25.00-1269085

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SECRETARY OF STATE

BEFORE THE TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	)
	) **DOCKET NO. T.B.A.**
SBH-KINGSPORT, LLC	) **CON No. CN1312-050D**
	)

NOTICE OF HEARING

Pursuant to the provisions of T.C.A. §§4-5-307 and 68-11-1610, NOTICE IS HEREBY GIVEN THAT:

SBH-Kingsport, LLC (hereafter, the "Petitioner") has requested a hearing before the Tennessee Health Services and Development Agency ("the HSDA") to contest the denial of certificate of need application No. CN1312-050D.

The HSDA has elected to have this proceeding initially heard by an Administrative Judge for the Administrative Procedures Division, Department of State, pursuant to T.C.A. §4-5-301(a)(2). The hearing is a "contested case" as defined by T.C.A. §4-5-102(3) and will be heard de novo. The Petitioner has the burden of proof. The hearing will commence on a date to be determined.

T.C.A. §4-5-305 provides that all parties to this hearing have a right to be represented by Counsel, at their own expense.

This proceeding is being held pursuant to T.C.A. §68-11-1610 which confers subject matter jurisdiction upon the HSDA to hear this case, and will be conducted in accordance with T.C.A. §§4-5-301, et. seq., the Rules of the HSDA, and the Rules of the

Tennessee Department of State, Administrative Procedures Division, Uniform Rules of Procedure for Hearing Contested Cases before the State Administrative Agencies.

The matters to be heard are whether the project meets the criteria set forth in T.C.A. §68-11-1609, Rules 0720-11-.01(1), (2), and (3) of the HSDA, and guidelines set forth in the state health plan.

Pursuant to T.C.A. § 68-11-1609(g)(1), and subject to T.C.A. § 68-11-1609(g)(2), any health care institution wishing to oppose a certificate of need application must file a written objection with the HSDA and serve a copy on the contact person for the applicant, not later than fifteen (15) days before the HSDA meeting at which the application is originally scheduled. An application for which the HSDA has received opposition shall be designated on the HSDA's agenda as an opposed application. Pursuant to T.C.A. § 68-11-1609(g)(2), a health care institution or other person may appear before the HSDA and express opposition to an application without complying with the requirements of T.C.A. § 68-11-1609(g)(1), provided that if a health care institution does not provide notice of its opposition as required by T.C.A. § 68-11-1609(g)(1), and if such health care institution initiates a contested case pursuant to T.C.A. §68-11-1610, then such health care institution shall be solely responsible for the HSDA's costs of the contested case proceeding and shall reimburse to the applicant the filing fee paid by the applicant, notwithstanding any other provision of law. (Payment of costs pursuant to this Section is limited to Health Care Institutions.) Noncompliance with T.C.A. § 68-11-1609(g)(1) shall not preclude a health care institution from intervening in a contested case proceeding initiated by the applicant.

Pursuant to T.C.A. §68-11-1610(d), the Administrative Judge to whom a case has been assigned shall convene the parties for a scheduling conference within fifteen (15) days of the date of the petition for contested case is filed. At the scheduling conference, the parties shall state their respective positions on the mediation alternative described below. If the parties are unable to agree on the mediation alternative, the scheduling order for the contested case adopted by the Administrative Judge shall establish a schedule that results in a hearing completed within one hundred eighty (180) days of the date on which the petition for contested case was received by the HSDA, with the initial order to be entered within sixty (60) days of the date the hearing is completed.

Pursuant to T.C.A. §68-11-1610(e), initial orders of the Administrative Judge in contested cases may be appealed in writing to the HSDA. The HSDA may decline to hear any appeal. If the HSDA reviews the order, it must do so in compliance with the Uniform Administrative Procedures Act, compiled in T.C.A. Title 4, Chapter 5. If the HSDA declines to review the order, the requesting party may appeal the order to the Davidson County Chancery Court in accordance with the Uniform Administrative Procedures Act, compiled in T.C.A. Title 4, Chapter 5.

Pursuant to T.C.A. §68-11-1610(f), as an alternative to the contested case process described in §68-11-1610(c), the parties may agree to mediation of the issues raised in the contested case. The mediator shall be designated by mutual agreement of the parties. The parties may designate a mediator who is not listed as a qualified Rule 31 mediator, but such mediator shall observe the standards of professional conduct set forth in Appendix 'A' to Rule 31, to the extent applicable. The mediator's fee shall be shared equally among the parties, except the State shall not be required to contribute to payment

of the mediator's fee. If mediation results in agreement of the parties, such agreement shall be memorialized in the order terminating the contested case. A mediation proceeding under §68-11-1610(f) shall not be subject to the scheduling order requirements set forth in §68-11-1610(c)(2). Pursuant to T.C.A. §68-11-1610(g), the policy of the State is that certificate of need contested cases should be resolved through mediation, and the parties to such proceedings are encouraged to pursue this alternative.

Pursuant to T.C.A. §68-11-1610(h), judicial review of the HSDA's final order in a contested case shall be as provided by law.

Pursuant to T.C.A. §68-11-1610(i), all costs of the contested case proceeding, including the Administrative Judge's costs, and deposition costs, including fees of expert witnesses, shall be assessed against the losing party in the contested case. If there is more than one losing party, the costs shall be divided equally among the losing parties. No costs shall be assessed against the HSDA.

Respectfully submitted this 16th day of July, 2014.

TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

By: _____

James B. Christoffersen (B.P.R. #17049)
General Counsel
Tennessee Health Services and Development Agency
161 Rosa L. Parks Blvd., 3rd Fl.
Nashville, Tennessee 37243
(615) 741-2364

CERTIFICATE OF SERVICE

I certify that copies of the foregoing have been mailed by first-class United States mail, postage prepaid, to:

SBH-Kingsport, LLC
William H. West, Esq.
Baker Donelson, Bearman,
Caldwell & Berkowitz
211 Commerce St., Suite 800
Nashville, TN 37201

Woodridge Psychiatric Hospital
Dan H. Elrod, Esq.
BUTLER SNOW O'MAR STEVENS &
CANNADA PLLC
The Pinnacle at Symphony Place
150 3rd Avenue South, Suite 1600
Nashville, TN 37201

This 16th day of July, 2014.

James B. Christoffersen, Esq.
General Counsel
Tennessee Health Services and
Development Agency

25.00-126908S

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SECRETARY OF STATE

BEFORE THE TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. _____**
Petitioner/Applicant in	)	
	)	
CON Application No. CN1312-050	)	

PETITION FOR CONTESTED CASE HEARING

Comes now SBH-Kingsport, LLC ("Petitioner") to petition the Tennessee Health Services and Development Agency ("HSDA"), pursuant to T.C.A. §68-11-1610, for a contested case hearing on the HSDA's denial of Petitioner's Certificate of Need Application Number CN1312-050 for SBH-Kingsport, LLC to establish a new 72-bed mental health hospital and to initiate inpatient psychiatric services in Kingsport, Sullivan County, Tennessee.

As basis for its petition, Petitioner hereby states as follows:

1. Pursuant to T.C.A. §§ 68-11-1601, *et seq.*, the Petitioner filed Certificate of Need Application Number CN1312-050 in December 2013, and then presented this CON application to the HSDA approval at its June 25, 2014 meeting.

2. At said meeting on June 25, 2014, the HSDA entertained a motion to approve the Petitioner's Certificate of Need Application Number CN1312-050. This motion failed to be approved by the HSDA on a vote of four members in favor to four members opposed to the motion for approval. Therefore, the HSDA deemed the motion to approve to be denied due to the lack of the majority of votes in its favor.

SBH-KINGSPORT 000006

3. The Petitioner respectfully asserts that, in failing to approve Certificate of Need Application Number CN1312-050, the HSDA erred as a matter of fact and law by failing to find and acknowledge that Certificate of Need Application Number CN1312-050 satisfied the three statutory criteria for a grant of a certificate of need as set forth in T.C.A. § 68-11-1609(b), commonly referred to as need, economic feasibility and contribution to orderly development of health care.

4. The Petitioner further asserts that CON application number CN1312-050 should have been granted by the HSDA in that the actions proposed in CON application CN1312-050, the establishment of a new 72-bed mental health hospital and the initiation of inpatient psychiatric services in Kingsport, Sullivan County, Tennessee are, as a matter of fact and law, necessary to provide needed healthcare in the area to be served. The Petitioner further asserts that the project proposed in CON application number CN1312-050 will contribute to the orderly development of adequate and effective healthcare facilities or services, and can be economically accomplished and maintained. Therefore, the Petitioner asserts that the project described in CON application number CN1312-050 satisfies all statutory criteria for the grant of a certificate of need as set forth in T.C.A. § 68-11-1609(b). The Petitioner respectfully asserts that the HSDA erred in denying CON application number CN1312-050 at its June 25, 2014 meeting.

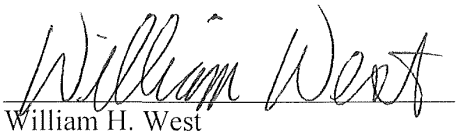
5. The Petitioner respectfully requests that, pursuant to T.C.A. § 68-11-1610, the HSDA initiate a contested case proceeding in this matter as provided by law. Based upon the fact that the Petitioner is the applicant for a certificate of need that the HSDA erroneously failed to grant, the Petitioner has standing, pursuant to T.C.A. § 68-11-1610, to request such a contested case proceeding.

6. At the conclusion of said contested case hearing, the Petitioner respectfully requests that the administrative judge and/or the HSDA reverse the prior act of the HSDA in refusing to grant a certificate of need for CON application number CN1312-050 and further determine that said certificate of need application should be granted based on appropriate findings of fact and conclusions of law holding that said application, CON application number CN1312-050, satisfies the statutory criteria for the grant of a certificate of need as set forth in T.C.A. § 68-11-1609(b), and that Petitioner's requested certificate of need should be, and is, granted.

7. Petitioner respectfully requests such further and other relief to which it may be lawfully entitled.

Respectfully submitted,

BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ
A Professional Corporation

By: 

William H. West
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
(615) 726-5600
Attorneys for Petitioner,
SBH-Kingsport, LLC

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Petition has been served by hand delivery upon:

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

on this 10 day of July, 2014.

William Dent

SBH-KINGSPORT 000009

CONTESTED CASE TRANSMITTAL FORM

Agency: Tennessee Health Services and Development Agency

Case Docket No(s).: T.B.A.

Brief Case Description: Petition for contested case challenging the denial of certificate of need application CN1312-050D, filed by SBH-Kingsport, LLC

Hearing Time Estimate: Five Days

Special Legal Requirements: None

Names, Addresses and Phone Numbers of Parties and Attorneys (including agency Attorney):

PETITIONER:

SBH-Kingsport, LLC
William H. West, Esq.
Baker Donelson, Bearman,
Caldwell & Berkowitz
211 Commerce St., Suite 800
Nashville, TN 37201
(615) 726-5600

RESPONDENT:

Tennessee Health Services and Development Agency
James B. Christoffersen, General Counsel
161 Rosa L. Parks Blvd., 3rd Fl.
Nashville, TN 37243
(615) 741-2364

Other Information - To initially be heard by an Administrative Judge sitting alone

25.00-126908J

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

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SECRETARY OF STATE

July 16, 2014

Department of State
Administrative Procedures Division
312 Eighth Avenue North
8th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

Re: SBH-Kingsport, LLC
CN1312-050D
Docket No.: T.B.A. - 25.00-126908

To Whom It May Concern:

Please find enclosed a petition for a contested case hearing that has been filed in regard to the above-referenced certificate of need application. I am also enclosing a contested case transmittal form and the Notice of Hearing. I am enclosing one extra copy, which I would appreciate your stamping and returning to me via messenger mail.

If you have any additional questions, or if anything further is needed, please let me know. Thank you for your attention to this matter.

Sincerely,

James B. Christoffersen
General Counsel

Attachments

cc: William H. West, Esq., Attorney for Petitioner
Dan H. Elrod, Esq., Attorney for Woodridge Psychiatric Hospital

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	
	)	**Docket No. 25.00-126908J**
Petitioner/Applicant	)	
	)	
	)	
CON Application No. CN1312-050	)	

PETITION TO INTERVENE

Mountain States Health Alliance ("MSHA"), through its undersigned counsel, seeks to intervene in the above contested-case proceeding as a Respondent, and in support of such intervention, states as follows:

1. On June 25, 2014, the Tennessee Health Services and Development Agency considered the application of Petitioner SBH-Kingsport, LLC ("SBH-Kingsport") for a certificate of need to establish a new 72-bed mental health hospital and to initiate inpatient psychiatric services in Kingsport, Sullivan County, Tennessee.

2. Through its representatives, MSHA appeared before the Agency and objected to the granting of a certificate of need to Petitioner for the new hospital and the initiation of the inpatient psychiatric services. MSHA opposed Petitioner's application because it fails to satisfy any of the criteria that govern CON applications in Tennessee—that is, the project is not needed, is not economically feasible and will not contribute to the orderly development of adequate and effective health care services.

3. At its meeting on June 25, 2014, the Agency voted to deny the Petitioner's certificate of need application by a vote of 4-4. SBH-Kingsport subsequently filed its Petition for Contested Case pursuant to Tenn. Code Ann. §§ 68-11-1601, *et seq.*

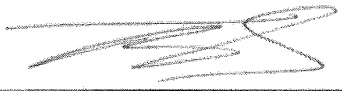
SBH-KINGSPORT 000012

4. This Petition to Intervene has been filed in a timely manner in accordance with Tenn. Code Ann. § 4-5-310.

5. The extent of intervention sought includes appearance in all stages of the proceeding, participation in discovery, the presentation of proof, the examination and cross-examination of witnesses, and receipt of all pleadings, orders and other documents.

Based on the foregoing, Mountain States Health Alliance respectfully requests that this Petition to Intervene be granted.

Respectfully submitted,



G. Brian Jackson (Tenn. BPR No. 015497)
Travis B. Swearingen (Tenn. BPR No. 025717)
BUTLER SNOW LLP
150 3rd Avenue South, Suite 1600
Nashville, TN 37201
(615) 651-6716
brian.jackson@butlersnow.com
travis.swearingen@butlersnow.com

Attorneys for Mountain States Health Alliance

SBH-KINGSPORT 000013

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent via electronic mail and First Class Mail to the following counsel of record:

James B. Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
Jim.christoffersen@state.tn.us

William H. West
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
(615) 726-5600
bwest@bakerdonelson.com



BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	
SBH-KINGSPORT, LLC	**DOCKET NO: 25.00-126908J**

ORDER

Pursuant to T.C.A. § 68-11-1610(d) a scheduling conference was held in this matter on August 1, 2014. William West represented the Petitioner SBH-Kingsport, LLC, Brian Jackson represented Intervenor, Mountain States Health Alliance, and Jim Christoffersen represented the Tennessee Health Services and Development Agency. The following determinations were made:

1. There being no opposition to the Petition to Intervene filed by Mountain States Health Alliance and for good cause shown it is **Ordered** that the Petition to Intervene is **Granted**.

2. The deadline to file a Petition to Intervene is **August 18, 2014**.

3. The parties have elected at this time not to mediate this matter.

4. The parties will submit an Agreed Scheduling Order on or before **August 22, 2014**.

5. By agreement of the parties, this matter is set for hearing **May 4-8, 2015**.

This Order entered this 14TH day of August, 2014

Leonard Pogue
Administrative Judge

LEP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**DOCKET NO: 25.00-126908J**
	)	

AGREED SCHEDULING ORDER

The parties herein (Petitioner, SBH-Kingsport, LLC; Intervenor, Mountain States Health Alliance, Inc.; and the Agency, Tennessee Health Services and Development Agency) have mutually agreed, as shown by the signatures of their respective counsel hereon, upon the following scheduling order for this matter as called for by the previous order entered in this matter.

