has characteristics of low, mid, and high range facilities, but its median defines it as a mid-range hospital. **Exhibit 1N 26** presents the number of ED visits per treatment room at TriStar Hendersonville, TriStar Portland FSED, and TriStar NorthCrest. This is then contrasted with the ACEP guideline for mid-range (mid-point between low range and high range) value based on the visit volume of the ED.

Exhibit 1N-26
TriStar Hendersonville, TriStar Portland FSED, and TriStar NorthCrest
Visits per ED Treatment Room Compared with ACEP Guidelines for Mid-Range ED

	TriStar Hendersonville ED visits per rm	TriStar Portland FSED visits per rm	TriStar NorthCrest ED visits per rm
ER Treatment Rooms	20	8	18
CY 2021	1,774	1,224	1,342
CY 2022	1,900	1,415	1,348
CY 2023	1,954	1,554	1,388
ACEP - Mid-Range	1,386	1,080	1,080
% Greater than ACEP	41.0%	43.9%	28.5%

Sources: Internal Data and American College of Emergency Physicians (ACEP), Emergency Department Design – A Practical Guide to Planning for the Future, Second Edition, pages 116-117; mid-range is the midpoint between low range and high range.

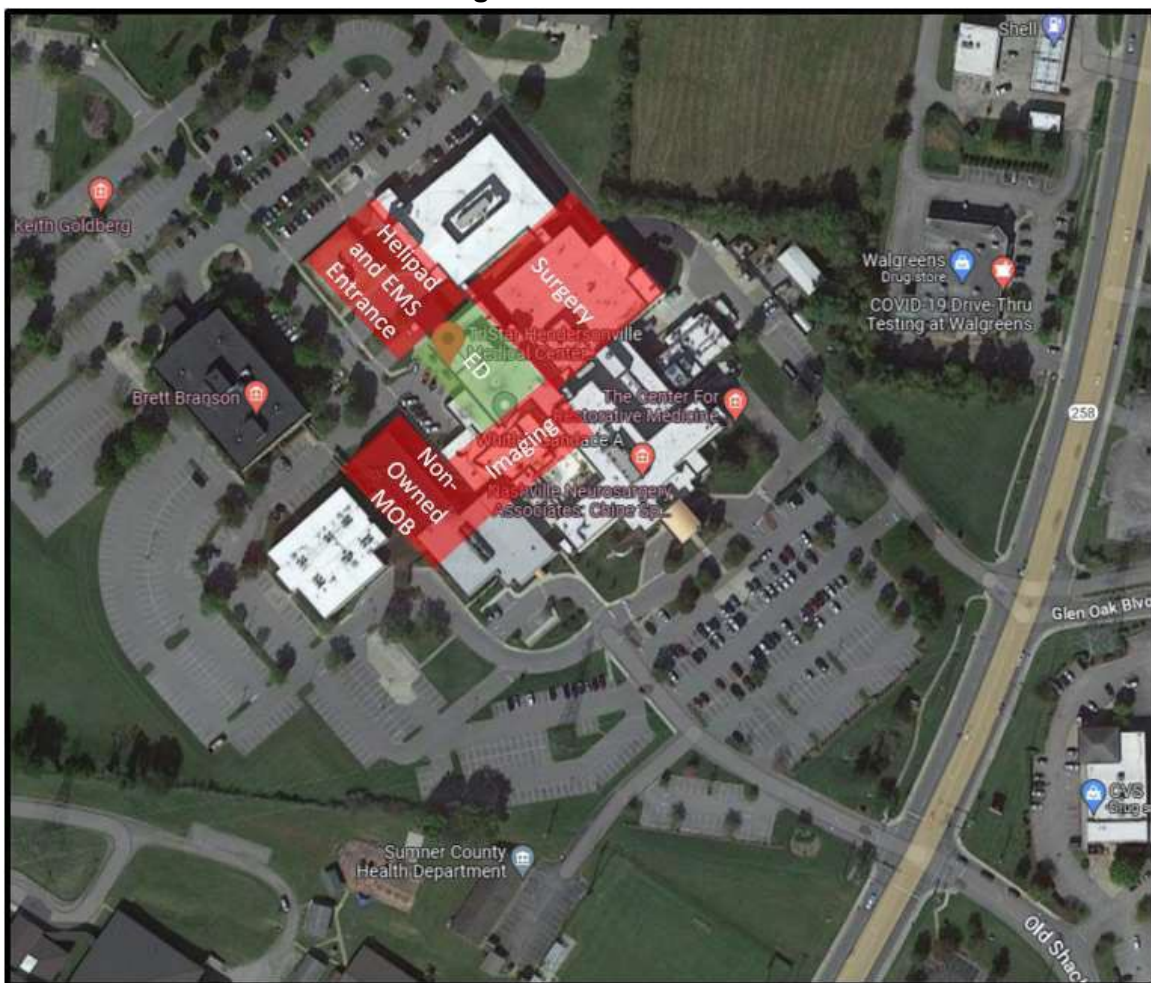
On-Campus Expansion at TriStar Hendersonville Is Not Viable

TriStar Hendersonville has evaluated several options to address its ED capacity constraints at its on-campus ED. It has worked to maximize staffing and processes such as patient flow. This is evidenced in its low LWOT rates (OP-23) and low wait times (OP-18) despite high visits per room and acuity of visits. It also recently completed a \$2.6 million enhancement project which included ED patient room renovation

and triage area expansion. However, ED capacity constraints continue to be a concern, in part due to population growth and continued growth in demand for emergency services.

TriStar Hendersonville's assessment of its on-campus ED and plans to build a 6-bed CDU are not viable long-term alternatives. The existing ED is "landlocked" as designed. Directly adjacent to the existing ED are departments that are very logistically tough to move: Surgery, Imaging, a Helipad, and a non-owned medical office building. The facilities and services adjacent to the ED preclude an on-campus expansion without major disruption to the existing hospital operations, relocation of powerhouse,⁹ ingress, egress and drop off. Further, significant renovation of existing space would be cost-prohibitive, disrupt quality of care to existing TriStar Hendersonville patients and would impact other service lines within the facility. See **Exhibit 1N-27** below.

Exhibit 1N-27
Satellite Image of TriStar Hendersonville



⁹ Relocation of the powerhouse is estimated to cost a minimum of \$25 million without consideration of the costs of construction of patient spaces.

TriStar White House FSED is Needed to Help Address TriStar Hendersonville Capacity Constraints and Growing Service Area Demands

The TriStar White House FSED project will provide additional capacity to accommodate the existing and projected increase in ED visits for the service area. It is projected that the TriStar FSED in White House will capture over 3,000 patients who would otherwise have gone to TriStar Hendersonville, reducing the capacity challenges at TriStar Hendersonville to some degree.

TriStar Hendersonville's ED has the highest number of visits by emergency patients from the service area. The TriStar Hendersonville ED is also highly utilized and experiencing significant capacity challenges. The TriStar Hendersonville on-campus ED cared for 39,089 patient visits in year 2023 and is on track to exceed that number in 2024. Emergency visits from patients in the service area in 2023 encompassed 11.4% of the total patient visits at TriStar Hendersonville. TriStar Hendersonville projects that 3,215 of those patients will shift to the TriStar White House FSED in Year One, which should help relieve some of the burden on TriStar Hendersonville's ED. See the Main Application - **Exhibit 27**.

3. Relationship to Existing Similar Services in the Area

A. All Applicants

Data:

The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed FSED on existing EDs in the service area and shall include how the applicant's services may differ from existing services. Utilize the below tables to address this portion of the standards.

Historical Utilization of Existing Providers Serving the Service Area

Currently, there is no emergency care provider in the service area. Historical utilization of existing providers serving the service area is presented below. **Exhibits 1N-28** and **1N-29** provide relative percentages of emergency care services provided in the service area in CY 2022. None of these EDs are located in the proposed service area. In total, zip code service area ED visits are understated due to the suppression of data points within the HDDS data, which may impact each provider's respective utilization percentages overall and in each zip code.

In 2023, the TriStar Hendersonville main campus ED provided approximately 27% of the service area ED visits and 43% of the emergency visits by White House zip code residents. Combined, in 2023, TriStar EDs provide approximately 77% of total ED visits. TriStar NorthCrest has the second highest number of service area ED visits (23%). TriStar Skyline has the third highest number of service area ED visits (13.1%).

The FSED Guide requires that the Applicant use HDDS data. The HDDS data provided is not limited to the service area for this project, truncates data from small zip codes, and suppresses data from lesser used EDs. Nevertheless, because it is required to be used **Exhibit 1N-28** below shows the utilization as required by the FSED Guide:

Exhibit 1N-28
Historical Utilization of Existing Providers by Service Area Patient Visits

Emergency Department	County	Service Area Resident ED Visits (A)	Total Service Area Resident ED Visits (B)	Patient Utilization in Service Area (A)/(B) X 100 = %
TriStar Hendersonville	Sumner	4,656	19,044	24.4%
TriStar NorthCrest	Robertson	3,956	19,044	20.8%
TriStar Portland FSED	Sumner	1,166	19,044	6.1%
SRMC	Sumner	1,110	19,044	5.8%
TriStar Skyline	Davidson	2,982	19,044	15.7%
VUMC	Davidson	1,781	19,044	9.4%

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TriStar Centennial	Davidson	1,231	19,044	6.5%
Other Area Hospital	Davidson & Other	2,162	19,044	11.4%
Total		19,044	19,044	100.0%

Source: HDDS data. Note: Where the zip codes are smaller than 20,000 people, the HDDS does not report the numbers separately. Accordingly, the zip code estimates are for 370 zip codes and 371 zip codes, which is a combined number of all 370 and 371 zip codes with less than 20,000 people. This means that the numbers will include visits for 37073 (Greenbrier), 37049 (Cross Plains), and 37073 (Greenbrier), along with other non-service area zip codes, including 37010 (Adams) and 37032 (Cedar Hill). Likewise, 37188 (White House) is included within 371 zip codes, which will also include 37186 (Westmoreland) and Orlinda (37141).

Using THA data for the same time period, 2022, a more accurate picture of historical ED utilization is shown in **Exhibit 1N-29** because that data reports all zip codes and does not suppress smaller hospital reported data.

Exhibit 1N-29
Hospital ED Utilization in the Proposed Service Area – 2022

Hospital ED	County	SA Resident ED Visits (A)	Total Service Area Resident ED Visits (B)	Patient Utilization in Service Area (A)/(B) X 100 = %
TriStar Hendersonville	Sumner	4,466	16,628	26.9%
TriStar NorthCrest	Robertson	3,851	16,628	23.2%
TriStar Skyline	Davidson	2,172	16,628	13.1%
Masked	Masked	1,533	16,628	9.2%
Other TriStar	Davidson & Others	1,164	16,628	7.0%
TriStar Portland FSED	Sumner	1,142	16,628	6.9%
Masked	Masked	1,095	16,628	6.6%
Masked	Masked	916	16,628	5.6%
Other Hospitals	Masked	289	16,628	1.7%
Total		16,628		100%

Source: THA Data, includes ED Visits admitted to Inpatient. Masking required by THA Data Use Policy.

Similarly, the FSED Application Guide requires **Exhibit 1N-30** to report the HDDS data for the service area. But, as noted, due to truncation of zip code data and suppression of lesser used ED data, the Applicant acknowledges that the HDDS data does not present an accurate picture in **Exhibit 1N-30**.

Exhibit 1N-30
Ranking of ED Providers Using HDDS Data

Attachment 1N – FSED Criteria and Standards

Zip Code	% Highest ED Visits	% 2nd Highest ED Visits	% 3rd Highest ED Visits	Top 3 Facilities Total
370 Zip Codes	TriStar NorthCrest 31.2%	TriStar Hendersonville 17.9%	TriStar Skyline 13.7%	62.8%
371 Zip Codes	TriStar Hendersonville 32.6%	TriStar Skyline 18.3%	VUMC 11.2%	62.1%
Total Service Area	TriStar Hendersonville 24.4%	TriStar NorthCrest 20.8%	TriStar Skyline 15.7%	60.9%

Source: HDDS data Note: Where the zip codes are smaller than 20,000 people, HDDS does not report the numbers separately. Accordingly, the zip code estimates are for 370 zip codes and 371 zip codes, which is a combined number of all 370 and 371 zip codes with less than 20,000 people. This means that the numbers will include visits for 37073 (Greenbrier), 37049 (Cross Plains), and 37048 (Cottontown), along with other non-service area zip codes, such as 37010 (Adams) and 37032 (Cedar Hill). Likewise, 37188 (White House) is included within 371 zip codes, which will include 37186 (Westmoreland) and Orlinda (37141).

A more accurate version of the requested data for the service area in this matter is shown in **Exhibit 1N-31** below. That data is reported by zip code without truncation and does not suppress visits to lesser used EDs.

Exhibit 1N-31
Ranking of ED Providers Using THA Data

Zip Code	% Highest ED Visits	% 2nd Highest ED Visits	% 3rd Highest ED Visits	% ED Visits Top 3 EDs
37088 White House	TriStar Hendersonville 43.5%	TriStar Skyline 13.1%	Other Hospital 11.0%	67.6%
37073 Greenbrier	TriStar Northcrest 48.6%	TriStar Skyline 15.9%	TriStar Hendersonville 10.3%	74.8%
37049 Cross Plains	TriStar NorthCrest 25.4%	TriStar Hendersonville 20.4%	TriStar Portland FSED 19.5%	65.3%
37048 Cottontown	TriStar Hendersonville 30.2%	Other Hospital 21.8%	TriStar Portland FSED 19.8%	71.7%
Total Service Area	TriStar Hendersonville 26.9%	TriStar NorthCrest 23.2%	TriStar Skyline 13.1%	63.2%

Source: THA Data, includes ED Visits admitted to Inpatient. Masking required by THA Data Use Policy

Attachment 1N – FSED Criteria and Standards

Utilization trends of the EDs used by the proposed service area patients are provided in response to Question 6N in the main application, which requests historical utilization data (see **Exhibit 1N-32** below). From 2021 through 2023, the total ED visits from the providers in the counties in the service area increased from 16,135 in 2021 to 16,628 in 2023. (See **Question 5N**).

Exhibit 1N-32
Historical Utilization of EDs in the Counties that Include the
Proposed Service Area Last Available 3 Years

Hospital ED	Calendar Years		
	CY 2020	CY 2021	CY 2022
TriStar Hendersonville	29,860	35,519	37,932
TriStar Portland FSED	9,795	11,319	12,432
SRMC	29,903	28,774	26,678
Sumner Station FSED	7,921	10,649	12,165
Sumner County Total	77,479	86,261	89,207
TriStar NorthCrest	29,097	22,009	24,098
Robertson County Total	29,097	22,009	24,098
Sumner/Robertson Total ED Visits	106,576	108,270	113,305

Source: Hospital Joint Annual Reports.

As the provider of 77% of ED services for the service area, TriStar Health proposes the TriStar White House FSED to enhance geographic access by bringing emergency services closer to the White House community while simultaneously shifting volume from its highly utilized EDs, especially TriStar Hendersonville, which is well over capacity according to ACEP guidelines.

TriStar Hendersonville Growth in ED Demand

The following shows the growth in the Applicant's emergency care demands from 2021 through 2023.

Exhibit 1N-33
TriStar Hendersonville Main Campus Trend in ED Visits CY 2021-23

Year	Visits	Treatment Rooms	TriStar Hendersonville ED Visits per Room	% Change Year Over Year
CY 2021	CY 2021	35,487	1,774	--
CY 2022	CY 2022	37,932	1,897	7%
CY 2023	CY 2023	39,089	1,954	3%

Source: 2021-2022 Hospital Joint Annual Reports; 2023 TriStar Hendersonville internal data.

Impact on Existing Providers¹⁰

The TriStar White House FSED will not have any meaningful impact on existing non-TriStar providers. The projected utilization for the proposed FSED is heavily based on the anticipation of shift volume of

¹⁰ Impact on existing providers is no longer a Criterion after the enactment of the 2021 CON Reform Law.

patients who would otherwise have gone to a TriStar ED. The basis for the projection is discussed in detail in response to **Question 6N**. Non-TriStar providers care for a minimal number of emergency patient visits from the service area. Growth anticipated in the service area is expected to generate approximately 1,302 incremental visits by the second year of operation of the proposed TriStar White House FSED (2028). Collectively, all visits to the TriStar White House FSED are expected to essentially shift from other TriStar Hendersonville emergency care providers as described in detail in the main application **Question 6N** and as shown in **Exhibit 1N-34** below, which is the same table as **Exhibit 27** in the main application.

Exhibit 1N-34
Projected TriStar White House FSED Visits
Projected Utilization - TriStar White House Project Year 1 (2027) and Project Year 2 (2028)

	Project Year 1 (2027)	Project Year 2 (2028)
Visits Shifted from TriStar Hendersonville	3,215	3,303
Visits Shifted from TriStar Portland	1,047	1,075
Visits Shifted from TriStar NorthCrest	1,836	1,886
Visits Shifted from Other TriStar Eds	1,661	1,706
Total Service Area Patient Visits	7,758	7,970
Visits from Patients from OUTSIDE the Service Area	1,940	1,993
Total Projected Visits	9,698	9,963

Note: Totals and percentages may not tie out due to rounding and will not foot with hand calculation.

In short, it is clear that the proposed project will have very little impact on non-TriStar existing providers serving the service area.

Consistent with the Consumer Advantage criteria, the proposed project will not negatively impact existing providers, rather the TriStar White House FSED will better serve the growing and aging service area population by providing an emergency access point closer to the homes of many patients in the service area while simultaneously addressing TriStar Hendersonville's capacity constraints.

Differentiation of the Proposed Service from Existing Services

There is no ED in the service area and thus no existing service to be differentiated from in the service area.

As previously established, TriStar facilities care for 77% of the emergency patient visits from the service area, with TriStar Hendersonville caring for 27% of those patient visits. The TriStar Hendersonville ED is very highly utilized and experiencing material capacity challenges at nearly 1,900 visits per ED room. As shown below, TriStar FSEDs serve patients in all acuity levels. The White House FSED will enable service area residents who need emergency care for high-risk conditions – requiring prompt and often specialized medical intervention – improved access to such services through the expansion of ED capacity in White House. It will also enable TriStar Hendersonville, which has top quality practices in and around the service area, to introduce those metrics at the new FSED site. These include operating with reduced waiting times for all patients and reduced rates of leaving without treatment at the main campus ED.

Exhibit 1N-35
Projected TriStar White House FSED Acuity Levels

Level of Care – CPT	TriStar Hendersonville (2023)	TriStar Portland FSED (2023)	TriStar White House FSED (Year 1)	Combined	Percent of Total
Level 1 – 99281	566	297	291	1,154	1.9%
Level 2 – 99282	1,410	692	825	2,927	4.8%
Level 3 – 99283	9,343	4,824	4,521	18,688	30.7%
Level 4 – 99284	18,123	5,206	3,317	26,646	43.7%
Level 5 – 99285	9,545	1,163	740	11,448	18.8%
Critical Care	68	14	5	87	0.1%
Total	39,055	12,196	9,698	60,949	100.0%

Source: Internal Records for TriStar Hendersonville and TriStar Portland FSED 2023.

Note: CPT Code and Level of Care – Level 5 and Critical Care are most acute and Level 1 is least.

Totals may not tie out due to rounding.

Urgent and primary care providers in and around the service area are not an alternative in the event of a need for emergency care. Importantly, urgent, and primary care service models:

- Are not 24/7 resources, generally operate with reduced hours on weekends, and are generally closed on major holidays (i.e. – Easter, Thanksgiving, Christmas, etc.);
- Are not able or required to provide any level of uncompensated care;
- Are not staffed with the types of professionals who often must work as a team to save life; and functionality while mobilizing additional inpatient resources for care after stabilization, and
- Are not equipped with complex imaging equipment as well as the same lab and pharmacy.

Furthermore, travel time will be shortened by the presence of the proposed TriStar White House FSED in the community closer to where service area patients live. This location will save travel time while simultaneously alleviating the demonstrated capacity challenges at TriStar Hendersonville.

“My friend’s son needed stitches on a Sunday morning. In White House there are no urgent care centers open before 9am. Instead of a quick stop for stitches she had to take her son to Nashville. We need something that’s open 24/7 to provide for our medical needs.”

– Rebekah Gibbs, Springfield Resident

“White House has been experiencing so much growth. Walk in clinics are so ridiculous with wait times and I have been told they are moving to by-appointment-only. I believe an ER will help disperse patients for the care needed to appropriate facilities.”

– Jessica Doeden, Cottontown Resident

“We need a closer ER to handle the bigger medical needs that our walk-in clinics can’t and that have later hours for overnight emergencies.”

–Jessica Hobbs, Springfield Resident

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“As a long time resident of Cottontown 30+ years, we had always had to travel at least 30 mins now almost 40 mins due to the population and growth of White House. White House absolutely needs a free standing ER since several of our urgent cares are no longer open or can’t treat certain conditions.”

– Amy Harrison, Cottontown Resident

B. Rural Service Area Applicants

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

☒ The proposed service area is not rural.

Data:

Complete the following table to provide patient origin data by ZIP Code for each existing facility as well as the proposed FSED in order to verify the proposed facility will not negatively impact the patient base of the existing rural providers. Applicants may add or remove as many columns and/or rows, as necessary. In an area designated as rural, the proposed facility should not be located within 10 miles of an existing facility. In rural proposed service areas, the location of the proposed FSED should not be closer to an existing ED facility than to the host hospital.

Not applicable. The proposed service area is in Sumner County which is not rural. Accordingly, this criterion does not apply. However, the same information requested below is provided in response to **Question 3A** above.

Patient Destination and Patient Origin in the Proposed Service Area – Rural: Table 3B1

Hospital ED	Patient Volumes					
	ZIP Code 1	ZIP Code 2	ZIP Code 3	ZIP Code 4	ZIP Code 5	ZIP Code 6
Hospital ED 1						
Hospital ED 2						
Hospital ED 3						
Hospital ED 4						
Hospital ED 5						
Other Hospitals						
Total						
Proposed FSED YR 1						

C. Critical Access Hospitals

☐ The proposed service area contains a critical access hospital(s). If this box is checked the applicant must provide the information below.

☒ The proposed service area does not contain a critical access hospital(s).

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Data:

The location of the proposed FSED should not be closer to an existing CAH than to the host hospital. Provide the distance of the proposed FSED from any existing CAH in the proposed service area and the distance of the proposed FSED from the host hospital ED.

Not Applicable.

4. Host Hospital Emergency Department Quality of Care

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

Data:

The Joint Commission’s “Hospital Outpatient Core Measure Set” is utilized to demonstrate the quality of care provided by EDs.

Please note that many of the measures in the Hospital Outpatient Core Measure Set are no longer collected or insufficient provider report to create a meaningful comparison.

Exhibit 1N-36, Quality of Care Provided at the Host Hospital ED:

Measure: OP-1 Median Time to Fibrinolysis						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
In the CY 2018 OPPS/ASC final rule, CMS removed the OP-1 measure from the hospital OQR						
Measure: OP-2 Fibrinolytic Therapy Received Within 30 Minutes						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
This measure was removed from CMS Star Rating calculation due to too few hospitals reporting. ¹²						
Measure: OP-4 Aspirin at Arrival						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile
In the CY 2018 OPPS/ASC final rule, CMS removed the OP-4 measure from the hospital OQR program. ¹³						
Measure: OP-5 Median Time to ECG						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th Percentile	25 th -50 th Percentile	50 th -75 th Percentile	≥75 th Percentile

¹¹ <https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment>

¹² https://www.qualityreportingcenter.com/globalassets/2019/11/oqr/pr_jan_2020-op-hc-preview-help-guide-508.pdf.

¹³ <https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment>.

In the CY 2019 OPPS/ASC final rule, CMS removed the OP-5 measure from the hospital OQR program.¹⁴

Measure: OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
TriStar Hendersonville	7/1/2022-6/30/2023	162 minutes	--	X	--	--

Source: Centers for Medicare and Medicaid Services (CMS) Hospital Compare

Measure: OP-20: Door to Diagnostic Evaluation by a Qualified Medical Personnel						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th	25 th -50 th	50 th -75 th	≥75 th
			Percentile	Percentile	Percentile	Percentile
In the CY 2018 OPPS/ASC final rule, CMS removed the OP-20 measure from the hospital OQR program. ¹⁵						

Measure: OP-21 ED-Median Time to Pain Management for Long Bone Fracture						
Emergency Department	Timeframe	Ed Time/Score	Check (X) Applicable Quartile			
			≤25 th	25 th -50 th	50 th -75 th	≥75 th
			Percentile	Percentile	Percentile	Percentile
In the CY 2018 OPPS/ASC final rule, CMS removed the OP-21 measure from the hospital OQR program. ¹⁶						

Measure: OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival						
Emergency Department	Timeframe	ED Time/Score	Check (X) Applicable Quartile			
			≤25th Percentile	25th-50th Percentile	50th-75th Percentile	≥75th Percentile
TriStar Hendersonville	7/1/2022-6/30/2023	80%	Not applicable. Only 36 out of 98 Tennessee hospitals reported data for this measure (i.e., a 36.7 percent response rate). A statistically significant comparison for percentile cannot be determined.			

Source: Centers for Medicare and Medicaid Services (CMS) Hospital Compare

Of the 8 CMS Quality of Care measures in the tables above, only 2 are still used by CMS' outpatient quality reporting (OQR) program:

¹⁴ <https://www.qualityreportingcenter.com/globalassets/migrated-pdf/oqr-december-2018-final-rule-qa-pm-508.pdf>.

¹⁵ <https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment>.

¹⁶ <https://www.cms.gov/newsroom/fact-sheets/cms-issues-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-payment>.

Attachment 1N – FSED Criteria and Standards

- OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients and Measure
- OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival.¹⁷

Percentile is a statistical calculation that shows relative standing for comparison within a set of data. If insufficient data is available within the dataset (e.g., a low response rate), a statistically significant percentile rank cannot be determined. Of the two measures reported by CMS, OP-18 is the only one with enough data available to calculate the percentile for hospitals in the state of Tennessee. For OP-18, TriStar Hendersonville scored median of 161, which is still well below the Tennessee and National averages. See **Exhibit 1N-16** above.

CMS Measure OP-18 is not meant to be compared across all hospitals, rather it is to be compared amongst like hospitals (i.e. high volume, geography, etc). TriStar Hendersonville is in the “High Volume” category of emergency departments as assigned by CMS based on total visit volume. As a result, TriStar Hendersonville’s peers also include other High Volume Hospitals within Tennessee. High Volume Hospitals have longer treatment times (i.e., time from arrival to departure) as they typically serve patients of higher acuity which require more resources, more tests, etc. Among the 19 High-Volume emergency departments in the state, TriStar Hendersonville has the 5th best score.

