

1
HEALTH SERVICES AND DEVELOPMENT AGENCY
MAY 25, 2016
APPLICATION SUMMARY

NAME OF PROJECT: CAH Acquisition Company 11, LLC d/b/a
Lauderdale Community Hospital

PROJECT NUMBER: CN1601-004

ADDRESS: 326 Asbury Avenue
Ripley (Lauderdale County), TN 38063

LEGAL OWNER: CAH Acquisition Company 11, LLC
326 Asbury Avenue
Ripley (Lauderdale County), TN 38063

OPERATING ENTITY: Rural Community Hospitals of America
1100 Main Street, Suite 2350
Kansas City, MO 64015

CONTACT PERSON: Tammie Hardy
(731) 220-2400

DATE FILED: January 14, 2016

PROJECT COST: \$20,262,987.00

FINANCING: 75% Commercial Loan, 25% New Market Tax Credits

PURPOSE FOR FILING: Relocation of an existing twenty-five (25) bed critical
access hospital, which includes ten (10) swing beds;
and 1.5T mobile magnetic resonance imaging (MRI)
services

DESCRIPTION:

CAH Acquisition Company 11, LLC d/b/a Lauderdale Community Hospital (LCH) a 25 bed critical access hospital located at 326 Asbury Avenue, Ripley (Lauderdale County), TN proposes to replace its existing 33 year old facility with a new 46,851 SF facility on its current campus. The new hospital's licensed bed complement will not change and will continue to offer the same services

CAH ACQUISITION COMPANY 11, LLC
D/B/A LAUDERDALE COMMUNITY HOSPITAL
CN1601-004
MAY 25, 2016
PAGE 1

currently provided, which include acute, emergency, swing bed, and outpatient services.

Note to Agency members: The Social Security Act permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds, as needed, to provide either acute or skilled nursing (SNF) care. As defined in the regulations, a swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

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

- 1. For relocation or replacement of an existing licensed health care institution:**
 - a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative**

Renovation of the existing 30 year old facility mechanical and electrical systems would require expensive upgrades to meet current healthcare and building codes. In addition, the current facility is not conducive to new equipment and/or technology.

The only option is to construct a new modern more energy efficient replacement hospital that allows for expansion and meets standards for healthcare and building codes.

It appears that this criterion has been met.

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

CAH Acquisition Company 11, LLC licensed bed occupancy was 24% in 2015. With a newly designed modern hospital, the applicant projects the inpatient occupancy to grow to 26.6% and 27.7% in Year 1 and Year 2, respectively, following completion of the project. The following outpatient services are expected to increase from 2015 to Year One (2018): ER visits from 10,432 to 10,876, an 8.5% increase; overall radiology procedures from 12,218 to 13,926, a 13.9% increase; and Lab Tests from 40,352 to 49,860, a

**CAH ACQUISITION COMPANY 11, LLC
D/B/A LAUDERDALE COMMUNITY HOSPITAL**

CN1601-004

MAY 25, 2016

PAGE 2

3

23.6% increase. Outpatient surgeries will slightly decrease from 56 in 2015 to 49 in 2018.

It appears that this criterion has been met.

Staff Summary

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

LCH proposes a state-of-the art modern replacement critical access hospital that will not only offer inpatient services, but will be designed to grow and expand outpatient services for residents of Lauderdale County. A new hospital will enable the applicant to take care of patients locally rather than having to travel to out of county larger tertiary facilities, and to recruit and retain highly qualified healthcare professionals to staff the clinical and ancillary departments.

If a new replacement hospital is approved, the applicant will probably not know the disposition of the current facility until the latter months of the construction period. In the supplemental response the applicant notes current options include donating the hospital to Lauderdale County for medical professional education, or selling it to be used as a nursing home.

An overview of the project is provided on pages 5-7 of the original application.

Need

- The original hospital was built in 1983 making improvements in patient access, infrastructure and facility upgrades, renovations and additions cost prohibitive.
- The life span of the hospital's mechanical and electrical equipment is past its date of replacement.
- The new modern facility will increase efficiencies in providing acute, emergency, swing bed and outpatient services.
- The new facility will improve the patient experience, be more financially sustainable, and meet the needs of the region, medical staff, and health system.

Ownership

- LCH is owned by HMC/CAH Consolidated, Inc. (HMC) is based out of Kansas City, Missouri.
- HMC owns 10 hospital subsidiaries located in Oklahoma (4), Kansas (3), Missouri (1), North Carolina (1), and Tennessee (1), and is in the business

**CAH ACQUISITION COMPANY 11, LLC
D/B/A LAUDERDALE COMMUNITY HOSPITAL**

CN1601-004

MAY 25, 2016

PAGE 3

of acquiring acute care hospitals located in rural communities and certified by the Centers for Medicare and Medicaid Services (CMS) as Critical Access Hospitals.

- HMC's business plan is to replace the existing facilities of all its hospitals with new facilities.
- HMC/CAH Consolidated, Inc. (HMC) owner of CAH Acquisition Company #11, LLC filed for Chapter 11 proceedings on October 10, 2011 in the United States Bankruptcy Court for the Western District of Missouri and received court approval in January 2013.
- On page 1 in Supplemental #1 the applicant states the final decree was entered by the bankruptcy court on March 29, 2013 and the case was closed. Please see page 170 in the HMC/CAH Consolidated, Inc. Financial Report for the period ending September 30, 2014 for additional details.

Facility Information

- The proposed new hospital will be located on a 23.98 acre parcel of land adjacent to the existing facility.
- The proposed newly constructed facility is planned at 46,851 square feet, a reduction from the current 78,341 SF facility.
- A floor plan drawing of the surgical suite is included in Attachment B. IV.
- LCH is a 25 bed licensed critical-access hospital. The Joint Annual Report for 2014 indicates the applicant staffs all 25 beds. Licensed bed occupancy and staffed bed occupancy was 10.8%.

The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

- *Licensed Beds - The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).*
- *Staffed Beds - The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.*

Note to Agency members: Eighteen of LCH's twenty-five beds are designated as swing beds. LCH did not report 1,164 skilled nursing days in the swing beds in the 2014 Joint Annual Report. The 2014 licensed occupancy is 23.7% when the acute inpatient bed days of 984 and skilled nursing bed days of 1,180 totaling 2,164 inpatient days are used to calculate licensed occupancy. Please refer to

**CAH ACQUISITION COMPANY 11, LLC
D/B/A LAUDERDALE COMMUNITY HOSPITAL**

**CN1601-004
MAY 25, 2016**

PAGE 4

Attachment 1 at the end of this summary that provides an overview of Critical Access Hospital's requirements relating to swing beds and skilled nursing facility (SNF) level of care.

Service Area Demographics

CAH Acquisition Company 11, LLC's declared primary service area is Lauderdale County.

- The total population of Lauderdale County is estimated at 28,529 residents in calendar year (CY) 2015 increasing by approximately 1.8% to 29,055 residents in CY 2019.
- The overall Tennessee statewide population is projected to grow by 3.7% from 2015 to 2019.
- The latest 2015 percentage of the Lauderdale County population enrolled in the TennCare program is approximately 28.4% as compared to the statewide enrollment proportion of 22%.

Service Area Historical Utilization

LCH is the only hospital in Lauderdale County.

The following two tables will display inpatient and outpatient historical and projected utilization for Year One (2018) and Year Two (2019) of the proposed project.

**CAH Acquisition Company 11, LLC
Inpatient Historical and Projected Utilization**

Year	Acute Days	SNF Days	Total Patient Days	Licensed Beds	Licensed Occupancy %
2013	1,392	1,006	2,398	25	26.3%
2014	984	1,180	2,164	25	23.7%
2015	979	1,210	2,189	25	24%
2018	1,098	1,329	2,427	25	26.6%
2019	1,142	1,382	2,524	25	27.7%
% Change 13-19	-18%	+37.4%	+5.2%	25	

Source: CN1601-004

The table above reflects the following:

- Acute inpatient days are projected to decrease from 1,392 in 2013 to 1,142 inpatient days in 2019 reaching a licensed occupancy percentage of approximately 27.7%.
- SNF days are projected to increase 37.4% from 1,006 days in 2013 to 1,392 days in Year Two (2019).
- Total inpatient days are projected to increase 5.2% from 2,398 days in 2013 to 2,524 days in Year Two (2019).

**CAH Acquisition Company 11, LLC
Outpatient Historical and Projected Utilization**

Year	Outpatient Surgeries	ER Visits	Radiology Procedures	Lab Tests
2013	296	11,446	15,374	44,145
2014	164	10,065	14,705	41,891
2015	56	10,432	12,218	40,352
2018	49	10,876	13,926	49,860
2019	51	11,093	14,483	51,855
% Change 2013-2019	-82.7%	-3.1%	-5.8%	+17.5%

Source: CN1601-004

The table above reflects the following:

- Outpatient surgeries are projected to decrease 82.6% from 296 in 2013 to 51 in 2019 (Year Two). The applicant attributes the 82.6% decrease to the 2015 retirement of the only surgeon on staff who gradually reduced his workload. Currently, the applicant is in the final stages of recruiting a surgeon.
- Emergency Room visits are projected to decrease 3.1% from 11,446 in 2013 to 11,093 in 2019.
- Total radiology procedures are projected to decrease 5.8% from 15,374 procedures in 2013 to 14,483 in 2019.
- Total hospital lab tests will increase 17.5% from 44,145 in 2013 to 51,855 in 2019.

Project Cost

Major costs are:

- Facility Lease-\$20,217,987 or 99.8% of total cost.
- For other details on Project Cost, see the Project Cost Chart on page 30 of the original application.

**CAH ACQUISITION COMPANY 11, LLC
D/B/A LAUDERDALE COMMUNITY HOSPITAL**

CN1601-004

MAY 25, 2016

PAGE 6

- Average total construction cost is expected to be \$298.60 per square foot for new construction, which is slightly above 3rd quartile cost of \$296.52/SF of previously approved hospital projects from 2012-2014.

**Statewide Hospital Construction Cost per Square Foot
2012-2014**

	Renovated Construction	New Construction	Total Construction
1st Quartile	\$110.98/sq. ft.	\$224.09/sq. ft.	\$156.78/sq. ft.
Median	\$192.48/sq. ft.	\$259.66/sq. ft.	\$227.88/sq. ft.
3rd Quartile	\$297.82/sq. ft.	\$296.52/sq. ft.	\$298.66/sq. ft.

Source: HSDA Applicant's Toolbox

Historical Data Chart

- According to the Historical Data Chart LCH experienced profitable net operating results for one of the three most recent years reported: (\$435,726) for 2013; \$576,974 for 2014; and (\$673,043) for 2015.
- Average Annual Net Operating Income (NOI) was unfavorable at approximately -4.5% of annual net operating revenue for the year 2015.

Projected Data Chart

- 2,427 inpatient days are projected in Year 1 (2018) and 2,524 in Year 2 (2019).
- Net operating income less capital expenditures for the proposed project will equal \$8,212.00 in Year 2018 increasing to \$444,938 in Year 2019.
- In Supplemental #1 the applicant indicates income taxes are not included in the Projected Data Chart because the consolidated tax return for HMC/CAH continues to have net operating loss carryforwards that would offset future income tax.

Charges

In Year One of the proposed project, the average charge per inpatient case is as follows:

Average Gross Charge

- \$20,749

Average Deduction from Operating Revenue

- \$13,503

Average Net Charge

- \$7,246

Payor Mix

- The applicant indicates it has contracts with all TennCare MCOs available to its service area population: United HealthCare Community Plan (formerly AmeriChoice), TennCare Select, Blue Care, and AmeriGroup.
- The applicant's projected payor mix in Year 1 of the project is shown in the table below.

**CAH Acquisition Company 11, LLC
Service Payor Mix, Year 1**

Payor Source	Gross Revenue Year 1	as a % of Gross Revenue Year 1
Medicare	\$18,830,535	37.8%
TennCare/Medicaid	\$11,013,951	22.07%
Blue Cross	\$4,752,356	9.52%
Commercial/Other	\$10,939,800	21.92%
Self-Pay	\$4,372,344	8.76%
Total	\$49,908,986	100%

Source: CN1601-004

Financing

The source of funding for the project is identified as follows:

15% from New Market Tax Credit (NMTC)

- A January 8, 2016 letter signed by the Executive Director of Community Hospitality Healthcare Services attests to the ability to finance the project with a NMTC subordinated \$3,000,000 7+ year term interest only note with an interest rate in the 2.5%-3% range.
- The New Market Tax Credit (NMTC) program was established by Congress in 2000 to attract private-sector capital investment into the nation's low-income areas to stimulate economic growth and create job growth by financing community development projects and business expansion.

85% from CBC Real Estate Group, LLC

- The remaining 85% of project costs (\$17.25 million) will be financed through a lease agreement with CBC Real Estate Group, LLC (CBC). CFG Capital Markets, LLC will originate and structure the lease transaction.
- CFG Capital Markets, LLC will broker financing by identifying commercial banks that will provide debt financing to LCH.
- A January 27, 2016 letter signed by the Director of CFG Capital Markets, LLC attests to the availability of 7 year term commercial bank loans with

an interest rate ranging from London Interbank Offered Rate (LIBOR) plus 3.5% to 4.5% to finance the remaining \$17.25 million project.

Note to Agency members: LIBOR is the average interbank interest rate at which a selection of banks on the London money market are prepared to lend to one another. LIBOR comes in 7 maturities (from overnight to 12 months) and in 5 different currencies. Source: global-rates.com

- Review of HMC/CAH Consolidated, Inc. Consolidated Balance Sheet ending September 30, 2014 revealed cash and cash equivalents of \$1,349,802, total current assets of \$18,814,047 and current liabilities of \$27,826,892 for a current ratio of 0.67 to 1.0.

Note to Agency Members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

In Supplemental #1 the applicant states the primary reason for a low liquidity ratio is related to HMC/CAH's exit from bankruptcy in 2013. At the time, HMC/CAH was under obligation to pay several million dollars of debt and extraordinary expense items. The applicant states HMC/CAH is currently in the recovery stage from bankruptcy.

Staffing

Total estimated staffing is estimated at approximately 107.76 fulltime equivalents (FTE) in Year 1. A breakout of the staffing in Year 1 includes the following:

- 15.05 FTE Administration
- 6.03 FTE Dietary
- 14.16 FTE Emergency
- 4.81 FTE HIM
- 5.51 FTE Housekeeping
- 8.55 Laboratory
- 22.38 FTE Med/Surg
- 5.40 FTE Pharmacy
- 2.98 FTE Plant Ops
- 8.13 FTE Radiology
- 0.22 FTE Surgery
- 14.54 FTE Therapies
- *Note: Generally speaking, one (1) FTE is equivalent to an individual that works 2,080 regular hours.*

CAH ACQUISITION COMPANY 11, LLC
D/B/A LAUDERDALE COMMUNITY HOSPITAL

CN1601-004

MAY 25, 2016

PAGE 9

Licensure/Accreditation

CAH Acquisition Company 11, LLC is licensed by the Tennessee Department of Health. The latest licensure survey was completed on June 15, 2011 with no deficiencies cited. A copy of the survey is located in Supplemental #1 Attachment #13.

CAH Acquisition Company 11, LLC is accredited by DNV GL-Healthcare with an accreditation cycle effective August 1, 2015 valid for up to thirty-six (36) months. DNV GL-Healthcare is authorized by the U.S. Department of Health and Human Services to measure hospital's compliance to Medicare Conditions for Participation. A letter from DNV-GL dated October 26, 2015 is included in Attachment 15 in the original application. The letter states the applicant is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals.

Corporate documentation, real estate deed information, performance improvement plan, utilization review plan, and patient bill of rights are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, denied or pending applications, or outstanding Certificates of Need for this applicant.

CERTIFICATE OF NEED INFORMATION FOR OTHER FACILITIES IN THE SERVICE AREA:

There are no Letters of Intent, denied applications, pending applications or outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE. PME (04/04/16)

**CAH ACQUISITION COMPANY 11, LLC
D/B/A LAUDERDALE COMMUNITY HOSPITAL
CN1601-004
MAY 25, 2016
PAGE 10**

Attachment 1

Hospitals, as defined in Section 1861(e) of the Social Security Act, and CAHs with a Medicare provider agreement that includes Centers for Medicare & Medicaid Services (CMS) approval to furnish swing bed services may use their beds as needed to furnish either acute or Skilled Nursing Facility (SNF)-level care. To receive, and retain, approval to furnish post-acute SNF-level care via a swing bed agreement, hospitals must:

Be located in a rural area, which includes all areas that are not delineated as urbanized by the United States (U.S.) Census Bureau based on the most recent census for which data is published (an urbanized area does not include an urban cluster);

Have fewer than 100 beds (excluding beds for newborns and intensive care-type units);

Have a Medicare provider agreement as a hospital;

Not have had a swing bed approval terminated within the 2 years previous to submission of the current application for swing bed approval (this requirement applies to all swing bed providers, including Critical Access Hospitals);

Not have had a nursing waiver granted as specified in the "Code of Federal Regulations" (CFR) at 42 CFR 488.54(c); and

Be substantially in compliance with the following SNF participation requirements as specified at 42 CFR 482.66(b)(1-8):

- Residents' rights;
- Admission, transfer, and discharge rights;
- Resident behavior and facility practices;
- Patient activities;
- Social services;
- Discharge planning;
- Specialized rehabilitative services; and
- Dental services.

REQUIREMENTS THAT APPLY TO CRITICAL ACCESS HOSPITALS

Critical access hospitals must be substantially in compliance with the following SNF participation requirements as specified at 42 CFR 485.645(d)(1-9):

- Residents' rights;
- Admission, transfer, and discharge rights;
- Resident behavior and facility practices;
- Patient activities (with exceptions for director of services);
- Social services;

Comprehensive assessment, comprehensive care plan, and discharge planning (with some exceptions);

- Specialized rehabilitative services;
- Dental services; and
- Nutrition.

A Critical Access Hospital may maintain no more than 25 inpatient beds. A Critical Access Hospital with Medicare approval to furnish swing bed services may use any of its inpatient beds for either inpatient or SNF-level services. A Critical Access Hospital may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds; however, it may not use a bed within these units for swing bed services.

LETTER OF INTENT



State of Tennessee
Health Services and Development Agency

Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the The Commercial Appeal which is a newspaper
of general circulation in Lauderdale (County), Tennessee, on or before January 10, 2016 (Month / day) (Year)
for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in
accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency,
that:

CAH Acquisition Company 11, LLC Hospital
(Name of Applicant) (Facility Type-Existing)
owned by: HMC/CAH Consolidated, Inc. with an ownership type of LLC
and to be managed by: Rural Community Hospitals of America, LLC
intends to file an application for a Certificate of Need
for [PROJECT DESCRIPTION BEGINS HERE]: See Attached Project Description

The anticipated date of filing the application is: January 15, 2016

The contact person for this project is Tammie Hardy (Contact Name) (Title)

who may be reached at: Lauderdale Community Hospital 326 Asbury Avenue
Ripley TN 38063 731 / 221-2200
(City) (State) (Zip Code) (Area Code / Phone Number)

Tammie Hardy (Signature) 1-7-16 (Date) tammie.hardy@lauderdalehospital.com (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the
last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File
this form at the following address:

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

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

CAH Acquisition Company 11, LLC Letter of Intent**Project Description:**

CAH Acquisition Company 11, LLC, d/b/a Lauderdale Community Hospital, is located at 326 Asbury Avenue, Ripley, Tennessee and has a growing inpatient census averaging around 8.5 patients per day. Lauderdale Community Hospital is proposing to build a new 25 bed facility on its current campus consisting of 46,851 square feet at an expected construction cost (including site preparation work) of \$19,999,460. The new hospital will replace the existing 33 year old facility that is outdated and does not provide the efficiencies that a new facility will provide. The new hospital will continue to offer the same services currently provided, which include acute, emergency, swingbed and outpatient services.

COPY

Lauderdale
Community Hospital

CN1601-004

CERTIFICATE OF NEED APPLICATION

FOR A REPLACEMENT HOSPITAL AT

LAUDERDALE COMMUNITY HOSPITAL

JANUARY 2016

**CONTACT:
TAMMIE HARDY
CHIEF EXECUTIVE OFFICER
LAUDERDALE COMMUNITY HOSPITAL
326 ASBURY AVE
RIPLEY, TN 38063
731-221-2200**

1. **Name of Facility, Agency, or Institution**

CAH Acquisition Company 11, LLC
 Name
 326 Asbury Avenue
 Street or Route
 Ripley
 City
 TN
 State
 Lauderdale
 County
 38063
 Zip Code

2. **Contact Person Available for Responses to Questions**

Tammie Hardy
 Name
 Lauderdale Community Hospital
 Company Name
 326 Asbury Avenue
 Street or Route
 Ripley
 City
 Employee
 Association with Owner
 Chief Executive Officer
 Title
 tammie.hardy@lauderdalehosp
 Email address
 TN
 State
 38063
 Zip Code
 731-220-2400
 Phone Number
 731-220-2499
 Fax Number

3. **Owner of the Facility, Agency or Institution**

CAH Acquisition Company 11, LLC
 Name
 326 Asbury Avenue
 Street or Route
 Ripley
 City
 TN
 State
 731-220-2200
 Phone Number
 Lauderdale
 County
 38063
 Zip Code

4. **Type of Ownership of Control (Check One)**

A. Sole Proprietorship

B. Partnership

C. Limited Partnership

D. Corporation (For Profit)

E. Corporation (Not-for-Profit)

F. Government (State of TN or Political Subdivision)

G. Joint Venture

H. Limited Liability Company

I. Other (Specify)

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

February 23, 2016

9:32 am

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

Rural Community Hospitals of America, LLC		
Name		
1100 Main Street, Suite 2350		Jackson
Street or Route		County
Kansas City	MO	64105
City	State	Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

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

A. Ownership	<input type="checkbox"/>	D. Option to Lease	<input type="checkbox"/>
B. Option to Purchase	<input type="checkbox"/>	E. Other (Specify)	<input type="checkbox"/>
C. Lease of 9 Years	<input checked="" type="checkbox"/>		

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. Type of Institution (Check as appropriate--more than one response may apply)

A. Hospital (Specify) CAH	<input checked="" type="checkbox"/>	I. Nursing Home	<input type="checkbox"/>
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	<input type="checkbox"/>	J. Outpatient Diagnostic Center	<input type="checkbox"/>
C. ASTC, Single Specialty	<input type="checkbox"/>	K. Recuperation Center	<input type="checkbox"/>
D. Home Health Agency	<input type="checkbox"/>	L. Rehabilitation Facility	<input type="checkbox"/>
E. Hospice	<input type="checkbox"/>	M. Residential Hospice	<input type="checkbox"/>
F. Mental Health Hospital	<input type="checkbox"/>	N. Non-Residential Methadone Facility	<input type="checkbox"/>
G. Mental Health Residential Treatment Facility	<input type="checkbox"/>	O. Birthing Center	<input type="checkbox"/>
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)	<input type="checkbox"/>	P. Other Outpatient Facility (Specify)	<input type="checkbox"/>
		Q. Other (Specify)	<input type="checkbox"/>

8. Purpose of Review (Check) as appropriate--more than one response may apply)

A. New Institution	<input type="checkbox"/>	G. Change in Bed Complement [Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation]	<input type="checkbox"/>
B. Replacement/Existing Facility	<input checked="" type="checkbox"/>	H. Change of Location	<input type="checkbox"/>
C. Modification/Existing Facility	<input type="checkbox"/>	I. Other (Specify)	<input type="checkbox"/>
D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify)	<input type="checkbox"/>		
E. Discontinuance of OB Services	<input type="checkbox"/>		
F. Acquisition of Equipment	<input type="checkbox"/>		

9. **Bed Complement Data**

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

	Current Beds		Staffed	Beds	TOTAL
	Licensed	*CON	Beds	Proposed	Beds at Completion
A. Medical	25	25	25	0	25
B. Surgical					
C. Long-Term Care Hospital					
D. Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolescent Psychiatric					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid Certified)					
M. Nursing Facility Level 1 (Medicaid only)					
N. Nursing Facility Level 2 (Medicare only)					
O. Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child and Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL	25	25	25	0	25

*CON-Beds approved but not yet in service

10. Medicare Provider Number
 Certification Type

11. Medicaid Provider Number
 Certification Type

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid?

13. Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Will this project involve the treatment of TennCare participants? If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract.

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

- I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.**

General Information and Ownership Structure

CAH Acquisition Company 11, LLC is a Delaware Limited Liability Company. CAH 11 is authorized to conduct business in Tennessee, and is the owner of all the assets and properties of a 25-bed acute care hospital located at 326 Asbury Avenue, Ripley, Tennessee 38063. The hospital is commonly known as Lauderdale Community Hospital. Hereafter, CAH Acquisition Company 11, LLC will be referred to as "CAH11" and/or the "Applicant" and Lauderdale Community Hospital will be referred to as "LCH".

HMC/CAH Consolidated, Inc. (HMC) is the parent company of CAH11. HMC is a Delaware corporation with its principal place of business in Kansas City, Missouri. HMC is in the business of acquiring acute care hospitals located in rural communities and certified by the Centers for Medicare and Medicaid Services ("CMS") as Critical Access Hospitals. HMC conducts its business through a consolidated group of ten hospital subsidiaries.

The HMC business plan is to replace the existing facilities of all its hospitals with new facilities. In addition to LCH, HMC currently has four hospitals in Oklahoma (one of which is a new hospital facility); three hospitals in Kansas (one of which has a new hospital facility under construction); one in Missouri (which is a new hospital facility); and one in North Carolina.

LCH (and the other non-HMC hospitals) is managed by Rural Community Hospitals of America, LLC (RCHA). RCHA is a West Virginia limited liability company with its principal place of business in Kansas City, Missouri. RCHA provides LCH (and each of the other HMC hospitals) with day-to-day management and business services. RCHA has approximately 86 full-time employees, which include hospital administrators, nurses, quality improvement specialists, accountants, lawyers, financial analysts, revenue cycle and reimbursement (cost reporting) specialists, patient services coordinators, managed care contract analysts, information technology (IT) specialists, and a variety of other senior and mid-level managers.

LCH is licensed as an acute care hospital in Tennessee and is certified by the Centers for Medicare and Medicaid Services ("CMS") as a Critical Access Hospital. LCH has an inpatient census that averages around 8.5 patients per day. In FY 2015 (during the months October-September) LCH had 2,967 patient days (inpatient, swing bed and

observation) and over 10,000 emergency room (ER) visits. Baptist Memorial Hospital (BMH) in Covington, Tennessee is the closest hospital to LCH and is located approximately 20 miles away. BMH has 92 licensed beds and approximately 4,000 annual patient days.

Project Cost, Funding, and Financial Feasibility

CAH11 is the owner of fee title to the real property and improvements located at 326 Ashbury Avenue, Ripley, Tennessee 38063. This tract of land is 34.95 acres, more or less. Applicant has divided this tract of land into two separate parcels consisting of 10.97 acres (Parcel 1) and 23.98 acres (Parcel 2). Parcel 1 is the tract of land on which the existing hospital facility is located. Parcel 2 is the tract of land on which the new hospital facility is proposed to be constructed.

Applicant proposes to enter into build-to-suit lease transaction for construction of the new hospital facility on Parcel 2. CAH11 (or its affiliate) will be the lessee, and Community Hospitality Healthcare Services (CHHS) will be the lessor.

The total project cost for the new hospital facility will be approximately \$23 million, of which \$3 million (or approximately 23%) will be New Market Tax Credits (NMTC). This investment will be provided through CHHS in the form of a subordinated interest-only promissory note with a term of no less than 7 years at an interest rate in the 2.5% to 3.0% range. The remaining \$20 million will be provided by CBC Real Estate Group, LLC, the project developer, in cooperation with a real estate investment trust (REIT). Applicant has engaged CFG Capital Markets, LLC, as its financial advisor, to originate and structure this aspect of the lease transaction.

At closing of the lease transaction, the lessee will convey fee title to Parcel 2 to the lessor. The lessee will leaseback Parcel 2 (together with the 25-bed new hospital facility that is to be constructed thereon) from the lessor. The hospital facility will have approximately 46,851 square feet.

In material part the lease agreement executed by CAH11 (as Lessee) and CHHS (as Lessor) will contain the following terms and conditions:

- 1) Lessee will accept the leasehold property in its "AS IS" condition, and will work with the project developer (appointed by the lessor) to ensure its satisfaction with the plans, specifications, scope of work and schedule for the to-be-constructed hospital facility to ensure adequacy and acceptability for its intended use.
- 2) The term of the lease is twenty (20) years. The lessee shall have two, 5-year renewal options. So long as it is not in default on the lease, the lessee will have the option (at agreed intervals) to repurchase the leasehold property at a pre-established pricing methodology. The purchase option is non-transferable.
- 3) The lease will be absolute net in nature whereby CAH11 will be responsible throughout the term for the payment of all amounts, liabilities, obligations and impositions related to the ownership, use, possession and operation of the leasehold property. This responsibility of the lessee will be in addition to the payment of the annual rent described below.

- 4) The annual rent for the first 12-month period following the closing shall be an amount equal to 10.5% of the transaction less an adjustment for New Market Tax Credits (NMTC). The NMTC adjustment is expected to equal to no less than \$300,000 or 10% of the value received from the New Market Tax Credits currently contemplated. Commencing on the date that is one year after lease commencement and each year thereafter, the annual rent shall be increased by one and a half percent (1.5%). The annual rent for the first year of the first renewal option shall be the greater of market rent or 101.5% of the prior year's rent. The annual rent shall be subject to annual increases of 1.5% thereafter.
- 5) The lessee will obtain and maintain throughout the lease term all approvals needed to use and operate the hospital facility as a Critical Access Hospital. The lessee will continuously operate the hospital facility only as a provider of healthcare services and shall maintain its certifications for reimbursement and licensure and all necessary accreditations.

Need

The new hospital will replace the existing, outdated facility that does not provide the efficiencies needed to compete in today's challenging environment. The current facility was put into service in 1983. As a result of the facility's age, operational deficiencies, accessibility issues for patients, and infrastructure challenges, significant facility upgrades or additions are not financially feasible. The intent of the proposed project will be to continue to offer the same services currently provided, which include acute, emergency, swing bed and outpatient services, but do it in a more operationally efficient manner. The intent is to improve the patient experience and create a facility that is financially sustainable and meets the future need of the region, the medical staff, and the health system.

Proposed Services, Equipment and Staffing

The proposal is to move all existing services and equipment to the replacement facility. There is no current plan to change the number or disposition of LCH's 25 beds, nor are there any planned changes in the services to be provided. No major equipment purchases are currently being contemplated. The facility employs 107 highly skilled workers and will continue to employ these employees with the replacement facility.

Service Area

LCH's primary service area consists of zip-code 38063 (Ripley, TN) which accounts for 78 percent of the hospitals total volume. The total population within the zip-code in 2018 is projected to be 17,015. The 65 plus population in 2018 is projected to be 2,744, which is 16.3% of the population.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

- A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of \$5 million) and other facility projects (construction cost in excess of \$2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.**

If the project involves none of the above, describe the development of the proposal.

As noted above, the LCH existing hospital facility is a 25-bed Critical Access Hospital located at 326 Asbury Avenue, Ripley, Tennessee. The hospital is over 30 years old and outdated from layout and design to the mechanical systems. The proposed project is to construct a state-of-the-art replacement facility to replace the old one. As noted above, the new hospital facility (Parcel 2) will be located adjacent to the existing hospital facility (Parcel 1) on real property that is already owned by CAH 11. No new services or major equipment will be acquired as part of the proposed project.

The replacement facility will be located on 23.98 acres (Parcel 2) at an expected construction cost (including site preparation work) of \$19,999,460.

The total cost per square foot for the replacement facility is projected to be \$299 which is slightly higher than the data used by HSDA for the years 2012-14. However, considering the data is nearly two years old the construction cost per square foot is within reason and has been priced by JEDunn Construction Company.

- B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.**

LCH is proposing to construct a replacement facility and is not adding or subtracting, converting or redistributing any beds. Nor will any beds be changing

their allocation. The existing 25 acute beds will be relocated to the replacement facility adjacent to the current campus.

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. **Adult Psychiatric Services –**
2. **Alcohol and Drug Treatment for Adolescents (exceeding 28 days) –**
3. **Birthing Center –**
4. **Burn Units –**
5. **Cardiac Catheterization Services –**
6. **Child and Adolescent Psychiatric Services –**
7. **Extracorporeal Lithotripsy –**
8. **Home Health Services –**
9. **Hospice Services –**
10. **Residential Hospice –**
11. **ICF/MR Services –**
12. **Long-term Care Services –**
13. **Magnetic Resonance Imaging (MRI) –**
14. **Mental Health Residential Treatment –**
15. **Neonatal Intensive Care Unit –**
16. **Non-Residential Methadone Treatment Centers –**
17. **Open Heart Surgery –**
18. **Positron Emission Tomography –**
19. **Radiation Therapy/Linear Accelerator –**
20. **Rehabilitation Services –**
21. **Swing Beds –**

This item is not applicable. No new health services will be initiated as a result of the construction of the replacement facility. The health services which are currently offered at the old facility will be part of the replacement facility.

D. Describe the need to change location or replace an existing facility.

The new facility allows for expansion for the future while covering today's needs. The existing structure was built in 1983 and will require expensive upgrades to bring it up to today's standards for Healthcare and building codes. The existing structure has low ceiling heights which are non-conducive to new equipment. Most of the building's mechanical and electrical equipment life span is past its date of replacement. New hospital systems are much more energy efficient and effective for today's hospital standards.

One of the major drawbacks of remodeling the existing facility is the phasing required to complete the remodel. The issues are: departments have to be relocated, areas divided into smaller pieces due to occupancy, and increased general cost due to a longer schedule. Typically, it takes twice as long to

completely remodel an existing facility as it does to construct new. You also have to deal with numerous infection control issues, life safety, and routing of patients and staff.

LCH was built and expanded when the norm was for patients to have lengthy inpatient hospital stays. As healthcare has changed, and with the mandates of healthcare reform, care is moving toward a more outpatient model, making it more important that healthcare facilities provide quick and easy access for patients to find the facility, park, and easily navigate the campus. The health system must prepare for the future by investing in a facility and services that will maximize returns in an increasingly challenging environment in terms of reimbursement models and payment reform.

- E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of \$1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

This item is not applicable. No such items of major medical equipment or other such equipment will be initiated as a result of the construction of the replacement facility.

- III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:

1. Size of site (*in acres*);
2. Location of structure on the site;
3. Location of the proposed construction; and
4. Names of streets, roads or highway that cross or border the site.

See Attachment 6

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

- (B) 1. 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.

The new hospital is to be found at the corner of US Highway 51 and Asbury Avenue in Ripley, TN and will be accessible by patients off Asbury Avenue. There are no public transportation routes in the area. The replacement facility is directly adjacent to the existing facility on the same 35 acre parcel of property.

- IV. **Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.**

NOTE: DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.

See Attachment 7

- V. **For a Home Health Agency or Hospice, identify:**

1. **Existing service area by County;**
2. **Proposed service area by County;**
3. **A parent or primary service provider;**
4. **Existing branches; and**
5. **Proposed branches.**

The proposed project does not include Home Health or Hospice services and it is therefore Not Applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), “no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care.” The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2” x 11” white paper.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate “Not Applicable (NA).”

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee’s Health: Guidelines for Growth.
 - a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

The proposed project helps the Hospital to better accomplish the Five Principles for Achieving Better Health as laid out in the Tennessee State Health Plan: 2014.

Healthy Lives

The proposed project will consist of a replacement hospital that is geared towards 21st century healthcare. The old facility was built at a time when the delivery of healthcare was primarily inpatient. The new facility will be state-of-the-art and while inpatient services will be offered the facility will be designed to grow and expand outpatient services and meet the needs of the community where they “live, work and learn.”

Access

If LCH does not replace its existing facility it is a matter of time before the entire facility will be outmoded and potentially not meet hospital code requirements. The proposed project assures inpatient and outpatient access to the community for decades to come.

In addition, the hospital will continue to offer charity care and participate in TennCare and the Medicare program. It is important to note that the hospital works to ensure care is provided to all patients regardless of income and will continue to do so with the replacement project.

Economic Efficiencies

Building to current healthcare standards will improve efficiencies in operations at the hospital. In addition, by being a rural provider LCH is able to more economically take care of patients locally than having those patients travel to larger tertiary facilities. The delivery of care costs less and is more convenient to the patient if done locally.

Quality of Care

LCH strives to constantly improve its quality of care and patient satisfaction. A new facility will only improve upon both quality and satisfaction.

Workforce.

The number one recruitment tool for healthcare professionals is a new facility. Providers and other healthcare professionals prefer to work in newer facilities. In addition, a replacement will allow LCH to maintain their current staff.

The Criteria and Standards for a replacement hospital include the following:

- (a) The applicants should provide plans which include costs for both renovation and relocation, demonstrating the strength and weaknesses of each alternative.**

As a critical access hospital, there are few options available to LCH beyond renovation, replacement or the status quo. The current status quo is becoming untenable. The current facility is over thirty years old. The life of the mechanical and electrical equipment is well past its date of replacement. In addition the current facility is not conducive to new equipment and/or technology. For these reasons, the applicant rejects the status quo option.

LCH is then limited to renovation or replacement; this is due primarily to the construction and licensing requirements that are unique to hospitals, i.e. oxygen and vacuum lines in the walls, air handling to achieve negative pressure, lead-lined walls in Radiology. A new facility allows for expansion for the future while covering today's needs. The existing structure will require expensive upgrades to bring it up to today's standards for healthcare and building codes. New hospital systems are much more energy efficient and effective for today's hospital standards and most importantly are tailored towards the outpatient setting. Based on the applicant's experience and concern for investing in an old facility, the option of renovation was rejected.

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

The below table shows the LCH's existing volumes for the last three years demonstrating the current demand for the proposed replacement hospital. With the replacement, the applicant will increase volume primarily captured from its primary service area. If a new hospital is not built within the next five years the applicant's fears volume will decline and threaten the long-term viability of the hospital.

Table 1: Demonstrate Existing Need

Volume Statistics	2013	2014	2015
DISCHARGES:			
ACUTE	356	281	255
SWINGBED	72	88	117
ER VISITS	11,446	10,065	10,432
SURGERIES	296	164	56
OUTPATIENT VISITS	7,187	7,391	6,441
ANCILLARY UTILIZATION			
RADIOLOGY:			
INPATIENT	815	401	550
OUTPATIENT	15,374	14,705	12,218
LABORATORY:			
INPATIENT	3,880	3,262	4,596
OUTPATIENT	44,145	41,891	40,352
PHYSICAL THERAPY:			
INPATIENT	2,235	2,682	2,489
OUTPATIENT	11,974	15,111	12,294

- b. **Applications that include a Change of Site for a health care institution provide a response to General Criterion and Standards (4) (a-c)**

This question is not applicable to this project.

2. **Describe the relationship of this project to the applicant facility's long-range development plans, if any.**

This project represents a significant step forward in regards to the development of LCH and its ability to provide quality healthcare to the Ripley area. In addition to improvements in quality of care, this project will make it possible for LCH to provide that care efficiently and maximize the benefit to patients and staff alike.

Since 2010 when the hospital was acquired from Baptist Memorial Health Care the long-range plan for the hospital has been for the old facility to be replaced. It is the applicant's desire to right size and maximize the use of the hospital which can only be done with a replacement facility.

3. **Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

The proposed service area is also the current service area of LCH. LCH receives 78% of its patients from Ripley, TN in Lauderdale County. Because LCH is a rural hospital the applicant does not expect the service area to change. The new facility will ensure that LCH does not lose patients in the future and that services will be maintained for future generations.

Please find Attachment 8 for a state map of Tennessee and Lauderdale County.

4. A. **Describe the demographics of the population to be served by this proposal.**

As noted in the table below, the primary service area of LCH is Ripley, TN. Ripley itself had a population of 17,260 as of 2013 and by 2018 the population is expected to decline slightly to 17,015 or a decrease of 1.4%.

Table 2: General Demographics

Ripley, TN (Zip Code 38063)			
	2010 CENSUS	2013 ESTIMATE	2018 FORECAST
Population	17,360	17,260	17,015
Households	6,594	6,560	6,512
Families	4,671	4,648	4,612
Median Age	36.1	36.8	37.7
Median Household Income	\$31,743	\$33,795	\$36,868
Average Household Income	\$42,601	\$45,375	\$49,087
Average Household Size	2.63	2.63	2.61
65 + Population	2,256	2,406	2,774
% 65 + Population	13.1%	13.9%	16.3%

People over the age of 65 are expected to grow from 13.9% of the total population in 2013 to an estimated 16.3% by 2018. Currently, Medicare represents 38% of LCH gross revenue and as the demographics suggest, the 65+ age cohort will continue to be a significant patient base for the hospital.

Table 3: +65 Age Cohort

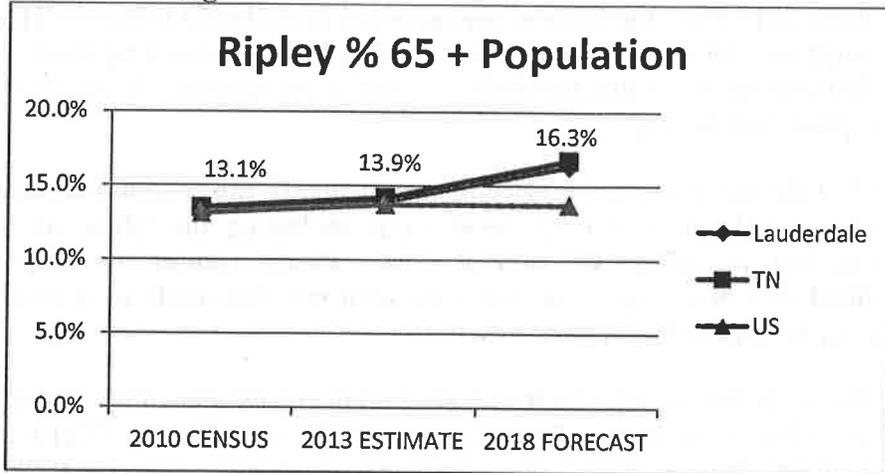


Table 4: Household by Income

Households by Income				
	2013 Estimate		2018 FORECAST	
	Number	Percent	Number	Percent
Less Than \$10,000	877	13.40%	845	13.00%
\$10,000 - \$14,999	640	9.80%	383	5.90%
\$15,000 - \$19,999	365	5.60%	500	7.70%
\$20,000 - \$24,999	486	7.40%	362	5.60%
\$25,000 - \$29,999	471	7.20%	513	7.90%
\$30,000 - \$34,999	581	8.90%	411	6.30%
\$35,000 - \$39,999	501	7.60%	645	9.90%
\$40,000 - \$44,999	229	3.50%	369	5.70%
\$45,000 - \$49,999	309	4.70%	259	4.00%
\$50,000 - \$59,999	533	8.10%	550	8.40%
\$60,000 - \$74,999	519	7.90%	503	7.70%
\$75,000 - \$99,999	511	7.80%	522	8.00%
\$100,000 - \$124,999	224	3.40%	287	4.40%
\$125,000 - \$149,999	82	1.20%	105	1.60%
\$150,000 - \$199,999	36	0.50%	46	0.70%
\$200,000+	196	3.00%	212	3.20%
Total	6,560	100.00%	6,512	100.00%

Table 5: Population by Age

Population by Age				
	2013 ESTIMATE		2018 FORECAST	
	Number	Percent	Number	Percent
Age 0-4	1,230	7.10%	1,087	6.40%
Age 5-9	1,262	7.30%	1,157	6.80%
Age 10-14	1,300	7.50%	1,222	7.20%
Age 15-19	1,212	7.00%	1,254	7.40%
Age 20-24	1,115	6.50%	1,171	6.90%
Age 25-29	1,081	6.30%	1,059	6.20%
Age 30-34	1,073	6.20%	1,017	6.00%
Age 35-39	996	5.80%	1,013	6.00%
Age 40-44	1,065	6.20%	944	5.50%
Age 45-49	1,198	6.90%	1,045	6.10%
Age 50-54	1,205	7.00%	1,122	6.60%
Age 55-59	1,095	6.30%	1,117	6.60%
Age 60-64	1,019	5.90%	1,035	6.10%
Age 65-69	815	4.70%	925	5.40%
Age 70-74	580	3.40%	698	4.10%
Age 75-79	417	2.40%	509	3.00%
Age 80-84	282	1.60%	309	1.80%
Age 85+	312	1.80%	333	2.00%
Total	17,257	100.00%	17,017	100.00%
Median	36.8		37.7	

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

LCH treats and is prepared for all special needs. But two special needs are predominant in Lauderdale County and are the ones the applicant concentrates on.

First, Lauderdale County has the second highest unemployment rate in the state and subsequently the county has a large low-income population. The average household income is 26% below the state average. The hospital is accustomed to managing the healthcare of TennCare/Medicaid. According to the TennCare Enrollment Report, as of November 15th there were 8,093 recipients of TennCare in Lauderdale County. Last year (2015), LCH topped \$4,000,000 in uncompensated care provided without reimbursement. The proposed hospital's

replacement facility will continue to have contractual agreements with TennCare/Medicaid and continue to serve the needs of underserved and indigent of Lauderdale County.

The second special need is the 65+ age group. People over the age of 65 are expected to grow from 13.9% of the total population in 2013 to an estimated 16.3% by 2018. Currently, Medicare represents 38% of LCH gross revenue and as the demographics suggest, the 65+ age cohort will continue to be a significant patient base for the hospital. As a result, LCH will continue to be an active utilizer of Medicare to serve this age group.

Medicare, TennCare/Medicaid along with other insurance companies will continue to make sure that all needs within the service area population, including health disparities, are met.

5. **Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions 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. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.**

There are no institutions similar to LCH in the service area and therefore this is not applicable.

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

The below Table shows utilization data for the last three years projected through 2021.

Table 6: Utilization

In/Outpatient Statistic	Actual			Projected					
	2013	2014	2015	2016	2017	2018	2019	2020	2021
Inpatient									
Acute Days	1,392	1,167	979	987	1,017	1,098	1,142	1,176	1,200
Swing Day	1,006	1,179	1,210	1,195	1,230	1,329	1,382	1,423	1,452
Outpatient									
Surgeries	296	164	56	44	45	49	51	52	53
ER Visits	11,446	10,065	10,432	10,453	10,663	10,876	11,093	11,315	11,541
Radiology Proc	15,374	14,705	12,218	12,519	12,895	13,926	14,483	14,918	15,216
Lab Tests	44,145	41,891	40,352	44,822	46,167	49,860	51,855	53,411	54,479

The methodology for the projection of the key drivers of LCH involves several different factors. First, the applicant built a baseline trend based on prior year results; LCH then projects the baseline forward with percentage changes in growth. Generally, the hospital assumes 2% volume growth unless special circumstances exist. In the case of the construction of a replacement facility volume growth is 8% in 2018 and 4% in 2019. The volume growth rates following new construction are conservative compared to the 7th Annual Rural Hospital Replacement Facility Study prepared in 2011 by Stroudwater Associates (see Attachment 9). The Stroudwater Study has shown that some Critical Access Hospitals have as much as a 40% volume growth in the first year following a replacement.

The applicant assumes that the construction period for the new facility will span 2017 and 2018 fiscal years. As a result, 2018 and 2019 have the increased volume growth mentioned above.

Table 7: Detailed Utilization Percent Increase by Projected Year

In/Outpatient Statistic	Projected Increase per Year					
	2016	2017	2018	2019	2020	2021
Inpatient						
Acute Days	-1%	-3%	8%	4%	3%	2%
Swing Day	-1%	3%	8%	4%	3%	2%
Outpatient						
Surgeries	-21%	2%	9%	4%	2%	2%
ER Visits	0%	2%	2%	2%	2%	2%
Radiology Proc	2%	3%	8%	4%	3%	2%
Lab Tests	11%	3%	8%	4%	3%	2%

ECONOMIC FEASIBILITY

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

- All projects should have a project cost of at least \$3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)

Confirmed – application fee is shown on Line F of the Project Costs Chart.

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

This section is Not Applicable – existing equipment will be relocated to the new facility.

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

Not Applicable. All existing equipment will be relocated to the new facility.

- For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.

Please See Attachment 10

2. Identify the funding sources for this project

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

- A. Commercial Loan—Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.**
- B. Tax-exempt Bonds—Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**
- C. General Obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**
- D. Grants—Notification of intent form for grant application or notice of grant award;**
- E. Cash Reserves—Appropriate documentation from Chief Financial Officer**
- F. Other—Identify and document funding from all other sources.**

The total project cost for the new hospital facility will be approximately \$23 million. The project will be funded from two sources.

1. New Market Tax Credits (NMTC) will provide \$3 million (or approximately 23%) of the total project cost. This investment will be provided through CHHS in the form of a subordinated, interest-only promissory note with a term of no less than 7 years at an interest rate of 2.5% to 3.0% range. A January 8, 2016 letter from Benjamin Cirka, Executive Director, CHHS is included at Attachment 11.
2. The remaining \$20 million will be provided by CBC Real Estate Group, LLC (CBC). CBC will act as the Project Developer and will arrange for this funding in cooperation with a designated real estate investment trust (REIT). The applicant has engage CFG Capital Markets, LLC, as its financial advisor to originate and structure this aspect of the lease transaction. A January 8, 2016 letter from Samer Tahboub, Director, CFG, is included in Attachment 11.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

This project's \$298.60 cost per SF for new construction is based on research conducted by LCH's architect and builder. The construction cost of \$298.60 is higher than the median costs for hospital construction projects submitted to HSDA for the years 2012-2014; however the pricing completed by LCH's architect and builder are more current and up to date. Even with the 2012-2014 data the proposed project construction is only slightly higher than HSDA's 3rd Quartile (See table below).