The parties herein shall accomplish the following tasks according to the schedule set forth below:

1. Serve initial written discovery on opposing parties on or by October 1, 2014.

2. On or by November 3, 2014, the parties shall respond to the initial written discovery served upon them.

3. The parties shall conduct their respective discovery depositions of individuals upon mutually agreeable dates, to be concluded no later than January 31, 2015.

4. The Petitioner herein shall designate its respective expert witness on or by February 6, 2015. The other parties shall designate their expert witnesses, if any, by February 20, 2015.

5. The depositions of said designated expert witnesses shall be concluded by April 3, 2015.

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6. Prehearing memoranda of law shall be submitted by the parties to the Administrative Judge on or by April 27, 2015.

7. Any motions *in limine* to be considered by the Administrative Judge shall be filed on or by April 24, 2015.

8. As previously ordered, the hearing herein shall occur from May 4 through May 8, 2015. The counsel for the Health Services and Development Agency shall obtain an appropriate location for the hearing unless otherwise agreed upon by the parties hereto.

9. After the conclusion of the hearing herein, the parties shall file their proposed findings of fact and conclusions of law within 30 days of receipt of the transcript in this matter. Any reply conclusions of law shall be filed within 15 days of receipt of the opposing parties' proposed findings of fact and conclusions of law.

It is hereby ORDERED, ADJUDGED and DECREED that: the parties hereto, having agreed to the above terms, by and through their respective counsel, this Agreement Scheduling Order be entered into the record in this matter.

Leonard Pogue

ADMINISTRATIVE JUDGE

AGREED AS TO ALL TERMS:

William West

William H. West, Esq., BPR #005543
Baker Donelson Bearman Caldwell &
Berkowitz, PC
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
(615) 726-5600
Attorneys for Petitioner,
SBH-Kingsport, LLC

G. Brian Jackson (by permission, WHW)

G. Brian Jackson, Esq., BPR #015497
Butler Snow O'Mara Stevens & Cannada, PLLC
150 Third Avenue South, Suite 1600
Nashville, TN 37201
(615) 651-6701
Attorneys for Intervenor, Mountain States
Health Alliance, Inc.

Jim Christoffersen (by permission, WHW)

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243
(615) 741-2364

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been sent via email, to the following:

G. Brian Jackson, Esq.
Butler Snow O'Mara Stevens & Cannada, PLLC
150 Third Avenue South, Suite 1600
Nashville, TN 37201

and

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

this 22 day of August, 2014.

William West

LFP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

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SECRETARY OF STATE

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**DOCKET NO: 25.00-126908J**
	)	

MOTION TO AMEND SCHEDULING ORDER

Comes now the Petitioner herein, SBH-Kingsport, LLC, to move this tribunal to amend the Scheduling Order previously entered in this matter as shown on the attached "Amended Scheduling Order", which is Exhibit A to this motion.

The changes proposed in this Motion and the proposed Amended Scheduling Order are as follows:

1. Alter the deadline for completing the discovery depositions of individuals so that they are concluded by a date no later than April 3, 2015.

2. Alter the date by which the non-petitioner parties shall designate their expert witness to a date no later than March 23, 2015.

3. Alter the date for the completed depositions of the designated expert witnesses to a date no later than April 17, 2015.

Counsel for the Petitioner and the Intervenor have conferred about these proposed amendments to the Scheduling Order by email and in person. It is the understanding of counsel for the Petitioner, who brings this motion, that counsel for the Intervenor does not agree with these proposed scheduling order changes. It is further the understanding of the counsel for the Petitioner that the counsel for the Intervenor desires to amend the date for the contested case hearing in this matter to a date in the summer of 2015 subject to the agreement of the other parties and this tribunal. The Petitioner cannot agree to

such a delay, but prefers to retain the existing contested case hearing date, May 4-May 8, 2015, as set forth in the original Scheduling Order and Exhibit A hereto.

Because these parties have not been able to agree on the proposed amendments to the Scheduling Order, counsel for the Petitioner hereby respectfully brings this motion to resolve these issues.

Respectfully submitted,

William H. West, Esq., BPR #005543
Baker Donelson Bearman Caldwell & Berkowitz
Suite 800
211 Commerce Street
Nashville, Tennessee 37201
(615) 726-5600
Attorneys for Petitioner, SBH-Kingsport, LLC

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**DOCKET NO: 25.00-126908J**
	)	

AMENDED SCHEDULING ORDER

Upon good cause shown, the prior scheduling order for this matter is hereby amended to provide as set forth below:

The parties herein shall accomplish the following tasks according to the schedule set forth below:

1. Serve initial written discovery on opposing parties on or by October 1, 2014.

2. On or by November 3, 2014, the parties shall respond to the initial written discovery served upon them.

3. The parties shall conduct their respective discovery depositions of individuals upon mutually agreeable dates, to be concluded no later than April 3, 2015.

4. The Petitioner herein shall designate its respective expert witness on or by February 6, 2015. The other parties shall designate their expert witnesses, if any, by March 23, 2015.

5. The depositions of said designated expert witnesses shall be concluded by April 17, 2015.

6. Prehearing memoranda of law shall be submitted by the parties to the Administrative Judge on or by April 27, 2015.

Exhibit A

7. Any motions *in limine* to be considered by the Administrative Judge shall be filed on or by April 24, 2015.

8. As previously ordered, the hearing herein shall occur from May 4 through May 8, 2015. The counsel for the Health Services and Development Agency shall obtain an appropriate location for the hearing unless otherwise agreed upon by the parties hereto.

9. After the conclusion of the hearing herein, the parties shall file their proposed findings of fact and conclusions of law within 30 days of receipt of the transcript in this matter. Any reply conclusions of law shall be filed within 15 days of receipt of the opposing parties' proposed findings of fact and conclusions of law.

It is hereby ORDERED, ADJUDGED and DECREED that: the parties hereto, having agreed to the above terms, by and through their respective counsel, this Agreement Scheduling Order be entered into the record in this matter.

_____

ADMINISTRATIVE JUDGE

Respectfully submitted:

William H. West, Esq., BPR #005543
Baker Donelson Bearman Caldwell &
Berkowitz, PC
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
(615) 726-5600
Attorneys for Petitioner,
SBH-Kingsport, LLC

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been sent via email, to the following:

Travis Swearingen, Esq.
G. Brian Jackson, Esq.
Butler Snow LLP
150 Third Avenue South, Suite 1600
Nashville, TN 37201

and

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

this 25 day of February, 2015.

William West

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

MOUNTAIN STATES HEALTH ALLIANCE'S MOTION FOR CONTINUANCE AND TO AMEND THE SCHEDULING ORDER

Mountain States Health Alliance ("MSHA") moves the Court to amend the Scheduling Order and continue this contested case hearing from its current setting on May 4, 2015. Despite efforts to complete discovery in the time originally allotted, the parties are significantly behind schedule – among other things, no depositions have yet been taken or even scheduled – and there simply is not enough time to adequately complete fact discovery, expert discovery, dispositive motions, and evidentiary motions in just 60 days.

Procedural History

This case involves SBH-Kingsport, LLC's proposal to build a new 72-bed freestanding psychiatric hospital in Kingsport at a projected cost of $12 million. Formed in 2006, SBH (Strategic Behavioral Health) is a for-profit subsidiary of Dobbs Management Service, a private

equity firm based in Memphis, Tennessee. The HSDA denied SBH's application at its meeting on June 25, 2014.

The HSDA denied SBH's application based in part on the fact that there is no need for a new 72-bed psychiatric hospital in the Tri-Cities. In an effort to create a need where none exists, SBH's application set forth an arbitrary service area that omitted Washington County, even though Washington County is located immediately adjacent to Sullivan County and even though Johnson City, which is located in Washington County, is obviously a key component of the Tri-Cities. Omitting Washington County from the service area made it possible for SBH to ignore the existence of Woodridge Psychiatric Hospital, MHSA's 84-bed facility in Johnson City and the largest provider of inpatient psychiatric and chemical dependency services in the region. Woodridge plays an especially vital role in providing psychiatric services in Upper East Tennessee in light of the fact that the state closed its psychiatric facility serving the area, and Woodridge now serves as the safety-net provider of psychiatric services for uninsured, chronically mentally-ill patients. In short, the information presented to the HSDA showed that any need for additional psychiatric services in the region could be met without constructing a new 72-bed hospital, and approving an unneeded facility would seriously harm Woodridge and thereby disrupt the provision of psychiatric services in the region.

SBH appealed the decision of the Agency and initiated this contested case. On August 22, 2014, the Court entered an Agreed Scheduling Order setting the following deadlines:

- Initial written discovery served by October 1, 2014;
- Responses to initial written discovery served by November 3, 2014;
- Party/Fact discovery depositions completed by January 31, 2015;
- Petitioner's expert disclosures served by February 6, 2015;
- Respondent's and HSDA's expert disclosure served by February 20, 2015;
- Expert depositions completed by April 3, 2015;
- Prehearing motions served by April 24, 2015;
- Hearing date beginning on May 4, 2015.

SBH-KINGSPORT 000028

The parties timely served written discovery on October 1. By agreement, the parties first extended the response deadline to November 17, 2014. Thereafter, SBH requested additional extensions of time, to which MSHA agreed. Finally, just before Thanksgiving, on November 21, the parties exchanged initial written discovery responses.

Although SBH initially served 1,304 pages of documents with its written responses, the vast majority of the material produced consisted of multiple copies of previously available public materials – hospital joint annual reports filed with the State, multiple copies of a CON application filed by MSHA in November 2009, multiple copies of the SBH CON application, etc. Only approximately 300 pages of produced material consisted of new, non-publicly available materials. SBH produced only 150 pages of emails. By comparison, MSHA produced almost 900 pages of emails relating to SBH's project. While SBH produced three years of pro formas, there were no documents showing how the pro formas were generated or the source of the projections contained therein. Similarly, SBH produced several iterations of the CON application, but failed to produce any documents related to the changes made to the application or showing why the assumptions made in the original application were wrong or how any such determinations were made. SBH's interrogatory responses identified Jim Shaheen, Doug Ginn and James Cagle as SBH employees who were personally involved in the preparation of the application, and yet SBH did not produce a single document authored by any of these people.

MSHA's counsel notified counsel for SBH of their concern with the deficiencies in SBH's document production and requested that SBH supplement its responses no later than January 15, 2015. In light of the delays in receiving a complete document production, MSHA suggested an extension of the fact discovery deadline to February 15, 2015, and asked for deposition dates of six SBH witnesses during that time period.

SBH-KINGSPORT 000029

On January 16, 2015, SBH served its First Supplemental Production of Documents containing approximately 2,000 pages of additional material. On January 23, 2015, SBH served a Second Supplemental Production of Documents containing an additional 30 pages of documents – including, for the first time, data from a statistician on which SBH apparently has based its entire project. On January 28, 2015, SBH served supplemental interrogatory responses.

As the parties were at that point approximately 60 days behind schedule, on January 27, 2015, MSHA's counsel contacted SBH's counsel and suggested amending the scheduling order and resetting the hearing date. Nearly three weeks passed before, on February 18, 2015, SBH responded that it could not agree to a trial continuance. SBH also provided, for the first time, proposed deposition dates for two of the six witnesses requested by MSHA. Further attempts to resolve this scheduling disagreement have been unsuccessful.

Argument

Although the parties have cooperated well in attempting to move this matter forward, the delays in obtaining a complete document production from SBH—originally due in early November but not received until the end of January--have made the parties' initial schedule unworkable. No depositions are currently scheduled. SBH has provided deposition dates for two of the six witnesses requested by MSHA. SBH has not yet even identified which MSHA employees it intends to depose. Once SBH does so, MSHA's counsel will have to check on those witnesses' availability both to meet in preparation and to sit for depositions. All witnesses in this case are located in either Memphis or Kingsport, Tennessee and counsel will be required to travel for the depositions.

Moreover, expert testimony will be critical in this case, as in most CON cases. In addition to reviewing documents just produced in January, the expert witnesses will need to review the deposition testimony of the fact witnesses. This is particularly true where the documents produced have contained little information supporting the assumptions and conclusions in SBH's application. Before the parties can proceed to expert disclosure and expert discovery, fact depositions will have to

be completed, transcripts prepared, and the experts will have to have a meaningful opportunity to review the same. Experts, like counsel, have other commitments and cannot reasonably be expected to perform their work without adequate time. SBH's proposed solution is to compress what the parties initially agreed would take six months into a period of 60 days. A case of this magnitude and complexity requires more.

To further complicate matters, there are a number of significant scheduling hurdles in the next few months:

- Mr. Jackson and Mr. Swearingen, counsel for MSHA, each has long-scheduled vacations in the first and third weeks of March.
- Counsel for all sides will be very actively involved in the HSDA meeting of March 25. Counsel are representing separate parties opposing plans for a new ambulatory surgery center and two new emergency departments in Brentwood, Tennessee. Both sides will be involved in significant preparations in advance of that meeting.
- Counsel for MHSA have a trial scheduled in the Eastern District of Pennsylvania from June 15 through July 10, 2015, which will involve multiple out of-state depositions, including expert witness depositions, to be taken and defended in April and will require significant preparation time beginning in mid-May.

MSHA respectfully submits that, despite the parties' best efforts, the scheduling order should be amended and the hearing date continued so that proper discovery can be conducted and completed in this matter.

Respectfully Submitted,



G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

SBH-KINGSPORT 000031

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services &
Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 2nd day of March, 2015.



BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

MOUNTAIN STATES HEALTH ALLIANCE'S RESPONSE TO SBH-KINGSPORT'S MOTION TO AMEND SCHEDULING ORDER

Mountain States Health Alliance ("MSHA") agrees with SBH-Kingsport that the scheduling order should be amended – the parties are behind schedule and no depositions have been taken. As set forth more fully in MHSA's competing Motion to Amend Scheduling Order, however, MHSA disagrees that discovery in this case can be completed in 60 days such that the existing contested case hearing date remains tenable. There simply is not enough time to adequately complete fact discovery, expert discovery, dispositive motions, and evidentiary motions in the time provided. MSHA respectfully submits that, despite the parties' best efforts, the scheduling order should be amended and the hearing date continued so that proper discovery can be conducted and completed in this matter.

Respectfully Submitted,



G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services & Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 2nd day of March, 2015.



LFP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

2015 MAR -4 PM 3:39
SECRETARY OF STATE

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**DOCKET NO: 25.00-126908J**
	)	

PETITIONER'S MEMORANDUM IN OPPOSITION TO MOUNTAIN STATES HEALTH ALLIANCE'S MOTION FOR CONTINUANCE AND TO AMEND SCHEDULING ORDER

Comes now the Petitioner herein, SBH-Kingsport, LLC, to file this Memorandum in Opposition to the motion filed by Mountain States Health Alliance (MSHA) on March 2, 2015, to continue the hearing and further amend the Scheduling Order in this matter.

The parties are in agreement that the Scheduling Order needs to be modified. However, the Petitioner opposes, and does not consent to, the continuance requested by MSHA. The parties have had significant discussions about this over the course of the last several weeks, via email and in person. On February 18, 2015, counsel for the Petitioner/Applicant emailed counsel for MSHA agreeing that the Scheduling Order in this matter needed modification, and proposing that the early May hearing schedule be maintained even though other deadlines should be moved.

When the parties could not reach agreement on this issue, the Petitioner, on February 25, 2015, filed a motion to amend the Scheduling Order. This motion reflects the basic content of its proposals in the email discussion of February 18, 2015 with counsel for MSHA.

The Petitioner initiated this appeal of the denial of its CON application by the HSDA, which took place on a vote of four in favor to four opposed. It has strategic planning and other reasons to expedite the hearing in this matter as much as possible.