Exhibit 1N-37 presents the minutes by hospital for the High Volume Hospitals and demonstrates that among peer hospitals, TriStar Hendersonville is in the best quartile.

Exhibit 1N-37

Comparative OP-18 Scores (Minutes) for High Volume Hospitals Compared to Peer Hospitals

Facility Name	City	Score
TriStar Southern Hills Medical Center	Nashville	128
TriStar Horizon Medical Center	Dickson	131
Sumner Regional Medical Center	Gallatin	155
St Francis Hospital	Memphis	157
TriStar Hendersonville Medical Center	Hendersonville	162
Blount Memorial Hospital	Maryville	173
Williamson Medical Center	Franklin	174
TriStar StoneCrest Medical Center	Smyrna	174
TriStar Skyline Medical Center	Nashville	188
Saint Francis Bartlett Medical Center	Bartlett	188
Tennova Health Care-Cleveland	Cleveland	190
Johnson City Medical Center	Johnson City	198
Wellmont Bristol Regional Medical Center	Bristol	209
Maury Regional Hospital	Columbia	218
Leconte Medical Center	Sevierville	230
Parkwest Medical Center	Knoxville	237
Cookeville Regional Medical Center	Cookeville	256

¹⁷ For OP-23, only 36 out of 98 Tennessee hospitals reported data (36.7 percent), and therefore a statistically significant comparison of percentile rank cannot be determined. Hendersonville score is at the median of the 36 reported hospitals.

Attachment 1N – FSED Criteria and Standards

Source: CMS Hospital Compare, May 2023. Times based on the 12-month period of July 1, 2022 through June 30, 2023.

Based on the data above, when considering like facilities, TriStar Hendersonville is within the top quartile.

TriStar Hendersonville is Recognized as a High Quality Hospital

TriStar Hendersonville has a four-star CMS rating and has a number of other quality recognitions. These include but are not limited to the following:

- Certified Primary Stroke Center (TJC)
- Accredited Chest Pain Center (TJC)
- Level III Trauma Center
- Achieved an “A” on a Leapfrog Hospital Safety Grade for the last six (6) quarters
- Healthgrades Patient Safety Excellence Award (2024) – Awarded to hospitals performing in the top 10% in the nation
- America’s 250 Best Hospital Awards (2024, 2023, 2022) - Top 5% in the nation for consistently delivering clinical quality
- America’s 100 Best Hospitals for Critical Care Award (2024, 2023, 2022)
- Americas 100 Best Hospitals for Gastrointestinal Care Award (2024, 2023, 2022)
- America’s 100 Best Hospitals for Gastrointestinal Surgery Award (2024, 2023, 2022, 2021)
- America’s 100 Best Hospitals for Orthopedic Surgery Award (2024)
- America’s 100 Best Hospitals for Pulmonary Care Award (2024, 2023, 2022)
- Stroke Care Excellence Award (2024)
- America’s 50 Best Hospitals for Surgical Excellence Award (2024)
- Surgical Care Excellence Award (2024, 2023)
- Fortune/PINC AI 100 Top Hospital (2023)
- Fortune/PINC AI Everest Award (2023) – Awarded for setting national benchmarks for the fastest, most consistent improvement rates and highest current year performance

5. Appropriate Model for Delivery of Care

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

FSEDs differentiate themselves from on-campus hospital EDs in terms of patient experience; hospital EDs have a reputation for long wait times, busy staff, crowded waiting rooms, and frequent diversion status. According to The Journal of Urgent Care Medicine, experience reflects an average of 3-hour wait times in the nation's hospital-based EDs, whereas FSEDs see patients in a few minutes and focus on getting patients out within 60 to 90 minutes.¹⁸

The patients who will benefit most, although not exclusively, from the proposed FSED are those who have an emergency medical condition requiring prompt and often specialized medical intervention. Urgent and primary care service models are not 24/7 resources, are not able to provide significant uncompensated care, and are not staffed with the types of professionals who often must work as a team to save life and functionality while mobilizing additional inpatient resources for care after stabilization.

Due to the historical growth in its service area, the TriStar Hendersonville ED is very highly utilized. Its visits per treatment room are the highest in Sumner County and currently higher than any other ED in adjoining Davidson County. It is incumbent on TriStar Hendersonville to expand its ED capacity to meet its current utilization as well as continue to meet the service area needs into the future. Evaluation of the means to expand its ED capacity to address capacity constraints resulted in the conclusion to expand off-site. This would not only address decompression through a shifting of patients from the TriStar Hendersonville main campus but it would also make ED services more readily available to the patients closer to where they live. Nearly all of the TriStar White House FSED service area patients being treated at TriStar Hendersonville live closer to the TriStar White House FSED.

The proposed FSED is an extension of emergency care provided by the TriStar Health system and will offer a much-needed alternative access point to emergency care for service area residents. The FSED will not only enhance access to patients with unforeseen, and sometimes critical, needs for medical intervention, but also will result in some patients choosing the FSED because it is closer, which in turn will alleviate some of the emergency service volume present at TriStar Hendersonville today.

Over the past decades, the healthcare industry has seen the decentralization and dissemination of healthcare access points to provide high quality care in a sustainable manner. The appropriateness of the FSED model is evident in the success of the FSED operated by TriStar Hendersonville in Portland and other TriStar affiliates. TriStar Health System operates 5 existing and 2 approved FSEDs in greater Nashville and the surrounding Middle Tennessee area. TriStar has recently been approved for a FSED in the Bellevue area, Nolensville, and East Nashville. EMS providers, including Sumner County EMS, which work with the TriStar Portland FSED, have recognized the value and appropriate model of FSEDs bringing patients in need of emergency care.

The proposed TriStar White House FSED will play a significant role in providing increased access to patients who need to be served at a higher level of care or admitted to a hospital setting through a combination of shifting ED utilization from TriStar Hendersonville to alleviate capacity constraints and meeting the needs of the increasing service area population.

¹⁸ <https://www.jucm.com/understanding-the-freestanding-emergency-department-phenomenon/>.

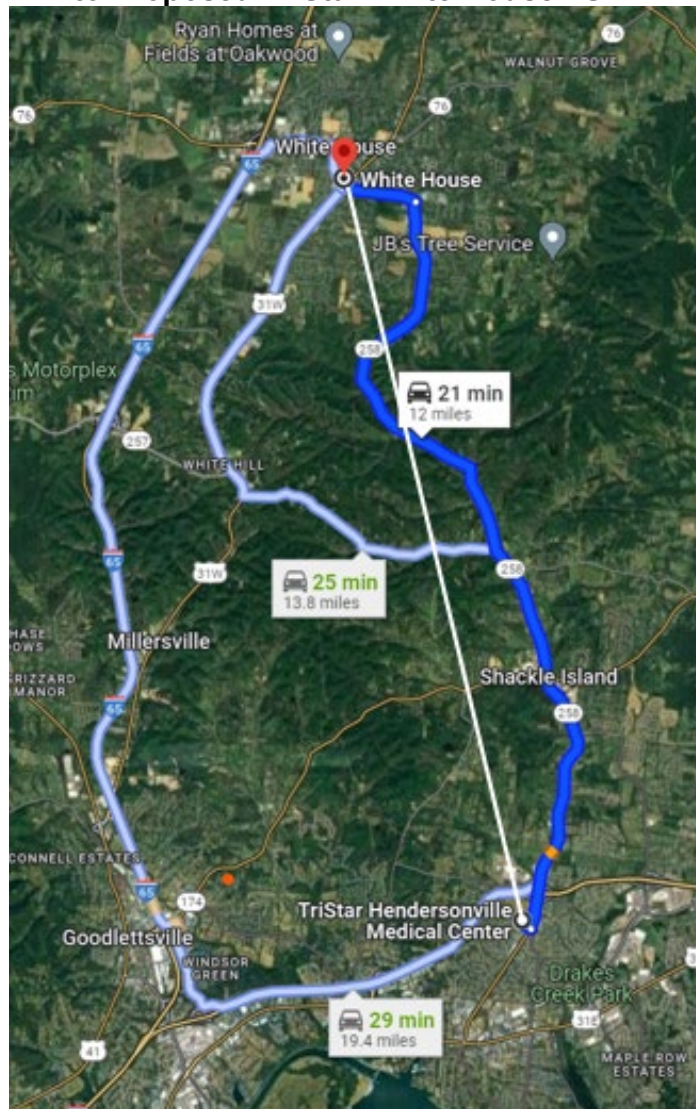
6. Geographic Location

Data:

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

The proposed TriStar White House FSED is located 12 to 19.4 driving miles northwest of the host hospital (9.725 miles as the crow flies), TriStar Hendersonville. The map in **Exhibit 1N-38** demonstrates that the proposed FSED is located within a 35-mile radius of the host hospital – TriStar Hendersonville, which is also the main provider of ED services in the service area.

Exhibit 1N-38
Within 35 Miles – Driving and Air Miles
Distance from TriStar Hendersonville
to Proposed TriStar White House FSED



Source: Google Map.

7. Access

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

By definition, an emergency department, including the TriStar White House FSED, as proposed here, must serve all who seek care as shown in its policies and procedures and based on EMTALA. TriStar currently serves 77% of the emergency patients from the service area. The host hospital, TriStar Hendersonville, currently serves approximately 27 percent of those emergency patients. TriStar Hendersonville provides state-of-the art care to all patients regardless of their ability to pay as evidenced by the significant percentage of TennCare/Medicaid and self-pay patients from the service area who receive emergency care at TriStar Hendersonville (see the Applicant's response to Criterion 8 below). Further, in CY 2023, TriStar Hendersonville wrote off over \$109 million in charity care dollars.¹⁹

TriStar makes allowances for all persons who have income at less than 400 percent of the poverty level. And for those who are below 200 percent of the poverty level, personal responsibilities are written off in their entirety. Furthermore, all self-pay patients will receive a discount similar to managed care, referred to as an "uninsured discount." This 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.

As demonstrated by TriStar Hendersonville's historical provision of emergency services for all patients, including medically indigent patients, and its historical provision of charity care overall, the FSED will serve equitably all of the proposed service area.

Further, TriStar Hendersonville complies with the No Surprises Act, which fully protects patients from any cost differential between services provided by in-network or out-of-network providers by holding the patients harmless from any such difference and this same policy/application of the law applies to the physician services to be provided in the FSED.

¹⁹ Charity care and uninsured discounts for TriStar Hendersonville in 2022 equaled \$98,432,806. 2022 Joint Annual Report, Schedule E, page 22.

8. Services to High Need Populations

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

Data:

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

The TriStar Hendersonville ED serves – and will continue to serve at both its existing and proposed locations – a significant number of uninsured and low-income patients presenting with emergency care needs. In CY 2023, 24.6% of TriStar Hendersonville ED patient visits were uninsured and/or low-income patients, including nearly 30% TennCare/Medicaid and 1% medically indigent/charity care patient visits. This compares to the service area’s rate of 24.5% TennCare/Medicaid and medically indigent/charity care patient visits. The proposed TriStar White House FSED will provide enhanced access to emergency care services for all patients, especially those who are uninsured, low income, or patients with limited access to emergency care.

Exhibit 1N-39
TriStar Hendersonville's ED Services to High Need Populations
by Payor Calendar Year 2023

	37188 White House		37073 Greenbrier		37049 Cross Plains		37048 Cottontown		Service Area		Host Hospital	
Payer Type	Total ED Patient Visits	% Total	Total ED Patient Visits	% Total	Total ED Patient Visits	% Total	Total ED Patient Visits	% Total	Total ED Patient Visits	% Total	Total ED Patient Visits	% Total
Medicare/Medicare Advantage	725	26.2%	152	25.0%	95	27.2%	254	34.2%	1,226	27.5%	11,307	28.9%
TennCare/ Medicaid	614	22.2%	165	27.2%	74	21.2%	110	14.8%	963	21.6%	9,209	23.6%
Commercial/Commercial Other	1,128	40.8%	222	36.6%	132	37.8%	316	42.6%	1,798	40.3%	11,671	29.9%
Self-pay	138	5.0%	38	6.3%	17	4.9%	24	3.2%	217	4.9%	4,095	10.5%
Medically Indigent/Free	83	3.0%	13	2.1%	12	3.4%	23	3.1%	131	2.9%	400	1.0%
Other	80	2.9%	17	2.8%	19	5.4%	15	2.0%	131	2.9%	2,407	6.2%
Total	2,768	100.0%	607	100.0%	349	100.0%	742	100.0%	4,466	100.0%	39,089	100.0%
<i>TennCare/ Medicaid/Medically Indigent/Free</i>	697	25.2%	178	29.3%	86	24.6%	133	17.9%	1,094	24.5%	9,609	24.6%

Source: TriStar Hendersonville Internal Data.

9. Establishment of Service Area

A. Establishment of Non-Rural Service Area



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



The proposed service area is rural.

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

Data:

Socio-demographics of the service area

Projected populations to receive services

Complete the following tables to demonstrate:

- Patient origin by ZIP Code for the hospital's existing ED in relation to the proposed service area for the FSED.**
- Patient Origin by ZIP Code of the service area residents (i.e., market share).**

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

The proposed service area is not in a rural area with more than 44,000 residents in 2024 and an expected growth to 49,000 residents by 2028. The service area has a high percentage of elderly residents who are the primary users of healthcare services. Additionally, 5.6% of the population is below the poverty line; White House – the location of the FSED has 5.4% below poverty line, according to the U.S. Census Bureau. Poverty and low income are associated with poor health due to greater barriers to accessing medical care, such as lack of health insurance and less ready access to primary care and health specialists. Thus, improving access to care for these individuals is an added benefit of this project as additional ED capacity will be placed in White House, where the main hospital and its 20 emergency treatment rooms are located.

**Exhibit 1N-40
Patient Origin, Ranked Highest to Lowest, Host Hospital, 2023**

Zip Code Area	ED Visits	% of Total	Cumulative %
37075 – Hendersonville	12,718	28.50%	28.50%
37148 – Portland	7,779	17.40%	45.90%
37066 - Gallatin	3,885	8.70%	54.60%
37072 - Goodlettsville	3,006	6.70%	61.30%
37188- White House	2,367	5.30%	66.60%
37115 - Madison	1,633	3.70%	70.30%
37186- Westmoreland	1,088	2.40%	72.70%
37048 - Cottontown	951	2.10%	74.80%
37022 - Bethpage	685	1.50%	75.90%

Attachment 1N – FSED Criteria and Standards

37172 - Springfield	563	1.30%	77.20%
37049- Cross Plains	553	1.20%	79.40%
37073- Greenbrier	493	1.10%	80.50%
37207- Nashville	347	0.80%	81.30%
37083- Lafayette	253	0.60%	81.90%
Subtotal	36,321	81.90%	
All Other	8,264	18.10%	100.00%
Total	44,585	100.00%	

Source: CY2023 Internal Data

ED Patient Destination by Hospital ED: Exhibit 1N-41

Exhibit 1N-41
ED Patient Destination by Hospital ED, 2023

ZIP Code/County	Service Area ED Patients ED 1	Service Area ED Patients ED 2	Other Service Area ED Patients ED 3	Subtotal of Service Area EDs	Patient ED 4	Patient ED 5	Patient ED 6	Patient ED 7	Patient ED 8	Patient ED 9	Patient ED 10	Other Hospital ED Patients	Total
	TriStar Hendersonville	Other Hospital	TriStar Portland FSED		TriStar NorthCrest	TriStar Skyline	TriStar Centennial	Other Hospital	TriStar Summit	Other Hospital	Other Hospital		
37188 White House	2,352	381	284	3,017	453	555	220	554	65	182	69	176	5,291
37073 Greenbrier	503	62	37	602	2,502	631	205	398	43	168	103	222	4,874
37049 Cross Plains	278	66	334	678	374	150	48	84	19	25	14	58	1,450
37048 Cottontown	573	457	487	1,517	50	106	85	134	17	50	30	98	2,087
Overall % by Hospital	27.00%	7.10%	8.30%	42.44%	24.70%	10.50%	4.10%	8.50%	1.10%	3.10%	1.60%	4.00%	100.00%

Source: THA, represents suppressed data file.

B. Establishment of Rural Service Area

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



The proposed service area is non-rural.

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

Data:

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

Not Applicable.

10. Relationship to Existing Applicable Plans; Underserved Area and Population

Data:

The proposal’s relationship to underserved geographic areas and underserved population groups shall be a significant consideration. Complete the following table of federally designated areas in the proposed service area to address this portion of the standards.

The TriStar White House FSED will be in zip code 37188, geographically at the center of its service area. At this location, it will improve access to underserved care populations, including low-income and Medicaid-eligible persons.

As shown in **Exhibit 1N-42** below, most of the zip codes that define the service area, and all of Robertson County, are considered underserved areas by the Health Resources and Services Administration. Specifically, the entire service area other than Cottontown is medically underserved with medically underserved populations, which means that there is a lack of primary care services in these areas, as well as a lack of primary care services for specific underserved populations, including low-income and Medicaid-eligible persons. For these populations in particular, access to geographically accessible emergency services is essential, as they have an identified lack of access to primary care. The entire service area is a health professional shortage area, meaning that the entire area lacks adequate access to primary care and/or mental health providers, as well as a mental health shortage area, which indicates a lack of sufficient services available to care for the behavioral health needs of the community. Absent these essential services in the service area, the proposed FSED will ameliorate geographic barriers to care for residents in need of emergency care.

The primary objective of the project is to increase access to care for those in this geographically isolated service area.

Exhibit 1N-42
Underserved Geographic Areas and Underserved Population Groups

Proposed Service Area Zip Code and/or County	Medically Underserved Area Check (X) if Applicable	Medically Underserved Populations Check (X) if Applicable	Health Professional Shortage Area Check (X) if Applicable	Shortage Area for Mental Health Services Check (X) if Applicable
37188 (White House)	X	X	X	X
37073 (Greenbrier)	X	X	X	X
37049 (Cross Plains)	X	X	X	X
37048 (Cottontown)			X	X
Robertson County	X	X	X	X
Sumner County			X	X

11. Composition of Services

Laboratory and radiology services, including but not limited to XRAY and CT scanners, shall be available on-site during all hours of operation. The FSED should also have ready access to pharmacy services and repository services during all hours of operation. Complete the following table to demonstrate the intent to provide the required services.

The TriStar White House FSED will have all required services in-house. See **Exhibit 1N-43** below.

Exhibit 1N-43
Composition of Services

Service	Hours Available	On-Site	Contracted or In-House
Laboratory	24/7/365	Yes	In-House
X-Ray	24/7/365	Yes	In-House
CT Scanners	24/7/365	Yes	In-House
Ultrasound	24/7/365	Yes	In-House
Pharmacy (*)	24/7/365	Yes	In-House
Respiratory	24/7/365	Yes	In-House
Other	N/A	N/A	N/A

**Note: A 0.6 FTE will staff the facility. 24/7/365 coverage will be accessible through the main ED.*

12. Pediatric Care

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

The TriStar Hendersonville ED is classified as a Primary Pediatric Emergency Facility. Its medical staff and department staff are therefore trained and qualified to serve pediatric patients and do so daily. TriStar Hendersonville and its Portland FSED treat a large percentage of pediatric patients within their emergency rooms. Notably the percentage of pediatric patient visits has increased steadily during the past three years. **Exhibit 1N-44** provides pediatric ED visits as a percentage of total visits from the proposed service area during the past three years.

Exhibit 1N-44
Pediatric ED Visits by Zip as a Percent of Total Proposed Service Area

Zip Code	2021	2022	2023
37188 (White House)	17.6%	18.8%	20.6%
37073 (Greenbrier)	17.1%	18.5%	16.8%
37049 (Cross Plains)	18.9%	17.2%	17.0%
37048 (Cottontown)	15.4%	17.8%	19.0%
Total	17.2%	18.4%	18.6%

Source: THA Data

The TriStar White House FSED will be staffed by the same Emergency Physician group that covers the main campus ED and Portland FSED. All physicians are required to have PALS (Pediatric Advanced Life Support) certification. As reflected in **Exhibit 1N-44**, 18.6% of the ED patient visits in calendar year 2023 from the proposed service area were children and adolescents.

Pediatric patients requiring admission at these EDs are generally transferred to Nashville area hospitals with specialized pediatric capabilities. The Children's Hospital at TriStar Centennial has an ED serving emergent pediatric patients 24/7; this ED is fully staffed with pediatric emergency fellowship trained physicians. The facility operates with a pediatric unit and ICU, offering a wide variety of sub-specialties. When needed, transfer to higher levels of pediatric care at The Children's Hospital at TriStar Centennial will be provided. Transfer to TriStar Health affiliates is regularly accomplished through direct communication between transferee and transferor facilities. Given common EMR, common emergency room physician group and common operational practices, TriStar is effective in timely securing

transfers. In addition, TriStar Hendersonville has a transfer agreement in place with the Monroe Carell Jr. Children's Hospital at Vanderbilt to accommodate transfers to that specialty pediatric hospital in the appropriate case. See Attachment 1C-1.

13. Assurance of Resources

The applicant shall document that it will provide the resources necessary to properly support the applicable level of emergency services. Such documentation should include, but not limited to, a letter of support from applicant's governing board of directors or chief financial officer.

TriStar Hendersonville fully commits to develop and maintain the facility resources, equipment, and staffing to provide the appropriate emergency services. The financial costs of maintaining and sustaining the resources necessary for this are set forth in the Projected Data Charts for the project; see response to Question 6C, Consumer Advantage Attributed to Competition in the main application form.

14. Adequate Staffing

A. All Applicants

The applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. If the applicant plans to contract with an emergency physician group, the applicant should provide information on the physician group's ability to meet the staffing requirements. Utilize the following table to demonstrate planned staffing.

The proposed staffing for the TriStar White House FSED is summarized in **Exhibit 1N-45** below. While the fact that the FSED will be a new facility necessarily compels the number of employees to be newly recruited, the Applicant is confident that it will be able to staff the facility when it is ready to open in 2027.

**Exhibit 1N-45
Staffing Patterns**

Position Type	FTEs Needed for Proposed FSED	FTEs Currently Employed	FTEs that will be Recruited
Physicians	4.2	0.0	4.2
Registered Nurses	11.5	0.0	11.5
ER Tech	0.0	0.0	0.0
EVS Tech	1.4	0.0	1.4
Radiology Tech	4.2	0.0	4.2
CT Tech (1)	0.0	0.0	0.0
Ultrasonographer (2)	0.5	0.0	0.5
Medical Tech	5.2	0.0	5.2
Other (3)	4.8	0.0	4.8

Total	31.8	0.0	31.8
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(1) *Included in Radiology Tech*

(2) *Also available on call*

(3) *Includes pharmacy and security staff*

The emergency room physician group for TriStar Hendersonville, including TriStar Portland FSED, is HCA-EmCare Holdings, LLC d/b/a Valesco Ventures. This same group will staff the proposed White House FSED as it will be a department of TriStar Hendersonville. Letters confirming this from the TriStar Hendersonville ER Medical Director and physician regional leadership are included in Attachment 5C-2.

TriStar Hendersonville is confident it will be able to fill each of the positions identified to staff the White House FSED. Its current track record lends credibility to this statement based on the following:

- TriStar Hendersonville has been able to appropriately staff its EDs and patient floors so as not to result in any related service or unit closures.
- The vacancy rate at the TriStar Hendersonville ED is 3.85% with two RN positions currently posted as part of a “hire again” program
- Staff turnover rate – including RNs -- at the TriStar Hendersonville ED is 3.95% and for RNs is only 5.38%, both well below industry averages.
- The vacancy rate at the TriStar Portland FSED is 14.29% with four RN positions open
- Staff turnover at the Portland FSED is 16.22% for all and 17.65% for RNs.
- The vacancy rate at the TriStar NorthCrest ED is 10.81.% with 2 RN positions currently posted.
- Staff turnover at TriStar NorthCrest’s ED is 17.48% and 35.29% for RNs.

TriStar Hendersonville’s successful employment experience as one of the major employers in Sumner County is evident in the above metrics. Its expertise in recruitment and retention will be extended to the TriStar White House FSED.

B. Non-Rural Staffing Requirements



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



The proposed service area is rural.

The applicant shall outline planned staffing patterns including the number and type of physicians and nurses. Each FSED is required to be staffed by at least one physician and at least one registered nurse at all times (24/7/365). Physicians staffing the FSED should be board certified or board eligible emergency physicians. If significant barriers exist that limit the applicant’s ability to recruit a board certified or board eligible emergency physician, the applicant shall document these barriers for the HSDA to take into consideration. Applicants are encouraged to staff the FSED with registered nurses certified in emergency nursing care and/or advanced cardiac life support. The medical staff of the FSED shall be part of the hospital’s single organized medical staff, governed by the same bylaws. The nursing staff of the FSED shall be part of the hospital’s single organized nursing staff. The nursing services provided shall comply with the hospital’s standards of care and written policies and procedures.

The proposed FSED will be operationally integrated with the main campus ED. As such, it will comply

with all the specific State Health Plan standards identified above for staff planning and recruitment; training and competencies; supervision; the presence of at least one Board-certified Emergency Physician and RN at all times, 24/7/365; staffing with RN's; operation under the same bylaws, hospital medical staff and nursing staff organizations, and hospital standards of care and written policies and procedures.

The Medical Director of the TriStar Hendersonville Emergency Department is Duane Harrison, MD. A copy of Dr. Harrison's C.V. is attached as **Attachment 5C-2** along with a letter indicating the need for this proposed project. Additionally, the FSED will be staffed by HCA-EmCare Holdings, LLC d/b/a Valesco Ventures. Valesco provides a variety of physician services to approximately 100 healthcare facilities nationwide. TriStar Hendersonville contracts with Valesco for Emergency Medicine physician services. Dr. Matthew Tincher serves as the Regional Vice President of Hospital Based Services for TriStar Division. Please see **Attachment 5C-2** for a letter of support from Matt Tincher, M.D.

C. Rural Staffing Requirements

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



The proposed service area is non-rural.

The applicant shall outline planned staffing patterns including the number and type of physicians. FSEDs proposed to be located in rural areas are required to be staffed in accordance with the Code of Federal Regulations Title 42, Chapter IV, Subchapter G, Part 485, Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs). This standard requires a physician, nurse practitioner, clinical nurse specialist, or physician assistant be available at all times the CAH operates. The standard additionally requires a registered nurse, clinical nurse specialist, or licensed practical nurse to be on duty whenever the CAH has one or more inpatients. However, because FSEDs shall be in operation 24/7/365 and because they will not have inpatients, a registered nurse, clinical nurse specialist, or licensed practical nurse shall be on duty at all times (24/7/365). Additionally, due to the nature of the emergency services provided at an FSED and the hours of operation, a physician, nurse practitioner, clinical nurse specialist, or physician assistant shall be on site at all times.