Table 8: HSDA Construction Cost

	Cost per SF			
	1st Quartile	Median	3rd Quartile	Lauderdale Community Hospital
New Hospital Construction	224.09	259.66	296.52	298.60

4. Complete historical and projected data charts on the following pages

PROJECT COSTS CHART**February 23, 2016****9:32 am**

A. Construction and equipment acquired by purchase:		
1.	Architectural and Engineering Fees	0
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	0
3.	Acquisition of Site	0
4.	Preparation of Site	0
5.	Construction Costs	0
6.	Contingency Fund	0
7.	Fixed Equipment (Not included in Construction Contract)	0
8.	Moveable Equipment (List all equipment over \$50,000)	0
9.	Other (Specify) [REDACTED]	0
B. Acquisition by gift, donation, or lease:		
1.	Facility (inclusive of building and land)	20,217,987
2.	Building only	0
3.	Land only	0
4.	Equipment (Specify) [REDACTED]	0
5.	Other (Specify) [REDACTED]	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) [REDACTED]	0
D.	Estimated Project Cost (A+B+C)	20,217,987
E.	CON Filing Fee	45,000
F.	Total Estimated Project Cost (D+E)	20,262,987
TOTAL		20,262,987

February 23, 2016**9:32 am****HISTORICAL DATA CHART**

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

	Year 2013	Year 2014	Year 2015
A. Utilization Data (Patient Days)	2,398	2,164	2,189
B. Revenue from Services to Patients			
1. Inpatient Services	\$ 6,862,824	\$ 5,450,236	\$ 5,789,102
2. Outpatient Services	24,086,893	27,208,705	27,848,838
3. Emergency Services	7,724,520	6,696,963	7,834,002
4. Other Operating Revenue (Specify) Cafeteria, Med Records, MCR HER, Grant Income	\$ 522,385	\$ 615,350	\$ 500,784
Gross Operating Revenue	\$ 39,196,622	\$ 39,971,254	\$ 41,972,726
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	\$ 19,817,700	\$ 20,231,496	\$ 23,976,735
2. Provision for Charity Care	837,130	176,674	274,237
3. Provisions for Bad Debt	3,415,875	3,835,255	2,843,619
Total Deductions	\$ 24,070,705	\$ 24,243,426	\$ 27,094,591
NET OPERATING REVENUE	\$ 15,125,917	\$ 15,727,828	\$ 14,878,135
D. Operating Expenses			
1. Salaries and Wages	\$ 5,884,252	\$ 6,141,906	\$ 6,244,450
2. Physician's Salaries and Wages	150,611	150,412	43,187
3. Supplies	1,250,825	1,301,259	1,279,405
4. Taxes	152,790	613,239	270,108
5. Depreciation	915,401	989,069	849,949
6. Rent	0	0	0
7. Interest, other than Capital	80,431	69,960	103,759
8. Management Fees:			
a. Fees to Affiliates	<u> </u>	<u> </u>	<u> </u>
b. Fees to Non-Affiliates	1,413,991	1,419,996	1,618,373
9. Other Expenses – Benefits, Med Specialist Fees, Purchased Services, Leases, Licenses, Utilities, Property Tax	4,956,309	4,019,391	4,167,110
Total Operating Expenses	\$ 14,804,610	\$ 14,705,232	\$ 14,576,341
E. Other Revenue (Expenses) – Offset to Income Taxes _____	\$ 0	\$ 479,059	\$ 150,053
NET OPERATING INCOME (LOSS)	\$ 321,307	\$ 1,501,655	\$ 451,847
F. Capital Expenditures			
1. Retirement of Principal	\$ 435,016	\$ 605,887	\$ 1,002,827
2. Interest	322,017	318,794	122,062
Total Capital Expenditures	\$ 757,033	\$ 924,681	\$ 1,124,890
NET OPERATING INCOME (LOSS)			
LESS CAPITAL EXPENDITURES	<u>\$ (435,726)</u>	<u>\$ 576,974</u>	<u>\$ (673,043)</u>

PROJECTED DATA CHART

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

	Year_2018_	Year_2019_
A. Utilization Data (Patient Days)	2,427	2,524
B. Revenue from Services to Patients		
1. Inpatient Services	6,940,971	7,435,168
2. Outpatient Services	34,395,985	36,642,245
3. Emergency Services	8,572,030	9,005,774
4. Other Operating Revenue (Cafeteria, Med Records, HER, MCR, Grant Income)_	448,828	448,828
Gross Operating Revenue	50,357,814	53,532,015
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	27,499,852	29,355,003
2. Provision for Charity Care	330,028	351,017
3. Provisions for Bad Debt	4,940,990	5,255,236
Total Deductions	32,770,870	34,961,256
NET OPERATING REVENUE	17,586,944	18,570,759
D. Operating Expenses		
1. Salaries and Wages	5,530,704	5,710,700
2. Physician's Salaries and Wages	0	0
3. Supplies	1,758,823	1,857,205
4. Taxes	482,600	642,454
5. Depreciation	1,277,778	1,277,778
6. Rent	0	0
7. Interest, other than Capital	42,674	42,674
8. Management Fees:		
a. Fees to Affiliates	0	0
b. Fees to Non-Affiliates	1,934,706	2,042,925
9. Other Expenses – Benefits, Purch Svcs, Benefits, Other Op	4,129,427	4,362,648
Total Operating Expenses	15,156,712	15,936,384
E. Other Revenue (Expenses) – Offset Income Taxes _____	261,990	438,012
NET OPERATING INCOME (LOSS)	2,692,222	3,072,388
F. Capital Expenditures		
1. Retirement of Principal	638,677	636,573
2. Interest	2,045,333	1,990,877
Total Capital Expenditures	2,684,010	2,627,450
NET OPERATING INCOME (LOSS)		

LESS CAPITAL EXPENDITURES

8,212

444,938

HISTORICAL DATA CHART-OTHER EXPENSES

<u>OTHER EXPENSES CATEGORIES</u>	Year 2013	Year 2014	Year 2015
1. BENEFITS	\$ 1,338,183	\$ 1,424,873	\$ 1,367,552
2. MEDICAL SPECIALIST FEES	656,572	655,464	687,866
3. PURCHASED SERVICES	878,541	871,526	695,203
4. Utilities	491,886	465,095	432,071
5. Leases	73,345	54,651	329,112
6. Insurance Expense	371,371	425,422	455,184
7. Licenses, Repairs & Maint, Dues, Chapter 11, et al	1,299,201	385,353	200,122
Total Other Expenses	\$ 5,109,099	\$ 4,282,384	\$ 4,167,110

PROJECTED DATA CHART-OTHER EXPENSES

<u>OTHER EXPENSES CATEGORIES</u>	Year 2018	Year 2019
1. Benefits	1,372,160	1,471,506
2. Medical Specialist Fees	730,497	745,107
3. Purchased Services	629,263	641,848
4. Utilities	258,395	266,147
5. Leases	396,066	421,256
6. Insurance Expense	547,786	582,625
7. Licenses, Repairs and Maint, Dues, et al	195,260	234,159
Total Other Expenses	4,129,427	4,362,648

5. Please identify the project's average gross charge, average deduction from operating revenue and average net charge.

Table 9: Average Charges, Deductions and Net

Average Gross Charges, Deductions and Net	Actual			Projected	
	2013	2014	2015	2018	2019
Patient Days	2,398	2,347	2,189	2,427	2,524
Gross Charges	38,674,237	39,355,904	41,471,942	49,908,986	53,083,188
Deductions	24,070,705	24,243,426	27,094,591	32,770,870	34,961,256
Net Patient Revenue	14,603,532	15,112,478	14,377,351	17,138,116	18,121,932
Average Cost					
Gross Charges	16,128	16,769	18,946	20,564	21,031
Deductions	10,038	10,330	12,378	13,503	13,852
Net Patient Revenue	6,090	6,439	6,568	7,061	7,180

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Since the proposed project does not involve the implementation of new services or additional beds, LCH does not anticipate an increase in charges other than normal inflationary increases of 3 percent and cost report adjustments that occur annually.

Please see Attachment 12 for LCH's current allowable reimbursement letters from the hospital's Medicare Intermediary.

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

There are no similar facilities to LCH in the service area or adjoining service areas. LCH is a Critical Access Hospital and is reimbursed based upon costs that are adjusted annually by Medicare. In addition, there are no new proposed charges with this application.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

As indicated in the Utilization Table and the Projected Data Chart, utilization rates will increase with a replacement facility. A replacement facility will mean a more efficiently designed configuration which will greatly enhance effectiveness of staff and providers.

dramatically reduce utility costs.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

LCH is currently running at a positive cash flow as of Fiscal Year 2015; this trend is expected to continue into 2016. Current cash reserves and anticipated positive cash flow in Fiscal Year 2016 is expected to cover any temporary cash flow issues during construction, as can be seen below.

Table 10: Cash Flow chart

Sources & Uses of Cash:	Actual			Projected					
	2013	2014	2015	2016	2017	2018	2019	2020	2021
Sources:									
Cash from Operations	914,692	2,171,933	1,179,732	2,103,264	1,908,854	1,924,668	2,359,289	2,647,420	2,705,475
Other	4,399,931	1,083,551	1,997,881	5,986,974	17,358,483	111,737	320,043	169,147	122,099
Total Sources	5,314,623	3,255,484	3,177,613	8,090,238	19,267,337	2,036,405	2,679,331	2,816,567	2,827,574
Uses:									
Total Uses	5,355,765	3,542,556	3,154,441	6,559,667	18,266,046	1,328,742	997,977	916,775	1,419,854
Net Source or Use of Cash	(41,142)	(287,072)	23,172	1,530,571	1,001,291	707,663	1,681,354	1,899,792	1,407,720
Beginning Cash	346,953	305,811	18,739	41,911	1,572,482	2,573,773	3,281,437	4,962,791	6,862,583
Ending Cash	\$305,811	\$18,739	\$41,911	\$1,572,482	\$2,573,773	\$3,281,437	\$4,962,791	\$6,862,583	\$8,270,303

9. 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. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

The replacement facility for LCH will continue to participate in state and federal programs including Medicare and TennCare/Medicaid. Medicare is 37.73% of utilization and Medicaid is 22.07%. The hospital also provides over \$4 million in indigent care annually. The applicant does not foresee a significant change in its current payor mix as a result of the proposed hospital replacement.

Please see below Table.

Table 11: Projected Payor Mix

Projected Payor Mix	Projected Revenue In 2018	% of Total
Medicare	18,830,535	37.73%
Medicaid	11,013,951	22.07%
Blue Cross	4,752,356	9.52%
Commercial/Oth	10,939,800	21.92%
Self-Pay	4,372,344	8.76%
	49,908,986	100.00%

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

See Attachment13

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

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

As a critical access hospital, there are few options available to LCH beyond renovation, replacement or the status quo. The current status quo is becoming untenable. The current facility is over thirty years old. The life of the mechanical and electrical equipment is well past its date of replacement. In addition the current facility is not conducive to new equipment and/or technology. For these reasons, the applicant rejects the status quo option.

LCH is then limited to renovation or replacement; this is due primarily to the construction and licensing requirements that are unique to hospitals, i.e. oxygen and vacuum lines in the walls, air handling to achieve negative pressure, lead-lined walls in Radiology). A new facility allows for expansion for the future while covering today's needs. The existing structure will require expensive upgrades to

bring it up to today's standards for healthcare and building codes. New hospital systems are much more energy efficient and effective for today's hospital standards and most importantly are tailored towards the outpatient setting. Based on the applicant's experience and concern for investing in an old facility, the option of renovation was rejected.

- b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.**

The applicant considered alternatives to new construction and determined that construction of a new facility with modern, state-of-the-art patient rooms was the optimal choice, as discussed above. A full renovation of a 30 year old facility is not cost-effective and would constitute a poor investment that will not meet the health needs of the community for the coming decades.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

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

As an existing provider of healthcare services, LCH has in place contractual and working relationships with existing healthcare providers within its service area. The following are existing agreements:

Amerigroup Community Care	Jackson-Madison County General Hospital
Arkansas Northeastern College	Lauderdale County Ambulance Authority
Baptist College of Health Sciences	Le Bonheur Children's Hospital Comprehensive Regional Pediatric Center
Baptist Health Services Group of the Mid-South Inc.	Le Bonheur Children's Medical Center
Baptist Memorial Hospital-Tipton	MultiPlan, Inc
BlueCross BlueShield of Tennessee	Prime Health Services, Inc.
CIGNA HealthCare of Tennessee, Inc	Tennessee College of Applied Technology-Ripley
Cigna-HealthSpring	Tennessee Hospital Association
Community Health Alliance	UnitedHealthcare of Tennessee, Inc
Concorde Career College	University of Memphis Loewenberg School of Nursing
DNV Healthcare, Inc	US Department of Health and Human Services
Dyersburg State Community College	Vanderbilt University Medical Center
Florida Agency for Healthcare Administration	Windsor Health Plan, Inc
Jackson State Community College	

The facility currently contracts with several managed care organizations and expects those relationships to continue.

BlueCare	PHCS
BluePreferred	Mail Handlers Benefit Plan
Blue Select	Correctional Medical Services
Blue Cross 65	Windsor Extra
Cover TN	Blue Advantage Plus HMO
Access TN	Humana Gold Plus Medicare HMO
Cover Kids	Medicare Advantra Freedom PFFS
AARP Health Options	Unison Medicare Advantage
Aetna PPO	Champus/Tricare
Coventry Healthcare	United Health Care Community Plan
GEHA	United Healthcare
Humana	United Healthcare Medicare HMO
Ironworkers #167	TennCare Select
Mutual of Omaha	

- 2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.**

The effect of this project on the healthcare environment in Lauderdale County is that the quality and efficiency of local healthcare will increase. Replacing a 30 year old facility with a new modern state-of-the-art facility in rural Ripley, TN will ensure that the community can receive care at home in their local community. It is costly for the families to have to travel to larger tertiary facilities for healthcare and a new facility will ensure access to local healthcare for decades to come.

In addition, a replacement facility will assist in the recruitment of physicians. As noted throughout the application, there are no existing providers in the same service area as this project and minimal to no instances of duplication or competition from this proposal.

- 3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.**

The current staffing patterns indicate 107 Full Time Employees with 66 providing direct patient care, although all employees meet/serve the patient population in some way. The number of patient care services provided will not change with the replacement facility. The Applicant currently and shall continue into the future to pay wages to its patient care givers that are consistent with the prevailing wages offered to similar employees in its service area. See table below for wage rate comparison.

Table 12: FTEs and Wage Rate Comparison

Department	FTEs	LCH Avg Wage Rate	Prevailing Wage Rate- TN
Administration	15.05	18.04	17.09
Dietary	6.03	13.83	9.54
Emergency	14.16	29.97	27.1
HIM	4.81	24.32	20.39
Housekeeping	5.51	13.48	14.88
Laboratory	8.55	24.33	18.07
Med/Surg	22.38	25.47	21.32
Other	0.13	32.10	27.48
Pharmacy	5.40	59.43	58.89
Plant Ops	2.98	20.43	28.75
Radiology	8.13	29.58	24.45
Surgery	0.22	42.89	24.42
Therapies	14.54	33.44	25.55
Average	107.89	26.52	27.48

4. **Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.**

The Applicant has qualified, licensed professional staff employed and/or contracted to deliver high quality care as required by the TN Department of Health. It is anticipated all current employees will transfer over to the new facility.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.**

The Applicant has reviewed, understands and adheres to all licensing certifications as required by the State of Tennessee for medical/clinical staff. These would include without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education. The Applicant continues to be certified and accredited through DNV, CLIA, JCAHO, TN DEPT OF HEALTH, AMERICAN COLLEGE OF RADIOLOGY, and TN BOARD OF PHARMACY

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).**

The Applicant has a Clinical Affiliation agreement with TN College of Applied Technology – Ripley. The purpose of this agreement is for the Applicant to provide clinical experience to students enrolled in the Four Rivers Regional Practical Nursing program.

The Applicant has a Clinical Affiliation Agreement with Jackson State Community College. The purpose of this agreement is for the Applicant to provide clinical experience to students enrolled in the Physical Therapist Assistant program of the college.

The Applicant has a Pediatric Training program Agreement with LeBonheur Children's Hospital. The purpose of this agreement is for Applicant's staff to have access to continuing education in order to maintain and update their skills in recognizing and stabilizing pediatric emergencies.

The Applicant has an agreement with Zaidi & Associates to assist in Clinical Internships available through this local physician provider.

7. (a) **Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

The Applicant is replacing its existing hospital. The Applicant is familiar with and understands all the licensure requirements of the Department of Health and all other Tennessee regulatory agencies and applicable Medicare requirements.

- (b) **Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.**

Licensure: Board for Licensing Health Care Facilities
State of Tennessee Department of Health

Accreditation: Certificate of Accreditation by DNV GL – Healthcare.
Continued deemed status in the Medicare program.

- (c) **If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.**

The existing facility's License is in good standing with the State of Tennessee Department of Health. A copy of the current facility's Hospital License is attached. See Attachment 14.

The existing facility's Certificate of Accreditation is in good standing with DNV GL – Healthcare. A copy of the Certificate of Accreditation is attached. See Attachment 14.

- (d) **For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.**

The existing facility was cited in the last DNV Reaccreditation survey on July 28 – 29, 2015. The Survey Report and Corrective Action Plan Submittal Form are attached; See attachment 15.

8. **Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Not applicable at this time.

9. **Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project**

Not applicable at this time.

10. **If the proposal is approved, please discuss whether the applicant will provide the Tennessee health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

Applicant will provide such data as needed by the State of Tennessee.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

The Commercial Appeal Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Patrick Maddox, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal to-wit:

January 10, 2016

Helen Curl

Subscribed and sworn to before me this 11th day of January, 2016.

Patrick Maddox Notary Public

My commission expires February 15, 2016.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide notice to the Health Services and Development Agency and all interested parties in accordance with TCA § 68-11-1001, as amended, and Rule of the Health Services and Development Agency, that GHA Acquisition Company, (GAC), a Hospital owned by HMC/GAH Consolidated Inc. with a new hospital type of 100 and to be managed by Rural Community Hospital of America (RCHA) plans to file an application for a Certificate of Need for GHA Acquisition Company's 110,000 sq. ft. Standards Community Hospital located at 226 S. Kirby Avenue, Ripley, Tennessee and has a growing inpatient capacity consisting around 85 inpatient per day additional Community Hospital. Proposing to build a new 25 bed facility on its current campus consisting of 10,651 square feet at an expected construction cost (including site preparation work) of \$10,994,480. The new hospital will replace the existing 33 year old facility that is outdated and does not provide the services that a new facility will provide. The new hospital will continue to offer the same services currently provided which include acute inpatient, ambulatory and outpatient services.

The anticipated date of filing the application is January 18, 2016. The contact person on this project is Tammy Hardy, CEO, who may be reached at Standards Community Hospital, 226 S. Kirby Avenue, Ripley, TN 38063, 731-224-2200.

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

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
1502 Bealeford Street
Nashville, Tennessee 37243

The published notice of intent must contain the following statement pursuant to TCA § 68-11-1001(d): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.



My Commission Expires 02/15/2016

DEVELOPMENT SCHEDULE

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

1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the "good cause" for such an extension.

N/A

Form HF0004

Revised 02/01/06

Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): 4/27/16

Assuming the CON approval becomes the final agency action on that date; indicate the number of days from the above agency decision date to each phase of the completion forecast.

<u>Phase</u>	<u>DAYS REQUIRED</u>	<u>Anticipated Date (MONTH/YEAR)</u>
1. <u>Architectural and engineering contract signed</u>	30	5/27/16
2. <u>Construction documents approved by the Tennessee Department of Health</u>	60	6/26/16
3. <u>Construction contract signed</u>	30	5/27/16
4. <u>Building permit secured</u>	45	6/11/16
5. <u>Site preparation completed</u>	60	6/26/16
6. <u>Building construction commenced</u>	60	6/26/16
7. <u>Construction 40% complete</u>	200	11/13/16
8. <u>Construction 80% complete</u>	365	4/27/17
9. <u>Construction 100% complete (approved for occupancy)</u>	425	6/25/17
10. <u>*Issuance of license</u>		
11. <u>*Initiation of service</u>		
12. <u>Final Architectural Certification of Payment</u>	500	9/8/17
13. <u>Final Project Report Form (HF0055)</u>	500	9/8/17

* For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.

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

AFFIDAVIT

JAN 14 10:18 AM '16

STATE OF Missouri
COUNTY OF Jackson

Trent Skaggs, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Trent Skaggs Sec VP
SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of January, 2016 a Notary
(Month) (Year)

Public in and for the County/State of Jackson County, Missouri

Linda K. Way
Notary Public - Notary Seal
STATE OF MISSOURI
Jackson County
My Commission Expires: Nov. 17, 2018
Commission #14444354

Linda K. Way
NOTARY PUBLIC

My commission expires November 17, 2018.
(Month/Day) (Year)

List of Tables

Table 1	Demonstrating Existing Need	Section C, Need, Item 1 (A)
Table 2	General Demographics	Section C, Need, Item 4 (A)
Table 3	+65 Age Cohort	Section C, Need, Item 4 (A)
Table 4	Household by Income	Section C, Need, Item 4 (A)
Table 5	Population by Age	Section C, Need, Item 4 (A)
Table 6	Utilization	Section C, Need, Item 6
Table 7	Detailed Utilization Percent Increase by Projected Year	Section C, Need, Item 6
Table 8	HSDA Construction Cost	Section C, Economic Feasibility, Item 3
Table 9	Average Charges, Deductions and Net	Section C, Economic Feasibility, Item 5
Table 10	Cash Flow Chart	Section C, Economic Feasibility, Item 8
Table 11	Projected Payor Mix	Section C, Economic Feasibility, Item 9
Table 12	FTEs and Wage Rate Comparison	Section C, Orderly Development of Healthcare, Item 3

List of Attachments

Attachment 1	Company Agreement and Certificate of Corporate Existence	Section A, Item 3
Attachment 2	Ownership Structure	Section A, Item 4
Attachment 3	Management Agreement	Section A, Item 5
Attachment 4	Deed of Trust	Section A, Item 6
Attachment 5	Existing MCO's and BHO's	Section A, Item 13
Attachment 6	Plot Plan	Section B, Item III (A)
Attachment 7	Floor Plan	Section B, Item IV
Attachment 8	Map of Proposed Service Area	Section C, Need, Item 3
Attachment 9	7 th Annual Rural Hospital Replacement Facility Study <i>How Replacement Facilities Impact Operations</i> Stroudwater Associates	Section C, Need, Item 6
Attachment 10	Project Cost Documentation	Section C, Economic Feasibility, Item 1
Attachment 11	Funding Documentation	Section C, Economic Feasibility, Item 2
Attachment 12	Medicare Rate Letters	Section C, Economic Feasibility, Item 6A
Attachment 13	Current Financial Statements and Most Recent Audited Financials	Section C, Economic Feasibility, Item 10
Attachment 14	Facility License	Section C, Orderly Development of Healthcare, Item 7 (c)
Attachment 15	Most Recent Certification of Licensure with any Deficiencies and subsequent Action Plans	Section C, Orderly Development of Healthcare, Item 7 (d)

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 5

Section A, Item 13

Existing MCO's and BHO's with which we have Agreements

Section A, Item 13

Existing MCOs and BHOs with which we have agreements

As an existing provider of healthcare services, LCH has in place contractual and working relationships with existing healthcare providers within its service area. The following are existing agreements:

Amerigroup Community Care	Jackson-Madison County General Hospital
Arkansas Northeastern College	Lauderdale County Ambulance Authority
Baptist College of Health Sciences	Le Bonheur Children's Hospital Comprehensive Regional Pediatric Center
Baptist Health Services Group of the Mid-South Inc.	Le Bonheur Children's Medical Center
Baptist Memorial Hospital-Tipton	MultiPlan, Inc
BlueCross BlueShield of Tennessee	Prime Health Services, Inc.
CIGNA HealthCare of Tennessee, Inc	Tennessee College of Applied Technology-Ripley
Cigna-HealthSpring	Tennessee Hospital Association
Community Health Alliance	UnitedHealthcare of Tennessee, Inc
Concorde Career College	University of Memphis Loewenberg School of Nursing
DNV Healthcare, Inc	US Department of Health and Human Services
Dyersburg State Community College	Vanderbilt University Medical Center
Florida Agency for Healthcare Administration	Windsor Health Plan, Inc
Jackson State Community College	

BlueCare	PHCS
BluePreferred	Mail Handlers Benefit Plan
Blue Select	Correctional Medical Services
Blue Cross 65	Windsor Extra
Cover TN	Blue Advantage Plus HMO
Access TN	Humana Gold Plus Medicare HMO
Cover Kids	Medicare Advantra Freedom PFFS
AARP Health Options	Unison Medicare Advantage
Aetna PPO	Champus/Tricare
Coventry Healthcare	United Health Care Community Plan
GEHA	United Healthcare
Humana	United Healthcare Medicare HMO
Ironworkers #167	TennCare Select
Mutual of Omaha	

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 6

Section B, Item III (A)

Plot Plan

Lauderdale Community Hospital

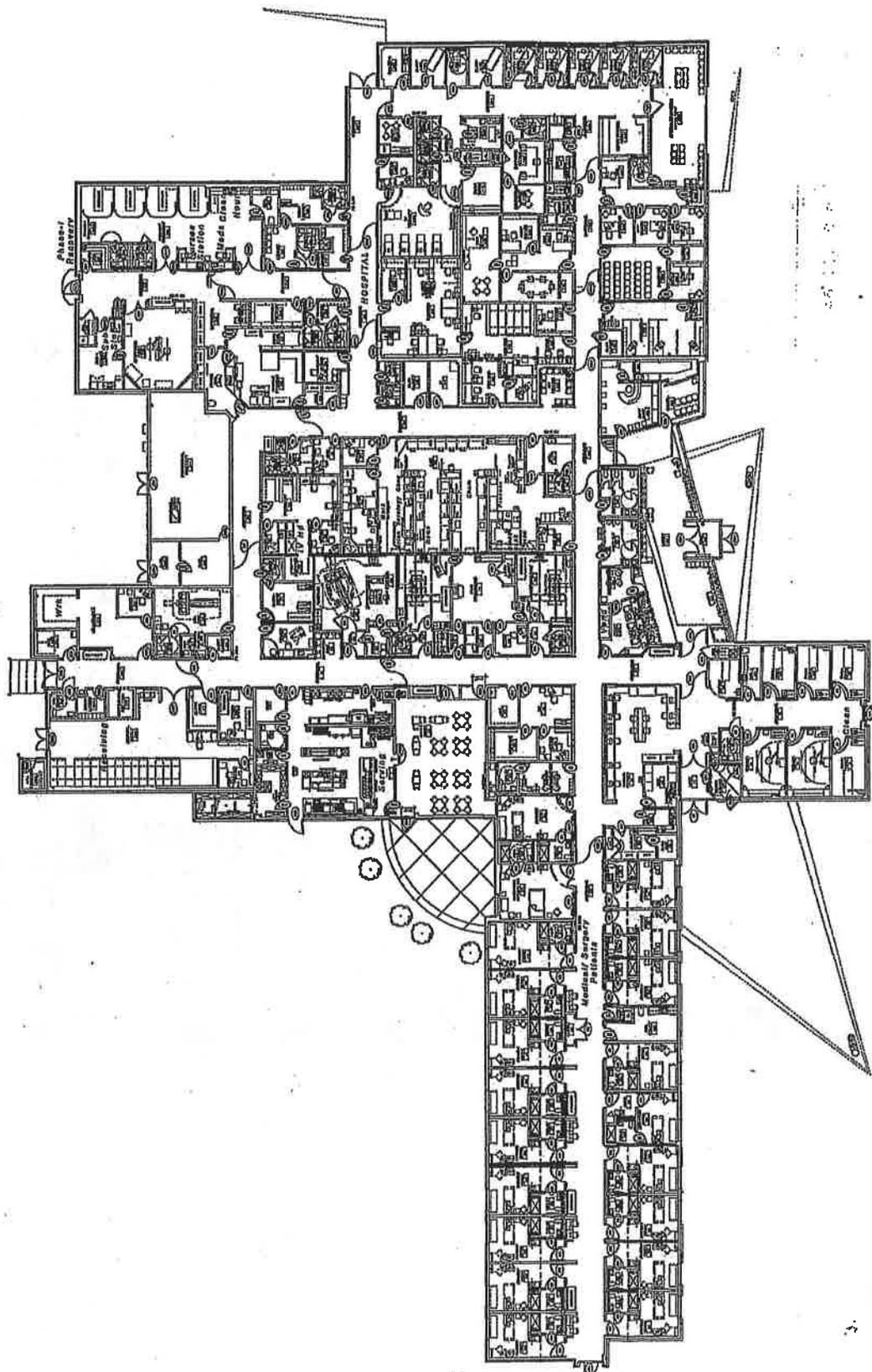
Tennessee Certificate of Need

Attachment 7

Section B, Item IV

Floor Plan

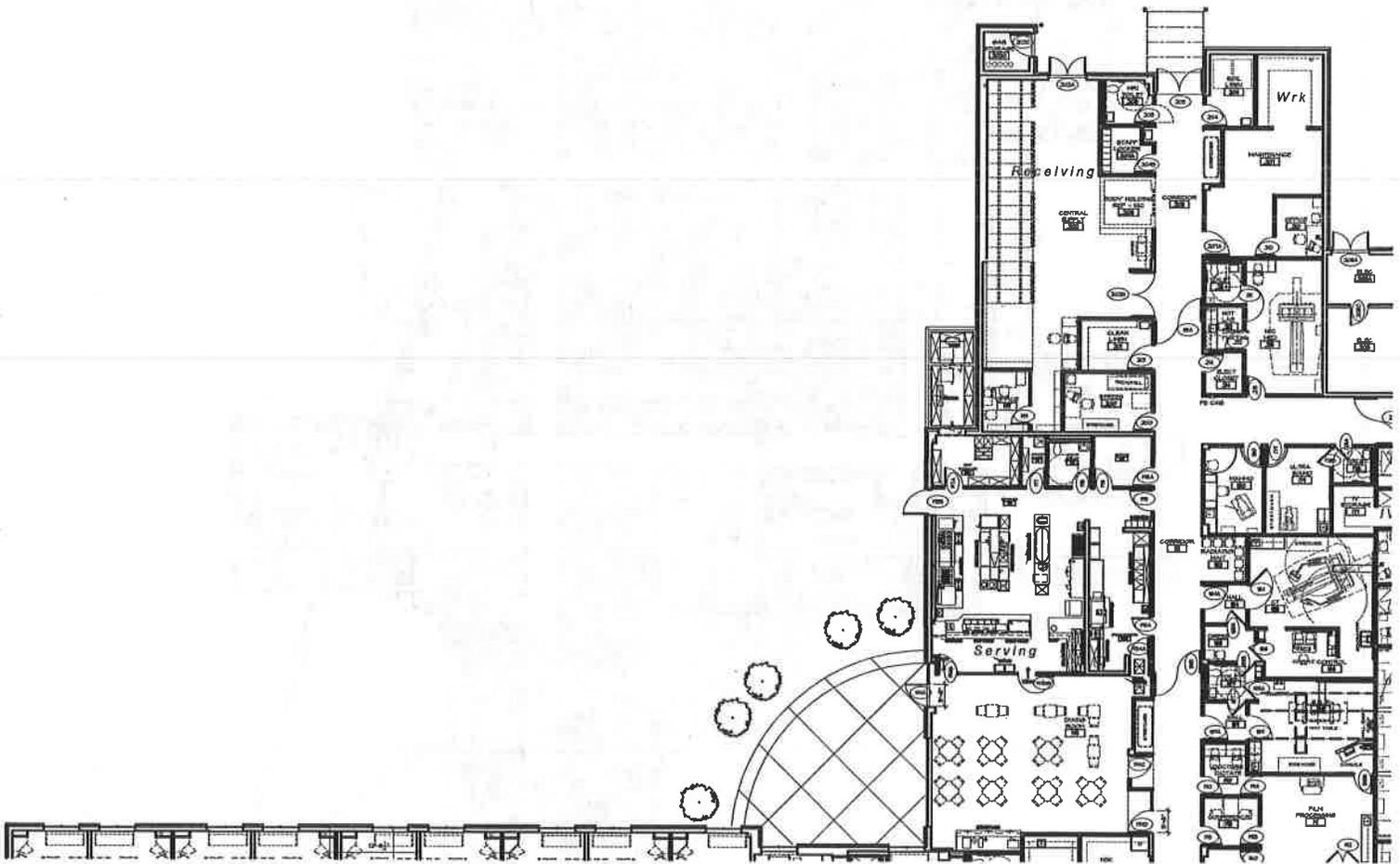
Attachment 7
Section B, Item IV
Floor Plan



January 29, 2016

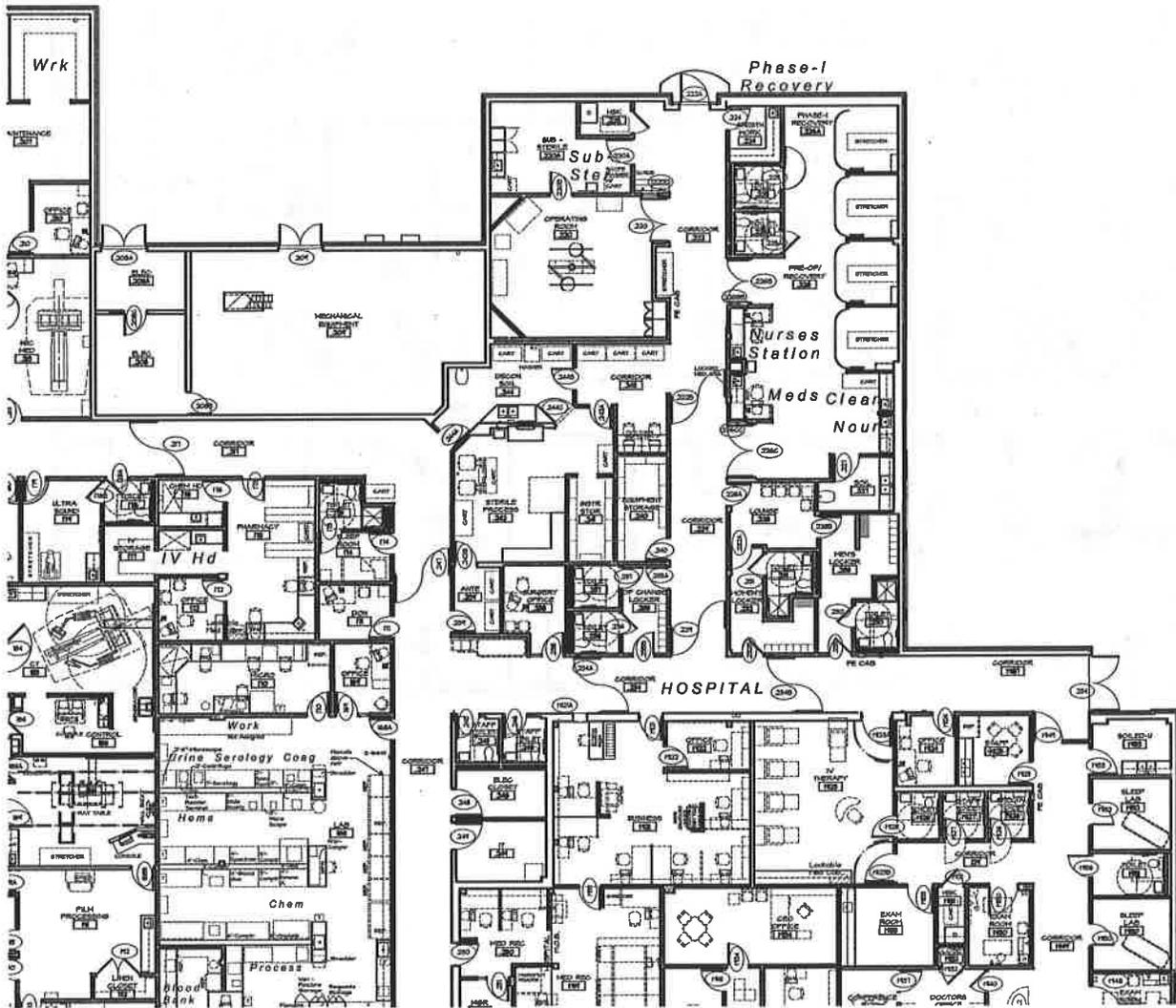
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Attachment 6
Question 9- Section B, Item IV
Floor Plan



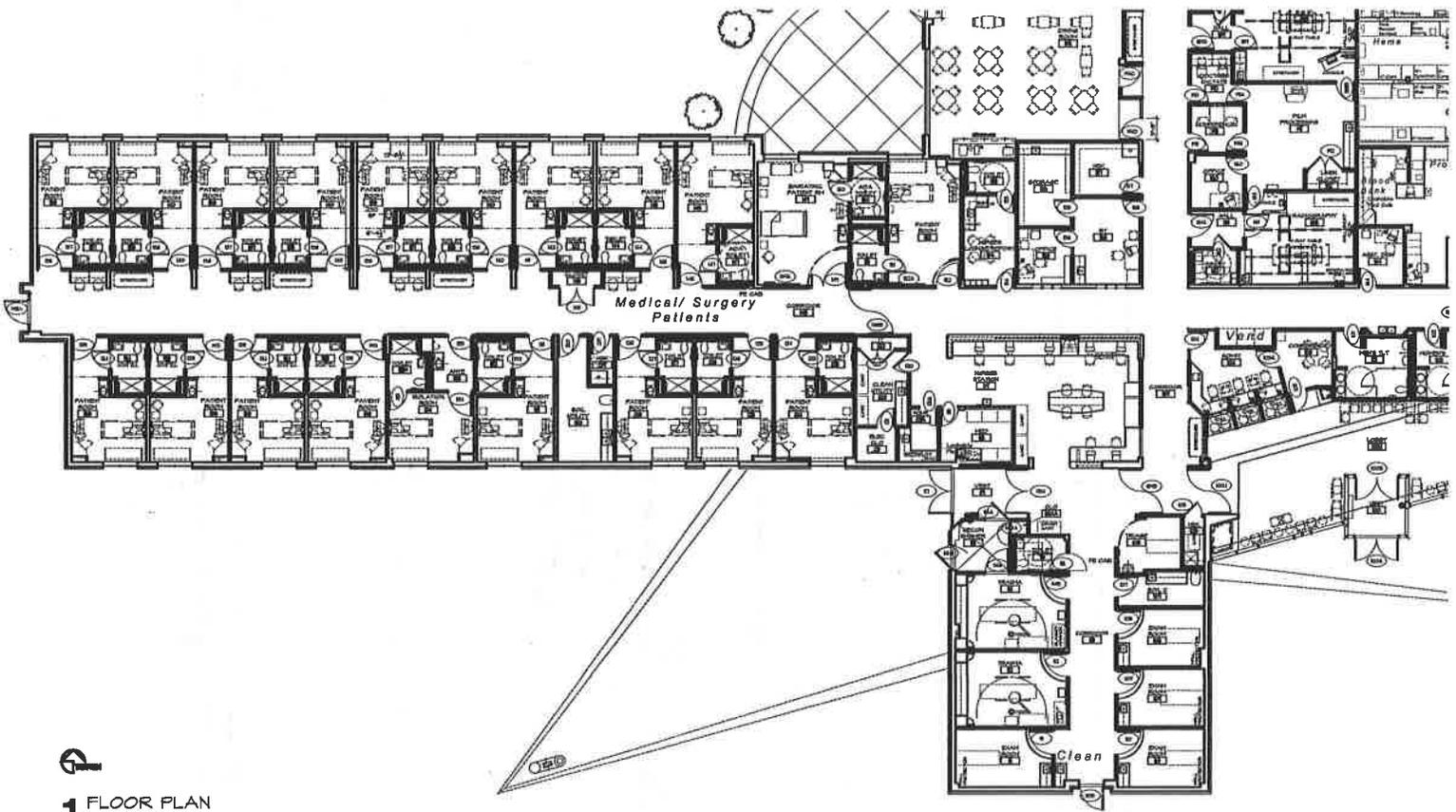
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January 29, 2016

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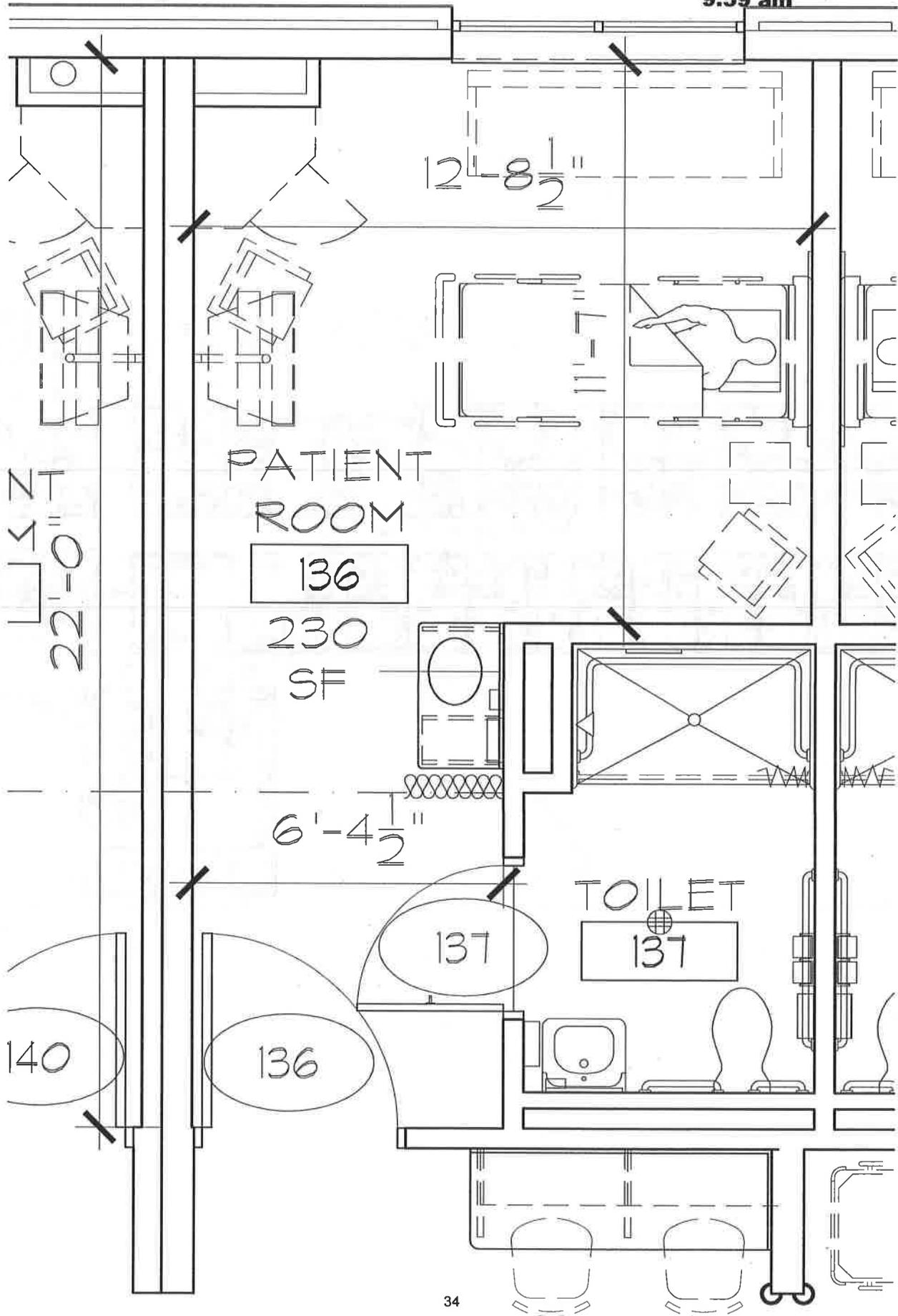


P

1 FLOOR PLAN
3/32" = 1'-0"

January 29, 2016

9:59 am



Lauderdale Community Hospital

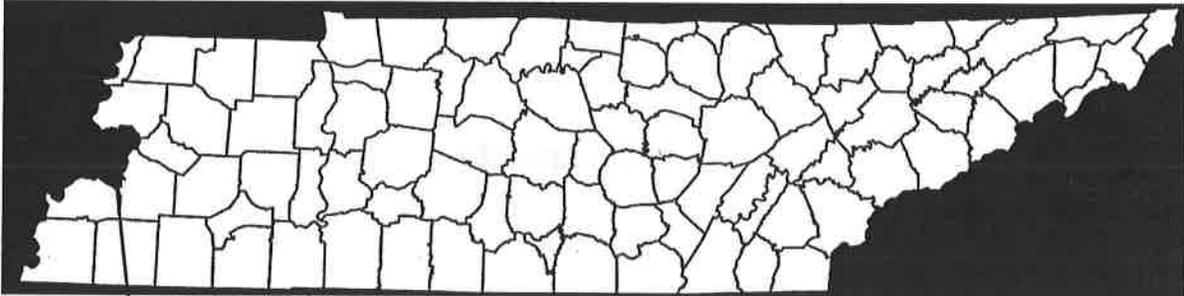
Tennessee Certificate of Need

Attachment 8

Section C, Need, Item 3

Map of Proposed Service Area

Attachment 8
Section C, Need, Item 3
Map of Proposed Service Area



Lauderdale County, Tennessee

Attachment 7
Question 11- Section C, (Need), Item 3
County Level Map of Tennessee



Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 9

Section C, Need, Item 6

7th Annual Rural Hospital Replacement Facility Study

How Replacement Facilities Impact Operations

Stroudwater Associates

Attachment 9
Section C, Need, Item 6
7th Annual Rural Hospital Replacement Facility Study

7th annual RURAL HOSPITAL
REPLACEMENT FACILITY STUDY

2011

How Replacement Facilities Impact Operations

prepared and sponsored by **STROUDWATER ASSOCIATES**

sponsored by **DOUGHERTY MORTGAGE LLC** **NEENAN**

RURAL COMMUNITIES THAT HAVE BUILT A CRITICAL ACCESS HOSPITAL HAVE PIONEERED A NEW ERA. FIND OUT HOW A REPLACEMENT FACILITY IMPACTED THEIR OPERATIONS AND BOTTOM LINES.



TABLE OF CONTENTS

THE 2011 RURAL HOSPITAL
REPLACEMENT FACILITY
STUDY IS PREPARED
AND SPONSORED BY

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SPONSORED BY
DOUGHERTY MORTGAGE LLC



COVER PHOTOS, LEFT, TRI-VALLEY
HEALTH CAMBRIDGE HOSPITAL,
CAMBRIDGE, NE, RIGHT, MELISSA
MEMORIAL HOSPITAL, HOLYOKE, CO.

The 2005, 2006, 2007, 2008,
2009 and 2010 studies are
available at www.stroudwater.com

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Design by anniecatherine, Portland, Maine.

Executive Summary 2

Study Purpose, Eligibility, Process and Design 4

Volume Experiences 6

Staffing 9

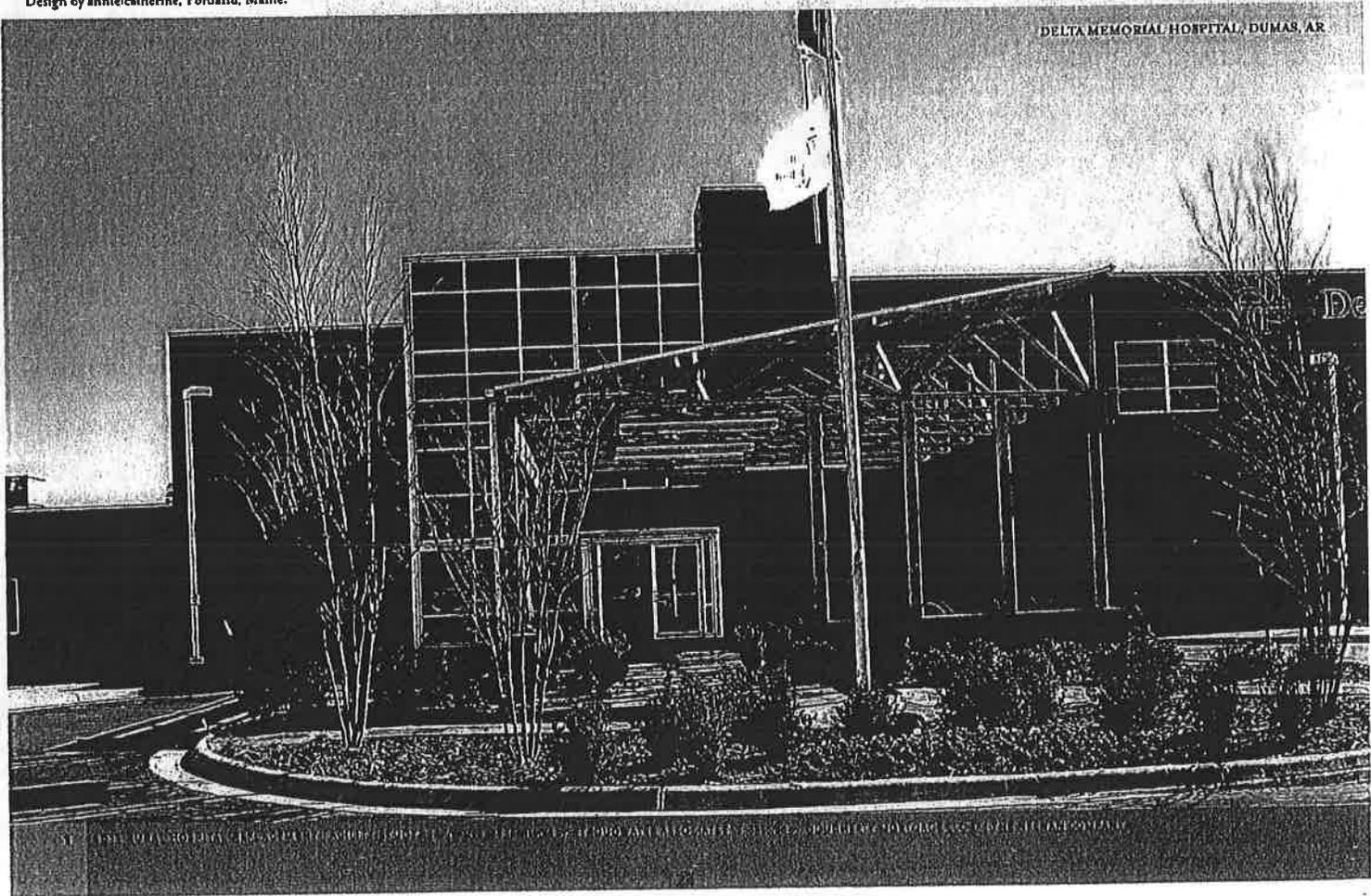
Financial Performance 11

Quality 15

Conclusions 17

Directory of Eligible CAHs 19

DELTA MEMORIAL HOSPITAL, DUMAS, AR



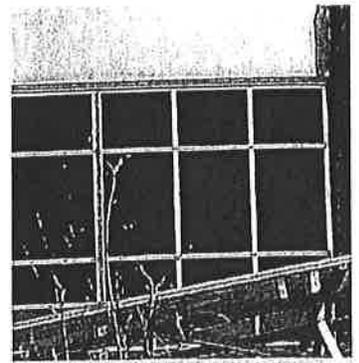
EXECUTIVE SUMMARY

In each of the past six years, the rural hospital replacement study has consistently shown that Critical Access Hospitals (CAHs) enjoy enhanced financial performance after replacement, in addition to other benefits such as higher employee retention and ease of recruitment. But the combination of a severe economic downturn and landmark healthcare reform legislation presents hospitals with a unique and perhaps unprecedented set of challenges. In 2010, the study began to examine the impact of the recent economic downturn on the performance of replacement facilities. This study looks further at the impact of the slumping economy and makes a first attempt to measure the performance of replacement CAHs against a standard which is becoming an increasingly important factor in healthcare reimbursement: quality.

The National Bureau of Economic Research declared the "Great Recession," which began in December of 2007, officially ended in June of 2009, making it the longest recession of the post World War II era. Even now, more than two years later, the effects of the recession linger and the outlook calls for a long, slow recovery to pre recession economic vitality. From 2004 through 2010, the Centers for Medicare & Medicaid Services (CMS) reported average annual growth in hospital discharges of only 1.6 percent and growth in patient days of only 0.3 percent annually. Many hospitals reported declining patient volumes in multiple lines of service.

The experiences of those facilities replaced during and immediately following the recession are most instructive to those considering replacement in the near future. In 2010, additional focus was added to examine the performance of hospitals replaced during 2006 and 2007, immediately before the recession, compared to those facilities replaced in earlier years. But performance data from those newest replacements was limited. In the 2011 study, the impact of the recession is further examined by adding more hospitals to the study, gathering an additional year of performance data for those hospitals replaced in 2006 and 2007, and taking a first look at the performance of those hospitals that opened during and even after the official end of the recession. With data from 114 rural hospital replacement facilities, Stroudwater focused additional analysis on those facilities which experienced their first years of operation during this difficult economic period. The results show that these facilities fared well. Rural facilities replaced during the period between 2006 and 2010 experienced solid growth in patient volumes as measured by patient days, outpatient visits, and adjusted patient days.

Looking more closely at the data, hospitals' experiences differed based on when the facilities were replaced. Hospitals were separated into three time-based cohorts: facilities replaced in 2005 or earlier (pre recession), facilities replaced in 2006 and 2007 (recession), and facilities replaced in 2008 and 2009 (post recession). As shown in the chart on the next page, hospitals in all three groups experienced strong volume growth in the first and second years of operation following replacement. The pre recession replacement hospitals were able to sustain substantial volume growth even beyond the first

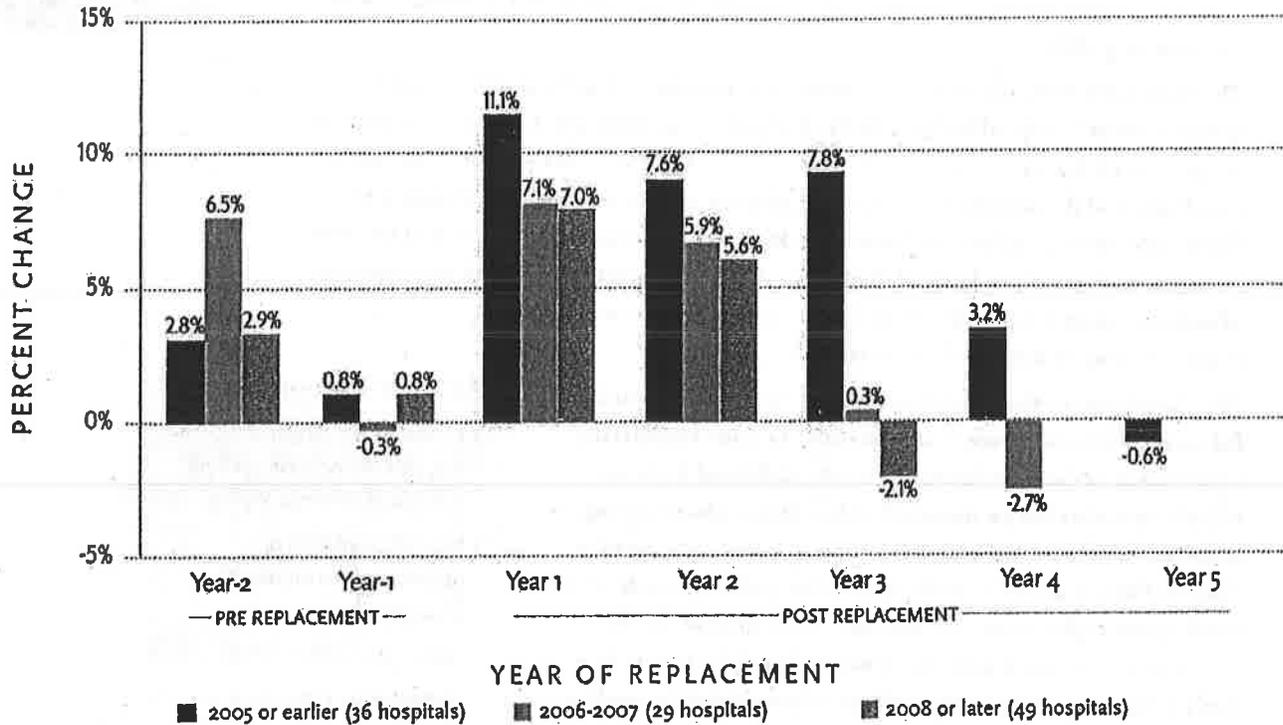


NEW FOR THE 2011 STUDY

- 23 new CAHs participating; a 25 percent increase over the number of 2010 participants
- New segmentation of hospitals based on year of replacement
 - 2005 and earlier (pre recession)
 - 2006-2007 (recession)
 - 2008 or later (post recession)
- Reporting on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores

two years of operation. Those replaced during the recession had no volume growth in the third year and lost volume in the fourth year following replacement. The post recession replacements lost volume in the third year of operations. Because many of the measures in this study are based on patient volume or are driven by patient volume, this pattern of results was repeated in performance with regards to staffing, operating costs, and profitability.