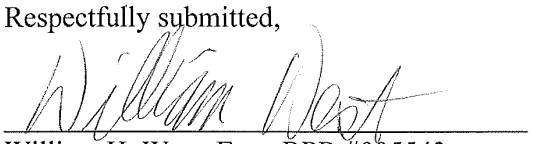
It made the contact person for the CON application, the primary presenter before the HSDA in this matter, available for deposition the first week in March 2015. His deposition will now take place, at the suggestion of counsel for MSHA, in the week of March 30, 2015.

Counsel for the Petitioner has also today specified the intial employees of MSHA which Petitioner wishes to depose. The Petitioner designated its expert witness in this matter a number of weeks ago.

In the initial scheduling discussions regarding the scheduling of the hearing in this matter, a significant cushion of time was preserved in the month of April 2015 for pretrial filings. That time is still available to wrap up the deposition issues in this matter, as proposed by Petitioner's motion to amend the Scheduling Order.

MSHA's counsel is correct that counsel for the parties in this matter have worked together cooperatively to try to resolve their scheduling differences. However, at this point, clearly this tribunal itself must resolve the issues raised by the motions filed by each party regarding the scheduling order and hearing date in this matter.

Respectfully submitted,



William H. West, Esq., BPR #005543
Baker Donelson Bearman Caldwell & Berkowitz
Suite 800
211 Commerce Street
Nashville, Tennessee 37201
(615) 726-5600
Attorneys for Petitioner, SBH-Kingsport, LLC

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been sent via email, to the following:

Travis Swearingen, Esq.
G. Brian Jackson, Esq.
Butler Snow LLP
150 Third Avenue South, Suite 1600
Nashville, TN 37201

and

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

this 4 day of March, 2015.

William West

N WHW 1479091 v1
2913023-000013 03/04/2015

25.00-126908S

BEFORE THE TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

RECEIVED
2015 MAR -9 AM 12:43
SECRETARY OF STATE

IN THE MATTER OF:	)	
	)	**DOCKET NO.**
SBH-KINGSPORT, LLC	)	**CON No. CN1312-050D**
	)	

THE HEALTH SERVICES AND DEVELOPMENT AGENCY'S RESPONSE TO MOUNTAIN STATES HEALTH ALLIANCE'S MOTION FOR CONTINUANCE

COMES NOW the Health Services and Development Agency ["Agency"], by and through counsel, and states that it is not opposed to Mountain States Health Alliance's ["MSHA"] motion to continue the hearing and further amend the scheduling order. In support thereof, the Agency avers as follows.

1. Though T.C.A. §68-11-1610(d) provides for a scheduling order that results in a hearing completed within one hundred eighty (180) days of the date on which the petition for contested case was received by the agency, the Chancery Court for Davidson County has interpreted this as directory, not mandatory. See Exhibit "A", attached hereto.

2. While the Agency and Administrative Judge should strive to honor the legislative intent of T.C.A. §68-11-1610(d), doing so has usually meant trying cases as expeditiously as can reasonably be accomplished given the circumstances of each contested case appeal of the approval or denial of a certificate of need application. This has rarely, if ever, resulted in the completion of a contested case hearing within 180 days.

CERTIFICATE OF SERVICE

I certify that copies of the foregoing have been mailed by first-class United States mail, postage prepaid, to:

William H. West, Esq.
Baker Donelson, Bearman,
Caldwell & Berkowitz
211 Commerce St., Suite 800
Nashville, TN 37201

Travis B. Swearingen, Esq.
G. Brian Jackson, Esq.
BUTLER SNOW O'MAR STEVENS & CANNADA PLLC
The Pinnacle at Symphony Place
150 3rd Avenue South, Suite 1600
Nashville, TN 37201

This 9th day of March, 2015.

James B. Christoffersen, Esq.
General Counsel
Tennessee Health Services and
Development Agency

5306099
RECEIVED
JAN - 9 2006
Clerk & Master, Chancery Court

IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE

SENIORHEALTH OF TENNESSEE, LLC,	)	
	)	
Petitioner,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	F09Y
	)	**Docket No. 05-2920-I**
and	)	
	)	
NASHVILLE REHABILITATION HOSPITAL, TENNESSEE CHRISTIAN MEDICAL CENTER, VANDERBILT UNIVERSITY MEDICAL CENTER, VANDERBILT STALLWORTH, CENTENNIAL MEDICAL CENTER, SUMMIT MEDICAL CENTER and SKYLINE MEDICAL CENTER,	)	
	)	
Intervenors.	)	

FILED
2006 JAN 13 AM 11:25
CLERK & MASTER
DAVIDSON CO. CHANCERY CT.

ORDER

This matter came before the Court on Petition of SeniorHealth of Tennessee for interlocutory review of a scheduling order entered by the administrative law judge in Administrative Case 25.00-079861J. In particular, the Court has been asked to construe Tennessee Code Annotated § 68-11-1610(d), which states:

> The administrative law judge to whom a case has been assigned shall convene the parties for a scheduling conference within fifteen (15) days of the date the petition for contested case is filed. At the scheduling conference, the parties shall state their respective positions on the mediation alternative described in this section. If the parties are unable to agree on mediation alternative, the scheduling order for the contested case adopted by the administrative law judge shall establish a schedule that results in a hearing completed within one hundred eighty (180) days of the date on which the petition for contested case was received by the agency, with the initial order to be entered within sixty (60) days of the date the

Exhibit 'A'

> hearing is completed. Extensions of time or variances from the scheduling order shall be granted sparingly, and only because of unforeseen developments that would cause substantial prejudice to a party.

The scheduling order entered by the administrative law judge in this case set the hearing to begin approximately two months after the expiration of the 180-day time period.

Having considered the stipulated administrative record, the briefs of the parties, and the arguments of counsel in open court, the Court hereby finds that the 180-day provision set forth in § 68-11-1610(d) is directory, not mandatory, and that substantial compliance with the 180-day provision is therefore adequate to satisfy the statutory requirement.

The Court further finds that the scheduling order as entered in this case, which sets the case for hearing within two months of the 180th day, constitutes substantial compliance. The scheduling order is therefore proper.

The Court's findings are based on the following:

1. The Court accepts jurisdiction over this interlocutory appeal, in that Petitioner would otherwise be without an adequate remedy at law;

2. The administrative law judge applied the 180-day provision as directory, not mandatory, and was not therefore relying on the "unforeseen developments" portion of the statute;

3. The Court is guided by the following statement of the law in *Presley v. Bennett*, 860 S.W.2d 857 (Tenn. 1993):

> In general, when determining whether a procedural requirement of a statute is directory or mandatory, the object is to ascertain the legislative intent by consideration of the entire statute, including its nature and purpose, and the consequences that would result from a construction one way or the other. ... Directory provisions require only substantial compliance. ... Statutory provisions relating to the mode or time of doing

> an act to which the statute applies are ordinarily held to be directory rather than mandatory.

Id. at 860 (citations omitted).

4. Section 68-11-1610(d) does not set forth a penalty or consequence if the 180-day time period is not met.

5. A party that has been denied a certificate of need could be financially and economically damaged by a delay in the hearing of the appeal.

6. Development of healthcare that is not orderly could cause damage to the public interest.

7. The overall purpose of the Health Services and Development Agency and of the statutory scheme is the orderly development of healthcare.

8. The legislative intent of the orderly development of healthcare can be met by substantial compliance with the statute.

9. The matters listed by the administrative law judge in support of the scheduling order are matters of legitimate concern.

10. The scheduling order entered in this case by the administrative law judge is substantially in compliance with § 68-11-1610(d).

IT IS THEREFORE ORDERED:

1. The Court accepts jurisdiction over this interlocutory appeal;

2. The Court denies Petitioner's request that it order the administrative law judge to withdraw the scheduling order;

3. The Court denies Petitioner's request that it order the completion of the administrative hearing in this case by March 29, 2006.

4. This case is DISMISSED, with prejudice. Costs are assessed against SeniorHealth, for which execution may issue.

Claudia Bonnyman, Chancellor

APPROVED FOR ENTRY:

Kathryn A. Stephenson
Sup. Ct. No. 13430
TRAUGER & TUKE
222 Fourth Ave. N.
Nashville, Tennessee 37219
(615) 256-8585

BEFORE THE TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

2015 MAR -9 P 12:43
SECRETARY OF STATE

IN THE MATTER OF:	)	
	)	**DOCKET NO.**
SBH-KINGSPORT, LLC	)	**CON No. CN1312-050D**
	)	

THE HEALTH SERVICES AND DEVELOPMENT AGENCY'S RESPONSE TO MOUNTAIN STATES HEALTH ALLIANCE'S MOTION FOR CONTINUANCE

COMES NOW the Health Services and Development Agency ["Agency"], by and through counsel, and states that it is not opposed to Mountain States Health Alliance's ["MSHA"] motion to continue the hearing and further amend the scheduling order. In support thereof, the Agency avers as follows.

1. Though T.C.A. §68-11-1610(d) provides for a scheduling order that results in a hearing completed within one hundred eighty (180) days of the date on which the petition for contested case was received by the agency, the Chancery Court for Davidson County has interpreted this as directory, not mandatory. See Exhibit "A", attached hereto.

2. While the Agency and Administrative Judge should strive to honor the legislative intent of T.C.A. §68-11-1610(d), doing so has usually meant trying cases as expeditiously as can reasonably be accomplished given the circumstances of each contested case appeal of the approval or denial of a certificate of need application. This has rarely, if ever, resulted in the completion of a contested case hearing within 180 days.

CERTIFICATE OF SERVICE

I certify that copies of the foregoing have been mailed by first-class United States mail, postage prepaid, to:

William H. West, Esq.
Baker Donelson, Bearman,
Caldwell & Berkowitz
211 Commerce St., Suite 800
Nashville, TN 37201

Travis B. Swearingen, Esq.
G. Brian Jackson, Esq.
BUTLER SNOW O'MAR STEVENS & CANNADA PLLC
The Pinnacle at Symphony Place
150 3rd Avenue South, Suite 1600
Nashville, TN 37201

This 9th day of March, 2015.

James B. Christoffersen, Esq.
General Counsel
Tennessee Health Services and
Development Agency

530699
RECEIVED
JAN - 9 2006
Clerk & Master, Chancery Court

IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE

SENIORHEALTH OF TENNESSEE, LLC,	)	
	)	
Petitioner,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	F09 Y
	)	**Docket No. 05-2920-I**
and	)	
	)	
NASHVILLE REHABILITATION HOSPITAL, TENNESSEE CHRISTIAN MEDICAL CENTER, VANDERBILT UNIVERSITY MEDICAL CENTER, VANDERBILT STALLWORTH, CENTENNIAL MEDICAL CENTER, SUMMIT MEDICAL CENTER and SKYLINE MEDICAL CENTER,	)	
	)	
Intervenors.	)	

FILED
2006 JAN 13 AM 11:25
CLERK & MASTER
DAVIDSON CO. CHANCERY CT.
bt
B&M

ORDER

This matter came before the Court on Petition of SeniorHealth of Tennessee for interlocutory review of a scheduling order entered by the administrative law judge in Administrative Case 25.00-079861J. In particular, the Court has been asked to construe Tennessee Code Annotated § 68-11-1610(d), which states:

> The administrative law judge to whom a case has been assigned shall convene the parties for a scheduling conference within fifteen (15) days of the date the petition for contested case is filed. At the scheduling conference, the parties shall state their respective positions on the mediation alternative described in this section. If the parties are unable to agree on mediation alternative, the scheduling order for the contested case adopted by the administrative law judge shall establish a schedule that results in a hearing completed within one hundred eighty (180) days of the date on which the petition for contested case was received by the agency, with the initial order to be entered within sixty (60) days of the date the

Exhibit 'A'

> hearing is completed. Extensions of time or variances from the scheduling order shall be granted sparingly, and only because of unforeseen developments that would cause substantial prejudice to a party.

The scheduling order entered by the administrative law judge in this case set the hearing to begin approximately two months after the expiration of the 180-day time period.

Having considered the stipulated administrative record, the briefs of the parties, and the arguments of counsel in open court, the Court hereby finds that the 180-day provision set forth in § 68-11-1610(d) is directory, not mandatory, and that substantial compliance with the 180-day provision is therefore adequate to satisfy the statutory requirement.

The Court further finds that the scheduling order as entered in this case, which sets the case for hearing within two months of the 180th day, constitutes substantial compliance. The scheduling order is therefore proper.

The Court's findings are based on the following:

1. The Court accepts jurisdiction over this interlocutory appeal, in that Petitioner would otherwise be without an adequate remedy at law;

2. The administrative law judge applied the 180-day provision as directory, not mandatory, and was not therefore relying on the "unforeseen developments" portion of the statute;

3. The Court is guided by the following statement of the law in *Presley v. Bennett*, 860 S.W.2d 857 (Tenn. 1993):

> In general, when determining whether a procedural requirement of a statute is directory or mandatory, the object is to ascertain the legislative intent by consideration of the entire statute, including its nature and purpose, and the consequences that would result from a construction one way or the other. ... Directory provisions require only substantial compliance. ... Statutory provisions relating to the mode or time of doing

> an act to which the statute applies are ordinarily held to be directory rather than mandatory.

Id. at 860 (citations omitted).

4. Section 68-11-1610(d) does not set forth a penalty or consequence if the 180-day time period is not met.

5. A party that has been denied a certificate of need could be financially and economically damaged by a delay in the hearing of the appeal.

6. Development of healthcare that is not orderly could cause damage to the public interest.

7. The overall purpose of the Health Services and Development Agency and of the statutory scheme is the orderly development of healthcare.

8. The legislative intent of the orderly development of healthcare can be met by substantial compliance with the statute.

9. The matters listed by the administrative law judge in support of the scheduling order are matters of legitimate concern.

10. The scheduling order entered in this case by the administrative law judge is substantially in compliance with § 68-11-1610(d).

IT IS THEREFORE ORDERED:

1. The Court accepts jurisdiction over this interlocutory appeal;

2. The Court denies Petitioner's request that it order the administrative law judge to withdraw the scheduling order;

3. The Court denies Petitioner's request that it order the completion of the administrative hearing in this case by March 29, 2006.

SBH-KINGSPORT 000048

4. This case is DISMISSED, with prejudice. Costs are assessed against SeniorHealth, for which execution may issue.

Claudia Bonnyman, Chancellor

APPROVED FOR ENTRY:

Kathryn A. Stephenson
Sup. Ct. No. 13430
TRAUGER & TUKE
222 Fourth Ave. N.
Nashville, Tennessee 37219
(615) 256-8585

LFP

State of Tennessee

RECEIVED
2015 MAY 11 PM 2:37
SECRETARY OF STATE

Department of State

STATE OF TENNESSEE (Agency):
Health Services and Development Agency

SUBPOENA
(ORDER TO APPEAR)
DUCES TECUM

Docket Number:
25.00-126908J

IN THE MATTER OF:
SBH-Kingsport, LLC
Applicant and Petitioner

vs. Health Services and Development Agency, Respondent and Mountain States Health Alliance, Intervenor

TO: (Name, Address & Telephone Number of Witnesses)
Alan Levine

President and CEO
Mountain States Health Alliance
400 North State of Franklin Road
Johnson City, TN 37604

You are hereby commanded to appear at the time, date and place specified for the purpose of giving testimony. In addition, if indicated, you are to bring the items listed. Failure to appear may be punished as provided by law.

TIME 10:00 a.m. Eastern Standard

DATE
May 29, 2015

PLACE
Baker Donelson
100 Med Tech Parkway
Suite 200
Johnson City, TN 37604

NOTICE: THE FAILURE TO SERVE AN OBJECTION TO THIS SUBPOENA WITHIN TWENTY-ONE DAYS AFTER THE DATE OF SERVICE OF THE SUBPOENA WAIVES ALL OBJECTIONS TO THE SUBPOENA, EXCEPT THE RIGHT TO SEEK THE REASONABLE COST FOR PRODUCING BOOKS, PAPERS, DOCUMENTS, ELECTRONICALLY STORED INFORMATION, OR TANGIBLE THINGS.