Not Applicable. The proposed service area is non-rural.

15. Medical Records

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

There is a retrieval system in place at the existing ED which will also be in place at the proposed FSED. An electronic health record is maintained to improve quality and availability of information. This same mechanism is used at all EDs operated within the TriStar Division.

16. Stabilization and Transfer Availability for Emergent Cases

The applicant shall demonstrate the ability of the proposed FSED to perform stabilizing treatment within the FSED and demonstrate a plan for the rapid transport of patients from the FSED to the most appropriate facility with a higher level of emergency care for further treatment. The applicant is encouraged to include air ambulance transport and an on-site helipad in its plan for rapid transport. The stabilization and transfer of emergent cases must be in accordance with the Emergency Medical Treatment and Labor Act.

The Applicant is a very experienced provider of emergency care. It is an existing provider that routinely arranges appropriate stabilization and transport to the most appropriate facility if higher levels of care are needed. The host hospital, TriStar Hendersonville, has a helipad. As a department of the hospital, the TriStar White House FSED will have the capability to provide helicopter transport in addition to ambulance transport. Therefore, construction of a helipad at the FSED is not currently being considered. In the future, if patient care dictates a need for one, TriStar Hendersonville will reconsider.

The TriStar White House FSED will serve as an extension of TriStar Hendersonville and will use the experience of the host hospital's ED to provide emergency services to the service area. The FSED will stabilize and transfer patients as appropriate in accordance with the Emergency Medical Treatment and Labor Act.

17. Education and Signage

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

The hospital will educate the community regarding the availability of emergency care at the TriStar White House FSED. The community will be educated through the development of written brochures available at the FSED, social media messages, website information, and mailings. The community will be educated about services provided at the FSED and the facilitation of transfers for inpatient care. TriStar Hendersonville will provide further education of service area residents through involvement in community activities and community boards. The proposed FSED has the support of Robertson County EMS demonstrating its understanding of the project and the proposed facility's capabilities.

18. Community Linkage Plan

The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health and outpatient behavioral health care system, including mental health and substance use, providers/services, providers of psychiatric inpatient services,

and working agreements with other related community services assuring continuity of care. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of ED usage.

TriStar Hendersonville works with other area providers and community access points to ensure that all patients have adequate access to care. These organizations include:

- Forward Sumner
- United Way of Sumner County
- United Way of Sumner County Fundraising Campaign
- United Way of Sumner County Mom and Baby Collection Drive
- March of Dimes
- American Heart Association – Greater Nashville
- American Cancer Society
- HCA Hope Fund
- Habitat for Humanity of Sumner County
- Portland Chamber of Commerce
- Portland Rotary Club
- Hendersonville Rotary Club
- Hendersonville Area Chamber of Commerce
- Gallatin Chamber of Commerce
- Community Life Bridge
- Volunteer State Community College – Nursing School Clinical Affiliation
- Volunteer State Community College – Allied Health Clinical Affiliation
- Humane Society of Sumner County
- YMCA of Middle Tennessee/Sumner County YMCA
- Blood Assurance
- Senior Citizen Center of Hendersonville
- D.A.R.E. of Sumner County
- Sumner County Resource Center
- Sumner County Public Schools
- TN Donor Services
- Interfaith Dental
- Leukemia and Lymphoma Society
- Cumberland Crisis Pregnancy Center
- Hendersonville Samaritan Association/Samaritan Center
- Leadership Sumner County
- Sumner County Health Department/Health Council
- Mother's Milk Bank of Tennessee
- Union University
- Welch College
- EMS Outreach and Education (including Stop the Bleed Training)
- Crush the Crisis
- Feed Sumner Food Bank and Ministry
- Grace Place Ministry
- Sumner County Family Resource Center Collection Drive
- Sumner County Board of Health and Health Council
- White House High School HOSA student program
- Liberty Creek High School HOSA student program

- Rachel's Gift partnership – infant loss education
- Bereavement Support Group /Bereavement Committee
- Stroke/Brain Injury Support Group
- Women Impacting the Community Luncheon with Hendersonville Area Chamber of Commerce
- Hendersonville Rotary Club Wine & Roses
- Men of Honor Luncheon
- Sumner Fest
- American College of Healthcare Executives of Middle Tennessee
- Career Day at Indian Lake Elementary
- Coat Drives for Veterans
- Nashville Health Council
- Salvus Center
- Blayklee's Bags distribution – infant loss
- Taste of Hendersonville
- Touch a Truck with the Hendersonville Parks and Recreation
- Sumner County Prevention Coalition

TriStar Hendersonville also works with a network of physician practices to ensure continuity of care for patients.

TriStar Hendersonville's sister facility NorthCrest also works with other area providers and community access points in the service area to ensure that all patients have adequate access to care. These organizations include:

- Robertson County Chamber of Commerce
- White House Chamber of Commerce
- Robertson County Rotary
- YMCA of Springfield
- UK College of Public Health
- EMS Board
- Open Door Pregnancy Center
- Friends of GREAT Summer Games
- Men of Valor
- Boy Scouts of America
- Leadership Robertson County
- Kiwanis
- Red Dress Luncheon
- March of Dimes
- Crush the Crisis
- Nashville Heart Walk
- Leukemia and Lymphoma Society
- HOSA Student Symposium
- Wave of Light

19. Data Requirements

The applicant shall agree to provide the Department of Health and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services and

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

The Applicant agrees to provide the Department of Health/HSDA, and 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.

20. Quality Control and Monitoring

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

The TriStar White House FSED will be included in TriStar Hendersonville's Quality Assessment and Process Improvement programs. Please see additional discussion in response to the quality-related questions in the main application.

21. Provider-Based Status

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

TriStar Hendersonville is an existing provider with current eligibility for Medicare and Medicaid reimbursement and will operate the proposed FSED in compliance with these guidelines, just as it operates its main campus ED and its Portland FSED.

22. Licensure and Quality Considerations

Any applicant for this CON service category shall be in compliance with the appropriate rules of the TDH, the EMTALA, along with any other existing applicable federal guidance and regulation. The applicant shall also demonstrate its accreditation status with the Joint Commission or other applicable accrediting agency. The FSED shall be subject to the same accrediting standards as the licensed hospital with which it is associated. Applicants should address the applicable quality measures found in the HSDA Agency Rules.

TriStar Hendersonville is in full compliance with the above standard. Evidence of accreditation and licensure is provided in **Attachment 2Q-1** and **Attachment 5C-1**. In addition to its certifications and accreditation, TriStar Hendersonville has a four-star CMS rating and has a number of other quality accomplishments. These include but are not limited to the following:

- Certified Primary Stroke Center (TJC)
- Accredited Chest Pain Center (TJC)
- Level III Trauma Center
- Achieved an "A" on a Leapfrog Hospital Safety Grade for the last six (6) quarters

- Healthgrades Patient Safety Excellence Award (2024) – Awarded to hospitals performing in the top 10% in the nation
- America's 250 Best Hospital Awards (2024, 2023, 2022) - Top 5% in the nation for consistently delivering clinical quality
- America's 100 Best Hospitals for Critical Care Award (2024, 2024, 2022)
- Americas 100 Best Hospitals for Gastrointestinal Care Award (2024, 2023, 2022)
- America's 100 Best Hospitals for Gastrointestinal Surgery Award (2024, 2023, 2022, 2021)
- America's 100 Best Hospitals for Orthopedic Surgery Award (2024)
- America's 100 Best Hospitals for Pulmonary Care Award (2024, 2023, 2022)
- Stroke Care Excellence Award (2024)
- America's 50 Best Hospitals for Surgical Excellence Award (2024)
- Surgical Care Excellence Award (2024, 2023)
- Fortune/PINC AI 100 Top Hospital (2023)
- Fortune/PINC AI Everest Award (2023) – Awarded for setting national benchmarks for the fastest, most consistent improvement rates and highest current year performance

Please refer to **Attachment 2Q-2** for a summary of TriStar Hendersonville's recent quality accomplishments.

Attachment 2N

County Level Map

TENNESSEE COUNTY MAP



 Counties containing Service Area

 Counties containing Service Area

Attachment 6N

Letters of Support

TriStar Hendersonville White House FSED
List of Letters of Support Submitted with CON Application Filed 8/1/24

	Author	Title and Organization
1	Representative Johnny Garrett	TN State Representative – District 45
2	Representative Sabi ‘Doc’ Kumar	TN State Representative – District 66
3	Senator Kerry Roberts	TN State Senator – District 23
4	Teresa Sexton	White House Resident
5	Jennifer Barton	White House Resident
6	Darlene Allen	Cross Plains Resident
7	Penny Brown	Goodlettsville Resident
8	Gavin Reeves	Greenbrier Resident
9	Helen Ankenbauer	Cottontown Resident
10	Tiffany Willis	Greenbrier Resident
11	Kailey Anglea	Cottontown Resident
12	Jessica Morgan	White House Resident
13	Charles Roach	Springfield Resident
14	Joseph Marlar	White House Resident
15	Karen Fairbanks	White House Resident
16	Kelly Parcher	Cottontown Resident
17	Jodi Cunningham	White House Resident
18	Michael McDaniel	White House Resident
19	Carmen Roach, RN	Registered Nurse
20	Rebekah Gibbs	Springfield Resident
21	Jessica Doeden	Cottontown Resident
22	Jessica Hobbs	Springfield Resident
23	Amy Harrison	Cottontown Resident
24	Dr. Duane Harrison	<i>See Attachment 5C-2</i>
25	Dr. Matthew Tincher	<i>See Attachment 5C-2</i>



SABI 'DOC' KUMAR

SENATOR
HOUSE DISTRICT 66

rep@sabikumar.com capitol.tn.gov

Legislative Address

Cordell Hall Building
425 Rep Ron Lewis Way, Suite 654
Nashville, TN 37240
615-741-2600

**House of Representatives
State of Tennessee**

July 23, 2024

CHAIRMAN

Insurance Committee

MEMBER

Insurance Subcommittee

Health Committee

Population Health Subcommittee

Government Operations Committee

Calendar and Rules Committee

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, 10th Floor
502 Leaderick Street
Nashville, Tennessee 37243

Re: TriStar Hendersonville White House FSED

Dear Mr. Grant,

As a Representative of District 66, I am called to advocate for the health of my constituents in Robertson County and all Tennesseans. I am writing to you today in support of TriStar Hendersonville's application for a freestanding emergency department in White House and ask that you grant them the required Certificate of Need.

For over 40 years, I practiced as a general, vascular and endoscopic surgeon in Robertson County, seeing thousands of patients each year. I am deeply acquainted with the medical infrastructure in the area and invested in Robertson County's health and wellbeing. Simply put, we need more convenient access to emergency care. Without this investment, we will fall behind the growth of our county as it is experiencing, and patient outcomes will suffer as a result.

White House is a rural community that is growing rapidly. Over the past two decades, the population has nearly doubled. However, this growing community still does not have convenient access to emergency care. Adding an ESU will allow patients to receive care in minutes. In an emergency, time is of the essence, and reducing the amount of time it takes for a patient to get to the emergency room will save lives. This ESU will dramatically improve the healthcare and quality of life for residents of Robertson County.

An ESU is needed and wanted in White House. TriStar Hendersonville already provides high-quality care to this community and has demonstrated their investment in the area. I respectfully ask that you approve this additional access point and grant TriStar Hendersonville the required Certificate of Need.

Sincerely,

Sabi 'Doc' Kumar

House Representative District 66
113th Tennessee General Assembly



SENATOR KERRY ROBERTS

July 23, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar Hendersonville White House FSED

Executive Director Grant,

It is my honor to represent Senate District 23, which includes Robertson County. It is in the best interest of my constituents and residents of the surrounding areas to have more timely access to emergency services. That is why I am writing to you today in support of TriStar Hendersonville's application to bring a freestanding emergency department to White House.

TriStar Hendersonville Medical Center has been part of the Sumner County community for over 40 years. TriStar Hendersonville's plan to expand their high-quality services to the White House community will provide residents of White House with the same trusted, patient-focused care they have delivered to Sumner and Robertson Counties for decades. The majority of White House residents already choose to travel to Hendersonville for their hospital care. It makes sense for TriStar Hendersonville to bring these essential healthcare services closer to home for White House residents.

The facility will be a full-service emergency room capable of caring for all levels of urgent medical needs. It will function as a satellite ER of TriStar Hendersonville, providing 24-hour emergency care through physicians and staff with the same clinical services as at the main campus ER. Minutes matter in an emergency, and the proposed emergency department will drastically reduce the time it takes for residents to receive care, thereby saving lives.

There is undoubtedly a need for emergency care in White House. I respectfully ask that you grant TriStar Hendersonville the necessary Certificate of Need to bring this emergency department to White House.

If you wish to discuss this further, please do not hesitate to contact me at 615-741-4499.

Sincerely,

Kerry Roberts
Senator District 23
Chairman, Senate Committee for Government Operations

07.26.2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar White House Emergency Room

Dear Mr. Logan Grant,

The roads from White House to Hendersonville or to the Portland ER are winding and only 2 lanes. If there is a wreck, you can be stuck for a bit. Minutes matter in an emergency. The interstate is backed up going north and south 60% of the time going from White House to Skyline. 31W is 2 lanes and winding in spots. Again, minutes matter. If there is snow and or icy conditions, it is dangerous drive from White house to Hendersonville, Portland, Skyline, and NorthCrest. It's safer for people to seek medical attention close by than be on the roads.

My mom has fell several times in the past requiring a trip to the ER by ambulance but not an overnight stay. It would have been easier on her to be close to home than being taken all the way to Skyline ER.

Having an ER in White House would be good for the people of White House. If a patient had to be transferred to another hospital, some of the triage/testing could already be done. MDs at the receiving facility would have some test results in hand when the patient arrived at a hospital.

For these reasons, the TriStar White House ER should be approved.

Thank you,

A handwritten signature in dark ink, appearing to read "Teresa Sexton". The signature is fluid and cursive, with the first name "Teresa" and last name "Sexton" clearly distinguishable.

Teresa Sexton
303 Hunterwood Drive
White House, TN 37188

29-July, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar White House Emergency Room

Dear Mr. Logan Grant,

We are an isolated area surrounded by ridiculous traffic problems including the main roads through White House as well as the interstate 65 that leads to Nashville or Bowling Green, the closest two larger cities with hospitals available. We truly just can't get there from here all too often.

My mother was a stroke patient who had a major stroke and was taken all the way to skyline which is the closest major hospital to us. She did survive that time but was rendered severely cognitively impaired and shortly thereafter had another major stroke which took her life. I can only imagine how things might have been different if she could have received immediate care here in White House.

To keep things like what happened to my mother from happening, we need a local ER. Please approve this facility.

Thank you,

Jennifer Barton

Jennifer Barton
126 Madeline Way
White House, TN 37188

July 26, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar Hendersonville - White House

Dear Mr. Grant,

Due to the continuing population growth in the White House area and other nearby communities, the need for this type of high-quality emergent healthcare that WILL save lives is an immediate NEED. The busy I-65 corridor has frequent motor vehicle crashes, families have emergencies of all types, childhood illnesses, etc. would benefit from having a local-easy access TriStar ER in White House will assist more swift treatment.

My husband suffered a cardiac arrest at our home in Cross Plains and I did CPR on him by myself until EMS arrived. The trip to TriStar Skyline was 23 miles away - but our best option at the time for emergent treatment. Fortunately for us, he survived with no complications. However, I feel certain his treatment could have been started at least 20 minutes sooner if we had not had to travel so far for emergent medical care.

The community and neighboring areas need quick convenient access to this higher level of emergent care in our own neighborhood and THIS will save lives! Additionally, this will add jobs to the local area! Saving lives and improving the workforce in this rural area!

Thank you,

A handwritten signature in dark ink, appearing to read "Darlene Allen". The signature is fluid and cursive, with the first name "Darlene" and the last name "Allen" clearly distinguishable.

Darlene Allen
4937 Somerville Road
Cross Plains, TN 37049

July, 26, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar White House ER CON Application

Dear Mr. Grant,

When you are sick, you don't feel like driving a lot of miles to get medical help. Plus, there are a lot of winding roads between White House and Hendersonville and White House and Springfield. Having more care available in White House where it's easy to get to would be great.

On January 4th I ended up very sick and ended up in the ER at Hendersonville. I had already gone to two walk in clinics who did nothing to help me. I am 62 years old and had a temp of 104, BP was ok, HR was 126. I was out of it. I passed out. I couldn't use my legs. The first clinic in Hendersonville sent me home after a Covid and flu test were negative. No other test was run. Charge \$802.02. Two days later after passing out, hallucinating, talking to people not there, my husband took me to a walk in clinic in WH. I tested positive for a UTI and was sent home on antibiotics. Two days later I ended up at Hendersonville ER with severe pain added to other symptoms. After all this, yes I had a severe UTI and a kidney stone in my left kidney. It took over 6 months for me to recover. I'm still on antibiotics.

This ER is needed for the elderly and the young parents with children. Please approve TriStar Hendersonville so that they can build an ER in White House and treat the patients who need them.

Thank you,

A handwritten signature in black ink that reads "Penny Brown". The signature is written in a cursive, flowing style.

Penny Brown
194 Spring Hollow Rd
Goodlettsville, TN 37072

07/25/2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission

Andrew Jackson Building, Ninth Floor
502 Leaderic Street
Nashville, Tennessee 37243

Re: Star Site House SOR

Executive Director Grant,

Site House Robertson County SOR as a lot of calls and is usually busy, not to mention a major interstate with constant construction going on would benefit from a close and local emergency room. It would also be more ideal than the urgent care facilities that only have odd opening hours.

I feel like quality hospital service is too far away from Site House. People have to take long drives through backroads and crowded highways. The community is just too big for that to be the case anymore. Site House needs quality emergency care. The real question is why shouldn't this be approved?

Thank you,



Gavin Reeves
2720 Leigets Circle Rd
Greenbrier, TN 37073

07/27/2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Federal Street
Nashville, Tennessee 37243
Re: TriStar Hendersonville White House ER

Dear Mr. Grant,

I have lived in the White House/Cottontown area for almost a decade and since then the community has grown exponentially. TriStar Hendersonville has been trusted within my family my entire life, and having the peace of mind that my family, and my community can be granted the opportunity to receive that trusted care in their own hometown would be a benefit to all.

Two years ago, while I was pregnant with my first child, my stepson experienced a reaction from a severe tree nut allergy that we were unaware of. It took minutes for his throat began to swell, and he was covered in hives. Sumner Regional, TriStar Hendersonville, and TriStar NorthCrest are all an equal distance of 10 minutes from White House. We were faced with a toss-up decision when our child couldn't breathe, a scenario that no parent should ever have to go through. Since becoming a mother, I realize more than ever that seconds matter when you are faced with potential danger to your children. Having a free standing ER within our community would give so many like myself peace of mind that our children are in the care of trusted TriStar professionals and can receive potentially life saving care within our own neighborhood.

I believe TriStar holds themselves, and their healthcare professionals to the highest standard for patient care and patient experience. TriStar has always been there for myself, my family, and its community. I feel it is White House's turn to experience the level of patient care that only TriStar healthcare professionals have to offer.

Thank you,

Helen Ankenbauer

Helen Ankenbauer
400 Hwy 76
Cottontown, TN 37043

July 26, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar White House Emergency Room

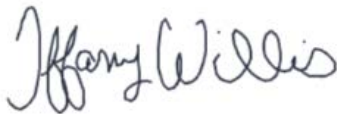
Dear Mr. Logan Grant,

This would be an incredible asset not only to the city of White House, but all its surrounding cities and residents as well. The need for state-of-the-art emergency care in this area is desperately needed. Having access to this type of facility, within a close proximity to many rural residents, will greatly decrease the risk of potentially fatal outcomes. TriStar is the leading healthcare corporation with the technology, staff and resources to provide our community with the emergency care it so desperately needs.

My mother was bit on the face, in her sleep, by a brown recluse and had a severe allergic reaction. Anaphylaxis was a serious threat and we had to travel 40 minutes to Hendersonville Medical Center's ER. In an event like that, time is of the essence and if we had a Tristar ER in White House we could have been there within 10-15 minutes.

TriStar provides high quality throughout the region. I see no reason why this would be any different. High-quality emergency care will benefit White House and if this ER is given approval, lives will be saved.

Thank you,

A handwritten signature in cursive script that reads "Tiffany Willis".

Tiffany Willis
4041 Bedwell Dr
Greenbrier, TN 37073

07/20/2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission

Andrew Jackson Building, Ninth Floor
502 Federal Street
Nashville, Tennessee 37243

Re: TriStar White House SNR

Executive Director Grant,

I live in Cottontown, Tennessee and I strongly support TriStar Hendersonville's application to put an emergency room in White House. I don't like having to drive 25 minutes to get to the nearest ER, it makes me uneasy thinking about having to travel all that time in an emergency health situation. Not to mention, they have to send an ambulance all the way out there and then it has to go all the way back, so that is double the time it would take to drive it.

I know this first-hand because my uncle had a seizure due to alcohol withdrawals and it took them a long time for an ambulance to get to my house. Then, they had to turn right around and travel that same distance to get him to an emergency room. That is a lot of time that could have been saved if there was an emergency room in White House.

I can't speak for all THCA facilities, but TriStar Hendersonville is the closest ER to me and every time I have had to go there they have treated me really well. I am also a nursing student and have interned at Skyline, and I cannot say enough good things about the staff and administration there. Good, quality care is badly needed in White House and the surrounding areas and TriStar is the best option for my community.

Thank you,

Kailey Anglea

Kailey Anglea
501 Sun Pie
Cottontown, TN 37043

26 July 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar White House ER CON Application

Dear Mr. Grant,

White House has grown so much over the last 20 years. The boom in population has warranted more readily accessible Emergency care. While our EMS teams do an amazing job to take care of us, having to be taken 30 mins away from my side of town to the closest hospital is scary. What if that 30 mins means the difference between life and death? That's a risk I hope we soon will no longer have.

Within the last year while herding up his cows, my stepfather was injured when he was thrown into a steel post by one of them. While EMS responded in less than 5 minutes when called, they had to take him to Skyline which over 30 mins from our home. We had no idea if he had any major injuries at the time or not so the entire drive down there was so nerve wracking knowing all the things that could go wrong.

TriStar is where my family and I always choose to go for medical care because of the excellent care that is provided. All of our doctors are associated with TriStar making the care seamless. There are many in our community that feel the same way and always choose TriStar. We have many members of our own community that work to serve our friends, families, and neighbors from within TriStar already, but this would allow us the opportunity to continue to do so. As well as it would provide much needed access to close emergency care to our areas. TriStar is dedicated to serving the people in the communities that it's embedded in and it is evident that they would have that same dedication to the White House community as well.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jessica Morgan', with a stylized, cursive script.

Jessica Morgan
7406 Ruby Keith Rd
White House, TN 37188

July 29, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar White House Emergency Room

Dear Mr. Logan Grant,

White House is an isolated town with no emergent access to healthcare and very challenging roads to get in and out of the town and other surrounding areas. This is a long overdue and is an urgent need for our community! People would have immediate access to receive treatment resulting in significant loss of life and escalated complications of medical conditions.

I was a teacher and coach at White House Heritage High School and we had multiple incidents where students and athletes were injured and delays in help of healthcare professionals was indeed a serious, potentially life threatening issue.

White House now has two senior living, skilled nursing and rehabilitation centers. If our senior citizens need help with emergent situations from their advanced cardiac and respiratory disease processes or injuries, falls, etc, it is very difficult for them to get out of the city and to a hospital. Given the huge population growth, two lane highways necessary in any direction to leave, constant traffic problems being construction or accidents on I65, two different school systems, White House on Sumner County side, White House Heritage on Robertson County side, both with students from kindergarten through seniors. They also have very competitive athletic programs on both sides inclusive of girls and boys and literally hundreds of our youth. There are also many youth programs outside of the school systems for hundreds and hundreds of young people in the city and surrounding area. Unfortunately, they get injured and need help close by. The TriStar ER would provide them with nearby and accessible ER care, which this community needs. Please approve the ER.

Thank you,

A handwritten signature in dark ink, appearing to read "Charles Roach". The signature is fluid and cursive, with the first name "Charles" written in a larger, more prominent script than the last name "Roach".

Charles Roach
216 Sanctuary Ct
Springfield, TN 37172

29-July, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar White House ER CON Application

Dear Mr. Grant,

I am in full support of TriStar Hendersonville's proposal to build an emergency room in White House. My community would benefit because from this ER because we would gain access to immediate medical attention in the case of an emergency. With so many schools and youth sports in the area, its almost irresponsible that we don't already have accessible emergency care. A TriStar emergency room in White House would enhance our preparedness and response capabilities and provided a much safer community.

Although I thankfully haven't needed emergency medical care recently, the scenario has crossed my mind. The closest ER to me right now is 30 minutes away. It is something that weighs on my mind and I can only imagine that my elderly neighbors or the new parents in my community worry about it even more. Also, a TriStar ER is the best option for this community because those neighbors would not have to travel all the way to downtown for follow up care, instead they could just go to NorthCrest or Hendersonville if they need to once the situation isn't an emergency.

The people of White House would benefit benefit because would have access to immediate medical attention in an emergency situation. A TriStar ER would allow residents of White House and the surrounding areas to have peace of mind and potentially life-saving access to care.

Sincerely,

Joseph Marlar

Joseph Marlar
3090 Dartmoor
White House, TN 37188

07/26/2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission

Andrew Jackson Building, Ninth Floor
502 Leaderic Street
Nashville, Tennessee 37243

Re: Star Site House SOR

Executive Director Grant,

Due to the aging population and influx of new residents, we need an emergency room in Site House.

Unfortunately I have not had an emergency situation while living in Site House, however, I have been taken by ambulance to Hendersonville Hospital following a fall, but it wasn't a life or death situation. It would have been nicer to have treatment in my hometown and now that my husband and myself are in our 70s, I think having an emergency room in Site House would greatly benefit us should that need arise in the future.

I give Star approval for the protection and preservation of our citizens. Site House needs this SOR and so I hope to see this built someday soon.

Thank you,

Karen Fairbanks

Karen Fairbanks
401 Rolling Acres Drive
Site House, TN 37188

26 July 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar White House ER Application

Mr. Grant,

White House has grown tremendously in the past 7 years and the only ER facility that we have access to is either the free standing TriStar ER in Portland, TN. There's also the ER at the TriStar Hendersonville hospital. Both are excellent, but to have something closer will be fantastic. I always use the TriStar ER in Portland when necessary, but it would be great to have a similar facility that's easier to get to.