**MEDIAN PERCENT CHANGE IN TOTAL PATIENT VOLUME
By Year Pre and Post Replacement**



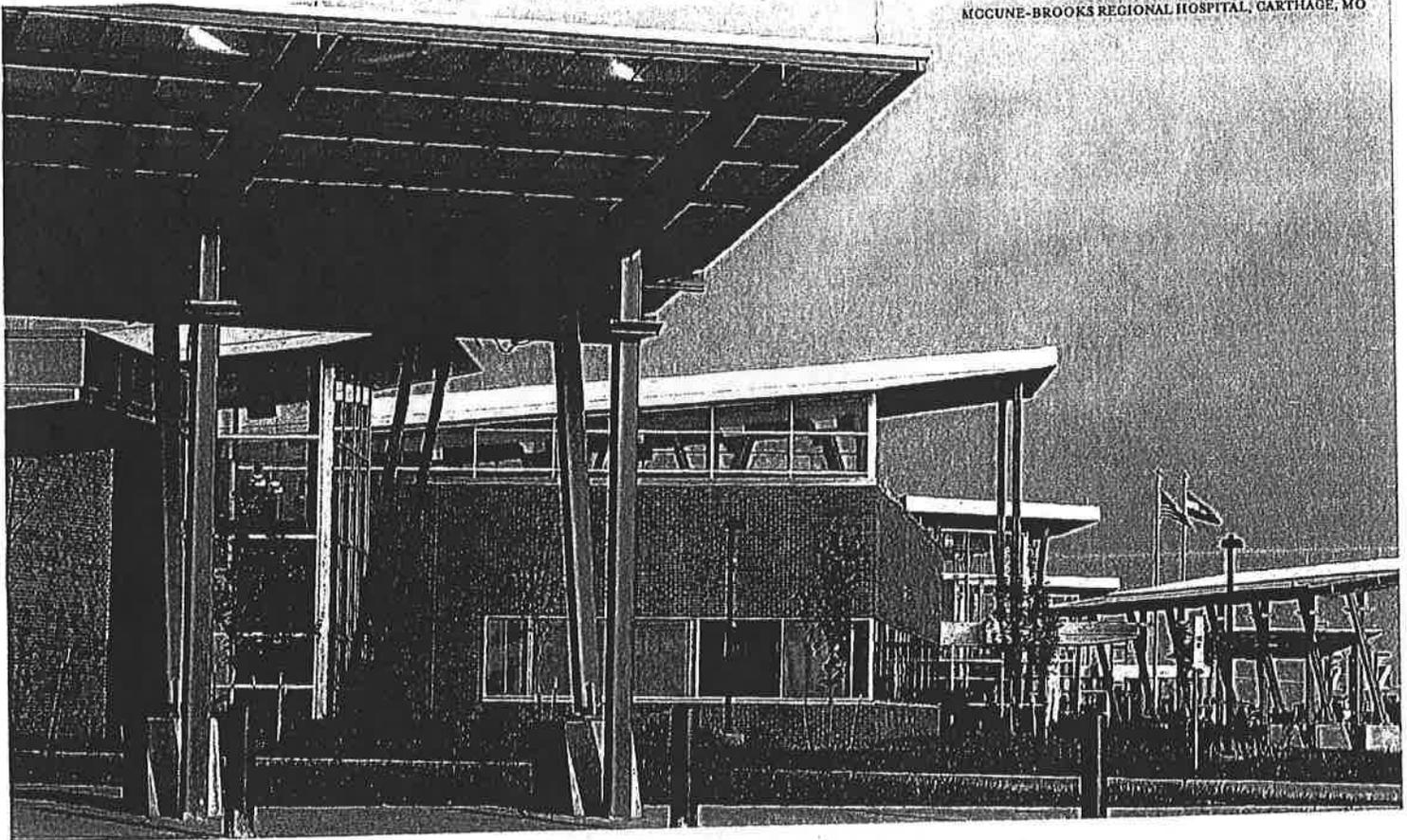
"The results of the study suggest that a replacement facility can be a platform for a financially viable hospital delivering a high quality patient experience."

While higher quality of care and a better patient experience are expectations of a new hospital facility, they are not assured. In 2011, CMS released data to be used for the Medicare Value Based Payment Program (VBPP) which included quality-related measures reported by all hospitals, including CAHs. Replacement CAHs scored higher than CAHs in general on every measure of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Additionally, replacement CAHs reported HCAHPS scores that would qualify for incremental payments under VBPP. While this program is currently not applicable to CAHs, research is underway to develop a similar program which would adjust CAH reimbursement based on quality measures.

While the challenges of a slow economy and healthcare reform will remain as important considerations for several years to come, the results of the study suggest that a replacement facility can be a platform for a financially viable hospital delivering a high quality patient experience.

STUDY PURPOSE, ELIGIBILITY, PROCESS and DESIGN

MCCUNE-BROOKS REGIONAL HOSPITAL, CARTHAGE, MO

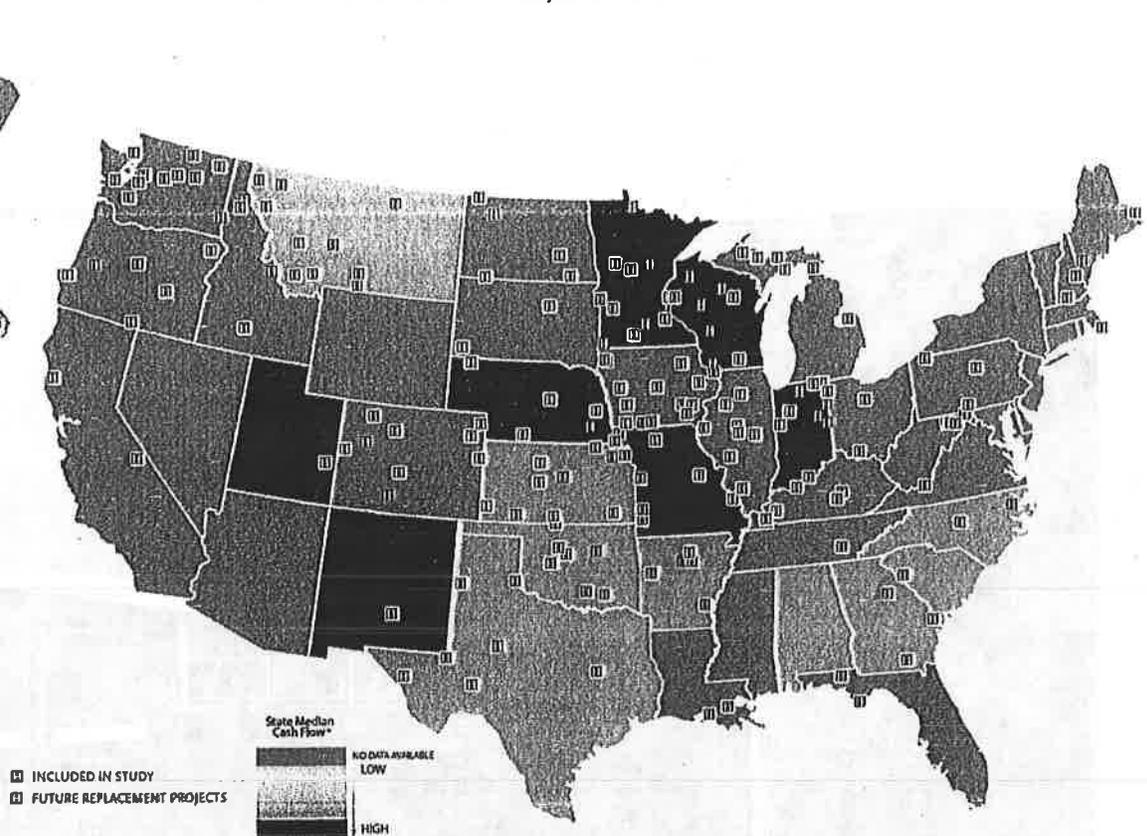


Purpose

When the study began in 2005, few resources existed for rural hospital leadership, boards, and community leaders to assist them in understanding what a new replacement facility hospital would do to or for their bottom line. The study's purpose is to gather and present quantitative and qualitative data from communities that have replaced their Critical Access Hospital (CAH) to educate those considering, embarking on, or in the midst of a replacement facility project.

The study typically generates discussion around a replacement in three pivotal areas: Driving Factors (why would we replace?); Access to Capital (what can we afford?); and the Role of Leadership (how do we do this?).

ELIGIBLE CAH REPLACEMENT FACILITIES: CURRENT AND PROJECTED



*Median cash flow margins for all CAHs within each state, as reported by the Flex Monitoring Team, August 2011

Eligibility

With the assistance of State Office of Rural Health and State Hospital Association representatives, a list of candidates is established. Stroudwater then validates the candidate list and ensures the eligibility criteria are met:

- Hospitals had Critical Access Hospital designation prior to replacement
- Opened clinical areas between January 1, 1998 and January 1, 2010
- Operations in the community for at least three years prior to replacement

Validated hospitals are included in the study. From 2005 to 2011 the number of hospitals included in the study has increased from 20 to 114. As shown on the map above, there are many other replacement projects underway or in the planning process.

Process

The methodology established in 2005 and followed in each subsequent year of the study was developed and vetted by an advisory panel which included governmental, academic, and financial experts as well as a national non-profit entity whose mission is to build capacity in rural hospitals. Quantitative and qualitative data contribute to the methodology.

The 2011 study uses publicly available cost report data, input from hospital CEOs and CFOs, the American Hospital Association Guide and the American Hospital Directory. The quantitative data analyzed for the purposes of the study include: volumes (patient days, outpatient visits, adjusted patient days), operating efficiency (gross Full Time Equivalents or FTEs, FTEs per adjusted patient day, operating expense per adjusted patient day) and financial results (operating margin, EBIDA, days cash and investments on hand).

Interviews with a sample of hospital CEOs and CFOs were conducted in prior years' studies to complement and further examine the quantitative data. The interviews focused on any impact, whether positive or negative, the replacement facility had on quality, staff recruitment and retention, and the economy of the local community. While no interviews were conducted with the facilities added to this year's study, the body of data gathered from historical interviews still forms an important component of the total findings in the study.

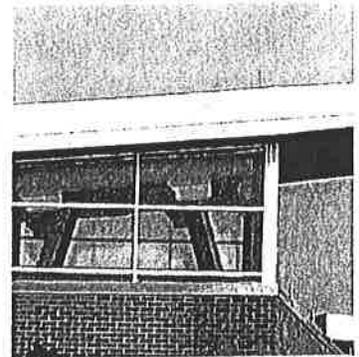
Design

A CAH's market potential, level of competition, physician support, management experience, historical financial performance, access to capital, and more are unique to the community served. To begin to control for these differences, the study compares data from before the replacement project to data after, with Year 1 for each hospital being the first year in which the hospital operated in its new facility for at least 6 months.

Volume Experiences

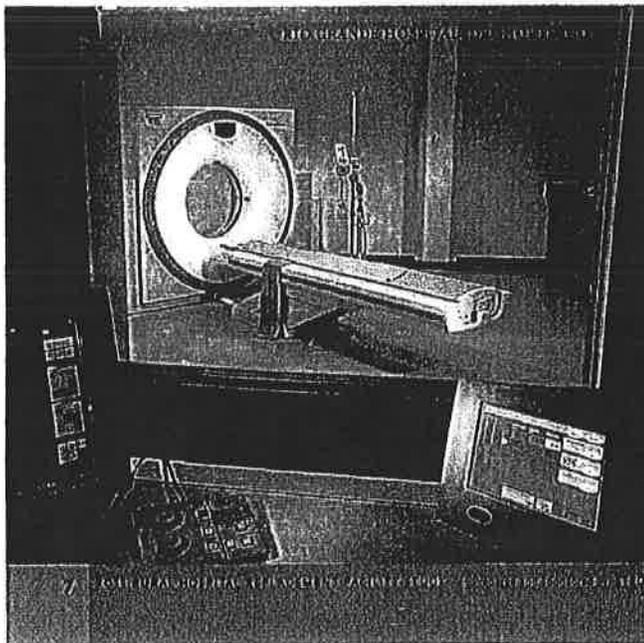
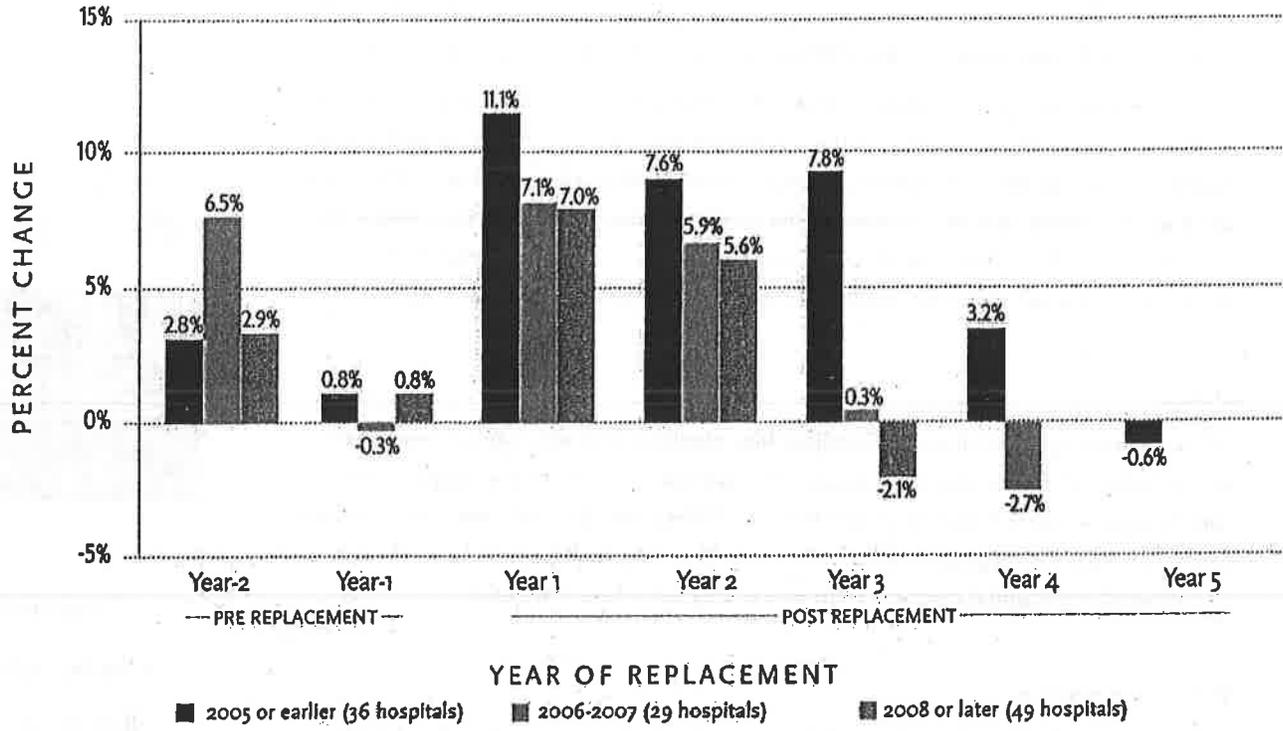
To label the new facilities included in this study as "replacements" may be a bit of a misnomer. Although each is different in overall scope, complexity, and volume levels, CAHs provide more outpatient than inpatient services. And these new facilities are designed to reflect the increased emphasis on ambulatory service. As such, to evaluate total volumes across such a varied spectrum, the study uses the industry standard approach of creating an overall measure of volume that takes both inpatient and outpatient volume into account. "Adjusted patient days" reflects in a common measure the total activity for different hospitals with different mixes of services provided.

Median volumes for all three cohorts of replacement CAHs were flat in the year prior to replacement. In the first year following replacement, all groups experienced growth in total patient volume, with those replaced in 2005 or earlier experiencing the largest post replacement increase of 11 percent, compared to 7 percent and 6 percent growth for the 2006-2007 cohort and the 2008 or later cohort, respectively. Additionally, the volume growth for the 2005 or earlier cohort continued longer and at greater levels than for the other two cohorts of replacement CAHs. Of the 114 participating hospitals, 27 (24 percent) reported accumulated volume losses post replacement, and 18 of those 27 were facilities replaced in 2008 or later.



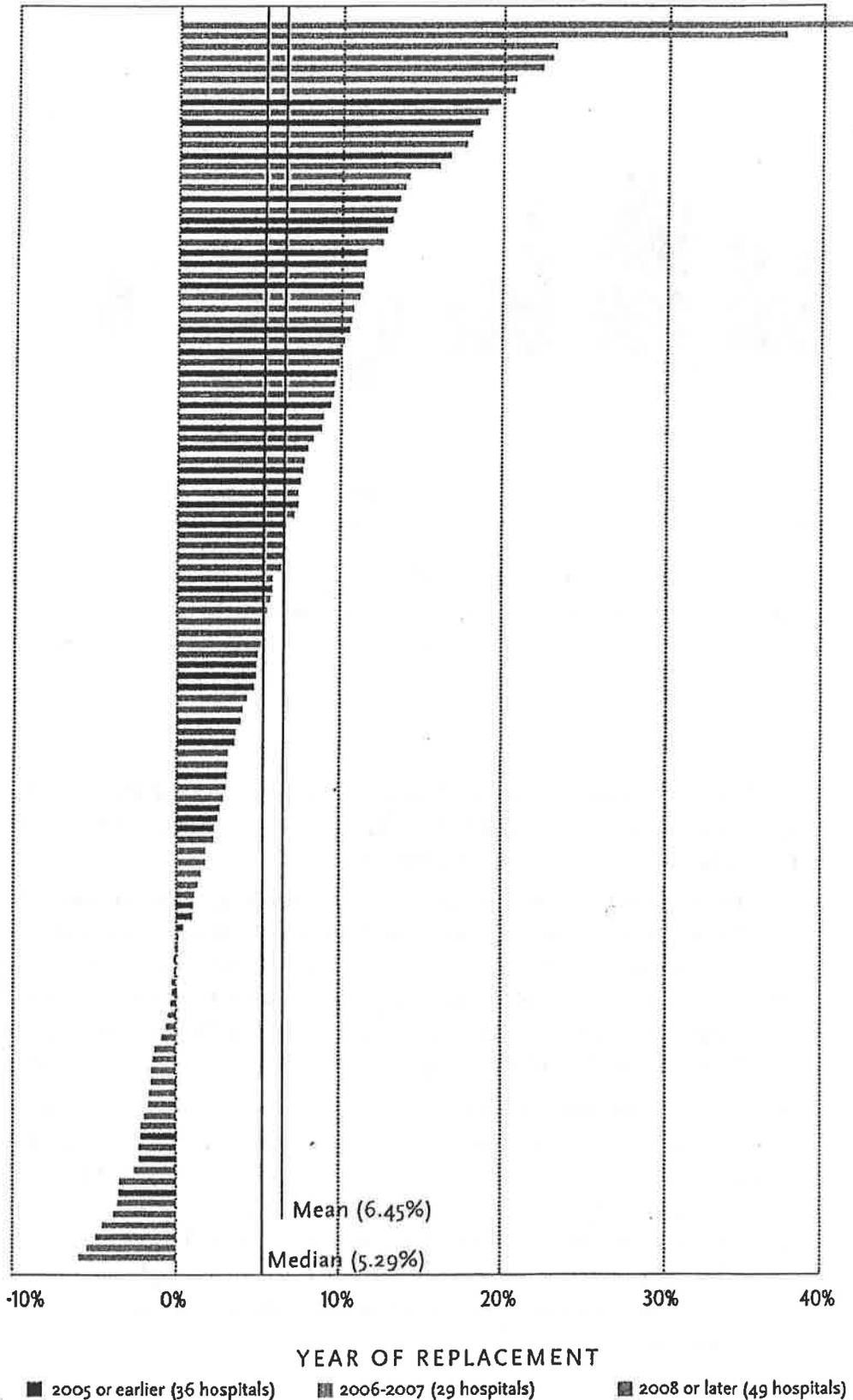
"In the first year following replacement, all groups experienced growth in total patient volume,..."

MEDIAN PERCENT CHANGE IN TOTAL PATIENT VOLUME
By Year Pre and Post Replacement



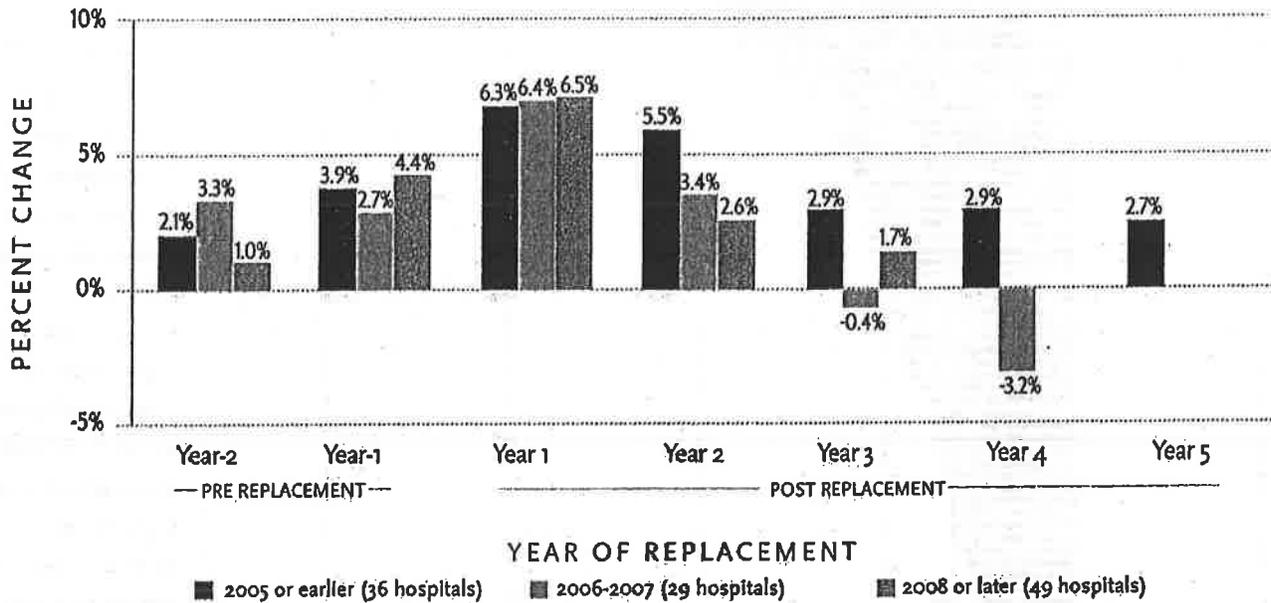
PHILLIPS COUNTY MEDICAL CENTER, MALTA, MT

PERCENT CHANGE IN TOTAL VOLUME
Average annual change for all years post replacement



While median values provide us with guidance regarding the general experience of the group, the results for individual facilities vary greatly from those medians. The graph to the left exhibits, for each facility, the average annual change in total volume for all years post replacement, ranging from a single year for the newest replacements up to five years for older replacements. The median annual growth rate for all hospitals for all years is 5.29 percent, but the volume changes range from a decrease of 6 percent to an increase of nearly 43 percent. Twenty-six of the 114 participating hospitals experienced declines in total volume. Half of those facilities which lost volume were replaced in 2005 or earlier, but the larger volume declines generally occurred in the most recent replacements. Similar variability was experienced in the other measures presented in this study.

MEDIAN PERCENT CHANGE IN STAFFING By Year Pre and Post Replacement

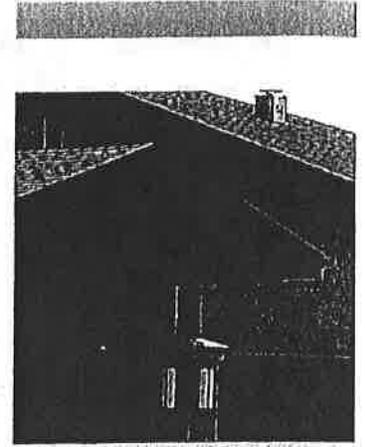


Staffing

Rural hospitals are often challenged with staff shortages, particularly with physician and other clinical professionals. The ability to both recruit and retain highly qualified professionals is integral to the health of an organization.

An enhanced ability to recruit higher quality personnel following replacement was cited by several of the CEOs interviewed. In particular, CEOs indicated that the promise of a new facility played a key role in the recruitment of physicians, who ultimately contribute to the volume growth discussed above. A number of facilities reported discontinued use of agency staffing and reduced turnover rates. Many organizations reported having no nursing vacancies and several indicated they have waiting lists.

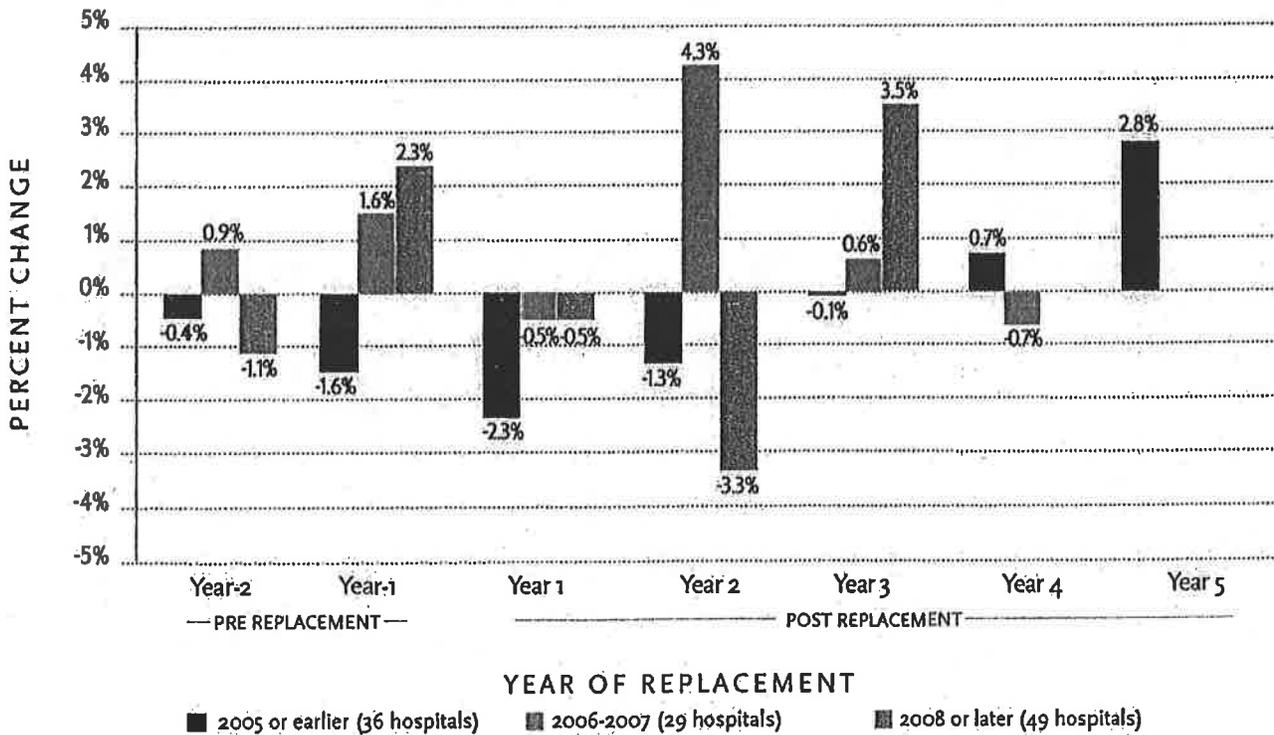
All facilities increased staffing at higher rates in their first post replacement year to support new volume being served by the facility. Hospitals replaced in 2005 or earlier continued to increase staff at a faster pace for the second year after replacement and by the third year had returned to growth rates similar to their pre replacement period. Hospitals replaced during 2006 and 2007, and 2008 or later slowed staffing increases back to pre replacement pace in Year 2, and by Year 3 were hiring at a slower pace than before replacement. This may be a result of the difficult economy as well as the less robust volume growth experienced by these facilities.

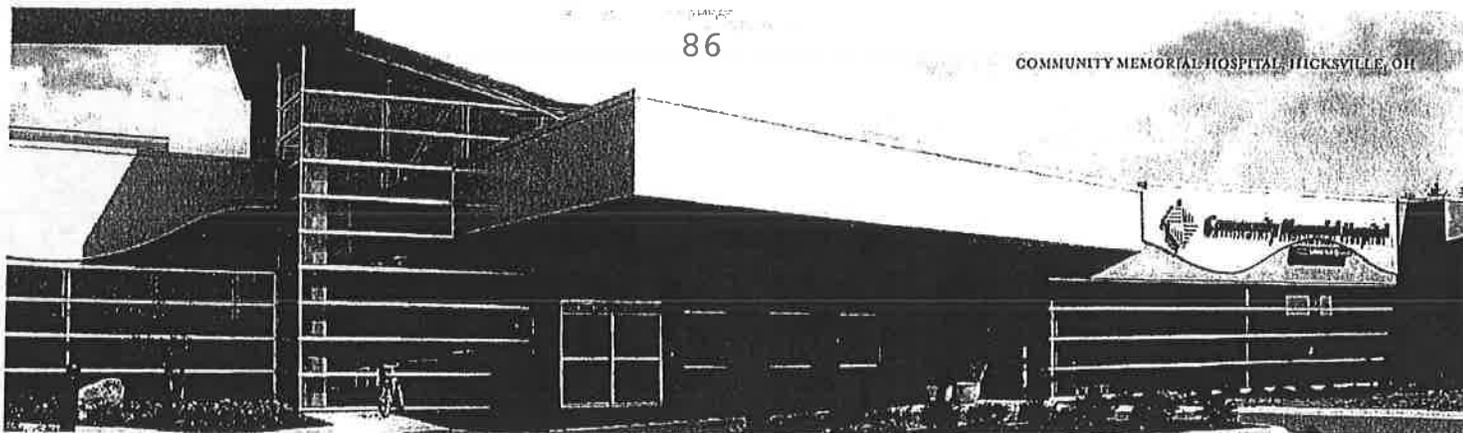


Even with higher staffing overall, the number of staff per unit of service (defined as Adjusted Patient Days) decreased on average for all replacement groups in the first year post replacement. This measure reflects improved efficiencies in the operations. However, facilities replaced in 2006-2007, and 2008 or later, saw declines in efficiency in the second and third years post replacement, as increased staffing was not matched by continued increases in volume. Approximately half of all participating hospitals experienced improved post replacement efficiency, with those hospitals replaced in 2005 or earlier being more likely to have improved efficiency.

"Approximately half of all participating hospitals experienced improved post replacement efficiency."

MEDIAN PERCENT CHANGE IN STAFFING EFFICIENCY
By Year Pre and Post Replacement



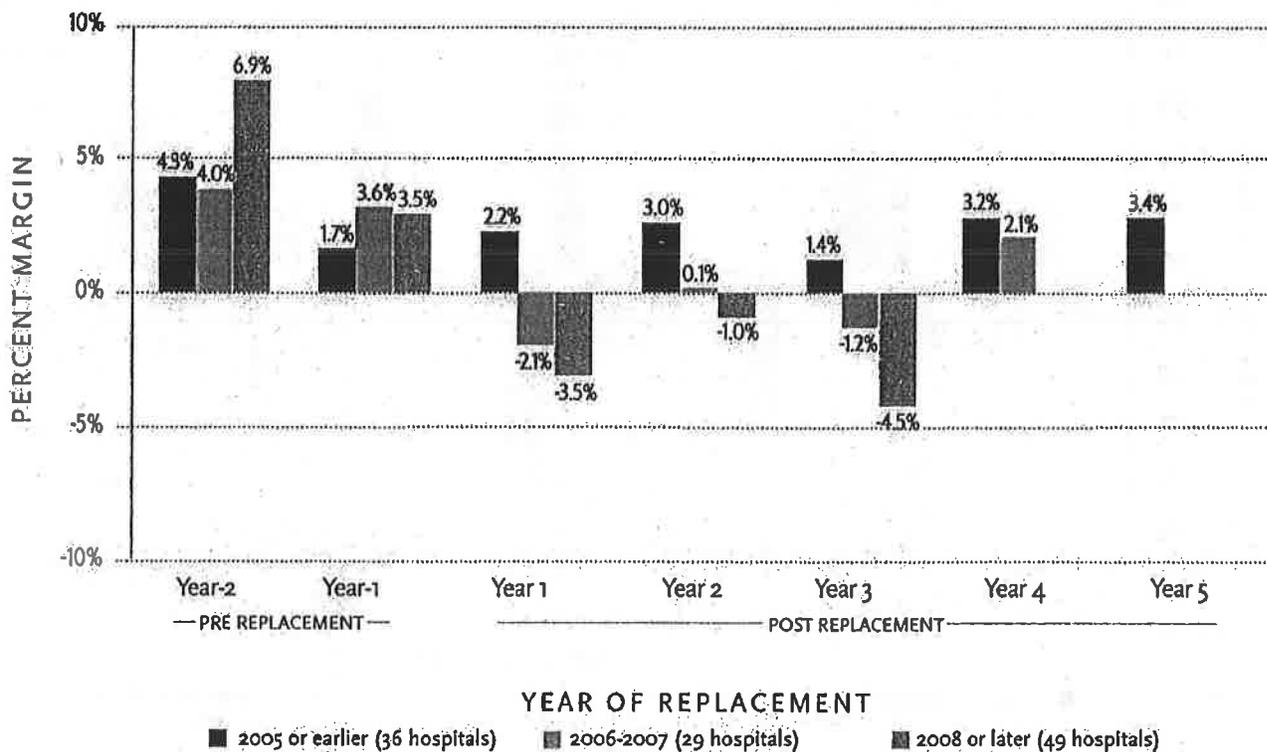


FINANCIAL PERFORMANCE

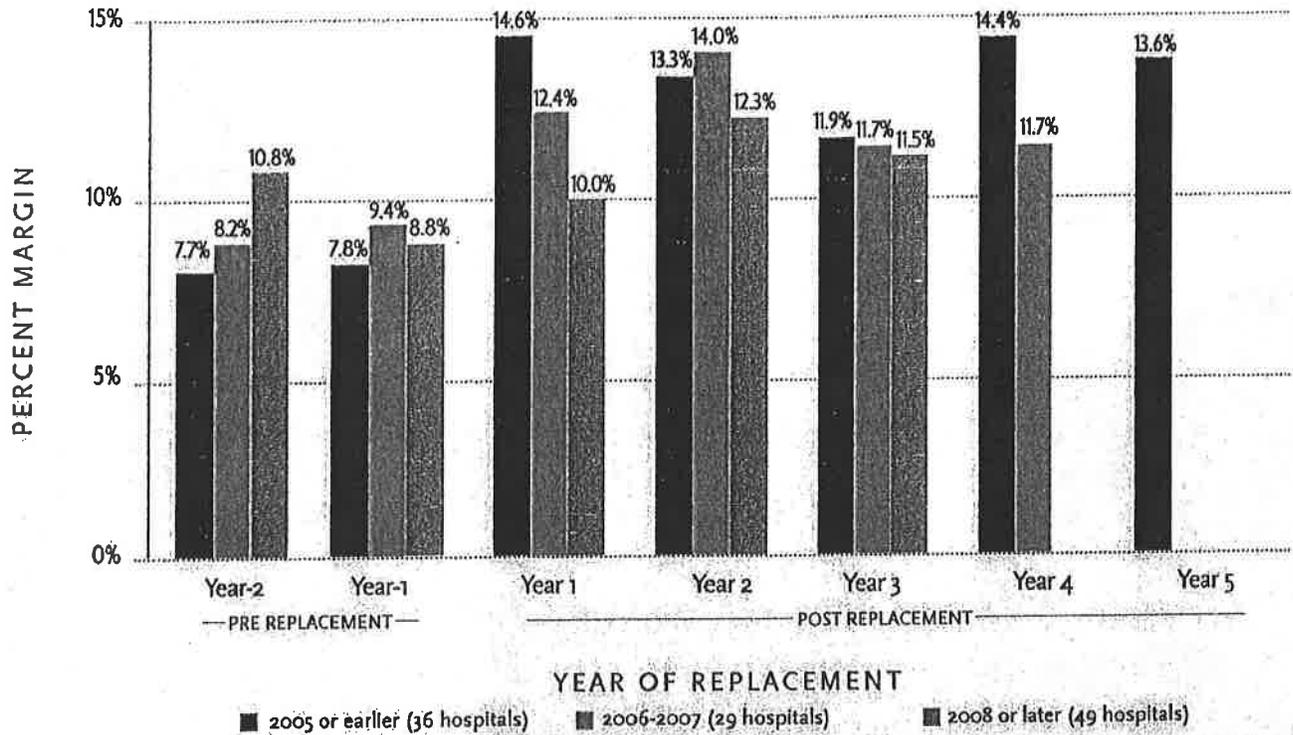
Total Margin

Facilities replaced in 2005 or earlier maintained total margins post replacement, as increased volume offset increases in facility costs, specifically interest and depreciation, and the cost of additional staffing. Those hospitals replaced in 2006-2007, and 2008 or later, saw margins decline as the volume increases post replacement were not enough to offset the higher costs. Facilities need to closely manage budgets in the first years following a facility investment in order to realize the benefits from any increases in patient volume.

**MEDIAN TOTAL MARGIN
By Year Pre and Post Replacement**

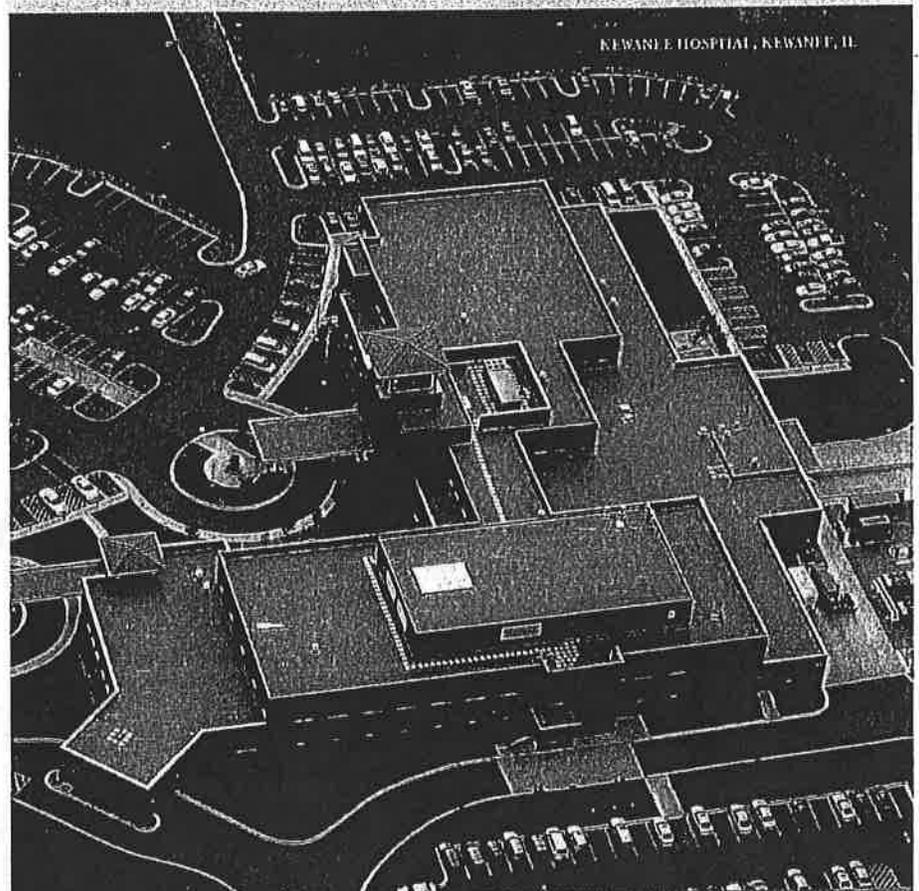


MEDIAN EBIDA MARGIN
By Year Pre and Post Replacement

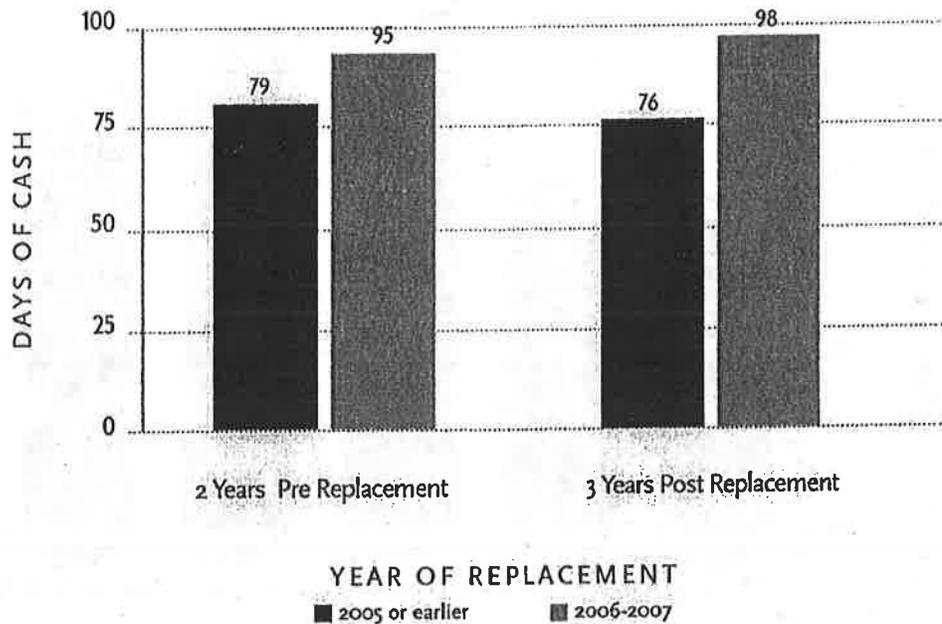


EBIDA Margin

Earnings Before Interest Depreciation and Amortization (EBIDA) is a measure that approximates cash flow. It displays less variation than total margin, and replacement CAHs in all three categories showed improvement in EBIDA post replacement. This suggests that the lower margins experienced by more recent replacements are driven by higher capital costs, specifically depreciation and interest, rather than operating costs, such as salaries. Boards generally target an EBIDA margin that reflects enough cash flow to sustain operations through the startup of the new facility.



AVERAGE DAYS CASH AND INVESTMENTS ON HAND
65 Hospitals with at Least Three Years Post Replacement Data



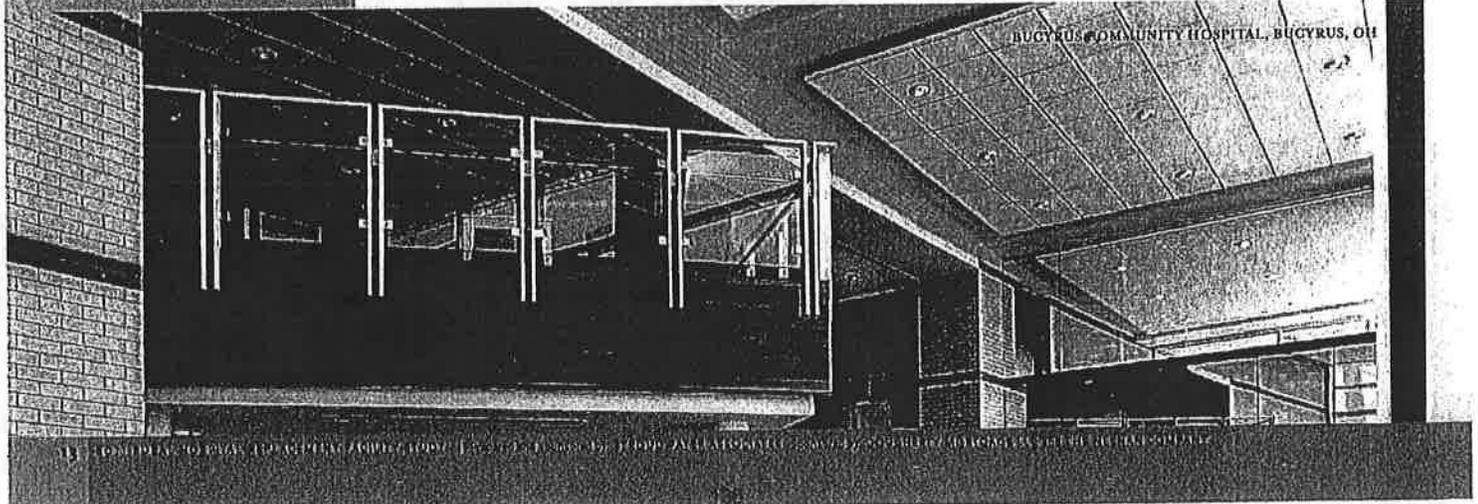
"All three cohorts of hospitals maintained cash levels on hand after replacement."

Average Days Cash on Hand

Post replacement days cash on hand varies with overall financial performance, the facility's initial reserves, and the amount of borrowing required to fund the replacement facility. Lenders evaluate cash on hand both prior to and following replacement to ensure working capital is sufficient.

All three cohorts of hospitals maintained cash levels following replacement. Cash on hand in the years immediately preceding replacement can fluctuate greatly due to the influx of cash borrowed for construction. Looking at the average of several years before and after replacement, those hospitals replaced during 2006 - 2007 had more cash on hand before replacement than facilities replaced in 2005 or earlier, but both groups maintained cash levels after replacement that were similar to their cash levels before replacement.

BUGYRUS COMMUNITY HOSPITAL, BUGYRUS, OH



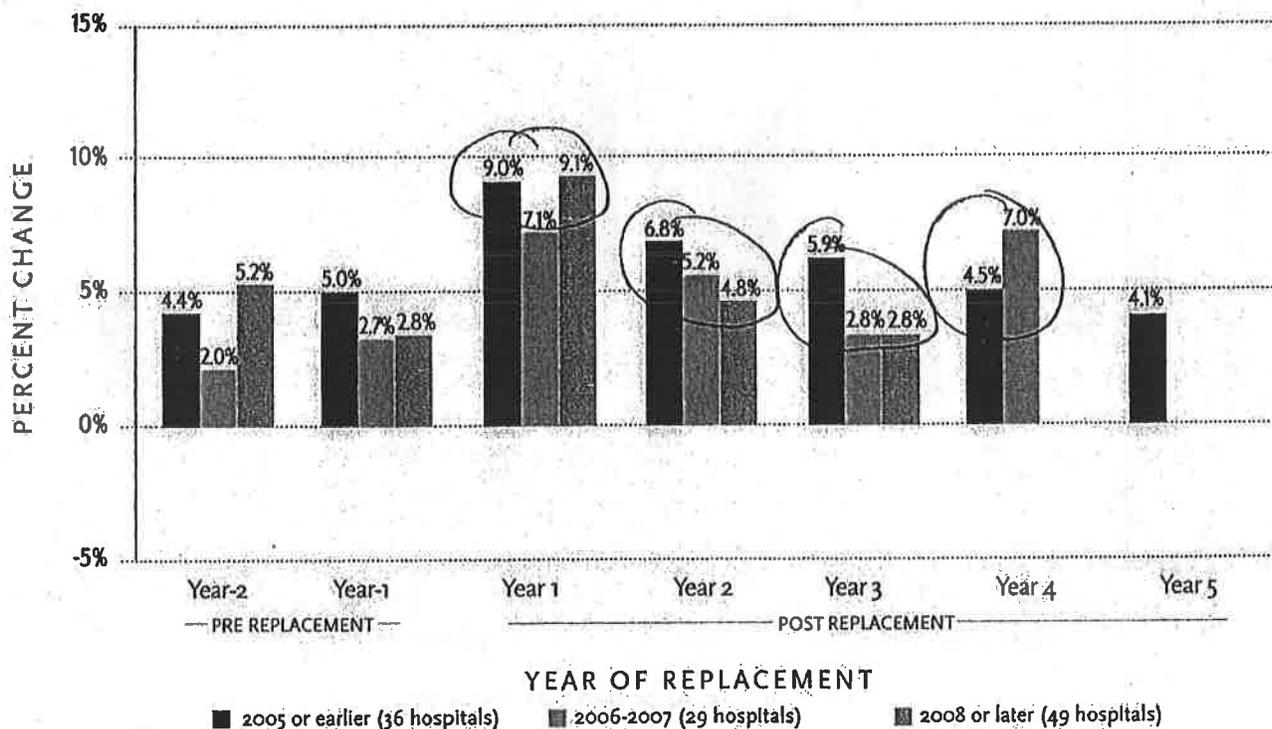
Outpatient Volume

Outpatient service volumes were growing approximately 3-5 percent per year prior to replacement. In the first year following replacement, outpatient volumes grew from 7-9 percent, with each replacement group experiencing at least 4 percent higher growth than pre replacement. The higher growth levels continued through the second post replacement year. By Year 3, growth in all three groups had returned to pre replacement levels.

Quality

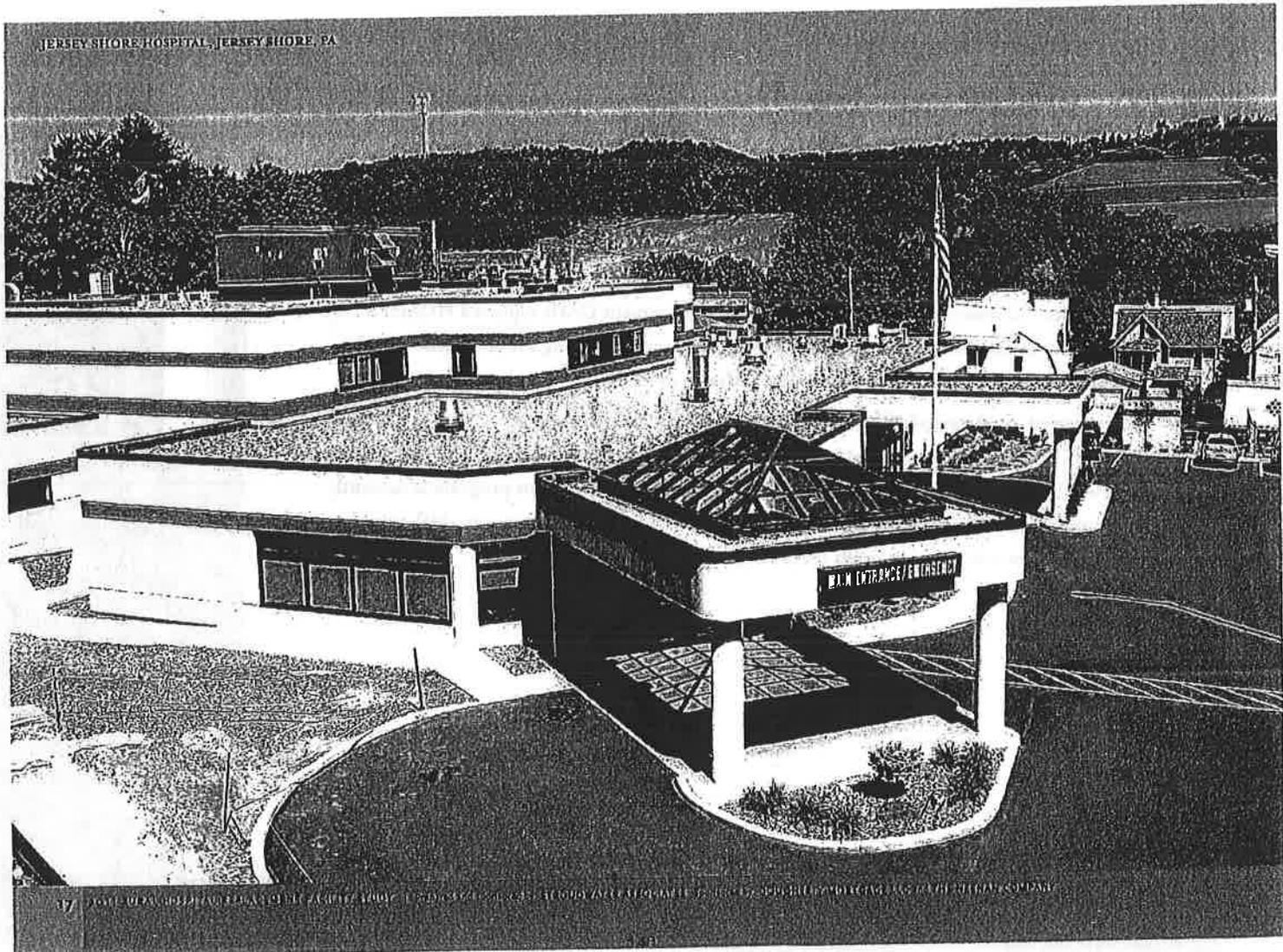
While higher quality of care and a better patient experience are expectations of a new hospital facility, they are not assured. As both public and private payers place increased emphasis on quality as a determinant in hospital reimbursement, organizations contemplating a replacement facility need to understand how these future reimbursement methods will affect them. Because CAHs are not required to report quality data, there are not large amounts of data available. However, in 2011 CMS released data to be used for the Medicare Value Based Payment Program (VBPP) which included quality-related measures reported by all hospitals, including CAHs. Only about 20 percent of CAHs reported core quality measures on patient care processes and outcomes. But approximately half of all CAHs reported scores for the Hospital Consumer Assessment of Healthcare Providers

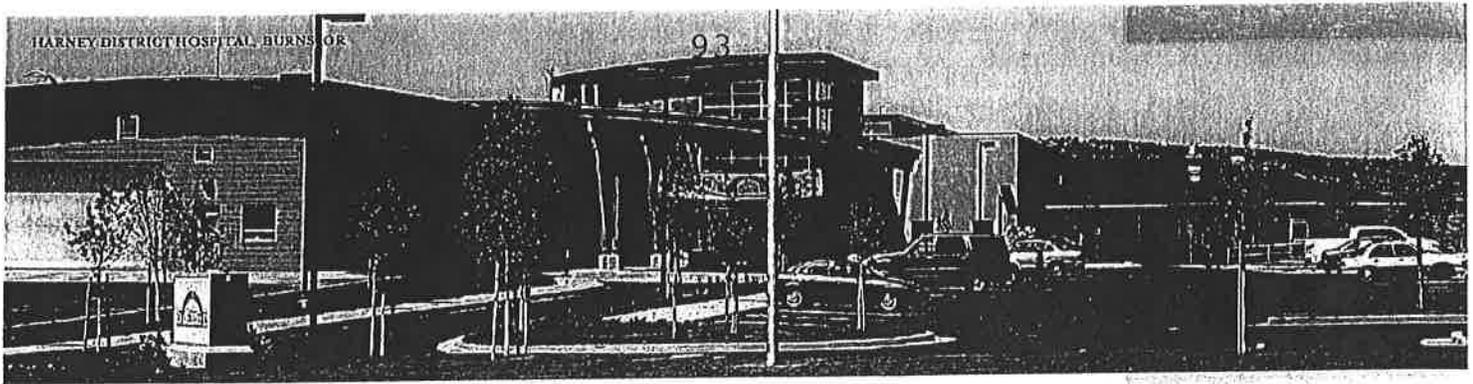
MEDIAN PERCENT CHANGE IN OUTPATIENT VISITS
By Year Pre and Post Replacement



CONCLUSIONS

Critical Access Hospitals, like all hospitals, face challenging times. Hospitals are still reimbursed based on the volumes of services provided, but a down economy has dampened demand for services. And patients are being given more responsibility for paying for those services, increasing hospitals' levels of bad debt and charity care. Healthcare reform is placing more emphasis on value, requiring hospitals to either lower costs or provide higher quality for the same price. This combination of factors might suggest to some that now is not the time for CAHs to replace their facilities. But the combination of increased outpatient volume, increased efficiency, improved EBIDA margin and higher HCAHPS scores might suggest that for some CAHs a replacement facility is a necessary element for future success.