ITEMS TO BRING:
All documents, including computer files and emails, in your possession, custody, or control generated, written, compiled, or otherwise developed by an executive employee, consultant for, or agent of Mountain States Health Alliance that refer to, mention, or relate in any way to the lack of access to mental health services in northeast Tennessee or southwest Virginia, Woodridge Psychiatric Hospital occupancy levels, bed count, finances, physical conditions, any plans for the re-purposing of hospital beds

[X] **Additional List Attached** (continued on separate page)

This subpoena is being issued on behalf of: (Party)
Petitioner, SBH-Kingsport, LLC

DATE ISSUED:
May 8, 2015

Attorney: (Name, Address & Telephone Number)
William West
Baker Donelson
211 Commerce Street, Suite 800
Nashville, TN 37201

ADMINISTRATIVE PROCEDURES DIVISION

Joyce Symes Bailey
ADMINISTRATIVE JUDGE

RETURN ON SERVICE

I certify that on the date indicated below I served a copy of this subpoena on the witness stated above by

[X] Certified mail, return receipt requested. Receipt No. 7196 9008 9111 1538 1912

[ ] Delivering a true copy thereof personally to: _____

Served by: Melissa H Smeet Date: 5/8/15

SS-5202

(Continued from Subpoena form)

at Indian Path Hospital, the re-purposing of Indian Path Hospital, or future plans therefor or SBH-Kingsport, LLC. Also included as items to bring are any studies, reports, memos, spreadsheets, analyses, or other documents or computer files, including emails, that mention, document or refer to the need for, or competition for, psychiatric hospital services or access to mental health services, including addiction treatment services, in northeast Tennessee or southwest Virginia that have been developed, compiled or utilized with regard to planning for any certificate of public advantage application proposed to be filed for northeast Tennessee by or on behalf of Mountain States Health Alliance and/or any other entity.

LFP

RECEIVED
2015 MAY 27 AM 10: 39
SECRETARY OF STATE

STATE OF TENNESSEE
DEPARTMENT OF STATE

STATE OF TENNESSEE (Agency)
Tennessee Health Services and Development Agency

SUBPOENA

Docket Number:
APD Dkt. No. 25.00-126908J

~~Duces Tecum~~

IN THE MATTER OF:
SBH-Kingsport, LLC

vs.

Tennessee Health Services and Development Agency, Respondent and Mountain States Health Alliance, Intervenor

TO: (Name, Address & Telephone Number of Witness)
Custodian of Records
Dobbs Management Service, LLC
6070 Poplar Avenue, Suite 750
Memphis, TN 38119

You are hereby commanded to appear at the time, date and place specified for the purpose of giving testimony. In addition, if indicated, you are to bring the items listed. Failure to comply may result in sanctions as provided by law.

TIME	DATE	ITEMS TO BRING:
	June 12, 2015	See attached Exhibit A.

PLACE
Travis B. Swearingen
Butler Snow LLP
150 3rd Ave. South, Suite 1600
Nashville, TN 37201

☒ Additional List Attached

THIS SUBPOENA IS BEING ISSUED ON BEHALF OF: (Party)
Mountain States Health Alliance, Intervenor

DATE ISSUED:
May 22, 2015

ATTORNEY OR REPRESENTATIVE: (Name, Address, & Telephone Number)
Travis B. Swearingen, Esq.
Butler Snow LLP
150 3rd Ave. South, Suite #1600
Nashville, Tennessee 37201
615-651-6734

J. Richard Collier
Chief Administrative Law Judge

J. Richard Collier

RETURN ON SERVICE

I certify that on the date indicated below I served a copy of this subpoena on the witness identified above by

[ ] Certified mail, return receipt requested. Receipt Number _____

[✓] Delivering a true copy thereof personally to: Mike Orians

Served by: Alan Beck Date: 5/22/15

SS-5202
(Rev Jan 2015)

Submit a copy of completed subpoena within five (5) business days to:
Administrative Procedures Division
Office of Tennessee Secretary of State
312 Rosa L. Parks Avenue North, 8th Floor
Nashville, TN 37243-1102

APD 2015-05-038

EXHIBIT A

INSTRUCTIONS

Pursuant to Rule 45 of the Tennessee Rules of Civil Procedure, the Custodian of Records of Dobbs Management Service, LLC is directed to produce all documents in his or her custody, control, and possession that are responsive to the request set forth below.

DEFINITIONS

1. The terms "SBH" or "SBH-Kingsport" shall mean, any subsidiaries, affiliates or parent companies, and any agent, attorney, representative, investigator, or other individual acting on behalf of those persons or entities.

2. The term "Strategic Behavioral Health, LLC" is intended to include all other entities, affiliates, subsidiaries of the SBH parent company including, but not limited to, the Strategic Behavioral Centers located in following locations:

a) Wilmington, North Carolina
b) Raleigh, North Carolina
c) Charlotte, North Carolina
d) Colorado Springs, Colorado
e) Las Vegas, Nevada – Red Rock
f) Las Vegas, Nevada – Montevista
g) College Station, Texas
h) El Paso, Texas
i) Johnstown, Colorado.

3. As used herein, "document" means, by way of illustration and not by way of limitation, the following items, whether printed, written, electronic, digital, or produced by hand: all original written, recorded, or graphic matters whatsoever and all non-identical copies, thereof, including but not limited to, papers, books, records, letters, photographs, calendars, slides, tangible things, correspondence, communications, telegrams, cables, telex messages, memoranda, notes, notations, work papers, transcripts, cables, minutes, reports and recordings of telephone or other conversations, or of interviews, or of conferences, or of other meetings, affidavits, statements, summaries, opinions, reports, studies, analyses, bulletins, notices, announcements, advertisements, instructions, charts, manuals, brochures,

publications, schedules, price lists, client lists, journals, statistical records, desk calendars, appointment books, diaries, lists, tabulations, books of account, receipts, records and invoices reflecting business operations, sound recordings, computer print-outs, "Web Sites" on the "Internet," electronic mail or "e-mail" communications (including instant messaging), text messages sent via mobile phone, "smart" phone, Blackberry or other similar device, all records kept by electronic, digital or intangible means, photographic means or mechanical means, any notes or drafts relating to the foregoing, and all things similar to any of the foregoing. In all cases where originals are not available, "document" also means identical copies of original documents and non-identical copies thereof.

4. The term "communication" means the expression of any statement, command, idea, knowledge, information, or other matter, whether by speech, writing, or otherwise, and includes any transfer of data or information from one location to another by or similar means.

5. The term "Project" shall mean and include all aspects of 72-bed, free-standing psychiatric hospital located in Kingsport, Sullivan County, Tennessee proposed by SBH at issue in this matter, as set forth in the CON application CN1312-050, and the materials filed in support of the same.

DOCUMENTS AND THINGS TO BE PRODUCED

1. All documents in Dobbs Management Services' possession, custody, or control related to or referencing the SBH-Kingsport Project.

2. All documents in Dobbs Management Services' possession, custody, or control identifying all fees paid to it by Strategic Behavioral Health, LLC or any of the SBH affiliated entities.

3. All documents in Dobbs Management Services' possession, custody, or control identifying all functions and services that Dobbs Management Services provides to Strategic Behavioral Health, LLC or any of the SBH affiliated entities.

4. All communications to and from Strategic Behavioral Health, LLC or any of the SBH affiliated entities relating to the Project.

5. All pro formas relating to Strategic Behavioral Health, LLC or any of the SBH affiliated entities relating to the Project.

6. All internal analyses, including any, projected return on investment relating to Strategic Behavioral Health, LLC or any of the SBH affiliated entities relating to the Project.

LFP

RECEIVED
2015 JUN 10 PM 4:07
SECRETARY OF STATE

BEFORE THE TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant/Petitioner,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
Intervenor.	)	
	)	

PETITIONER'S MOTION FOR LEAVE TO DISCLOSE MSHA'S "HIGHLY CONFIDENTIAL" DOCUMENTS TO INDIVIDUALS SUBJECT TO THE PROTECTIVE ORDER AND MEMORANDUM IN SUPPORT THEREOF

MOTION

Comes now the Applicant/Petitioner herein, SBH-Kingsport, LLC ("SBH") to move, pursuant to Section 9 of the Protective Order, respectfully for leave to disclose certain documents, labeled "highly confidential," which were produced in discovery by Mountain States Health Alliance ("MSHA"). SBH's attorneys seek leave to disclose these documents only to Jim Shaheen and Mike Garone, who are executives with the Applicant and who have executed the documentation necessary to make themselves subject to the Protective Order in this matter.

MEMORANDUM

As set forth in the Exhibits hereto, counsel for SBH-Kingsport, LLC ("SBH") and counsel for MSHA have exchanged numerous emails and letters concerning the disclosures requested in this matter.

In an email to MSHA attorneys later included as an attachment to Exhibit 1, certain correspondence in this matter, counsel for SBH requested on May 12, 2015 that MSHA permit them to disclose approximately 569 documents produced in discovery by MSHA to Mr. Shaheen and Mr. Garone. On June 3, 2015, as shown by the letter from Travis Swearingen to William West attached hereto as Exhibit 2 to this Motion, MSHA's attorneys agreed to permit such disclosure for approximately 92 documents out of the 569. MSHA has produced in discovery in this matter more than 1,600 numbered documents. However, many of the numbered documents are cover sheets for spreadsheets, produced electronically, which stretch on for many pages when printed out. If all of these pages are counted, there have been more than approximately 2,000 or more documents produced by MSHA in this matter, of which most have been labeled by MSHA as "highly confidential".

Thus, counting spreadsheets as single pages, there are approximately 477 documents which remain at issue concerning Exhibit 1's requested disclosures to Mr. Garone and Mr. Shaheen.

In Exhibit 2 to this Motion, while counsel for MSHA appeared to agree to disclose 92 documents, 24 of the documents do not actually exist. MSHA documents labeled 1545 - 1568 are, as produced, on pages that are labeled "intentionally left blank." Furthermore, MSHA

documents 1228 - 1246 consist of a copy of the grant from the Tennessee Department of Mental Health and Substance Abuse Services to MSHA, which is very likely a public document under the Tennessee Public Records Act. Therefore, only 49 of the 92 documents agreed upon by MSHA counsel for disclosure constitute documents that could possibly be considered confidential. A number of these contain publicly available information, such as monthly patient commitment volumes, or hospital patient origin data, which is frequently available on the public joint annual reports that Tennessee hospitals have to file with the State of Tennessee.

For purposes of resolving part of this dispute, counsel for SBH agree that pages which show actual payment rates to MSHA facilities for services to patients, such as MSHA documents 1359 - 1367, can be eliminated from this request for leave to disclose to Mr. Shaheen and Mr. Garone. However, there are numerous other documents, such as "patient flow sheets", MSHA documents 1441 - 1518, which simply consist of one page per day charts of actual occupancy of individual buildings at Woodridge Psychiatric Hospital. These, and the variations they describe, are highly probative of issues in the case. Therefore, the executives with SBH, Mr. Garone and Mr. Shaheen, need to be able to see these documents and analyze them themselves in order to present SBH's case to this tribunal for resolution in this matter. Similarly, documents which describe "deferrals" of patients away from Woodridge Psychiatric Hospitals and other facilities by month, such as MSHA document 1440, are also highly probative of primary issues in this case and should be disclosed to Mr. Garone and Mr. Shaheen as they prepare for the hearing in this matter.

Furthermore, SBH's expert, Daniel Sullivan, will be producing his expert witness report by June 15, 2015. In it, he will surely utilize many of MSHA's "Highly Confidential" documents, both for data and as exhibits. Either Mr. Garone or Mr. Shaheen will be required to supplement and execute the interrogatories related to expert witness reports served upon SBH by MSHA. In order for Mr. Garone or Mr. Shaheen to be able to supplement these interrogatories under oath, he will unavoidably be exposed to "highly confidential" information or documents.

For example, Interrogatory 1.(c) requires the person answering the interrogatory to state "a summary of the factual grounds for each opinion or conclusion," while Interrogatory 1.(b) requires the answering individual to state "the substance of the facts, opinions, and conclusions to which the expert is expected to testify". This Interrogatory requires that the person answering the Interrogatory have access to many, if not most, of the "highly confidential" documents covered by this motion, and most likely other such documents as well. Thus, leave to disclose should be granted by this tribunal as requested in this motion for this discovery-related reason as well.

Mr. Garone and Mr. Shaheen remain subject to the Protective Order that they have agreed to abide by in this matter. Therefore, the documents requested to be disclosed to these individuals by counsel for SBH, with the exceptions of the limitations acknowledged herein above concerning documents which disclose actual billing rates for payers to MSHA facilities, should be disclosed to Mr. Garone and Mr. Shaheen, who are pledged not to disclose such documents except as permitted by the Protective Order entered in this matter.

In light of the foregoing, and in light of the efforts by counsel to resolve this matter previously through numerous letters and emails, counsel for the Petitioner, SBH-Kingsport, LLC, hereby respectfully requests that this tribunal grant them leave pursuant to Section 9 of the Protective Order to disclose the documents listed in its counsel's email of May 12, 2015, to Mr. Garone and Mr. Shaheen, subject to the limitations acknowledged above against disclosing actual MSHA payment rate information.

Respectfully submitted,



William H. West, Esq. (B.P.R. No. 5543)
Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
615-726-5561
Counsel for SBH-Kingsport, LLC, Applicant/Petitioner

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been delivered via email to:

Travis Swearingen, Esq.
Brian Jackson, Esq.
Butler Snow LLP
150 Third Avenue South, Suite 1600
Nashville, TN 37201

and

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

this 10 day of June, 2015.

William West

BAKER DONELSON
BEARMAN, CALDWELL & BERKOWITZ, PC

BAKER DONELSON CENTER, SUITE 800
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WILLIAM WEST, SHAREHOLDER
DIRECT DIAL: (615) 726-5561
DIRECT FAX: (615) 744-5561
E-MAIL ADDRESS: bwest@bakerdonelson.com

June 1, 2015

Via Email and U.S. Postal Service

Brian Jackson, Esq.
Travis Swearingen, Esq.
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201

Re: SBH-Kingsport, LLC CON Appeal: New Request for Supplementation of Prior Discovery Responses pursuant to Rule 26.05, and other discovery issues

Dear Brian and Travis:

I am writing to you concerning various discovery matters that are outstanding in the SBH-Kingsport, LLC CON contested case proceeding. In my prior letter to Travis of May 20, 2015, attached hereto as Exhibit 1 (without certain extraneous exhibits), I requested that your client, Mountain States Health Alliance, supplement its discovery responses with regard to certain requests for production listed therein. In my letter of May 22, 2015 to Brian, I made a similar request with regard to certain other requests for production of documents.

This letter constitutes a new request pursuant to TROP Rule 26.05(3) that Mountain States Health Alliance supplement all its discovery responses to any interrogatory or request for production of documents served on MSHA in this matter by Baker Donelson on behalf of our client, SBH-Kingsport, LLC.

I also wanted to follow up on my May 22, 2015 letter to Brian concerning the failure of MSHA to produce the documents referred to by Ms. Bailey in pages 37 through 42 of her deposition, even though they were responsive to numerous requests for production of documents served upon MSHA by SBH-Kingsport, LLC, and particularly Request No. 34 thereof. We still have not had a response to my May 22, 2015 letter to Brian, which is attached hereto as Exhibit 2. We need to obtain those documents as soon as possible, given, as Travis has noted, we are less than 60 days from the hearing in this matter. Please let me know by Wednesday of this week, June 3, 2015, when we can expect to receive those documents referenced in my May 22,

Ex. 1

2015 letter to Brian as well as when we can expect to receive the other supplementation of discovery requested herein or in Exhibits 1 and 2 hereto. If we do not receive a meaningful response to these requests, we will be forced to file a motion to compel the production of the documents referred to in my May 22, 2015 letter to Brian concerning Ms. Bailey's deposition testimony and the related requests for production of documents. As I have repeatedly indicated, I would rather not file such a motion, but I will do so if I am forced to by nonresponsiveness.