Because the area is growing by leaps and bounds, we need this ER. Please vote to approve TriStar so that they can bring this ER to White House.

Thank you,

A handwritten signature in blue ink, appearing to read 'Kelly Parcher', with a stylized flourish at the end.

Kelly Parcher
1126 Maxwell Branch Rd
Cottontown, TN 37048

07/27/2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission

Andrew Jackson Building, Ninth Floor
502 Leaderic Street
Nashville, Tennessee 37243

Re: Star Site House SOR

Executive Director Grant,

The House is rapidly growing and this facility would save lives. I live in this community and my family and friends would benefit from a stabilizing location when minutes matter most. CHA would be welcomed in this community.

My mother was here visiting and fell down a flight of stairs. We had to drive to Skyline Medical Center with her in excruciating pain. Had a SOR been available, they would have been able to get her comfortable, treat the pain, do appropriate diagnostics and recommend next steps.

CHA has a strong mission that is patient centric and improves outcomes. They have success across the S with SORs and have the support to ensure timely and quality care. I feel strongly that CHA would do a great job serving the House if approved.

Thank you,



Kodi Cunningham
26 Apple Branch Road
The House, TN 37043

26-July, 2024

Mr. Logan Grant

Executive Director
Tennessee Health Facilities Commission

Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

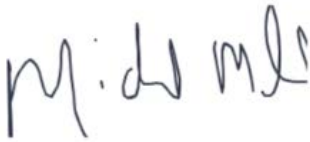
Re: TriStar Hendersonville White House FSER Application

Dear Mr. Grant,

White House needs an ER because it will greatly reduce time it takes to get lifesaving care. We have certainly talked about how not having local emergency care could be an issue if ever we had a life threatening emergency. I'm sure other residents feel the same way.

Due to population growth, it is an urgently needed addition. Population is continuing to grow, with many thousands more people that have moved in since 2022. This is needed, so I ask that you approve the TriStar FSER for the good of this community.

Thank you,

A handwritten signature in dark ink, appearing to read "m. d. mcl", is positioned above the printed name of the sender.

Michael McDaniel
205 Amber Lane
White House, TN 37188

July 19, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar Hendersonville White House FSED

Dear Mr. Grant,

My name is Carmen Roach, I am currently a home health RN case manager and I take care of patients in Robertson, Sumner, and Davidson County. Many of my patients reside in the communities of White House, Cottontown, Springfield, Greenbrier, Cross Plains, Millersville, and Goodlettsville. I see patients in White House multiple times a day.

I've been an RN for 38 years. Prior to working as a home health nurse, I worked in an emergency department. I was so excited to here that an emergency department is coming to White House. It's what the community needs, and it will save lives and help so many people there.

White House is experiencing excessive growth right now, and the current infrastructure cannot support the growth there right now. As a home health nurse, I make various trips to White House during the week, and the route is not easy to navigate. It is a curvy two-lane road down Highway 76 or 31-W. The speed-limit most of the way is 30 mph. I-65 is notorious for wrecks and construction and being shut down. You never know when you get on I-65 how the traffic is going to be, and once you get on I-65 in White House you can't get off of it until the Bethel Road exit, which is approximately 5 miles on the interstate. When there is a wreck going down the ridge on I-65, the entire interstate shuts down. When that happens, people have to re-route and go 31-W because they can't get down I-65, which makes traffic even worse. There are also multiple school systems in White House, and when school is in session, my morning commute and afternoon commutes to and from White House can take up to an hour to get from one side of White House to the other because of the excessive amount of traffic along these roads.

Cross Plains is another community that would benefit from this ER's construction. There is nothing near Cross Plains. Cross Plains consists of an elderly community of farmers, and it is very rural. When they need care, it is incredibly difficult to get out of Cross Plains to I-65. Especially when minutes matter.

Many of the elderly patients in this community can't get to the nearest emergency rooms easily. NorthCrest isn't easily accessible because it is on the opposite side of Springfield from White House. To get to NorthCrest, patients have to go down Highway 76 which is known for having bad wrecks all of the time, and then you have to go through the city of Springfield. It's faster to get to Skyline sometimes than NorthCrest if you are on the opposite side of White House. It can take my patients up to 45 minutes, maybe longer depending on the time of day to get from White House to NorthCrest. There is a new senior living facility and skilled nursing facility in White House and if any of the patients there needed care, they could not get them to care quickly right now. Right now, there is nowhere close to send those patients when time is of the essence in an emergency. Their ability to drive is limited, and they deserve to have the care they need in a place where they can get to it.

While I was taking care of an elderly patient with a cardiac condition in White House, I advised him that he needed to go to a hospital or to his Cardiologist. His Cardiologist was in Nashville, and he could not drive himself to an ER. His wife was afraid to drive him to Nashville because of the traffic, and there was nowhere close for him to go. They ended up calling an ambulance, and he had congestive heart failure as a result of the delay in treatment and required an extensive hospital stay.

One of the boys on my son's soccer team broke his leg and had to go all the way to Nashville for care. It was extremely painful for him to be riding in the back of an ambulance for such a long way in that type of pain. If there had been a freestanding ER in White House at the time, he would have been able to get care there. There are lots of people in White House who have stories like this. This could be prevented with a closer ER.

Pretty much all of the patients that I see in the White House community are already treated by TriStar physicians, so if something were to happen to them it would be easier for them to be treated by physicians who already cover their care. NorthCrest, Hendersonville, and Skyline are the three closest hospitals to White House, so if they start treatment at a TriStar ER facility in White House and need a higher level of care later, the transition to receiving a higher level of care, if necessary, at NorthCrest, Hendersonville, or Skyline would be much faster because they already started to receive care at a TriStar facility. I want my patients to have options, and this TriStar branded emergency department will provide my patients in the area with a strong choice.

My family has been actively involved in the White House community. Areas from White House to Cottontown need alternatives to aid the expanding population because the needs of these communities are continuing to grow. My family lived in White House for over 20 years before moving to Springfield, Tennessee. My husband coached high school football at White House Heritage School, 2 of my 4 children graduated from White House Heritage High School, and one of my children taught and served as Head Coach of the girls' and boys' soccer team at White House Heritage High School. Most of my family members still currently live in White House, and I have seen firsthand the growth and development taking place in the area. The many White House area daycares and schools would benefit from the peace of mind that more ER capacity from a trusted provider would bring.

A freestanding ER would be cheaper financially for my patients to get care locally rather than having to pay for an ambulance ride downtown, when they can get that same care around the corner. Everyone should have access to high quality emergency care that they can get to in a timely fashion. This FSER will reduce the time that it takes for them to get care, and in doing so, will save lives. I can confidently say that the community in White House needs this and will be better off if it is approved.

For these reasons, I ask that you give TriStar approval to bring this emergency room to White House.

Thank you,



Carmen Roach

26-July, 2024

Mr. Logan Grant

Executive Director
Tennessee Health Facilities Commission

Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar Hendersonville White House FSER Application

Dear Mr. Grant,

I work for HCA and live in White House. A place for immediate health care needs with our growing community is absolutely essential.

My friend's son needed stitches on a Sunday morning. In White House there are no urgent care centers open before 9am. Instead of a quick stop for stitches she had to take her son to Nashville. We need something that's open 24/7 to provide for our medical needs.

Hendersonville Medical Center and Skyline Medical Center are the closest hospitals to White House with easy access and the ability to transport. They also have their own ground and air transport to make it easy if we were to need emergent transfer to a higher level of care.

TriStar is the right choice for the community. They provide care for a lot of White House residents already and have high standards for quality. White House needs this ER, so I ask that you approve the TriStar White House ER.

Thank you,

A handwritten signature in blue ink, appearing to read 'Rebekah Gibbs', with a stylized, flowing script.

Rebekah Gibbs
2102 SAVAGE CREEK DR
Springfield, TN 37172

07.26.2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar White House ER CON Application

Dear Mr. Grant,

White House has been experiencing so much growth. Walk in clinics are so ridiculous with wait times and I have even been told they are moving to by-appointment-only. I believe an ER will help disperse patients for the care needed to appropriate facilities.

Having to take my son into Centennial is just a traffic and parent nightmare. When your child is crying in pain a 45-minute commute to an ER is torture.

I think having a fully operational Emergency room would give so much added peace of mind to the community. The closest emergent facility is at least a 30-minute drive. That alone adds to the time it will take someone to actually receive the care they need. Cutting down the commute time could potentially save lives!

Thank you,

A handwritten signature in dark ink that reads "Jessica Doeden". The signature is written in a cursive, flowing style.

Jessica Doeden
1030 Briarwood Dr
CottonTown, TN 37048

July 26, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission

Andrew Jackson Building, Ninth Floor
502 Madison Street
Nashville, Tennessee 37243

Re: iStar Site House SOR

Executive Director Grant,

We need a closer SOR to handle the bigger medical needs that our walk-in clinics can't and that have later hours for overnight emergencies. 25 minutes to the nearest SOR is scary when you are in a life/death situation.

The House needs an SOR to keep up with the growth of the community. People will benefit from having a closer emergency care option. For these reasons, I ask that you give the iStar Site House SOR a vote of approval.

Thank you,



Jessica Hobbs
1045 W. Lafayette Ln
Springfield, TN 37172

July 26, 2024

Mr. Logan Grant
Executive Director
Tennessee Health Facilities Commission
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243
Re: TriStar White House Emergency Room

Dear Mr. Logan Grant,

As a long time resident of Cottontown 30+ years, we had always had to travel at least 30 mins now almost 40 mins due to the population and growth of White House. White House absolutely needs a free standing ER since several of our urgent cares are no longer open or can't treat certain conditions. I highly recommend and would love to see HCA come to White House.

My daughter rode a toy and went down a flight of stairs and busted her mouth and bit through her tongue. Have you ever had to try and console a child that is bleeding like crazy and no one in White House could treat it? We need a closer facility that can treat things like that.

TriStar Hendersonville should be approved to help provide an emergency service to this growing community. We need more emergency care, and they are right for the job.

Thank you,

A handwritten signature in black ink, appearing to read "Amy Harrison".

Amy Harrison
407 West Hester Road
Cottontown, TN 37048

Attachment 1C-1

Transfer Agreements:
Ascension St. Thomas;
Vanderbilt University Medical Center; and
Vanderbilt Pediatric

PATIENT TRANSFER AGREEMENT

THIS PATIENT TRANSFER AGREEMENT (this "Agreement") is entered into effective 7/17/2019 ("Effective Date") by and between Saint Thomas Health on behalf of its controlled Affiliates, a Tennessee not for profit corporation ("Hospital") and Hendersonville Hospital Corporation d/b/a TriStar Hendersonville Medical Center, ("Transferor").

RECITALS:

- A. Hospital and Transferor each operate health care entities located in Tennessee.
- B. Saint Thomas Health is a health system which includes eight hospital campuses serving the Middle Tennessee area: Saint Thomas Midtown Hospital, Saint Thomas West Hospital, Saint Thomas Rutherford Hospital, Saint Thomas Hickman Hospital, Saint Thomas DeKalb Hospital, Saint Thomas Highlands Hospital, Saint Thomas River Park Hospital and Saint Thomas Stones River Hospital.
- B. The parties desire to assure a continuity of care and appropriate medical treatment for the needs of each patient in their respective facilities, and have determined that, in the interest of patient care, the parties should enter into an agreement to provide for the transfer of patients from Transferor to Hospital on the terms and conditions set forth herein.

NOW THEREFORE, in consideration of the mutual promises herein contained and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows.

1. Term and Termination.

(a) **Term.** This Agreement shall be effective on the date first written above and shall continue for a period of one (1) year, at which time it shall automatically renew for successive one (1) year periods, unless earlier terminated in accordance with the terms hereof.

(b) **Termination.** Either party may terminate this Agreement without cause upon thirty (30) days written notice to the other party. The Agreement may also be terminated at any time by mutual consent of both parties. Notwithstanding the termination of this Agreement, each party shall reasonably provide for the continuity of care to all patients who are involved in the transfer process at the time of the termination of this Agreement. This Agreement shall terminate immediately should the other party fail to maintain the licenses, certifications or accreditations, including Medicare certification, required to operate its facility as it is currently being operated

2. Transfer.

(a) Upon such time that a patient's physician determines that the patient needs to be transferred from Transferor to Hospital pursuant to Transferor's physician's order, Hospital agrees to admit the patient as promptly as possible and provide healthcare services as necessary, provided all conditions of eligibility are met. Transferor agrees to send the following with each patient at the time of transfer, or as soon thereafter as possible in emergency situations:

- (i) an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption; and

- (ii) essential identifying and administrative information.
- (b) Transferor shall also perform the following:
 - (i) notify Hospital of the impending transfer;
 - (ii) receive confirmation that Hospital can accept the patient, and that a Hospital medical staff physician has done so;
 - (iii) obtain patient's consent to the transfer; and
 - (iv) arrange for the transportation of the patient, including mode of transportation and the provision of one or more health care practitioners as necessary.

3. Readmission of Patient

(a) When a patient has been transferred to Hospital from Transferor and is admitted and stabilized, but no longer requires specialized services or treatment only available at Hospital, Transferor agrees to accept the transfer of, and to readmit, the patient for further required hospitalization within 24-48 hours of such determination. In the event Transferor referring physician does not accept the patient, the Transferor's Chief of Medical Staff or other authorized representative shall facilitate identification of an appropriate accepting physician for the transfer. Only patients who are appropriate for transfer and who consent shall be transferred to Transferor.

4. Relationship of the Parties.

(a) The parties agree that the relationship between the parties is that of independent contractors and not partners or joint venturers.

(b) Nothing in this Agreement shall in any way affect the autonomy of either party. Each party shall have exclusive control of its management, assets and affairs. Neither party assumes any liability for the debts or obligations of the other party.

(c) Neither party shall be responsible, financially or otherwise, for the care and treatment of any patient while that patient is admitted to, or is under the care of, the other party's facility.

(d) Each party may contract or affiliate with other facilities during the term of this Agreement.

5. Patient Billing.

(a) The facility in which the patient is receiving services at the time that charges are incurred shall have the sole responsibility for billing and collecting such charges from the patient. Neither party shall assume any responsibility for the collection of any accounts receivables of the other party.

(b) **The following clause ONLY applies in the event Transferor is a Skilled Nursing Facility.** Hospital shall bill Transferor, and Transferor shall compensate Hospital, for all services that are included in Medicare's Skilled Nursing Facility consolidated billing requirements ("Covered Services") provided to Facility patients who are Medicare beneficiaries at 30% of Hospital's charges as set

forth in its charge master in effect at the time services are rendered. Hospital will submit invoices to Transferor within 45 days following the rendering of services. Transferor shall pay each invoice within 30 days of the date of invoice. Late payments shall bear interest at a rate equal to the maximum rate of interest allowed by law. Transferor shall have the sole authority to bill Medicare for the Covered Services, and Hospital will not bill Medicare for any Covered Service. Transferor's obligation to pay Hospital's invoices is not contingent upon Transferor's receipt of reimbursement from Medicare or any other payor or party and will not be delayed if a claim is denied. However, Hospital will reasonably cooperate with Transferor in appealing a denial, but Hospital shall not be responsible for any costs associated with the appeal

6. EMTALA. The parties agree that any patient transfers made pursuant to this Agreement shall be in compliance with 42 U.S.C. § 1395dd, et seq. and any amendments thereto ("EMTALA"), EMTALA's implementing regulations, such other requirements as may be imposed by the Secretary of Health and Human Services, and any other applicable Federal or State patient transfer laws.

7. Indemnification. Transferor agrees to indemnify, defend and hold Hospital, its officers, trustees, employees and agents harmless, to the extent permitted by applicable law, from or against any loss, injury, damage or liability incurred by reason of any act or failure to act by Transferor, its officers, employees or agents in connection with the performance of this Agreement.

Hospital agrees to indemnify, defend and hold Transferor, its officers, employees and agents harmless, to the extent permitted by applicable law, from or against any loss, injury, damages or liability incurred by reason of any act or failure to act by Hospital, its officers, trustees, employees and agents in connection with the performance of this Agreement.

8. Insurance. Each party agrees to maintain insurance as will fully protect it from any and all claims, including malpractice, in amounts adequate to insure the party's perspective interest. A party may satisfy such requirement through a program of self-insurance or reinsurance. Upon the written request of Hospital, the Transferor shall provide Hospital with copies of the certificates of insurance and policy endorsements for all insurance coverage required by this agreement.

9. Confidential Information. Each party acknowledges that, as a result of its performance of its duties under this Agreement, it, its employees or agents may directly or indirectly receive medical information ("Patient Medical Information") regarding the other party's patients. Each party further acknowledges that Patient Medical Information is confidential pursuant to applicable State and federal law ("Applicable Privacy Laws"), including but not limited to, privacy standards imposed pursuant to the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Each party agrees, therefore, that any Patient Medical Information it, its employees or agents receive regarding the other party's patients shall be treated as confidential to the extent necessary to comply with Applicable Privacy Laws.

10. Compliance. In compliance with federal law, including the provisions of Title IX of the Education Amendments of 1972, Section 503 and 504 of the Rehabilitation Act of 1973, the Age Discrimination in Employment Act of 1967 and 1975 and the Americans with Disabilities Act of 1990, and Title VI of the Civil Rights Act of 1964 each party hereto will not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service, AIDS and AIDS related conditions in its administration of its policies, including admissions policies, employment, or program activities.

11. Record Availability. Transferor agrees that, until the expiration of four (4) years after the furnishing of any goods and services pursuant to this Agreement, it will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or

any of their duly authorized representatives, copies of this Agreement and any books, documents, records and other data of Transferor that are necessary to certify the nature and extent of the costs incurred by Hospital in purchasing such goods and services. If Transferor carries out any of its duties under this Agreement through a subcontract with a related organization involving a value or cost of ten thousand dollars (\$10,000) or more over a twelve-month period, Transferor will cause such subcontract to contain a clause to the effect that, until the expiration of four (4) years after the furnishing of any good or service pursuant to said contract, the related organization will make available upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, copies of this Agreement and any books, documents, records and other data of said related organization that are necessary to certify the nature and extent of costs incurred by Transferor for such goods or services. Transferor shall give Hospital notice immediately upon receipt of any request from the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives for disclosure of such information.

Transferor agrees to indemnify, defend and hold Hospital harmless from and against any loss, liability, judgment, penalty, fine, damages (including punitive and/or compounded damages), costs (including reasonable attorneys' fees and expenses) suffered or incurred by Hospital as a result of, in connection with, or arising from Transferor's failure to comply with this Section 6.

12. Anti-Referral; Fraud & Abuse Provisions. Any remuneration exchanged between the parties shall at all times be commercially reasonable and represent fair market value for rendered services or purchased items. No remuneration exchanged between the parties shall be determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals or any other business generated between the parties. Transferor does not have an indirect compensation arrangement with Hospital (as defined in the Stark II Regulations). Nothing contained herein requires the referral of any business between the parties.

13. Exclusion from Federal Health Care Programs. Transferor represents and warrants that it has not been nor is it about to be excluded from participation in any Federal Healthcare Program. Transferor agrees to notify Hospital within one (1) business day of Transferor's receipt of a notice of intent to exclude or actual notice of exclusion from any such program. The listing of Transferor or any Transferor-owned subsidiary on the Office of Inspector General's exclusion list (OIG website) or the General Services Administration's Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs (GSA website) for excluded individuals and entities shall constitute "exclusion" for purposes of this paragraph. In the event that Transferor is excluded from any Federal Healthcare Program, this Agreement shall immediately terminate. For the purposes of this paragraph, the term "Federal Healthcare Program" means the Medicare program, the Medicaid program, the Maternal and Child Health Services Block Grant program, the Block Grants for State for Social Services program, any state Children's Health Insurance program, or any similar program. Further, Transferor agrees to indemnify and hold Hospital harmless from and against any loss, liability, judgment, penalty, fine, damages (including punitive and/or compounded damages), costs (including reasonable attorneys' fees and expenses) incurred by Hospital as a result of Transferor's failure to notify the Hospital of its exclusion from any Federal Healthcare Program.

14. Ethical and Religious Directives. The parties acknowledge that the operations of Hospital and its affiliates are in accordance with the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church or its successor (the "Directives") and the principles and beliefs of the Roman Catholic Church are a matter of conscience to Hospital and their affiliates. The Directives are located at <http://www.usccb.org/about/doctrine/ethical-and-religious-directives/index.cfm>. It is the intent and agreement of the parties that neither the Agreement nor any part hereof shall be construed to require

Hospital or its affiliates to violate the Directives in their operation and all parts of the Agreement must be interpreted in a manner that is consistent with the Directives.

15. Corporate Compliance. Hospital has in place a Corporate Responsibility Plan, which has as its goal to ensure that Hospital complies with federal, state and local laws and regulations. The plan focuses on risk management, the promotion of good corporate citizenship, including a commitment to uphold a high standard of ethical and legal business practices, and the prevention of misconduct. Transferor acknowledges Hospital's commitment to corporate responsibility. Transferor agrees to conduct its business transactions with Hospital in accordance with the principles of good corporate citizenship and a high standard of ethical and legal business practices.

16. Miscellaneous.

(a) The parties agree to provide each other with information regarding the resources each has available and the type of patients or health conditions that each is able to accept.

(b) Neither party shall use the name of the other in any promotional or advertising material unless the other party has been given the opportunity to review the material and prior written approval for the material and its use has been obtained.

(c) This Agreement supersedes all prior agreements, whether written or oral, between the parties with respect to its subject matter and constitutes a complete and exclusive statement of the terms of the agreement between the parties with respect to its subject matter. This Agreement may not be amended, supplemented, or otherwise modified except by a written agreement executed by the party to be charged with the amendment.

(d) If any provision of this Agreement is held invalid or unenforceable by any court of competent jurisdiction, the other provisions of this Agreement will remain in full force and effect. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable.

(e) This Agreement shall be governed by and construed and enforced in accordance with the laws and in the courts of the State where the Hospital is located.

(f) Hospital may assign this Agreement, without the consent of Transferor, to an entity that directly or indirectly controls, is controlled by, or is under common control with, Hospital. For the purposes of this paragraph, the terms "control" means, with respect to a person, the authority, directly or indirectly, to (i) act as controlling member, shareholder or partner or such person, (ii) appoint, elect or approve at least a majority of the individual members, shareholders or partners of such person, or (iii) appoint, elect or approve at least a majority of the governing body of such person. Except as set forth above, neither party may assign this Agreement or any obligation hereunder without first obtaining the written consent of the other party. Any attempted delegation or assigning in violation of this paragraph shall be null and void. Subject to the foregoing, this Agreement shall be binding on and inure to the benefit of the parties and their respective heirs, administrators, successors and permitted assigns. Nothing expressed or referred to in this Agreement will be construed to give any person other than the parties to this Agreement any legal or equitable right, remedy or claim under or with respect to this Agreement or any provision of this Agreement, except such rights as shall inure to a successor or permitted assignee pursuant to this paragraph.

(g) In the event that any legal action or other proceedings, including arbitration, is brought for the enforcement of this Agreement or because of an alleged dispute of breach, the prevailing party shall be awarded its costs of suit and reasonable attorney's fees.

(h) All notices, consents, waivers and other communications required or permitted by this Agreement shall be in writing and shall be deemed given to a party when (a) delivered to the appropriate address by hand or by nationally recognized overnight courier service (costs prepaid); or (b) received or rejected by the addressee, if sent by certified mail, return receipt requested, in each case to the following addresses and marked to the attention of the person (by name or title) designated below (or to such other address or person as a party may designate by notice to the other parties):

If to Hospital: Saint Thomas Health
102 Woodmont Blvd., Suite 800
Nashville, TN 37205

With a copy to: Ascension Southeast Legal Services
102 Woodmont Blvd., Suite 600
Nashville, TN 37205

If to Transferor: TriStar Hendersonville Medical Center
355 New Shackle Island Road
Hendersonville, TN 37075

(i) The headings of the various sections of this Agreement are inserted merely for convenience and do not expressly or by implication limit, define or extend the specific terms of the sections so designated. Any rule of construction or interpretation otherwise requiring this Agreement to be construed or interpreted against any party shall not apply to any construction or interpretation hereof.

(j) This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement. The exchange of copies of this Agreement and of signature pages by facsimile transmission shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes. Signatures of the parties transmitted by facsimile shall be deemed to be their original signatures for all purposes.

[Signatures on following page]

IN WITNESS WHEREOF, the parties have executed this Patient Transfer Agreement as of the date first above written.

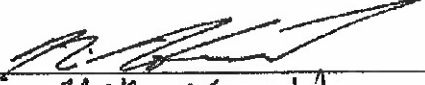
HOSPITAL:

SAINT THOMAS MIDTOWN HOSPITAL
SAINT THOMAS WEST HOSPITAL
SAINT THOMAS RUTHERFORD HOSPITAL
SAINT THOMAS HICKMAN HOSPITAL
SAINT THOMAS DEKALB HOSPITAL
SAINT THOMAS HIGHLANDS HOSPITAL
SAINT THOMAS RIVER PARK HOSPITAL
SAINT THOMAS STONES RIVER HOSPITAL
BY: SAINT THOMAS HEALTH, their parent

By: 
Name: Michelle Robertson
Title: Chief Operating Officer
Date: 7/17/2019

TRANSFEROR:

**Hendersonville Hospital Corporation d/b/a TriStar
Hendersonville Medical Center**

By: 
Name: Nick Howard
Title: COO
Date: 7/16/2019

MUTUAL AGREEMENT FOR EMERGENCY PATIENT TRANSFER

BY AND BETWEEN

PARTICIPATING HOSPITALS - 2002

In consideration of the needs of the residents of the area serviced by the institutions listed below, this Agreement is entered into by the hospitals that are listed on the Participants' Signatory Page. In the event of a natural or human-related disaster, as defined under the Davidson County Comprehensive Emergency Management Plan and comparable state and federal agencies, in which a participating institution's ability to provide continuity of care is prohibited, the participating institutions will mutually agree to provide hospitalization, when possible, for patients of the other institutions named in this agreement should the emergency require evacuation of patients. In the event of a national emergency declared by the President of the United States or the United States Congress, or a presidentially declared natural or technological disaster, a Federal party to this agreement must abide by its Federal Department policy and directives on emergency preparedness.

To the extent possible, under all the circumstances, emergency patient transfers shall be conducted in compliance with COBRA regulations, 42 USC 1395dd et seq. and any amendments thereto and such other requirements as may be imposed by the Secretary of Health and Human Services. This provision does not apply to any Federal party not subject to such statute or Health and Human Services Regulations.