STROUDWATER ASSOCIATES

Stroudwater Associates is a prominent healthcare advisory firm with a dedicated team that is passionate about the health of rural people and places. With offices in Portland, Maine and Atlanta, Georgia Stroudwater provides strategic, financial, facility planning, and operational consulting services to a national clientele — from academic medical centers to small, rural hospitals, and from integrated health systems to stand-alone community hospitals.

Jim Putia, Senior Consultant, 207.221.8271 jputia@stroudwater.com

Eric Shell, Principal, 207.221.8252 eshell@stroudwater.com

Brian Haapala, Principal, 207.221.8264 bhaapala@stroudwater.com

Research and analysis conducted with the assistance of Julie Spalding, M.H.A. Candidate, Sloan Program in Health Administration, Cornell University, Intern Summer 2011

DOUGHERTY MORTGAGE LLC

Dougherty Mortgage, LLC is an approved FHA/HUD Lender and GNMA Issuer specializing in financing acute care facilities throughout the United States. As a full service mortgage banking firm, Dougherty Mortgage is committed to providing excellent service, conducting business based on sound lending practices and creative deal structuring. Together with affiliate Dougherty & Company, an investment banking firm, Dougherty Mortgage provides financing options to borrower clients based on an intimate knowledge of available loan programs and our commitment to meeting the unique needs of each client.

Charles Ervin, Senior Vice President, 406.586.5131 CErvin@doughertymarkets.com

Kurt Apfelbacher, Vice President, 612.376.4083 KApfelbacher@doughertymarkets.com

Andleeb Dawood, Vice President, 406.586.5131 ADawood@doughertymarkets.com

THE NEENAN COMPANY

The Neenan Company has provided integrated design and construction services in the healthcare industry for more than 20 years. In the past 10 years, Neenan has completed over 200 healthcare projects totaling over 2,000,000 square feet of healthcare projects across the United States. The Neenan Company collaborates with our clients in transforming their built environment, facilitating improved patient access and a heightened quality of care. At Neenan, we bring together professionals of many disciplines to work concurrently, under one roof — entwining planning, design, functionality, performance and cost — to create sustainable facility solutions for our clients. We serve physician groups, hospitals, and healthcare providers across the nation to transform their organizations through their facilities.

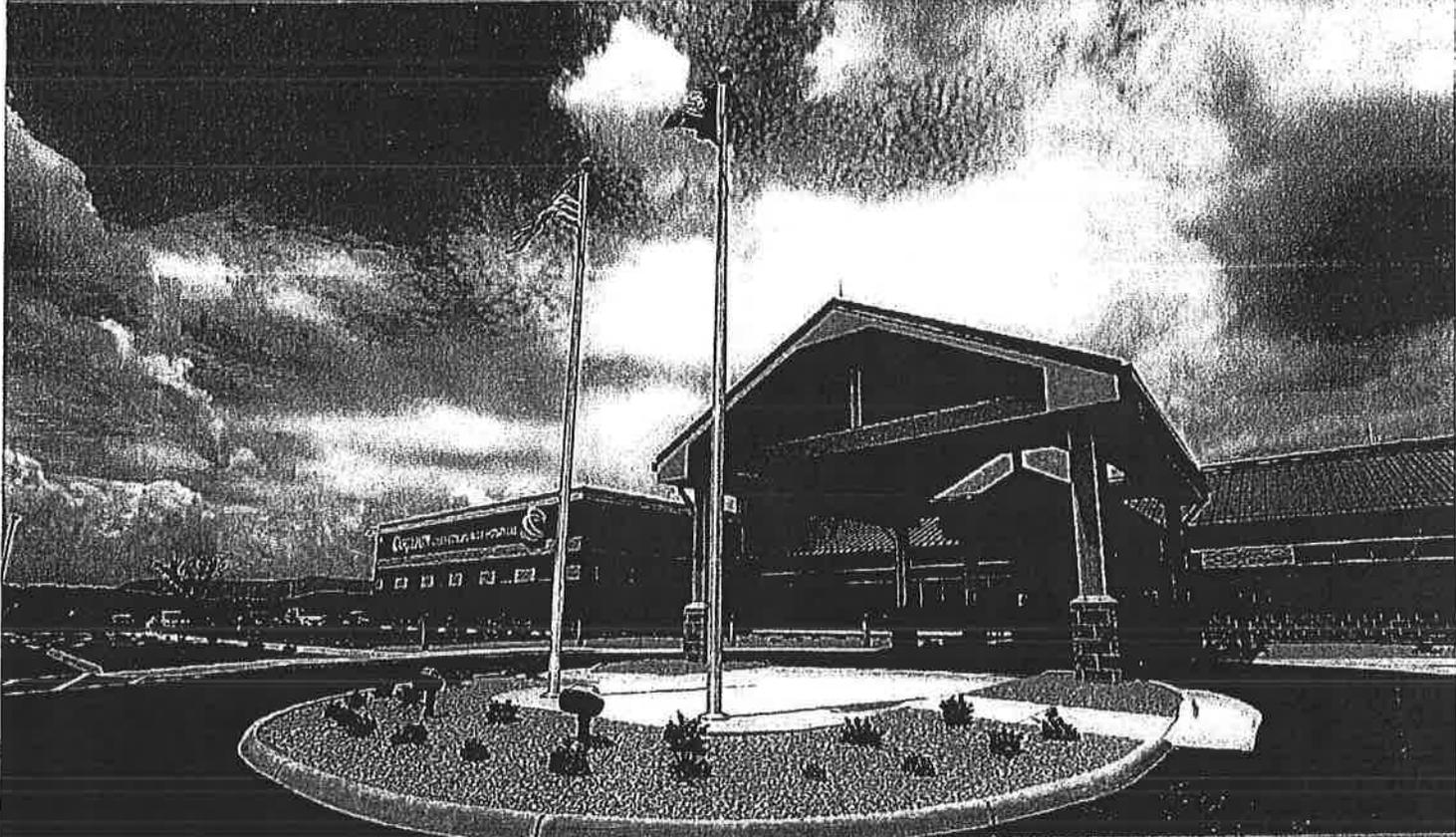
Michael Curtis, Vice President Business Development, 303.710.1873 michael.curtis@neenan.com

2011 DIRECTORY

FACILITY NAME	STATE	ADMIN/CEO	TEL	POP
Abbeville Area Medical Center	SC	Rich Osmus	864-366-5011	17,869
Adams County Regional Medical Center	OH	Saundra Stevens	937-386-3400	31,306
Adams Memorial Hospital	IN	Marvin Baird	260-724-2145	42,402
Amery Regional Medical Center	WI	Michael Karuschak	715-268-8000	26,823
Atchison Hospital	KS	John Jacobson	913-367-2131	17,889
Atoka County Medical Center	OK	Paul Reano	580-889-3333	13,321
Baptist Health Medical Center - Heber Springs	AR	Edward Lacy	501-887-3000	23,322
Barton County Memorial Hospital	MO	Rudy Snedigar	417-681-5100	19,688
Bell Memorial Hospital	MI	Richard Ament	906-486-4431	24,722
Bertie Memorial Hospital	NC	Jeff Sackrison	252-794-6600	12,456
Booneville Community Hospital	AR	Dzaidi Daud	479-675-2800	11,243
Bridgton Hospital	ME	David Frum	207-647-6000	33,665
Bucyrus Community Hospital	OH	Scott Landrum	419-562-4577	21,796
Caldwell Medical Center	KY	Charles Lovell	270-365-0300	19,183
Carilion Giles Community Hospital	VA	James Tyler	540-266-6000	26,700
Casey County Hospital	KY	Rex Tungate	606-787-6275	13,423
Cass Regional Medical Center	MO	Chris Lang	816-380-3474	28,112
Chatham Hospital	NC	Carol Straight	919-799-4000	25,570
Chippewa County-Montevideo Hospital & Medical Clinic	MN	Mark Paulson	320-269-8877	12,409
Clark Fork Valley Hospital	MT	Gregory Hanson	406-826-4800	10,238
Clinch Memorial Hospital	GA	Phillip Cook	912-487-5211	7,712
Community Hospital of Bremen	IN	Scott Graybill	574-546-2211	10,663
Community Medical Center	NE	Ryan Larsen	402-245-2428	8,271
Community Memorial Hospital	OH	Mel Fahs	419-542-6692	13,131
Cottage Grove Community Hospital	OR	Mary Anne McMurren	541-942-0511	18,988
Crete Area Medical Center	NE	Carol Friesen	402-826-2102	11,294
Delta Memorial Hospital	AR	Cris Bolin	870-382-4303	11,146
Doctor's Memorial Hospital	FL	Jo Ann Baker	850-547-8000	19,582
Drumright Regional Hospital	OK	Darrel Morris	918-382-2300	5,958
Ellsworth County Medical Center	KS	Roger Masse	785-472-3111	11,201
Fall River Health Service	SD	Tricia Uhlir	605-745-3159	8,008
Family Health West	CO	Errol Snider	970-858-9871	12,236
Faulton Area Medical Hospital	SD	Jay Jahng	605-598-6262	2,407
Fort Logan Hospital	KY	Mike Jackson	606-365-4600	27,537
Franklin Foundation Hospital	LA	Parker Templeton	337-828-0760	17,424
Fulton County Medical Center	PA	Jason Hawkins	717-485-3155	21,439
Grand River Hospital and Medical Center	CO	Jim Coombs	970-625-1510	25,576
Harney District Hospital	OR	Jim Bishop	541-573-7281	6,888
Harrison County Hospital	IN	Steve Taylor	812-738-4251	40,895
Hayward Area Memorial Hospital	WI	Tim Gullingsrud	715-934-4321	18,955
Heart of the Rockies RMC	CO	Ken Leisher	719-530-2210	22,501
Hermann Area District Hospital	MO	Dan McKinney	573-486-2191	7,832
Holton Community Hospital	KS	Ron Marshall	785-364-2116	10,302
Hospital "A", U.S.A.	-	-	-	36,861
Hospital "B", U.S.A. calais	-	-	-	13,532
Hudson Hospital & Clinics	WI	Marian Furlong	715-531-6000	35,763
Indiana University Health Blackford Hospital	IN	Steven West	765-348-0300	19,050
Indiana University White County Memorial Hospital	IN	Stephanie Long	574-583-7111	19,891
Iraan General Hospital	TX	Teresa Callahan	432-639-2575	1,799
Jefferson County Health Center	IA	Deb Cardin	641-472-4111	20,781
Jersey Shore Hospital	PA	Carey Plummer	570-398-0100	34,508
Jones Regional Medical Center	IA	Eric Briesemeister	319-462-6131	19,688
Keokuk County Health Center	IA	Ray Brownsworth	641-622-2720	3,564
Kewanee Hospital	IL	Margaret Gustafson	309-852-7500	25,010
Kingfisher Regional Hospital	OK	Nancy Schmid	405-375-3141	11,250
Kit Carson County Memorial Hospital	CO	Joe Stratton	719-346-5311	9,034
LakeWood Health Center	MN	Jason Breuer	218-634-2120	4,490

FACILITY NAME	STATE	ADMIN/CEO	TEL	POP
Lakewood Health System Hospital	MN	Tim Rice	218-894-1515	20,106
Limestone Medical Center	TX	Penny Gray	254-729-3281	9,339
Madison Valley Medical Center	MT	Loren Jacobson	406-682-6862	6,064
Marshall County Hospital	KY	Kathy Long	270-527-4800	37,417
McCune-Brooks Regional Hospital	MO	Bob Copeland	417-358-8121	32,978
Meade District Hospital	KS	Mickey Thomas	620-873-2141	8,005
Melissa Memorial Hospital	CO	John Ayoub	970-854-2241	3,037
Memorial Hospital	IL	Ada Bair	217-357-8500	14,797
Midwest Medical Center	IL	Tracy Bauer	815-777-1340	7,845
Mitchell County Hospital	TX	Robbie Dewberry	325-728-3431	10,700
Moloka'i General Hospital	HI	Janice Kalanihuia	808-553-5331	5,680
Morton General Hospital	WA	Ron DeArth	360-496-3537	11,451
Mountainview Medical Center	MT	Aaron Rogers	406-547-3321	1,923
Mountrail County Medical Center	ND	Rick Wittmeier	701-628-2424	2,224
Munising Memorial Hospital	MI	Kevin Calhoun	906-387-4110	6,489
North Canyon Medical Center	ID	David Butler	208-934-4433	20,618
North Valley Hospital	MT	Jason Spring	406-863-3500	34,258
Oakes Community Hospital	ND	Lee Boyles	701-742-3291	11,632
Okeene Municipal Hospital	OK	Shelly Dunham	580-822-4417	5,671
Orange City Municipal Hospital	IA	Martin Guthmiller	712-737-4984	12,843
Osceola Medical Center	WI	Jeffrey Meyer	715-294-2111	11,836
Our Lady of Victory Hospital	WI	Cynthia Eichman	715-644-6144	13,508
Ozark Health Medical Center	AR	Kirk Reamey	501-745-7000	22,142
Parkview LaGrange Hospital	IN	Rob Myers	260-463-9000	35,826
Farmer Medical Center	TX	Lance Gatlin	806-250-2754	7,381
Phillips County Hospital & Family Health Clinic	MT	Ward Van Wichen	406-654-1100	3,825
Potomoc Valley Hospital	WV	Linda Shroyer	304-597-3500	20,815
Providence Mount Carmel Hospital	WA	Bob Campbell	509-685-5100	25,461
Providence Valdez Medical Center	AK	Sean McAllister	907-835-2249	4,121
Pullman Regional Hospital	WA	Scott Adams	509-332-2541	36,739
Ringgold County Hospital	IA	Gordon Winkler	641-464-3226	6,346
Rio Grande Hospital	CO	Arlene Harms	719-657-2510	18,002
River's Edge Hospital & Clinic	MN	Colleen Spike	507-931-2200	15,372
Riverwood Healthcare Center	MN	Michael Hagen	218-927-2121	14,494
Rooks County Health Center	KS	Michael Sinclair	785-434-4553	5,314
Sacred Heart Hospital	WI	Monica Hilt	715-453-7700	12,679
Sanford Luverne Medical Center	MN	Tammy Loosbrock	207-283-2321	11,700
Saunders Medical Center	NE	Ken Archer	402-443-4191	7,580
Scheurer Hospital	MI	Dwight Gascho	989-453-3223	12,781
Shoshone Medical Center	ID	Gary Moore	208-784-1221	12,113
Southern Coos Hospital & Health Center	OR	James Wathen	541-329-1031	10,148
Southwest Health Center	WI	Don Rohrbach	608-348-2331	27,731
St. James Medical Center - Mayo Health System	MN	Scott Thoreson	507-375-3391	9,108
St. James Parish Hospital	LA	Mary Ellen Pratt	225-746-2990	15,217
St. Vincent Randolph Hospital	IN	Cheech Albarano	765-584-0004	18,383
Steele Memorial Medical Center	ID	Jeff Hill	208-756-5600	10,492
Story County Medical Center	IA	Todd Willert	515-382-2111	10,910
The Memorial Hospital	CO	George Rohrich	970-824-9411	17,349
Tomah Memorial Hospital	WI	Philp Stuart	608-372-2181	22,840
Tri-Valley Health / Cambridge Memorial Hospital	NE	Roger Steinkruger	308-697-1124	5,150
Wallowa Memorial Hospital	OR	David Harman	541-426-3111	6,962
Washington County Hospital and Clinics	IA	Dennis Hunger	319-653-5481	20,587
Weatherford Regional Hospital	OK	Debbie Howe	580-772-5551	22,897
West River Health Services	ND	Jim Long	701-567-4561	14,562
Wilson Medical Center	KS	Dennis Shelby	620-325-2611	4,385
Winkler County Memorial Hospital	TX	Bill Ernst	432-586-8299	6,947
Yuma District Hospital and Clinics	CO	John Gardner	970-848-5405	9,302

Population is defined as the sum total of populations in all ZIP codes in which the hospital had at least 10% market share of 2010 Medicare admissions.



prepared and sponsored by **STROUDWATER ASSOCIATES**

sponsored by **Douglas MORTGAGE LLC**



Stroudwater Associates
50 Sewall Street, Suite 102
Portland, ME 04102
800.977.5712
www.stroudwater.com

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Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 10

Section C, Economic Feasibility, Item 1

Project Cost Documentation

Lauderdale Community Hospital
Ripley, TN
June 30, 2015
 Concept Estimate



Construction Cost Summary

Description	Quantity	Cost	Unit Cost
Sitework	150 Cars	1,290,053	8,575
1 Story Hospital	37,611 SF	11,131,829	295.97
1 Story Medical Building	9,241 SF	1,892,453	204.79
Construction Subtotal	46,852 SF	14,314,335	\$305.52
Design Fees & Reimbursables	8%	1,145,147	24.44
Design Contingency	4%	618,379	13.20
Construction Contingency	4%	572,573	12.22
Escalation to 3rd Qtr 2016	6%	999,026	21.32
Total Construction Cost	46,852 SF	\$17,649,461	\$376.71

Lauderdale Community Hospital
 Ripley, TN
 June 30, 2015
 Concept Estimate



Sitework

Item	Description	Cost
1	General Requirements	86,434
2	Excavation and Grading	409,337
3	Asphalt Paving	162,944
4	Concrete Work	77,221
5	Site Structures	0
6	Fencing	0
7	Specialty Paving	20,149
8	Signage and Striping	16,555
9	Site Specialties	29,292
10	Site Utilities	40,992
11	Storm Drainage Systems	66,517
12	Fire Protection	51,059
13	Landscaping and Irrigation	89,551
14	Electrical	141,160
	Subtotal	1,191,210
	Permits, Bonds and Insurance	37,412
	Contingency	0
	Escalation	0
	Fee	61,431
	Total	\$1,290,053

Hospital

Lauderdale Community Hospital
 Ripley, TN
 June 30, 2015
 Concept Estimate



1 Story Hospital
 37,611 SF

Item	Description	Cost	Cost/SF
1	General Requirements	745,833	19.83
2	Excavation	96,694	2.57
3	Building Structure	910,847	24.22
4	Building Skin	260,933	6.94
5	Interior Masonry	0	0.00
6	Rough Carpentry	111,573	2.97
7	Finish Carpentry and Millwork	421,577	11.21
8	Membrane Roofing	260,191	6.92
9	Sheet Metal	47,920	1.27
10	Caulking and Dampproofing	63,955	1.70
11	Doors, Frames and Hardware	363,287	9.66
12	Glass and Glazing Systems	244,366	6.50
13	Plaster and Drywall Systems	707,790	18.82
14	Stone and Tile	44,836	1.19
15	Ceilings	169,738	4.51
16	Flooring	235,502	6.26
17	Painting	80,869	2.15
18	Specialties	175,425	4.66
19	Equipment and Furnishings	167,158	4.44
20	Special Construction	67,005	1.78
21	Elevators	0	0.00
22	Fire Protection	6,765	0.18
23	Plumbing	1,483,853	39.45
24	HVAC Systems	2,047,123	54.43
25	Electrical	1,565,678	41.63
	Subtotal	10,278,919	273.30
	Permits, Bonds and Insurance	322,823	8.58
	Contingency	0	0.00
	Escalation	0	0.00
	Fee	530,087	14.09
	Total	\$11,131,829	\$295.97

Skin/Floor Area Ratio 41%
 Glass/Skin Area Ratio 23%

Total Skin Cost, Contact Area \$46.50 /SF
 Skin Cost, Bldg Area \$13.43 /SF

MOB

Lauderdale Community Hospital
 Ripley, TN
 June 30, 2015
 Concept Estimate



1 Story Medical Building
9,241 SF

Item	Description	Cost	Cost/SF
1	General Requirements	126,794	13.72
2	Excavation	26,315	2.85
3	Building Structure	233,552	25.27
4	Building Skin	63,703	6.89
5	Interior Masonry	0	0.00
6	Rough Carpentry	29,658	3.21
7	Finish Carpentry and Millwork	102,366	11.08
8	Membrane Roofing	78,658	8.51
9	Sheet Metal	10,827	1.17
10	Caulking and Dampproofing	14,719	1.59
11	Doors, Frames and Hardware	98,289	10.64
12	Glass and Glazing Systems	51,700	5.59
13	Plaster and Drywall Systems	180,436	19.53
14	Ceramic Tile	0	0.00
15	Ceilings	43,229	4.68
16	Flooring	47,334	5.12
17	Painting	20,411	2.21
18	Specialties	15,016	1.62
19	Equipment and Furnishings	5,956	0.64
20	Special Construction	0	0.00
21	Elevators	0	0.00
22	Fire Protection	27,535	2.98
23	Plumbing	158,085	17.11
24	HVAC Systems	189,702	20.53
25	Electrical	223,170	24.15
	Subtotal	<u>1,747,455</u>	<u>189.10</u>
	Permits, Bonds and Insurance	54,881	5.94
	Contingency	0	0.00
	Escalation	0	0.00
	Fee	90,117	9.75
	Total	<u>\$1,892,453</u>	<u>\$204.79</u>

Skin/Floor Area Ratio 38%
 Glass/Skin Area Ratio 14%

Total Skin Cost, Contact Area \$48.93 /SF
 Skin Cost, Bldg Area \$12.49 /SF

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 11

Section C, Economic Feasibility, Item 2

Funding Documentation

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 11

Question 14- Section C, Economic Feasibility, Item 2

Funding Documentation

January 29, 2016

9:59 am



CHHS

Community Hospitality Healthcare Services

January 8th, 2016

Jim Shaffer, President
 CAH Acquisition Company 11, LLC
 d/b/a Lauderdale Community Hospital
 1100 Main, Suite 2350
 Kansas City, MO 64105

Re: Lauderdale Hospital Replacement Facility

Dear Mr. Shaffer,

Community Hospitality Healthcare Services has received an array of information regarding the proposed replacement of the Lauderdale Hospital facility located in Ripley, Tennessee. As a federally certified "Community Development Entity" (CDE) by the CDFI Fund at the US Treasury with a national footprint, we would be interested in providing a sub-allocation of New Markets Tax Credits to the project. With a focus on healthcare infrastructure and job creation in distressed communities, we have funded dozens of projects with similar attributes. The project is located in a highly qualified census tract within a rural community. Based upon the geography and initial estimates of community impacts, including creation of quality jobs and services provided to the community, the project meets our initial thresholds for underwriting. Receipt of final NMTC investment from CHHS is contingent upon:

- Obtaining all necessary entitlements and approvals required by law, including Certificates of Need;
- Securing first-lien debt and additional capital sources required to fully fund the project;
- Collection of additional transaction diligence items;
- Availability of allocation at the time the project is ready to commence closing process; and
- Final underwriting and approval.

We anticipate that the NMTC investment will provide up to 23% (approximately \$3 million) of the capital required to complete the project, in the form of a subordinated interest-only note with a term of no less than 7 years at an interest rate in the 2.5-3% range. We look forward to working with you on this highly impactful project.

Sincerely,

Benjamin Cirka
 Executive Director
 Community Hospitality Healthcare Services

**CFG CAPITAL**
MEMBER FINRA/SIPC**January 29, 2016**
9:59 am
MARKETS, LLC

Attachment 11
Question 14, Economic Feasibility, Item 2
Funding Documentation

January 27, 2016

Jim Shaffer, President
CAH Acquisition Company 11 LLC
d/b/a, Lauderdale Community Hospital
1100 Main, Suite 2350
Kansas City, MO 64105

Re: Lauderdale Hospital Replacement Facility

Dear Mr. Shaffer,

CFG Capital Markets, LLC, ("CFGCM") appreciates the opportunity to work with you on the proposed \$23,000,000 replacement of the Lauderdale Community Hospital in Ripley, Tennessee. This letter confirms our engagement to facilitate the development of the replacement facility including identifying commercial banks to provide construction financing based on current markets conditions. Based on our discussions with lending sources to date, we believe there is debt financing available for the development of the replacement facility.

We believe lending institutions will provide up to 75% of project costs (approximately \$17.25 million) with the New Market Tax Credits and equity accounting for the balance. The terms of the debt will depend on the institution providing the loan, but should generally reflect a seven-year term to mirror the New Market Tax Credit component and the interest rate should generally range between LIBOR plus 350 to 450.

The commitment to provide the debt financing will be subject to customary underwriting and due diligence of the lender, including, but not limited to:

- Obtaining all necessary entitlements and approvals, including the Certificate of Need;
- Third party reports;
- Lender site visit; and
- Lender underwriting criteria.

We, and the initial lenders we have spoken to, believe this project is highly desirable based on the performance of the current facility.

CFGCM is not itself a lending institution, but based on our deep ties in the lending community for healthcare facilities, we believe the debt financing can be obtained. We look forward to working with you and your team to assist you with the development of this replacement Critical Access Hospital.

Sincerely,

Samer S. Tahboub
Director
CFG Capital Markets, LLC

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 12

Section C, Economic Feasibility, Item 6A

Medicare Rate Letters



CAHABA
GOVERNMENT
BENEFIT
ADMINISTRATORS, LLC

107



Attachment 12

Section C, Economic Feasibility, Item 6A
LCH Medicare rate letters

March 13, 2015

Medicare Interim Rate Review Summary

Provider Number	441314	Provider Name	CAH ACQUISITION COMPANY 11 LLC
Rate Review Period Ended	03/12/2015	Cost Reporting Period	09/30/2015
Target Completion Date	03/12/2015	Actual Completion Date	03/12/2015

Your revised rates and effective dates are listed below. Blank indicates rate is not being changed or is not applicable to your facility.

PIP Biweekly Rate
Pass Through Biweekly Rate

Effective:
Effective:

Pass Through Breakdown

	Part A	Part B	Total
Bad Debts			
GME/Allied Health			
CRNA			
Organ Acquisition			
Other			
Total:			

Operating Intern to Bed
Medicaid Ratio
Per Diem \$1,875.00
Outpatient Percentage 0.33
Rural Health Rate
Other (Describe)

Effective:
Effective:
Effective: 03/15/2015
Effective: 03/15/2015
Effective:
Effective:

Lump Sum Payment Due Provider/(Program):

Part A	Part B	Total
\$0.00	\$0.00	\$0.00

If total is positive, the amount due provider will be applied to any outstanding overpayments as noted below. The remaining balance will be included in your remittance within 15 days of this notice.

If the total is negative, please refer to letter titled "First Request for Payment of Lump Sum Adjustment" for repayment instructions.

Invoice Description Invoice Amount Remaining Balance

Completed By: B15476
Approved By: B9718

Date: 03/12/2015
Date: 03/12/2015

Work Object ID: IR-25787
Workload Number: 10301
PTAN: 441314
NPI: 1932421401



March 13, 2015

Medicare Interim Rate Review Summary

Provider Number	44Z314	Provider Name	CAH ACQUISITION COMPANY 11 LLC
Rate Review Period Ended	03/12/2015	Cost Reporting Period	09/30/2015
Target Completion Date	03/12/2015	Actual Completion Date	03/12/2015

Your revised rates and effective dates are listed below. Blank indicates rate is not being changed or is not applicable to your facility.

PIP Biweekly Rate	Effective:
Pass Through Biweekly Rate	Effective:

Pass Through Breakdown

	Part A	Part B	Total
Bad Debts			
GME/Allied Health			
CRNA			
Organ Acquisition			
Other			
Total:			

Operating Intern to Bed		Effective:
Medicaid Ratio		Effective:
Per Diem	\$1,580.00	Effective: 03/15/2015
Outpatient Percentage		Effective:
Rural Health Rate		Effective:
Other (Describe)		Effective:

Lump Sum Payment Due Provider/(Program):

Part A	Part B	Total
\$0.00	\$0.00	\$0.00

If total is positive, the amount due provider will be applied to any outstanding overpayments as noted below. The remaining balance will be included in your remittance within 15 days of this notice.

If the total is negative, please refer to letter titled "First Request for Payment of Lump Sum Adjustment" for repayment instructions.

Invoice Description Invoice Amount Remaining Balance

Completed By: B15476
Approved By: B9718

Date: 03/12/2015
Date: 03/12/2015

Work Object ID: IR-25788
Workload Number: 10301
PTAN: 44Z314
NPI: 1962725242



STATE OF TENNESSEE
 COMPTROLLER OF THE TREASURY
 DEPARTMENT OF AUDIT
 DIVISION OF STATE AUDIT

SUITE 1500
 JAMES K. POLK STATE OFFICE BUILDING
 NASHVILLE, TENNESSEE 37243-0264
 PHONE (615) 401-7897
 FAX (615) 532-2765

September 24, 2015

Mr. Scott Tongate
 Lauderdale Community Hospital
 326 Asbury Avenue
 Ripley, TN 38063

Re: Critical Access Hospital Revised Rate
 Provider No: 044-1314

Dear Mr. Tongate:

We have computed new interim supplemental reimbursement rates for your facility. The data used to calculate these rates come from your Joint Annual Report filed with the state for the fiscal year ended September 30, 2013. Your facility will be reimbursed quarterly through these revised rates.

The new interim rates for your facility, effective for dates of service on and after July 1, 2015, are:

Inpatient Services	\$ 437.79
Outpatient Services	20.14 % of charges

If you have any questions concerning the interim rate calculation, please contact Karen Degges at (615) 747-5203 or by e-mail at Karen.Degges@cot.tn.gov.

Sincerely,

Gregg S. Hawkins *KD*

Gregg S. Hawkins, CPA
 Assistant Director

cc: William Aaron, Bureau of TennCare

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 13

Section C, Economic Feasibility, Item 9

Most Current Financial Statements and most recent Audited Financials

Attachment 13
 Section C, Economic Feasibility, Item 9
 Most Current Financial Statements and most Recent Audited Financial Statements

Lauderdale Community Hospital
 Income Statement- Current Month to Prior Month Comparison
 For the Period ended, November 30, 2015

	November-15			YTD		
	Actual	Prior Month	Var	Prior Year	Actual	Var
	828,570	577,804	43.4%	503,959	1,406,374	57.4%
	2,987,859	3,211,049	-8.6%	2,683,910	6,208,908	13.1%
	-	-	#DIV/0!	205	6,449	-100.0%
Patient Revenue:	3,826,429	3,788,854	1.0%	3,188,074	7,615,282	49.2%
Inpatient Services			64.4%			
Outpatient Services			11.7%			
Clinic Services/Professional Fees			-100.0%			
Total Patient Revenue	3,826,429	3,788,854	1.0%	3,188,074	7,615,282	49.2%
Total Deductions From Revenue	2,729,982	2,765,808	-2.0%	2,072,664	4,093,757	34.7%
Net Patient Services Revenue	1,096,447	1,003,045	9.3%	1,115,411	2,095,492	-8.6%
Realization %	28.65%	26.47%		34.99%	27.57%	35.94%
Other Revenue	27,122	-	#DIV/0!	138,853	58,978	-65.8%
Total Operating Revenues	1,123,569	1,003,045	12.0%	1,254,264	2,158,470	-12.6%
Operating Expenses:						
Salaries and Wages	436,380	96,951	341.0%	570,186	894,284	-23.1%
Benefits	101,288	99,927	1.3%	120,832	200,219	-13.3%
Supplies	70,797	57,820	22.4%	84,995	170,724	-7.9%
Medical Specialist Fees	68,820	59,911	-1.8%	57,570	116,639	3.3%
Purchased Services	82,546	118,333	-30.2%	100,412	142,456	-12.7%
Management Fees	118,333	98,455	20.2%	118,333	236,666	0.0%
Other Operating Expenses	99,416	-	#DIV/0!	103,835	197,871	-6.7%
Total Operating Expenses	967,559	533,396	81.4%	1,156,162	1,958,639	-15.0%
E.B.I.T.D.A.	156,010	469,650	-66.8%	98,101	199,631	20.8%
Extraordinary Items						#DIV/0!
Depreciation and Amortization	(57,649)	(57,624)	-100.0%	(71,716)	(115,474)	-19.5%
Interest Expense	(25,654)	(33,191)	73.7%	(28,995)	(58,945)	-3.6%
Interest Income	-	0	#DIV/0!	6	0	-93.7%
Net Income Before Taxes	72,706	378,635	-80.8%	(2,603)	25,312	-164.5%

Oct-15

Nov-15

Balance Sheet			
ASSETS			
Current Assets:			
Cash and cash equivalents		51,457	18,222
Patient accounts receivable		9,600,868	9,857,394
Less: Reserves for Uncollectible		(6,288,204)	(6,510,061)
Home Office Settlement			
Supplies		194,594	188,109
Prepaid expenses		452,311	418,397
Third-Party Settlement		1,695,435	934,743
Other current assets		141,253	131,054
Total Current Assets		5,847,715	5,037,859
Property & Equipment, at cost:			
Construction in Progress		42,150	42,150
Land and improvements		127,359	127,359
Buildings and improvements		3,524,189	3,524,189
Equipment and fixtures		2,335,725	2,335,725
Total PP&E		6,029,423	6,029,423
Less accumulated depreciation and amortization		(4,958,833)	(5,016,482)
Net Property and Equipment		1,070,591	1,012,941
Other Assets:			
Investments		-	-
Goodwill		-	-
Restricted Cash		-	-
Other		329,249	329,249
Total Other Assets		329,249	329,249
Total Assets		7,247,555	6,380,049

	Oct-15	Nov-15
LIABILITIES		
Current Liabilities:		
Current maturities of LTD	571,302	510,258
Accounts payable	1,644,216	1,540,676
Cure Payable	50,179	50,179
Due/(From) HMC	(3,130,272)	(4,142,414)
Accrued Liabilities	1,554,042	1,571,457
Other Current Liabilities	878,872	904,868
Total Current Liabilities	1,568,339	435,025
Long-Term Debt	3,958,642	4,157,827
Deferred Revenue	139,903	133,821
Stockholders' Equity:		
Members Equity	567,380	567,380
Retained Earnings	1,060,684	1,060,684
Net Income	(47,394)	25,312
Total Stockholders' Equity	1,580,670	1,653,376
Total Liabilities and Stockholders Equity	7,247,555	6,380,049

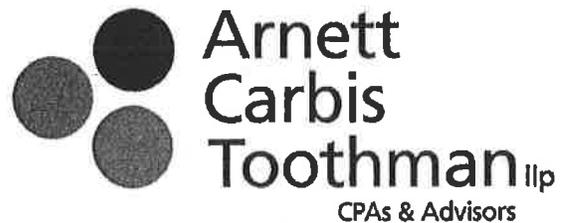


Consolidated, Inc.

HMC/CAH CONSOLIDATED, INC.

***Consolidated Financial Report and
Supplemental Information***

September 30, 2014



CONTENTS

INDEPENDENT AUDITORS' REPORT	1 – 2
FINANCIAL STATEMENTS:	
Consolidated balance sheet	3
Consolidated statement of operations	4
Consolidated statement of stockholders' equity (deficit)	5
Consolidated statement of cash flows	6
Notes to consolidated financial statements	7 – 26
SUPPLEMENTARY INFORMATION:	
Consolidated schedule – balance sheet information – 2014	27
Consolidated schedule – operating information – 2014	28



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INDEPENDENT AUDITORS' REPORT

To the Board of Directors
 HMC/CAH Consolidated, Inc.
 Kansas City, Missouri

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of HMC/CAH Consolidated, Inc. which comprise the balance sheet as of September 30, 2014, and the related consolidated statements of operations, stockholders' equity (deficit) and cash flows for the year then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above presents fairly, in all material respects, the financial position of HMC/CAH Consolidated, Inc. as of September 30, 2014, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter**Reorganization Proceedings under Chapter 11 of the United States Bankruptcy Code**

As discussed in Note 1 to the consolidated financial statements, on October 10, 2011, the Corporation filed a voluntary petition for reorganization under Chapter 11 of the United States Bankruptcy Code. On December 12, 2012, the Bankruptcy Court entered an order confirming the plan of reorganization, which became effective on January 17, 2013.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the consolidated balance sheet as a whole. The consolidating information is presented for purposes of additional analysis rather than to present the financial position, results of operations, and cash flows of the individual companies and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Annell Corbin Toothman LLP

Charleston, West Virginia
June 5, 2015

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED BALANCE SHEET
September 30, 2014
ASSETS

Current assets	
Cash and cash equivalents	\$ 1,349,802
Patient accounts receivable, net of estimated uncollectibles of \$13,008,000	12,913,137
Inventory of supplies	2,070,845
Prepaid expenses	2,424,146
Other receivables	<u>56,117</u>
Total current assets	<u>18,814,047</u>
Property and equipment, net	<u>23,335,735</u>
Assets Limited as to use	<u>1,145,088</u>
Other assets	
Deferred financing cost, net	<u>786,474</u>
Total assets	<u>\$ 44,081,344</u>

LIABILITIES AND STOCKHOLDERS' EQUITY (DEFICIT)

Current liabilities	
Current installments of long-term debt	\$ 4,747,871
Deferred revenue – current portion	954,001
Accounts payable	11,567,034
Reorganization obligations current portion	1,793,640
Estimated third-party payor settlements	1,227,000
Accrued expenses	<u>7,537,346</u>
Total current liabilities	<u>27,826,892</u>
Long-term debt, excluding current portion	38,390,294
Reorganization obligations, excluding current portion	1,259,196
Estimated third-party payor settlements	3,732,389
Deferred revenue	<u>3,076,613</u>
Total liabilities	<u>74,285,384</u>
Stockholders' equity (deficit)	<u>(30,204,040)</u>
Total liabilities and stockholders' equity (deficit)	<u>\$ 44,081,344</u>

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED STATEMENT OF OPERATIONS
Year Ended September 30, 2014

Revenues	
Patient service revenue (net of contractual allowances and discounts)	\$ 104,178,383
Provision for bad debts	<u>(15,757,181)</u>
Net patient service revenue less provision for bad debts	88,421,202
Other operating revenue	1,450,344
Electronic health record incentive reimbursement	<u>755,301</u>
Total revenues	<u>90,626,847</u>
Expenses	
Salaries and wages	42,934,730
Payroll taxes and benefits	7,850,655
Supplies and other	16,339,274
Medical professionals	3,226,316
Purchased services	8,194,122
Management fees	9,751,498
Depreciation and amortization	4,237,758
Interest expense	<u>3,282,378</u>
Total expenses	<u>95,816,731</u>
Operating loss	(5,189,884)
Non-operating income	
Investment income	<u>58,651</u>
Net loss	<u>\$ (5,131,233)</u>

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY
Year Ended September 30, 2014

	Retained Earnings (Deficit)	Preferred Capital Stock		Common Capital Stock		Total Stockholders' Equity (Deficit)
		Par Value	Additional Paid in Capital	Par Value	Additional Paid in Capital	
BALANCE, SEPTEMBER 30, 2013	\$ (49,020,560)	\$ 189	\$ 22,656,672	\$ 290,892	\$ 1,000,000	\$ (25,072,807)
Net loss	(5,131,233)	-	-	-	-	(5,131,233)
BALANCE, SEPTEMBER 30, 2014	\$ (54,151,793)	\$ 189	\$ 22,656,672	\$ 290,892	\$ 1,000,000	\$ (30,204,040)

See accompanying notes to consolidated financial statements

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED STATEMENT OF CASH FLOWS
Year Ended September 30, 2014

Cash flows from operating activities	
Net loss	\$ (5,131,233)
Adjustments to reconcile net loss to net cash used in operating activities:	
Depreciation and amortization	4,237,758
Provision for bad debts	15,757,181
Loss on sale of property and equipment	9,456
(Increase) decrease in:	
Patient accounts receivable	(20,032,954)
Inventory of supplies	31,311
Prepaid expenses	(163,311)
Other receivables	1,610,342
Increase (decrease) in:	
Accounts payable and accrued expenses	1,577,152
Third-party payor settlements	1,142,084
Deferred revenue	<u>(933,984)</u>
Net cash used in operating activities	<u>(1,896,198)</u>
Cash flows from investing activities	
Purchase of property and equipment	(836,758)
Proceeds from sale of property and equipment	145,000
Change in assets whose use is limited, net	<u>(320,623)</u>
Net cash used in investing activities	<u>(1,012,381)</u>
Cash flows from financing activities	
Principal payments on long-term debt	(5,304,821)
Proceeds from the issuance of long-term debt	10,170,000
Payment on reorganization liabilities	(807,602)
Deferred financing costs	<u>(582,776)</u>
Net cash provided by financing activities	<u>3,474,801</u>
Net increase in cash and cash equivalents	566,222
Cash and cash equivalents, beginning of year	<u>783,580</u>
Cash and cash equivalents, end of year	<u>\$ 1,349,802</u>
Supplemental disclosure of noncash financing and investing activities	
Cash paid for interest	<u>\$ 3,282,378</u>
Capital lease obligations incurred for equipment	<u>\$ 1,665,412</u>
Long-term debt obligations incurred for property and equipment	<u>\$ 770,000</u>

See accompanying notes to consolidated financial statements

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS****Note 1. Summary of Significant Accounting Policies****Description of Business Organization**

HMC/CAH Consolidated, Inc. (HMC) was incorporated on May 15, 2007 in the state of Delaware and was capitalized on May 31, 2007 through a combination of Common Stock, Series A Preferred Stock and Short-Term Debt issuances.

HMC is in the business of acquiring and operating acute care hospitals located in rural communities that are certified as critical access hospitals (CAHs) by the Center for Medicare and Medicaid Services (CMS). HMC plans to replace the existing medical facilities of the CAHs it acquires with newly-constructed medical facilities.

HMC conducts its business through a consolidated group of wholly-owned subsidiaries (HMC Hospitals). HMC and the HMC Hospitals are hereinafter referred collectively as the "Corporation." Since commencing business on May 31, 2007, the Corporation has purchased the business and assets of twelve CAHs, all of which for the year ending September 30, 2014 were in operation. The CAHs that HMC has acquired are as following:

1. CAH Acquisition Company #1, LLC (CAH1) - June 1, 2007 - Washington County Community Hospital, Plymouth, North Carolina.
2. CAH Acquisition Company #2, LLC (CAH2) - October 1, 2007 - Oswego Community Hospital, Oswego, Kansas.
3. CAH Acquisition Company #3, LLC (CAH3) - January 1, 2008 - Horton Community Hospital, Horton, Kansas.
4. CAH Acquisition Company #5, LLC (CAH5) - September 1, 2008 - Hillsboro Community Hospital, Hillsboro, Kansas.
5. CAH Acquisition Company #7, LLC (CAH7) - December 1, 2008 - Prague Community Hospital, Prague, Oklahoma.
6. CAH Acquisition Company #6, LLC (CAH6) - March 1, 2009 - I-70 Community Hospital, Sweet Springs, Missouri.
7. CAH Acquisition Company #4, Inc. (CAH4) - April 1, 2009 - Drumright Regional Hospital, a CAH located in Drumright, Oklahoma.
8. CAH Acquisition Company #9, LLC (CAH9) - July 1, 2009 - Selling Community Hospital, Selling, Oklahoma.
9. CAH Acquisition Company #12, LLC (CAH12) - February 1, 2010 - Fairfax Community Hospital, Fairfax, Oklahoma.
10. CAH Acquisition Company #11, LLC (CAH11) - April 1, 2010 - Lauderdale Community Hospital, Ripley, Tennessee.
11. CAH Acquisition Company #10, LLC (CAH10) - May 1, 2010 - Yadkin Valley Community Hospital, Yadkinville, North Carolina.
12. CAH Acquisition Company #16, LLC (CAH16) - August 1, 2010 - Haskell County Community Hospital, Stigler, Oklahoma.

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS****Plan of Reorganization (the "Plan")**

HMC/CAH Consolidated, Inc. (HMC) and its twelve critical access hospital subsidiaries (HMC Hospitals) were HMC/CAH and debtors-in-possession (collectively, Debtors) in Chapter 11 proceedings filed on October 10, 2011 in the United States Bankruptcy Court for the Western District of Missouri.

On September 7, 2012, HMC/CAH proposed a Plan to the court and the creditors. The Plan was structured so that secured creditors would receive full payment of their principal balances, except for secured creditor HPGC Hospital Investments, LLC (HHI). The proposed Plan gave unsecured creditors the option to take either an immediate discounted payment of their claims (the Discount Option), or full payment over a period of eleven years at a 2% interest rate (the 100% Option).

In December 2010 creditor HHI (after funding \$15 million of its \$31 million commitment) defaulted on its loan agreement with HMC/CAH. HMC/CAH filed suit against HHI and after the Chapter 11 proceeding was filed in October 2011; this litigation provided HMC/CAH with a legal basis to dispute HHI's \$15 million secured claim. Prior to the voting on the Plan, HMC/CAH and HHI reached a settlement whereby HHI, in exchange for its agreement to reduce its secured claim to \$5 million, was given a \$10 million preferred equity interest in HMC/CAH.

On November 12, 2012, the Plan was put to a vote. All of the eligible secured creditor classes and the required number of unsecured creditors voted to accept the Plan. The total dollar amount of the unsecured claims was approximately \$7 million; and of that amount, approximate \$2 million elected the 100% Option and \$5 million elected the Discount Option.

At the December 12, 2012 confirmation hearing the court entered its order confirming the Joint Plan (Confirmation Order) which became final for purposes of appeal on December 26, 2012. Approximately \$4 million in cash was needed by HMC/CAH to fund their exit from the Chapter 11 proceeding. The Plan contemplated, and the Confirmation Order authorized, HMC/CAH to enter into a Management Rights Sale transaction in order to raise this cash. Thereafter, on January 17, 2013, the Management Rights Sale (Note 22) closed and HMC/CAH filed their notice of the effective date of the Plan.

Implementation of the Plan

Subsequent to the January 17, 2013 effective date, the provisions of the Plan were implemented as follows:

1. HMC/CAH used the \$4 million of sales proceeds to fund the "pots" of money at the HMC Hospitals in the aggregate amount of approximately \$1 million to make the pro rata payments to the unsecured creditors who elected the Discount Option;
2. HMC/CAH used the \$3 million of sales proceeds remaining to pay all other accumulated reorganization costs
3. The capital structure of HMC and the secured lender terms and lien priorities of HMC/CAH were reorganized. (Note 10)

Principles of Consolidation: The consolidated financial statements include the accounts of HMC/CAH Consolidated, Inc. and its subsidiaries (collectively referred to as the Corporation in the accompanying footnotes). All significant intercompany balances and transactions are eliminated in consolidation.

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Use of Estimates: The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents are highly liquid interest-bearing bank deposits and repurchase agreements. The carrying amount of cash and cash equivalents approximates fair market value. For purposes of the statement of cash flows, the Corporation considers all highly liquid financial instruments purchased with an original maturity of three months or less to be cash equivalents.

Patient Accounts Receivable: Patient accounts receivable are carried at the original charge less an estimate made for doubtful or uncollectible accounts. In evaluating the collectability of accounts receivable, the Corporation analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. The allowance is based upon a review of the outstanding balances aged by financial class. Management uses collection percentages based upon historical collection experience to determine collectability. Management also reviews troubled, aged accounts to determine collection potential. For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Corporation records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. Recoveries of accounts previously written off are recorded as a reduction to bad debt expense when received. Interest is not charged on patient accounts.

The Corporation's allowance for doubtful accounts for self-pay patients was 89 percent of self-pay accounts receivable at September 30, 2014. In addition, the Corporation's self-pay write offs were approximately \$6.3 million for fiscal year 2014. The Corporation's uninsured discount policy is 30% for patients with no third-party coverage and who did not qualify for charity care. The Corporation does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write offs from third-party payors.

Inventory of Supplies: The inventory of supplies is maintained on a first-in, first-out basis and is stated at the lower of cost or market.

Property and Equipment: Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

	Years
Buildings and improvements (including those under capital and financing leases)	10 – 40
Equipment	3 – 10
Equipment under capital leases	3 – 5

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**

Deferred Financing Costs: Deferred financing costs are amortized over the period the obligation is outstanding using the straight-line method, which is not materially different than the effective interest method. Amortization expense related to the deferred financing costs was \$46,128 for the year ended September 30, 2014.

Net Patient Service Revenue: The Corporation has agreements with third-party payors that provide for payments at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Income Taxes: The Corporation provides for income taxes in accordance with financial accounting standards, which requires the asset and liability approach be used to determine deferred income taxes. Deferred tax assets and deferred tax liabilities are recognized for the expected future consequences of temporary differences between the financial reporting basis and the tax basis of assets and liabilities. A valuation allowance is provided when it is more likely than not that a deferred tax asset will not be realized.

The Corporation's wholly owned limited liability companies and corporations are treated as partnerships for federal income tax purposes. Consequently, federal income taxes are not payable by, or provided for, by the wholly owned limited liability companies and corporations. The Corporation is taxed individually on the wholly owned limited liability companies and corporation's earnings.

Uncertain Tax Positions: The Corporation applies the income tax standard for uncertain tax positions. As a result of the Corporation evaluates its tax positions and determined it has no uncertain tax positions as of September 30, 2014. The Corporation's 2012 and 2013 tax years are open for examination by federal and state taxing authorities.

Subsequent Events: The Corporation has evaluated subsequent events through June 5, 2015, the date on which the financial statements were available to be issued.

New or Recent Accounting Pronouncements: In May 2014, the FASB issued Revenue from Contracts with Customers (Topic 606). This ASU will affect any entity that either enters into contracts with customers to transfer goods or services or enters into contracts for the transfer of nonfinancial assets unless those contracts are within the scope of other standards such as insurance or lease contracts, and will supersede the revenue recognition requirements in Accounting Standards Codification (ASC) Topic 605, *Revenue Recognition*, and most industry-specific authoritative accounting guidance. In addition, this ASU will amend the existing requirements for the recognition of a gain or loss on the transfer of nonfinancial assets that are not in a contract with a customer such as assets within the scope of ASC Topic 360, *Property, Plant, and Equipment*, and intangible assets within the scope of ASC Topic 350, *Intangibles—Goodwill and Other* to be consistent with the guidance on recognition and measurement of this ASU. Under the requirements of this ASU, financial reporting entities should recognize contractual revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The ASU will require a step process for contractual revenue recognition that will require financial reporting entities to identify contractual relationships that produce revenue, identify the performance obligations within those contracts, determine contractual transaction prices of those contracts, allocate the transaction price to the performance obligations of those contracts, and to recognize revenue as the financial reporting entity satisfies the contractual performance obligations. The amendments of this ASU are effective for public entities for annual and interim reporting periods beginning after December 15, 2016, with early application not permitted. For nonpublic entities, the amendments of this ASU are effective for annual reporting periods beginning after December 15, 2017, and interim periods within annual periods beginning after December 15, 2018, with earlier application permitted no earlier than the effective date for public entities. Once adopted, an entity should apply the amendments of the ASU by either retrospectively applying to all

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**

period presented using practical expedients prescribed by the ASU, or retrospectively with the cumulative effect of initial application recognized at the date of initial application with disclosure of the impact that the cumulative effect would have had on individual financial statement line items for the prior periods presented before the initial application. The management of the Corporation has not yet concluded their evaluation of the potential effects of this new accounting and financial reporting standard update.

Note 2. Net Patient Service Revenue

The Corporation has agreements with third-party payors that provide for reimbursement to the Corporation at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Corporation billings at established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with major third-party payors follows:

- **Medicare**

The HMC Hospitals are licensed as Critical Access Hospitals. Inpatient services and most outpatient services rendered to Medicare program beneficiaries are paid based on a cost reimbursement methodology at 101% of allowable cost. Other outpatient services are paid based on fee schedules.

- **Medicaid**

Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed under various methodologies depending on the particular state in which the Hospital is located. In some circumstances the Hospitals are reimbursed for cost reimbursable services at tentative rates with final settlement determined after submission of annual cost reports by the Hospitals and audits thereof by the Medicaid fiscal intermediary. Other states reimbursement includes prospectively determined rate per discharge, discounts from established charges and prospectively determined daily rates.

- **Other**

HMC Hospitals have also entered into payment agreements with commercial insurance carriers. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Concentration of Revenues

Revenue from the Medicare and Medicaid programs accounted for approximately 45 percent and 12 percent, respectively, of the Corporation's gross patient revenue, for the year ended September 30, 2014. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation.