I also wanted to follow up on several other discovery matters. We still have not heard back from Travis concerning our request that Mr. Garone and Mr. Shaheen be permitted to view numerous "highly confidential" MSHA documents. It is vitally important for our firm to have their assistance in preparing for the July hearing in this matter. It is only fair that they be allowed to review these documents, knowing, as I have indicated before, that they are bound by the protective order that they have agreed to abide by, which protects MSHA from the documents' improper disclosure.

Also, I wanted to advise Travis that it appears that we can have his requested depositions of James Cagle and Matt Doyle scheduled for June 11, 2015. We have conferred with the staff at our East Memphis office, and they are holding a conference room there for us beginning at 1:00 through the end of the day on June 11. Our East Memphis office is located at 6060 Poplar Avenue, Suite 440. Their direct dial phone number is 901-579-4104. James Cagle has already confirmed that he is available to be deposed at that date, and I am awaiting confirmation by Matt Doyle, who has previously indicated that he is flexible for depositions that week. By doing it in East Memphis in the afternoon, it is possible for both Brian and me to go down and back in the same day.

Please let me know what your responses to this letter are. I look forward to working with you in resolving these or any other issues in discovery prior to the hearing herein.

Sincerely,

Bill

William West

WHW/mhh

cc: Jim Shaheen

N WHW 1514769 v1
2913023-000013 06/01/2015

BAKER DONELSON
BEARMAN, CALDWELL & BERKOWITZ, PC

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DIRECT FAX: (615) 744-5561
E-MAIL ADDRESS: bwest@bakerdonelson.com

May 20, 2015

Travis B. Swearingen , Esq.
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201

Via Email and Hand Delivery

Re: SBH-Kingsport, LLC's Response to your letter to me of May 15, 2015

Dear Travis:

I agree with your letter's statement that there are a number of outstanding discovery issues remaining in this matter. It is my view, as set forth more fully below, that you and I need to have a conference with Judge Pogue to resolve a number of these issues. I respond below to your issues in the order that you raised them in your letter, and I add several issues of my own to address with Judge Pogue.

First, thank you for agreeing to produce Mr. Levine for a deposition. However, we cannot agree to the limitations on Mr. Levine's testimony set forth in your letter. In an MSHA press release and in various newspaper articles related to MSHA's COPA plans, Mr. Levine has stressed matters directly relevant to the SBH-Kingsport, LLC CON application, and it is therefore necessary for us to depose him on a basis more broad than you have specified. We should address these issues with Judge Pogue, if we cannot resolve them ourselves.

Second, after further analysis, we agree to withdraw the subpoena duces tecum for Mr. Levine's documents. However, the documents covered by that subpoena are also covered by SBH-Kingsport's Requests for Production of Documents already served upon MSHA in late 2014, and responded to by MSHA on November 21, 2014. MSHA's responses to those requests are now Exhibit 14 to Kasey McDevitt's deposition.

SBH-Kingsport's Requests for Production Nos. 18, 19, 24, 25, 37 and 39 in McDevitt deposition Exhibit 14 cover all of the topics covered by the subpoena duces tecum. As you know, Rule 26.05 of the Tennessee Rules of Civil Procedure required MSHA to supplement its

Ex. 1

response to the Requests for Production of Documents served on it by SBH-Kingsport, especially as to the Requests listed above. This letter is SBH-Kingsport's request for MSHA's supplementation of its prior responses to SBH's Requests for Production listed above, pursuant to Rule 26.05(3) of the Tennessee Rules of Civil Procedure. Therefore, MSHA has a duty to supplement its prior responses as to the requests for production listed above, and possibly others as well. Please advise as to when we may expect such supplementation.

Third, you make it sound in your May 15, 2015 letter as though Mountain States did not learn of the Dobbs Management Service's contacts regarding SBH-Kingsport's CON application until the depositions of Mr. Shaheen and Mr. Garone this month. However, MSHA has known since November 21, 2014, when it received SBH-Kingsport's answers to MSHA's interrogatories, that Mike Orians, an executive with the Dobbs Management Services Company, was consulted about the October 2013 decision by SBH-Kingsport, LLC to file the CON at issue. This is set forth in Exhibit 7 to Mr. Garone's deposition, SBH-Kingsport, LLC's responses to the MSHA's first set of interrogatories, particularly in the response to number 4(a) thereto. Furthermore, SBH-Kingsport, LLC's responses to interrogatory number 7 in Exhibit 7 indicate that Mr. Orians assisted in the development of corporate documentation components of the CON application. As you know, Mr. Orians volunteered to be subject to a deposition by the attorneys for MSHA on Thursday, May 6, 2015. However, the attorneys for MSHA decided not to take his deposition on that day, and have not requested to do so since.

I have not been authorized to accept service of any process or subpoena on behalf of Dobbs Management Services. Furthermore, as I have indicated previously, as to any of these issues. Dobbs Management Services is represented by Dale Allen, an attorney with the Adams & Reese law firm here in Nashville. Should you issue a subpoena upon, and attempt to compel a production of documents from, Dobbs Management Services, you should also copy Mr. Allen on that subpoena as he will no doubt become involved in the matter. SBH-Kingsport, LLC does not control the documents held by Dobbs Management Services.

With regard to the fourth point in your May 15, 2015 letter, we received from the court reporter Mr. Shaheen's deposition transcript via email yesterday. At his deposition, Mr. Shaheen testified extensively on the finances of SBH and the financial feasibility of the proposed project. However, should you wish to take an additional deposition on those points, James Cagle, the CFO of Strategic Behavioral Health, is the individual whom you should depose. Mr. Cagle was also made available on May 5, 2015 for a deposition, but, once again, the attorneys for MSHA decided not to take his deposition then. However, we will make Mr. Cagle available to you for deposition. I spoke today with Mr. Cagle. He is available for a deposition on June 5, 2015, or any day from June 8 through June 12, 2015. That deposition should take place in Memphis, where Mr. Cagle resides. The deposition may be taken at the offices of Baker Donelson in downtown Memphis, just as were the depositions of Mike Garone and Jim Shaheen.

I would like to raise some additional discovery-related issues of my own with regard to matters that Judge Pogue may have to resolve in our conference. First, I wanted to follow up on

my email to you of May 12, 2015, a copy of which is attached hereto as Exhibit 1 to this letter. As provided for in the protective order previously entered in this matter, we requested in that email that Mr. Garone and Mr. Shaheen, who have executed the necessary documents protecting the confidentiality of MSHA documents, be granted access to the MSHA documents I have listed in my email of May 12, 2015. I understand that you did not have the opportunity to review my request in detail prior to our depositions in Johnson City on May 14 and 15, 2015, but as we complete discovery and prepare for the hearing it is vitally necessary for the adequate presentation of the Petitioner's case in this matter that its executives be able to examine the MSHA documents listed, acknowledging all the while that they are bound by the terms of the protective order against disclosing them outside the terms of the protective order.

I plan to file a discovery conference motion with Judge Pogue, pursuant to TRCP 26.06, to resolve the outstanding discovery issues described herein, if we cannot resolve them ourselves quickly, particularly as to your proposed limitations on the scope and time of our examination of Mr. Levin. If we cannot resolve at least that issue this week, I will have to serve MSHA's attorneys with a notice of deposition for Mr. Levine that schedules his deposition in early or mid-June, so that you have time to respond to our scheduling conference motion as provided by the rule. Of course, we can also present a joint scheduling motion to Judge Pogue to resolve all these issues promptly. Give me a call to discuss.

In order to clarify any matters raised in this letter, I have also attached as Exhibit 2 to this letter the MSHA/Wellmont press release concerning the certificate of public advantage and related newspaper articles concerning Mr. Levine's comments in public regarding his assertions that the certificate of public advantage is made necessary by the need for increased addiction care and access to mental health services in northeast Tennessee and southwest Virginia.

Sincerely,

William West

WHW/mhh

cc: Mike Garone
Jim Shaheen

N WHW 1510649 v1
2913023-000013 05/20/2015

West, Bill

From: West, Bill
Sent: Tuesday, May 12, 2015 2:24 PM
To: Travis Swearingen (Travis.Swearingen@butlersnow.com)
Cc: Brian.Jackson@butlersnow.com
Subject: access to MSHA highly confidential documents for Mike Garone and Jim Shaheen

Travis: In order to be able to prepare fully for the upcoming depositions and hearing in the Strategic Behavioral Health-Kingsport CON appeal, we would like to disclose the following documents marked "Highly Confidential" to Mike Garone and Jim Shaheen, who have already executed the paperwork committing them to comply with the protective order previously entered in this matter. The documents to be disclosed are, by the Bates numbers given them by MSHA, the following:

63-109;
630-732;
792-798;
874-919;
1062-1073;
1187-1227;
1228-1257;
1258-1423;
1400-1423;
1440-1571.

Please let me know as soon as you can if you have any objection to our disclosing these documents to Mr. Shaheen and Mr. Garone, pursuant to the protective order. Thanks. -Bill

Exhibit 1

BUTLER | SNOW

June 3, 2015

William West
Baker, Donelson, Bearman, Caldwell & Berkowitz, PC
Baker Donelson Center, Suite 800
211 Commerce Street
Nashville, TN 37201

Re: SBH-Kingsport, LLC, CON Application No. CN1312-050.

Dear Bill:

I am writing in response to your June 1, 2015 letter.

We accept the date of June 11, 2015 for the depositions of Mr. Cagle and Mr. Doyle beginning at 1:00 p.m. in your Baker Donelson East Memphis office. We will arrange for a court reporter.

With respect to your request to de-designate certain Highly Confidential documents, I have reviewed the 569 pages you identified. From that set, MSHA agrees to reclassify the following documents as Confidential pursuant to the Protective Order:

630-631
633-646
651
653-659
661
730
792
1228-1246
1400-1402
1518-1524
1525-1533
1542-1544
1545-1568

The remaining documents contain confidential, sensitive, and proprietary financial information, including information about patient charges, contractual writeoffs, profit by service line and DRG, and revenue projections. Furthermore, these documents contain private census information and strategic planning materials. Disclosure of these materials to a potential competitor would cause harm to MSHA.

The Pinnacle at Symphony Place
150 3rd Avenue South, Suite 1600
Nashville, TN 37201

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T 615.651.6700
F 615.651.6701
www.butlersnow.com

BUTLER SNOW LLP

Ex. 2

With respect to your request for documents related to the 2013 VOS initiative mentioned by Marlene Bailey during her deposition, we do not agree that these documents were responsive to SBH's Request for Production of Documents. Nevertheless, in response to your request, I am producing them on the enclosed CD. They are Bates-labeled MSHA 1626-1635.

In response to your previous request for supplementation, I am enclosing a supplemental document production Bates-labeled MHSA 1636-1862. This will also acknowledge receipt of your request for supplementation of MSHA's interrogatory responses, which will be forthcoming in due course.

Please find enclosed a request for SBH-Kingsport to supplement its discovery responses. In addition, several weeks ago you informed me that you had received SBH's audited financials for 2014. I have previously asked that those be provided to us. Please let me know when we can expect to receive them.

Finally, over the past three months, I have repeatedly requested that you agree to a new proposed scheduling order that I have circulated on several occasions. Despite making additional revisions that you have requested, I have never received your approval. We are now less than two months from trial, and we need to have a scheduling order. Accordingly, I will submit the proposed order to the Court on Friday. Please let me know if you would like to submit it as an agreed order.

Sincerely,



Travis B. Swearingen

TBS/cpa
Enclosures
cc: G. Brian Jackson, Esq.

LPP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

RECEIVED
2015 JUN 18 PM 4:13
SECRETARY OF STATE

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

MOUNTAIN STATES HEALTH ALLIANCE'S RESPONSE TO PETITIONER'S MOTION FOR LEAVE TO DISCLOSE "HIGHLY CONFIDENTIAL" DOCUMENTS

Strategic Behavioral Health ("SBH") initiated this contested case after unsuccessfully seeking permission to build a new psychiatric hospital in Kingsport. Mountain States Health Alliance ("MSHA"), which owns Woodridge Psychiatric Hospital in Johnson City, is the Respondent. If the CON were to be approved, MSHA and SBH would be direct competitors.

As in every Certificate of Need case, discovery in this matter included the exchange of internal financial documents, strategic planning information, detailed data about health care services and other non-public, confidential, proprietary and sensitive information. At the commencement of the discovery process, both parties agreed to the entry of an Agreed Protective Order to provide safeguards against disclosing information that might be used by either party for unfair competitive advantage. Both parties have availed themselves of the protections of the

Order by designating certain sensitive information (documents and deposition testimony) as "Highly Confidential." The distribution of such Highly Confidential information is limited to the attorneys in this case and expert witnesses who agree to abide by the provisions of the Order.

The Applicant has now moved the Court to strip the Highly Confidential designation from certain documents produced by MSHA and to allow its senior executives access to this information. These contents of the Highly Confidential documents at issue include the following:

- Patient charge data (the amounts charged for health care services)
- Contractual write-off data, providing information about negotiated insurance contracts
- Data about profit by individual service line and by diagnosis
- Daily census information, tracking the number of patients in Woodridge's facility, by unit, age and geographic origin; and
- Strategic planning material, including service line strategic plans authored by Woodridge's staff.

All of these materials have already been made available to SBH, through its attorneys and through its testifying expert. SBH has not offered a persuasive explanation of why its executives should also be permitted to obtain this sensitive, non-public information.

ARGUMENT

MSHA is not attempting to shield documents from discovery; the documents have already been produced to SBH, subject to the Agreed Protective Order. In arguing that its executives should be given unfettered access to MSHA's sensitive non-public information, SBH merely states the documents are "highly probative of issues in the case." SBH offers no detailed explanation as to why these particular documents are especially important or how they are

actually prejudiced by observing the restrictions agreed to in the Protective Order.

This case will rely heavily on expert testimony from health planning and other experts. The documents in question have already been made available to SBH's testifying expert, as well as to SBH's attorneys. Therefore, SBH cannot claim real prejudice from the reasonable restrictions (**agreed to by the parties**) that apply to sensitive, non-public information exchanged in this contested case. SBH has failed to explain exactly why its two executives need the materials and what they intend to do with them that SBH's planning expert has not already done. There is no question that it may be inconvenient for SBH to rely only on its attorneys and its experts to review certain non-public documents. But such inconvenience was anticipated and assumed by the parties when they agreed to the provisions of the Agreed Protective Order. And mere inconvenience does not amount to real prejudice. Absent a showing that SBH cannot advance some critical argument in this case, there is no justification for stripping the documents of the protection of the Agreed Protective Order.

It does not take much imagination to understand why disclosure of the protected information to SBH's executives would cause substantial competitive harm to MSHA. For example, the details of contracts between hospitals and insurers are highly sensitive. Disclosing those details to SBH would give SBH the ability to negotiate more favorable terms. Similarly, knowing MSHA's most profitable service lines would allow SBH to target those services in its own facilities. Given that SBH has not even demonstrated any real need for the information—other than convenience—disclosure should not be compelled.

Simply filing an unsuccessful application for a CON should not give an applicant the right to access the confidential and sensitive business information of a competitor. Such a result would dramatically alter the nature of CON contested cases and would effectively punish MSHA

for participating in this case by exposing its commercial secrets to a potential competitor. Both sides recognized these issues when they entered into the Agreed Protective Order, and SBH has failed to show why that agreement should be disregarded now.

CONCLUSION

Based on the foregoing, MSHA respectfully requests the Court deny SBH's motion for leave to disclose highly confidential documents.