In this agreement, the institution requiring evacuation of patients is hereafter referred to as "TRANSFERRING INSTITUTION" and the institution receiving patients is referred to as "RECEIVING INSTITUTION".

Now therefore, the parties agree as follows:

1. When the need exists for the evacuation of patients from the TRANSFERRING INSTITUTION to the RECEIVING INSTITUTION, the RECEIVING INSTITUTION agrees to facilitate prompt admission of such evacuated patients subject to availability of appropriate space and the ability to provide the services needed by the patients, and to the extent permitted by laws applicable to the participant. Unless otherwise agreed to between the Chief Executive Officers of the TRANSFERRING INSTITUTION and the RECEIVING INSTITUTION, a patient may only be admitted for inpatient care by the patient's attending physician who has medical staff privileges at the RECEIVING INSTITUTION or by a member of the RECEIVING INSTITUTION's medical staff through a referral by the patient's attending physician. The TRANSFERRING INSTITUTION is responsible for notifying family members of the new location of the patient.

2. When a patient has been transferred to the RECEIVING INSTITUTION from the TRANSFERRING INSTITUTION and it is determined that the need no longer exists to retain the patient at the RECEIVING INSTITUTION but the patient does require further hospitalization and/or follow-up, the TRANSFERRING INSTITUTION agrees to readmit that patient for the appropriate hospitalization and/or follow-up and to provide or arrange for transportation back to the TRANSFERRING INSTITUTION. The RECEIVING INSTITUTION may discharge patients per physician's order. The TRANSFERRING INSTITUTION will be notified of the discharge.
3. The TRANSFERRING INSTITUTION and RECEIVING INSTITUTION agree to provide each other with information regarding the type of resources and services the patient needs, the health conditions of the patient, and other needs of the patient, and any and all other information necessary to provide care for the patient.
4. The RECEIVING INSTITUTION and the TRANSFERRING INSTITUTION agree to send with each patient, at the time of transfer or, in case of disaster, as promptly as possible after the transfer, an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption together with essential, identifying and administrative information.
5. The RECEIVING INSTITUTION agrees to grant temporary reciprocity to those members of the medical staff of the TRANSFERRING INSTITUTION in certain specialties or departments as agreed to by the Chief Executive Officers of the TRANSFERRING INSTITUTION and the RECEIVING INSTITUTION. The RECEIVING INSTITUTION reserves the right to deny temporary reciprocal privileges to any member of the medical staff of the TRANSFERRING INSTITUTION, for any reason or no reason in its sole discretion. As soon as possible the TRANSFERRING INSTITUTION will provide a current listing of all credentialed medical staff who are to be granted temporary reciprocal privileges hereunder to the credentialing offices of the RECEIVING INSTITUTION, along with such credentialing documentation as reasonably requested by RECEIVING INSTITUTION.
6. The RECEIVING INSTITUTION agrees to grant temporary reciprocity to certain licensed professional patient care providers employed by the TRANSFERRING INSTITUTION, as agreed to by the Chief Executive Officers of the TRANSFERRING INSTITUTION and the RECEIVING INSTITUTION. The RECEIVING INSTITUTION reserves the right to deny such temporary reciprocity to any licensed professional patient care providers employed by TRANSFERRING INSTITUTION, for any reason or no reason in its sole discretion. As soon as possible, the TRANSFERRING INSTITUTION will provide a listing of licensed professional patient care providers to be granted reciprocity in order to work at the RECEIVING INSTITUTION, including pertinent licensing and certification information and documentation as reasonably requested by RECEIVING INSTITUTION. Prior to such individuals' commencing work at RECEIVING INSTITUTION, they shall report to an administrator of RECEIVING INSTITUTION, and shall thereafter comply with all appropriate directives of the administration of the RECEIVING INSTITUTION. Such individuals will remain on the payroll of the TRANSFERRING INSTITUTION who will continue normal insurance and workers compensation insurance coverage, unless other arrangements have been made.

7. The RECEIVING INSTITUTION and the TRANSFERRING INSTITUTION agree to notify the other institution promptly and in writing of any incident, occurrence, or claim arising out of or in connection with the transfer or medical treatment of a patient transferred from one facility to another under this Agreement, and to the extent permitted by laws applicable to the participant to cooperate with the other institution in this investigation of said incident, occurrence or claim, including provision of any medical records and information the other institution should request.
8. The INSTITUTIONS named on this Agreement will carry general liability, including broad form contractual, and professional liability insurance in a minimum amount of \$1,000,000/\$3,000,000 and shall provide a certificate of said coverage with this Agreement. This does not apply to governmental agencies prohibited/restricted by law.
9. The RECEIVING INSTITUTION and the TRANSFERRING INSTITUTION hereby agree to indemnify and hold the other institution harmless from any and all liability and claims of liability arising out of the sole negligence of the other institution's staff, employees, representative, and authorized agents alleged to have occurred during the other institution's care and treatment of patients transferred pursuant to this Agreement. However, in the case of government agencies, such agencies to the extent permitted by law and not inconsistent with the doctrine of sovereign immunity, such government agencies accept responsibility for negligent acts and omissions of its agents and employees and damages proximately caused thereby.
10. Neither the TRANSFERRING INSTITUTION, any of its employees or medical staff are to be construed as an agents or employees of the RECEIVING INSTITUTION. Neither the RECEIVING INSTITUTION, nor any of its employees or medical staff are to be construed as agents or employees of the TRANSFERRING INSTITUTION. Each party to this Agreement shall be considered to be an independent party and shall not be construed to be an agent or representative of any of the other parties, and therefore, has no liability for the acts or omissions of any of the other parties.
11. The TRANSFERRING INSTITUTION agrees that it will be responsible for payment of transportation services incurred when transferring patients to the RECEIVING INSTITUTION from the TRANSFERRING INSTITUTION. It is agreed that the services rendered by the TRANSFERRING INSTITUTION or the RECEIVING INSTITUTION shall be charged to the patient and that the TRANSFERRING INSTITUTION will not be held responsible for payment for services rendered to a patient by RECEIVING INSTITUTION nor shall the RECEIVING INSTITUTION be held responsible for services rendered to a patient by the TRANSFERRING INSTITUTION.
12. No party entering this Agreement shall use the name of any other party in this Agreement in any promotional or advertising material unless review and specific written approval of the material and intended use shall first be obtained from the party whose name is to be used.
13. Nothing in this Agreement shall be construed as limiting the right of any party entering into this Agreement to affiliate or contract with any other party on either a limited or general basis, while this Agreement is in effect.

14. The individual governing bodies of the institutions entering this Agreement shall have the exclusive control of the management, assets and affairs of their respective institutions.
15. By agreeing to admit an individual pursuant to the terms of this Agreement, the RECEIVING INSTITUTION does not assume legal responsibility for the individual until it assumes physical custody and control over said individual. Any responsibility incurred thereby shall terminate when the individual ceases to be a patient in said institution except for the results of the quality of care dispensed during the tenure of stay at the institution.
16. All institutions entering this Agreement shall comply with all federal and state laws or regulations applicable to this Agreement. If any provision of this Agreement shall at any time, conflict with any state or federal laws applicable thereto or shall conflict with any regulation of any regulatory agency having jurisdiction with respect thereto, the state or federal law shall govern except that a Federal party hereto does not waive any sovereign immunity except as specifically provided by act of Congress.
17. This agreement shall be reviewed on an annual basis, and revised if necessary. This Agreement will automatically renew itself. However, an institution may elect to terminate its participation in this Agreement. In that event, that institution shall terminate its participation in this Agreement by written notification to the other institutions at least ninety (90) days prior to the desired date of termination. However the termination of one institution shall not void this Agreement, and the terms and conditions of this Agreement shall remain effective and in force with the remaining institutions. An institution shall automatically be terminated from this Agreement should it fail to maintain licensure or certification as provided by law or regulation.
18. No revision in or amendment to this Agreement shall be valid unless such revision or amendment is in writing and executed by all parties hereto.
19. This agreement constitutes the entire understanding and agreement among the parties hereto with respect to the subject matter hereof and contains all the Agreements among the parties with respect to the subject matter and supersedes and replaces all agreements, both oral and written. There are no arrangements, understandings, restrictions, representations, or warranties among any of the parties hereto, except as provided herein this Agreement.
20. This Agreement cannot be amended, modified, supplemented or rescinded except in writing by the parties hereto. No waiver of any provision of this Agreement shall be valid unless such waiver is in writing signed by the parties hereto.
21. Each party hereby irrevocably consents to the jurisdiction of all state and federal courts sitting in Davidson County, Tennessee, agree that venue for any such action shall lie exclusively in such courts and agree that such courts shall be the exclusive forum for any legal actions brought in connection with this Agreement or the relationships among the

parties hereto except that a Federal party hereto does not waive any sovereign immunity except as specifically provided by act of Congress.

22. The headings used in the Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement.
23. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors or assigns, provided that appropriate written evidence of such assignment, signed by the assignor, is duly received by the other parties hereto.
24. This Agreement shall be governed in all respects by, and be construed in accordance with, the laws of the State of Tennessee and of the federal government except that a Federal party hereto does not waive any sovereign immunity except as specifically provided by act of Congress.
25. The failure by any party to enforce at any time any of the provisions of this agreement or any rights with respect thereto, or to exercise any election herein provided, shall in no way be considered to be a waiver of such provisions, rights, or elections, or in any way affect the validity of this Agreement. The exercise by any party of any rights or elections under the terms or covenants of this Agreement shall not preclude or prejudice any party from exercising the same or any other right it may have under this Agreement, irrespective of any previous action or proceeding taken by the parties.
26. In compliance with federal law, including provisions of Title IX of the Education Amendments of 1972, Section 503 and 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, the parties hereto will not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service in its administration of its policies, programs, or activities; its admissions policies; other programs; or employment.
27. This Agreement may be executed in one or more counterparts (facsimile transmission or otherwise), each of which counterpart shall be deemed an original Agreement and all of which shall constitute but one Agreement.
28. It is mutually agreed that any duty, obligation or liability of all parties assumed by this Agreement or any subsequent extensions or revisions thereto should continue until such time as the duty, obligation, or liability ceases to exist.

MUTUAL AGREEMENT FOR EMERGENCY PATIENT TRANSFER
BY AND BETWEEN PARTICIPATING HOSPITALS

PARTICIPANT'S SIGNATORY PAGE

We the undersigned, agree to abide by the MUTUAL AGREEMENT FOR EMERGENCY
PATIENT TRANSFER BY AND BETWEEN PARTICIPATING HOSPITALS.

Name of Facility: HENDERSONVILLE Medical Center

Name of President/CEO/Director or Designee: Jeff D. Pea

Authorized Signature: 

Title: CEO

Date: 5.22.02

MUTUAL AGREEMENT FOR EMERGENCY PATIENT TRANSFER
BY AND BETWEEN PARTICIPATING HOSPITALS

PARTICIPANT'S SIGNATORY PAGE

We the undersigned, agree to abide by the MUTUAL AGREEMENT FOR EMERGENCY
PATIENT TRANSFER BY AND BETWEEN PARTICIPATING HOSPITALS.

Name of Facility: VANDERBILT UNIVERSITY HOSPITAL

Name of President/CEO/Director or Designee: NORMAN B. URMY

Authorized Signature: NB Urmey

Title: EXECUTIVE VICE PRESIDENT, CLINICAL AFFAIRS

Date: 4/25/02

ADDENDUM to contract with Vanderbilt Univ. Hospital (hereafter referred to as "provider/vendor");
(Patient Transfer)

The below "Placeholder language" agreement should be inserted (in addition to the Business Associate language) into any new contract or any contract we are renewing.

HIPAA Requirements

Provider agrees to comply with the Health Insurance Portability and Accountability of 1996, as codified at 42 U.S.C. & 1320d ("HIPAA") and any current and future regulations promulgated thereunder 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. Part 142 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements". Provider agrees not to use or further disclose any Protected Health Information (as defined in 45 C.F.R. Section 164.501) or Individually Identifiable Health Information (as defined in 42 U.S.C. Section 1320d), other than as permitted by HIPAA Requirements and the terms of this Agreement.

Provider will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations.

Ineligible Persons

Provider represents and warrants to Hendersonville Medical Center that provider/vendor, 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 USC § 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 provider/vendor being excluded from participation in the Federal Healthcare Programs. This shall be an ongoing representation and warranty during the term of this Agreement and provider/vendor shall immediately notify Hendersonville Medical Center of any change in the status of the representations and warranty set forth in this section. Any breach of this section shall give Hendersonville Medical Center the right to terminate this Agreement immediately for cause.

to the best of provider's knowledge,

that may affect Hendersonville Medical Center.

Lee Ann Bartley
By: Hendersonville Medical Center

Lee Ann Bartley
Printed Name

Martin P. Sandler
By: (provider/vendor's name)

Martin P. Sandler, M.D.
Printed Name

HIM director/Facility Privacy Officer
Title

Associate Vice Chancellor for Hospital Affairs
Title

8/11/08
Date

September 8, 2008
Date

**MUTUAL AGREEMENT FOR EMERGENCY PATIENT TRANSFER
BY AND BETWEEN PARTICIPATING HOSPITALS**

LIST OF PARTICIPATING FACILITIES

Baptist Hospital	2000 Church Street Nashville, TN 37236
Centennial Medical Center	2300 Patterson St. Nashville, TN 37203
Columbia Cheatham Medical Center	313 North Mainstreet Ashland City, TN 37015
Gateway Health Systems	1771 Madison Street Clarksville, TN 37043
Hendersonville Hospital- <i>Medical Center</i>	355 New Shackle Island Rd. Hendersonville, TN 37075
Metropolitan Nashville Bordeaux Hospital	1414 County Hospital Road Nashville, TN 37218
Metropolitan Nashville General Hospital	1818 Albion Street Nashville, TN 37208
Middle Tennessee Medical Center	400 N. Highland Ave Murfreesboro, TN 37130
Skyline Medical Center	3441 Dickerson Pike. Nashville, TN 37207
Northcrest Medical Center	100 Northcrest Drive Springfield, TN 37172
Saint Thomas Hospital	4220 Harding Rd. (Box 380) Nashville, TN 37202
Select Specialty Hospital	2405 Parman Place Nashville, TN 37203
Southern Hills Medical Center	391 Wallace Rd. Nashville, TN 37211
Summit Medical Center	5655 Frist Boulevard Nashville, TN 37076
Tennessee Christian Medical Center	500 Hospital Drive Madison, TN 37115
University Medical Center	1411 Baddour Parkway Lebanon, TN 37087
Vanderbilt Medical Center	1161 21 st Ave. South Nashville, TN 37232
Veterans Administration Medical Center	1310 24 th Ave. South Nashville, TN 37212
Williamson Medical Center	P.O. Box 681600 Franklin, TN 37068

TENNESSEE EMERGENCY MEDICAL SERVICES FOR CHILDREN
INTERFACILITY PEDIATRIC TRANSFER AGREEMENT
BETWEEN
VANDERBILT UNIVERSITY
AND
HENDERSONVILLE MEDICAL CENTER

In consideration of the needs of the patients of the area served by both the institutions herein named, this Agreement is effective January 1, 2014 and entered into by and between Vanderbilt University, a Tennessee not-for-profit corporation acting by and through its Monroe Carell Jr. Children's Hospital at Vanderbilt (hereinafter referred to as "VANDERBILT"), and Hendersonville Medical Center, (hereinafter referred to as "FACILITY").

WITNESSETH:

WHEREAS, VANDERBILT is a Comprehensive Regional Pediatric Center ("CRPC") serving residents of the area served by VANDERBILT and FACILITY; and

WHEREAS, FACILITY may require the services of VANDERBILT for health care needs of critically ill and/or injured pediatric patients served by FACILITY;

NOW, THEREFORE, in consideration of the promises herein contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto agree as follows:

I. TERMS AND CONDITIONS:

- A. VANDERBILT will provide treatment and hospitalization within its capabilities for critically ill and/or injured pediatric patients of FACILITY on an as-needed basis when requested by FACILITY.
- B. FACILITY will transfer pediatric patients only when the patients need specialized treatment, care or tests that are not available at FACILITY, but are available at VANDERBILT. Prior to transfer, FACILITY will provide necessary stabilizing treatment within its capabilities in order to treat a patient's emergency medical condition, if applicable.
- C. A pediatric patient may only be transferred to VANDERBILT after a VANDERBILT attending physician accepts the patient's transfer after speaking with a FACILITY physician. If VANDERBILT's attending physician has approved and agreed to the transfer of the pediatric patient after concluding that all conditions of eligibility are met, and subject to availability of appropriate personnel, space and facilities at VANDERBILT, VANDERBILT agrees to facilitate prompt admission of the pediatric patient. The parties hereto agree to conduct any patient transfers in compliance with state and federal law, including 42 U.S.C. 1395dd *et seq.* and any amendments and regulations promulgated thereto ("EMTALA"), and such other requirements as may be imposed by the Secretary of Health and Human Services and state law (collectively, "Applicable Law").
- D. FACILITY shall provide or arrange appropriate transportation for a pediatric patient for the purpose of his or her transfer from one institution to the other under this Agreement. The appropriate method of transportation is dependent upon the pediatric patient's condition, and

such transportation (e.g., ground, fixed wing or rotary wing) will be determined after consultation between the transferring and receiving physicians.

- E. FACILITY has the responsibility for explaining the risks and benefits of transfer to, and obtaining consent for transfer from, the parents or legal guardian of the patient.
- F. If the admitting physician or transferring physician should deem it medically necessary for the pediatric patient to be accompanied by personnel and/or equipment during the transfer, FACILITY shall provide or arrange for, at no cost or expense to VANDERBILT, the appropriate personnel and/or equipment for the transfer.
- G. FACILITY agrees to send with each pediatric patient at the time of transfer pertinent medical and other information necessary to continue the pediatric patient's treatment without interruption, together with essential identifying and administrative information. If any such records are not available at the time of transfer, FACILITY shall send them to VANDERBILT as soon as practicable thereafter.
- H. VANDERBILT shall assume responsibility for patient care at the time it takes physical custody of the pediatric patient, and shall remain responsible for patient care only during the time that VANDERBILT has such physical custody of the pediatric patient.
- I. VANDERBILT shall not assume responsibility (legal, medical, or otherwise) for the patient until it has assumed physical control of the patient.
- J. If FACILITY is an inpatient facility, then it is agreed by VANDERBILT and FACILITY as follows: When a patient has been transferred to VANDERBILT from FACILITY and it is determined by the VANDERBILT attending physician that the patient has been stabilized and no longer has an emergency medical condition, requires emergency treatment, or needs additional specialty services provided at VANDERBILT, but the patient does require further hospitalization, FACILITY agrees to readmit that patient for appropriate hospitalization within 24-48 hours of such determination. In the event FACILITY's referring physician does not accept the patient, FACILITY's Chief of Medical Staff or other authorized representative of FACILITY shall facilitate identification of an appropriate accepting physician and transfer of the patient back to FACILITY.
- K. FACILITY shall cooperate in providing information and data requested by VANDERBILT to facilitate compliance with CRPC reporting requirements.
- L. FACILITY shall arrange for the transfer of the pediatric patient's personal belongings in connection with the transfer of the pediatric patient.
- M. FACILITY shall provide the parents or legal guardian with driving directions to VANDERBILT and information regarding VANDERBILT and its services.

II. BILLING AND PAYMENT

- A. It is agreed that the services rendered by VANDERBILT or the VANDERBILT physicians shall be charged to the patient, the patient's insurance carrier or other third party payor, and any payments made on such claims shall be the property of VANDERBILT or the VANDERBILT physicians. FACILITY shall not be held responsible for payment of services rendered to a patient by VANDERBILT or the VANDERBILT physicians. VANDERBILT

and the VANDERBILT physicians shall not be held responsible for payment of services rendered to a patient by FACILITY.

- B. After the pediatric patient is accepted by VANDERBILT, FACILITY will provide VANDERBILT with all financial information necessary to enable VANDERBILT to bill patient, patient's insurer, managed care organization ("MCO"), or other third party payor, prior to patient's transfer from FACILITY to VANDERBILT whenever possible. In no event shall this provision be interpreted to allow FACILITY or VANDERBILT to delay screening of, or stabilizing treatment for, an emergency medical condition in order to inquire about the patient's method of payment or insurance status.
- C. When a pediatric patient is accepted by VANDERBILT, FACILITY will assist VANDERBILT in obtaining any necessary authorizations or pre-certifications from the pediatric patient's insurer, MCO or other third party payor in regard to the patient's transfer to VANDERBILT.

III. TERM AND TERMINATION

- A. This Agreement shall be effective from the date listed above and continue until it is terminated in accordance with the provisions herein. This Agreement shall be reviewed on a periodic basis and at that time, both parties will evaluate the program and policies, discuss any related problems, and make necessary revisions. Neither party shall be bound by this Agreement until it is signed by the appropriate officials as indicated on the signature page of this Agreement.
- B. Notwithstanding any other terms and conditions hereunder, this Agreement may be terminated without cause by either party by written notification to the other party at least thirty (30) days prior to the desired effective date of termination.
- C. In the event that either party shall become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets or shall avail itself of, or become subject to, any proceedings under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of rights of creditors, then, at the option of either party, this Agreement may be terminated immediately by either party and be of no further force and effect.
- D. In the event that either party sells all or substantially all of its assets, there is a sale of a majority ownership of either party, or there occurs a material change in the management or ownership of either party, this Agreement may be terminated by either party and be of no further force and effect.
- E. Each party warrants it is duly licensed under the laws of its state and agrees to abide by applicable state and/or federal laws and regulations governing the licensure and operation of its facility. Each party further agrees to give prompt notice in writing to the other party in the event of institution of proceedings for suspension or revocation of its license, and to notify the other party in the event of any suspension or revocation of its license within twenty-four (24) hours of its occurrence. This Agreement will immediately terminate upon the revocation or suspension of licensure of either party. Further, either party, at its sole discretion, may terminate this Agreement in the event the other party is given notice of the institution of proceedings to suspend or revoke its licensure or to exclude it from participation in a federal health care program.

IV. INDEMNIFICATION

Each party shall indemnify and hold harmless the other party, its trustees, officers, agents and employees, from any judgments, damages, costs and expenses, including reasonable attorney's fees, from any claim, action or proceeding to the extent arising out of its own negligent acts or omissions in the performance of this Agreement. Indemnitor's obligations as set forth in the preceding sentence are conditioned upon (i) Indemnitee promptly notifying Indemnitor of any claim, demand or action, or any incident of which Indemnitee has actual or constructive knowledge, which may reasonably result in a claim, demand or action, and for which Indemnitee will look to Indemnitor for indemnification under this Section, (ii) Indemnitee, its directors, officers, agents, and employees, cooperating fully with Indemnitor in Indemnitor's investigation and review of any such claim, action or incident, and (iii) Indemnitee not entering into any admissions, agreements or settlements which may affect the rights of Indemnitee or Indemnitor without the prior written consent and approval of Indemnitor. Indemnitor reserves the right, in its sole discretion, to assume the defense of Indemnitee in any such claim, action or proceeding.

V. INSURANCE

- A. Each party shall procure and maintain for the term of this Agreement comprehensive general liability insurance, including broad form contractual, in a minimum amount of \$2,000,000/\$4,000,000. Such coverage shall act as primary insurance and no coverage of the other party shall be called upon to contribute to a loss.
- B. Each party shall procure and maintain for the term of this Agreement professional liability insurance, in a minimum amount of \$2,000,000/\$4,000,000 in coverage for all of its personnel who may participate in this Agreement. Such coverage shall be for a minimum of five (5) years following expiration or termination of this Agreement and shall provide for a retroactive date no later than the inception date of this Agreement.
- C. Each party shall procure and maintain, during the term of this Agreement, workers' compensation and employer liability insurance or a self-insurance program covering all of its employees who are engaged in any work under this Agreement.
- D. The parties shall provide each other with Certificates of Insurance evidencing the above coverage upon request.
- E. It is agreed that VANDERBILT may choose to provide the coverage stated above through a program of self-insurance.

VI. CONFIDENTIALITY

The parties agree to maintain all information which relates to or identifies a particular patient, including but not limited to the name, address, medical treatment or condition, financial status, or any other personal information which is deemed to be confidential in accordance with applicable state and federal law and standards of professional ethics and to train their employees, contractors, subcontractors, agents, and representatives to comply with such confidentiality requirements.

VII. NOTIFICATION OF CLAIMS

The parties agree to notify each other as soon as possible in writing of any incident, occurrence, or claim arising out of or in connection with this Agreement which could result in a liability or claim of liability to the other party. Further, the notified party shall have the right to investigate said incident or occurrence and the notifying party will cooperate fully in this investigation.

VIII. NOTICES

All notices or other communication provided for in this Agreement shall be given to the parties addressed as follows:

FACILITY: Sherry Cox
Hendersonville Medical Center
355 New Shackle Island Road
Hendersonville, TN 37075

VANDERBILT: CEO, Monroe Carell Jr. Children's Hospital at Vanderbilt
2200 Children's Way
Suite 2400
Nashville, TN 37232-9900

with a copy to: Office of Contracts Management
3319 Crystal Terrace, Suite 100
Vanderbilt University
Nashville, TN 37203-6869

IX. MEDIA

Each party agrees it will not use the other party's name, marks, or logos in any advertising, promotional material, press release, publication, public announcement, or through other media, written or oral, without the prior written consent of the other party.

X. MEDICAL RECORDS

All medical records and case histories of patients treated by VANDERBILT shall be kept at VANDERBILT, and shall be the property of VANDERBILT. FACILITY will be provided access to such medical records only with prior written consent of the patient and subject to VANDERBILT policies and Section XXII of this Agreement.

XI. DISCRIMINATION

The parties agree that they will comply with all applicable federal and state anti-discrimination statutes and regulations. Without limiting the generality of the foregoing, the parties agree not to discriminate against any patient based on financial status or payor source.

XII. ASSIGNMENT AND BINDING EFFECT

Neither party shall assign, subcontract, or transfer any of its rights or obligations under this Agreement to a third party without the prior written consent of the other party. If an assignment, subcontract, or

transfer of rights does occur in accordance with this Agreement, this Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors or assigns.

XIII. INDEPENDENT CONTRACTOR

Each party shall be considered to be an independent party and shall not be construed to be an agent or representative of the other party, and therefore, has no liability for the acts or omissions of the other party. In addition, neither party, nor any of its employees, agents, or subcontractors, shall be deemed to be employees or agents of the other party. Therefore, neither party nor any of its employees, agents or subcontractors, shall be entitled to compensation, workers compensation, or employee benefits of the other party by virtue of this Agreement.