The Corporation's patient service revenues are particularly sensitive to regulatory and economic changes in certain states where the Corporation generates significant revenues. The following is an analysis by state of revenues as a percentage of the Corporation's total revenues for those states in which the Corporation generates significant revenues for the year ended September 30, 2014:

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

	Hospital Campuses in State as of September 30, 2014	Revenue Concentration by State	
		Amount	% of Revenues
Oklahoma	5	\$ 29,360,290	33.2%
Tennessee	1	15,112,479	17.1%
North Carolina	2	21,282,779	24.1%
Kansas	3	14,866,124	16.8%
Missouri	1	7,799,530	8.8%
Total		<u>\$ 88,421,202</u>	

Charity Care

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. The revenues associated with self-pay patients are generally reported at the Corporation's gross charges. The Corporation evaluates these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the local hospital's policy for charity care. The Corporation provides care without charge to certain patients that qualify under the local charity care policy of each of its hospitals. For the year ended September 30, 2014, the Corporation estimates that its costs of care provided under its charity care programs approximated \$350,000. The Corporation does not report a charity care patient's charges in revenues or in the provisions for doubtful accounts as it is the Corporation's policy not to pursue collection of amounts related to these patients.

The Corporation's management estimates its costs of care provided under its charity care programs utilizing a calculated ratio of costs to gross charges multiplied by the Corporation's gross charity care charges provided. The Corporation's gross charity care charges include only services provided to patients who are unable to pay and qualify under the Corporation's local charity care policies. To the extent the Corporation receives reimbursement through the various governmental assistance programs in which it participates to subsidize its care of indigent patients, the Corporation does not include these patients' charges in its cost of care provided under its charity care program. During the year ended September 30, 2014, the Corporation recognized revenues of approximately \$400,000 under such programs.

The Corporation derives a significant portion of its revenues from Medicare, Medicaid and other payors that receive discounts from its established billing rates. The Corporation must estimate the total amount of these discounts to prepare its consolidated financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Corporation estimates the allowance for contractual discounts on a payor-specific basis given its interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Corporation's estimates. Additionally, updated regulations and contract negotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Changes in estimates related to the allowance for contractual discounts affect revenues reported in the Corporation's accompanying consolidated statement of operations.

Cost report settlements under reimbursement agreements with Medicare and Medicaid are estimated and recorded in the period the related services are rendered and are adjusted in future periods as final settlements are determined. There is a reasonable possibility that recorded estimates will change by a material amount in the near term. The net adjustments to estimated cost report settlements from prior years resulted in a decrease to net revenue for the year ended September 30, 2014, of approximately \$830,000. The Corporation's management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under these programs.

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. The Corporation believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the Corporation's financial statements. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

A summary of gross and net patient service revenue for all of the Corporation's payors for the year ended September 30, 2014:

Gross patient service revenue	\$ 202,647,951
Less provision for:	
Contractual adjustments	97,773,794
Provision for bad debts	15,757,181
Charity care	695,774
Net patient service revenue	<u>\$ 88,421,202</u>

Patient service revenue, net of contractual adjustments and discounts (but before the provision for bad debts), recognized during the year ended September 30, 2014 from these major payor sources, is as follows:

	Third-Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	<u>\$ 91,234,389</u>	<u>\$ 12,943,994</u>	<u>\$ 104,178,383</u>

Note 3. Cash Concentrations

The Corporation maintains cash and cash equivalents on deposit with financial institutions. At times the balance in these accounts may be in excess of Federally insured limits. However, management believes these financial institutions are financially sound and these concentrations do not present a significant risk to the Corporation.

Note 4. Concentration of Credit Risk

The Corporation grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of net receivables from patients and third-party payors at September 30, 2014 was as follows:

Medicare	36%
Medicaid	5%
Blue Cross	12%
Commercial and other	29%
Self-pay	18%
	<u>100%</u>

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 5. Assets Limited as to Use

The composition of assets limited as to use at September 30, 2014 is as follows:

Held by trustee under indenture agreements	
Cash and cash equivalents	\$ 1,145,088
Total assets limited as to use	<u>\$ 1,145,088</u>

Investment income and gains and losses for cash and cash equivalents are comprised of the following for the year ended September 30, 2014:

Income	
Investment income	\$ 58,651
	<u>\$ 58,651</u>

Note 6. Property and Equipment and Commitments

A summary of property and equipment at September 30, 2014 follows:

Land and land improvements	\$ 1,761,165
Buildings and leasehold improvements	28,796,172
Equipment and fixtures	<u>25,209,310</u>
	55,766,647
Less accumulated depreciation and amortization	<u>35,638,152</u>
	20,128,495
Construction in progress	<u>3,207,240</u>
	\$ 23,335,735
Property and equipment, net	<u>\$ 23,335,735</u>

Construction in progress at September 30, 2014 primarily consists of costs incurred for the planning of replacement facilities. The projects are in the planning phase. No commitments for additional cost have been made as of the date of this financial statement report.

Note 7. Long-Term Debt

A summary of long-term debt as of September 30, 2014 is as follows:

Note payable to First Liberty Bank, monthly installments of \$59,623, including variable interest of prime plus 1.5% (6.25% at September 30, 2014) through 2037, secured by property and equipment and a second priority on accounts receivable. The note is 90% guaranteed by the U.S. Department of Agriculture.	\$ 8,677,531
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HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note and Mortgage payable to First Liberty Bank, monthly installments of \$48,747, including variable interest (4.75% at September 30, 2014) through 2034, secured by accounts receivable and property and equipment. Loan was made to refinance HUD loan and to provide financing for hospital improvements. Loan is 70% guaranteed by the United States Department of Agriculture (USDA).	7,405,946
Note payable to Health Acquisition Company (HAC), LLC, interest only Payable monthly at 7.00% through 2024, loan made for working capital for hospitals, includes pledge of stock and all of the LLC interests. In connection with the loan, HMC granted to HAC the right and option to purchase the Option interests for \$6 million to be paid in full by HAC's conversion of the note payable into interests equal to 80% of the total interests of HMC. Term of the option commences on October 1, 2015, and ends on the note maturity date.	6,000,000
Note payable to HPCG Hospital Investments, LLC (HHI), various monthly installments including interest of 6.00% through 2021; secured by accounts receivable and fixed assets (various lien positions).	4,216,000
Note payable to HMC/CAH Note Acquisition, LLC, monthly installments of \$64,747, including interest of 7.00% through 2020; secured by accounts receivable and intangibles (various lien positions).	3,706,203
Note payable to Triumph Healthcare (formerly Doral Healthcare), monthly installments of \$53,417, including variable interest based on LIBOR (7.00% at September 31, 2014) through 2018; secured by accounts receivable. \$1,000,000 of the loan amount is held by the lender as a certificate of deposit and is recorded in Assets Limited as to Use and \$500,000 is held by lender in reserve.	2,767,857
Note payable to CFG Community Bank, monthly installments of \$18,293, including interest of 6.25% based on 20 year amortization with final balloon payment in January 2016, secured by property and equipment and accounts receivable (various lien positions).	2,304,852
Note payable to shareholders, various monthly installments including interest of 6.00% through September 2018; secured by accounts receivable.	2,133,518
Note payable to Citizens Bank, monthly installments of \$10,589, including interest of prime plus 1.5% based on 20 year amortization with one final balloon payment in January 2017, secured by accounts receivable and property and equipment.	1,355,827
Notes payable to Sun Finance, monthly installments of \$24,166, including interest of 6.00% through 2018, secured by CAH 4 equity interests; notes were originally for \$1.25 million at CAH 6 and CAH 16, reduced to \$1M during bankruptcy and debt was transferred to HMC.	1,045,090

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note payable to First Liberty Bank, monthly installments of \$7,326, including interest of 6.00% through 2021, secured by accounts receivable and property and equipment.	475,812
Notes payable to various lenders, monthly payments ranging from \$1,177 to \$15,394, interest at various fixed rates maturing through 2016.	311,930
Capital lease obligations, monthly payments ranging from \$538 to \$11,829, various rates of interest from 1.625% to 20.028% maturing through 2020, secured by related equipment.	<u>2,737,599</u>
Total long-term debt	43,138,165
Less current maturities	<u>4,747,871</u>
Long-term debt, net of current maturities	<u>\$ 38,390,294</u>

Scheduled principal repayments on notes payable and capital lease obligations are as follows:

Year ending September 30,	Notes Payable	Capital Lease Obligations
2015	\$ 3,453,827	\$ 1,499,605
2016	5,621,061	711,125
2017	4,751,513	568,252
2018	3,632,729	326,034
2019	3,403,526	30,495
Thereafter	<u>19,537,910</u>	<u>15,895</u>
Total	<u>\$ 40,400,566</u>	3,151,406
Less: Amount representing interest on obligations under capital lease		<u>413,807</u>
Total		<u>\$ 2,737,599</u>

The Corporation had the following assets under capital lease included in property and equipment at September 30, 2014:

Movable equipment	\$ 5,561,312
Less: accumulated amortization	<u>3,048,458</u>
Total	<u>\$ 2,512,854</u>

Restrictive Covenants

The provisions of the debt agreements described above contain various restrictive covenants related to financial and operational matters to be satisfied as long as the debt is outstanding. As of September 30, 2014, the Corporation did not meet all of these requirements. Subsequent to the year ended September 30, 2014, the Corporation received waivers related to the matters of non-compliance.

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 8. Estimated Third-Party Payor Settlements

Estimated third-party payor settlements consist of amounts due from/(to) the Medicare and Medicaid programs for settlement of current and prior cost reports. A significant amount of the Medicare settlements are on Extended Repayment Plans (ERPs). Terms of the ERP include repayments extending from six months to five years. The estimated settlements by program at September 30, 2014 are as follows:

Medicare	\$ (5,721,580)
Medicaid	<u>762,191</u>
Total	(4,959,389)
Less current maturities	<u>(1,227,000)</u>
Long-term portion	<u>\$ (3,732,389)</u>

Note 9. Accrued Expenses

Details of accrued expenses at September 30, 2014 are as follows:

Accrued payroll, benefits and payroll taxes	\$ 2,013,603
Accrued paid time off	1,795,985
Management fees payable – related party	1,415,437
Accrued property taxes	211,731
Other accrued expenses	<u>2,100,590</u>
	<u>\$ 7,537,346</u>

Note 10. Capitalization

The capital stock of the Corporation at September 30, 2014 are as follows:

Common Stock, par value .00001 a share, authorized 4,000,000 shares, issued and outstanding 290,892 shares	\$ 290,892
Class 2 Earnout Rights 1,000,000 nonvoting shares – additional paid in capital	1,000,000
Series A Preferred stock, par value .00001 a share, authorized 10,000,000 shares, issued and outstanding 9,571,367 shares	96
Series A Preferred stock, additional paid in capital and accumulated dividends	12,456,765
Series B Preferred Stock – par value .00001 a share, authorized 7,000,000 shares, issued and outstanding 6,363,636 shares	64
Series B Preferred Stock – additional paid in capital	6,999,936
Series C Preferred Stock – par value \$.00001 a share, authorized 3,200,000 shares, issued and outstanding 2,909,091 shares	29
Series C Preferred Stock – additional paid in capital	<u>3,199,971</u>
Total capital stock	<u>\$ 23,947,753</u>

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Class 2 Earnout Rights

Subject to the terms of the Plan, Class 2 Earnout Rights are One Million Dollars (\$1,000,000) in non-voting equity interests in the Corporation that are to be provided to Participating New Equity Owners in Ratable Proportion to the funds that such Participating New Equity Owners provide to fund distributions to creditors pursuant to the Joint Plan.

No distributions shall be made to owners of Class 2 Earnout Rights until all senior classes have been paid in full, at which point the Class 2 Earnout Rights will receive distributions on the same terms and conditions and using the same formula as was used for determining distributions in connection with Class 1 Earnout Rights.

Class 2 Earnout Rights will accrue interest at an annual rate of 2%.

Preferred Stock Dividends

The Corporation's Series A Preferred Stock Agreement stipulates that the Series A Preferred Stock will carry an annual 8% cumulative dividend, payable upon a liquidation or redemption. No dividends or distributions can be made with respect to Common Stock until the Series A Preferred Stock has received its liquidation preference. Thereafter, for any other dividends or distributions, preferred participates with Common Stock on an as-converted basis. The Corporation intends to employ all available funds for the development of its business and, accordingly, does not intend to declare or pay any cash dividends on its Series A Preferred Stock or Common Stock in the foreseeable future. As of September 30, 2014, approximately \$4,700,000 of dividends have accumulated on the Series A Preferred Stock.

In full satisfaction of its Allowed HHI General Unsecured Claim, HHI received Series B Preferred Stock with comparable economic rights to Series A preferred stock (and with the same priority for any distributions, based on their preferred stock ownership) and Series C Preferred Stock.

Warrants

In accordance with the reorganization plan, the holder of the Sun Finance Secured Claim was granted, upon the Effective Date, (i) 250,000 shares of common stock in Reorganized HMC and (ii) new warrants exercisable for the purchase of 1,250,000 shares of common stock in Reorganized HMC and on the same terms and conditions as those certain warrants issued to the holder of the Sun Finance Secured Claim before the Petition Date and which may be exercised at Sun Finance's discretion.

Note 11. Deferred Revenue

Deferred revenue in the consolidated balance sheet at September 30, 2014, consists of the following:

Management rights sales	\$ 2,919,243
Electronic health records incentive payments	<u>1,111,371</u>
	<u>\$ 4,030,614</u>

Amounts are classified as follows in the accompanying consolidated balance sheet at September 30, 2014:

Current portion	\$ 954,001
Long-term portion	<u>3,076,613</u>
	<u>\$ 4,030,614</u>

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

Note 12. Reorganization Obligations and Earnout Contingency

Reorganization obligations at September 30, 2014 consist of the following:

Cure payable amounts	\$ 1,427,522
Earnout payable amounts	<u>1,625,314</u>
	<u>\$ 3,052,836</u>

Classification in the consolidated balance sheet at September 30, 2014 is as follows:

Current portion	\$ 1,793,640
Long-term portion	<u>1,259,196</u>
	<u>\$ 3,052,836</u>

Cure Payable Amounts

Pursuant to the terms of the Plan, certain contracts were assumed by the Corporation as part of the reorganization plan. Cure payments consisting of pre-petition amounts and post-petition amounts owed are being made to those parties over the course of 36 months starting at the date of the confirmation order.

Class 1 Earnout Rights

Pursuant to the terms of the Plan, Class 1 Earnout Rights are those rights of holders of \$1,929,257 in Allowed General Unsecured Claims that have elected Option 2 treatment to the payment of 100% of the amount of such Allowed Claims pursuant to interests in a note or notes payable and issued by the Corporation for the aggregate amount of the Class 1 Earnout Rights with each holder's interest equal to the full amount of such holder's Allowed General Unsecured Claim. The Class 1 Earnout Rights shall be paid if certain operating performance benchmarks are met. For the year ended September 30, 2014 those benchmarks were not met.

Class 1 Earnout Rights will accrue interest at an annual rate of 2% which accrued interest shall be payable only at the time of an Option 2 Payment Event.

Note 13. Lessee Lease Commitment and Total Rental Expense

The Corporation leases office and medical space and equipment under long-term operating lease arrangements that expire at various dates. Total rental expense for all operating leases was approximately \$1.4 million for 2014.

Note 14. Related Party Transactions**HPCG Hospital Investment, LLC**

HPCG Hospital Investment, LLC (HHI) in exchange for its agreement to reduce its secured claim to \$5 million, was given a \$10 million preferred equity interest in HMC. As of September 30, 2014, HMC has reflected notes payable to HHI totaling \$4,216,000, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately \$151,000 related to loan agreements with HHI.

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS****Rural Community Hospitals of America, LLC (RCHA)**

On January 17, 2013, HMC/CAH, as sellers, and Rural Community Hospitals of America, LLC (RCHA), as buyer, closed the Management Rights Sale transaction. The key financial terms of that transaction were as follows:

1. HMC/CAH received a cash payment of \$4,000,000 from RCHA for the purchase of HMC's "home office" assets (i.e. those assets necessary for management of the HMC Hospitals). The amount was recorded as deferred revenue and amortized over the estimated life of the management contracts or approximately 7 years.
2. RCHA hired all of HMC's "home office" employees (i.e. those employees involved in the day-to-day management of HMC/CAH hospitals, including the CEOs of the HMC Hospitals).
3. RCHA assumed certain HMC "home office" liabilities, contracts and leases, including sublicenses and sublets of HMC's Kansas City "home office and central business offices (CBOs) in Tulsa, Oklahoma and Alma, Missouri.
4. HMC/CAH executed management agreements for each of the HMC Hospitals.
5. Pursuant to terms of each management agreement, RCHA (Manager), is to receive a management fee equal to 11% of cash collected. For the year ended September 30, 2014, management fees paid to RCHA were \$9,751,500.

RCHA is a West Virginia limited liability company. The President of RCHA directly or indirectly owns a 50% interest in RCHA. The RCHA President owns directly or indirectly a 50% interest in Sun Finance Corporation. The RCHA President was a member of the HMCs' Board of Directors, but resigned from HMCs' Board of Directors prior to HMC engaging RCHA as its management Company. The aggregate of the minimum fees payable to RCHA for all of the subsidiary hospitals is \$9,697,000. Total amounts incurred for management fees were approximately \$9,750,000 for the year ended September 30, 2014. As of September 30, 2014, HMC has reflected management fees payable to RCHA totaling \$1,415,437, included in accrued expenses in the accompanying consolidated balance sheet.

Sun Finance, Inc.

Sun Finance, Inc. (Sun) is the sole member of RCHA. Sun is not a shareholder or holder of an equity interest in HMC. Sun made a loan to HMC in January 2011. The purpose of the loan was for working capital.

Sun Finance was part of the "shareholder loan" in 2011, although they have never been a Series A shareholder. The RCHA President was on the board of directors and the finance committee and is a 50% owner in Sun. Their debt after bankruptcy was transferred to I-70 and part was given to them as Common Stock Warrants. As of September 30, 2014, HMC has reflected notes payable to Sun totaling \$1,045,090, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately \$25,000, related to loan agreements with Sun.

HMC/CAH Note Acquisition Company, LLC

HMC/CAH Note Acquisition Company, LLC, is related through common ownership of the Corporation's preferred stock. Gemino Healthcare Finance made a loan to HMC and its hospital subsidiaries in fiscal 2010. The purpose of the loan was to provide a revolving credit line and working capital source to HMC and its hospitals. HMC/CAH Note Acquisition Company, LLC, was formed in 2012 for the purpose of purchasing, at par, the revolving credit loan from Gemino Healthcare Finance. The purchase price was paid directly to Gemino Healthcare Finance. Following the closing of the purchase, Note Acquisition received loan payments of principal and interest under the Gemino note directly from HMC and its hospital

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**

subsidiaries. As of September 30, 2014, HMC has reflected notes payable to Note Acquisition totaling \$3,706,203, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately \$158,000, related to loan agreements with Note Acquisition.

Health Acquisition Company, LLC

Health Acquisition Company, LLC (HAC) participated in a working capital loan to HMC. The members of HAC are Scott L. White, Paul Nusbaum, Steven F. White and Larry A. Pack.

In connection with the loan, HMC granted to HAC the right and option to purchase the Option interest for \$6 million to be paid in full by HAC's conversion of the note payable into interests equal to 80% of the total interests of HMC. Term of the option commences on October 1, 2015 and ends on the note maturity date. As of September 30, 2014, HMC has reflected notes payable to HAC totaling \$6,000,000, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately \$245,000, related to loan agreements with HAC.

Shareholder Notes

This was a loan totaling \$2.3 million for use as working capital. All lenders are shareholders, other than Sun Finance. This debt was transferred to I-70 as part of the reorganization plan. As of September 30, 2014, HMC has reflected notes payable to shareholders totaling \$2,133,518, included in long-term debt in the accompanying consolidated balance sheet. During the year ended September 30, 2014, HMC incurred interest costs of approximately \$56,000, related to loan agreements with shareholders.

Insurance Broker

The Corporation utilizes a Series A Preferred shareholder as an insurance broker for health and workers' compensation insurance. There were no funds paid to them as a result of their brokerage by HMC for the year ended September 30, 2014.

Note 15. Income Taxes

The provision for income tax benefit and change in valuation allowance for the year ended September 30, 2014 consists of the following:

Current	\$ -
Deferred	12,491,183
Change in valuation allowance	<u>(12,491,183)</u>
Total benefit for income taxes	<u>\$ -</u>

The Corporation's effective income tax rate is lower than what would be expected if the federal statutory rate were applied to income before income taxes primarily because of certain expenses deductible for financial reporting purposes that are not deductible for tax purposes.

Deferred income taxes are provided for certain income and expenses, which are recognized in different periods for tax and financial reporting purposes. Deferred income taxes result primarily from differences in the accounting for depreciation and amortization expenses for financial and tax reporting purposes. The Corporation has net operating loss carry forwards of approximately \$15,900,000 to reduce future income tax liabilities which will expire through 2027.

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**

Note 16. Defined Contribution Pension Plan

The Corporation has established a defined contribution pension plan under which employees become participants upon reaching age 21 and completion of one year of service. The Corporation does not match employee contributions. The contributions are deposited with the plan administrator who invests the plan assets in accordance with participant's directives.

Note 17. Commitments and Contingencies**Malpractice Insurance**

The Corporation has insurance coverage to provide protection for professional liability losses on a claims made basis. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently will be uninsured.

Litigation

The Corporation is involved in litigation arising in the ordinary course of business. Claims alleging malpractice have been asserted against the Corporation and are currently in various stages of litigation. It is the opinion of management, however, that estimated malpractice costs accrued at September 30, 2014 are adequate to provide for potential losses resulting from pending or threatened litigation as well as claims arising from unknown incidents from services provided to patients that may be asserted.

Asset Retirement Obligation

The *Asset Retirement and Environmental Obligations* Topic 410 of the FASB Accounting Standards Codification, clarifies when an entity is required to recognize a liability for a conditional asset retirement obligation. Management has considered this Topic, specifically as it relates to its legal obligations to perform asset retirement activities, such as asbestos removal, on its existing properties. Management of the Corporation believes that there is an indeterminate settlement date for the asset retirement obligations because the range of time over which the Corporation may settle the obligations is unknown and cannot be estimated. As a result, management cannot reasonably estimate a liability related to these potential asset retirement activities. However, management does not believe that remediation of such obligations will have a material effect on the consolidated financial statements.

Note 18. Fair Value Disclosures**Fair Value Measurements**

The *Fair Value Measurements and Disclosures* Topic 820 of the FASB Accounting Standards Codification defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements.

Under the FASB's authoritative guidance on fair value measurements, fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, the Corporation uses various methods including market, income and cost approaches. Based on these approaches, the Corporation often utilizes certain assumptions that market participants would use in pricing the asset or liability, including assumptions about risk and or the risks inherent in the inputs to the valuation technique. These inputs can be readily observable, market corroborated, or generally unobservable inputs. The Corporation utilizes valuation techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Based on the observability of the inputs used in the valuation techniques the Corporation is required to provide the following information according to the fair value hierarchy. The fair value hierarchy ranks the

HMC/CAH CONSOLIDATED, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

quality and reliability of the information used to determine fair value. Financial assets and liabilities carried at fair value will be classified and disclosed in one of the following three categories:

- Level 1 – Quoted prices for identical assets and liabilities traded in active exchange markets, such as the New York Stock Exchange.
- Level 2 – Observable inputs other than Level 1 including quoted prices for similar assets or liabilities, quoted prices in less active markets, or other observable inputs that can be corroborated by observable market data.
- Level 3 – Unobservable inputs supported by little or no market activity for financial instruments whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques, as well as instruments for which the determination of fair value requires significant management judgment or estimation; also includes observable inputs for nonbinding single dealer quotes not corroborated by observable market data.

Fair Value on a Recurring Basis

The table below presents the recorded amount of assets measured at fair value on a recurring basis.

ASSETS:	Total at September 30, 2014	Fair Value Measurements Using:		
		Level 1	Level 2	Level 3
Restricted cash				
Cash and cash equivalents	\$ 1,145,088	\$ 1,145,088	\$ -	\$ -
	\$ 1,145,088	\$ 1,145,088	\$ -	\$ -

Assets Recorded at Fair Value on a Nonrecurring Basis

The Corporation has no assets and liabilities that are recorded at fair value on a nonrecurring basis.

Note 19. Asset Purchase Agreements Contingencies or Commitments**Prior CAH Acquisitions**

Some of the asset purchase agreements for the twelve CAHs included covenants by the Corporation to commence and complete the construction of replacement hospital facilities and medical office buildings within a certain period of time. Some of these agreements also included certain public interest covenants regarding services, indigent care, financial assistance and admission policies, participation in government reimbursement programs and other similar requirements.

If the Corporation failed to substantially comply with the public interest covenants or closed the hospital business without a successor to carry out the terms and conditions of the asset purchase agreement all ownership and facilities associated with the hospital business could revert back to the seller.

Some of these covenants were performed before the Chapter 11 proceedings were filed. The covenants that remained to be performed were not assumed by the Debtors during the Chapter 11 proceeding and (except as noted below with regard to CAH1) the Plan does not include or otherwise obligate the Debtors to perform any of the remaining covenants.

As of September 30, 2014, these liabilities are not reflected in the financial statements, because under section 11 (Discharge of Debtors) of the Confirmation Order, all such liabilities were discharged and the Debtors' liability in respect to all such covenants was extinguished completely effective January 17, 2013.

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS****Chapter 11 Claim of Washington County (NC)**

The asset purchase agreement for the acquisition of Washington County Community Hospital included a covenant that within three years from June 1, 2007, the Corporation must either construct a replacement hospital facility or pay Washington County (NC) the liquidated amount of \$700,000. The County filed and was granted an unsecured claim based on this covenant. In the Plan, the County elected the Discount Option and was paid \$54,348 in full discharge of its unsecured claim on January 17, 2013.

Note 20. Electronic Health Records (EHR)

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments beginning in 2011 for eligible hospitals and professionals that implement and achieve meaningful use of certified electronic health record (EHR) technology that demonstrate improved quality and effectiveness of care. Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology in each period over a four-year period. An additional Medicaid incentive payment is available to providers that adopt, implement or upgrade certified EHR technology. However, in order to receive additional Medicaid incentive payments in subsequent years, providers must demonstrate continued meaningful use of EHR technology.

During the year ended September 30, 2014, HMC applied for and recognized in other revenue and support \$755,301, related to Medicare and Medicaid EHR incentive payments. HMC has recorded deferred revenue of \$1,111,372 for the year ended September 30, 2014, for the difference in the amounts of Medicare and Medicaid share of qualifying expenditures and the amounts amortized to income. Management determined the average useful life of the assets is five years; therefore, the expected incentive revenue will be recognized ratably over five years. HMC intends to apply for additional funds in the coming years.

The Corporation's attestation of compliance with the meaningful use criteria is subject to audit by the Federal government or its designee. The recognition of the grant income is based on management's best estimate and the amounts recognized are subject to change. Any subsequent changes in the recognition of the grant income will impact the results of operations in the period in which they occur.

Note 21. Subsequent Events – Sale and Closure of Facilities**Selling (OK) Community Hospital (Sale):**

On July 1, 2009, CAH9 (as buyer) purchased the business and assets of Seiling Community Hospital from Seiling Municipal Hospital Authority (as seller). In connection with the purchase, CAH9 entered into a lease of the hospital facility with the City of Seiling, Oklahoma.

In early 2014, the Authority stated to the Corporation its desires to repurchase the hospital from CAH9. On July 1, 2014, CAH9 (as seller) entered into an agreement to sell the business and assets of the hospital (including the clinic in Vici (OK) and the site for the replacement facility) to the Authority (as buyer). The assets included in the sale were all inventory, fixed and moveable equipment, operating, property and capital leases. The assets excluded from the sale were cash, deposits, escrows, prepaids, certificates of deposit, investments, accounts receivable, cost report receivables for all periods prior to closing. The Authority also assumed all liabilities accruing after the closing. The sales price was \$50,000 for the assets and \$105,000 for land. The effective date of the sale was October 1, 2014, on which date the lease of the hospital facility from the City terminated.

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS****Yadkin Valley Community Hospital (NC) (Closure):**

On May 1, 2010, CAH10 (as buyer) purchased the business and assets of Yadkin Valley Community Hospital Community Hospital from the County of Yadkin, North Carolina (as seller). In connection with the purchase, CAH10 entered into a lease of the hospital facility with the County. The term of the lease expires on July 31, 2015.

On February 16, 2015, the County issued a request for proposal to lease the hospital facility. Three companies responded to the proposal – Hugh Chatham Memorial Hospital (HC), Community Hospital Corporation (CHC) and Wake Forest Baptist Medical Center (WFB). On April 17, 2015, HC withdrew from the sales process. As of the date of this report, no proposals were obtained to assume the operations of this hospital. Management has begun legal and regulatory proceedings to close the Hospital and cease operations. Management does not anticipate the closure of this hospital will have a significant financial impact on the Corporation.

Note 22. Management Plans

In the midst of the challenges facing all rural hospitals overall, improvements continue to be made in HMC operations.

- Savings initiatives have been implemented again in 2014 at each HMC facility. The total savings created represented over 5.65% of annual operating costs; or approximately \$5 million. The impact of these savings began to be realized in November 2014.
- HMC divested itself through the sale of Selling Community Hospital back to the City of Selling at the end of September, 2014. HMC was providing Selling with a subsidy of approximately \$60,000 per month with little or no opportunity for a hospital replacement. Therefore, the strategic operating decision was made to sell the hospital back to the City.
- The management team has aggressively implemented point of service collections (POS) collections due to the growing amount of deductibles and coinsurance created as part of the Affordable Care Act. This initiative will reduce bad debts and will improve cash flows by over \$2.5 million per year over a two year period beginning in 2014.
- The closure of Yadkin Valley is in process as of the report date. The closure of this facility, which has consistently had operating losses, will improve overall financial condition and operating results of the Corporation in future years.
- A number of facilities have expanded outpatient surgery services to respond to decreases in inpatient volumes. This has been accomplished by making improvements to surgical areas, some of which were completed in 2014, as well as by recruiting or making arrangements to share surgeons with other hospitals. These changes are expected to generate \$800,000 of additional net revenue in for a service line that has historically been very profitable.
- HMC facilities have added the several new primary care providers as part of an aggressive recruiting campaign. In addition, several new family practice physicians will also begin employment by July/August 2015.
- Efforts are also underway to reduce expenses further at the hospitals by limiting purchased services and other professional fees. Expenses in purchased services in FY 2014 are down \$783,651, or 10.02% of operating expenses. Professional Fees are down \$669,555 or 21.50%

HMC/CAH CONSOLIDATED, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**

- In addition, HMC's central billing offices improved processing time efficiency and added technological tools to support such efficiencies.
- Management also adopted a new budget and monitoring process called 6QF that requires corporate operational leadership and the facility CEOs to review quarterly results for ongoing process improvements efforts. Additionally, a new internal audit process was added to verify operating results related to an institution's ongoing cash flow results. The CEOs are now incentivized for their performance which is tied to the results of these new operating processes.
- The leadership team has added several new staff members to the executive team (including a new CFO, COO and Regional VP) to improve overall corporate oversight. All of the new team members have a strong operational background that includes successful tenures as CEOs in critical access hospitals. They have detailed knowledge of hospital operations with daily hands-on experience to work with the hospitals to improve processes while growing revenue to improve profitability.
- Constructing three new facilities utilizing federally secured financing that will result in improved operating results and cash flows at those facilities based upon financial forecast prepared by an independent third party accounting firm. These include: Hillsboro and Oswego in Kansas, and Prague in Oklahoma.
- HMC has started new lines of services in their facilities, these include an OP Psych program at Drumright, genetic lab testing for medication effectiveness at Drumright and Prague, Sleep Lab at Horton and Pain Management Clinic at Hillsboro to name a few.

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED SCHEDULE – BALANCE SHEET INFORMATION
September 30, 2014

	Drumright	Fairfax	Haskell	Hillsboro	Horton	I-70	Lauderdale	Oswego	Prague	Selling	Washington	YadkinValley	HMC	Eliminations	Consolidated
ASSETS															
Current assets															
Cash and cash equivalents	\$ 921,389	\$ 16,818	\$ 42,810	\$ 20,895	\$ 20,360	\$ 22,047	\$ 17,606	\$ 17,330	\$ (8,233)	\$ 3,492	\$ 13,905	\$ 18,333	\$ 243,230	\$ -	\$ 1,349,802
Lockbox transfers	(174,284)	36,849	189,175	80,819	10,569	-	1,133	(506,730)	-	10,262	102,600	272,305	-	-	12,013,137
Patient accounts receivable, net	1,445,368	703,501	1,038,038	853,160	712,032	1,110,783	2,102,955	783,004	618,838	273,000	1,627,814	1,660,468	-	-	2,070,845
Inventory of supplies	160,260	226,751	251,853	216,871	185,071	110,882	209,237	79,355	110,376	42,982	259,901	183,255	-	-	2,424,148
Prepaid expenses	271,156	160,707	212,878	70,452	93,421	289,282	439,424	65,823	143,420	93,990	280,044	254,788	-	(8,040)	-
Due from (to) related party	3,314,703	150,839	2,140,290	1,234,648	1,957,795	(919,435)	2,765,377	3,136,330	635,650	(662,374)	(1,658,324)	1,233,635	(14,529,404)	-	-
Other receivables	-	305	-	-	52,939	-	-	2,824	-	-	-	-	-	-	68,117
Total current assets	5,977,690	1,375,559	3,881,772	2,498,375	3,038,347	1,151,588	5,838,742	3,972,819	1,541,054	(65,400)	1,095,049	3,025,014	(14,299,123)	-	18,814,047
Property and equipment, net	5,900,465	830,887	646,833	793,909	483,433	6,426,927	2,083,755	3,150,113	887,885	-	1,717,746	834,790	32,432	-	23,335,735
Assets limited as to use	145,000	-	-	-	-	-	-	-	-	-	-	-	1,000,000	-	1,145,000
Other assets	-	-	-	-	-	-	-	-	-	-	-	-	9,447,301	(9,447,301)	785,674
Investment in subsidiaries	444,354	-	-	-	-	183,164	35,133	-	-	-	-	-	123,833	-	786,474
Deferred financing cost, net	444,354	-	-	-	-	183,164	35,133	-	-	-	-	-	8,971,124	(8,447,301)	786,474
Total assets	\$ 12,476,409	\$ 2,006,226	\$ 4,528,595	\$ 3,292,283	\$ 3,481,630	\$ 7,793,349	\$ 7,854,611	\$ 6,770,632	\$ 2,408,919	\$ (65,400)	\$ 2,782,789	\$ 4,059,834	\$ (3,886,419)	\$ (9,447,301)	\$ 44,081,344
LIABILITIES AND STOCKHOLDERS' EQUITY (DEFICIT)															
Current liabilities															
Current maturities of long-term debt	\$ 382,858	\$ 158,854	\$ 83,277	\$ 108,255	\$ 164,132	\$ 870,899	\$ 850,055	\$ 121,100	\$ 44,846	\$ 16,164	\$ 441,833	\$ 123,577	\$ 1,674,534	\$ -	\$ 4,747,871
Deferred revenues-current portion	26,346	71,896	69,672	418,067	911,209	1,489,065	1,649,822	514,706	767,558	453,484	1,310,608	838,282	571,428	-	11,567,634
Accounts payable	890,841	678,665	1,138,067	418,067	911,209	1,489,065	1,649,822	514,706	767,558	453,484	1,310,608	838,282	571,428	-	11,567,634
Reorganization obligations-current portion	131,831	128,793	123,207	114,546	131,175	74,906	152,528	113,873	109,376	126,115	181,654	282,782	181,424	-	1,783,640
Estimated third-party settlements	970,905	331,732	733,888	80,776	(189,359)	(815,164)	(233,151)	565,355	(305,819)	177,999	(708,887)	1,039,355	48,829	-	1,227,000
Accrued expenses	575,715	478,513	464,667	445,056	575,852	803,673	1,348,693	325,400	483,276	209,635	981,150	709,956	48,829	-	7,537,910
Total current liabilities	2,984,497	1,842,083	2,629,096	1,779,732	1,623,447	2,668,703	2,932,871	1,637,234	1,076,557	1,084,337	2,485,068	2,906,583	2,977,808	-	27,888,802
Long-term debt, excluding current portion	7,000,221	110,799	79,401	269,500	609,224	10,540,533	3,467,744	482,128	81,982	-	3,084,784	234,065	11,848,918	-	38,590,294
Reorganization obligations, excluding current portion	150,028	25,075	48,643	12,979	43,723	3,748	62,724	12,017	6,226	3,078	503,759	788,670	18,429	-	1,269,195
Estimated third-party payor settlements	870,671	370,281	624,963	382,172	174,048	116,459	585,132	646,734	-	128,978	7,085	149,867	-	-	3,732,389
Deferred revenues	26,346	143,072	139,745	-	-	129,329	145,886	-	134,320	-	-	-	2,347,815	-	3,076,813
Total liabilities	11,432,263	2,491,901	3,420,747	1,824,289	2,450,440	13,456,799	7,192,257	2,778,113	1,279,065	1,214,454	5,380,884	4,148,185	17,195,069	-	74,285,384
Stockholders' equity (deficit)															
Member equity	2,871,455	1,385,263	1,640,858	1,308,602	870,280	1,000,000	887,380	204,838	1,695,289	148,000	1,254,058	-	22,656,861	(12,062,819)	22,656,861
Preferred stock	-	-	-	-	-	-	-	-	-	-	-	-	1,290,892	-	1,290,892
Common stock	(1,847,312)	(1,850,938)	(433,187)	155,392	161,820	(5,663,441)	(105,026)	3,788,183	(425,445)	(1,408,854)	(3,851,954)	(88,281)	(44,828,258)	3,265,518	(51,151,793)
Retained earnings	1,024,148	(885,673)	1,107,848	1,483,994	1,041,220	(5,663,441)	482,354	3,992,819	1,129,854	(1,260,854)	(2,597,806)	(89,381)	(20,891,505)	(9,447,301)	(20,204,040)
Total stockholders' equity (deficit)	1,024,148	(885,673)	1,107,848	1,483,994	1,041,220	(5,663,441)	482,354	3,992,819	1,129,854	(1,260,854)	(2,597,806)	(89,381)	(20,891,505)	(9,447,301)	(20,204,040)
Total liabilities and stockholders' equity (deficit)	\$ 12,476,409	\$ 2,006,226	\$ 4,528,595	\$ 3,292,283	\$ 3,481,630	\$ 7,793,349	\$ 7,854,611	\$ 6,770,632	\$ 2,408,919	\$ (65,400)	\$ 2,782,789	\$ 4,059,834	\$ (3,886,419)	\$ (9,447,301)	\$ 44,081,344

HMC/CAH CONSOLIDATED, INC.

CONSOLIDATED SCHEDULE - OPERATING INFORMATION
Year Ended September 30, 2014

	Overnight	Patina	Haskell	Hillsboro	Horizon	I-70	Lauderdale	Owens	Prairie	Belling	Washington	Yadkin/Valley	Consolidated Hospitals	HSC	Eliminations	Consolidated
Revenues																
Gross patient revenue	\$ 31,658,773	\$ 10,034,190	\$ 10,039,281	\$ 6,940,579	\$ 12,995,262	\$ 13,622,345	\$ 38,355,004	\$ 7,359,765	\$ 11,456,893	\$ 4,819,748	\$ 33,990,919	\$ 22,988,508	\$ 202,047,951	\$ -	\$ -	\$ 202,047,951
Contractual allowance	(11,906,643)	(4,348,084)	(10,741,280)	(2,238,393)	(5,375,293)	(4,703,743)	(20,221,499)	(2,708,570)	(3,095,707)	(1,243,770)	(18,244,256)	(10,723,493)	(97,773,794)	-	-	(97,773,794)
Charity care	(16,399)	(28,176)	(12,780)	(95,817)	(83,539)	(61,943)	(176,894)	(30,807)	(33,816)	(31,179)	(82,691)	(18,607)	(859,774)	-	-	(859,774)
Provision for bad debts	(1,023,652)	(695,201)	(1,111,009)	(145,854)	(879,078)	(1,037,211)	(3,835,253)	(120,560)	(720,973)	(374,723)	(2,569,672)	(1,023,833)	(13,707,181)	-	-	(15,792,181)
Net patient service revenue	8,620,679	4,702,722	7,174,167	4,169,748	6,528,348	7,709,530	15,112,479	4,641,028	5,008,840	3,167,077	12,597,294	5,225,225	66,421,202	-	-	66,421,202
Other operating revenue	74,187	24,784	38,599	\$2,721	154,894	73,771	319,742	47,838	26,375	47,367	94,547	98,335	1,041,918	871,802	(163,376)	1,459,344
Electronic health record incentive reimbursement	36,347	211,515	79,873	-	-	64,379	295,608	-	-	-	-	-	759,301	-	-	759,301
Total revenues	8,761,193	5,000,028	7,293,738	4,219,499	6,445,242	7,839,080	19,727,829	4,486,000	8,092,179	3,214,444	12,121,801	9,320,740	69,218,421	871,802	(163,376)	69,626,847
Expenses																
Salaries and wages	4,243,826	2,794,643	3,331,083	2,252,179	3,501,209	3,584,081	8,292,318	2,458,769	3,118,193	1,897,593	6,282,931	4,403,711	43,988,198	-	(163,376)	42,834,730
Payroll taxes and benefits	693,766	892,768	811,608	398,873	859,824	800,430	1,424,874	391,415	469,898	285,194	1,078,117	698,360	7,650,855	-	-	7,850,665
Supplies and other	1,838,703	895,399	1,578,384	843,284	1,399,923	1,309,146	2,920,885	828,000	1,055,470	678,309	2,117,480	1,400,944	16,163,844	176,430	-	18,336,274
Medical professionals	300	-	497,173	233,824	61,023	124,255	365,464	83,340	6,990	83,220	654,184	518,893	3,328,316	-	-	3,228,319
Purchased services	949,718	455,191	536,508	363,550	749,060	587,941	871,527	280,644	859,863	489,270	787,072	833,508	7,963,081	631,041	-	8,194,122
Management fees	1,035,000	615,099	618,095	589,599	770,004	822,927	1,416,996	813,000	883,191	519,999	1,275,000	891,669	4,761,498	-	-	4,227,766
Depreciation and amortization	748,284	200,982	170,833	87,468	342,682	817,148	189,070	140,012	134,569	39,830	497,287	282,193	4,337,728	-	-	3,262,378
Interest expense	858,882	89,129	88,773	195,863	69,532	879,683	309,272	122,557	19,170	81,363	364,043	101,959	2,675,059	807,319	-	2,675,059
Total expenses	9,622,137	5,046,714	7,293,538	4,632,235	7,333,367	8,738,992	14,545,499	4,765,830	6,170,659	3,073,151	12,347,084	8,461,204	64,660,317	1,313,789	(163,376)	65,616,731
Operating Income (loss)	(870,944)	(846,686)	(10,800)	(712,666)	(788,125)	(899,912)	1,182,330	(279,830)	(878,480)	(858,707)	(125,283)	(140,464)	(4,442,096)	(741,987)	-	(5,189,601)
Non-operating Income																
Investment income	2,187	175	300	6,895	44,668	1,678	618	83	429	120	833	259	59,583	85	-	59,651
Net Income (Loss)	\$ (868,757)	\$ (846,511)	\$ (10,500)	\$ (705,841)	\$ (743,457)	\$ (799,234)	\$ 1,182,801	\$ (277,101)	\$ (883,861)	\$ (758,587)	\$ (124,450)	\$ (140,185)	\$ (4,382,333)	\$ (741,902)	\$ -	\$ (5,131,233)

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 15

Section C, Orderly Development of Healthcare, Item 7 (d)

Most Recent Certification of Licensure with any deficiencies and
subsequent Action Plans

October 26, 2015

Tammie Hardy
Chief Executive Officer
CAH Acquisition Company 11, LLC
d/b/a Lauderdale Community Hospital
326 Asbury Ave
Ripley, TN 38063

Program: CAH
CCN: 441314
Survey Type: Medicare Recertification/DNV Reaccreditation
Certificate #: 188730-2015-AHC-USA-NIAHO
Survey Dates: July 28-29, 2015
Accreditation Decision: Full accreditation
Date Acceptable Plan of Correction Received: 9/24/2015
Method of Follow-up: Acceptable Plan of Correction,
Self- Attestation, Document Review
Effective Date of Accreditation: 8/1/2015
Expiration Date of Accreditation: 8/1/2018
Term of Accreditation: Three (3) years

Dear Ms. Hardy:

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, CAH Acquisition Company 11, LLC d/b/a Lauderdale Community Hospital is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485) and awarded full accreditation for a three (3) year term effective on the date referenced above. DNV GL Healthcare USA, Inc. is recommending your organization for continued deemed status in the Medicare Program.

This accreditation is applicable to all facilities operating under the above-referenced CCN number at the following address(es):

CAH Acquisition Company 11, LLC d/b/a Lauderdale Community Hospital - 326 Asbury Ave
- Ripley, TN 38063

This accreditation also encompasses the swing beds in place and CAH Acquisition Company 11, LLC d/b/a Lauderdale Community Hospital is deemed in compliance with the Medicare Conditions of Participation at 42 C.F.R §485.645 to meet the special requirements for CAH providers of long-term care services ("swing-beds").

This accreditation requires an annual survey and the organization's continual compliance with the DNVHC Accreditation Process. Failure to complete these actions or otherwise comply with your Management System Certification/Accreditation Agreement may result in a change in your organization's accreditation status.

Congratulations on this significant achievement.

Sincerely,



Patrick Horine
Chief Executive Officer
cc: CMS CO and CMS RO IV (Atlanta)

**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

Survey Date: July 28 - 29, 2015

**Survey type: NIAHO (CAH)(Reaccreditation) ISO
 Stage 2 (Compliance)**

Report Date: August 12, 2015

DNV GL Project #: PRJC-389121-2012-MSL-USA

CAP received date: August 21, 2015

Clarification request date: September 18, 2015 (due to DNV GL HC by September 25, 2015)

Updated CAP received date: September 22, 2015; Updated September 24, 2015

Objective Evidence for NC-1 non-conformance category finding(s) due: January 21, 2016
 (within 60 business days from date the client is notified via email of approval by DNV GL HC)

The Organization must complete the Corrective Action Plan in the section below marked "Organization Response"
 DNV GL- Healthcare Surveyors will follow-up on all corrective action plans during the next survey or as required if
 prior to next survey

Total Number of Nonconformities: 0 NC-1 Condition-level 8 NC-1 5 NC-2

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-1	Quality Management System ISO 9001 Quality Management System (Control of Documents)	<input type="checkbox"/> NC-1 Condition-level <input checked="" type="checkbox"/> NC-1 <input type="checkbox"/> NC-2	QM.2 (SR.3) / (SR.3a) ISO 9001:2008;4.2.3	485.641(b)

Requirement (Description):

SR.3 The organization will initiate and continue implementation of the ISO 9001 methodology to achieve compliance or certification as stated in QM.1. The organization will initiate a process to begin the implementation to address:

SR.3a Control of Documents: the organization's documents (i.e. policies, procedures, forms) are structured in a manner to ensure that only the proper revisions are available for use;

ISO 9001:2008;4.2.3 Control of documents

Documents required by the quality management system shall be controlled. Records are a special type of document and shall be controlled according to the requirements given in 4.2.4.

A documented procedure shall be established to define the controls needed

- a) to approve documents for adequacy prior to issue,*
- b) to review and update as necessary and re-approve documents,*
- c) to ensure that changes and the current revision status of documents are identified,*
- d) to ensure that relevant versions of applicable documents are available at points of use,*
- e) to ensure that documents remain legible and readily identifiable,*
- f) to ensure that documents of external origin determined by the organization to be necessary for the planning and operation of the quality management system are identified and their distribution controlled, and*
- g) to prevent the unintended use*

**Survey Report and
 Corrective Action Plan Submittal Form**



The requirement was NOT MET as evidenced by the following:

Please note this nonconformity remains open from the previous survey and has been elevated to an NC-1.

Finding #1

A review of the organization's current document control procedure/process revealed that the controls related to external documents have not been fully addressed and/or established. This deficiency is a "carry-over" from the previous survey.

Finding #2:

During the survey process, some policies were found to be out of compliance with the organization's current document control procedure/process:

1. Emergency Department *Plan of Care* form: Does not include revision date or form number to reference if need to edit form.
2. Medical-Surgical unit: Crash cart had two different versions of the Broselow pediatric tape (version 2007 Edition B and version 2011 Edition A).
3. Hospital is using old version of the CMS "Important Message from Medicare" notice (Form #5201.5; Rev. 3/2010). Hospital staff was not aware of new version available (Form: CMS-R-193; Approved 7/2010) which includes a section to document the time when the patient signs and dates form.
4. The Blueprint for Quality and Patient Safety 2015 did not follow the same format as other policies.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Did not have a full understanding of what the external documents were; therefore, could not address or establish controls.

#2 a. Policies were found out of compliance /without consistency. New form was not created with form number and was not updated with revision number as required.

#2 b. The 2007 Broselow pediatric tape was on the pediatric crash cart in addition to the newest version of 2011. Use of old materials in training was cause of accidental placement of old materials back into cart.

#2 c. "Important Message from Medicare" notice was old version, 3/2010. Hospital staff was not aware of new version available due to being under new management and not having support from the large company anymore. LCH staff was responsible to obtain own information and all reference links had not been set up at that time.

#2 d. The Blueprint for Quality and Patient Safety 2015 was formatted incorrectly for the manual by the prior Quality personnel.

Organization Corrective Action Plan (CAP): #1 New Quality personnel has researched external documents and now better understands definition. Policy on Control of Records and Documents describes our external documents, replacement and/or retention of those documents. This will be communicated at upcoming employee meetings/forums.

#2 a. Policies were found out of compliance /without consistency. ED POC form will include a form number and a revision date going forward to comply with policy and regulations.

#2 b. The 2007 Broselow pediatric tape was disposed of at the time of the survey. Policy will be followed going forward to dispose of old documents when replacing with new documents, according to retention policy and control of records.

#2 c. "Important Message from Medicare" notice has been replaced with the most recent approved version, 7/2010, to document time. Registration and admission clerks/personnel are being trained/educated on completion of the newest form.

#2 d. The Blueprint for Quality and Patient Safety 2015 has now been put into policy format and includes newest available information for quality management program.

Person/Function responsible for implementation of Corrective Action Plan:	Michelle Simpson, Heather Fowlkes, Cheryl Manns Quality Educator HIM Director
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Monthly Multidisciplinary Policy Review Council (MPRC) to review all forms prior to going to MSQI to ensure form #/revision#; Monthly review of websites by quality to ensure all new data is available as soon as possible. Develop indicator on Quality data to check off this monthly action. Old documents to be disposed of as new documents arrive to replace as per record retention guidelines/policy/matrix.

DNV GL- HEALTHCARE USE ONLY

CAP accepted date: 9/15/15	DNV GL reviewer: jlds
Clarification requested date:	DNV GL reviewer:

**Survey Report and
 Corrective Action Plan Submittal Form**



Clarification request:

Date CAP verified effective/closed:

DNV GL reviewer:

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- **Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.**
- **High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.**

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

General instructions:

Provide performance measure(s) data, findings, results of internal reviews (internal audits), or other supporting documentation, including timelines to verify implementation of the corrective action measure(s). Documentation should also include, **as applicable:**

- Policy name and number / version, approval date & approved by
- Date education completed, % of education completed, plans for staff who did not complete education, including current staff, new hires and plans for ongoing competency
- Internal Audit (IA): objective evidence should reference the audit schedule including the cycle or time period for which it covers (i.e. 2015, 2015-2016, etc.), audit titles or key processes covered, date(s) audits were conducted, date(s) IA findings were addressed/followed up, CAP validation date, etc.
- Management Review: meeting dates, summarized information that addresses the inputs and outputs as required

Providing dates, internal file titles and numbers (i.e. policy number, form number, etc.), and titles of those involved in the implementation are key. The objective evidence submitted should allow for an auditor to trace the corrective action with enough specificity at the next onsite survey activity and provide performance measure(s) data, findings, and results of IA to attest to implementation of the corrective action.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC - date on page 11.

**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-2	Quality Management System ISO 9001 Quality Management System (Control of Records)	<input type="checkbox"/> NC-1 Condition-level <input checked="" type="checkbox"/> NC-1 <input type="checkbox"/> NC-2	QM.2 (SR.3) / (SR.3b) ISO 9001:2008;4.2.4	485.641(b)

Requirement (Description):

SR.3 The organization will initiate and continue implementation of the ISO 9001 methodology to achieve compliance or certification as stated in QM.1. The organization will initiate a process to begin the implementation to address:

SR.3b Control of Records: the organization ensures that suitable records are maintained for the CoP and NIAHO® requirements;

ISO 9001:2008;4.2.4 Control of records

*Records established to provide evidence of conformity to requirements and of the effective operation of the quality management system shall be controlled.
 The organization shall establish a documented procedure to define the controls needed for the identification, storage, protection, retrieval, retention and disposition of records.
 Records shall remain legible, readily identifiable and retrievable.*

The requirement was NOT MET as evidenced by the following:

Please note that this nonconformity remains open from the previous survey and has been elevated to an NC-1.

The organization has a record control procedure and matrix; however, it does not adequately address the controls needed for identification, storage, protection, and retrieval of records. In addition, the matrix does not encompass all of the "ISO" specific records that must be controlled. For example, the records related to internal audits and corrective actions are not addressed in the organization's record control matrix.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: We have a record retention matrix that does not address internal audits and corrective actions. Internal audits were just implemented this year.

Organization Corrective Action Plan (CAP): We will correct our record retention matrix and add verbiage to the control of records and documents policy.