Respectfully Submitted,

G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

SBH-KINGSPORT 000073

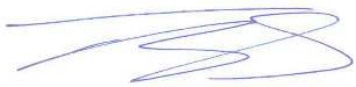
CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services &
Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 18th day of June, 2015.



Travis B. Swearingen

SBH-KINGSPORT 000074

LFP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant/Petitioner,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
Intervenor.	)	
	)	

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2015 JUN 22 PM 2:58
SECRETARY OF STATE

PETITIONER'S REPLY MEMORANDUM REGARDING ITS MOTION FOR LEAVE TO DISCLOSE MSHA'S "HIGHLY CONFIDENTIAL" DOCUMENTS TO INDIVIDUALS SUBJECT TO THE PROTECTION ORDER HEREIN

Comes now the Applicant/Petitioner herein, SBH-Kingsport, LLC ("SBH") to file this Reply Memorandum in response to the response to its motion filed by the Intervenor, Mountain States Health Alliance ("MSHA") on June 18, 2015.

One of the primary issues in this proceeding is what, if any, financial and utilization impact the project proposed by SBH in its CON application herein will have on Woodridge Psychiatric Hospital ("WPH") , which is the d/b/a through which MSHA delivers its inpatient psychiatric healthcare in Washington County.

Many of the documents claimed to be highly confidential and produced in this matter by MSHA have to do with utilization of WPH in years past. Additionally, certain MSHA planning documents, which concern WPH's projected utilization and operational issues, have been produced by MSHA and labelled "highly confidential" by its attorneys. A number of these were referenced by, or included as exhibits to, the report generated by SBH's expert witness, Mr. Dan Sullivan, which was delivered to attorneys for MSHA by SBH's attorneys on June 15, 2015.

MSHA's attorneys have consented to permit Mr. Garone and Mr. Shaheen, the executives of SBH who have signed on to the confidentiality order, to view Mr. Sullivan's report, but they have not consented to permit Mr. Shaheen or Mr. Garone to view the exhibits which have been designated "highly confidential" by MSHA.

SBH bears the burden of proof in this matter. It is exremely unfair to SBH to restrict its executives, particularly Mr. Shaheen, from being able to see these documents deemed "highly confidential" by MSHA in the five weeks that remain prior to this hearing, which commences on July 27, 2015. Many, if not most, of these documents will be placed into the public domain through the hearing process from July 27 through July 31, 2015.

If Mr. Shaheen, who is CEO of SBH and has extensive expertise in the development and operations of psychiatric hospitals, is prevented from seeing the documents which represent the nuts and bolts of the operations of Woodridge Psychiatric Hospital, in preparation for this hearing that will be highly prejudicial to SBH's capability of fully preparing its proof. It will especially be unfair given that most of the documents will become public through the processes of a contested case hearing in late July. Much of the information in some of them will also become public later through the joint annual report process which MSHA must participate in.

SBH-KINGSPORT 000076

Delays in disclosing these documents to Mr. Shaheen and Mr. Garone now may also cause the hearing to be extended, to give them time to analyze these documents.

The documents at issue were generally produced in discovery by MSHA in November 2014, approximately seven months ago. Whatever the criticality of their information was seven months ago, the passage of seven months, and their pending public status in late July 2015, makes it unfair and prejudicial, as a matter of law, for Mr. Shaheen to be the deprived of access to them in order to assist SBH's attorneys in preparation for the hearing in this matter.

Contrary to MSHA's arguments on this motion, if these documents are disclosed to Mr. Shaheen and Mr. Garone, they are not "stripped of the protection" of the protective order. Mr. Shaheen and Mr. Garone are subject to the protective order by their own voluntary agreement to abide by the terms of the order. Furthermore, the request made by SBH for these documents through this motion specifically excludes any contractual details which would "give SBH the ability to negotiate more favorable terms." Mr. Shaheen, given his extensive experience in the psychiatric hospital business, does not need to see that level of information in order to prepare for this hearing. However, Mr. Shaheen and Mr. Garone need to have access to the documents specified in the motion, which excludes the contractual term information specified by MSHA, in order that they may fully participate in the presentation of proof in this case, but also to be able to cooperate fully with SBH's attorneys to assist those attorneys in presenting the best case possible for SBH as it bears its burden of proof in this matter.

Given all these factors, SBH, through its attorneys, respectfully requests that this tribunal grant the motion it has filed to disclose these documents now labelled as "highly confidential",

SBH-KINGSPORT 000077

less those specified in the motion, to Mr. Shaheen and Mr. Garone, who remain subject to the terms of the protective order.

Respectfully submitted,

William H. West, Esq. (BPR No. 5543)
Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
615-726-5561
Counsel for SBH-Kingsport, LLC, Applicant/Petitioner

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been delivered via email to:

Travis Swearingen, Esq.
Brian Jackson, Esq.
Butler Snow LLP
150 Third Avenue South, Suite 1600
Nashville, TN 37201

and

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

this 22 day of June, 2015.

William West

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	
SBH-KINGSPORT, LLC	**DOCKET NO: 25.00-126908J**

ORDER

This matter came for consideration upon SBH's Motion for Leave to Disclose "Highly Confidential" Documents to which Intervenor Mountain States Health Alliance has responded in opposition. Having considered the motion and memorandum in support, response, reply, and arguments of counsel, it is **ordered** that the motion is **granted** only to Jim Shaheen and only to the disclosure of "utilization" documents.

This Order entered this 2ND day of July, 2015.

Leonard Pogue
Administrative Judge

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2015 JUL 20 PM 4:05
SECRETARY OF STATE

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	

AMENDED SCHEDULING ORDER

This Amended Scheduling Order amends the Court's initial Scheduling Order, dated August 22, 2014. The parties herein (Petitioner, SBH-Kingsport, LLC ("SBH"); Intervenor, Mountain States Health Alliance, Inc. ("MSHA"); and the Agency, Tennessee Health Services and Development Agency) shall accomplish the following tasks according to the schedule set forth below:

1. SBH shall disclose its Rule 26 experts on or before June 10, 2015. This disclosure shall be accompanied by supplemental interrogatory answers and/or expert witness disclosure information setting forth the information required by Tenn. R. Civ. P. 26.02(4)(A).

2. MSHA shall disclose its Rule 26 experts on or before July 10, 2015. This disclosure shall be accompanied by supplemental interrogatory answers and/or expert witness disclosure information setting forth the information required by Tenn. R. Civ. P. 26.02(4)(A).

3. The Parties shall supplement their written discovery responses by July 10, 2015.

4. All expert depositions will be completed by July 22, 2015.

5. All motions *in limine* and pre-hearing memoranda of law shall be filed by July 20, 2015.

6. The contested case hearing in this matter is scheduled to occur from July 27, 2015 until July 31, 2015.

IT IS SO ORDERED this 22ND day of JULY, 2015.

Leonard F. Pogue
Administrative Law Judge

APPROVED FOR ENTRY:

William West w/permission as (#25717)
William H. West (BPR No. 005543)
Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

Attorneys for SBH-Kingsport, LLC

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Suite 1600
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(615) 651-6700

Counsel for Mountain States Health Alliance

James B. Christoffersen w/permission as (#25717)
James B. Christoffersen (BPR No. 017049)
General Counsel
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY
Andrew Jackson State Office Bldg. 500
Deaderick Street, Suite 850
Nashville, TN 37219

Attorney for Tennessee Health Services & Development Agency

SBH-KINGSPORT 000082

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	Docket No. 25.00-126908J
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

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ORDER GRANTING MOUNTAIN STATES HEALTH ALLIANCE'S MOTION FOR CONTINUANCE AND TO AMEND SCHEDULING ORDER

Before the Court is a motion by Mountain States Health Alliance, Inc. ("MSHA") to amend the Scheduling Order and continue this contested case hearing from its current setting on May 4, 2015. Through a competing motion, SBH-Kingsport, LLC ("SBH"), opposed MSHA's motion to the extent MSHA requested a continuance of the hearing date. SBH submitted that, while the scheduling order should be amended, all requisite tasks could be accomplished with sufficient expediency to maintain the hearing date of May 4, 2015. MSHA opposed SBH's motion, restating its position that the scheduling order should be amended and the hearing should be continued to a later date. In a hearing before the Court on March 10, 2015, the Court heard arguments from all parties on the matter.

The parties are in agreement that the discovery process is significantly behind schedule, at least partly due to a delayed production of discoverable information from SBH. Having reviewed MSHA's Motion, SBH's Motion, and MSHA's Response thereto, and having heard from the parties on the matter, the Court, for good cause shown, hereby grants Mountain States Health Alliance's Motion for Continuance and to Amend the Scheduling Order. SBH's Motion is denied as moot. An updated scheduling order will be published in a separate order.

IT IS SO ORDERED this 22ND day of JULY, 2015.

Leonard F. Pogue
Administrative Law Judge

Approved for Entry:

G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

SBH-KINGSPORT 000084

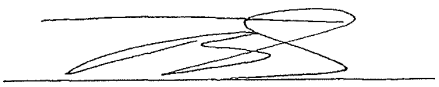
CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services &
Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 30th day of June, 2015.



LFP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	Docket No. 25.00-126908J
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

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SECRETARY OF STATE

AGREED PROTECTIVE ORDER

It appearing to the Administrative Law Judge that the parties agree to entry of this Protective Order to govern the production and use of confidential and proprietary information in this case by the parties and/or by any non-party, it is hereby ORDERED that:

1. As used herein, the following terms are defined as follows:

   A. The term "document" shall have the full meaning ascribed to it under Tenn. R. Civ. P. 34(a);

   B. The term "testimony" includes all depositions, affidavits, declarations, sworn discovery responses, and like materials;

   C. The term "producing party" means a party that submits documents or testimony in response to, or in the course of, discovery in this matter.

2. The terms of this Order shall not be construed so as to result in waiver, by any party, of any privilege which would otherwise apply to documents, information or testimony requested in discovery. The parties expressly reserve the right to assert claims of privilege with regard to any, document, information or testimony requested in discovery and to withhold production of said document, information or testimony pending hearing and final resolution of the claim of privilege.

3. Due to the nature of this case and the sensitive, proprietary information requested through discovery, the parties agree that all documents produced in response to discovery requests, responses to interrogatories, responses to requests for admission, or testimony may be marked "Confidential" as follows: (a) in the case of documents, by stamping each page of the document with the word "Confidential;" (b) in the case of interrogatory answers, or responses to requests for admission, by stamping the confidential portion with the word "Confidential ;" and, (c) in the case of testimony, by having the pages of the transcript that contain confidential information stamped "Confidential," and binding those pages separately. All information that the parties designate as "Confidential" shall be used only for purposes of this Contested Case Hearing, and for no other purpose. Under no circumstances may a party other than the producing party use any information designated "Confidential" for any business, competitive or non-litigation purpose. Information designated as "Confidential" may be disclosed only to the following: (1) the parties' outside and in-house counsel, and their staff; (2) any experts or consultants retained by either party, and their staff; (3) current or former officers or employees of a party to the extent deemed necessary in good faith by their counsel for the prosecution or defense of this action; (4) witnesses or deponents in this case, to the extent deemed necessary in good faith by disclosing counsel for the prosecution or defense of this action; (5) authors or

original recipients; (6) any court reporter, typist or videographer recording or transcribing testimony or argument in this action; (7) clerical, ministerial, or litigation support service providers, such as outside copying support, electronic discovery, or trial presentation or graphics personnel, retained to assist a party or its counsel; and (8) the Administrative Law Judge, Administrative Procedures Division, Health Services and Development Agency, courts of competent jurisdiction and court reporters.

4. Due to the highly confidential and sensitive, proprietary nature of certain information requested through discovery, the parties agree that the producing party may designate documents produced in response to discovery requests, responses to interrogatories, responses to requests for admission, or testimony as "Highly Confidential." Such material may be designated "Highly Confidential" by labeling documents in the same manner described above in Paragraph 3. Information designated "Highly Confidential" shall be afforded all protections given to information designated as "Confidential." In addition, information designated "Highly Confidential" may only be shown, provided or disclosed to the following: (1) outside counsel for either party, and their staff; (2) any experts or consultants retained by either party, and their staff; (3) authors or original recipients; (4) officers and employees of the producing party; and (5) the Administrative Law Judge, Administrative Procedures Division, Health Services and Development Agency, courts of competent jurisdiction and court reporters.

5. Any party may, prior to or within ten (10) days after the entry of this order, designate as "Confidential" or "Highly Confidential " any document produced prior to the entry of this order. Counsel for the designating party shall provide all counsel with appropriately marked documents and any counsel who received unmarked documents prior to their designation shall promptly destroy all unmarked copies of documents following their proper designation.

6. If any document or testimony deemed "Confidential" or "Highly Confidential" pursuant to this Order needs to be filed in this contested case matter, it shall be filed under seal with a designation that the material contained therein is to be treated as confidential or highly confidential.

7. Either party may object to the designation of information as "Confidential" or "Highly Confidential." When a party so objects, its counsel shall either notify counsel for the party claiming confidentiality in writing, or in the case of live testimony, by stating that objection on the record. Counsel for the parties shall then confer in good faith in an attempt to resolve the issue. If the parties are unable to agree, the producing party shall have fifteen (15) days after the meeting of counsel in which to seek protection under this Order. If no protection is sought within fifteen (15) days, then the document or testimony designated as confidential or highly confidential shall lose such designation. Until such issue is finally determined, the document or testimony shall be given the confidential treatment initially assigned to it and provided for in this Order.

8. Prior to any person other than undersigned counsel and its staff receiving any information designated as either "Confidential" or "Highly Confidential," that person must receive a copy of this Protective Order and must sign an Agreement to Abide by Agreed Protective Order, a copy of which is attached hereto as Exhibit 1. If the person is unable or unwilling to sign the Agreement to Abide by Agreed Protective Order, then that person must not receive the information designated "Confidential" or "Highly Confidential." Counsel for the party disclosing the information shall maintain a record of all such disclosures and shall keep a copy of all such Agreements to Abide by Agreed Protective Order and, at opposing counsel's request, shall produce a copy of that record to opposing counsel within fifteen (15) days.

9. If counsel determines it necessary for the prosecution or defense of this action that information designated either as "Confidential" or as "Highly Confidential" should be disclosed to a witness or other person other than as provided by in this Protective Order, counsel must first contact opposing counsel and request written permission to make such disclosure. If written permission is given, the witness receiving the confidential information shall not retain a copy of the confidential information. if written permission is not given, counsel for the party seeking disclosure shall request leave of the Administrative Law Judge or the court to make such disclosure.

10. Thirty (30) calendar days after the conclusion of all proceedings in this contested case, including any appeals, all originals or copies of documents, deposition transcripts or other information identified by any party as "Confidential" or "Highly Confidential," shall be returned to counsel for the producing party. This provision applies to documents and information in paper or electronic format. Alternatively, any receiving party may, at its option and cost, destroy such materials in a secure manner that ensures confidentiality and renders the information no longer recognizable. If a party chooses to securely destroy documents, the destroying party must certify the destruction of the documents in writing to counsel for the producing party.

Notwithstanding this provision, at the termination of the matter, a receiving party shall not be required to delete information that may reside on their respective electronic disaster recovery systems that are overwritten in the normal course of business. To the extent it is later discovered that Confidential or Highly Confidential information from such electronic disaster recovery system has been restored in the normal course of business, however, such information shall be destroyed as set forth in this paragraph.

Furthermore, outside counsel of record may retain (in paper or electronic format) any

documents designated as Confidential or Highly Confidential, as well as any documents, databases, pleadings, deposition transcripts, work papers, or other work product that contain or refer to such documents. Any documents retained by outside counsel are to be maintained for archival purposes only and counsel's obligations of confidentiality continue until the documents are permanently destroyed.

This paragraph does not apply to actual Confidential Information on file with the Administrative Law Judge or the Agency, as the parties are without authority to impose this obligation on them.