XIV. COUNTERPART SIGNATURE

This Agreement may be executed in one or more counterparts (facsimile transmission or otherwise), each of which shall be deemed an original and all of which shall constitute but one Agreement.

XV. WRITTEN AMENDMENT/WAIVERS

This Agreement cannot be amended, modified, supplemented or rescinded except in writing signed by the parties hereto. No waiver of any provision of this Agreement shall be valid unless such waiver is in writing signed by the parties hereto.

XVI. GOVERNING LAW AND JURISDICTION

This Agreement shall be governed in all respects by, and be construed in accordance with, the laws of the State of Tennessee. Each party hereby (i) consents to the jurisdiction of all state and federal courts sitting in Davidson County, Tennessee, (ii) agrees that venue for any such action shall lie exclusively in such courts, and (iii) agrees that such courts shall be the exclusive forum for any legal actions brought in connection with this Agreement or the relationships among the parties hereto.

XVII. ACCESS TO BOOKS AND RECORDS

To the extent applicable, until the expiration of four years after the furnishing of services pursuant to this Agreement, the parties shall upon written request, make available to the Secretary of Health and Human Services or the Comptroller General or their duly authorized representative the contract, books, documents, and records necessary to verify the nature and extent of the cost of such services. If either party carries out any of its obligations under this Agreement by means of a subcontract with a value of \$10,000 or more, that party agrees to include this requirement in any such subcontract.

XVIII. CONSTRUCTION OF AGREEMENT

The headings used in this Agreement have been prepared for the convenience of reference only and shall not control, affect the meaning, or be taken as an interpretation of any provisions of this Agreement. This Agreement has been prepared on the basis of mutual understanding of the parties and shall not be construed against either party by reason of such party's being the drafter hereof.

XIX. NON-EXCLUSIVITY

Each party shall have the right to enter into similar agreements with other parties.

XX. COMPLIANCE WITH PATIENT TRANSFER REQUIREMENTS

All parties hereto agree that any patient transfers shall be in compliance with Applicable Law. In the event of an inconsistency between the provisions of this Agreement and any mandatory provision of Applicable Law, the Applicable Law shall control. Where provisions of this Agreement are different than those in Applicable Law but are nonetheless permitted by Applicable Law, the provisions of this Agreement shall control.

XXI. PATIENT REFERRALS

The parties agree that any benefits to either party hereunder do not require, are not payment for, and are not in any way contingent upon the admission, referral, or other arrangement for the provision of any item or service reimbursed under Medicare or Medicaid/TennCare.

XXII. HIPAA REQUIREMENTS

The parties acknowledge that each party is a "covered entity" as that term is defined at 45 C.F.R. § 160.103. As such, the parties agree to comply with applicable requirements of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d et seq. ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), as each may be amended from time to time, and any current and future regulations promulgated thereunder, including without limitation the federal privacy regulations contained in 45 C.F.R. Part 160 and Part 164, Subpts. A and E (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Part 160 and Part 164, Subpts. A and C (the "Federal Security Regulations"), the federal breach notification rules contained in 45 C.F.R. Part 160 and Part 164, Subpts. A and D, and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements". The parties agree not to use or further disclose any Protected Health Information, as defined in the Federal Privacy Regulations, other than as permitted by HIPAA Requirements and the terms of this Agreement, or as otherwise authorized by the patient in accordance with applicable laws.

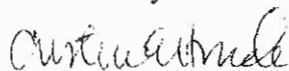
XXIII. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement between the parties hereto with respect to the subject matter herein and supersedes any other agreements, restrictions, representations, or warranties, if any, between the parties hereto with regard to the subject matter herein.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives on the last signature date specified below.

FOR VANDERBILT UNIVERSITY

Recommended by:



Christina M. Estrada, M.D.
Director, Pediatric Emergency Medicine
Monroe Carell Jr. Children's Hospital at Vanderbilt

Date

3/30/14

Luke Gregory

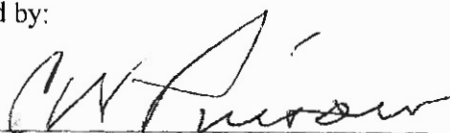
Chief Executive Officer

Monroe Carell Jr. Children's Hospital at Vanderbilt

Date

4/3/14

Approved by:



C. Wright Pinson, MBA, MD
Deputy Vice Chancellor for Health Affairs
Senior Associate Dean for Clinical Affairs
CEO of the Vanderbilt Health System

Date

4/7/14

FOR HENDERSONVILLE MEDICAL CENTER

 , CEO

Date

2/20/14

Date

Attachment 4E-1

Equipment List > \$50,000

42 Working Vendor Item Summary

Report Filters:

Report Time:

11/04/2021 12:50

Ted Bennett

Budget = FSER Template - Updated 9/14/21

Equipment items > \$50k

GE Logiq 8 Ultrasound	\$60,884
GE Physiologic Monitoring	\$98,240
(1 fixed and 4 portable monitors with central station)	
GE XR646 Rad Room	\$130,202
GE Optima XR240 Portable X-ray	\$63,811
GE Revolution EVO CT System	\$376,446

Attachment 4N-1

Financial Assistance Policy for
Uninsured Patients,
Charity Financial Assistance Policy for
Uninsured and Underinsured Patients,
and
Discount Policy for Patients



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.

Determines the patient cannot make payment or establish arrangements for payment.

Assigns the Medicaid Pending IPLAN as the primary payer.

Assigns the Charity Pending IPLAN as the secondary payer.

Assigns the Charity Pending IPLAN as the secondary payer.

Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.

Presents the Financial Assistance Application to the patient or responsible party.

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.

Collects payment for elective cosmetic or facility flat rate procedure.

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.

Determines the patient cannot make payment or arrangements for payment.

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Determines the charges will be over the Medicaid eligibility threshold.

Assigns the Medicaid Pending IPLAN as the primary payer.

Assigns the Charity Pending IPLAN as the secondary payer.

Assigns the Uninsured Discount IPLAN as the tertiary payer.

Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.

Presents the Financial Assistance Application to the patient or responsible party.

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.

Determines the patient cannot make payment or arrangements for payment.

Determines the complete charges for services cannot be made at time of registration or
Determines the charges will not be over the Medicaid eligibility threshold.

Assigns the Charity Pending IPLAN as the primary payer.

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.

Presents the Financial Assistance Application to the patient or responsible party.

Documents account.

Self-Pay – Emergency Department Registrations

Patient Access

EMTALA guidelines must be adhered to for all ED patients.

Assign the Charity Pending IPLAN as the primary payer.

Assign the Uninsured Discount IPLAN as the secondary payer.

Documents account accordingly.

Self-Pay – Emergency Department Departures (able to pay)

Patient Access

Determines the patient can make payment or arrangements for payment.

Removes the Charity Pending IPLAN (if assigned at time of registration)

Assigns the Uninsured IPLAN as the primary payer. If the patient opts out for the ESP process, assign the appropriate ESP IPLAN.

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.

Self-Pay – Emergency Department Departures (unable to pay)



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Patient Access

Determines the patient cannot make payment or arrangements for payment.

Ensures the Charity Pending IPLAN is the primary payer

Ensures the Uninsured IPLAN is the secondary payer.

Reviews and obtains a signature on the Uninsured Patient Information Document from the patient or responsible party.

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.

Notifies Payment Compliance of accounts with Uninsured Discount Plan as the primary payer that are final billed and do not reflect an Uninsured Discount.

Ensures that all Statements are held until the Uninsured Discount is posted for patients who have the Uninsured Discount Plan as the primary payer.

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.

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

Deletes the Charity Pending IPLAN and the system will automatically move the Uninsured Discount Plan to the primary position

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.

Remove Third Party IPLAN from account.

Add Pending Medicaid as primary payer and Charity Pending 099-50 as secondary payer.

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.
Adds the Uninsured – Partially Exhausted Benefits IPLAN (099-49) into the secondary position following the partially exhausted benefits payer IPLAN.

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.

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 collector

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 (FA) for the purposes of processing a charity write-off for certain patients receiving services at HCA-affiliated, non-partnership, acute-care hospitals and hospitals.

PURPOSE:

To define the policy for providing partial or full financial relief to patients who have received emergency services, who meet certain income requirements, who do not qualify for state or federal assistance for the date of service, who are uninsured or underinsured, and who are unable to make partial or full payment on outstanding balances. In addition, with respect to the FA 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.

- To be eligible for a charity write-off review, a patient must have incurred emergent, non-elective services.
- 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 PL thresholds are met as set forth in Section 3, below.
- For purposes of this policy, an uninsured patient is one who has no third party payer coverage for emergent health care services, who provides documentation that the patient is unable to pay for some or all of the provided non-elective hospital services and who satisfies the financial eligibility criteria set forth herein.
- 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.
- 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, Medicare, Medicare secondary payer, private insurance company, or other private, non-governmental third party payer, that the payment has been

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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

Medicare Accounts

i. All Medicare patients (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 (PR 11-12).

ii. In addition to the AA, 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 1042
- Supporting 1099's
- Copies of all bank statements for last 6 months
- Most recent bank and broker statements listed in the Federal Tax Return
- Current credit report

iii. Qualifying 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. At these requirements are met must be supported by a State Medicaid remittance advice. When claiming an amount as Medicare and Medicaid 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 and Medicaid adjustment. Charity write-offs for Medicaid exhausted beneficiaries may be less than \$1,500.

iv. Patients who qualify for a Medicare Savings Program (Qualified Medicare beneficiary, Specified Low-Income Medicare beneficiary (SLI), or Qualifying Individual) will be eligible for a full charity write-off. Charity write-offs for Medicare Savings Program qualified patients may be less than \$1,500.

Non-Medicare Accounts

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i Generally, for all non-Medicare Accounts, the following will be acceptable supporting documentation in 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 AAA 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

CC 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 complete the AAA, 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

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- 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. Termination 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 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 without 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.

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- 201-0000 balances capped at 10% of annual household income
 - 010-4000 balances capped at 4% of annual household income
- Upon request by a patient and, if there are extenuating circumstances, accounts without 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 ICD-9 codes on their account: 92.1, 92.2, 92.3, 92.4, 92.5, or 92.1, and NO 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 PL. The patient balance caps are as follows:

E/M Levels 1-3

201-0000 balance capped at \$1500
010-4000 balanced capped at \$1750

E/M Levels 4 +

201-0000 balance capped at \$2500
010-4000 balanced capped at \$2750

In the event that Section 9A or above provides more relief to the patient, then Section 9A or above will be used to determine patient responsibility.

10 Patients Who Are Uninsured

Notwithstanding 9A and 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 9A or 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.

DEPARTMENT: Operations Support	POLICY DESCRIPTION: Charity Financial Assistance Policy for Uninsured and Underinsured Patients
PAGE: 6 of 6	REPLACES POLICY DATED: 11/01/2017-10/1/2020
APPROVED: 02/27/2023	EFFECTIVE DATE: 07/01/2023
ANNUAL REVIEW DATE: 07/27/2024	REFERENCE NUMBER: PARA.PP.OPS.016

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.

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 Operations Support Director, Hospital Chief Financial Officer or an SSC Executive as defined in the Charity Review Appeal Process policy (PARA.PP.OPS.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.

REFERENCE:

- PARA.FT.OPS.606 Federal Charity Guidelines
- PARA.FT.OPS.638 Financial Assistance Application
- PARA.MF.OPS.804 Collection Charity Letters
- PARA.PARS.PP.009 Medicare Bad Debt and Recovery Logs Policy
- PARA.PP.OPS.019 Utilizing the Artiva Charity Process

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.

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

Attachment 4N-2

Non-Discrimination Policy

Equal Employment Opportunity, Anti-Harassment, and Respectful Workplace Policy

Index

Equal Employment Opportunity, Anti-Harassment, and Respectful Workplace Policy - HR.ER.072

DEPARTMENT: Human Resources

POLICY DESCRIPTION: Equal Employment Opportunity, Anti-Harassment, and Respectful Workplace

PAGE: 1 of 5

REPLACES POLICY DATED: HR.ER.013 (7/1/21); HR.ER.024 (11/1/16); HR.ER.059 (8/1/18)

EFFECTIVE DATE: January 1, 2022

REFERENCE NUMBER: HR.ER.072

APPROVED BY: Ethics and Compliance Policy Committee

SCOPE: All Company-affiliated subsidiaries including, but not limited to hospitals, ambulatory surgery centers, outpatient imaging centers, physician practices, HealthTrust Workforce Solutions, Corporate Departments (Organization Units), Groups, and Divisions (collectively, "Affiliated Employers" and individually, "Affiliated Employer").

PURPOSE: To ensure all colleagues are treated in accordance with the mission and values of the organization in compliance with federal, state, and local laws addressing harassment and discrimination. By outlining responsibilities and requirements for behavior and conduct; ensuring that we act in accordance with our mission, values, and applicable laws; and clearly defining the obligations to identify and report potential violations of this policy, it is the purpose of this policy to create and sustain a safe, welcoming, and productive work environment for all colleagues, patients, and visitors.

POLICY:

A. Equal Employment Opportunity and Unlawful Harassment

1. HCA Healthcare and its Affiliated Employers are equal opportunity employers, committed to promoting an inclusive culture that embraces and nurtures our patients, colleagues, partners, physicians and communities. Equal employment opportunities are provided to all colleagues and applicants for employment without regard to race, color, religion, sex, gender, national origin, age, pregnancy, disability, sexual orientation, gender identity or expression, genetic information or protected veteran status, or status in any group protected by federal, state or local law. This policy applies to all terms and conditions of employment, including, but not limited to, hiring, placement, promotion, termination, layoff, transfer, leaves of absence, compensation, and training. Reasonable accommodations will be made to known qualified individuals with disabilities. As used within this paragraph, "genetic information":

- a. includes information about an individual's genetic tests, genetic tests of a family member, and family medical history; and

b. does not include information about the sex or age of an individual or the individual's family members; information that an individual currently has a disease or disorder; or tests for alcohol or drug use.

2. Unlawful harassment is a form of discrimination and violates the policies of HCA Healthcare and its Affiliated Employers. This policy expressly prohibits any form of unlawful colleague harassment based on race, color, religion, sex, gender, national origin, age, pregnancy, disability, sexual orientation, gender identity or expression, genetic information, protected veteran status, or status in any group protected by federal, state or local law. Such harassment may include, but is not limited to, offensive comments, jokes, or innuendoes in printed material, material distributed through electronic media, or items posted on walls or communication boards. Improper interference with the ability of colleagues to perform their expected job duties is not tolerated. Harassment becomes unlawful where:

- a. Enduring the offensive conduct becomes a condition of continued employment, or
- b. The conduct is severe and pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive.

3. Examples of prohibited harassment or discrimination include, but are not limited to:

- a. Degrading words or name calling used to describe an individual.
- b. Displays of reading materials, objects, or pictures containing negative stereotypes in the workplace.
- c. Using e-mail, voicemail, facsimile, instant messaging, or any other digital media or Affiliated Employer property for the transmission of discriminatory or otherwise inappropriate material.
- d. Offensive jokes, pranks, vandalism, negative comments, threatening language toward others, or other conduct related to the characteristics identified in this policy under Section A.1.

4. Each member of management is responsible for creating an atmosphere free of discrimination and harassment. Further, colleagues are responsible for respecting the rights of their coworkers.

B. Sexual Harassment

1. Colleagues' right to work in an environment free of harassment and disruptive behavior includes the right to a work environment free from sexual harassment. Sexual harassment will not be tolerated. Sexual harassment includes, but is not limited to, unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual nature, especially where:

- a. Submission to such conduct is made either explicitly or implicitly a term or condition of employment;
- b. Submission to or rejection of such conduct is used as the basis for decisions affecting an individual's employment; or
- c. Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive working environment.

2. Behaviors that produce a hostile or offensive work environment will not be tolerated. These behaviors include but are not limited to:

- a. unwelcome sexual remarks, advances, and/or propositions;
- b. unwelcome touching or other physical contact;
- c. unwelcome requests for dates or other social engagements;
- d. offensive comments, jokes, innuendoes, and other sexually-oriented statements; or
- e. sexually suggestive printed material, material distributed through electronic media, e-mail, voicemail, facsimile, instant messaging or any other digital media or Affiliated Employer property or items posted on walls or bulletin boards.

3. Each member of management is responsible for creating an atmosphere free of sexual harassment. Further, each colleague is responsible for respecting the rights of coworkers.

C. Respectful Workplace

1. Even when conduct does not rise to the level of unlawful harassment, relationships marred by disrespectful behavior have a negative impact on the quality and safety of care delivered. The establishment of positive, respectful relationships is crucial to preventing these behaviors. Respect is promoted through communication, collaboration, support, and fairness, each of which is foundational to establish healthy relationships with others.

2. Respectful individuals act and speak in a manner that preserves the safety, dignity, autonomy, self-esteem and civil rights of others. In doing so, they must consider the audience, setting, and tone prior to expressing their thoughts in words or actions. The goal is to do this in a constructive manner and in an appropriate setting so as not to impede providing the utmost quality of care to our patients and creating a safe, welcoming, and productive work environment.

3. Management is responsible for creating a workplace that promotes physical and mental well-being. When colleagues do not feel safe, the work environment is left vulnerable, and everyone's safety is compromised and serious problems in the workplace can occur.

4. Under Section 7 of the National Labor Relations Act, colleagues who are "employees" have the right to express their concerns, whether positive or negative, regarding their terms and conditions of employment. We expect such colleagues to exercise those rights in a respectful and courteous manner that does not negatively affect the delivery of safe, effective, efficient, and compassionate care to our patients. This furthers our goal of maintaining a safe, respectful, and productive work environment for colleagues, volunteers, students, contract staff, physicians or any other person doing business with or for our business entity.

5. Representative Examples of Prohibited Conduct, include, but are not limited to:

- a. **Incivility:** the acts of rude and discourteous conduct, gossiping and spreading rumors, the use of profane or obscene language in a demeaning or offensive way, inappropriately refusing to assist a coworker, or similar acts.
- b. **Bullying:** the combination of repeated, unwanted harmful actions intended to humiliate or offend the recipient by abusing or misusing power, creating feelings of defenselessness and

injustice, or undermining an individual's inherent right to dignity. Bullying can also include workplace mobbing, which is a form of bullying aimed at an individual from a work group.

c. **Violence:** the threat or use of verbal or physical harm or force against an individual that reduces or eliminates their sense of being safe or actual safety.

d. **Retaliation:** any adverse action or behavior that is seeking revenge against another for opposing or reporting inappropriate actions.

e. **Intimidation:** the use of demeaning or undermining comments or actions with the intention to compel or deter another coworker from taking appropriate action or to cause distress to another by withholding support.

D. Reporting Obligations

1. HCA Healthcare and its Affiliated Employers encourage colleagues to report all incidents of harassment or other violations of this policy. If a colleague experiences any job-related harassment based on race, color, religion, sex, gender, national origin, age, pregnancy, disability, sexual orientation, gender identity or expression, genetic information or protected veteran status, or status in any group protected by federal, state or local law; believe that they have experienced job-related harassment or were treated in an unlawful, discriminatory manner; or experiences disrespectful behavior, the colleague should promptly report the incident to their supervisor and/or Human Resources, who will investigate the matter and take appropriate action. In addition, if a colleague believes that they have witnessed behavior that violates this policy, they are highly encouraged to report that conduct to their supervisor and/or Human Resources.

2. Colleagues should normally report these items to the colleague's supervisor, who must immediately notify Human Resources. However, if the colleague believes it would be inappropriate to discuss the matter with their supervisor, the colleague may bypass the immediate supervisor and report the incident directly to Human Resources. Additionally, colleagues may report issues at any time to the HCA Healthcare Ethics Line at (800) 455-1996 or online at <http://hcahealthcareethicsline.ethix360.com>.

3. Confidentiality safeguards will be applied in handling complaints of harassment, discrimination, retaliation, or other issues arising under this policy. To the extent possible, the privacy of the complainant, witnesses, and individual(s) accused are kept confidential, although absolute confidentiality cannot be promised.

4. If it is determined that a violation of this policy occurred, appropriate disciplinary action will be taken against the offending colleague, up to and including termination of employment. However, the level of discipline issued as a result of an investigation is typically a confidential matter between the employer and the colleague receiving discipline, and may not be shared with other individuals.

5. Any form of retaliation against any colleague for filing a good faith complaint under this policy or for assisting in a complaint investigation, even if the investigation produces insufficient corroboration to support the claim, is strictly prohibited.

E. Policy Violations and Other Policy Application Guidelines

1. Colleagues who knowingly make a false allegation, provide false or misleading information in the course of an investigation, or otherwise act in bad faith may be subject to appropriate discipline, up to and including termination; reference the Non-Retaliation Policy, EC.030, and Discipline, Counseling, and Corrective Action Policy, HR.ER.008.
2. Colleagues do not have the right to legal or any other representation during interviews conducted under this policy unless otherwise required by law.
3. Colleagues participating in an investigation are prohibited from recording any part of the investigatory process unless approved by all individuals involved in the recording. "Recording" includes all forms of recording including, but not limited to, audio, video, digital, etc., methods of recording.
4. When the alleged harasser is a member of the medical staff or another practitioner with clinical privileges, investigation and/or corrective action, as appropriate, will be handled in accordance with the applicable Medical Staff Policies and Bylaws.

DISCLOSURE:

If there is any conflict between the information in this policy and a Collective Bargaining Agreement (CBA), the CBA prevails for covered colleagues.

REFERENCES:

1. [HCA Healthcare Code of Conduct](#)
2. Appropriate Use of Communications Resources and Systems Policy, [EC.026](#)
3. Non-Retaliation Policy, [EC.030](#)
4. Communication Boards Policy, HR.ER.007
5. Discipline, Counseling, Corrective Action Policy, HR.ER.008
6. Employee Dispute Resolution Process Policy, HR.ER.011
7. Limitations on Employment Policy, [HR.ER.019](#)
8. Binding Arbitration Policy, HR.ER.054

Referenced Policies

[Discipline, Counseling, Corrective Action Policy](#)

[Job Postings Policy](#)

[Solicitation Policy](#)

[Code of Conduct](#)

Attachment 1C-2

List of Non-HCA Affiliations

Home Health Agency	Address	Files
Adoration Home Health Nashville, TN	Multiple Locations	
All Heart Health Nashville	2 International Plaza #201, Nashville, TN 37217	20
Amedisys Home Health Care	Multiple Locations	
Beaconess HomeCare	677 Lebanon Rd., Apt Guliet, TN 37122	2
Lifeline Home Care Springfield	210 Park Plaza Dr #200, Springfield, TN 37172	14
NHC HomeCare Andersonville	1000 Laurel Park Ct Suite 7, Andersonville, TN 37075	15
NHC HomeCare Springfield	101 Moreland Drive, Springfield, TN 37172	14
SunCrest Home Health Nashville	4400 Hickerson Pike Suite 200, Nashville, TN 37207	1
TN Quality Home Care	Multiple Locations	
Skilled Nursing Facilities	Address	Files
AAC Hancock	115 Hickerson Road, Goodlettsville, TN 37072	1
Metcalf Center for Rehab and Healing	421 Ocala Dr, Nashville, TN 37211	62
Creekside Center for Rehab and Healing	6000 Due West Avenue, Madison, TN 37115	16
Callatin Center for Rehab and Healing	400 N Water Avenue, Callatin, TN 37066	16
Lebanon Center for Rehab and Healing	701 Castle Heights Ct, Lebanon, TN 37077	47
Life Care Center of Old Dickory Village	1250 Robinson Road, Old Dickory, TN 37100	1
Nashville Center for Rehabilitation	200 Edgewood Avenue, Nashville, TN 37203	2
NHC HealthCare Andersonville	70 Old Sycamore Island Road, Andersonville, TN 37075	1
NHC HealthCare Springfield	6000 1st Avenue, Springfield, TN 37172	14
Signature HealthCare of Clarksville	100 Old Farmers Road, Clarksville, TN 37040	71
Signature HealthCare of Portland	215 Highland Cir Dr, Portland, TN 37140	17

StoneRidge Health Center	5121 Greer Road, Goodlettsville, TN 37072	111
McCandree Post Acute and Rehabilitation	447 Lebanon Pike, Nashville, TN 37076	247
McInters of Smyrna	202 Mon Springs Road Smyrna, TN 37167	475
Rebecca Center for Rehabilitation and Healing	2200urfreesboro Pike, Nashville, TN 37210	275
McInters of Springfield	704 5 th Avenue S, Springfield, TN 37172	111
McInters Creech Health and Rehabilitation	425 McInters Drive, McInters Creech, TN 37100	227
LAC	Address	Files
Select Specialty Hospital Nashville	2000 Hayes St Nashville, TN 37020	272
Hospice	Address	Files
Adoration Hospice	Multiple Location	
Alive Hospice	Multiple Locations	
Aveanna Hospice	Multiple Locations	
Caris Healthcare Springfield	2000 Memorial Blvd S, Springfield, TN 37172	116

Attachment 1C-3

Community Benefit Report

TriStar Hendersonville

Hendersonville, Tennessee

TriStar Hendersonville Medical Center has served Sumner County for 45 years with nationally recognized care closer to home.

Our Birth Center features private suites, breastfeeding support and the only Level II NICU north of downtown Nashville.

Celebrating 10 years of service to Sumner County, TriStar Portland emergency room is our satellite campus, which offers 24/7 emergency care as well as outpatient imaging and lab services.