Person/Function responsible for implementation of Corrective Action Plan:	Cheryl Manns, HIM, Risk manager	Michelle Simpson CNO/Quality
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015	
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	The Control of Records and Documents policy and record retention matrix will go before MPRC (Multidisciplinary Policy Review Council) annually for update and revisions.	

DNV GL- HEALTHCARE USE ONLY

CAP accepted date:	DNV GL reviewer:
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:
DNV GL final follow-up and closure of NC:	

150

Survey Report and Corrective Action Plan Submittal Form



DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- **Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.**
- **High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.**

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 1.

151
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-3	Quality Management System System Requirements	<input type="checkbox"/> NC-1 Condition-level <input checked="" type="checkbox"/> NC-1 <input type="checkbox"/> NC-2	QM.6 (SR.2) / (SR.3) <i>ISO 9001:2008;4.2.1</i> <i>ISO 9001:2008;4.2.2</i>	

Requirement (Description):

In establishing the Quality Management System, the CAH shall be required to have the following as a part of this system:

- SR.2 Written document defining the scope of the Quality Management System, to include all clinical and non-clinical services;
- SR.3 Statement of the Quality Policy;

ISO 9001:2008;4.2.1 General

The quality management system documentation shall include

- a) documented statements of a quality policy and quality objectives,
- b) a quality manual,
- c) documented procedures and records required by this International Standard, and
- d) documents, including records, determined by the organization to be necessary to ensure the effective planning, operation and control of its processes.

ISO 9001:2008;4.2.2 Quality manual

The organization shall establish and maintain a quality manual that includes

- a) the scope of the quality management system, including details of and justification for any exclusions (see 1.2),
- b) the documented procedures established for the quality management system, or reference to them, and
- c) a description of the interaction between the processes of the quality management system.

The requirement was NOT MET as evidenced by the following:

Please note that this nonconformity remains open from the previous survey and has been elevated to an NC-1.

The organization's current quality manual, "The Blueprint for Quality and Patient Safety 2015", does not adequately address or include all of the above listed required elements of a compliant quality manual. Specifically, the document does not address ISO exclusions i.e. 7.3 Design and Development.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: Limited understanding of quality management system by the new Quality staff.

Organization Corrective Action Plan (CAP): "The Blueprint for Quality and Patient Safety 2015" has been updated to include correct policy formatting, a commitment to comply with all regulations, and exclusions as well as documented procedures for non-conforming products, control of records and nursing policies.

Person/Function responsible for implementation of Corrective Action Plan: Michelle Simpson, Quality

Date for implementation of Corrective Action Plan: (generally within 60 days)
~~October 11, 2015~~
 UPDATE 9/22/2015 mns - September 27, 2015

Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)
 The Quality Policy management will go through MPRC (Multidisciplinary Policy Review Council) annually with discussion of measures of effectiveness at Quality meeting annually.

152
**Survey Report and
 Corrective Action Plan Submittal Form**



DNV GL- HEALTHCARE USE ONLY	
CAP accepted date: 9/15/15	DNV GL reviewer: jlds
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:
DNV GL final follow-up and closure of NC:	
<p>DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:</p> <ul style="list-style-type: none"> - Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved. - High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance. <p>This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.</p>	
OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE	
<p>General instructions:</p> <p>See instructions under NC-1-1 above.</p> <p>DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any <u>specific</u> policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.</p>	
Submitted by:	
Submission date:	
Objective evidence summary:	
<p>Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC - date on page 11.</p>	

153
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-4	Anesthesia Services Policies and Procedures	<input type="checkbox"/> NC-1 Condition-level <input checked="" type="checkbox"/> NC-1 <input type="checkbox"/> NC-2	AS.3 (SR.1) / (SR.2) / (SR.2a) / (SR.2c) / (SR.2c(1)) <i>ISO 9001:2008;7.5.1</i> <i>ISO 9001:2008;8.2.3</i>	485.639(b) 485.639(b)(1) 485.639(b)(2)

Requirement (Description):

AS.3 POLICIES AND PROCEDURES

SR.1 Policies on anesthesia/sedation procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities.

SR.2 The policies must ensure that the following are provided for each patient:

SR.2a a pre-anesthesia or pre-sedation evaluation must be performed for each patient who will receive general, regional or monitored anesthesia. Patients who will be receiving moderate sedation must be monitored and evaluated before, during and after a procedure by a trained practitioner, however a pre anesthesia evaluation is not required because moderate sedation is not considered to be "anesthesia" and is not subject to this requirement. This evaluation will include a documented airway assessment, anesthesia risk assessment, and anesthesia drug and allergy history, by an individual qualified and privileged to administer anesthesia/sedation, immediately before or procedure requiring anesthesia services

SR.2c for inpatient or outpatient surgery, a post-anesthesia evaluation for proper anesthesia recovery is completed and documented within 48 hours after surgery or prior to discharge if less than 48 hours by the individual who administers the anesthesia or, if approved by the medical staff, by any individual qualified and credentialed to administer anesthesia or as identified in AS.2 SR.3;

SR.2c(1) A post-anesthesia evaluation for anesthesia recovery is required each patient who will receive general, regional or monitored anesthesia. Patients who will be receiving moderate sedation must be monitored and evaluated before, during and after a procedure by a trained practitioner, however, a post-anesthesia evaluation is not required because moderate sedation is not considered to be "anesthesia" and is not subject to this requirement. This evaluation must be completed in accordance with State law and CAH policies and procedures approved by the medical staff and reflect current standards of care.

Interpretive Guidelines:

Pre-anesthesia evaluation:

In accordance with current standards of anesthesia care, the pre-anesthesia evaluation of the patient includes, at a minimum:

- Review of the medical history, including anesthesia, drug and allergy history;*
- Interview and examination of the patient;*
- Notation of anesthesia risk according to established standards of practice (e.g. ASA classification of risk);*
- Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);*
- Additional pre-anesthesia evaluation, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation);*

Survey Report and Corrective Action Plan Submittal Form



Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.

Post-anesthesia evaluation:

A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The evaluation is required any time general, regional, or monitored anesthesia has been administered to the patient. While current practice dictates that the patient receiving moderate (conscious) sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, a post-anesthesia evaluation is not required.

The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area. Except in cases where post-operative sedation is necessary for the optimum medical care of the patient (e.g., ICU), the evaluation generally would not be performed immediately at the point of movement from the operative area to the designated recovery area. Accepted standards of anesthesia care indicate that the evaluation may not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc. The evaluation can occur in the PACU/ICU or other designated recovery location. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge. The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:

Respiratory function, including respiratory rate, airway patency, and oxygen saturation;

Cardiovascular function, including pulse rate and blood pressure;

Mental status;

Temperature;

Pain;

Nausea and vomiting; and

Postoperative hydration.

Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

ISO 9001:2008;7.5.1 Control of production and service provision

The organization shall plan and carry out production and service provision under controlled conditions.

Controlled conditions shall include, as applicable,

a) the availability of information that describes the characteristics of the product,

b) the availability of work instructions, as necessary,

c) the use of suitable equipment,

d) the availability and use of monitoring and measuring equipment,

e) the implementation of monitoring and measurement, and

f) the implementation of product release, delivery and post-delivery activities.

ISO 9001:2008;8.2.3 Monitoring and measurement of processes

The organization shall apply suitable methods for monitoring and, where applicable, measurement of the quality management system processes. These methods shall demonstrate the ability of the processes to achieve planned results. When planned results are not achieved, correction and corrective action shall be taken, as appropriate.

NOTE: When determining suitable methods, it is advisable that the organization consider the type and extent of monitoring or measurement appropriate to each of its processes in relation to their impact on the conformity to product requirements and on the effectiveness of the quality management system.

155
**Survey Report and
 Corrective Action Plan Submittal Form**



The requirement was NOT MET as evidenced by the following:

In four (4) of four (4) medical records reviewed related to the pre- and post-anesthesia evaluation, the following was identified:

Finding #1: Pre-Anesthesia Evaluation (1 of 4 records reviewed)
 MR#13: The pre-anesthesia evaluation lacked documentation of the anesthesia history.

Finding #2: Post-Anesthesia Evaluation (4 of 4 records reviewed)
 MR#10, #11, #12 & #13: The post-anesthesia evaluation lacked documentation of the hydration status.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Anesthesia history has all points available to cover on form; however, the CRNA missed a couple of items that could have been pertinent to the history.
 #2 Hydration status was not listed on the anesthesia record and therefore, inadvertently missed as an assessment.

Organization Corrective Action Plan (CAP): Anesthesia staff will be trained by surgery supervisor to address all pertinent findings in history.

#2 Hydration status has been added the to form# 5119.1, revised 7/15;

Person/Function responsible for implementation of Corrective Action Plan:	Denise Nichols, Surgery supervisor
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Anesthesia history and hydration status will be monitored for completion by surgery staff on a monthly basis on Quality to ensure sustained compliance with 100% history/hydration status.

DNV GL- HEALTHCARE USE ONLY

CAP accepted date: 9/15/15	DNV GL reviewer: jlds
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- **Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.**
- **High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.**

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such

156
**Survey Report and
Corrective Action Plan Submittal Form**



document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC - date on page 14.

157
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-5	Patient Rights Specific Rights	<input type="checkbox"/> NC-1 Condition-level <input checked="" type="checkbox"/> NC-1 <input type="checkbox"/> NC-2	PR.1 (SR.1) ISO 9001:2008;7.2.1	

Requirement (Description):

PR.1 SPECIFIC RIGHTS

The CAH shall inform, whenever possible, each patient and/or legal representative of the patient's rights in advance of providing or discontinuing care. The written listing of these rights shall be provided to the patient and /or family and shall include policies and procedures that address the following:

SR.1 Beneficiary Notice of non-coverage and right to appeal premature discharge;

ISO 9001:2008;7.2.1 Determination of requirements related to the product

The organization shall determine

- a) requirements specified by the customer, including the requirements for delivery and post-delivery activities,
- b) requirements not stated by the customer but necessary for specified or intended use, where known,
- c) statutory and regulatory requirements applicable to the product, and
- d) any additional requirements considered necessary by the organization.

NOTE: Post-delivery activities include, for example, actions under warranty provisions, contractual obligations such as maintenance services, and supplementary services such as recycling or final disposal.

**200.3 - Notifying Beneficiaries of their Right to an Expedited Review
 (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)**

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use a revised version of the Important Message from Medicare (IM) a statutorily-required notice, to explain the beneficiary's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than 2 calendar days before discharge.

**200.3.2 - The Follow-Up Copy of the Signed Important Message from Medicare
 (Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)**

A "follow-up" copy of the signed IM must be delivered to the beneficiary using the following guidelines:

Delivery Timeframe. The follow-up copy must be delivered as far in advance of discharge as possible, but no more than 2 calendar days before the planned date of discharge. Thus, when discharge seems likely within 1- 2 calendar days, hospitals should make arrangements to deliver the follow-up copy of the notice, so that the beneficiary has a meaningful opportunity to act on it. However, when discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge, if necessary. If the follow-up copy of the notice must be delivered on the day of discharge, hospitals must give beneficiaries who need it at least 4 hours to consider their right to request a QIO review. Beneficiaries may choose to leave prior to that time; however, hospitals must not pressure a beneficiary to leave during that time period. If the hospital delivers the follow-up copy, and the beneficiary status subsequently changes, so that the discharge is beyond the 2-day timeframe, hospitals must deliver another copy of the signed notice again within 2 calendar days of the new planned discharge date. Hospitals may not develop procedures for delivery of the follow up copy routinely on the day of discharge.

Beneficiary Signature and Date. The IM must be signed and dated by the beneficiary to indicate that he or she has received the notice and can comprehend its contents, unless an appropriate reason for the lack of signature is recorded on the IM, such as a properly annotated signature refusal.

**Survey Report and
Corrective Action Plan Submittal Form**



Alternative to Delivery of the Signed Copy. A hospital may choose to deliver a new copy of the IM (not a copy of the signed IM) during the required timeframes; however, the hospital must obtain the beneficiary's or representative's signature and date on the notice again at that time.

Exception to Delivery of the Follow-Up Copy. If delivery of the original IM is within 2 calendar days of the date of discharge, no follow-up notice is required. For example, if a beneficiary is admitted on Monday, the IM is delivered on Wednesday and the beneficiary is discharged on Friday, no follow-up notice is required.

If a beneficiary receives and signs the initial copy of the IM as part of the preadmission process, the follow-up copy of the notice must be delivered if delivery of the initial copy occurred more than 2 calendar days prior.

Documentation. Hospitals must document timely delivery of the follow-up copy of the IM in the patient records, when applicable. Hospitals are responsible for demonstrating compliance with this requirement. If hospitals have processes in place to document delivery of other information related to discharge that includes a beneficiary signature and date, hospitals may include the follow-up copy of the notice in those documents. If there are no other existing processes in place, hospitals may use the "Additional Information" section of the IM to document delivery of the follow-up copy, for example, by adding a line for the beneficiary's or representative's initials and date.

Reference: Medicare Claims Processing Manual, Chapter 30 - Financial Liability Protections (Rev. 2878, 02-21-14).

The requirement was NOT MET as evidenced by the following:

Finding #1: Medical Records

In seven (7) of seven (7) medical records reviewed related documentation of the beneficiary notice of non-coverage and right to appeal premature discharge ("Important Message from Medicare"), the following were identified:

- a. MR#6 & #7: Open records, patients > 65 years of age, inpatient status: Unable to locate *initial* beneficiary notice in the medical record.
- b. MR#4, #6, #7, #9, #15 & #17: Closed record, patient 82 years old, inpatient status: Unable to locate discharge notice in the medical record.
- c. MR #9: Admitted to observation status on 7/22/2015, then to inpatient status on 7/24/2015. Initial beneficiary notice was signed and dated for 7/29/2015 (record was reviewed on 7/28/2015). Either date was > within 2 days of admission.
- d. MR #18: Notice presented was dated on day of discharge. However, not signed (or timed) by patient.

Finding #2: CMS Beneficiary Notice Form

It was identified that the hospital has been utilizing an outdated beneficiary notice for patients to sign and date. The old form (CMS Form #5201.5; dated 3/2010) does not have a section to document the *time* when the patient signs and dates form to acknowledge having received the notice. The updated form has a revision date of 7/2010. Since the time was not documented when the patient signed the form, surveyor is unable to determine whether the hospital met the required time frame to inform the patient of their beneficiary notice of non-coverage and right to appeal a premature discharge.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 No consistent method of checks were being performed to ensure beneficiary notice was in the record and consistently being signed within 2 days of discharge.
#2 "Important Message from Medicare" notice was old version, 3/2010. Hospital staff was not aware of new version available.

Organization Corrective Action Plan (CAP): #1 Case management will be responsible for maintaining a new form (QI.F.001.00) to monitor "Important Message" and "Advance Directives" to ensure signage at admission, initiated by registration clerks, and before discharge and if follow-up is required. We also will revise our process to have observation patients sign the important Message to Medicare Patients in an effort to not miss weekend patients and those patients changed from observation to inpatient.

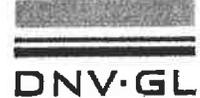
#2 "Important Message from Medicare" notice has been replaced with the most recent approved version, 7/2010, to document time. Director has signed up to receive e-alerts from the CMS website. Registration and admission clerks/personnel are being trained/educated on completion of the newest form.

**Survey Report and
 Corrective Action Plan Submittal Form**



Person/Function responsible for implementation of Corrective Action Plan:	Michelle Simpson, Judy King, Denise Nichols, Cheryl Manns CNO/Quality Case Mgmt, Case Mgmt, HIM Director
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Monthly UR meetings to monitor utilization review in addition to meeting requirements of new form with Important Message (IM) and Adv.Directives (AD). Quality data will be entered monthly for number of IM and AD.
DNV GL- HEALTHCARE USE ONLY	
CAP accepted date: 9/17/15	DNV GL reviewer: P. Horine
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:
DNV GL final follow-up and closure of NC:	
<p>DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:</p> <ul style="list-style-type: none"> - Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved. - High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance. <p>This information is to be submitted to DNV Healthcare via <u>DNVClientDropBox@dnvgl.com</u> within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.</p>	
OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE	
<p><i>General instructions:</i></p> <p>See instructions under NC-1-1 above.</p> <p>DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any <u>specific</u> policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.</p>	
Submitted by:	
Submission date:	
Objective evidence summary:	
<p><i>Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via <u>DNVClientDropBox@dnvgl.com</u> within 60 business days from the date client is notified of approval by DNV GL HC – date on page 11</i></p>	

160
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-6	Patient Rights Specific Rights (Pain Management)	<input type="checkbox"/> NC-1 Condition-level <input checked="" type="checkbox"/> NC-1 <input type="checkbox"/> NC-2	PR.1 (SR.11) <i>ISO 9001:2008;7.2.1</i>	

Requirement (Description):

PR.1 SPECIFIC RIGHTS

The CAH shall inform, whenever possible, each patient and/or legal representative of the patient's rights in advance of providing or discontinuing care. The written listing of these rights shall be provided to the patient and /or family and shall include policies and procedures that address the following:

SR.11 Pain Management

ISO 9001:2008; 7.2.1 Determination of requirements related to the product

The organization shall determine

- a) requirements specified by the customer, including the requirements for delivery and post-delivery activities,*
- b) requirements not stated by the customer but necessary for specified or intended use, where known,*
- c) statutory and regulatory requirements applicable to the product, and*
- d) any additional requirements considered necessary by the organization.*

The requirement was NOT MET as evidenced by the following:

Finding #1: Hospital Policy

Per hospital policy, the pain goal is to be developed related to patient's ability to function and activities of daily living. There is a section in the electronic medical record to document this. Hospital policy is not being following related to this requirement (see MR #1, #2, #3, #4, #6, #7 & #20).

Reference: Lauderdale Community Hospital policy #PC.S.015.05, "Pain Management," Revised 3/2015

Finding #2: Medical Records

In seven (7) of seven (7) medical records reviewed related to pain management, the following was identified:

- a. MR #1: Patient presented with chest pain and stated pain level at "5" (0-10 numeric scale). Nurses interviewed stated that pain reassessment occurs within one hour *after* pain intervention. Patient was medicated at 0420 and 0434. Pain was reassessed greater than one hour after intervention at 0555.
- b. MR #6: 7/28/2015 at 0855- Patient was medicated for pain. No pain assessment was documented prior to intervention
- c. MR #20: 9/25/2015 at 1637- Patient was medicated for pain. No documentation of pain assessment *prior* to or pain reassessment *after* intervention.

Hospital policy does not address a certain time frame for pain reassessment after an intervention. However, each nurse who was interviewed articulated that reassessment occurs within one hour *after* an intervention.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Pain goal is not being documented in the EMR per hospital policy. Nursing inadvertently skips this at times due to not having a "hard stop" which requires this to be documented.
 #2 Nurses are not documenting pain assessment and reassessment consistently due to not having a "hard stop" to document prior to and after pain medications. There is a way to document this in the EMR, but this "Action Queue" is also used by so many other processes that it does not indicate which event needs documenting or doing without going through a long process.

Organization Corrective Action Plan (CAP): #1 EMR provider is going to be contacted to see if they can produce a

161
**Survey Report and
 Corrective Action Plan Submittal Form**



<p>"hard stop" on the pain goal to ensure consistency in evaluating the goal of pain for a patient. Education will be provided to the nursing staff. If no improvement in documentation, will implement pain assess/reassess form in paper version. #2 Nurses will be re-educated during upcoming staff meetings to document pain assessment and reassessment and an attempt will be made to require a reassessment for "effectiveness of medication" in the EMR. If no improvement in documentation, will implement pain assess/reassess form in paper version.</p>	
Person/Function responsible for implementation of Corrective Action Plan:	Heather Fowlkes, Cassandra Williams Judy King RN Specialist/Educator Nurse Manager MS supv
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Pain assessment and reassessment will be reviewed and educated to nursing staff during staff meetings on Aug 30, sept 1-3. ED Nurse Manager and Clinical Educator will review records for next 2 months to indicate whether training has been effective in pain assessment and reassessment. If no improvement in documentation, will implement pain assess/reassess form in paper version.
DNV GL- HEALTHCARE USE ONLY	
CAP accepted date: 9/15/15	DNV GL reviewer: jlds DNV GL NOTE: The policy revision is not outlined in the corrective action submitted and needs to be part of the internal CAP. This will be reviewed in detail at the next on site survey. "Hospital policy does not address a certain time frame for pain reassessment after an intervention. However, each nurse who was interviewed articulated that reassessment occurs within one hour <i>after</i> an intervention."
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:
DNV GL final follow-up and closure of NC:	
<p>DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:</p> <ul style="list-style-type: none"> - Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved. - High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance. <p>This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.</p>	
OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE	
<p>General instructions: See instructions under NC-1-1 above.</p> <p>DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does</p>	

**Survey Report and
Corrective Action Plan Submittal Form**



not approve or endorse the use of any *specific* policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC - date on page 14.

163
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-7	Patient Rights Advance Directives	<input type="checkbox"/> NC-1 Condition-level <input checked="" type="checkbox"/> NC-1 <input type="checkbox"/> NC-2	PR.2 (SR.1) / (SR.5) ISO 9001:2008;7.5.1	

Requirement (Description):

PR.2 ADVANCE DIRECTIVE

The CAH must allow the patient to formulate advance directives and to have CAH staff and practitioners comply with the advance directives in accordance with Federal and State law, rules and regulations.

- SR.1 The CAH shall document in the patient's medical record whether or not the patient has executed an advance directive.
- SR.5 When the advance directive exists and is not in the patient's medical record, a written policy for follow-up and compliance shall exist.

Interpretive Guidelines:

The CAH must document in a prominent part of the patient's medical record whether or not the patient has executed an advance directive.

The CAH must not condition the provision of care or otherwise discriminate against an individual on the basis of whether or not the patient has executed an advance directive.

The CAH must ensure compliance with State law regarding the provision of an advance directive and inform individuals that complaints concerning the advance directive requirements may be filed with the State survey agency and this accreditation body.

When the advance directive exists and is not in the patient's medical record, a written policy must be in place to address the follow-up and compliance. When necessary, the CAH will take the appropriate steps to secure a copy of the patient's advance directives.

ISO 9001:2008;7.5.1 Control of production and service provision

The organization shall plan and carry out production and service provision under controlled conditions. Controlled conditions shall include, as applicable,

- a) the availability of information that describes the characteristics of the product,*
- b) the availability of work instructions, as necessary,*
- c) the use of suitable equipment,*
- d) the availability and use of monitoring and measuring equipment,*
- e) the implementation of monitoring and measurement, and*
- f) the implementation of product release, delivery and post-delivery activities.*

The requirement was NOT MET as evidenced by the following:

Finding #1: Hospital Policy

Hospital policy does not address or outline the follow-up and compliance process per standards. Nurses were unable to articulate the process to follow when patients indicate that they have an advance directive but is not with them upon presentation to hospital.

Reference: Lauderdale Community Hospital, "Advance Directive," Reviewed 10/2014

Finding #2: Medical Records

In four (4) of six (6) medical records reviewed related to the advance directives process, the following was identified:

**Survey Report and
 Corrective Action Plan Submittal Form**



- a. MR#2: Patient and Registrar signed and dated the "Patient Self-Determination Form" but did not complete the information required. Unable to determine whether he or she was in possession of an advance directive.
- b. MR#4, #6: Patient was admitted on 7/10/2015 and 7/23/2015, respectively. Upon admission, it was documented that the patient had an advance directive but was not brought to the hospital. The staff requested the family to bring in a copy of the advance directive. However, there was no further documentation of attempts to secure a copy for the medical record by the date record was reviewed (on 7/28/2015).
- c. MR #9: It was documented upon admission that the patient had a copy of their advance directive "on file." However, unable to locate a copy in the medical record.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Hospital policy does not address follow-up on advance directives.
 #2 Nursing relies on clerks to ask for advance directives and obtain a copy if required. No follow-up for placement of advanced directives (AD) copy has been educated to the nurses one on one; therefore, there was inconsistent documentation of follow-up.

Organization Corrective Action Plan (CAP): #1 Hospital policy will be revised to include follow up process on AD.
 #2: Clerks will be educated to input "priority note" on pt notes sidebar to obtain AD. Charge nurses are to be educated to follow up on placement of AD copy to chart and document efforts in chart. We have a new form that case management will own (#QLF.001.00) that has a check-box to follow up on AD and check if AD copy is in the chart.

Person/Function responsible for implementation of Corrective Action Plan:	Cassandra Williams, Judy King, Denise Nichols, Heather Fowlkes Nurse manager Case mgmt Case mgmt Clinical Educator
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Monthly UR meetings to monitor utilization review In addition to meeting requirements of new form with Important Message (IM) and Adv.Directives (AD). Chart review of quality data will be entered monthly for number of IM and AD.

DNV GL- HEALTHCARE USE ONLY

CAP accepted date: 9/15/15	DNV GL reviewer: jlds DNV GL NOTE: The education for the policy revision is not outlined in the corrective action submitted and needs to be part of the internal CAP. This will be reviewed in detail at the next on site survey.
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Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- **Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.**
- **High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.**

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

165
**Survey Report and
Corrective Action Plan Submittal Form**



General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any *specific* policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL HC – date on page 11.

166
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-8	Physical Environment Life Safety Management	<input type="checkbox"/> NC-1 Condition-level <input checked="" type="checkbox"/> NC-1 <input type="checkbox"/> NC-2	PE.2 (SR.1) / (SR.3) / (SR.3a-3h) / (SR.6) / (SR.6a(1)) / (SR.8) PE.1 (SR.3) / (SR.4) <i>NFPA 13-1999;6-1.1.5,A-1.1.5</i> <i>NFPA 25-1998;3-3.1.1</i> <i>NFPA 72-1999;7-3.2</i> <i>NFPA 80-1999;19.4</i> <i>NFPA 90A-1999;3-4.7</i> <i>NFPA 101-2000;7.9.3,7.2.1.1.1,7.2.1.1.2,7.2.1.5.1,7.2.1.7.1,7.2.1.7.2,7.2.1.7.3,8.2.3.2.4.2,19.2.1</i> <i>ISO 9001:2008;6.3</i> <i>ISO 9001:2008;6.4</i>	485.623(d)(1)(i)

Requirement (Description):

PE.2 LIFE SAFETY MANAGEMENT

SR.1 The CAH shall meet the applicable provisions of the 2000 edition of the Life Safety Code® of the National Fire Protection Association.

SR.3 The CAH must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with firefighting and emergency management authorities; including training of staff in the following areas:

The fire control plan shall provide for the following (NFPA 101-2000, 18.7.2.2 & 19.7.2.2):

- SR.3a Use of alarms
- SR.3b Transmission of alarm to fire department
- SR.3c Response to alarms
- SR.3d Isolation of fire
- SR.3e Evacuation of immediate area
- SR.3f Evacuation of smoke compartment
- SR.3g Preparation of floors and building for evacuation
- SR.3h Extinguishment of fire

SR.6 Health care occupancies shall conduct unannounced fire drills, but not less than one (1) drill per shift per calendar quarter that transmits a fire alarm signal and simulates an emergency fire condition. When fire drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. (NFPA 101-2000, 18.7.1.2. & 19.7.1.2). False alarms may be used (up to 50% of total drills) if all elements of the fire plan are exercised.

Business occupancies shall conduct at least one unannounced fire drill annually per shift.

SR.6a Fire drills must be thoroughly documented and evaluate the CAH's knowledge to the items listed in PE.2, SR.3

SR.6a(1) At least annually, the CAH shall evaluate the effectiveness of the fire drills, The report of effectiveness shall be forwarded to Quality Management oversight

**Survey Report and
Corrective Action Plan Submittal Form**



SR.8 The CAH shall require that Life Safety systems (e.g., fire suppression, notification, and detection equipment) shall be tested and inspected (including portable systems).

PE.1 FACILITY

The facility shall be constructed, arranged, and maintained to ensure patient safety, and to provide adequate space and will be appropriate for the services provided.

SR.3 The CAH shall have a process in place, as required and/or recommended by local, State, and national authorities or related professional CAHs, to maintain a safe environment for the CAH's patients, staff, and others.

SR.4 The CAH shall have a written policies and procedures to define how unfavorable occurrences, incidents, or impairments in the facility's infrastructure, Life Safety, Safety, Security, Hazardous Material/Waste, Emergency, Medical Equipment, and Utilities Management are prevented, controlled, investigated, and reported throughout the CAH.

Finding #3

NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection

Systems, 1998 Edition 3-3.1.1 A flow test shall be conducted at the hydraulically most remote hose connection of each zone of a standpipe system to verify the water supply still adequately provides the designed pressure at the required flow. Where a flow test of the hydraulically most remote outlet(s) is not practical, the authority having jurisdiction shall be consulted for the appropriate location for the test. A flow test shall be conducted every 5 years.

Finding #4

NFPA 72, National Fire Alarm Code, 1999 Edition 7-3.2 Testing. Testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. If automatic testing is performed at least weekly by a remotely monitored fire alarm control unit specifically listed for the application, the manual testing frequency shall be permitted to be extended to annual. Table 7-3.2 shall apply.

Finding #6

NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 1999 Edition 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary.

Surveyor Note: Per CMMS S & C Memo 10-04-LSC a hospital may elect to inspect dampers in healthcare occupancies every 6 years in accordance with the 2007 edition of NFPA 80 and NFPA 105.

NFPA 80, Standard for Fire Doors and Other Opening Protections 19.4 Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.

Finding #7

NFPA 101, Life Safety Code, 2000 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1½ hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

Finding #8

NFPA 101, Life Safety Code-2000 Edition 7.2.1.1.1 A door assembly in a means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.1. Such an assembly shall be designated as a door.

7.2.1.1.2 Every door and every principal entrance that is required to serve as an exit shall be designed and constructed so that the path of egress travel is obvious and direct. Windows that, because of their physical configuration or design and the materials used in their construction, have the potential to be mistaken for doors shall be made inaccessible to the occupants by barriers or railings.

7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is

168
**Survey Report and
Corrective Action Plan Submittal Form**



occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.

7.2.1.7.1 Where a door is required to be equipped with panic or fire exit hardware, such hardware shall meet the following criteria:

(1) It shall consist of cross bars or push pads, the actuating portion of which extends across not less than one-half of the width of the door leaf and not less than 34 in. (86 cm), nor not more than 48 in. (122 cm), above the floor.

Exception: Existing installations shall be permitted to be minimum 30 in. (76 cm) above the floor.

(2) It shall be constructed so that a horizontal force not to exceed 15 lb. (66 N) actuates the cross bar or push pad and latches.

7.2.1.7.2 Only approved panic hardware shall be used on doors that are not fire doors. Only approved fire exit hardware shall be used on fire doors.

7.2.1.7.3

19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.

Finding #9

NFPA 101, Life Safety Code, 2000 Edition

8.2.3.2.4.2 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:

(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:

- a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.
- b. It shall be protected by an approved device that is designed for the specific purpose.

(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:

- a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.
- b. It shall be protected by an approved device that is designed for the specific purpose.

(3) *Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:

- a. The material shall be capable of maintaining the fire resistance of the fire barrier.
- b. The material shall be protected by an approved device that is designed for the specific purpose.

(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:

- a. It shall be made on either side of the fire barrier.
- b. It shall be made by an approved device that is designed for the specific purpose.

Finding #10

NFPA 13, Standard for the Installation of Sprinkler Systems, 1999 Edition.

6-1.1.5 Sprinkler piping or hangers shall not be used to support non-system components.

A-1.1.5 The rules covering the hanging of sprinkler piping take into consideration the weight of water-filled pipes plus a safety factor. No allowance has been made for the hanging of non-system components from sprinkler piping.

Finding #11

NFPA 101, Life Safety Code, 2000 Edition

7.2.1.1.1 A door assembly in a means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of 7.2.1. Such an assembly shall be designated as a door.

7.2.1.1.2 Every door and every principal entrance that is required to serve as an exit shall be designed and constructed so that the path of egress travel is obvious and direct. Windows that, because of their physical configuration or design and the materials used in their construction, have the potential to be mistaken for doors shall be made inaccessible to the occupants by barriers or railings.

7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is

occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.

7.2.1.7.1 Where a door is required to be equipped with panic or fire exit hardware, such hardware shall meet the following criteria:

(1) It shall consist of cross bars or push pads, the actuating portion of which extends across not less than one-half of the width of the door leaf and not less than 34 in. (86 cm), nor not more than 48 in. (122 cm), above the floor.

Exception: Existing installations shall be permitted to be minimum 30 in. (76 cm) above the floor.

(2) It shall be constructed so that a horizontal force not to exceed 15 lb. (66 N) actuates the cross bar or push pad and latches.

7.2.1.7.2 Only approved panic hardware shall be used on doors that are not fire doors. Only approved fire exit hardware shall be used on fire doors.

7.2.1.7.3

19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.

ISO 9001:2008;6.3 Infrastructure

The organization shall determine, provide and maintain the infrastructure needed to achieve conformity to product requirements. Infrastructure includes, as applicable,

- a) buildings, workspace and associated utilities,
- b) process equipment (both hardware and software), and
- c) supporting services (such as transport, communication or information systems).

ISO 9001:2008;6.4 Work environment

The organization shall determine and manage the work environment needed to achieve conformity to product requirements.

NOTE: The term "work environment" relates to those conditions under which work is performed including physical, environmental and other factors (such as noise, temperature, humidity, lighting or weather).

The requirement was NOT MET as evidenced by the following:

Finding #1

During the physical environment document review with Hospital Staff the surveyor noted that the Hospital does not have a Barrier Protection Plan to provide for the isolation of possible fire.

Finding #2

During the physical environment document review with Hospital Staff the surveyor noted the hospital still lacks objective evidence of an annual evaluation of the fire drills.

Surveyor note: This is a repeat finding from last year's survey, NC-2-13.

Finding #3

During the physical environment document review with Hospital Staff the surveyor noted there is no objective evidence the hospital has completed the 5 year standpipe flow test for the fire sprinkler system.

Finding #4

During the physical environment document review with Hospital Staff the surveyor noted there is no objective evidence the hospital conducted a quarterly fire sprinkler system inspection for the 2nd quarter of 2015. This inspection includes Supervisory Signal Devices, Emergency Services Notification Transmission Equipment, Fire department Connections and water flow and tamper switch inspections/testing.

Finding #5

170
**Survey Report and
Corrective Action Plan Submittal Form**



During the physical environment document review with Hospital Staff the surveyor noted on the Townsend Systems Annual Fire Equipment Inspection Report completed 5/21/2015 4 horn/strobes failed testing, 2 Duct Detectors failed testing and the smoke detectors in AHU's 3 & 4 failed testing. There is no objective evidence these discrepancies have been repaired.

Finding #6

During the physical environment document review with Hospital Staff the surveyor noted there is no objective evidence the hospital has completed the 6 year fire/smoke damper inspections/testing for the hospital's fire/smoke dampers.

Finding #7

During the physical environment document review with Hospital Staff the surveyor noted the last annual testing of the hospital's battery backup emergency egress lights was conducted in February of 2014. This testing is required to be completed every 12 months and the hospital is 5 months overdue as of the date of this survey.

Finding #8

During the physical environment document review with Hospital Staff the surveyor noted on the Hospital's Fire and Smoke Door Inspection Report dated 4/14/2015 there are 7 doors that are missing either top or bottom latching hardware. There is no objective evidence these Fire/Smoke doors have been repaired.

Finding #9

During the physical environment building tour with Hospital Staff the surveyor noted Fire/Smoke wall penetrations in the following locations:

1. P/T Unit Corridor at 1 hour Smoke Barrier Wall-One penetration
2. Med/Surg Corridor at 1 hour Smoke Barrier Wall-2 penetrations

Finding #10

During the physical environment building tour with Hospital Staff the surveyor noted Equipment/cables/wires hanging off of the Fire Sprinkler Lines in the following locations:

1. P/T Unit Corridor-Fixed electrical conduit wired to sprinkler lines, Communication Cables, and 4 insulated water pipes lying on top of the fire sprinkler line.
2. Med/Surg Corridor-Communication Cables, wires and flexible conduit

Lauderdale Community Hospital Policy SF.035.001, Automatic Sprinkler System, states that " nothing should be supported by the pipes in the Automatic Sprinkler System".

Finding #11

During the physical environment building tour with Hospital Staff the surveyor noted the entrance/exit door at the ED Registration counter contains a mechanical latch operated by a key in the path of egress. When the latch is engaged, there is no egress from the hospital through this door. The door is noted on the Architectural Drawings as a main egress pathway out of the hospital and is mark with an exit sign over the door.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Plant Operations did not have a Barrier Protection Plan.

#2 Safety Officer thought the 2014 summary with the Quality Lead was objective evidence of annual evaluation.

#3 LCH does not have a fire hose connector to the hospital for standpipe flow test.

#4 Employee change-over at "Superior" caused the July 1st quarterly fire sprinkler inspection to be missed. They arrived on July 30th.

#5 Failed testing discrepancies had not been repaired due to funding and Townsend refusal to come out until completely pd off.

#6 6 year inspections/testing for fire/smoke damper had not been performed due to waiting on contract to be signed.

#7 23 emergency lights testing to be completed every 12 months was late due to process change and documentation.

#8 7 doors missing either top or bottom latching hardware not repaired due to one of the two were in working order and LCH previously understood only one had to work since very expensive to replace.

#9 Penetrations in P/T and Med/Surg were unknown by LCH plant operations.

#10 Lines and pipes hanging off the sprinkler lines not recognized by plant operations.

#11 Main egress door contained a keyed lock instead of push to exit.

Organization Corrective Action Plan (CAP): #1 New policy has been created for the Barrier Protection Plan.

171
**Survey Report and
 Corrective Action Plan Submittal Form**



#2 New plan to take fire drills to safety committee, and on the MSQI and board. (Done at Safety meeting Aug 20, 2015).
 #3 New letter from Fire Chief explaining that we do not have fire/water hose hook-up for standpipe flow test.
 #4 Superior came on July 30th to perform the quarterly fire sprinkler system inspection.
 #5 Work order has been turned in for Townsend to repair discrepancies in failed testing. Accounts payable have been notified to get this account paid in order for the work to be performed.
 #6 Our staff is going to training to inspect the fire/smoke dampers as evidenced by NFPA 80 (Chap 19) and NFPA 105 (chap 5,6,7). Maintenance records to be kept. Dampers to be numbered with established location, picture with closed and open and will repair as needed.
 #7 23 emergency lights with batteries to be replaced annually (8 have already been replaced and will replace the rest upon arrival).
 #8 Latching doors – quotes will be obtained to repair/replace the hardware for each door (at least 2 doors at a time) until all complete.
 #9 Penetrations have already been repaired in P/T and Med/Surg locations.
 #10 Cables/wires hanging off Fire sprinkler lines: all will be pulled up/off during damper maintenance expected to occur by ~~Oct 11, 2015~~.
 UPDATE 9/22/2015 mns – occur by September 27, 2015
UPDATE 9/24/2015 mns – Cables/wires hanging off Fire sprinkler lines: all will be pulled off during damper maintenance and plan to perform 30 per month until complete – implementing September 24, 2015
 #11 Exit Door lock has already been disabled on 8/13/2015.

Person/Function responsible for implementation of Corrective Action Plan:	Curt Langley – Plant Operations director
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015 UPDATE 9/24/2015 mns – September 24, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Monthly log is maintained in Life safety book for quarterly fire sprinkler system, failed testing, fire/smoke dampers, and emergency lighting.

DNV GL- HEALTHCARE USE ONLY

CAP accepted date: Findings# 1, #2, #4,#9,#11 09/15/2015	DNV GL reviewer: R.Snelling
Findings #5,#6,#7,#8,#10 10/15/2015	R. Snelling, CPEO
Clarification requested date: 09/15/2015	DNV GL reviewer: R.Snelling

Clarification request:

Finding #3: Fire Chief documentation needed for CAP completion. Please submit.

Findings #5,#6,#7,#8,#10
 The corrective actions for these six findings must be completed within 60 days of the last day of the survey. This date is September 27, 2015. If these actions cannot be completed by this date the hospital may request a CMS-approved time extended waiver through DNV GL-Healthcare.
 (Please see attached documentation on requests for CMS- approved time extended waivers)

- If the CAP will be implemented by this date, please submit an update to the CAP in the above applicable **ORGANIZATION RESPONSE SECTION**. Preface the updated documentation with **UPDATE xx/xx/2015**
- If the CAP will not be implemented by this date, initiate the LSC waivers or Fire Safety Evaluation System (FSSES) equivalencies below.

172
**Survey Report and
 Corrective Action Plan Submittal Form**



Updated documents submitted by client:

August 11, 2015

To Whom It May Concern:

1) Lauderdale Community Hospital does not have a fire / water hose test as
 in the original flow testing and therefore the analytic portion of
 standard flow test

[Signature]
 Fire Chief Tracy Woods

2) Lauderdale Community Hospital staff will be trained to inspect the fire /
 water pumps to standards by NFPA 80 (Section 11) and NFPA 101
 (Chapter 5.6 and 9) compliance records will be maintained. Documents
 will be stored at each standard location with a permit taken during
 closure and opening with records as needed

[Signature]
 Fire Chief Tracy Woods

3) The City of Columbus Public Safety Department/Police will be
 designated as a buffer as per guidelines

[Signature]
 Fire Chief Tracy Woods



LauderdaleCommunity
 Hospital 7825.pdf



TOWNSEND CK
 10-6-15.pdf



quote.pdf



FW pod townsend
 check.msg

Date CAP verified effective/closed:

DNV GL reviewer:

DNV GL final follow-up and closure of NC:

DNV Healthcare requests the following objective evidence be provided to attest to the above listed Organization Corrective Plan:

- **Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans, if compliance is not yet achieved.**
- **High level summary of the most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance.**

This information is to be submitted to DNV Healthcare via DNVClientDropBox@dnvgl.com within 60 business days (see date listed on page 1). The status of the CAP and measurable evidence of sustained compliance will be reviewed at the next annual survey.

OBJECTIVE EVIDENCE SUBMISSION – CLIENT USE

173

Survey Report and Corrective Action Plan Submittal Form



General instructions:

See instructions under NC-1-1 above.

DNV does not review specific policies, procedures or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Please do not send copies of policies, procedures or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

Submitted by:

Submission date:

Objective evidence summary:

Insert objective evidence summary here. Supporting documentation may be included as a pasted attachment in this section. This information is to be submitted via DNVClientDropBox@dnvgl.com within 60 business days from the date client is notified of approval by DNV GL-HC - date on page 11.

174
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-1	Infection Control Infection Control System	<input type="checkbox"/> NC-1 Condition-level <input type="checkbox"/> NC-1 <input checked="" type="checkbox"/> NC-2	IC.1 (SR.1,6) <i>ISO 9001:2008;6.4</i> <i>ISO 9001:2008;8.3</i>	485.623(c)(4) 485.635(a)(3)(vi)

Requirement (Description):

IC.1 INFECTION PREVENTION AND CONTROL SYSTEM

- SR.1 The CAH shall have a process in place, as required and/or recommended by the Centers for Disease Control (CDC) and related professional CAHs, to maintain a sanitary environment for CAH patients, staff, and others. This process shall provide the means for avoiding and transmitting infections and communicable diseases.
- SR.6 The CAH, through its individual who assumes full legal authority and responsibility for operations of the CAH, Medical Director and nurse executive/leader shall ensure that the Infection Control System and associated activities adequately address issues identified throughout the CAH and there are prevention, correction, improvement and training programs to address these issues and provide adequate resources to accomplish the associated activities of the infection control program,.

Interpretive Guidelines:

The CAH must maintain an infection control program for the prevention, control, and surveillance of infections (which includes, but is not limited to nosocomial infections) and communicable diseases of patients and personnel (which includes, but is not limited to patient care staff).

The infection control surveillance program will include specific measures for prevention, detection, control, intervention, education, collection of data and investigation of infections and communicable diseases in the CAH that covers patients and CAH staff. The infection control program must be continually evaluated for effectiveness and when necessary, corrective and/or preventive action taken to reduce risks of infections. The infection control program will encompass nationally recognized systems of infection control guidelines to reduce the risk and transmission of infections and communicable diseases (e.g., the Centers for Disease Control and Prevention (CDC) Guidelines for Prevention and Control of Nosocomial Infections, the CDC Guidelines for Preventing the Transmission of Tuberculosis in Health Care Facilities, the Society for Healthcare Epidemiology of America (SHEA), the Association of periOperative Registered Nurses (AORN), the Occupational Health and Safety Administration (OSHA) regulations, and the Association for Professionals in Infection Control and Epidemiology (APIC) infection control guidelines).

The CAH must provide for and maintain a sanitary environment to avoid the sources and transmission of infections and communicable diseases. All areas of the CAH must be regularly cleaned and sanitary including all CAH units, campuses and off-site locations (as applicable). The infection control surveillance program will include monitoring of housekeeping and maintenance (including when applicable areas of the CAH are under repair, renovation or construction) as well as any other activities to ensure the CAH maintains a sanitary environment.

The CAH shall have a documented process, policies and procedures to define how infections and communicable diseases are prevented, controlled and investigated throughout the CAH. These policies and procedures will include:

- *Mitigation of risks associated with patient infections present upon admissions to include:*
 - *Early Identification of patients who require isolation and techniques for precaution in accordance with CDC guidelines*
 - *Appropriate use of personal protective equipment (i.e. gowns, masks, gloves, eye protection)*
- *The CAH leaders are responsible for implementing and ensuring corrective/preventive action(s) are implemented and effective in addressing infection control issues.*

- A process for identifying, reporting, investigating preventing, controlling infections and communicable diseases; to include both inpatient and outpatient populations as well as CAH staff;
- A process for adequately addressing issues identified throughout the CAH and for the prevention, correction, improvement and training programs to address these issues;

The chief executive officer (Color individual who assumes full legal authority and responsibility for operations of the CAH), the medical staff and the nurse executive/leader, must ensure that the CAH-wide quality management oversight and staff in-service training programs address problems identified through the infection control program.

The chief executive officer (CEO, or individual who assumes full legal authority and responsibility for operations of the CAH), the medical staff, and the nurse executive/leader are responsible for implementing corrective action plans to address problems identified by the infection control officer(s). These plans should be evaluated for effectiveness and revised if needed, and documentation concerning corrective actions and outcomes should be maintained.

ISO 9001:2008;6.4 Work environment

The organization shall determine and manage the work environment needed to achieve conformity to product requirements.

NOTE: The term "work environment" relates to those conditions under which work is performed including physical, environmental and other factors (such as noise, temperature, humidity, lighting or weather).

ISO 9001;2008;8.3 Control of nonconforming product

The organization shall ensure that product which does not conform to product requirements is identified and controlled to prevent its unintended use or delivery. A documented procedure shall be established to define the controls and related responsibilities and authorities for dealing with nonconforming product.

Where applicable, the organization shall deal with nonconforming product by one or more of the following ways:

- a) by taking action to eliminate the detected nonconformity;
- b) by authorizing its use, release or acceptance under concession by a relevant authority and, where applicable, by the customer;
- c) by taking action to preclude its original intended use or application;
- d) by taking action appropriate to the effects, or potential effects, of the nonconformity when nonconforming product is detected after delivery or use has started.

When nonconforming product is corrected it shall be subject to re-verification to demonstrate conformity to the requirements.

Records of the nature of nonconformities and any subsequent actions taken, including concessions obtained, shall be maintained (see 4.2.4).

The requirement was NOT MET as evidenced by the following:

During survey activity, the following items were identified:

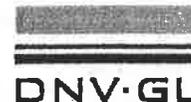
Finding #1: Nonconforming Products/Outdated Supplies

- a. Medical-Surgical:
 - 1) Crash cart: Shiley trach tubes size 6 (1 box) expired 3/2015
- b. Emergency Department:
 - 1) Fast track: Culture swabs (x2) expired 5/2015
 - 2) Supply room: Ice machine- grate had rusted areas and white-colored deposits; per staff, machine is old and difficult to clean

Finding #2: Clean Equipment

- a. Process to identify and store clean equipment: Per staff, cleaned equipment are either covered with plastic bag (if able to fit) or have an orange tape applied. In soiled utility room, it was identified that these are

**Survey Report and
 Corrective Action Plan Submittal Form**



dirty and therefore, do not have an orange sticker. However, in medical-surgical unit's clean supply room, bedside commodes were stored *without* either a plastic bag or orange sticker, yet were noted to be in the clean supply room. Staff were unable to identify reason for inconsistency in process.

Finding #3: Equipment Set-up

Emergency Room: Per staff, all rooms are set up with opened packages of suction tubing and Yankauer catheter at bedside. Staff was not expecting an impending patient. Staff was unable to articulate how long supply items have been hanging or number of patients who have been through this area since supplies were originally set up. However, current practice is not to discard these supplies until they have been used. Staff acknowledged that it could be weeks or a month(s) before supplies are used. There were visible layers of dust on equipment. These pose an infection control risk.

Finding #4: Fans

Stand-up fans are being utilized in patient rooms in Medical-Surgical and Emergency Departments. Per staff, there is no documented process to clean/sterilize these fans in between use on each patient. Facilities department is called to clean the fans when the blades are visibly dirty. Fans that were located in room #4 in the Emergency Department and inpatient unit were visibly dusty but were still available for patient use. Current practice poses an infection risk.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1a1 LCH did not have any other trach tubes to replace expired box due to funding; #1b1 Culture swabs were pulled from all rooms, so did not know to check for expired supplies in that room.
 #1b2 Ice Machine with rusted areas and white deposits due to machine being old and difficult to clean.
 #2 No consistent process house-wide for bedside commodes noted to be visually clean. ER has orange stickers/MS did not.
 #3 Visible dust on suction equipment: Staff always felt more in control with supplies "ready" when needed than having to pull together supplies and connect in an emergency situation.
 #4 Visible dust on fans. IC risk. No documented process to clean between patients.

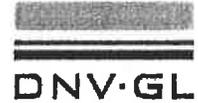
Organization Corrective Action Plan (CAP): #1a1 Pull expired supplies out of crash cart unless have a manufacturer's recommendation to use as a non-conforming product. #1b1 Check all rooms for any expired supplies regardless if supposed to be in the room or not. #1b2 Recommendations to repaint ice machine or until able to buy a new ice machine.
 #2 New process house-wide to use orange stickers on bedside commodes. ADD to safety rounds to check and ensure compliance followed.
 #3 Process change to make a "cook bag" to bag up all suction supplies together to keep equipment "clean" before use.
 #4 Recommend to IC to clean between patients and to terminally clean while taken apart by maintenance after work order completed when visibly dirty. ADD to safety rounds to check and ensure compliance is followed.

Person/Function responsible for implementation of Corrective Action Plan:	Cassandra Williams Nurse manager	Judy King MS supv	Cindy Kidd IC/EH	Curt Langley Plant Operations
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015			
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Safety committee to round in areas and add these processes to monthly checks to ensure follow through and sustained compliance.			

DNV GL- HEALTHCARE USE ONLY

CAP accepted date: 9/17/15	DNV GL reviewer: P. Horine
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:
DNV GL final follow-up and closure of NC:	

177
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-2	Utilization Review Utilization Review Process	<input type="checkbox"/> NC-1 Condition-level <input type="checkbox"/> NC-1 <input checked="" type="checkbox"/> NC-2	UR.1 (SR.2) / (SR.3) ISO 9001:2008;7.5.2	

Requirement (Description):

The CAH shall have a process in place (either directly or through agreement or arrangement) for review and evaluation to ensure appropriate utilization of services provided by the CAH organizational and medical staff services to patients, particularly those patients entitled to benefits under both Medicare and Medicaid.

SR.2 Medical necessity of professional services.

SR.3 Professional services furnished, including medications.

ISO 9001:2008;7.5.2 Validation of processes for production and service provision

The organization shall validate any processes for production and service provision where the resulting output cannot be verified by subsequent monitoring or measurement and, as a consequence, deficiencies become apparent only after the product is in use or the service has been delivered.

Validation shall demonstrate the ability of these processes to achieve planned results.

The organization shall establish arrangements for these processes including, as applicable,

- a) defined criteria for review and approval of the processes,*
- b) approval of equipment and qualification of personnel,*
- c) use of specific methods and procedures,*

The requirement was NOT MET as evidenced by the following:

A review of the organization's Utilization Review process revealed that the organization has a written "Utilization Management Plan" (October 2014) that addresses the utilization review function and related processes. In addition to this document, it was identified that the medical staff by-laws (Revision 2015) also address the unitization review function and related processes. Review of UR records/documents and through interviews with UR staff it was determined that the organization does not consistently follow its' own requirements. Additionally, it was noted that the UR Plan (October 2014) and medical staff by-laws (revision 2015) are not in concert.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: Utilization Management Plan and Bylaws are not consistent.

Organization Corrective Action Plan (CAP): Quality/CNO and Risk Manager to compare and unite processes to be consistent. UR to meet monthly through MSQI.

Person/Function responsible for implementation of Corrective Action Plan:	Michelle Simpson, CNO/Quality; Cheryl Manns, Risk
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Place on MPRC agenda to review annually by placing into Patient Care policies and combining all 3 policies re: utilization review if possible. UR to meet monthly through MSQI.

DNV GL- HEALTHCARE USE ONLY

CAP accepted date: 9/15/15	DNV GL reviewer: jlds
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:
DNV GL final follow-up and closure of NC:	

178
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-3	Patient Rights Grievance Procedure	<input type="checkbox"/> NC-1 Condition-level <input type="checkbox"/> NC-1 <input checked="" type="checkbox"/> NC-2	PR.5 (SR.2) / (SR.3) / (SR.4) <i>ISO 9001:2008;7.2.3</i>	

Requirement (Description):

The CAH shall develop and implement a formal grievance procedure that provides for the following:

- SR.2 The governing body's review and resolution of grievances or the written delegation of this function to an appropriate person or committee;
- SR.3 A referral process for quality of care issues to the Utilization Review, Quality Management or Peer Review functions, as appropriate; and,
- SR.4 Specification of reasonable timeframes for review and response to grievance

Interpretive Guideline:

The CAH must develop and implement a formal grievance procedure to identify the process that will be followed and the required correspondence, including grievance resolution, to be provided to the patient.