For purposes of this Order, "termination of this action" shall occur upon full settlement of all issues involved in the contested case hearing or the exhaustion of all appeals of the Health Services and Development Agency's decision after the contested case hearing.

11. Nothing in this Order shall limit the use of information designated "Confidential" or "Highly Confidential" by the producing party.

12. The terms of this Order do not preclude, limit, restrict or otherwise apply to the use of documents at the contested case hearing or appeals thereof, except as provided herein.

13. Any inadvertent failure to assert confidentiality shall not preclude a party from designating any documents or testimony as confidential, in which event the items subject to such designation shall thereafter be treated as confidential. The producing party shall notify the other party of such designation in writing.

14. Subject to the provisions herein, if another court, administrative agency, or any other person subpoenas or orders production of confidential material that a party has obtained through discovery in this case under the terms of this Protective Order, such party shall immediately notify the producing party or non-party of the pendency of such subpoena or order,

shall object to such production on the basis of this Protective Order, and shall use its best efforts to afford the producing party or non-party an opportunity to be heard by the court, administrative agency, or other body prior to any disclosure of confidential material.

15. The production (whether inadvertent or not) of any document, tangible thing, information or other material covered by an attorney-client, attorney work product, or other applicable evidentiary privilege that would enable a party or non-party to withhold documents, tangible things, information or other material from production shall not constitute a waiver or impairment of any claim of privilege (including under the attorney-client privilege or work product doctrine) concerning any, such documents, tangible things, information or other material or the subject matter thereof. Any such party or non-party shall have the right to re-designate as privileged or withhold such documents, tangible things, information or other material that it produces or has produced. If production occurs, the allegedly privileged materials, together with all copies and notes thereof, shall be returned to the producing party or non-party or, in the case of notes, destroyed, as soon as practicable after demand of the producing party or non-party or its designee. Return of the allegedly privileged information in no way prejudices or impairs the returning party's rights to challenge the privilege contention of the producing party or non-party; provided, however, that, if the producing party has made a demand for return as set forth above, the basis of such challenge shall not include an argument that the producing party waived the privilege or protection by inadvertent production.

16. In the event that a party seeks discovery from a non-party to this matter, the non-party may invoke the terms of this Protective Order with respect to the designation of any confidential information provided to the parties by so advising the parties to this matter in writing and abiding by the terms of this Protective Order.

17. Until such time as this Protective Order has been entered by the Administrative Law Judge, the parties agree that, upon execution by the parties, it will be treated as though it has been "So Ordered."

IT IS SO ORDERED.

Leonard F. Pogue
Administrative Law Judge

APPROVED FOR ENTRY:

William H. West (BPR No. 005543)
Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

Attorneys for SBH-Kingsport, LLC

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Travis B. Swearingen (BPR No. 025717)
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(615) 651-6700

Counsel for Mountain States Health Alliance

James B. Christoffersen (BPR No. 017049)
General Counsel
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Andrew Jackson State Office Bldg. 500
Deaderick Street, Suite 850
Nashville, TN 37219

Attorney for Tennessee Health Services & Development Agency

SBH-KINGSPORT 000093

EXHIBIT I

AGREEMENT TO ABIDE BY AGREED PROTECTIVE ORDER

I, _____, certify my understanding that information designated as "Confidential" and/or "Highly Confidential" is being provided to me pursuant to the terms and restrictions of the Agreed Protective Order entered in this contested case hearing styled *In Re: SBH-Kingsport, LLC*, Docket No. 25.00-126908J, and that I have been given a copy of and have read that Order and agree to be bound by it and submit to the jurisdiction of the Health Services and Development Agency and the Tennessee Secretary of State in connection with that Order. I understand that all such information and copies thereof, including, but not limited to, any notes or other transcriptions made therefrom, shall be maintained in a secure manner and shall be returned no later than thirty (30) days after the termination of this contested case hearing to counsel for the party or other person who provided such information.

_____
Signature

_____
Printed Name

_____
Date

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SECRETARY OF STATE

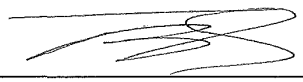
BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

MOUNTAIN STATES HEALTH ALLIANCE'S RESPONSE TO SBH-KINGSPORT'S MOTION TO AMEND SCHEDULING ORDER

Mountain States Health Alliance ("MSHA") agrees with SBH-Kingsport that the scheduling order should be amended – the parties are behind schedule and no depositions have been taken. As set forth more fully in MHSA's competing Motion to Amend Scheduling Order, however, MHSA disagrees that discovery in this case can be completed in 60 days such that the existing contested case hearing date remains tenable. There simply is not enough time to adequately complete fact discovery, expert discovery, dispositive motions, and evidentiary motions in the time provided. MSHA respectfully submits that, despite the parties' best efforts, the scheduling order should be amended and the hearing date continued so that proper discovery can be conducted and completed in this matter.

Respectfully Submitted,



G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services & Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 2nd day of March, 2015.



RECEIVED
2015 JUL 20 PM 4:04
SECRETARY OF STATE

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

MOUNTAIN STATES HEALTH ALLIANCE'S MOTION FOR CONTINUANCE AND TO AMEND THE SCHEDULING ORDER

Mountain States Health Alliance ("MSHA") moves the Court to amend the Scheduling Order and continue this contested case hearing from its current setting on May 4, 2015. Despite efforts to complete discovery in the time originally allotted, the parties are significantly behind schedule – among other things, no depositions have yet been taken or even scheduled – and there simply is not enough time to adequately complete fact discovery, expert discovery, dispositive motions, and evidentiary motions in just 60 days.

Procedural History

This case involves SBH-Kingsport, LLC's proposal to build a new 72-bed freestanding psychiatric hospital in Kingsport at a projected cost of $12 million. Formed in 2006, SBH (Strategic Behavioral Health) is a for-profit subsidiary of Dobbs Management Service, a private

equity firm based in Memphis, Tennessee. The HSDA denied SBH's application at its meeting on June 25, 2014.

The HSDA denied SBH's application based in part on the fact that there is no need for a new 72-bed psychiatric hospital in the Tri-Cities. In an effort to create a need where none exists, SBH's application set forth an arbitrary service area that omitted Washington County, even though Washington County is located immediately adjacent to Sullivan County and even though Johnson City, which is located in Washington County, is obviously a key component of the Tri-Cities. Omitting Washington County from the service area made it possible for SBH to ignore the existence of Woodridge Psychiatric Hospital, MHSA's 84-bed facility in Johnson City and the largest provider of inpatient psychiatric and chemical dependency services in the region. Woodridge plays an especially vital role in providing psychiatric services in Upper East Tennessee in light of the fact that the state closed its psychiatric facility serving the area, and Woodridge now serves as the safety-net provider of psychiatric services for uninsured, chronically mentally-ill patients. In short, the information presented to the HSDA showed that any need for additional psychiatric services in the region could be met without constructing a new 72-bed hospital, and approving an unneeded facility would seriously harm Woodridge and thereby disrupt the provision of psychiatric services in the region.

SBH appealed the decision of the Agency and initiated this contested case. On August 22, 2014, the Court entered an Agreed Scheduling Order setting the following deadlines:

- Initial written discovery served by October 1, 2014;
- Responses to initial written discovery served by November 3, 2014;
- Party/Fact discovery depositions completed by January 31, 2015;
- Petitioner's expert disclosures served by February 6, 2015;
- Respondent's and HSDA's expert disclosure served by February 20, 2015;
- Expert depositions completed by April 3, 2015;
- Prehearing motions served by April 24, 2015;
- Hearing date beginning on May 4, 2015.

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The parties timely served written discovery on October 1. By agreement, the parties first extended the response deadline to November 17, 2014. Thereafter, SBH requested additional extensions of time, to which MSHA agreed. Finally, just before Thanksgiving, on November 21, the parties exchanged initial written discovery responses.

Although SBH initially served 1,304 pages of documents with its written responses, the vast majority of the material produced consisted of multiple copies of previously available public materials – hospital joint annual reports filed with the State, multiple copies of a CON application filed by MSHA in November 2009, multiple copies of the SBH CON application, etc. Only approximately 300 pages of produced material consisted of new, non-publicly available materials. SBH produced only 150 pages of emails. By comparison, MSHA produced almost 900 pages of emails relating to SBH's project. While SBH produced three years of pro formas, there were no documents showing how the pro formas were generated or the source of the projections contained therein. Similarly, SBH produced several iterations of the CON application, but failed to produce any documents related to the changes made to the application or showing why the assumptions made in the original application were wrong or how any such determinations were made. SBH's interrogatory responses identified Jim Shaheen, Doug Ginn and James Cagle as SBH employees who were personally involved in the preparation of the application, and yet SBH did not produce a single document authored by any of these people.

MSHA's counsel notified counsel for SBH of their concern with the deficiencies in SBH's document production and requested that SBH supplement its responses no later than January 15, 2015. In light of the delays in receiving a complete document production, MSHA suggested an extension of the fact discovery deadline to February 15, 2015, and asked for deposition dates of six SBH witnesses during that time period.

On January 16, 2015, SBH served its First Supplemental Production of Documents containing approximately 2,000 pages of additional material. On January 23, 2015, SBH served a Second Supplemental Production of Documents containing an additional 30 pages of documents – including, for the first time, data from a statistician on which SBH apparently has based its entire project. On January 28, 2015, SBH served supplemental interrogatory responses.

As the parties were at that point approximately 60 days behind schedule, on January 27, 2015, MSHA's counsel contacted SBH's counsel and suggested amending the scheduling order and resetting the hearing date. Nearly three weeks passed before, on February 18, 2015, SBH responded that it could not agree to a trial continuance. SBH also provided, for the first time, proposed deposition dates for two of the six witnesses requested by MSHA. Further attempts to resolve this scheduling disagreement have been unsuccessful.

Argument

Although the parties have cooperated well in attempting to move this matter forward, the delays in obtaining a complete document production from SBH—originally due in early November but not received until the end of January--have made the parties' initial schedule unworkable. No depositions are currently scheduled. SBH has provided deposition dates for two of the six witnesses requested by MSHA. SBH has not yet even identified which MSHA employees it intends to depose. Once SBH does so, MSHA's counsel will have to check on those witnesses' availability both to meet in preparation and to sit for depositions. All witnesses in this case are located in either Memphis or Kingsport, Tennessee and counsel will be required to travel for the depositions.

Moreover, expert testimony will be critical in this case, as in most CON cases. In addition to reviewing documents just produced in January, the expert witnesses will need to review the deposition testimony of the fact witnesses. This is particularly true where the documents produced have contained little information supporting the assumptions and conclusions in SBH's application. Before the parties can proceed to expert disclosure and expert discovery, fact depositions will have to

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be completed, transcripts prepared, and the experts will have to have a meaningful opportunity to review the same. Experts, like counsel, have other commitments and cannot reasonably be expected to perform their work without adequate time. SBH's proposed solution is to compress what the parties initially agreed would take six months into a period of 60 days. A case of this magnitude and complexity requires more.

To further complicate matters, there are a number of significant scheduling hurdles in the next few months:

- Mr. Jackson and Mr. Swearingen, counsel for MSHA, each has long-scheduled vacations in the first and third weeks of March.
- Counsel for all sides will be very actively involved in the HSDA meeting of March 25. Counsel are representing separate parties opposing plans for a new ambulatory surgery center and two new emergency departments in Brentwood, Tennessee. Both sides will be involved in significant preparations in advance of that meeting.
- Counsel for MHSA have a trial scheduled in the Eastern District of Pennsylvania from June 15 through July 10, 2015, which will involve multiple out of-state depositions, including expert witness depositions, to be taken and defended in April and will require significant preparation time beginning in mid-May.

MSHA respectfully submits that, despite the parties' best efforts, the scheduling order should be amended and the hearing date continued so that proper discovery can be conducted and completed in this matter.

Respectfully Submitted,

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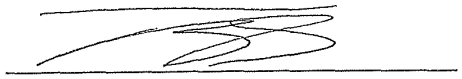
CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
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Via e-mail
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Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 2nd day of March, 2015.



SBH-KINGSPORT 000102

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

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MOUNTAIN STATE HEALTH ALLIANCE'S PRETRIAL BRIEF

The applicant, SBH-Kingsport, LLC (a subsidiary of Strategic Behavioral Health or "SBH") seeks a Certificate of Need to build a new, freestanding 72-bed psychiatric hospital in Kingsport, Tennessee. The application was denied by the Health Services and Development Agency and SBH initiated this contested case. Mountain States Health Alliance ("MSHA") owns and operates Woodridge Psychiatric Hospital ("Woodridge") in Johnson City, just 24 miles from the proposed site of the project.

Among other things, the proof at trial will show:

- The genesis of this project was not any actual community healthcare need, but the internal financial goals of SBH, a for-profit provider that has never operated a hospital in Tennessee and decided to move forward with this project mainly because of cheap building and labor costs in the Tri-Cities. SBH conducted only a cursory analysis, and did not even meet with representatives of the Department

of Mental Health and Substance Abuse Services, or the Bureau of TennCare before deciding to seek a CON.

- SBH initially planned to locate its new hospital in Johnson City and moved the location to Kingsport, not for any legitimate health planning reason, but merely with the goal of avoiding opposition to its CON.

- For CON purposes only, SBH created a gerrymandered, unrealistic service area that claims that its hospital in Kingsport would not serve Washington County (where Johnson City is located), even though Washington County is immediately contiguous to Sullivan County (Kingsport) and even though all of SBH's analysis about the need for the project (such as it was) included Washington County. Instead of including neighboring Washington County in its service area, SBH reached over a mountain range deep into Virginia. In fact, the gerrymandered service area includes three counties in Virginia, and only two in Tennessee. SBH created this fictional service area in an attempt to maximize the perceived bed need for its project while excluding consideration of the negative harmful effects on other community providers, such as Woodridge.

- SBH has elected to build a 72-bed facility, not because of any analysis actually suggesting a need for 72 beds, but because SBH had already designed a 72-bed "template" architectural schematic which it has used to build in other states.

- If the contrived and unreasonable service area is disregarded and an appropriate service area is applied to the project, it is undisputed that there is no need for a new 72-bed psychiatric hospital under the State Health Plan.

- SBH has emphasized the need to serve child and adolescent patients with the project, but the child and adolescent population is actually declining in the gerrymandered service area. By contrast, the child and adolescent population is growing in Washington County, which SBH claims is outside its gerrymandered service area.

- SBH will not be offering any service or treatment not already available in the Tri-Cities; the project is completely duplicative.

- MSHA is a cornerstone of the TennCare program and has provided hundreds of millions of dollars in charity care and uncompensated care over the past few years alone. SBH provides virtually no charity care at its existing hospitals.

- In 2012, the State closed the Lakeshore Mental Health Institute, the public mental health hospital for East Tennessee. Woodridge stepped forward and agreed to care for those patients. Since 2012, Woodridge has been the safety-net provider for uninsured psychiatric patients in Upper East Tennessee, for which it receives limited and inadequate compensation. SBH will not be treating those patients at

all, and will mostly seek to admit patients with private insurance and government payors.

- A substantial number of patients from Sullivan County receive psychiatric services at Woodridge, in Johnson City. It is obvious that many if not most of those patients who have insurance would be diverted from Woodridge to SBH if this project were approved. The impact of redirecting Sullivan County patients and other area patients from Woodridge to SBH would be very substantial, and would cost Woodridge between $1.5 and $2 million annually, using conservative assumptions. Woodridge currently operates at marginal profitability and MSHA, while operationally healthy, is burdened by substantial debt and faces formidable challenges in today's healthcare environment.

- Perhaps realizing that bed need calculations based on a gerrymandered service area provide little support for the project, SBH is expected to argue that Woodridge has experienced capacity issues over the last two years and that this provides a justification for building a new hospital. But the reason that occupancy at Woodridge has increased is because of a concerted effort on the part of management to increase access to psychiatric services. This does not mean that more inpatient beds are needed.