Justin Coury
Chief Executive Officer

Additional location: TriStar Portland ER



8,264

Patient admissions

51,448

Total annual ER visits

48,866

Outpatient visits

844

Colleagues

159

Licensed beds

Key services:

- Advanced Primary Stroke Center
- Cardiology
- Emergency
- Neonatology
- Obstetrics
- Orthopedics
- Rehabilitation services
- Robotic-assisted surgery
- Surgical care
- Surgical weight loss
- Trauma (Level III)
- Urology
- Wound care

Attachment 4C-1

Clinical Training Affiliations

School / Program List

School	Program
APSU Lab	Med Lab Science (BS)
	Phlebotomy
APSU Nursing	Nursing
APSU Radiation	Radiology
Belmont Nursing	Nursing
Belmont OT	PT/OT
Belmont PT	PT/OT
Belmont Pharm	Pharmacy
Cumberland U	Nursing
Fortis-Nashville Nursing	Nursing
Galen	Nursing
Lipscomb Pharm	Pharmacy
Lipscomb Nursing	Nursing
Lipscomb PA	Physician Assistant
MarianU	Nursing
MTSA	Nursing Anesthesia
Nashville State CST	Instrument Sterile Tech
Nashville State OTA	PT/OT
	PTA / OTA
Nashville State Surg Tech	Surg Tech
South Nashville BSN	Nursing
South Nashville OTA	PTA/OTA
TN Tech	Nursing
Trevecca PA	Physician Assistant
TSU HIM	HIM/HIT
TSU OT	PT/OT
TSU PT	PT/OT
TSU Resp	Respiratory
UAB Nursing	Nursing
Union H	Nursing
University of Mississippi Speech	Speech
UTC PT	PT/OT
UTHSC OT	PT/OT
UTHSC PT	PT/OT
UTHSC Speech	Speech
Vanderbilt	Nursing
Vol State Nursing	Nursing
Vol State EMS	EMT/AEMT
	Paramedic
Vol State Lab	Clinical Lab Tech (AAS)
Vol State PTA	PT/OT
	PTA/OTA
Vol State Radiology	Radiology
Vol State Respiratory	Respiratory
Vol State Sonography	Sonography
WKYU ASN	Nursing
WKYU BSN	Nursing
WKYU PT	PT/OT

Vendor / Contract Name

Austin Peay State University
Belmont University
University of Alabama for the University of Alabama at Birmingham
Chamberlain College of Nursing, LLC
Cumberland University
Fortis College
Galen University
Lipscomb University
Marian University
Maryville University
Middle Tennessee School of Anesthesia
South College
Tennessee College of Applied Technology
Tennessee State University
Trevecca Nazarene University
Union University School of Nursing
University of Alabama in Huntsville
University of Missouri
University of Tennessee Memphis
University of Tennessee Knoxville
University of Tennessee Chattanooga
Vanderbilt University
Volunteer State Community College
Walden University
Western Kentucky University

Attachment 4C-2

Tennessee EMTALA Transfer Facility
Policy,
Tennessee EMTALA Medical Screening
Examination and Stabilization,
EMTALA Provision On-Call Coverage,
EMTALA Central Log Policy, and
Tennessee EMTLA – Signage Policy



Origination12/2000
Last12/2023
Approved
Last Revised06/2020
Next Review12/2026

OwnerMelony Scott: Dir
Emergency Svcs
Policy AreaEMTALA
ApplicabilityTriStar
Hendersonville
Medical Center &
TriStar Portland

EMTALA, TN Transfer Facility Policy

DATE:5/1/2019

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.

- a. 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.
- b. **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.

1. 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.

2. **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.

3. **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.

4. **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 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.

- 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.

- a. **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.
- a. **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.
- b. **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.

1. 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.

1. **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.

2. **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.

1. 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 appropriate 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.

1. **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.

2. **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.

1. 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.

- v. 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).

Attachments

[Emergency Medical Condition \(EMC\) Identified](#)

Approval Signatures

Step Description	Approver	Date
Administration	Taylor Young-Sawyer: COO	12/2023
	Lisa Hochstetler: CNO Hendersonville Med Ctr	10/2023
	Patrick Rafferty: COO Hendersonville Med Ctr	08/2023
	Melony Scott: Dir Emergency Svcs	08/2023

Applicability

TriStar Hendersonville Medical Center



Origination 12/2000
Last Approved 12/2023
Last Revised 06/2020
Next Review 12/2026

Owner Melony Scott: Dir
Emergency Svcs
Policy Area EMTALA
Applicability TriStar
Hendersonville
Medical Center &
TriStar Portland

TN EMTALA, Medical Screening Examination and Stabilization

DATE:5/1/2017

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.

- a. 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:
 1. Whether the hospital DED has the personnel and resources necessary to render adequate medical treatment to all existing patients in the DED
 2. 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
 3. 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
 1. all persons with the same medical condition are moved to this location regardless of their ability to pay for treatment
 2. there is a bona fide medical reason to move the individual, and
 3. 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.

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.
 1. 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.
 2. 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.
 - ii. *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.
 - iii. *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.

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:
 1. is qualified to conduct such an examination through appropriate privileging and demonstrated competencies;
 2. 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);
 3. is performing the screening examination based on medical staff approved guidelines, protocols or algorithms; and
 4. 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;

c) and 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 individual's refusal to sign the Partial Refusal of Care or the Against Medical Advice Form (see [Partial Refusal of Care or Against Medical Advice Form](#)). 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](#).
- 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.

e. 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.

- d. 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.
- e. 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.
- f. 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.

Approval Signatures

Step Description	Approver	Date
Administration	Taylor Young-Sawyer: COO	12/2023
	Lisa Hochstetler: CNO Hendersonville Med Ctr	10/2023
	Patrick Rafferty: COO Hendersonville Med Ctr	08/2023

Applicability

TriStar Hendersonville Medical Center

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Owner Kristi Dozier: Dir
Med Staff Svcs
Policy Area EMTALA
Applicability TriStar
Hendersonville
Medical Center &
TriStar Portland

EMTALA, Provision of On-Call Coverage Facility Policy

DATE:8/1/2016

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.

Approval Signatures

Step Description	Approver	Date
Administration	Taylor Young-Sawyer: COO	01/2024
	Lisa Hochstetler: CNO	01/2024
	Hendersonville Med Ctr	

Taylor Young-Sawyer: COO

12/2023

Kristi Dozier: Dir Med Staff
Svcs

11/2023

Applicability

TriStar Hendersonville Medical Center

COPY



Origination 12/2000
 Last 02/2021
 Approved
 Last Revised 02/2021
 Next Review 02/2024

Owner **Melony Scott: Dir
 Emergency Svcs**
 Policy Area **EMTALA**
 Applicability **TriStar
 Hendersonville
 Medical Center &
 TriStar Portland**

Tennessee EMTALA Central Log Policy

DATE: 2/1/2016

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 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.

Approval Signatures

Step Description

Approver

Date

Administration

Patrick Rafferty: COO
Hendersonville Med Ctr 02/2021

Lisa Gann: CNO Hendersonville
Med Ctr 01/2021

Patrick Rafferty: COO
Hendersonville Med Ctr 12/2020

Melony Scott: Director
Emergency Services 12/2020

COPY



Origination 12/2000
 Last 03/2021
 Approved
 Last Revised 03/2021
 Next Review 03/2024

Owner Melony Scott: Dir
 Emergency Svcs
 Policy Area EMTALA
 Applicability TriStar
 Hendersonville
 Medical Center &
 TriStar Portland

EMTALA, Signage

DATE:2/1/2016

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.

Approval Signatures

Step Description	Approver	Date
Administration	Patrick Rafferty: COO Hendersonville Med Ctr	03/2021

Lisa Hochstetler: CNO
Hendersonville Med Ctr

03/2021

Melony Scott: Director
Emergency Services

03/2021

Patrick Rafferty: COO
Hendersonville Med Ctr

03/2021

COPY

Attachment 5C-1

License

Board for Licensing Health Care Facilities



License No. 0000000135

No. of Beds 0159

This is to certify, that a license is hereby granted by the Health Facilities Commission to

HENDERSONVILLE HOSPITAL CORPORATION

to conduct and maintain a

Hospital

TRISTAR HENDERSONVILLE MEDICAL CENTER

Located at

355 NEW SHACKLE ISLAND ROAD, HENDERSONVILLE

County of

SUMNER

, Tennessee.

This license shall expire

SEPTEMBER 17

2024

, and is subject

to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Health Facilities Commission, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the Health Facilities Commission issued thereunder.

In Witness Whereof, we have hereunto set our hand and seal of the State this 27TH *day of* JULY *, 2023.*

In the Distinct Category(ies) of:

TRAUMA CENTER LEVEL 3
STEMI-RECEIVING CENTER
STROKE RELATED-PRIMARY
GENERAL HOSPITAL
PEDIATRIC BASIC HOSPITAL



By Caroline R. Ayers, Esq., C.H.C.
DIRECTOR, LICENSURE & REGULATION

By Loan
EXECUTIVE DIRECTOR

Attachment 2Q-1

The Joint Commission Certificate,
The Joint Commission Letter,
TriStar Hendersonville CAP,
TriStar Portland FSED CAP,
TriStar Hendersonville CLIA, and
Portland FSED CLIA

TriStar Hendersonville Medical Center

Hendersonville, TN

has been Accredited by

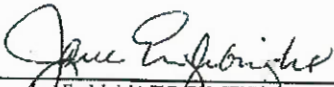


The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

July 2, 2022

Accreditation is customarily valid for up to 36 months.


Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #5174
Print/Reprint Date: 09/12/2022


Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.





September 9, 2022

Justin Coury
CEO
TriStar Hendersonville Medical Center
355 New Shackle Island Road
Hendersonville, TN 37075

Joint Commission ID #: 5174
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards
Compliance
Accreditation Activity Completed : 9/9/2022

Dear Mr. Coury:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning July 2, 2022 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Please note, if your survey was conducted off-site (virtually): Your organization may be required to undergo an on-site survey once The Joint Commission has determined that conditions are appropriate to conduct on-site survey activity.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations



COLLEGE of AMERICAN
PATHOLOGISTS

CERTIFICATE OF ACCREDITATION

TriStar Hendersonville Medical Center
Main Laboratory
Hendersonville, Tennessee
Henning E. Gertz, MD

CAP Number: 1565001

AU-ID: 1181474

CLIA Number: 44D0307141

The organization named above meets all applicable standards for accreditation and is hereby accredited by the College of American Pathologists' Laboratory Accreditation Program. Reinspection should occur prior to **February 4, 2025** to maintain accreditation.

Accreditation does not automatically survive a change in director, ownership, or location and assumes that all interim requirements are met.

Kathleen G. Beavis, MD, Accreditation Committee Chair

Emily Volk, MD, FCAP, President, College of American Pathologists





COLLEGE of AMERICAN
PATHOLOGISTS

CERTIFICATE OF ACCREDITATION

**TriStar Portland
Laboratory
Portland, Tennessee
Henning E. Gertz, MD**

CAP Number: 8840905

AU-ID: 1707091

CLIA Number: 44D2068939

The organization named above meets all applicable standards for accreditation and is hereby accredited by the College of American Pathologists' Laboratory Accreditation Program. Reinspection should occur prior to **March 20, 2025** to maintain accreditation.

Accreditation does not automatically survive a change in director, ownership, or location and assumes that all interim requirements are met.

Kathleen G. Beavis, MD, Accreditation Committee Chair

Emily Volk, MD, FCAP, President, College of American Pathologists



**CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF ACCREDITATION**

LABORATORY NAME AND ADDRESS
HENDERSONVILLE HOSPITAL CORPORATION
DBA TRISTAR HENDERSONVILLE MEDICAL CEN
355 NEW SHACKLE ISLAND ROAD
HENDERSONVILLE, TN 37075

CLIA ID NUMBER
44D0307141

EFFECTIVE DATE
02/28/2023

LABORATORY DIRECTOR
HENNING E GERTZ M.D.

EXPIRATION DATE
02/27/2025

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



Monique Spruill
Monique Spruill, Director
Division of Clinical Laboratory Improvement & Quality
Quality & Safety Oversight Group
Center for Clinical Standards and Quality

126 Certs2_041823

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

<u>LAB CERTIFICATION (CODE)</u>	<u>EFFECTIVE DATE</u>	<u>LAB CERTIFICATION (CODE)</u>	<u>EFFECTIVE DATE</u>
BACTERIOLOGY (110)	03/04/1999	COMPATIBILITY TESTING (550)	07/27/1995
MYCOLOGY (120)	03/04/1999		
PARASITOLOGY (130)	11/28/2000		
VIROLOGY (140)	07/27/1995		
GENERAL IMMUNOLOGY (220)	07/27/1995		
ROUTINE CHEMISTRY (310)	07/27/1995		
URINALYSIS (320)	07/27/1995		
ENDOCRINOLOGY (330)	07/27/1995		
TOXICOLOGY (340)	03/29/2003		
HEMATOLOGY (400)	07/27/1995		
ABO & RH GROUP (510)	07/27/1995		
ANTIBODY TRANSFUSION (520)	07/27/1995		
ANTIBODY NON-TRANSFUSION (530)	07/27/1995		

FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
CLINICAL LABORATORY IMPROVEMENT AMENDMENTS
CERTIFICATE OF ACCREDITATION**

LABORATORY NAME AND ADDRESS
HENDERSONVILLE HOSPITAL CORP
DBA TRISTAR PORTLAND ER
105 REDBUD DR-ER LAB
PORTLAND, TN 37148

CLIA ID NUMBER
44D2068939

EFFECTIVE DATE

06/24/2023

EXPIRATION DATE

06/23/2025

LABORATORY DIRECTOR
HENNING E GERTZ M.D.

Pursuant to Section 353 of the Public Health Services Act (42 U.S.C. 263a) as revised by the Clinical Laboratory Improvement Amendments (CLIA), the above named laboratory located at the address shown hereon (and other approved locations) may accept human specimens for the purposes of performing laboratory examinations or procedures.

This certificate shall be valid until the expiration date above, but is subject to revocation, suspension, limitation, or other sanctions for violation of the Act or the regulations promulgated thereunder.



Monique Spruill

Monique Spruill, Director
Division of Clinical Laboratory Improvement & Quality
Quality & Safety Oversight Group
Center for Clinical Standards and Quality

115 Certs2_053023

If you currently hold a Certificate of Compliance or Certificate of Accreditation, below is a list of the laboratory specialties/subspecialties you are certified to perform and their effective date:

<u>LAB CERTIFICATION (CODE)</u>	<u>EFFECTIVE DATE</u>
PARASITOLOGY (130)	06/24/2015
VIROLOGY (140)	06/24/2015
GENERAL IMMUNOLOGY (220)	06/24/2015
ROUTINE CHEMISTRY (310)	06/24/2015
URINALYSIS (320)	06/24/2015
ENDOCRINOLOGY (330)	06/24/2015
TOXICOLOGY (340)	06/24/2015
HEMATOLOGY (400)	06/24/2015

<u>LAB CERTIFICATION (CODE)</u>	<u>EFFECTIVE DATE</u>
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FOR MORE INFORMATION ABOUT CLIA, VISIT OUR WEBSITE AT WWW.CMS.GOV/CLIA
OR CONTACT YOUR LOCAL STATE AGENCY. PLEASE SEE THE REVERSE FOR
YOUR STATE AGENCY'S ADDRESS AND PHONE NUMBER.
PLEASE CONTACT YOUR STATE AGENCY FOR ANY CHANGES TO YOUR CURRENT CERTIFICATE.

Attachment 5C-2

Medical Director
Letter of Supports and *Curriculum Vitae*

July 26, 2024

Mr. Logan Grant
Executive Director
Health Facilities Commission
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar White House CON Application

Dear Mr. Grant:

I have served as the Director of Emergency Services at TriStar's Hendersonville Medical Center since 1992. I serve in the same capacity for the Portland Campus Freestanding ED since they opened in 2014. I assumed the role of Co-Medical Director of the Sumner County EMS in 2011, and I served in this position until 2023. As a result of my background and experience in this capacity, I'm familiar with the healthcare needs in our area.

This letter is to convey my support for TriStar Hendersonville Medical Center's CON application to develop a new freestanding emergency department in White House, Tennessee.

When I began as the Emergency Room director, White House and the surrounding areas was a small community with less than 10,000 people. More families are relocating to White House and the surrounding communities and the traffic to and from those areas is only increasing. Having a freestanding emergency department in White House will significantly reduce the amount of time needed to travel to an ER, especially during times of traffic congestion and severe weather. The most direct routes to the closest facilities, largely require navigating curvy two-lane roads with little to no lighting in many areas.

This freestanding emergency department will also assist in alleviating congestion in ERs outside of the service area, including TriStar Hendersonville's Emergency Room, which sees the highest number of patients from the service area. When I started, the annual census for TriStar Hendersonville was 6,800 patients per year. At present, we are currently service over 40,000 patients in a 12-month span. The post pandemic emergency room volume will only continue to explode. The emergency room is now seen as the one place to refer complex patients with multiple complaints, difficult and lengthy workups, and volume surges from physician offices and urgent care centers in our community. Patients are choosing emergency rooms for their care because of inability to see community-based providers in what they consider reasonable time frames. The emergency healthcare needs of the Sumner and Robertson County communities have outgrown the current operational structure.

My greatest concern is always for the patients. Our patients in the service area will greatly benefit from the TriStar White House FSED. They can get the care closer to home, while reducing TriStar

Mr. Logan Grant

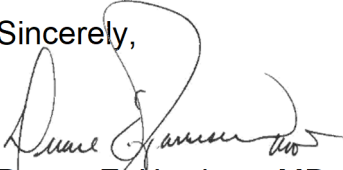
July 23, 2024

Page 2

Hendersonville's capacity constraints. This facility will fill a critical gap in access to care and will assuredly save lives.

I strongly urge you to approve TriStar Hendersonville's CON application for this free-standing emergency room in White House.

Sincerely,

A handwritten signature in black ink, appearing to read "Duane E. Harrison, MD". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Duane E. Harrison, MD
Director Emergency Services
TriStar Hendersonville Medical Center
TriStar Portland Emergency Room

DUANE E. HARRISON MD

1651 Noah Lane, Gallatin TN 37066
DuaneHarrisonMD@gmail.com

Emergency Medicine Physician with 36 years of Clinical Practice and Emergency Room Management

EXPERIENCE

2014 - PRESENT

IVMEDICAL DIRECTOR, ENVISION HEALTH CARE

Medical Staff Leadership Position responsible for Management of both the Hospital based ED and the Free-Standing ED that operates under the Hendersonville Medical Center hospital license. Responsible for Physician Performance Oversight, Development of Policies and Procedures, Development of working policies with all specialties that are utilized in providing care in an Emergency Setting, Work with Nursing Leadership in Joint Commission compliance measures, Routine Focused Professional Practice Evaluations, provide a monthly schedule with routine evaluations of staffing needs based on patient arrival patterns/acuity/volume.

1988 - 2018

OWNER - MEDICAL DIRECTOR, WOBEGONE INCORPORATED

Developed an Emergency Room Management Company that was responsible for Staffing Hospital Emergency rooms, when contracts were awarded after an RFP process for an Emergency Room Service.

Developed BLUEGRASS MEDICAL BILLING, for Procedural Based Billing of Emergency Medicine Groups.

Developed EDson SCRIBE, to provide scribes for Emergency Room Physicians, and jobs for pre-med college students, and graduates of Junior Colleges with degrees in HIM (Health Information Management)

Provided Consultative Services to Hospital Boards and C-Suites, specifically related to the management of their Emergency Rooms

List of Hospital Clients

- Jackson Purchase Medical Center, Mayfield KY
- Crockett Memorial Hospital, Lawrenceburg TN
- Hendersonville Medical Center, Hendersonville TN
- Massac Memorial Hospital, Metropolis IL
- Milan General Hospital, Milan TN
- Greenview Medical Center, Bowling Green KY
- Murray Calloway County Hospital, Murray KY
- Region One Health, Memphis TN
- Bradley Memorial Hospital, Cleveland TN

EDUCATION

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MAY, 1983

MEDICAL DOCTOR, MEHARRY MEDICAL COLLEGE NASHVILLE TN

INDUCTEE INTO THE ALPHA OMEGA ALPHA HONOR MEDICAL SOCIETY

Society founded in 1902, which is the national medical honor society that signifies a lasting commitment to professionalism, leadership, scholarship, research and community service

MAY, 1979

BACHELOR OF SCIENCE, OAKWOOD UNIVERSITY HUNTSVILLE AL

Major in Chemistry, Minor in Biology

MAGHIA CUM LAUDE — With Great Distinction

SKILLS

- CONFLICT RESOLUTION
- AN EMPATH
- CRITICAL THINKING

ACTIVITIES

ADMINISTRATIVE ELDER RIVERSIDE SEVENTH-DAY ADVENTIST CHURCH

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

GOLF MEMBER TENNESSEE GRASSLANDS

EXERCISE ENTHUSIAST

GRANDPARENT

July 23, 2024

Mr. Logan Grant
Executive Director
Health Facilities Commission
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Re: TriStar White House CON Application

Dear Mr. Grant:

This letter is to convey my support for TriStar Hendersonville Medical Center's CON Application to develop a new freestanding emergency department (FSED) in White House, TN.

I currently serve as TriStar's Regional Vice President for Hospital Based Services, and I previously served as Emergency Department Medical Director at TriStar Horizon Medical Center and TriStar Natchez FSED. I have been a Sumner County resident for 22 years, and served for many years on the medical staff at TriStar Hendersonville Medical Center. Accordingly, I am keenly aware of the operational needs of the Hendersonville ED and the emergency healthcare needs of our Sumner and Robertson County communities.

In recent years, Sumner and Robertson County saw enormous growth in their populations, driven largely by economic and residential development in the areas. With this ongoing development, White House and its surrounding areas have become home to large populations which have difficulty accessing an emergency room due to a myriad of reasons, including having to travel two-lane roads to access.

In addition, the White House FSED will assist in relieving the capacity challenges seen at TriStar Hendersonville's main campus ED. In 2023, the American College of Emergency Physicians (ACEP) criteria recommended low range emergency department see 1,600 patients per treatment room per year and a high range emergency department see 1,212 patients per treatment room per year. Currently TriStar Hendersonville is exceeding the standard for both high and low range emergency departments, with a patient volume of over 1900 patient visits per bed per year, and this is only expected to increase.

A well-placed FSED can save lives. I have seen this time-sensitive, life-saving treatment have tremendous impact for each Free-Standing ED which I serve, and I am certain the White House FSED will serve a similar purpose for our neighbors in White House.

1000 Health Park Drive, Suite 500
Brentwood, TN 37027

TriStarHealth.com

Mr. Logan Grant

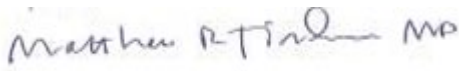
July 23, 2024

Page 2

TriStar Health's growing network of FSEDs provided emergency care to over 60,000 patients last year, when traditional hospital emergency rooms were not able to meet community needs. The White House FSED is an opportunity for TriStar Hendersonville to enhance access to its patient base who currently have limited access to emergency care that largely requires navigating winding secondary road – while simultaneously relieving Hendersonville's ED capacity constraints.

The White House FSED will fill a critical gap in access to care and improve hospital operational efficiencies, and I strongly urge you to approve the proposed project. Thank you for your time and consideration.

Sincerely,

A handwritten signature in blue ink that reads "Matthew R. Tincher MD".

Matthew Tincher, MD FACEP
Regional Vice President
Hospital Based Services
TriStar Division

Matthew R. Tincher, MD FACEP

237 Bayshore Drive | Hendersonville, TN 37075 | mtinche@gmail.com | (615) 554-3572

EMERGENCY DEPARTMENT LEADERSHIP

Accomplished ED leader with 15+ years of success in improving patient outcomes and increasing patient safety through targeted strategies that streamline operational processes. Combines detailed process analysis, proven best practices, and solid leadership to consistently achieve hospital objectives.

PROFILE

Team building strategist with a focus on establishing a culture committed to excellence, efficiency, and compassionate care. Consistently strives to develop innovative operational strategies that improve clinical quality, increase patient satisfaction, and support growth.

LEADERSHIP SUMMARY

Operations Management
Medical Staff Leadership
Quality & Safety Initiatives
Policy/Protocol Development
EMR Implementation

PROFESSIONAL EXPERIENCE

HCA HEALTHCARE

6/2024 – PRESENT

Regional VP
Hospital Based Services
TriStar Division

ENVISION HEALTHCARE

4/2018 – 5/2024

Senior Vice President
Alliance Operating Unit
TriStar Division

Regional Medical Director
Alliance Operating Unit
TriStar Division

10/2016 - 3/2018

TRISTAR HORIZON MEDICAL CENTER

Chief Medical Officer
Medical Director, Emergency Department
Chief-of-Staff
Vice Chief-of-Staff
Medical Director, Dickson Co EMS

5/2018 - PRESENT
2007 - 2018
2012 - 2014
2010 - 2012
2008 - 2019

OPERATIONS MANAGEMENT & STRATEGIC PLANNING EXPERIENCE

- Reduced Arrival-to-Greet, Discharged LOS, and Low Acuity LOS by >30% through process improvement designed to streamline workflow, accurately assess acuity, and positively impact patient throughput.
- Achieved gains in inpatient admissions by developing strategies to mitigate transfers.
- Implementation of a successful strategic plan to improve ED patient satisfaction.

TEAM MANAGEMENT & PATIENT CARE EXPERIENCE

- Development of a cohesive team driven by common goals through the establishment of clear expectations in the setting of a positive culture dedicated to quality care.
- Accurate identification of staff strengths, weaknesses, and motivators to promote growth and generate real-world gains in team productivity.
- Close collaboration with executive leadership teams to develop and implement strategic plans.

EDUCATION

RESIDENCY

Emergency Medicine, Emory University Atlanta, GA	1998-2001
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DOCTOR OF MEDICINE

University of Cincinnati Cincinnati, OH	1994-1998
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BACHELOR OF SCIENCE IN CHEMISTRY

Lipscomb University Nashville, TN	1989-1994
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AWARDS

EmCare Alliance Group	Emergency Medicine Excellence Award	2016
EmCare Alliance Group	Medical Director of the Year	2015

Attachment 5C-3

Most Recent Quality/Patient Safety Plan



Origination 02/2006
Last Approved 05/2024
Last Revised 05/2024
Next Review 05/2025

Owner Keli Green: VP Quality
Policy Area Admin - Governance
Applicability TriStar Hendersonville Medical Center & TriStar Portland

Plan for Patient Safety, Performance Improvement and Risk Management

Purpose: This plan describes the philosophy and framework for continuous improvement at Tristar Hendersonville Medical Center.

Mission & Values: Above all else we are committed to the care and improvement of human life. In pursuit of our mission we strive to deliver high quality, cost effective care and believe the following values 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.

Scope: This plan includes all departments, services, and health care professionals. It shall be ongoing and include effective mechanisms to monitor patient care, as well as identify, evaluate, and resolve problems that may impact the quality or safe delivery of care.

The program plan includes and/or integrates with the following components:

- Loss Control
- Risk Assessment & Evaluation
- Safety & Security Management
- Employee Health

- Patient Safety
- Quality Improvement
- Credentialing
- Confidentiality of Protected Health Information (PHI)
- Patient Relations/Complaint Management
- Claims Management

Quality Assessment and Performance Improvement Philosophy & Methodology:

Leadership recognizes the cyclic nature of performance improvement and strives to base process design/re-design on our mission, values and opportunities related to life threatening issues, safety, regulatory imperative, risk management/liability, complaints/grievances, and/or adverse outcome/complication.