Definition elements: A "patient grievance" is a formal or informal written or verbal complaint that is made to the CAH by a patient, or the patient's representative, when a patient issue cannot be resolved promptly by staff present. If a complaint cannot be resolved promptly by staff present or is referred to a complaint coordinator, patient advocate, or CAH management, it is to be considered a grievance.

ISO 9001:2008 7.2.3 Customer communication

The organization shall determine and implement effective arrangements for communicating with customers in relation to

- a) product information,*
- b) enquiries, contracts or order handling, including amendments, and*
- c) customer feedback, including customer complaints.*

The requirement was NOT MET as evidenced by the following:

During the review of the patient grievance process it was noted that the organization does not clearly define the difference between a complaint and a formal grievance. The policy, "Patient Resolution of Complaints" (10/14) has definitions of grievance with potential harm and grievances without potential harm. The policy does not identify when a complaint can be elevated to grievance status. The organization's established time frame for resolving grievances is 2-5 days. A review of the grievance log revealed that this time frame is not being met. It was noted that most of the grievances are generated in the ED and this information is forwarded to the ED medical director who is only available every three months which at times impacts resolution time frames.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: Organization did not define complaint and grievance as easily understood. The policy does not clearly identify when a complaint can be elevated to grievance status. Time frame of 2-5 days is not being met.

Organization Corrective Action Plan (CAP): Policy to be revised to define complaint and grievance into easily understood terms. Policy to identify when a complaint can be elevated to grievance status. Time frame to be reviewed and revised to meet guidelines.

179
**Survey Report and
 Corrective Action Plan Submittal Form**



Person/Function responsible for implementation of Corrective Action Plan:	Cheryl Manns, Risk Management Director
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Policy to go to Multidisciplinary Policy Review Council (MPRC) with revisions and will be reviewed annually.
DNV GL- HEALTHCARE USE ONLY	
CAP accepted date: 9/15/15	DNV GL reviewer: jlds DNV GL NOTE: The the corrective action submitted addresses a policy revision and the method for follow up follows the policy revision only; however, the method for follow up should address audits for compliance with the new process/procedure/policy. This needs to be part of the internal CAP. This will be reviewed in detail at the next on site survey.
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:
DNV GL final follow-up and closure of NC:	

180
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-4	Physical Environment Safety Management	<input type="checkbox"/> NC-1 Condition-level <input type="checkbox"/> NC-1 <input checked="" type="checkbox"/> NC-2	PE.3(SR.1) / (SR.2) / (SR.3) / (SR.4) <i>NFPA 99-1999;3-3.3.4.2,4-3.5.2.1,8-3.1.11.2</i> <i>OSHA 29 CFR 1910.303</i> <i>DOT 49 CFR 172.704</i> <i>ISO 9001:2008;6.3</i> <i>ISO 9001:2008;6.4</i>	485.623(b)

Requirement (Description):

PE.3 SAFETY MANAGEMENT

- SR.1 The CAH shall have processes in place to maintain safe and adequate facilities for its services. Diagnostic and therapeutic facilities must be located for the safety of patients.
- SR.2 The CAH shall require that facilities, supplies, and equipment be maintained and ensure an acceptable level of safety and quality. The extent and complexity of facilities shall be determined by the services offered. 485.623(c)(4)
- SR.3 The CAH shall require proper ventilation, light and temperature controls in pharmaceutical, food preparation, and other appropriate areas. 485.623(b)(5)
- SR.4 The CAH shall maintain an environment free of hazards and manages staff activities to reduce the risk of occupational related illnesses or injuries.

Finding #1

NFPA 99, Standard for Health Care Facilities, 1999 Edition

3-3.3.4.2 Line Isolation Monitor Tests. *The proper functioning of each line isolation monitor (LIM) circuit shall be ensured by the following:*

- a) *The LIM circuit shall be tested after installation, and prior to being placed in service, by successively grounding each line of the energized distribution system through a resistor of 200 X V ohms, where V = measured line voltage. The visual and audible alarms [see 3-3.2.2.3(b)] shall be activated.*
- b) *The LIM circuit shall be tested at intervals of not more than 1 month by actuating the LIM test switch [see 3-3.2.2.3(f)]. For a LIM circuit with automated self-test and self-calibration capabilities, this test shall be performed at intervals of not more than 12 months. Actuation of the test switch shall activate both visual and audible alarm indicators.*
- c) *After any repair or renovation to an electrical distribution system and at intervals of not more than 6 months, the LIM circuit shall be tested in accordance with paragraph (a) above and only when the circuit is not otherwise in use. For a LIM circuit with automated self-test and self-calibration capabilities, this test shall be performed at intervals of not more of not more than 12 months.*

Finding #2

OSHA 29 CFR 1910.303

1910.303(b)(1) Examination. *Electric equipment shall be free from recognized hazards that are likely to cause death or serious physical harm to employees. Safety of Equipment shall be determined using the following considerations: OSHA 1910.305(j)(1)(iv) Fixtures installed in wet or damp locations shall be identified for purpose and shall be so constructed or installed that water cannot enter or accumulate in a wire way, lamp holders, or other electrical parts.*

Finding #3

DOT 49 CFR 172.704

A hazmat employer must train all hazmat employees in general awareness training, function-specific regulatory training, and safety training (e.g., healthcare professionals shall have training to properly use any packaging authorized for the transportation of infectious substances).

Finding #4

NFPA 99, Standard for Health Care Facilities, 1999 Edition

8-3.1.11.2 Storage for nonflammable gases less than 3000 ft³ (85 m³).

(h) Cylinder or container restraint shall meet 4- 3.5.2.1(b)27.

4-3.5.2.1 Gases in Cylinders and Liquefied Gases in Containers—Level 1.

(b) Special Precautions — Oxygen Cylinders and Manifolds. Great care shall be exercised in handling oxygen to prevent contact of oxygen under pressure with oils, greases, organic lubricants, rubber, or other materials of an organic nature. The following regulations, based on those of the CGA Pamphlet G-4, Oxygen, shall be observed:

27. Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.

ISO 9001:2008;6.3 Infrastructure

The organization shall determine, provide and maintain the infrastructure needed to achieve conformity to product requirements. Infrastructure includes, as applicable,

- a) buildings, workspace and associated utilities,
- b) process equipment (both hardware and software), and
- c) supporting services (such as transport, communication or information systems).

ISO 9001:2008; 6.4 Work environment

The organization shall determine and manage the work environment needed to achieve conformity to product requirements.

NOTE: The term "work environment" relates to those conditions under which work is performed including physical, environmental and other factors (such as noise, temperature, humidity, lighting or weather).

The requirement was NOT MET as evidenced by the following:

Finding #1

During the physical environment building tour with hospital staff, the surveyor noted in the Hospital Sleep Lab there is an active Line Isolation Monitor. There is no objective evidence the hospital has conducted the required annual testing on the Line Isolation Monitor.

Finding #2

During the physical environment building tour with hospital staff, the surveyor noted there are 2 active Hydrocollators located in the Physical Therapy Unit that are not plugged into required GFCI electrical outlets.

Finding #3

During the physical environment document review of the Hazardous Materials and Waste Documents with hospital staff, the surveyor noted the staff that sign the Steri-Cycle Manifest for the Bio-Medical Waste transported off the hospital property have not had the required DOT training.

Finding #4

During the physical environment building tour with hospital staff, the surveyor noted in the Mechanical Office there are 3 "H" Cylinders of Medical Air that are not individually chained.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 Line was disconnected. LCH did not conduct Line Isolation Monitor on line.

#2 Hydrocollators not plugged into required GFCI electrical outlets.

#3 LCH staff unaware of required DOT training to sign Steri-Cycle manifest.

#4 x3 "H" cylinders not individually chained because staff thought all chained together would be sufficient.

Organization Corrective Action Plan (CAP): #1 Will begin testing annually as required.

182
**Survey Report and
 Corrective Action Plan Submittal Form**



#2 Hydrocollators plugged into required GFCI electrical outlets on 7/29/2015.
 #3 Steri-Cycle video has been requested although they state we have to purchase it before they will give it to us. Will continue to discuss requirements to obtain by ~~October 11, 2015~~. **UPDATE 9/22/2015 mns – by September 27, 2015**
 #4 3 "H" cylinders chained individually on 7/29/2015.

Person/Function responsible for implementation of Corrective Action Plan:	Curt Langley, Plant Operations
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns – September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Line isolation monitor will be added to quality annually; Video training to be placed on quality for materials management, plant ops, security, and environmental services employees to view and sign training.

DNV GL- HEALTHCARE USE ONLY

CAP accepted date: Findings #2,#3,#4 09/15/2015	DNV GL reviewer: R.Snelling
Finding #1 10/15/15	R. Snelling, CPEO
Clarification requested date: 09/15/2015	DNV GL reviewer: R.Snelling

Clarification request:

Finding#1
 The corrective actions for this finding must be completed within 60 days of the last day of the survey. This date is September 27, 2015. If these actions cannot be completed by this date the hospital may request a CMS-approved time extended waiver through DNV GL-Healthcare.
 (Please see attached documentation on requests for CMS- approved time extended waivers)

- If the CAP will be implemented by this date, please submit an update to the CAP in the above applicable **ORGANIZATION RESPONSE SECTION**. Preface the updated documentation with **UPDATE xx/xx/2015**
- If the CAP will not be implemented by this date, initiate the LSC waivers or Fire Safety Evaluation System (FSES) equivalencies below.

FEE FOR ADDITIONAL SERVICES

LSC waivers or Fire Safety Evaluation System (FSES) equivalencies

CMS has implemented a new process to allow hospitals to request a waiver for the Life Safety Code (LSC) or Fire Safety Evaluation System (FSES) equivalencies. This process involves a CMS-required review and recommendation to the CMS Regional Office (RO) by the hospital's CMS-approved Accreditation Organization (AO) after review of documents submitted by the hospital to the AO to support the request. The time for the AO to review documents for a hospital-requested LSC waiver or FSES equivalency determination and submit a written recommendation to the CMS RO is considered an additional service requested by the hospital not covered in our agreement; therefore, DNV GL review of a waiver request or FSES equivalency determination will result in an additional fee. The fee will be charged based on the time spent by DNV GL in reviewing the hospital waiver request and preparing and submitting a written recommendation to the RO. The minimum fee will be one surveyor day (\$3,500) and the maximum is not expected to exceed 2 surveyor days (\$7,000). In the event the review is expected to involve more time than 2 surveyor days, the hospital will be contacted for written approval before DNV GL begins a review of the hospital's LSC waiver or FSES equivalency request.

Please indicate the hospital's willingness to proceed with a LSC waiver or FSES equivalency request by returning written confirmation by electronic mail to:

Randall Snelling, Chief Physical Environment Officer
Randall.Snelling@dnvgl.com

After receipt of this written request, a contract amendment will be prepared and submitted to the hospital for approval.

DNV GL review of a hospital LSC waiver or FSES equivalency request will not begin until a signed contract amendment is received.

061915

Date CAP verified effective/closed:

DNV GL reviewer:

DNV GL final follow-up and closure of NC:

184
**Survey Report and
 Corrective Action Plan Submittal Form**



Organization: Lauderdale Community Hospital – Ripley, TN

NC Number	Process or Standard	Non-conformance category	DNV GL requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-5	Physical Environment Utility Management	<input type="checkbox"/> NC-1 Condition-level <input type="checkbox"/> NC-1 <input checked="" type="checkbox"/> NC-2	PE.8(SR.2) / (SR.3) / (SR.6) / (SR.10) <i>NFPA 110-2010;8.3.3,8.3.4,8.3.4.1,8.4.1,8.4.2,8.4.2.3,8.4.3,8.4.4</i> <i>ISO 9001:2008;6.3</i>	485.623(c)

Requirement (Description):

PE.8 UTILITY MANAGEMENT

- SR.2 The CAH shall have a process in place to evaluate critical operating components
- SR.3 The CAH shall develop maintenance, testing, and inspection processes for critical utilities.
- SR.6 The CAH shall provide for reliable emergency power sources with appropriate maintenance as required.
- SR.10 All relevant utility systems shall be maintained inspected, and, tested.

Finding #1&2

NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition

8.3.3 *A written schedule for routine maintenance and operational testing of the EPSS shall be established.*

8.3.4 *A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available.*

8.3.4.1 *The permanent record shall include the following:*

- (1) *The date of the maintenance report*
- (2) *Identification of the servicing personnel*
- (3) *Notation of any unsatisfactory condition and the corrective action taken, including parts replaced*
- (4) *Testing of any repair for the time as recommended by the manufacturer*

8.4.1 *EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.*

8.4.2 *Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:*

- (1) *Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer*
- (2) *Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating*

8.4.2.3 *Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.*

primary source.

8.4.3 *The EPS test shall be initiated by simulating a power outage using the test switch(es) on the ATs or by opening a normal breaker. Opening a normal breaker shall not be required.*

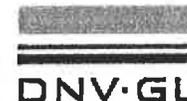
8.4.4 *Load tests of generator sets shall include complete cold starts.*

ISO 9001:2008;6.3 Infrastructure

The organization shall determine, provide and maintain the infrastructure needed to achieve conformity to product requirements. Infrastructure includes, as applicable,

- a) buildings, workspace and associated utilities,*
- b) process equipment (both hardware and software), and*
- c) supporting services (such as transport, communication or information systems).*

**Survey Report and
 Corrective Action Plan Submittal Form**



The requirement was NOT MET as evidenced by the following:

Finding #1

During the physical environment document review with hospital staff, the surveyor noted that the hospital was not conducting the required monthly Emergency Generator Test properly. The hospital is not running the emergency generator under full hospital load for the monthly load test.

Finding #2

During the physical environment document review with hospital staff, the surveyor noted there is no objective evidence the hospital is conducting an annual load bank test on the Emergency Generator. The Hospital's calculated full load for the emergency generator is less than 30% of the emergency generator's manufacturer's name plate full load. The Hospital is not checking or recording the emergency generator exhaust gas temperatures.

Corrective Action Plan due date: August 22, 2015

ORGANIZATION RESPONSE

Cause that led to the nonconformity: #1 LCH not running hospital generator on full load for the monthly load test as generator will not perform full load.

#2 Annual load bank test was not being performed at full load due to needing outside source to perform.

Organization Corrective Action Plan (CAP): #1 Weekly testing of the generator continues every Monday with full hospital load to be performed monthly as required.

#2 \$1800 test to be performed by Cummins annually since full load is less than 30%. Emergency generator exhaust gas temperature are recorded every Monday on log.

Person/Function responsible for implementation of Corrective Action Plan:	Curt Langley, Plant Operations
Date for implementation of Corrective Action Plan: (generally within 60 days)	October 11, 2015 UPDATE 9/22/2015 mns - September 27, 2015
Organization method for follow-up: (specify method for monitoring or follow-up, frequency of monitoring, measures of effectiveness, evidence of sustained compliance)	Full hospital load to be included on weekly testing of the generator. \$1800 full load test to be included in Safety Meeting bimonthly until completed, then added to annual testing.

DNV GL- HEALTHCARE USE ONLY

CAP accepted date: 09/15/2015	DNV GL reviewer: R. Snelling
Clarification requested date:	DNV GL reviewer:
Clarification request:	
Date CAP verified effective/closed:	DNV GL reviewer:
DNV GL final follow-up and closure of NC:	

CERTIFICATE OF ACCREDITATION

Certificate No.:
188730-2015-AHC-USA-NIAHO

Initial date:
8/1/2015

Valid until:
8/1/2018

This is to certify that:

Lauderdale Community Hospital

326 Asbury Ave, Ripley, TN 38063

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX



Patrick Norine
Chief Executive Officer



**Supplemental #1
-COPY-**

**CAH Acquisition Company
11, LLC**

CN1601-004

January 29, 2016**9:59 am****State of Tennessee****Health Services and Development Agency**

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

www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

1. Section A, Applicant Profile Item 2

Please provide an entire email address for contact and submit a replacement page. The LOI provides a contact number of 731-221-2200, but is listed as 731-220-2400 in the application. Please clarify.

The contact number for Tammie Hardy at LCH is 731-221-2200; her email address is Tammie.Hardy@lauderdalehospital.com. The email address is very long therefore it has been included here

2. Section A, Applicant Profile Item 3

Please clarify if CAH Acquisition Company 11, LLC currently or previously been under bankruptcy protection.

CAH Acquisition Company 11, LLC filed for Chapter 11 reorganization on October 10, 2011 in the US. District Bankruptcy Court for the Western District of Missouri. On January 17, 2013, a Plan for Reorganization was approved by the bankruptcy court. The Final Decree was entered by the Court on March 29, 2013 and the case was closed. See Attachment 1

3. Section A, Applicant Profile Item 5

Please provide the ownership structure of Rural Community Hospitals of America, LLC.

RCHA is a West Virginia LLC. Its sole member is Sun Finance, Inc. which is also a West Virginia corporation. The shareholders of Sun Finance are Paul Nusbaum(50%) and Steve White(50%), both of which are West Virginia residents.

4. Section B. I. Project Description and Applicant Profile Item 6

Please clarify the following from the above four bullet points: 1) Who will be holding the lease, 2) Who is paying for the construction of the hospital, 3) Please provide financial documentation the entity that will construct the hospital has the funds to do so, 4) If the applicant will lease the new hospital please specify in "Applicant Profile 6" on page 3 of the application, and provide a fully executed lease or an option to lease agreement.

During the construction period, a NewCo will be established that will hold the lease. The NewCo will be partially owned and fully guaranteed by CBC Real Estate Group, LLC (CBC). CHHS will also be part of the NewCo as well as CFG. For funding capabilities with regard to CFG and CHHA, please refer to Attachment 2. The applicant will lease the new hospital. In Attachment 3, the latest term sheet regarding the lease is provided.

What is the relationship between HMC/CAH Consolidated, Inc. and Community Hospitality Healthcare Services (CHHS).

CHHS is a Community Development Entity which is required when utilizing New Market Tax Credits. Once the facility is built and the NewCo established, CHHS will become part of the NewCo.

Please provide an overview of CHHS.

CHHS is a nationally recognized community development entity specializing in investing in healthcare businesses and healthcare infrastructure in America's most severely distressed communities. CHHS provides catalytic debt and equity investments to high-impact projects in medically underserved low-income communities throughout the U.S. Investments are prioritized based upon their ability to provide healthcare services to low-income individuals and families, and provide entry-level jobs and upward mobility via career ladder resources. These investments have reduced the overall cost burden of care on a national basis while addressing disparities in low-income communities by providing increased access to care and employment opportunities. Project funding provides for expansion of services, construction and improvement of new or existing space, investments in job training, workforce development and career ladder programs as well as computer systems and medical equipment.

CBC Real Estate Group, LLC has a combined experience of over 100 years in commercial real estate development, brokerage, leasing, financing and property management. CBC principals combine to maintain real estate and financial holdings exceeding \$400,000,000. During the last 30 years, CBC has been involved in the development and acquisition of more than 5 million square feet of commercial real estate projects throughout the country.

CFG is a leading provider of full-service, comprehensive financing solutions for healthcare facilities across the country.

5. Section B. I. Project Description

The applicant notes total project cost for the new facility will be approximately \$23 million, of which \$3 million (or approximately 23%) will be New Market Tax Credits on pages 6 and 23. However, there appears to be a calculation error in the percentage calculation. Please clarify.

The anticipated percentage is actually 15%. CHHS anticipates that the tax credits could cover as much as 23%, but the applicant used a more conservative 15%.

In addition, the Project Costs Chart totals \$20,044,459, not \$23,000,000 as reflected in the Project Summary on page 6. Please clarify.

The total project comes out to \$23,000,000 because there is \$3,000,000 of debt refinancing included in the project. However, because the refinancing is not related in any way to the construction, it was excluded from the "Projects Costs Chart." For purposes of this application the total project cost is \$20,126,780.

January 29, 2016**9:59 am**

Ms. Tammie Hardy
Page 3

Please provide an overview of New Market Tax Credits (NMTC) and how it applies to this project.

The New Markets Tax Credit Program (NMTC) was designed by Congress to attract private-sector capital investment into the nation's low-income areas to help stimulate economic growth and create jobs by financing community development projects and business expansion.

This program was established by Congress in December 2000 as a credit against federal income taxes for making qualified equity investments in investment vehicles known as Community Development Entities (CDEs). The credit provided to the investor (either corporate or individual) totals 39 percent of the cost of the investment and is claimed over a seven-year period. The CDE's are charged with making investments into qualified projects or businesses in low-income communities.

The program is overseen by the Community Development Finance Institutions Fund, an arm of the US Treasury Department. It is run on a competitive basis, providing the authority to allocate the resource to projects and businesses to the specialized entities noted above- Community Development Entities. Rules regarding the types of businesses that can be funded and the types of funding that can be provided are extensive and it is a function of the CDE's receiving the allocations to make sure that the projects receiving allocations are compliant with the program. Specific exclusions include land-banking, golf courses, massage parlors and tanning salons as well as farms and liquor stores. The resource is often used to help finance the gap on commercial real estate projects and to fund business expansion. Each CDE that receives an allocation has specific guidelines that it must meet in order to remain in compliance with its agreement to use the resource. It is important to find out from the CDE that you may be working with if your project is eligible for their resources early on.

Many projects blend other sources of subsidy with the New Markets Tax Credit. Historic Credit, both federal and state, Brownfield grants and notes and tax-incremental financing are common additional resources that are used to help make transactions more financially viable. One important thing to remember when you are considering a NMTC subsidized project, however, is that this resource is only able to fill a financial gap; it will not make an infeasible project feasible.

New Markets Tax Credit represents \$3,000,000 or 15 % of the funding for this project.

It is noted the service area consists of zip code 38603 located in Ripley County, Tennessee. However, it appears a portion of Zip Code 38603 is located in the State of Missouri. Please clarify. If so, is there a bridge or ferry for Missouri residents in Zip Code 38603 to have access to Lauderdale Community Hospital?

The zip code for Ripley, TN is actually 38063, as is indicated in the application. Zip code 38063 is wholly in Lauderdale County and the State of Tennessee.

Please clarify the reason the applicant chose a Zip code 38603 as a service area, rather than Lauderdale County as a whole.

Zip code 38063 was characterized as the PRIMARY service area because 78% of the hospital's business comes from that zip code.

January 29, 2016**9:59 am**

Ms. Tammie Hardy
Page 4

Please clarify if the existing hospital has a cafeteria, and if the future hospital will have a cafeteria. Please discuss.

The existing hospital does have a cafeteria. The future hospital will also have a cafeteria. In the "Square Footage and Cost per Square Footage Chart", the cafeteria and kitchen combine for a total of 2,733 sq. ft.

Please provide a brief overview of the MRI and CT scanner services Lauderdale Community Hospital provides.

MRI services are provided via a mobile unit that is licensed for four days a week but is currently available one day a week. CT scanner services is available 24/7 as the scanner is inhouse.

Ms. Tammie Hardy
Page 5

6. Section B. II. A.

The applicant notes the expected construction cost (including site preparation work) is \$19,999,460. However, that is the estimated project cost minus the CON filing fee. Please clarify.

The construction cost with site work is actually \$15,313,361

Table 1: Project Cost

Project Cost Chart Chart Description	Chart Location	Construction Cost
Preparation of Site	Project Cost Chart, A.4	1,290,053
Construction Costs	Project Cost Chart, A.5	14,023,308
Construction Cost with Site Work		15,313,361
Architectural Fees	Project Cost Chart, A.1	1,145,147
Contingency Fund	Project Cost Chart, A.6	1,190,952
Interest Incurred during Construction period	Project Cost Chart, C.3	2,350,000
Project Cost less CON Filing Fee		19,999,460

The square footage and cost per square footage chart is noted. However, please revise the chart to include the Proposed Final Cost/SF section and resubmit.

See Attachment 4

Please indicate the existing average patient room size and the proposed patient room size of the 25 bed newly constructed hospital.

Room size in the current facility is based on whether they are private or semiprivate rooms. Private rooms have a total of 251 sq feet while a semiprivate is 282.6 Sq Ft. In the replacement facility, private rooms will total 237 sq ft.

Please clarify if all patient rooms will be private or semi-private.

Yes, all patient rooms will be private.

7. Section B. II. D.

Please clarify if the current 25 bed hospital has ever been renovated. If so, please discuss.

LCH was acquired in March of 2010 and since that date there have been no major renovation which is also the impetus for the proposed project. Since acquisition of the hospital it has always been the intent to replace the outdated facility.

8. Section B. III. A. Plot Plan

The plot plan is noted. Please provide an enlarged plot plan of lot 2 for the replacement hospital.

See Attachment 5

9. Section B. IV. Floor Plan

The floor plan is noted. However, please provide larger more legible unduplicated copies of each wing and section on 8 ½ x 11 paper.

See Attachment 6

10. Section C. (Need) 1. Specific Criteria (Construction, Renovation, Expansion, and Replacement of Healthcare Institutions) 1.b

Please clarify the reason acute bed discharges decreased from 356 in 2013 to 255 in 2015, while swing bed utilization increased from 72 to 117 during the same timeframe.

During that timeframe, while inpatient acute discharges were decreasing, observation days were increasing. The applicant believes that this is part of a trend towards more outpatient services than inpatient. Swing bed utilization increased in response to efforts to bring local patients back to LCH for their rehabilitation instead of being discharged early from larger, PPS hospitals.

Why did inpatient lab and physical therapy inpatient services increase from 2013 to 2015 while inpatient acute and swing bed discharges decreased.

Inpatient ancillary services began increasing independently of discharges in 2014 when LCH hired a hospitalist to assist with weekend and overnight care, relieving the burden from local providers. In addition, while it is true that inpatient acute discharges did decrease from 2013 to 2015, swing bed discharges actually increased from 72 to 117 in that time period. It is this increase that also explains the increase in lab and physical therapy inpatient services; swing bed patients tend to make more use of ancillary services than acute especially therapy.

What factors attributed to the decrease in surgeries from 296 in 2013 to 56 in 2015?

The only surgeon on staff gradually reduced his workload and retired in 2015. The Applicant is currently in the final stages of recruiting a general surgeon. He is reviewing the Letter of Intent and coming back on February 1st.

The applicant is also pursuing the opportunity of partnering with a group in Jackson, TN. They have a variety of specialists who provide pediatric, adolescent, and adult medical and

surgical services. The applicant is looking to partner with this well-established group and offer the same services to our community.

While historically, the applicant has employed a surgeon, one is not employed as of the submission of this document. As a result, no revenue, salaries or direct expenses are included in projected financials on the Projected Data Chart.

What factors attributed to the decrease in overall outpatient services from 2013 to 2015?

There are three factors that impact this change. First, a new urgent care clinic opened in Riply, TN in July 2014, which performs lab and x-ray services. Second, a new rural clinic opened in Ripley, TN in February, 2013. Last, with some outpatient procedures considered elective, higher deductibles become a factor in the decision of having any outpatient services performed.

How much of the overall lower utilization in hospital services from 2013 to 2015 can be attributed to the condition of the physical plant and equipment?

With an older, outdated building, the recruitment of a surgeon and family practitioner has been more difficult. The ability to both recruit and retain highly qualified professionals to staff the clinical and ancillary departments is certainly a challenge.

11. Section C. (Need) 3. Service Area County Level Map

The County level map designating the applicant's declared service area is noted. However, please label Tennessee Counties and submit.

See Attachment 7

12. Section C, Need, Item 4.A.

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for your proposed service area.

Variable	Lauderdale County (for comparison Purposes)	Zip Code 38063**	Tennessee
Current Year (2015, Age 65+*	3,982	2,572	1,051,862
Projected Year (2019), Age 65+*	4,452	2,905	1,219,696
Age 65+, % Change*	11.8%	12.9%	16%
Age 65+, % Total (2015)*	14.0%	14.7%	15.6%
2015, Total Population*	28,529	17,481	6,735,706
2019, Total Population*	29,055	17,647	7,035,572
Total Pop. % Change*	1.8%	1.0%	4.5%
TennCare Enrollees*	8,093	4,959	1,481,270
TennCare Enrollees as a % of Total Population*	28.4%	28.4%	22.0%
Median Age 2015**	37.1	37.0	38.7
Median Household Income 2015**	\$32,533	\$31,064	\$44,301
Population % Below Poverty Level***	26.00%	34.10%	17.6%

* State of Tennessee

**Tactician / Mapscape.com

*** <http://quickfacts.census.gov/qfd/states/47/4763340.html>

What is the source of their ZIP Code demographics provided in the application?

The applicant uses Tactician.com for demographic information.

13. Section C. (Economic Feasibility) Item 1. (Project Cost Chart)

The following definition regarding items acquired by lease in Tennessee Health Services and Development Agency Rule 0720-2-.01 (12)(d) states “ If the acquisition is by lease, the cost is either the fair market value of the property, or the total amount of the lease payments, whichever is greater.”

Please find attached the appraisal of building and land for LCH (Attachment 8). The appraisal of land was \$120,000 for all 34.95 acres. Per the plot plan, parcel 2, where the new facility will be built, is marked at 23.976 acres. Based on acreage, the land of parcel 2 should be valued at \$82,321 ($\$120,000 / 34.95 * 23.976 = \$82,321$). This amount has been added to the Project Cost Chart. See Attachment 9

Please provide documentation of the fair market values of both the land and the building and the calculation of the total amount of the lease payments over the term of the lease. Please insert the greater amount in line B.1 of the Project Costs cost and resubmit a replacement page.

See Attachment 9

Please provide documentation from a licensed architect or construction professional:

- 1) a general description of the project,**
- 2) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and**
- 3) attesting that the physical environment will conform to applicable federal standards, manufacturer’s specifications and licensing agencies’ requirements including the latest AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.**

In Attachment 10, a letter, which includes, a brief project description and documentation on construction has been provided by the contractor JeDunn. JeDunn is a privately owned construction company that was founded in 1924 and has grown to be #186 on Forbes list of largest private companies.

A letter of attestation has also been provided in Attachment 10 from the architect on the project.

14. Section C. (Economic Feasibility) Item 2. Funding

The documentation of the availability of funding is noted. However, please revise the letters to reference the dollar amount of funding that will be provided.

See Attachment 11

The funding of 75% of project costs from CFG Capital Markets, LLC and 23% of the capital costs from Community Hospitality Healthcare Services is noted. However, how will the remaining 3% of Project Costs be funded?

The percentages are actually 85% (\$17M/\$20M) from CFG Capital Markets, LLC and 15% (\$3M/\$20M) from Community Hospitality Healthcare Services.

The applicant notes total Project Costs of \$23,000,000 which does not match the Project Costs Chart. If needed, please provide a replacement page for page 23 reflecting the correct funding amount.

As discussed in question 5 above, the applicant has included in the project \$3,000,000 of debt refinancing which is not related in any way to the construction. Because of this, it was excluded from the "Projects Costs Chart." The project cost is \$20,126,780.

15. Section C. (Economic Feasibility) Item 3

Please provide factors that contribute to higher construction costs of \$299.32 for the proposed hospital project which is slightly higher than the \$296.52 cost PSF 3rd quartile of hospital projects approved from 2012-2014.

JeDunn Construction estimates that construction inflation was 3% in 2015. The historical inflation adjusted cost per square foot for the 3rd quartile for 2016 is \$305 per square foot.

16. Section C. (Economic Feasibility) Item 4

The applicant completed older versions of the Projected and Historical Data Chart. Please complete the attached Historical and Projected Data Charts and submit. Please specify the unit of measure (i.e. - patient days) in line "A. utilization Data" for both of the above charts.

See Attachment 12

Historical Data Chart

There appears to be calculation errors in total operating expenses for 2013 and 2014. Please correct and submit a revised Historical Data Chart.

See Attachment 12

Why did charity care decline from \$837,130 in 2013 to \$274,237 in 2015?

A new urgent care center and a rural clinic opened in Ripley, TN over the last couple of years. They have taken cases away where charity care would be an option.

The retirement of principal in the amount of \$1,002,827 is noted for 2015. However, please explain how the Capital Expenditure affected Net Operating Income Less Capital Expenditures. Does this mean there is no remaining debt for the existing facility?

The retirement of capital in the amount of \$1,002,827 is not a true impact on profitability in 2015. The \$1,002,827 was only the principal payments made on debt in 2015 while the capital interest was the interest payments made in 2015. Capital interest expense is an expense on our income statement but retirement of capital is not an expense line on our financial statements. Depreciation expense is the retirement of capital expense over the useful life of the debt instrument. The reporting of retirement of capital "doubles up" our retirement of capital. When we finance the purchase of capital expenditures, we try to set up our debt instrument loans to the same length of time as the useful life of the capital expenditures. That way over the useful life of the capital the depreciation expense

matches our retirement of capital. Since the depreciation is straight line, an equal amount is depreciated each 12 months. When financing a debt instrument, less is paid in the first 12 months of the retirement of capital than the last 12 months of retiring the debt instrument.

Projected Data Chart

Please clarify why there are no management fees in the Projected Data Chart.

There are management fees in the projected data chart; they are included in line 8. However, with the new form provided, management fees will be much easier to discern.

See Attachment 12

Why is there no dollar amount in B.4 "other operating revenue" in the Projected Data Chart in Year One and Two, while there was \$500,784 assigned in the Historical Data Chart in 2015?

Other operating revenue is included in line B-4 on the historical data chart and on line E on the projected data chart. This will be corrected on the new, provided forms.

See Attachment 12

Is it realistic for outpatient services to increase from \$14,753,755 in 2015 to \$34,395,985 in Year One (2018) and for emergency services to decrease from \$20,930,088 in 2015 to \$8,572,030 in Year One? Please discuss.

The allocation of revenue was not consistently projected into the categories. This has been corrected on the new forms. See attachment 12

Is it noted the applicant is a for profit hospital. Please clarify the reason there are no taxes allocated in Year One and Year Two in the Projected Data Chart?

The Hospital is a part of a consolidated tax return which had no taxable income in 2014. In addition, the consolidated tax return for HMC/CAH continues to have Net Operating Loss carryforwards that would offset future income tax.

17. Section C. (Economic Feasibility) Item 5

Table sixteen identifying the project's average gross charge, average deduction from operating revenue, and average net charge is noted. The amounts do not match up with the Projected Data Chart. Please clarify and resubmit if needed.

The applicant pulled up gross charges, deductions, and net patient revenue from the projected data chart and they do match the figures in "Table Nine." Please keep in mind that for purposes of gross revenue, other operating revenue was excluded in "Table Nine" because it is not 'patient revenue'.

18. Section C. (Economic Feasibility) 7.

Please indicate the amount of utility cost savings the applicant will experience in Year One (2018) by moving to a new replacement hospital.

It is estimated that the new facility will incur approximately \$258,000 in utility cost in 2018. The applicant expects that to increase to approximately \$266,000 by 2019. That is an annual cost savings of approximately \$174,000 from 2015 to 2018. While some of these savings can be attributed to a new, energy efficient facility, it is also because the applicant will have emigrated from a facility of 78,341 Sq Ft to 46,851 Sq Ft.

19. Section C. (Economic Feasibility) Item 9.

The applicant notes the hospital provides over \$4 million in indigent care annually. Please clarify if the \$4 million dollar amount includes Provision for Bad Debt.

Yes, that figure includes provision for bad debts. Please see below the calculation of uncompensated care for LCH.

Table 2

Type	FY 2012	FY 2013	FY 2014
Charity	\$529,165	\$837,130	\$176,674
Bad Debt	\$3,972,229	\$3,415,875	\$3,835,255
Medicaid Uncompensated	-	\$360,498	\$174,521
Medicare Sequestration	-	\$56,359	\$43,455
Total Uncomp Care	\$4,501,394	\$4,669,862	\$4,229,905

20. Section C. (Economic Feasibility) Item 10.

Please provide the most recent audited financial statements for Lauderdale Community Hospital.

Lauderdale Community Hospital does not get audited as an individual business. The audit is done of the parent company, HMC/CAH Consolidated Inc, of which Lauderdale is a member. The latest audit for HMC/CAH Consolidated Inc. was provided with the original application as attachment 13.

The consolidated balance sheet for HMC/CAH, Inc. for the period ending September 30, 2014 indicates total liabilities of \$27,826,892 exceed current assets of \$18,814,047. Please clarify.

The primary reason for a low liquidity ratio is related to HMC/CAH's exit from bankruptcy. At the time, HMC/CAH was burdened with several million dollars of debt and millions in extraordinary expense items. We are recovering from our exit from bankruptcy; as our financials indicate. However, even with our low current ratio, it has not discouraged lenders from working with HMC/CAH to finance replacement facilities. It is not our current financial condition but the financial advantages the applicant would have with a new facility that is driving lender interest.

21. Section C. (Economic Feasibility) Item 11.b

If approved, please discuss what will happen to the existing hospital.

As noted in the application, the disposition of the existing building is in flux. There is talk of donating it to the County to be used for Medical Professional Education. But there is

January 29, 2016**9:59 am**

Ms. Tammie Hardy
Page 13

also the option of selling it to be used as a nursing home. The disposition of the facility will probably not be known until the latter months of the construction period.

22. Section C. Orderly Development, Item 7.d

Please indicate the date of the last survey by the Tennessee Department of Health. If needed, please provide a copy of survey and acceptance of the corrective action plan, if applicable.

The date of the last survey was June 15, 2011. See Attachment 13

23. Section C. Orderly Development, Items 8 and 9

Please provide a response indicating if there are any final order or judgements by a licensing agency, or any final civil or criminal judgments for fraud or theft against any person or entity with more than 5% ownership interest in the project.

As of today's date, the applicant is not aware of any orders or judgments against any person or entity with more than 5% ownership interest in the project.

AFFIDAVIT

JAN 29 16 09:59

STATE OF MISSOURI

COUNTY OF JACKSON

NAME OF FACILITY: LAUDERDALE COMMUNITY HOSPITAL

I, Trent Skaggs, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Trent Skaggs Exec VP
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28th day of January, 2016,
witness my hand at office in the County of Jackson, State of Missouri

Linda K Way
Notary Public - Notary Seal
STATE OF MISSOURI
Jackson County
Commission Expires: Nov. 17, 2018
Commission #14444354

Linda K Way
NOTARY PUBLIC

My commission expires Nov 17, 2018.

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 4

Question 6- Section B, Item II(A)

Revised Square Footage and Cost per Square Foot Chart

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 8

Question 13- Section C, Economic Feasibility, Item 1

Facility Appraisal

**SUMMARY OF SALIENT FACTS**

Property	Baptist Memorial Hospital – Lauderdale 326 Asbury Avenue Ripley, Tennessee
Assessor's Parcel Number	094-027.04
Interest Appraised	Fee Simple Estate
Effective Date of Appraisal:	March 8, 2010
Date of Physical Inspection	March 8, 2010
Date of Report	March 8, 2010
Type of Value	To estimate the market value of the fee simple interest of the subject facility's going concern as of the date specified within this report.
Intended Use	In connection with conventional financing
Land Size	1,522,422 square feet, or 34.95 acres (per county assessor)
Zoning	H-1 (Hospital and Medical)
Building Description	The improvements include a one-story, approximately 80,000-square-foot, critical access hospital built in 1982 that contains 25 acute-care and 10 geriatric psychiatric beds. The quality of construction and the condition of the improvements are average.
Licensing	25 beds (Pediatric Basic and Critical Access) 10 beds (Geriatric Psychiatric)
Highest and Best Use:	
As Vacant	Medically related use
As Developed	Continue use as is

**Value Indicators:****Cost Approach**

Land	\$120,000
Improvements	9,700,000
Equipment	<u>1,620,470</u>
Value Indication	\$11,440,470

Sales Comparison Approach

Value Indication	\$3,890,000
------------------	-------------

Income Capitalization Approach

Adjusted Patient Days	4,563
EBITDA	\$707,332
Capitalization Rate	<u>18.0%</u>
Value Indication (rounded)	\$3,930,000

Value Conclusion - Fee Simple	\$3,930,000
-------------------------------	-------------

This value may be allocated as follows:

Land	\$120,000
Improvements	2,189,530
Equipment	1,620,470
Business	<u>0</u>
Total	\$3,930,000

Special Limiting Conditions:

It is assumed that the subject is efficiently managed, with proven and ready operations, and is an established business.

In arriving at the opinion expressed in this report, we assumed that the title to the property is free and clear and held under responsible ownership. Management is considered to be a competent and professional healthcare provider.

Some of Management's assumptions inevitably may not materialize and unanticipated events and circumstances may occur. Therefore, actual results achieved may vary from Management's forecasts and the variations may be material.

Historical operating data was provided by the owner. It is assumed this financial data is correct and will accurately reflect the operating performance of the subject property. Otherwise, our valuation conclusions may be subject to change.

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 9

Question 13- Section C, Economic Feasibility, Item 1

Project Costs Chart

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 10

Question 13- Section C, Economic Feasibility, Item 1

Construction Documentation



Attachment 10 208
Question 13, Section C, Economic
Feasibility, Item 1
@Construction Documentation

SUPPLEMENTAL #1

January 29, 2016

9:59 am LOCUST STREET
KANSAS CITY, MO 64106

TEL 816.474.8600 | FAX 816.391.2510

www.jedunn.com

January 25, 2016

Mr. Larry Arthur
Rural Community Hospitals of America, LLC
1100 Main Street Suite 2350
Kansas City, MO 64106

Re: Lauderdale Community Hospital – Ripley, TN

Dear Larry,

We are pleased to be working on the Lauderdale Community Hospital project in Ripley TN. We will construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specification and requirements. Attached you will find the preliminary budget breakdown, qualification, schedule and projected cash flow. The project is being designed by ACI/Boland/FSC, Inc. and Bob D. Campbell. We anticipate and 150-180 day process for design, bidding and permitting through CON. We anticipate a 3rd quarter, 2016 construction start.

We appreciate the opportunity to submit this budget proposal and look forward to providing our services on this project.

Feel free to contact me if you have any questions or comments.

JE DUNN CONSTRUCTION

Joseph L. Cisper

CC: File
Jeff Yartz
Rob Clevenger
Jim R. Miller



Lauderdale Community Hospital
 Ripley, TN
 June 30, 2015
 Concept Estimate



Construction Cost Summary

Description	Quantity	Cost	Unit Cost
Sitework	150 Cars	1,290,053	8,575
Medical Facility	46,851 SF	13,024,282	277.99
Construction Subtotal	46,851 SF	14,314,335	\$305.53
Design Fees & Reimbursables	8%	1,145,147	24.44
Design Contingency	4%	618,379	13.20
Construction Contingency	4%	572,573	12.22
Escalation to 3rd Qtr 2016	6%	999,026	21.32
Total Construction Cost	46,851 SF	\$17,649,461	\$376.71

Lauderdale Community Hospital
Ripley, TN

June 30, 2015

Concept Estimate



Sitework

<i>Item</i>	<i>Description</i>	<i>Cost</i>
1	General Requirements	86,434
2	Excavation and Grading	409,337
3	Asphalt Paving	162,944
4	Concrete Work	77,221
5	Site Structures	0
6	Fencing	0
7	Specialty Paving	20,149
8	Signage and Striping	16,555
9	Site Specialties	29,292
10	Site Utilities	40,992
11	Storm Drainage Systems	66,517
12	Fire Protection	51,059
13	Landscaping and Irrigation	89,551
14	Electrical	141,160
	Subtotal	1,191,210
	Permits, Bonds and Insurance	37,412
	Contingency	0
	Escalation	0
	Fee	61,431
	Total	\$1,290,053

Lauderdale Community Hospital

Ripley, TN

June 30, 2015

Concept Estimate

**1 Story Hospital**

37,610 SF

Item	Description	Cost	Cost/SF
1	General Requirements	745,833	19.83
2	Excavation	96,694	2.57
3	Building Structure	910,847	24.22
4	Building Skin	260,933	6.94
5	Interior Masonry	0	0.00
6	Rough Carpentry	111,573	2.97
7	Finish Carpentry and Millwork	421,577	11.21
8	Membrane Roofing	260,191	6.92
9	Sheet Metal	47,920	1.27
10	Caulking and Dampproofing	63,955	1.70
11	Doors, Frames and Hardware	363,287	9.66
12	Glass and Glazing Systems	244,366	6.50
13	Plaster and Drywall Systems	707,790	18.82
14	Stone and Tile	44,836	1.19
15	Ceilings	169,738	4.51
16	Flooring	235,502	6.26
17	Painting	80,869	2.15
18	Specialties	175,425	4.66
19	Equipment and Furnishings	167,158	4.44
20	Special Construction	67,005	1.78
21	Elevators	0	0.00
22	Fire Protection	6,765	0.18
23	Plumbing	1,483,853	39.45
24	HVAC Systems	2,047,123	54.43
25	Electrical	1,565,678	41.63
	Subtotal	10,278,919	273.30
	Permits, Bonds and Insurance	322,823	8.58
	Contingency	0	0.00
	Escalation	0	0.00
	Fee	530,087	14.09
	Total	\$11,131,829	\$295.98

Skin/Floor Area Ratio 41%
Glass/Skin Area Ratio 23%

Total Skin Cost, Contact Area \$46.50 /SF
Skin Cost, Bldg Area \$13.44 /SF

212

MOB

SUPPLEMENTAL #1

January 29, 2016

9:59 am

Lauderdale Community Hospital

Ripley, TN

June 30, 2015

Concept Estimate

**1 Story Medical Building**

9,241 SF

Item	Description	Cost	Cost/SF
1	General Requirements	126,794	13.72
2	Excavation	26,315	2.85
3	Building Structure	233,552	25.27
4	Building Skin	63,703	6.89
5	Interior Masonry	0	0.00
6	Rough Carpentry	29,658	3.21
7	Finish Carpentry and Millwork	102,366	11.08
8	Membrane Roofing	78,658	8.51
9	Sheet Metal	10,827	1.17
10	Caulking and Dampproofing	14,719	1.59
11	Doors, Frames and Hardware	98,289	10.64
12	Glass and Glazing Systems	51,700	5.59
13	Plaster and Drywall Systems	180,436	19.53
14	Ceramic Tile	0	0.00
15	Ceilings	43,229	4.68
16	Flooring	47,334	5.12
17	Painting	20,411	2.21
18	Specialties	15,016	1.62
19	Equipment and Furnishings	5,956	0.64
20	Special Construction	0	0.00
21	Elevators	0	0.00
22	Fire Protection	27,535	2.98
23	Plumbing	158,085	17.11
24	HVAC Systems	189,702	20.53
25	Electrical	223,170	24.15
	Subtotal	1,747,455	189.10
	Permits, Bonds and Insurance	54,881	5.94
	Contingency	0	0.00
	Escalation	0	0.00
	Fee	90,117	9.75
	Total	\$1,892,453	\$204.79

Skin/Floor Area Ratio 38%
 Glass/Skin Area Ratio 14%

Total Skin Cost, Contact Area \$48.93 /SF
 Skin Cost, Bldg Area \$12.49 /SF

January 29, 2016

9:59 am



ACI/BOLAND, INC. – KANSAS CITY
 1421 E 104th Street, Suite 100
 Kansas City, Missouri 64131
 T.816.763.9600
 F.816.763.9757

January 26, 2016

Mr. Larry Arthur
 Rural Community Hospitals of America, LLC
 1100 Main Street Suite 2350
 Kansas City, MO 64106

Re: Lauderdale Community Hospital – Ripley, TN

Dear Larry:

We look forward to working with you on the hospital replacement project at Lauderdale Community Hospital. As you are aware, we attest that our design will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the latest AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

Should you need any further information from me during this process please feel free to contact me directly.

Sincerely,

ACI BOLAND, Inc.

A handwritten signature in black ink, appearing to read 'V. L. Mosby', written over a large, stylized, looping flourish.

Victor L. Mosby,
 Principal / Architect

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 12

Question 16- Section C, Economic Feasibility, Item 4

Historical and Projected Data Charts

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 13

Question 22- Section C, Orderly Development, Item 7(d)

Last Survey by the Tennessee Dept of Health

January 29, 2016

9:59 am

Attachment 13
Question 22- Section C, (Orderly
Development), Item 7(d)
Last Survey by the Tennessee Dept of Health



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGHWAY 45 BYPASS
JACKSON, TENNESSEE 38305
(731)984-9684

June 21, 2011

Mr. Scott Tongate, Administrator
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

RE: Licensure Survey

Dear Mr. Tongate:

We are pleased to advise you that no deficiencies were cited as a result of the licensure survey completed at your facility on **June 15, 2011**. The attached form is for your files.

If this office may be of any assistance to you, please do not hesitate to call (731) 984-9711.

Sincerely,

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CS/TW

Enclosure

January 29, 2016

9:59 am

PRINTED: 06/21/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53188A	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2011
--------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER LAUDERDALE COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 328 ASBURY AVENUE RIPLEY, TN 38063
-------------------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

H 002	1200-8-1 No Deficiencies This Rule is not met as evidenced by: Based on record review, observation and interview, the facility was found in compliance with State requirements for Hospitals. No deficiencies were cited during this annual licensure survey.	H 002	COPY	
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-------------	--

Division of Health Care Facilities

LABORATORY DIRECTOR FOR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM 6500

COPY

(X6) DATE

ORHE11

If continuation sheet 1 of 1

January 29, 2016**9:59 am**

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
2975 C HIGHWAY 46 BYPASS
JACKSON, TENNESSEE 38305
(731)984-9684

June 21, 2011

Mr. Scott Tongate, Administrator
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

RE: PECU Licensure Survey

Dear Administrator:

We are pleased to advise you that no deficiencies were cited as a result of the licensure survey conducted at your facility on **June 15, 2011**. The attached form is for your files.

If this office may be of any assistance to you, please do not hesitate to call (731) 984-9684.

Sincerely,

Handwritten signature of Cella Skelley in cursive.

Cella Skelley, MSN, RN
Public Health Nurse Consultant 2

Handwritten initials CS/TW.
CS/TW

Enclosure

January 29, 2016

9:59 am

PRINTED: 06/21/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53188A	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2011
NAME OF PROVIDER OR SUPPLIER LAUDERDALE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 326 ASBURY AVENUE RIPLEY, TN 38063		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 002	1200-8-30 No Deficiencies This facility complies with all requirements for participation as BASIC level in the Pediatric Emergency Care Unit program. No deficiencies were cited during the annual licensure survey conducted on 6/15/11.	P 002		

COPY

Division of Health Care Facilities

COPY

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6809

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COPY

If continuation sheet 1 of 1

January 29, 2016**9:59 am**

STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
 WEST TENNESSEE HEALTH CARE FACILITIES
 2975 C HIGHWAY 45 BYPASS
 JACKSON, TENNESSEE 38305

June 21, 2011

Mr. Scott Tongate, Administrator
 Lauderdale Community Hospital
 326 Asbury Avenue
 Ripley, TN 38063

RE: Fire Safety Licensure Survey

Dear Mr. Tongate:

Enclosed is the statement of deficiencies for the fire safety licensure survey completed at your facility on **June 15, 2010**. Based upon 1200-8-1, you are asked to submit an acceptable plan of correction for achieving compliance with completion dates, and signature **10 days from the date of this letter**.

Please address each deficiency separately with positive and specific statements advising this office of a plan of correction that includes acceptable time schedule, which will lead to the correction of the cited deficiencies. Enter on the right side of the State Form, opposite the deficiencies, your planned action to correct the deficiencies and the expected completion date. The completion date can be no longer than **45 days from the day of survey**. Before the plan can be considered "acceptable," it must be signed and dated by the administrator

Your plan of correction must contain the following:

- How the deficiency will be corrected;
- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How ongoing compliance will be monitored.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If assistance is needed, please feel free to call me at 731-984-9711.