Tristar Hendersonville Medical Center the FOCUS-Plan-Do-Check-Act (FOCUS-PDCA) Model and team collaboration as a systematic way to evaluate existing processes and make improvements. Anyone at any level of the organization (including hospital staff, leadership, medical staff, or patients/visitors) can suggest an opportunity for improvement to the Quality Leadership Team.

Tristar Hendersonville Medical Center will perform a proactive risk assessment of a high-risk procedure at least every 18 months. The steps in the process will be evaluated for failure modes or undesirable variation. The effect and severity will be assessed and processes may be redesigned to minimize the effects and protect patient from the failure modes of the process.

TriStar Hendersonville Medical Center employs a systematic approach to improving performance. The Lean model for performance improvement is the tool utilized throughout the organization for increasing efficiency, decreasing waste, and using empirical methods to decide what matters, rather than uncritically accepting pre-existing ideas. As waste is eliminated, quality improves and time and cost are reduced. The FOCUS PDCA (PLAN, DO, CHECK, ACT) model for performance improvement is the tool utilized throughout the organization for assessing, measuring, designing, executing and evaluating improvement opportunities.

Steps	FOCUS-PDCA Subsets	Useful Tools
F	Find a process to improve: • Process Prioritization • Customer Research • Review strategic/operational plan	Customer surveys Data Collection Sentinel Event Alerts Brainstorming
O	Organize to improve the process. • Select a multidisciplinary team of individuals who have process knowledge • Create a plan	Brainstorming
C	Clarify current knowledge of the process.	Flowchart Group Decision

	• Look at current process • Identify quick and easy improvements • Standardize best current method	Making Tools Data Collection
U	Understand the sources of process variation. • Stabilize the process • Identify process variables	Cause and Effect Diagram Data Collection methods Flowchart Pareto Diagram Run Chart Scatter plot Control Charts Histogram Group Decision Making Tools
S	Select the process improvement. • Evaluate improvement alternatives for their potential effectiveness and feasibility • Select the improvement	Flowchart Evaluation Matrix Group Decision Making Tools
P	Plan the improvement. • Plan the implementation of the improvement • Plan the continued data collection	Data collection Brainstorming
D	Do the improvement process. • Make the change • Measure the impact of the change	Flowchart Data Collection Methods Run Chart
C	Check the results. • Examine data to determine whether the change led to expected improvement	Pareto Diagram Cause and Effect Diagram Run Chart Control Charts Histogram Customer Surveys
A	Act to hold the gain and continue to improve the process. • Develop a strategy for maintaining the improvements • Determine whether or not to continue working on the Process	Flowchart Group Decision Making Tools

Objectives: The overall objectives of the hospital's Quality, Patient Safety, and Risk Management plan

include:

- Improving patient safety and reducing risk to patients, staff and visitors.
- Promoting a Culture of Safety and striving to become a High Reliability Organization.
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, employees, and medical staff are able to proactively identify and manage actual or potential risks to patient safety.
- Assuring that quality improvement initiatives continue to focus on high priority areas of clinical care, monitoring of process and outcome indicators; redesigning processes and systems and providing education to foster improvement.
- Meeting the expectations of the HCA internal initiatives, as well as, the external regulatory agencies and accrediting bodies through the identification of opportunities to improve patient care, demonstration of appropriate action taken, and follow up on the effectiveness of action taken.
- Reviewing and tracking of all variance reports, litigations, patient complaints/grievances, adverse outcomes, near misses (close calls) and sentinel events to identify gaps, opportunities, or trends.
- Maintaining compliance with current standards for risk management by adapting practice and policies when standards update.
- Identification of actual and potential causes of patient occurrences and implementation of programs, policies, and procedures to eliminate or reduce such occurrences.
- Analysis of patient grievances, which relate to patient care and quality of medical services provided.

Role of HCA Patient Safety Organization (PSO), LLC:

HCA established a Patient Safety Organization, LLC in spring of 2014 in accordance with provisions of the Patient Safety and Quality Improvement Act (Public Law 109-41). The PSO is a component of its parent entity, HCA. The mission of the PSO is to conduct activities to improve patient safety and the quality of healthcare delivery. The vision is to assist participating providers in the elimination of preventable patient harm. The activities of the organization include

- Improve patient safety and the quality of health care delivery
- Collect and analyze Patient Safety Work Product (PSWP)
- Develop and disseminate information regarding patient safety
- Utilize PSWP to encourage a culture of safety and provide guidance to effectively minimize patient risk.
- Maintain procedures to preserve confidentiality and provide appropriate security of PSWP
- Utilize qualified medical personnel
- Operate a patient safety evaluation system (PSES) and provide feedback to participants of the PSO
- Utilize the Serious Event Analysis (SEA) process to identify the root causes of adverse events.

Tristar Hendersonville Medical Center participates as a member of the HCA Patient Safety Organization

(PSO), LLC. The Patient Safety Director serves as the designated PSO Contact and oversee all activities of the PSO for the hospital. The Hospital provides patient safety work product (PSWP) documents as requested by the PSO. The Hospital receives information from the PSES to evaluate opportunities for improving patient safety and quality care. All information submitted remains confidential within the PSO.

Leadership & Governance:

Leaders play a key role in facilitating quality improvement and ensuring a safe environment. The Tristar Hendersonville Medical Center Hospital leadership structure includes The Board of Trustees, Medical Executive Committee; Hospital Administrators, and Department Leaders. The Board of Trustees has the ultimate authority and accountability for the Quality, Patient Safety, and Risk Management program. All leaders are responsible to support an environment that promotes continuous process improvement, quality outcomes, and reduction of risk.

Quality Assessment & Performance Improvement: Assessing performance improvement includes data collection, aggregation, benchmarking and analysis. An overall assessment of performance to the plan is conducted at least annually and reported through our leadership and governance structure.

At Tristar Hendersonville Medical Center data is collected at regular intervals, assessed over time and we benchmark our performance against relevant national standards as well as internally against other HCA hospitals providing similar services. When unfavorable performance trends are identified, action plans are developed using our FOCUS-PDCA methodology.

Evaluation of the performance and outcomes of the Quality, Patient Safety, and Risk Management program include all of the following:

- Performance improvement priorities identified as high-risk by hospital leadership
 - For 2024, this includes:
 - Non-Ventilator Hospital Acquired Pneumonia (NV-HAP) Prevention
 - Hospital Acquired Infection (HAI) prevention
 - Stroke DTN
 - SEP1
- Operative and other procedures that place the patient at risk, including operative and pathology diagnosis discrepancies.
- Adverse events related to moderate or deep sedation or anesthesia.
- Use of blood and blood components including all reported and confirmed transfusion reactions.
- Risk Management activities including sentinel events, serious event analysis, litigations, patient complaint/grievance trends or gaps.
- Restraint usage
- Results of resuscitation and the Rapid Response Team (RRT) trends.
- Significant medication errors and significant adverse drug reactions.
- Staff perceptions of patient safety and risk reduction effectiveness.

- Organ procurement effectiveness via conversion rate.
- Fall prevention
- Patient rights
- Patient flow processes
- Autopsies, when performed
- Core measures and other required publicly reported data, including Hospital Acquired Conditions and electronic Quality Care Measures.
- Adherence to National Patient Safety Goals
- Participation in HCA's 2024 Clinical Safety Improvement Program (CSIP)
- Tristar Hendersonville Medical Center 2024 clinical performance improvement goals (appendix A) within the HCA Clinical Scorecard priorities (Appendix B)
- Reporting of medical/healthcare associated errors
- Accreditation submission requirements and performance improvement measures of all certified disease-specific programs, including:
 - Stroke
 - Trauma
 - Chest Pain
 - Total Hip & Total Knee

Risk Management Program:

Objectives

- Identification of actual and potential causes of patient occurrences and implementation of programs, policies, and procedures to eliminate or reduce such occurrences.
- Ensuring that there is a mechanism for notifying patients, and when appropriate, their families, about anticipated outcomes of care.
- Conducting clinical assessment and analysis of complex organizational systems, and development and implementation of corrective action plans.
- Evaluation of the impact on patient care and safety of the buildings, grounds, equipment, and internal physical systems.
- Investigation and analysis of the frequency and causes of general categories and specific types of adverse occurrences causing injury to patients, employees, and visitors.
- Development of appropriate measures to minimize the risk of injury and adverse outcomes.
- Analysis of patient grievances, which relate to patient care and quality of medical services provided.
- Minimization of occurrence of legal claims and controlling losses by developing and coordinating risk initiatives in collaboration with Health Care Indemnity (HCI) Risk Management Department.
- Compliance with all applicable state and federal laws, regulations, and standards.

Responsibility

- Leaders play a key role in the Risk Management Program
 - Tristar Hendersonville Medical Center Leadership includes The Board of Trustees (BOT), Medical Executive Committee (MEC), Hospital Administration, and Department Leaders.
 - The Board of Trustees has the ultimate authority and accountability for the Risk Management Program.
 - All Leaders are responsible for modeling and supporting an environment that promotes continuous improvement and the elimination of avoidable harm.
- All healthcare providers, employees, and volunteers are responsible for reporting safety incidents or any adverse or unusual occurrences (with or without injuries,) to the Patient Safety Director/designee via the Patient Safety Evaluation System (PSES).
- The Patient Safety Director/designee has the authority for, and responsibility of, developing and implementing appropriate measures to minimize the risk of avoidable harm to patients, visitors, and staff, and to minimize the probability of loss or damage of any property.
- Serious Safety Event management process are outlined in detail in the Serious Safety Event Identification, Notification and Management policy.

Risk Management Functions and Responsibilities

- Clinical Risk Management:
 - Conducts clinical risk assessment and analysis of complex organizational systems within the facility and facilitates the development and implementation of corrective action plans.
 - Assists in resolution of treatment related problems such as patient refusal of treatment, consent issues, and discharges Against Medical Advice (AMA).
 - Coordinates development of corrective action plans to address identified risk exposures and vulnerabilities.
 - Counsels clinical personnel on family/care provider conflicts and responds to adverse patient outcomes.
 - Oversees full participation in the HCA's Clinical Safety Improvement Program (CSIP).
- Data Management and Complex Systems Analysis:
 - Analyzes incidents/occurrences reported in the PSES, and identifies trends/opportunities for improvement.
 - Provides trend analysis reports to appropriate facility leadership and committees.
- Claims Management:
 - Thoroughly investigate and respond to all patient complaints reported to Patient Safety, has authority to delay and appropriately modify patient billing under direction of the CFO, and will work with senior leadership and department leaders to resolve of all complaints timely.
 - Maintains Risk Management Data and files in compliance with State and Federal Agencies, Regulatory Bodies, and HCA standards.

- Identifies occurrences that are potentially compensable events and submits a Probable Claims Report (PCR) to the HCI for review.
- Provides notification of critical adverse events and probable claims to HCA Healthcare Indemnity HCI Claims Management office, and facility and division leadership as appropriate.
- Assists HCI and other designated legal team members (as determined or assigned by HCI, such as defense counsel or legal consultants) with any and all processes necessary to the defense of claims against Hospital and/or staff.
- Completes Interrogatories, Requests of Production, and any other processes as deemed appropriate and necessary.
- Oversees investigations of incidents that could lead to professional/general liability claims.
- Works with patients, families, and visitors where appropriate to resolve complaints or grievances within the guidelines approved by HCI and facility administration.
- Coordinates interviews and depositions of facility staff.
- Monitors all claims activity through meticulous record keeping.
- Assists in sequestering of medical records, X-Rays, and other diagnostic and treatment material as appropriate, and manages access to and control over records and other sequestered items.

Appendix A

2024 Goals

- Prevent all Hospital Acquired Conditions and Hospital Acquired infections. This includes, but is not limited to, air embolism, incompatible blood transfusion, patients with retained foreign bodies, number of vascular catheter (central line) infections, incidence of DVT/PE for all patients, iatrogenic Pneumothorax, falls with injuries, indwelling urinary catheter associated urinary tract infections (UTIs), and Stage III/IV pressure ulcers.
- Full participation in the Clinical Safety Improvement Program and receive 100% of available credit offered by the end of 4th Quarter of 2024.
- Increase close call and near miss reporting to be at least 10% of reported events by the end of 4th Quarter of 2024.

Appendix B

Domain	Metric Description	Goal
Stroke	Thrombolytic Treatment	15.00%
	45 Minute Door-to-Needle	80.00%
Overall	SEP-1	71.00%
	Overall Mortality	0.72
	Overall Complications	0.66
	30 Day Readmission Medicare FFS	14.10%
	30 Day Readmission All Payor	11.67%
OB	Postpartum Hemorrhage	3.00%
	Unexpected Complications in Newborns	21.35
	NTSV Cesarean Section	23.60%
Infection	Clostridioides difficile (CDIFF)	0.212
	Methicillin-Resistant Staphylococcus aureus (MRSA)	0.390
	Surgical Site Infection from Abdominal Hysterectomy (HYST)	0.315
	Surgical Site Infection from Colon Surgery (COLO)	0.348
	Catheter-Associated Urinary Tract Infection (CAUTI)	0.253
	Central Line-Associated Bloodstream Infection (CLABSI)	0.334
Engagement	RN Engagement Index	73
	Physician Engagement Index	44.00%
	HCAHPS Inpatient Overall Rating	69.80%
	ER Overall Rating	68.00%
ED	ER Overall Rating in FSEDs	68.00%
	ER Overall Rating in Hospital-Based EDs	68.00%
	45 Minute Door-to-Needle	80.00%
	Sepsis POA Bundle Compliance	75.00%
	Sepsis POA Antibiotics < 1 Hour	65.00%
CV	Percutaneous Coronary Intervention (PCI) Mortality	1.88%

Attachments

[image1.png](#)

Approval Signatures

Step Description	Approver	Date
BOT	Keli Green: VP Quality	05/2024
MEC	Keli Green: VP Quality	05/2024

Older Version Approval Signatures

BOT	Keli Green: VP Quality	05/2023
MEC	Keli Green: VP Quality	05/2023
QRM	Keli Green: VP Quality	05/2023
BOT	Keli Green: VP Quality	05/2022
MEC	Keli Green: VP Quality	05/2022
QRM	Keli Green: VP Quality	04/2022
BOT	Keli Green: VP Quality	09/2021
MEC	Keli Green: VP Quality	08/2021
QRM	Keli Green: VP Quality	07/2021
	Lisa Gann: CNO - Hendersonville Med Ctr	05/2019
	Janet Von Roeder: VPQ	05/2019
	Lisa Gann: CNO - Hendersonville Med Ctr	04/2019
	Cynthia Hansen: VP Quality	04/2019
	Lisa Gann: CNO - Hendersonville Med Ctr	09/2018
	Cynthia Hansen: VP Quality	09/2018
	Lisa Gann: CNO - Hendersonville Med Ctr	05/2018
	Cynthia Hansen: VP Quality	03/2018
	Lisa Gann: CNO - Hendersonville Med Ctr	01/2018
	Cynthia Hansen: VP Quality	01/2018
	Lisa Gann: CNO - Hendersonville Med Ctr	06/2017
	Cynthia Hansen: VP Quality	03/2017

Applicability

TriStar Hendersonville Medical Center

COPY

Attachment 5C-4

Staff Education Policies

Education and Training Policy

Index

Policy - Education and Training - HR.LD.003

ORGANIZATION UNIT (DEPARTMENT):

Human Resources

PAGE: 1 of 2

EFFECTIVE DATE: May 1, 2015

DIVISION/LOB/ENTERPRISE: Enterprise-Wide

SCOPE:

Applies to volunteers, contract staff, and colleagues excluding employee groups listed as “At Will” in the Limitations on Employment policy **HR.ER.019** and colleagues with a written employment agreement.

PURPOSE:

To outline training opportunities for colleague development and provide guidelines for acquiring and maintaining required training as defined by his/her job description

DEFINITIONS:

1. **Training and Ongoing Education:** Training and ongoing education topics offered by the business entity are based on orientation and job training needs, safety concerns, quality improvement findings, new equipment or technology, new policies and procedures, and individual or group self-identified learning needs. Assessment of training designated as mandatory by the business entity, and the skills associated with the training, may be part of the competency assessment; reference Competency Assessment policy **HR.LD.001**.

2. **Regulatory Training:** The business entity provides specific training annually to meet regulatory requirements and the standards established by the business entity.

RESPONSIBILITIES:

1. Business entity:

- a. The business entity identifies a role that has primary responsibility for the oversight and design of ongoing education and training programs to meet regulatory standards as well as the needs of the population served and services offered.
- b. It is the business entity's responsibility to define and execute a strategy to continually monitor the education and training needs of staff to address competency gaps and job performance deficiencies.

Development may include clinical, patient care, managerial, leadership, technical, computer, and safety topics.

c. The business entity has the responsibility to ensure education and training requirements defined in job descriptions are in good standing.

2. Colleagues:

a. All colleagues are responsible for attending business entity, position-specific, or regulatory training deemed mandatory by their manager or administrative personnel.

b. For outside training or seminars, all colleagues are responsible for obtaining prior approval from their manager or designee and for recording attendance on an in-service record.

c. Colleagues who are interested in pursuing educational opportunities toward a degree should consult with their manager or HR Business Partner for information on programs available through the business entity; reference Educational Reimbursement policy **HR.TR.002**.

REQUIREMENTS:

Education and training documentation should be maintained as part of the "Approved List" in the colleague record; reference Employee Records policy **HR.WF.001**.

TIME REPORTING:

1. Time spent attending lectures, meetings, and training programs need not be counted as hours worked, provided the following conditions are met:

a. The meetings are held outside working hours.

b. Attendance by the colleague is voluntary. Attendance is not voluntary if the colleague is led to believe that non-attendance would adversely affect his employment.

c. The course, lecture, or meeting is not directly related to the colleague's job.

· Training is directly related to a colleague's job if it is designed to make them more effective in the present job, not if it teaches a different job.

d. If a colleague, on their own initiative, attends school, college, or trade school after hours, that time is not hours worked even if the courses are job-related.

DISCLOSURE:

If there is any conflict between the information in this policy and a Collective Bargaining Agreement (CBA), the CBA prevails for covered colleagues.

REFERENCED POLICIES:

1. Education Reimbursement, HR.TR.002

2. Job Descriptions, HR.LD.004

3. Licensure Verification, HR.ER.018

4. Certification, Verification, and Renewal, HR.ER.041

5. Competency Assessment, HR.LD.001
6. Limitations on Employment, HR.ER.019
7. Code of Conduct
8. TJC HR Standard, HR.01.05.03: Staff participate in ongoing education and training

WORK INSTRUCTIONS:

1. Documentation and roster maintenance
2. Ongoing educational needs assessment

PROCESS MAPS:

1. To be completed at a future date

Referenced Policies

[Job Descriptions Policy](#)[Licensure Verification Policy](#)[Limitations on Employment Policy](#)[Competency Assessment Policy](#)

Attachment 2Q-2

Awards



Nationally recognized care in Sumner County

TriStar Hendersonville Medical Center has received numerous accolades for exceeding national standards in delivering superior quality care. Our team advocates for your best interest and puts responsiveness, safety and research-based protocols at the forefront of everything we do. **Our greatest honor is the reward of your trust.**



Certified Primary Stroke Center, Certified Chest Pain Center, Total Knee and Total Hip disease-specific certifications



Recipient of the Fortune/PINC AI Top 100 Hospitals® and Everest Award

Healthgrades 2024 recipient: America's 250 Best Hospitals™, America's 100 Best Hospitals for Pulmonary Care Award™, America's 100 Best Hospitals for Orthopedic Surgery Award™, America's 100 Best Hospitals for Gastrointestinal Surgery Award™, America's 100 Best Hospitals for Gastrointestinal Care Award™, America's 100 Best Hospitals for Critical Care Award™, America's 50 Best Hospitals for Stroke Care Award™; Excellence Awards for Stroke Care™, Patient Safety™ and Critical Care™

Learn more about our accolades at
[TriStarHendersonville.com/QualityCare](https://www.tristarhendersonville.com/QualityCare)



TriStar Hendersonville
MEDICAL CENTER

Supplemental Responses
To Questions In
Main Application

The below supplements the Projected Utilization tables at the bottom of Question 2N.

Unit Type: ED Visits

Zip Code	Projected Utilization Service Area Residents TriStar White House FSED (Year 1)	% of Total
37188 (White House)	3,741	38.57%
37073 (Greenbrier)	1,637	16.88%
37049 (Cross Plains)	1,134	11.69%
37048 (Cottontown)	1,246	12.85%
Service Area Subtotal	7,758	80.00%
Outside of Service Area	1,940	20.00%
Total	9,698	100.00%

Unit Type: ED Visits

Zip Code	Projected Utilization Service Area Residents TriStar White House FSED (Year 2)	% of Total
37188 (White House)	3,899	39.13%
37073 (Greenbrier)	1,609	16.15%
37049 (Cross Plains)	1,171	11.75%
37048 (Cottontown)	1,291	12.96%
Service Area Subtotal	7,970	80.00%
Outside of Service Area	1,993	20.00%
Total	9,963	100.00%

The below appends the Historical and Projected Data Charts in the HFC Portal for response to Question 6C of the Main Application.

6C. See INSTRUCTIONS to assist in completing the following tables.

The instructions indicate to provide three years of historical data for "Project Only" or "Total Facility." As the project does not exist, it is impossible to complete a historical "Project Only" chart. Thus, above TriStar Hendersonville presents the "Total Facility". The above is for the entire TriStar Hendersonville facility including its Portland FSED, which is a department of TriStar Hendersonville. From a financial reporting perspective, ED patients who are discharged are considered outpatients, and ED patients who are admitted are considered inpatients. Therefore, the gross revenue from these patients is grouped in this way. Both admissions and ED visits are identified above in the unit of measure line items.

An ED-visits-only historical data chart for the facility would not be meaningful because the patients and their revenue are fully integrated into the hospital as a whole. With approximately 16 percent of ED patients admitted on average during the three historical years presented, an ED-only response would leave out the revenue experience of these inpatients. For this reason, TriStar Hendersonville has provided the historical data chart for the Entire Facility in the same way presented in the previously approved FSED CON projects submitted by TriStar Hendersonville affiliates.

On the following page is the projection for the "Project Only," TriStar White House FSED. The only unit of measure for the projected data chart is ED visits. For the purposes of the projections, all revenues are identified on the emergency services line item, which is the same way presented in the previously approved FSED CON projects submitted by TriStar Hendersonville affiliates.

The below appends the text in the box in the HFC Portal for responses to Question 10C of the Main Application.

- 10C. 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. 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.**

TriStar Hendersonville also offers a prompt pay discount of 20 percent for patients paying estimated deductible and co-pays at the time of service. When recording this discount, it is reflected in the contractual allowance line and not shown as charity or bad debt. Please see **Attachment 4N-1** for a copy of the policy that governs this practice, Discount Policy for Patients.

The below appends the “check marks” in the HFC Portal for responses to Question 7Q of the Main Application.

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 following responses are made with respect to facilities managed by the TriStar Division, which includes the Applicant, Hendersonville Hospital Corporation d/b/a TriStar Hendersonville Medical Center.

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 Hendersonville Medical Center, to the best of its knowledge, information, and belief, as well as other TriStar Division facilities. 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.

Been subject to any of the following:

- **Final Order or Judgment in a state licensure action:**

No

The applicant assumes for the purpose of this question that “state licensure action” refers to facility licensure. The Applicant has 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:**

No

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

No

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

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:**

No

- **Suspension or termination of participation in Medicare or TennCare/Medicaid programs:**

No

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

No

Because of the breadth of the term “regulatory action,” and the potential scope as including matters completely unrelated to healthcare, Applicant interprets this inquiry to be asking about “any healthcare regulatory or criminal action.”

No facility in the TriStar Division has been the subject of a criminal action.

With regard to an investigation, in a prior application TriStar Hendersonville disclosed that it was part of an investigation that was commenced by the Department of Justice (“DOJ”) in June of 2021, related to anatomic pathology services performed by third-party pathology laboratories on behalf of certain HCA patients. TriStar Hendersonville cooperated with the investigation and produced documents and other information to the DOJ. In May of 2024, a *qui tam* lawsuit that had been filed by a private individual was unsealed, and it alleged facts similar to those at issue in the DOJ investigation. Both the DOJ and the State of Tennessee declined to intervene in that lawsuit.

Responding to HFC inquiries on prior applications:

On December 29, 2021, TriStar Centennial and TriStar Skyline entered into settlement agreements with the Office of the Inspector General of the U.S. Department of Health and Human Services (“OIG”). These settlements were in connection with 2017 CMS surveys that resulted in a Statement of Deficiency (CMS-2567) for each Hospital setting forth CMS’s alleged EMTALA violations. TriStar Centennial and TriStar Skyline each responded with a Plan of Correction (with no acknowledgement of liability) that CMS accepted. The OIG then cited TriStar Centennial and TriStar Skyline with similar EMTALA violations. TriStar Centennial and TriStar Skyline disputed the OIG’s position. However, to avoid the uncertainty and expense of litigation, TriStar Centennial and TriStar Skyline each settled with the OIG pursuant to which TriStar Centennial and TriStar Skyline each paid the U.S. Department of Health and Human Services \$725,000 without any admission of wrongdoing or any concession as to the lack of merit of the allegations by the OIG. Neither of these settlements involved the payment of any civil penalties involving claims related to the provision or healthcare services, and neither are matters to which the referenced facilities are presently subject to an investigation or action of any kind. These matters are included in light of the public nature of the announced settlements and because the Staff has asked about at least one of these settlements in the past.

On January 18, 2024, TriStar Greenview Regional Hospital (“TriStar Greenview”) entered in to a settlement agreement with the Office of the Inspector General of the U.S. Department of Health and Human Services (“OIG”). That settlement was in connection with a 2021 CMS survey that resulted in a Statement of Deficiency (CMS-2567) setting forth CMS’s alleged EMTALA violations. TriStar Greenview responded with a Plan of Correction (with no acknowledgement of liability) that CMS accepted. The OIG then cited TriStar Greenview with similar EMTALA violations, i.e., that TriStar Greenview violated EMTALA when a physician on its medical staff failed to come to the hospital when covering ED call. TriStar Greenview disputed the OIG’s position. However, to avoid the uncertainty and expense of litigation, the OIG and TriStar Greenview agreed to a settlement pursuant to which TriStar Greenview paid the U.S. Department of Health and Human Services \$90,000 without any admission of wrongdoing or any concession as to the lack of merit of the allegations by the OIG. The settlement did not involve the payment of any civil penalties involving claims related to the provision or healthcare services, and is not a matter to which the referenced facility is presently subject to an investigation or action of any kind. This matter is included in light of the public nature of the announced settlement and because the Staff has asked about similar types of settlements in the past.