Sincerely,

Celia Skelley

Celia Skelley, MSN, RN
 Public Health Consultant Nurse 2

CS/TW *tr*

January 29, 2016

9:59 am

PRINTED: 06/21/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53188A	(X2) MULTIPLE CONSTRUCTION A. BUILDING 77 - LICENSE B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2011
--------------------------------------------------	---------------------------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER LAUDERDALE COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 326 ASBURY AVENUE RIPLEY, TN 38083
-------------------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 900	<p>1200-8-1-.09 Life Safety</p> <p>This Rule is not met as evidenced by: 2-3.5.1*</p> <p>In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors.</p> <p>Detectors should not be located in a direct airflow nor closer than 3 ft (1 m) from an air supply diffuser or return air opening. Supply or return sources larger than those commonly found in residential and small commercial establishments can require greater clearance to smoke detectors. Similarly, smoke detectors should be located farther away from high velocity air supplies.</p> <p>Based on observation, it was determined that the facility failed to maintain the required space between smoke detectors and air supply and air return openings.</p> <p>The findings included:</p> <p>Observation of the facility on 6/15/11, revealed a smoke detector inside the surgery hallway too close to the air supply diffuser; a smoke detector outside the anesthesia office too close to the air supply diffuser, and a smoke detector inside the radiology entrance was too close to the air return diffuser.</p>	H 900		
H 902	<p>1200-8-1-.09 (2) Life Safety</p> <p>(2) The hospital shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift</p>	H 902		

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6699

ORHE21

If continuation sheet 1 of 2

January 29, 2016

9:59 am PRINTED: 08/21/2011
FORM APPROVED

Division of Health Care Facilities

JAN 29 10 08:57

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNP53188A	(X2) MULTIPLE CONSTRUCTION A. BUILDING 77 - LICENSE B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2011
NAME OF PROVIDER OR SUPPLIER LAUDERDALE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 326 ASBURY AVENUE RIPLEY, TN 38063		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 902	<p>Continued From page 1</p> <p>for hospital personnel in each separate patient-occupied hospital building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of patient(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.</p> <p>Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.</p> <p>This Rule is not met as evidenced by: Based on document review, it was determined that the facility failed to conduct fire drills for all shifts.</p> <p>The findings included:</p> <p>During document review on 6/15/11, the facility failed to provide documentation that second shift fire drills had been conducted for the third and fourth quarter of 2010, and the first quarter of 2011.</p>	H 902		

January 29, 2016**9:59 am**09:59:01 PM
1/29/2016*(HMC/CAH Consolidated, Inc.) -for the period ending September 30, 2014***Capitalization (long-term debt to capitalization) ratio**

Measures the proportion of debt financing in a business's permanent (long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions.	Long-Term Debt	Total Equity (Net Assets)	Capitalization Ratio
Capitalization Ratio Formula: $(\text{Long-term debt} + (\text{Long-term debt} + \text{Total equity (net assets)}) \times 100)$	\$43,381,879	-\$30,204,040	3.29

COPY
Supplemental- #2

**CAH Acquisition Company 11,
LLC**

CN1601-004

February 23, 2016**9:32 am****State of Tennessee****Health Services and Development Agency**

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

www.tn.gov/hsda Phone: 615-741-2364/Fax:615/532-9940

February 2, 2016

Tammie Hardy
Lauderdale Community Hospital
326 Asbury Avenue
Ripley, TN 38063

RE: Certificate of Need Application CN1601-004
CAH Acquisition Company 11, LLC

Dear Ms. Hardy:

This will acknowledge our January 29, 2016 receipt of your supplemental response for a Certificate of Need for the construction and replacement of a 25 bed Critical Bed Access Hospital located at 326 Asbury Avenue, Ripley (Lauderdale County), TN 38063.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12 PM, Thursday February 11, 2016. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

1. Section A, Applicant Profile Item 6

It appears the applicant will enter into an Option to Purchase Agreement or Lease Agreement. If so, please revise the response to question #6 and provide a replacement page 3R.

See Replacement Page 3R and Attachment 1

2. Section A, Applicant Profile Item 13

The applicant indicates being contracted with AmeriGroup and TennCare Select. However, the 2014 Joint Annual Report for the applicant indicates no inpatient revenue for either plan. Please clarify.

The Amerigroup contract became effective 1/1/14. The state did not autoselect patients in the Lauderdale area into Amerigroup until 1/1/15. So, in 2015 the applicant should start seeing volume in Amerigroup.

TennCare Select is a very small portion of the TennCare patient population in Lauderdale County. There is TennCare Select volume in 2014, however it is outpatient only.

Ms. Tammie Hardy
Page 2

3. Section B. I. Project Description and Applicant Profile Item 6

The lease agreement is Attachment 3 in Supplemental #1 is noted. However, the applicant provided a lease agreement that is not fully executed and legally binding. Furthermore, the Lessor is left blank and not identified in the lease agreement. The applicant states in the supplemental response that a new company will be established during the construction period that will hold the lease (lessor).

Once the new company is established that will hold the lease, a copy of the partnership agreement, or corporate charter and certificate of corporate existence, if applicable, from the Tennessee Secretary of State is requested. Please also provide an ownership chart of the new company (lessor). A fully executed signed option to lease or lease agreement must be provided.

An executed copy of the Lease between the parties (i.e. Lessor and Lessee) is not yet available. In lieu thereof the applicant has provided a fully executed signed Lease Term Sheet which, among other things, gives the Lessee a series of options to lease the Project from the Lessor for an aggregate term of 30 years. You'll notice in the attached fully executed Lease Term Sheet that the project cost is listed as \$23M. As you may recall, there is \$3M of debt restructuring in addition to construction. We discussed this and agreed to go with the project cost at \$20M despite this difference. See Attachment 1.

It appears that a copy of a fully executed joint venture agreement between all parties that will form the "NewCo" that will hold the lease agreement is needed to confirm site control of the project.

CBC Real Estate Group (CBC) will be the party that forms the new company (NewCo) as the wholly owned subsidiary of CBC. Lessor will hold the Lease and control the Property and the Project during the construction period. During the construction period, NewCo will act as the developer of the Project for CBC.

If the applicant, CAH Acquisition Company #11, LLC owns the 23.976 acre tract, then why is the applicant proposing to lease the 23+ acre tract from the lessor (to be named)?

The Project is structured as a build-to-suit lease transaction under which Lessor is obligated to construct the Project in accordance with LCH's plans and specifications. Upon final completion of the project, Lessor will lease the Property back to Lessee.

In order to accomplish a build-to-suit lease transaction of this type, LCH will (upon the signing of the Lease) deed and convey fee simple title to the 23+ acre tract to Lessor. This conveyance will enable Lessor to perform its obligations under the Lease to construct the Project to LCH's plans and specifications and lease the Property back to Lessee.

It is noted CAH Acquisition Company #11, LLC holds the deed to the 35 acre property. Please provide a ground lease between CAH Acquisition Company #11, LLC and the lessor.

There will not be a ground (land only) lease involved in the Project. As noted above, the Project is structured as a build-to-suit lease transaction, under which the parties (i.e. the Lessor and the Lessee) sign an agreement (i.e. the Lease) leasing the Property and Project (i.e. both land and improvements) back to the Lessee.

In the lease agreement it is noted the CAH Management Company or affiliate will provide a corporate guaranty for lease payments of the facility. Please clarify.

HMC/CAH Consolidated, Inc., a Delaware for profit corporation ("HMC") is the sole member of LCH (the applicant) and will provide a corporate guaranty to Lessor of the payments and obligations under the Lease.

It is noted that at closing of the lease transaction, the lessee will convey fee title to the lessor. The lessee will leaseback Parcel 2 from the lessor. Is this included in the lease provided, or will there be a separate lease? If so, please provide.

The obligation of LCH to deed fee title to Lessor is stated in the Lease Term Sheet (Attachment 1) and this obligation will also be stated in the Lease.

Please provide a diagram reflecting the following for each phase of the proposed project: 1) funding, 2) development 3) turnkey transaction, and 4) final ownership of assets and operations.

See Attachment 2

4. Section B. I. Project Description

It is noted private rooms in the proposed bed newly constructed hospital will be 237 SF. However, the floor plan for room #136 indicates 230 SF. Please clarify.

230 SF is correct.

The 2014 Joint Annual Report indicates the current facility has a helipad. Please clarify if the existing helipad will be used for the new proposed facility.

No. A new helipad will be built as part of the new construction and the existing helipad will no longer be used.

The applicant provided a list of 12 HMC/CAH hospitals which filed for bankruptcy in the past. However, it appears there are 3 hospitals not listed (CAH Acquisition Co., LLC 13, CAH Acquisition Co., LLC 14, CAH Acquisition Co., LLC 15). What is the status of these hospitals?

When the Chapter 11 proceeding was filed in October 2011, HMC owned and operated only the 12 listed hospital subsidiaries. HMC has never owned and operated more than the 12 listed subsidiaries. HMC has never owned and operated any hospital subsidiaries numbered 13, 14 and 15.

5. Section C. (Economic Feasibility) Item 1. (Project Cost Chart)

The following definition regarding items acquired by lease in Tennessee Health Services and Development Agency Rule 0720-2-.01 (12)(d) states " If the acquisition is by lease, the cost is either the fair market value of the property, or the total amount of the lease payments, whichever is greater."

Please provide documentation of the fair market values of both the land and the building and the calculation of the total amount of the lease payments over the term of the lease. Please insert the greater amount in line B.1 of the Project Costs cost and resubmit a replacement page.

Ms. Tammie Hardy
Page 4

See Attachment 3 and requested replacement page

Escalation to 3rd Qtr. 2016 cost of \$999,026 in the Construction Cost Summary located on page 45 of supplemental #1 is noted. However, please clarify where this cost is allocated in the Project Costs Chart.

The Escalation to 3rd Qtr 2016 cost of \$999,026 was included on line A.5 (Construction Cost) of the Project Costs Chart. Or it was until the applicant changed the Project Costs Chart to represent total of lease payments (per previous question)

6. Section C. (Economic Feasibility) Item 2. Funding

The funding of 85% of project costs from CFG Capital Markets, LLC and 15% of the capital costs from Community Hospitality Healthcare Services (CHHS) is noted. However, the letter from CHHS notes up to 23%. Please clarify and revise if needed and provide a replacement page 23.

New Market Tax Credit (NMTC) is a program enacted by Congress to encourage private sector capital investment into low-income communities in order to stimulate economic development and create jobs. The NMTC program accomplishes these goals by offering tax credit-enhanced financing to qualified projects through qualified community development entities (CDEs). CDEs use standard industry lender underwriting and approval requirements.

The NMTC program is subject to an annual allocation of federal tax credits by Congress to CDEs.

CHHS is a qualified CDE and has been a NMTC industry leader for many years. CHHS receives annual allocations of tax credits from the NMTC program. CHHS states in its letter of support for the Project that the build-to-suit transaction described in the Lease Term Sheet meets its initial thresholds for underwriting. See Attachment 4.

CHHS further states that it anticipates providing tax credits from its NMTC allocation for FY2016 totaling up to 23% of Project cost. In this regard, it should be noted that in order to be conservative in its financing proposal for the Project, the applicant has included NMTCs totaling only 15% in the funding calculation for the Project.

Documentation on the NMTC program along with CHHS's estimate on the amount of tax credits that will be made available for the Project were attached to the original CON in the form of the support letter from CHHS as well as an overview of NMTC provided in answer to Question 5 (Section B.I.) of the Supplemental Submission. Both are attached to this Supplemental request as well. No replacement page 23 is required. See Attachment 4.

It is noted the New Markets Tax Credit represents \$3,000,000 or 15% of the funding project. However, please clarify if the New Market Tax Credit is awarded in a competitive application process, or is it guaranteed. If the applicant is relying on financing \$3,000,000 using New market Tax Credit, please provide a letter from the funding source guaranteeing \$3,000,000 in New Market Tax Credit.

The NMTC process is indeed a competitive one, with certain criteria being required to qualify. However, based on CHHS's experience with applying and getting these credits from the Federal Government, estimates are such that they will provide up to 23% of the

project cost. Documentation on this process along with CHHS conclusions on the amounts available for the project were attached to the original CON in Attachment 11 in the form of a letter from CHHS as well as the overview of NMTCs provided in answer to Question 5 (Section B.I.) of the Supplemental Submission. Both are attached to this Supplemental request as well. See Attachment 4

The letter from CFG (not a lending institution) regarding the \$17.25 million to fund the project is noted. However, as prescribed in the Certificate of Need application, a letter is required from each lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions. Please provide.

While CFG is not a lending institution, they are facilitating the capital raise for this project. CBC is the lessor and developer and will be providing \$17 million of the debt required for this project. CHHS is a lender and will be providing the remaining \$3 million in the form of tax credits. Both CFG and CHHS have provided letters of intent which were attached to the original CON with revised copies attached to the Supplemental Questions #1. Also, please find the fully executed Term Sheet in Attachment 1 for clarification of these relationships.

7. Section C. (Economic Feasibility) Item 4

The applicant indicates there were 2,347 patient days in 2014 in the Historical Data Chart and 1,167 patient days in Table Six on page 20. However, the 2014 Joint Annual Report indicates there were 984 patient days in 2014. Please clarify. If necessary, please revise and submit replacement pages.

The Joint Annual Report (JAR) is correct; there are 984 acute patient days in 2014. A replacement Historical Data Chart will be provided. The Historical Data Chart however, will not tie directly to the JAR. The JAR looks specifically at acute days; meanwhile the Historical Data Chart as well as all financial projections also take into consideration Swing Bed Days. The two together will give you the 2,164 days found on the revised Historical Data Chart. ($984 + 1,180 = 2,164$)

It is noted the applicant allocated \$120,055 in the Historical Data Chart while the hospital experienced a loss of \$673,041 in 2015. Please breakout the \$120,055 tax expense and explain the reason why it was allocated.

The taxes shown on line 4 are not income taxes and therefore were not allocated. As stated previously, LCH is part of the HMC/CAH Consolidated tax return, which had no taxable income in 2014 or 2015. So no income taxes were allocated. Below please find a listing of the taxes in question.

Table1: Tax Expense Breakout

LCH CON HISTORICAL DATA					
Tax Breakout					
	Historical			Projected	
Joint Annual Report for the applicant reflects \$125,180 in local property taxes paid. Please include:					
Corporate Franchise Tax *	23,589	2,383	7,407	7,500	7,500
Property Tax	129,201	125,180	106,151	206,610	190,442
Sales Tax	-	6,617	6,497	6,500	6,500
Income Tax	-	479,059	150,053	261,990	438,012
TOTAL	152,790	613,239	270,108	482,600	642,454

The 2014 Joint Annual Report for the applicant reflects \$125,180 in local property taxes paid. Please include local property taxes in the Projected Data Chart for Year One and Year Two.

As you can see in Table 1 above, local property taxes have been included in the Historical Data Chart. Likewise, the Projected Data Chart has projected taxes (line d.4) of \$482,600 and \$642,454 in years one and two respectively. The projection of local property taxes is embedded in those two numbers. Please see replacement pages for the Historical and Projected Data Charts.

It is noted the hospital is part of the consolidated tax return which had no taxable income in 2014. It is also noted the applicant, CAH Acquisition Company 11, LLC, experienced \$1,182,861 in net income in 2014. Please revise the Projected Data Chart by allocating tax expense for 2018 and 2019 to CAH Acquisition Company #11, then accounting for the offset of the tax expense. This will account for the taxable income expense and the offset of income taxes.

As you can see above in Table 1 and also in the replacement pages for the Historical and Projected Data Charts, An estimate for income taxes has been added. On the data charts, the taxes are included on line D.4 with the offset showing on Line E.

8. Section C. (Economic Feasibility) Item 10.

The Capitalization (long-term debt to capitalization) ratio table for HMC/CAH Consolidated, Inc. for the latest audited financial reporting year is noted. However, the ratio appears to be incorrect. It appears from the data provided the ratio calculates to 58.95. Please verify.

(HMC/CAH Consolidated, Inc.)- For the period ending 20XX.

Capitalization (long-term debt to capitalization) ratio

Measures the proportion of debt financing in a business's permanent (long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by	Long-Term Debt	Total Equity (Net Assets)	Capitalization Ratio

short-term financing decisions.			
Capitalization Ratio Formula: (Long-term debt ÷ (Long-term debt + Total equity (net assets)) x 100)	\$43,381,879	\$-30,204,040	329.2

Accordinging calculation for this ratio, it indicates that 329.2 is correct. $43,381,879 / (43,381,879 + (-30,204,040)) = 43,381,879 / 13,177,839 = 3.29 * 100 = 329.2$ The reservation with this calculation may be the presence of negative equity on the balance sheet. Because net equity is negative, the denominator, which normally adds debt to equity, is in effect subtracting equity. With the denominator being so much lower, we end up with an inflated ratio. The presence of negative equity on the balance sheet is related to many prior years of negative operating results; results that came during the years when HMC/CAH was turning around LCH and building a financially stable and profitable hospital that can properly service the Ripley, TN area into the future. Current profits are shrinking that equity figure and the applicant is confident that LCH will have positive equity in the future. The applicant believes that this ratio cannot be applied properly when negative equity exists as it artificially inflates the result. In addition, the ratio is meant as a predictor of future performance and given that the negative equity is representative of an unprofitable past that is no longer true, the applicant believes that this ratio should not be used.

The HMC/CAH Consolidated Inc. financial information for the year ending September 30, 2014 is noted. On page 190 of the report, it is noted 12 out of the 13 hospitals owned by HMC/CAH Consolidated, Inc. was operating at a net loss totaling \$5,131,233. In addition, the only hospital owned by HMC/CAH Consolidated, Inc. that operated with net income for the year ending September 30, 2014 was the applicant, Lauderdale Hospital (CAH Acquisition Company 11, LLC), with \$1,182,861. Please respond to the following:

- **Please identify and discuss the factors that made the applicant, Lauderdale Hospital (CAH Acquisition Company 11, LLC), more financially viable with net income of \$1,182,861, from the other 12 hospitals which operated at a net loss.**

Fiscal Year 2014 had some extraordinary items in it that affected the bottom line of all facilities, some more than others. HMC/CAH Consolidated emerged from bankruptcy in 2013 and because of this, no audit had been done during that time (2010 to 2013). As a result, 2014 had a lot of cleanup from prior years as well as one-time bankruptcy adjustments in it that were all booked in 2014 in anticipation of the applicant's first audit since 2010. The net result was lower than expected bottom lines. However, despite the bankruptcy and subsequent adjustments, HMC/CAH Consolidated still produced a positive EBITDA.

However, there are several advantages that LCH enjoys over her sister facilities. First, LCH is a large hospital in comparison to most of the other facilities. LCH has 25 beds; meanwhile 8 of the 12 facilities have no more than 15 beds; so LCH is equipped to take more volume than the rest. LCH also has a primary service area without any direct competitors in it. The closest competitor is Baptist Memorial Hospital, which is approximately 20 miles away in Covington, TN. The primary service area also has a population topping 17,000; the next closest primary service area is no more than 10,000. LCH has our most active ER in the system and, up until lately,

our most prolific surgeon. Lastly, LCH is in Tennessee and Tennessee does more than any other state the applicant operates in to cover the medically indigent. Between the TennCare program that covers the cost of Medicaid eligible patients and the Uncompensated Care Fund pool, LCH is better reimbursed for Medicaid and uninsured patients than most other facilities.

- **Please provide a date when HMC/CAH Consolidated, Inc. projects the corporation as a whole will operate with net income.**

There are many variables, the largest of which is the timing regarding replacement facilities and the associated financing. In our latest projections, which assumes LCH replacement in 2016 as well as other facilities within the system throughout 2016-7, HMC/CAH Consolidated could see a small, positive net income in 2016. However, it would be 2018 before any significant bottom line gains would be seen. But these projections all assume no significant changes to Medicare and/or Medicaid reimbursement rates in the future. They also assume no major regulatory changes in the future. Based on the information available now, 2018 is projected to offer a positive net income.

The applicant also feels that other factors need to be taken into account when contemplating future profitability with regard to HMC/CAH Consolidated. HMC/CAH was not created with the idea of operating hospitals in old, outdated buildings. The original business plan included replacing these facilities and capitalizing on the CAH program as illustrated in the Stroudwater Replacement Facility Study of 2011. Obviously this business plan was interrupted by the bankruptcy and only now is HMC/CAH getting back to their original plan. While replacing LCH is part of this plan, LCH's sister facility in Hillsboro, Ks has already closed on their financing and have started the construction process. Pending CON approval and closing on LCH, three more sister facilities await similar treatment behind LCH. It is the applicant's belief that HMC/CAH has turned the corner and will continue to see more profitability as more facilities are replaced.

9. Section C. Orderly Development, Item 7.d.

Please provide a copy of the last accreditation survey conducted by Certificate of Accreditation by DNV GL-Healthcare.

The latest accreditation survey was provided with the original CON as attachment 15. However, the applicant found out that the actual certificate itself was left out. As a result, it is included here in Attachment 5.

10. Section C. Orderly Development, Items 8 and 9

There appears to be a recent civil judgement against CAH Acquisition 10, LLC (Yadkin Valley Community Hospital, Yadkinville, NC) and the parent company Rural Community of America, LLC. Please provide an overview of the civil judgement and amount of penalties assessed.

HMC/CAH Consolidated, Inc. ("HMC") is the wholly owned subsidiary of CAH Acquisition Company 10, LLC ("CAH10").

In May 2010, CAH10 purchased from the County of Yadkin, North Carolina (the "County") the business and assets of *Hoots Memorial Hospital* which was located in Yadkinville, North Carolina (the "Hospital"). After the closing of the Hospital purchase, CAH10 renamed the Hospital - *Yadkin Valley Community Hospital*. The County retained ownership of the hospital building and improvements (the "Hospital Premises") and leased the Hospital Premises to CAH 10. The original Hospital lease was amended in 2012 and again in April 2013. In January 2013, CAH10 entered into a management agreement with Rural Community Hospitals of America ("RCHA"). At that time of the April 2013 amendment, the expiration date of the Hospital lease was extended to April 30 2015.

Prior to the end of the extended term, the County of Yadkin informed CAH 10 that it would not renew or extend the Hospital lease beyond the April 30, 2015 expiration date, because it wanted to replace CAH 10 with another hospital operator, Hugh Chatham Memorial Hospital ("Hugh Chatham"). In January 2015, CAH10 entered into negotiations with Hugh Chatham to sell to it the business and assets of the Hospital. During the first four months of 2015, the parties engaged in negotiations and due diligence.

As the April 30, 2015 lease expiration date approached with no sale agreement in place with Hugh Chatham, CAH 10 informed the County that it would need to issue the notice under the Worker Adjustment and Retraining Notification Act (WARN)), a United States labor law which protects employees and communities by requiring covered employers to provide 60 calendar-day advance notification of a closings and layoffs of employees. The notice stated that the hospital would close on April 30. The County refused to expend the Hospital lease and the WARN notice was issued on February 27, 2015.

Negotiations with Hugh Chatham continued and, on March 24, 2015, a non-binding term sheet for the sale of the Hospital business and assets was signed by CAH 10 and Hugh Chatham. The term sheet anticipated the sale of the hospital to occur by August 1, 2015. Thereafter, the County extended the Hospital lease through July 31, 2015 in order to allow the parties to finish the sale transaction contemplated by the March 24, 2015 term sheet. On April 16, 2015, Hugh Chatham (without explanation) ended negotiations with CAH10 and cancelled the term sheet.

In early May, 2015, CAH 10 put the County on notice that due to the loss in key managerial and clinical staff and the overall economic deterioration of the hospital, CAH10 might have to close the hospital prior to July 30, 2015. Attempts were made to negotiate a long term lease with the County but the County would not offer acceptable lease terms. Thereafter, CAH 10 attempted to transfer licensure and provider numbers to the County but it refused to accept the transfer.

In May, RCHA (in its capacity as the manager of the Hospital) made the decision to close the hospital due to patient safety concerns arising from the loss key personnel and the continuing deterioration of economic and clinical operations at the Hospital. On May 22, 2015, the North Carolina Department of Health visited the hospital and reviewed the plans to close the hospital and gave their approved of the plans. At approximately 6:00 p.m. on that day, RCHA closed the hospital.

Following the May 22, 2015 closure, the County filed a lawsuit seeking damages. CAH 10 and the other defendants (HMC and RCHA) are vigorously defending its position that the closure of the Hospital was, among other things, necessary to protect patient safety.

In accordance with Tennessee Code Annotated, §68-11-1607(c)(5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the

Ms. Tammie Hardy
Page 10

applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Resubmittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional examination fee." For this application, the sixtieth (60th) day after written notification is March 21, 2016. If this application is not deemed complete by this date, the application will be deemed void. Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

- (1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.
- (2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staffs are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart, HSD Examiner

PME
Enclosure

February 23, 2016
9:32 am

STATE OF MISSOURI

COUNTY OF JACKSON

Trent Skaggs, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed

appropriate by the Health Services and Development Agency are true and complete.

Trent Skaggs Exec VP
SIGNATURE/TITLE

Sworn to and subscribed before me this 18 day of Feb, 2016 a Notary
(Month) (Year)

Public in and for the County/State of Missouri

Linda K. Way
Notary Public - Notary Seal
STATE OF MISSOURI
Jackson County
My Commission Expires: Nov. 17, 2018
Commission #14444354

Linda K. Way
NOTARY PUBLIC

My commission expires Nov 17, 2018
(Month/Day) (Year)

List of Attachments

Attachment 1	Fully Executed Term Sheet	Section A, Item 6
Attachment 2	Project Diagram	Section B, Item I
Attachment 3	Comparison of Fair Market Value to Total Lease Payments	Section C, Economic Feasibility, Item 1
Attachment 4	CHHS Letter of Intent and Overview	Section C, Economic Feasibility, Item 1
Attachment 5	Latest Certificate of Accreditation	Section C, Orderly Development, Item 7.d

List of Replacement Pages

Replacement Page 3R	Ownership Structure	Section A
Replacement Page	Project Costs Chart	Section C
Replacement Pages	Historical and Projected Data Charts	Section C

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 1

Question 1- Section A, Item 6

Fully Executed Term Sheet

CBC REAL ESTATE GROUP**LEASE TERM SHEET****January 1, 2016**

This term sheet or letter of intent is not a binding agreement or gives rise to any legal liability between the parties, but is merely an expression of their intent with respect to the build-to-suit lease transaction ("Transaction") described below and sets forth preliminary negotiating points. For purposes of this letter agreement, the Transaction is defined as the development of an approximately \$23,000,000 replacement critical access hospital in Ripley, Tennessee ("Project"). The agreement of the parties will only become binding upon the execution of a definitive lease agreement ("Lease") and other related agreements with respect thereto.

Lessee: CAH Acquisition Company 11 LLC d/b/a Lauderdale Community Hospital ("LCH") or an affiliate to be formed and managed by LCH (collectively "Lessee"). LCH is the owner and operator of a critical access hospital in Ripley, Tennessee.

Lessor: CBC Real Estate Group ("CBC") or a new company ("NewCo") to be formed and managed by CBC ("collectively "Lessor").

Deed of Property: Upon the signing of the Lease, Lessee deeds to Lessor fee simple title to a tract of real property located at 326 Ashbury Avenue, Ripley, Tennessee 38063 consisting of 23.976 acres of land and a to be build-to-suit 25-bed replacement critical access hospital of approximately 46,000 square feet ("Property").

Lease of Property. Upon the signing of the Lease, Lessor leases to Lessee the Property, and Lessee accepts the Property in "AS IS" condition.

CBC appoints NewCo to act as the developer of the Project. Lessee works with Lessor to ensure that the Project is built and constructed in accordance with the plans, specifications, scope of work and schedule for approved by the parties and to ensure the adequacy and acceptability of the Project.

Lessee shall provide its own inventory and supplies, FFE and other items not included in Lessor's scope of work.

Lessor is not making any warranties or representations concerning the Property or the Project, or suitability for their intended use.

Lease Type: The Lease shall be absolute net in nature whereby the Lessee shall be responsible throughout the term of the Lease for the payment of all amounts, liabilities, obligations and impositions related to the ownership, use, possession and operation of the Property, including, but not limited to, all utilities, all real estate taxes, insurance premiums, maintenance, repairs and capital

improvements. This responsibility of the Lessee will be in addition to the payment of Base Rent (defined below).

- Lease Term:** The Lease shall be for a term of nine (9) years. Lessee shall have one 6-year option and three 5-year renewal options.
- Base Rent:** The annual rent ("Base Rent" for the first 12-month period following the issuance of a Certificate of Occupancy (the "CO") shall be an amount equal to 10.5% of the Transaction less an adjustment for New Market Tax Credits ("NMTC Adjustment"). The NMTC Adjustment is expected to equal to not less than \$300,000 or 10% of the value received from the New Market Tax Credits currently contemplated for the Project. For avoidance of doubt, it is proposed the annual Base Rent for the first 12-month period following CO shall be \$2,115,000 and shall be paid monthly in 12 equal amounts each year on the first (1st) day of each Lease month.
- Facility Renovations:** From time to time during the term of the Lease, Lessee shall have the right to modify and alter the Property as necessary subject to Lessor's approval of plans and the contractor which approval shall not be unreasonably withheld. Lessee shall obtain a payment and performance bond to ensure lien free completion of such alterations.
- Adjustment of Rent:** Commencing on the date that is one year after the commencement of the Lease and each year thereafter, the annual Base Rent shall be increased by one and a half percent (1.5%).
- The annual Base Rent for the first year of each renewal option shall be the greater of: a) market rent, or b) 101.5% of the prior year's Base Rent. In either case, the annual Base Rent shall be subject to annual increases of 1.5% thereafter.
- Use of Property:** Lessee covenants that it will obtain and maintain throughout the term of the Lease all approvals needed to use and operate the Property as a critical access hospital. Lessee covenants that during the term of the Lease it will continuously operate the Property only as a provider of healthcare services and shall maintain its certifications for reimbursement and licensure and all necessary accreditations.
- Insurance Requirements:** Lessee covenants that it shall carry all forms of insurance coverage (e.g. GL/PL, Property, Earthquake, Flood, Wind, Business Interruption, Employee Dishonest/Theft, Auto, etc.) acceptable to Lessor's lender and loan Servicer including but not limited to coverage amounts and insurer rating. Lessor and Lessor's lender shall be named as an additional insured party on all Lessee policies.

Financial Statements:	Lessee covenants to provide monthly financials and audited annual financial statements to Lessor in a timely manner throughout the term of the Lease.
Lessee Repurchase Option:	So long as Lessee is not in default on the Lease, Lessee shall have the option, commencing on the date that is a minimum of 120 months after the closing of the Transaction and expiring at the end of 144 months following the closing of the Transaction, to repurchase the Property at a pre-established pricing methodology. The repurchase price shall be equal to the sum of the contractual rent payments to be received by Lessor for the immediate 12-month period after the repurchase date plus the annual NMTC Adjustment, divided by ten percent (10.0%). This purchase option is non-transferable.
Assignment and Subletting:	Lessee shall not assign the Lease or sublease any space in the Property without the prior written consent of Lessor.
Capital Improvement Obligation:	<p>Lessee shall be required to make capital improvements and repairs to the Property and the physical plant of the Property in an amount equal to the minimum required by any lender in connection with consummating Lessor's financing or refinancing of the Project. Proof of such expenditures shall be provided at the end of each Lease year or upon request.</p> <p>Lessee shall timely complete at its own expense all repairs and replacements required by any lender in connection with consummating Lessor's financing or refinancing of the Project.</p>
Events of Default:	Events of default by Lessee shall include all standard and customary events, including, but not limited to, failure to pay Base Rent, failure to pay real estate taxes, bankruptcy filing, loss of necessary licensing, abandonment, etc.
Events of Performance Default:	The Lease shall contain industry standard and customary coverage covenants to secure financing or refinancing of the Project.
Guaranty & Security:	<p>HMC/CAH Consolidated, Inc. ("Guarantor") will provide a corporate guaranty for payments and obligations of Lessee. Subject to Lessor's review of the corporate financials, additional guarantor(s) may be required.</p> <p>Lessor will receive a security interest in all Lessee's assets and personal property at the Property. In addition, Lessee shall be required to fund an amount equal to six month's Base Rent as security deposit paid into the account in 48 equal monthly payments beginning at the start of the Lease. The security deposit</p>

shall be increased every three years based on the then current Base Rent.

Covenants:

The Lease shall contain industry standard and customary financial covenants to secure financing or refinancing of the Project.

**Cooperation & Compliance
With Lessor Financing:**

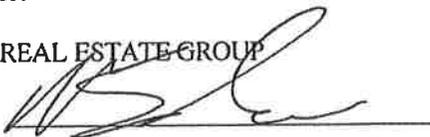
Lessee, shall execute such documentation as is typically required by Lessor's lender (government agency or a private lender), including but not limited to a Lessee Regulatory Agreement, Deposit Control Agreements, SNDAs, Estoppel certificates, Subordination of Management Agreement, and Intercreditor Agreements with Lessee's Accounts Receivable Lender. Lessee shall be responsible for all expenses in connection with its own review of the aforesaid documentation.

In addition, to the terms laid out above, the Lease shall include all standard and customary language and agreements regarding casualty and loss, condemnation, insurance proceeds, Lessee's personal property, indemnification, quiet enjoyment, etc.

Dated as of the day and year written above.

Lessor:

CBC REAL ESTATE GROUP

By: 

Mike Belew
Executive Vice President of Development

Lessee:

CAH ACQUISITION COMPANY II LLC

By: 

Jim Shaffer
President

Guarantor:

HMC/CAH CONSOLIDATED, INC.

By: 

Jim Shaffer
President

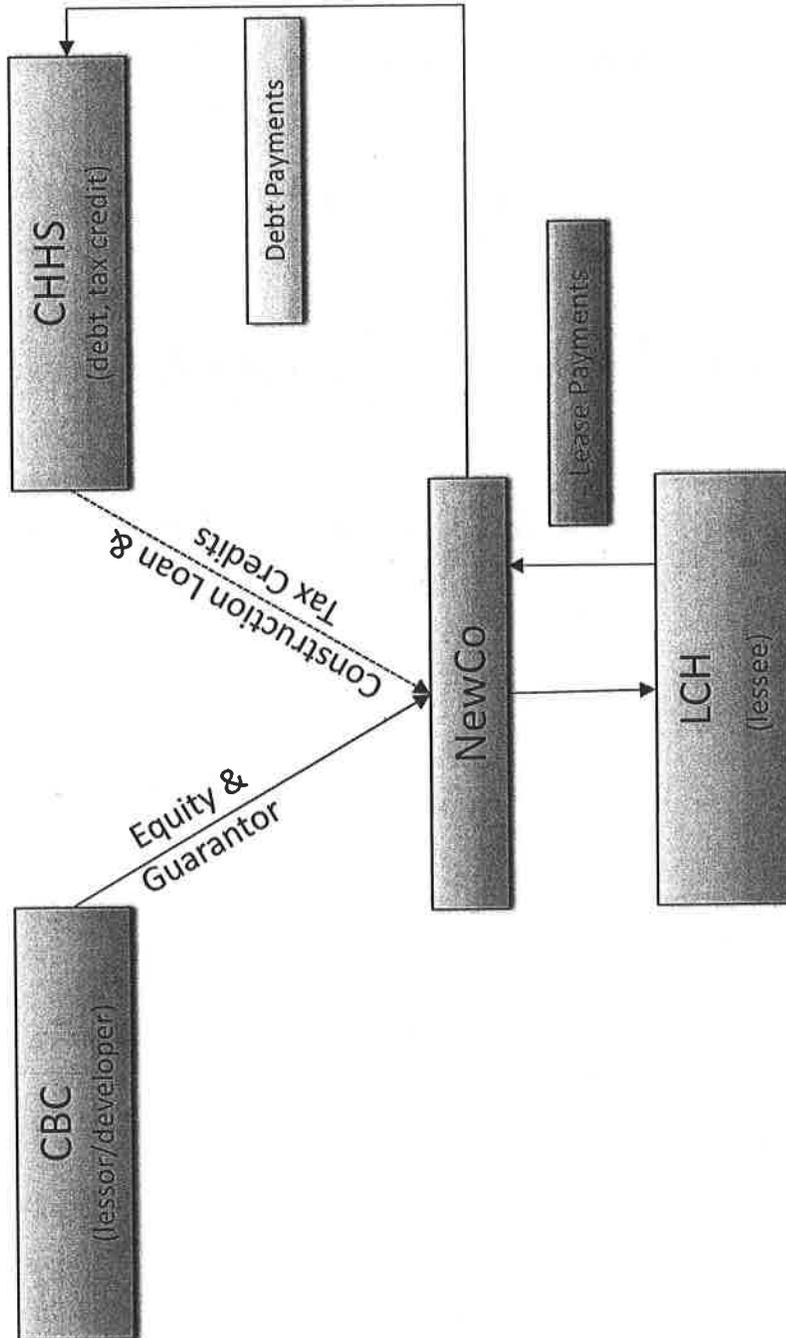
Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 2

Question 3, Section B, Item I

Project Diagram



Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 3

Question 5- Section C, Economic Feasibility, Item I

Comparison of Fair Market Value to Total Lease Payments

CAH 11 (Lauderdale Community Hospital)

Comparison of Fair Market Value to Total Lease Payments

Fair Market Value

Land	<u>82,321</u>	82,321
------	---------------	--------

Building

Construction	14,023,308
Sitework	1,290,053
Architectural and Engineering Fees	1,145,147
Contingency Fund	1,190,952
CON Fee	44,999

Reserve for One Yr's Debt Service	<u>2,350,000</u>	<u>20,044,459</u>
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Fair Market Value of Land and Building	<u><u>20,126,780</u></u>
----------------------------------------	--------------------------

Lease Payments

Year #1	2,115,000
Year #2	2,146,725
Year #3	2,178,926
Year #4	2,211,610
Year #5	2,244,784
Year #6	2,278,456
Year #7	2,312,633
Year #8	2,347,322
Year #9	<u>2,382,532</u>

Total of All Lease Payments during the Term	<u><u>20,217,987</u></u>
---------------------------------------------	--------------------------

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 4

Question 6- Section C, Economic Feasibility, Item II

CHHS Letter of Intent and Overview

February 23, 2016

9:32 am



CHHS
Community Hospitality Healthcare Services

January 8th, 2016

Jim Shaffer, President
CAH Acquisition Company 11, LLC
d/b/a Lauderdale Community Hospital
1100 Main, Suite 2350
Kansas City, MO 64105

Re: Lauderdale Hospital Replacement Facility

Dear Mr. Shaffer,

Community Hospitality Healthcare Services has received an array of information regarding the proposed replacement of the Lauderdale Hospital facility located in Ripley, Tennessee. As a federally certified "Community Development Entity" (CDE) by the CDFI Fund at the US Treasury with a national footprint, we would be interested in providing a sub-allocation of New Markets Tax Credits to the project. With a focus on healthcare infrastructure and job creation in distressed communities, we have funded dozens of projects with similar attributes. The project is located in a highly qualified census tract within a rural community. Based upon the geography and initial estimates of community impacts, including creation of quality jobs and services provided to the community, the project meets our initial thresholds for underwriting. Receipt of final NMTC investment from CHHS is contingent upon:

- Obtaining all necessary entitlements and approvals required by law, including Certificates of Need;
- Securing first-lien debt and additional capital sources required to fully fund the project;
- Collection of additional transaction diligence items;
- Availability of allocation at the time the project is ready to commence closing process; and
- Final underwriting and approval.

We anticipate that the NMTC investment will provide up to 23% of the capital required to complete the project, in the form of a subordinated interest-only note with a term of no less than 7 years at an interest rate in the 2.5-3% range. We look forward to working with you on this highly impactful project.

Sincerely,

A handwritten signature in black ink, appearing to read "BCirka", written over a horizontal line.

Benjamin Cirka
Executive Director
Community Hospitality Healthcare Services

What is the relationship between HMC/CAH Consolidated, Inc. and Community Hospitality Healthcare Services (CHHS).

CHHS is a Community Development Entity which is required when utilizing New Market Tax Credits. Once the facility is built and the NewCo established, CHHS will become part of the NewCo.

Please provide an overview of CHHS.

CHHS is a nationally recognized community development entity specializing in investing in healthcare businesses and healthcare infrastructure in America's most severely distressed communities. CHHS provides catalytic debt and equity investments to high-impact projects in medically underserved low-income communities throughout the U.S. Investments are prioritized based upon their ability to provide healthcare services to low-income individuals and families, and provide entry-level jobs and upward mobility via career ladder resources. These investments have reduced the overall cost burden of care on a national basis while addressing disparities in low-income communities by providing increased access to care and employment opportunities. Project funding provides for expansion of services, construction and improvement of new or existing space, investments in job training, workforce development and career ladder programs as well as computer systems and medical equipment.

CBC Real Estate Group, LLC has a combined experience of over 100 years in commercial real estate development, brokerage, leasing, financing and property management. CBC principals combine to maintain real estate and financial holdings exceeding \$400,000,000. During the last 30 years, CBC has been involved in the development and acquisition of more than 5 million square feet of commercial real estate projects throughout the country.

CFG is a leading provider of full-service, comprehensive financing solutions for healthcare facilities across the country.

5. Section B. I. Project Description

The applicant notes total project cost for the new facility will be approximately \$23 million, of which \$3 million (or approximately 23%) will be New Market Tax Credits on pages 6 and 23. However, there appears to be a calculation error in the percentage calculation. Please clarify.

The anticipated percentage is actually 15%. CHHS anticipates that the tax credits could cover as much as 23%, but the applicant used a more conservative 15%.

In addition, the Project Costs Chart totals \$20,044,459, not \$23,000,000 as reflected in the Project Summary on page 6. Please clarify.

The total project comes out to \$23,000,000 because there is \$3,000,000 of debt refinancing included in the project. However, because the refinancing is not related in any way to the construction, it was excluded from the "Projects Costs Chart." For purposes of this application the total project cost is \$20,126,780.

Ms. Tammie Hardy
Page 3

Please provide an overview of New Market Tax Credits (NMTC) and how it applies to this project.

The New Markets Tax Credit Program (NMTC) was designed by Congress to attract private-sector capital investment into the nation's low-income areas to help stimulate economic growth and create jobs by financing community development projects and business expansion.

This program was established by Congress in December 2000 as a credit against federal income taxes for making qualified equity investments in investment vehicles known as Community Development Entities (CDEs). The credit provided to the investor (either corporate or individual) totals 39 percent of the cost of the investment and is claimed over a seven-year period. The CDE's are charged with making investments into qualified projects or businesses in low-income communities.

The program is overseen by the Community Development Finance Institutions Fund, an arm of the US Treasury Department. It is run on a competitive basis, providing the authority to allocate the resource to projects and businesses to the specialized entities noted above- Community Development Entities. Rules regarding the types of businesses that can be funded and the types of funding that can be provided are extensive and it is a function of the CDE's receiving the allocations to make sure that the projects receiving allocations are compliant with the program. Specific exclusions include land-banking, golf courses, massage parlors and tanning salons as well as farms and liquor stores. The resource is often used to help finance the gap on commercial real estate projects and to fund business expansion. Each CDE that receives an allocation has specific guidelines that it must meet in order to remain in compliance with its agreement to use the resource. It is important to find out from the CDE that you may be working with if your project is eligible for their resources early on.

Many projects blend other sources of subsidy with the New Markets Tax Credit. Historic Credit, both federal and state, Brownfield grants and notes and tax-incremental financing are common additional resources that are used to help make transactions more financially viable. One important thing to remember when you are considering a NMTC subsidized project, however, is that this resource is only able to fill a financial gap; it will not make an infeasible project feasible.

New Markets Tax Credit represents \$3,000,000 or 15 % of the funding for this project.

Lauderdale Community Hospital

Tennessee Certificate of Need

Attachment 5

Question 9- Section C, Orderly Development, Item 7.d

Latest Certificate of Accreditation

CERTIFICATE OF ACCREDITATION

Certificate No.:
188730-2015-AHC-USA-NIAHO

Initial date:
8/1/2015

Valid until:
8/1/2018

This is to certify that:

Lauderdale Community Hospital

326 Asbury Ave, Ripley, TN 38063

has been found to comply with the requirements of the:
NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Critical Access Hospitals (42 C.F.R. §485).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX



Patrick Norine
Chief Executive Officer





State of Tennessee
Health Services and Development Agency

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

www.tn.gov/hstda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the The Commercial Appeal which is a newspaper
of general circulation in Lauderdale (County), Tennessee, on or before January 10, 2016 (Month / day) (Year)
for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in
accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency,
that:

CAH Acquisition Company 11, LLC Hospital
(Name of Applicant) (Facility Type-Existing)
owned by: HMC/CAH Consolidated, Inc. with an ownership type of LLC
Rural Community Hospitals of America, LLC
and to be managed by: intends to file an application for a Certificate of Need
for [PROJECT DESCRIPTION BEGINS HERE]: See Attached Project Description

The anticipated date of filing the application is: January 15, 2016

The contact person for this project is Tammie Hardy (Contact Name) (Title)
who may be reached at: Lauderdale Community Hospital 326 Asbury Avenue (Company Name) (Address)
Ripley TN 38063 731 / 221-2200 (City) (State) (Zip Code) (Area Code / Phone Number)
Tammie Hardy (Signature) 1-7-16 tammie.hardy@lauderdalehospital.com (Date) (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the
last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File
this form at the following address:

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

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

CAH Acquisition Company 11, LLC Letter of Intent

Project Description:

CAH Acquisition Company 11, LLC, d/b/a Lauderdale Community Hospital, is located at 326 Asbury Avenue, Ripley, Tennessee and has a growing inpatient census averaging around 8.5 patients per day. Lauderdale Community Hospital is proposing to build a new 25 bed facility on its current campus consisting of 46,851 square feet at an expected construction cost (including site preparation work) of \$19,999,460. The new hospital will replace the existing 33 year old facility that is outdated and does not provide the efficiencies that a new facility will provide. The new hospital will continue to offer the same services currently provided, which include acute, emergency, swingbed and outpatient services.

**CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954**

DATE: March 31, 2016

APPLICANT: CAH Acquisition Company 11, LLC
d/b/a Lauderdale Community Hospital
326 Asbury Avenue
Ripley, Tennessee 38063

CN1601-004

CONTACT PERSON: Tammy Hardy
326 Asbury Avenue
Ripley, Tennessee 38063

COST: \$20,262,987

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:

CAH Acquisition Company 11, LLC (CAH11) d/b/a Lauderdale Community Hospital (LCH), located at 326 Asbury Avenue, Ripley, Tennessee 38063 seeks Certificate of Need approval for the replacement of a 25-bed Critical Access Hospital on 23.98 acres adjacent to the existing hospital.

HMC/CAH Consolidated, Inc. (HMC) is the parent company of CAH11. HMC is a Delaware corporation with its principal place of business in Kansas City, Missouri. HMC is in the business of acquiring acute care hospitals located in rural communities and certified by CMS as Critical Access Hospitals (CAH). HMC conducts its business through a consolidated group of 10 hospital subsidiaries.

The project consists of 40,190 square feet of new construction at a cost of \$299.32 per square foot. The project cost is slightly higher than the 3rd Quartile of HSDA construction costs from 2012-2014.

HMC's business plan is to replace the existing facilities of all its hospitals with new facilities. In addition to LCH, HMC has four hospitals in Oklahoma, three hospitals in Kansas, one in Missouri, and one in North Carolina.

LCH and the other HMC hospitals are managed by Rural Community Hospitals of America, LLC (RCHA). RCHA is a West Virginia limited liability company with its principal place of business in Kansas City, Missouri. RCHA provides LCH and the other HMC hospitals with day to day management and business services.

The total project cost is \$20,262,987 of which \$3,000,000 will be New Market Tax Credits (NMTC). This investment will be provided through Community Hospitality Healthcare Services (CHHS) in the form of a subordinated interest only promissory note with a term of no less than 7 years at an interest rate in the 2.5% to 3.0% range. The New Market Tax Credit (NMTC) program was a product of the bipartisan legislation enacted in the Community Renewal Tax Relief Act of 2000. The program uses tax incentives to attract private capital investments in both urban and rural low

income areas of the United States. The remaining amount will be provided by CBC Real Estate Group, LLC, the project developer, in cooperation with a real estate investment trust (REIT). The applicant has engaged CFG Capital Markets, LLC, as its financial advisory, to originate and the structure this aspect of the lease transaction.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee’s State Health Plan*.

NEED:

The applicant’s designated service area consists of zip code 38063 (Ripley, Tennessee, Lauderdale County) which accounts for 78% of the hospital’s total volume. According to the applicant, the projected 2018 population is estimate to be 17,015. The 65+ population is projected to be 2,744, or 16% of the population. The 2016 population of Lauderdale County is 28,658, increasing to 29,186 in 2020, an increase of 1.8%.

The existing facility was built in 1983 and would require extensive upgrades to bring it up to today’s standards for Healthcare and building codes. The facility has low ceilings that re not conducive to new equipment and the buildings mechanical and electrical equipment is past their dates of replacement. LCH was built and expanded when patients had longer hospital stays. As healthcare has changed over the years, patient care has moved toward more of an outpatient model, with an emphasis on quick and easy access to the facility. The applicant states they must prepare for the future by investing in a facility and services that will maximize returns in an increasingly challenging environment in terms of reimbursement and payment reform.

In recent years inpatient acute care discharges have decreased while observation days have increased; a trend the applicant believes is more toward outpatient services than inpatients service. Swing bed utilization has increased as a result of efforts to bring back local patients for rehabilitation instead of being discharged early from lager hospitals. LCH currently has no surgeon on staff, but is in the final stages of recruiting a general surgeon. Having an outdated, older facility makes it difficult to recruit surgeons and family practitioners. Additionally, the applicant is pursuing an opportunity to partner with a physician’s group in Jackson, Tennessee that has a variety of specialists.

Lauderdale Community Hospital 2014 Licensed and Staffed Bed Occupancy

Facility	Licensed Beds	Staffed Beds	Licensed Occupancy	Staffed Occupancy	Patient Days	ER Visits
Lauderdale Community Hospital	25	25	10.8%	10.8%	984	10,399

Source: *Joint Annual Report of Hospitals 2014*, Division of Health Statistics, Tennessee Department of Health

The new hospital will replace the outdated facility that does not offer the efficiencies to compete in today’s market place. The applicant intends to continue to offer acute care, emergency services, swing beds, and outpatient service in a more efficient manner. The intent is to improve the patient experience and create a facility that is financially sustainable.

TENNCARE/MEDICARE ACCESS:

The applicant participates in both the Medicare and TennCare/Medicaid programs. The applicant contracts with TennCare MCOs United Healthcare Community Plan and TennCare Select.

The applicant projects year one Medicare revenues of \$18,830,535 or 37.73% of total gross revenues, and TennCare/Medicaid revenues of \$11,013,951 or 22.07% of total gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:

The Department of Health, Division of Policy, Planning, and Assessment have reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and if the projections are based on the applicant’s anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located on page 30 of Supplemental 2. The total estimated project cost is \$20,262,987.

Historical Data Chart: The Historical Data Chart is located on page 32 of Supplemental 2. The applicant reported 2,398, 2,164, and 2,189 patient days in 2013, 2014, and 2015 with net operating revenues of (\$435,726), \$576,974, and (\$673,043 each year respectively.

Projected Data Chart: The Projected Data Chart is located on page 33 of Supplemental 2. The applicant projects 2,427 and 2,524 patient days in years one and two with net operating revenues of \$2,684,010 and \$2,627,450 each year, respectively.

Historical and Projected Financial Performance

Financial Measure	2015	Year 1
Average Gross Charges		
Patient Days	2,427	2,427
Gross Operating Revenue	\$41,972,726	\$49,908,986
Deductions	\$27,094,591	\$32,770,870
Net Patient Revenue	\$14,878,135	\$17,138,116
Average Cost		
Gross Charges	\$19,174	\$20,564
Deductions	\$12,378	\$13,303
Net Patient Revenue	\$6,797	\$7,061

LCH sees no option other than renovation or replacement of their existing facility. The current facility is over 30 years old and the electrical and mechanical systems are in need of replacement. The facility is not conducive to modern day equipment and technology due to low ceilings. A new facility would allow for expansion for the future plus correct current issues. New hospital systems are more energy efficient and effective for today’s hospital standards and most importantly are tailored towards the outpatient setting. The applicant relies on their experience and concern for investing in an old facility and opts to replace the facility entirely.

Note to Agency Members: *The applicant, CAH Acquisition Company 11, LLC filed for Chapter 11 Bankruptcy dated February 27, 2013 in United States Bankruptcy Court For the Western District of Missouri, Kansas City Division, Case No. 11-44748-11. The Motion was granted on March 29, 2013. Additionally, the applicant has a civil judgement filed against CAH Acquisition 10, LLC by Yadkin Valley Community Hospital, Yadkin, North Carolina pending which they report they are "rigorously defending its position that the closure of the facility was among other things, necessary to protect patient safety".*

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:

The applicant list all contractual and working relationships with other healthcare providers on page 30 and 31 of the application.

The applicant reports that this project will have a positive effect on the healthcare system in Lauderdale County by bringing quality and efficiency via replacement of a thirty year old facility with a modern state-of-the-art facility in rural Ripley, Tennessee; ensuring members of the community can receive care at home in their local community. The cost to travel to the larger

tertiary facilities for healthcare is a burden to members of the community as well. The new facility would also help in the recruitment of physicians to the area.

The current staffing consists of 107 FTE staff, 66 of which are providing direct patient care. There will be no change in staff or services.

LCH has a Clinical Affiliation Agreement with Jackson State Community College and a Pediatric Training Agreement with Le Bonheur Children’s Hospital.

The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and certified by DNV GL Healthcare.

The applicant has a civil judgement filed against CAH Acquisition 10, LLC by Yadkin Valley Community Hospital, Yadkin, North Carolina pending which they report they are “rigorously defending its position that the closure of the facility was among other things, necessary to protect patient safety”.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee’s State Health Plan*.

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

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

Not applicable.

- 2. For relocation or replacement of an existing licensed health care institution:
 - a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

LCH sees no option other than renovation or replacement of their existing facility. The current facility is over 30 years old and the electrical and mechanical systems are in need of replacement. The facility is not conducive to modern day equipment and technology due to low ceilings. A new facility would allow for expansion for the future plus correct current issues. New hospital systems are more energy efficient and effective for today’s hospital standards and most importantly are tailored towards the outpatient setting. The applicant relies on their experience and concern for investing in an old facility and opts to replace the facility entirely.

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

The applicant provided the hospital’s existing volumes for the last three years:

	2013	2014	2015
Discharges			
Acute	356	281	255
Swing Beds	72	88	117

ER Visits	11,446	10,065	10,432
Surgeries	296	164	56
Outpatient Visits	7,187	7,391	6,441
Radiology Inpatient	815	401	550
Radiology Outpatient	15,374	14,705	12,218
Laboratory Inpatient	3,880	3,262	4,596
Laboratory Outpatient	44,145	41,891	40,352
Physical Therapy Inpatient	2,235	2,682	2,489
Physical Therapy Outpatient	11,974	15,111	12,294

According to the applicant, with the proposed replacement facility, they will increase volume primarily captured from its primary service area. If a new hospital is not built within five years the applicant fears volume will decline and threaten the long term viability of the hospital.

3. For renovation or expansions of an existing licensed health care institution:
 - a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.
 - b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Not applicable.