- Inpatient hospitalization is the last resort in caring for mental illness. Outpatient, residential, and stepdown programs are less restrictive and less expensive options, and should be the primary focus of healthcare resources devoted to psychiatric treatment.

- Building more inpatient beds is not the most cost-effective solution to transient episodes of high occupancy at Woodridge. Woodridge is currently collaborating with an outpatient provider to create a 12-bed Child & Adolescent Crisis Stabilization Unit, which will create functional bed capacity and will help avoid the necessity of inpatient hospitalization for many patients.

In sum, this project is an economically-driven effort in search of a legitimate health planning rationale. No such rationale exists. Moreover, the project will do real and lasting harm to a nonprofit system that is providing vital community services. As the HSDA concluded, the CON should be denied.

Introduction and Background

A. The Parties

1. Mountain States Health Alliance

Mountain States Health Alliance is a Tennessee non-profit health care system with its principal offices in Johnson City. MSHA provides comprehensive medical care to people in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. MSHA owns and operates 13 hospitals, including Johnson City Medical Center, a 501-bed regional tertiary referral and Level I trauma center, Indian Path Medical Center, a 239-bed hospital in Kingsport, and Niswonger Children's Hospital, a 69-bed children's hospital in Johnson City that is one of only six St. Jude Affiliate Clinics and serves more than 200,000 children in the area. MSHA's hospitals also include Woodridge, an 84-bed facility in Johnson City which treats over 4,000 patients annually.

MSHA provides vital health care services, including in many rural areas which are traditionally underserved, and to patients with limited financial resources. As one of the largest TennCare providers in the State, MSHA plays an essential role in supporting the TennCare program. In Fiscal Year 2014 alone, MSHA provided more than **$41 million** in unreimbursed care to Medicaid and TennCare patients, in addition to more than **$20 million** in charity care, more than $12 million in subsidized health care services, almost $12 million in contribution to health profession education and approximately $5 million in community health improvement services.

In addition to MSHA's system-wide community contributions, Woodridge Psychiatric Hospital has played an especially critical role as the safety-net hospital for psychiatric patients in the Tri-Cities area. Lakeshore Mental Health Institute ("Lakeshore") in Knoxville, the state regional mental health institution in East Tennessee, closed in June 2012. When Lakeshore

closed, Woodridge made the commitment to provide mental health services to uninsured psychiatric patients in East Tennessee who otherwise would have no access to care. Woodridge has served over 3,000 such patients since that time. Although Woodridge receives an annual grant from the State for this role, the grant covers only the partial costs of treating these patients, and the number of patients covered by the grant is capped. In each of the past three years, the number of uninsured patients actually seen at Woodridge has exceeded the cap.

Additionally, Woodridge is a critical partner of the Department of Psychiatry and Behavioral Sciences at James H. Quillen College of Medicine at East Tennessee University State ("ETSU") as Woodridge provides both financial and educational support to the ETSU program. Woodridge currently subsidizes 10 residency slots at an annual cost of $450,000 to the hospital. Additionally, Woodridge annually provides $45,000 to help support two faculty positions. Without this support, the Department of Psychiatry and Behavioral Sciences would face increased financial pressure which would hinder its ability to offer the most effective and successful psychiatry residency program.

Furthermore, Woodridge offers ETSU residents with the opportunity to achieve hundreds of hours of face-to-face patient interaction per month (up to 1800 hours in a month). This clinical experience is invaluable to residents as they continue to hone their education, knowledge and skillset. As the primary psychiatric hospital in this region which offers a full spectrum of mental health services, Woodridge is a unique and invaluable educational tool to help train the next generation of psychiatrists.

In addition to the training opportunities Woodridge affords, ETSU serves in a critical role in the management of Woodridge. Specifically, ETSU professors provide psychiatric care and services for the "Spruce" unit at Woodridge, a 14-bed unit focused primarily on older adult and

geriatric patients. For all TennCare patients that ETSU psychiatry sees through these programs, Woodridge subsidizes each service at a rate of $45 per treatment. Over 80% of the patients served at Woodridge have governmental insurance (Medicare, Tenncare/Medicaid) or are uninsured.

2. Strategic Behavioral Health

Strategic Behavioral Health (SBH) is a privately-owned, closely-held, for-profit company that develops, owns and operates psychiatric hospitals, including residential facilities for child and adolescent patients. SBH currently operates eight facilities in Nevada, New Mexico, North Carolina, and Texas. SBH does not currently own or operate any hospitals in Tennessee.

B. Tennessee CON Process — Background, Purpose and Policy

Beginning in the 1970s, the federal government urged states to control rising health care costs by using health planning to manage the escalating growth of health care services and facilities. To this end, in 1973, the Tennessee General Assembly enacted legislation creating the Tennessee Health Facilities Commission and Tennessee's CON process.[1] Approximately 35 states, including Tennessee, use Certificates of Need to regulate capital expenditures on health care facilities. The Tennessee Legislature reaffirmed the State's commitment to the CON program as recently as 2002, when it enacted the "Tennessee Health Services and Planning Act of 2002", Tenn. Code Ann. §§ 68-11-1601, *et seq.* (hereafter referred to as "Health Planning Act of 2002"). This Act made few substantive changes in the CON law, although it did replace the former Commission with a newly-constituted Agency.

In the Health Planning Act of 2002 the Legislature also stated the "declared . . . public policy of this state that the establishment and modification of health care institutions, facilities

[1] *See East Tennessee Health Improvement Council, Inc. v. Tennessee Health Facilities Comm.*, 626 S.W.2d 272, 274 (Tenn. Ct. App. 1981); *see also* Tennessee Health Services and Development Agency website, "Certificate of Need Program," § I, "CON History."

and services shall be accomplished in a manner that is orderly, economical and consistent with the effective development of necessary and adequate means of providing for the health care of the people of Tennessee."[2] According to the Agency, "[t]he CON program assures that health care projects are accomplished in an orderly and economical manner, consistent with the development of adequate and effective health care for the people of Tennessee."[3] Some of the nation's largest employers and purchasers of health care have concluded that health care costs are lower in states with a CON process than in states without such a process."[4]

C. **CON General Criteria and Guidelines For Growth**

The Tennessee Legislature has adopted three primary criteria that must be considered in determining whether a Certificate of Need should be granted:

> No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services.[5]

In addition to the three general criteria, the Agency is also directed to consider the State Health Plan:

> In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. Until the state health plan is approved and adopted, the agency shall use as guidelines the current criteria and standards adopted by the state health planning and advisory board, and any changes implemented by the planning division pursuant to § 68-11-1625.

Id. The "current criteria and standards" referred to in the statute are set forth in a publication entitled *Guidelines for Growth* (2000 ed.) ("State Health Plan"). The State Health Plan incorporates the three general statutory criteria of need, economic feasibility and contribution to the orderly development of healthcare. The State Health Plan also contains additional

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[2] Tenn. Code Ann. § 68-11-1603.
[3] *See*, HSDA website, "CON Basics."
[4] *See*, Gaffney, M., Zimmerman, M. "An old-fashioned way to control costs; well-run certificate-of-need program can help rein in rising health care spending." **Modern Healthcare, Vol. 32.45 (November 11, 2002, p. 32)**
[5] T.C.A. §68-11-1609(b).

considerations stemming from the three general criteria.[6] The State Health Plan contains a specific methodology for determining need for select regulated healthcare services, including psychiatric inpatient services. To award a CON to a party that does not satisfy the objective criteria in the State Health Plan and that has not offered any compelling reason for disregarding those criteria, would constitute a "clear error in judgment."[7]

D. The Proposed Project

SBH proposes to build a new, freestanding 72-bed psychiatric hospital in Kingsport. The discovery in this case has revealed the following about the origin and development of this proposal:

In the summer of 2012, SBH hired an academic statistician to evaluate 95 potential expansion markets across the United States where the company might want to construct a new psychiatric hospital. The statistician prepared a series of spreadsheets in connection with this assignment. One of the 95 potential locations evaluated by SBH was "Johnson City, Tennessee." Johnson City ranked 34th out of 95 potential locations in terms of overall bed need, and 25th out of 95 in terms of unmet bed need. In calculating bed need for these 95 locations, the statistician was instructed by SBH leadership to consider all existing psychiatric beds within a 60 mile radius (Woodridge is within 25 miles of all major Tri-Cities population centers).

From these 95 locations, the statistician identified the top 27 potential locations, to which he performed further examination. The additional analyses ranked each potential location using weighted scores based on overall need, unmet need, the presence of competition (with preference given to low-competition locations), the percentage of Medicaid vs. commercially insured

[6] T.C.A. §68-11-1609(b) also authorized the Agency to set out additional criteria for consideration in its Rules. These additional general criteria are promulgated at Tenn. Comp. Rules & Regs. 0720-4-.01. *Id.*

[7] *See Maury Regional Hospital v. Tennessee Health Services and Development Agency and Spring Hill Hospital*, Case No. 08-1133-I, at 22-23. (Chancery Court of Davidson County, Sept. 3, 2009).

patients (with preference given to commercially insured), staffing ratio requirements (with preference given to states where lower staffing levels were permitted), staffing cost (with preference given to cheaper staffing), proximity to higher education (a positive) and whether or not the location was in a CON state. In this analysis, the location for the potential Tennessee project (now described as the "Tri-Cities") scored at or below the median in every category except for building costs (10th cheapest out of 27) and staffing costs (2nd cheapest out of 27). In the final weighted analysis, the Tri-Cities ranked 15th out of 27 potential locations for a new psychiatric hospital.

Around early September of 2013, SBH's CEO, Jim Shaheen, decided to proceed with the Tri-Cities project because "staffing became more and more important to [him]" and the cost of hiring staff in the Tri-Cities was the second cheapest of the 27 potential locations. Mr. Shaheen designated Michael Garone, SBH's new Director of Development, to take charge of the project. Mr. Garone's expertise is in marketing, not clinical health care.

Initially, SBH planned to locate the new hospital in Johnson City, not Kingsport. In fact, on October 1, 2013, SBH submitted an application for economic development incentives from the Johnson City Industrial Bond Board. As neither Mr. Garone nor Mr. Shaheen had ever been to the Tri-Cities, in early October, Mr. Garone visited Johnson City for two days during which he met a handful of individuals.

Despite the fact that SBH devoted the entirety of its limited due diligence on Johnson City, by early November, SBH executives had reversed course and decided to place their proposed new hospital in Kingsport instead. This decision was not based on any health planning analysis of need, but was rather an effort to avoid a CON dispute, made in consultation with SBH's CON attorney. As stated in an email from SBH's Director of Development:

> You will notice that we have switched the physical location of the project from Johnson City to Kingsport in an attempt to avoid Mountain States Health Alliance from contesting our application.

P-00037, Email from Mike Garone, Nov. 4, 2013.

SBH filed its application for a CON in December 2013, less than 60 days after the company first set foot in the Tri-Cities. The CON application as filed not only moved the location of the hospital to Kingsport, it even claimed the new hospital would be serving an area that excluded Johnson City (in Washington County, immediately adjacent to Sullivan County, where Kingsport is located). In other words, although the project had initially been planned for Johnson City, and although all of SBH's internal analyses had looked at need in terms of the Tri-Cities area as a whole, including evaluation of all existing beds in a 60-mile radius, Washington County and Woodridge were hardly mentioned in SBH's application. SBH claimed a service area that included a larger area in Virginia than in Tennessee. The claimed service area reached two counties beyond Sullivan County into Virginia, but inexplicably excluded counties to the south that were immediately contiguous to Sullivan County, including Washington County (Johnson City). Consistent with SBH's plan to "avoid Mountain States Health Alliance from contesting our application," excluding Washington County from the service area meant that Woodridge, MSHA's existing 84-bed psychiatric hospital in Johnson City, was simply ignored in evaluating the need for a new psychiatric hospital in Kingsport, even though the two facilities would be in adjacent counties, only 24 miles apart.

This service area makes no sense, not only in terms of the well-established economic and community ties between Johnson City and Kingsport (which, along with Bristol, make up the Tri-Cities Combined Statistical Area), but also in terms of the historical flow of patients from Sullivan County to Woodridge and other providers that were artificially excluded from the

asserted service area. The omission of Washington County is especially indefensible in that the county is experiencing more growth than Sullivan County. The contrived nature of SBH's claimed service area is underscored by the fact that SBH has included psychiatric beds at Wellmont Bristol Regional Medical Center (Bristol, TN) in its analysis of need, but has excluded psychiatric beds located at Ridgeview Medical Center (Bristol, VA), even though those beds are only three miles and a six-minute drive apart from the Tennessee beds.

Indeed, even as SBH claimed a service area excluding Washington County in its application, discovery in this case has revealed that, for internal purposes, SBH continued to evaluate the project in the context of the larger Tri-Cities region. For example, on January 10, 2014, SBH executives made an internal presentation to representatives of the company's owners that identified a "catchment area" consisting of 25-mile and 50-mile radii around Kingsport, which would have included Woodridge and other psychiatric providers. SBH's CEO admitted that the catchment area is the area from which SBH expects to draw its patients.

As discussed further below, if a reasonable and realistic service area is applied to evaluate SBH's project, as it should be, there is simply no need for a new 72-bed psychiatric hospital in Kingsport under the State Health Plan or on any other basis. At most, there may be a need under the population-based formula of the State Health Plan for up to 30 beds, which is fewer than half those being sought here. Moreover, to the extent SBH is basing its argument for need on the fact that beds are not always immediately available at Woodridge, there are far more economical and efficient ways of addressing any such transient operational shortages than simply creating more inpatient beds. The evidence will show that Woodridge is taking steps to provide additional community resources to help increase availability of inpatient beds, including a Crisis Stabilization Unit for children and adolescents.

In addition to inflating need through a contrived service area, SBH has glossed over and continues to minimize the harm that this proposal would cause to MSHA. The proposed project would serve very few, if any, uninsured patients, leaving those patients to continue being cared for mostly at Woodridge. Although SBH claims it will provide 5% charity/indigent care at its new hospital, even that low estimate is simply not credible and is not based on any written analysis, much less on the historical performance of other SBH facilities, which treat few charity patients. SBH's Michael Garone admitted in his deposition that "it would make sense" for uninsured patients to continue to be seen at Woodridge and SBH has taken no steps to offer services for those patients. Moreover, Woodridge draws a substantial number of insured patients from Sullivan County, and diversion of those patients to a new SBH hospital will have a very negative impact on Woodridge, amounting to between $1.5 and 1.9 million annually.

SBH's application came before the HSDA on June 25, 2014. Woodridge opposed the application. After presentations by both sides and discussion, the Agency denied the application by a 4-4 vote. SBH filed this appeal. For the reasons set forth herein, and as will be further established at trial, the application for a CON should be denied.

The Project Does Not Satisfy Any of the Statutory Criteria

The proof at the hearing will demonstrate that the project is not needed under the applicable *Guidelines* criteria. Furthermore, the utilization projections for the proposed facility are not supported by an appropriate service area market analysis; thus, the utilization projections remain unsupported and economic feasibility cannot be demonstrated. Moreover, SBH has failed to consider less costly alternatives to the construction of a new 72-bed freestanding hospital. Finally, the proposal will simply duplicate existing services and will have a significant

adverse impact on Woodridge. Therefore, the proposal does not contribute to the orderly development of adequate and effective health care services.

A. There is no Need for a New 72-bed Psychiatric Hospital in the Tri-Cities.

The need for this project must be evaluated upon the following factors:

a. The relationship of the proposal to any existing applicable plans (e.g., the State Health Plan)

b. The population to be served by the proposal;

c. The existing or certified services or institutions in the area;

d. The reasonableness of the service area;

e. The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities and low-income groups;

f. Comparison of utilization/occupancy trends and services offered by other area providers;

g. The extent to which Medicare, Medicaid (TennCare) and medically indigent patients will be served by the project.

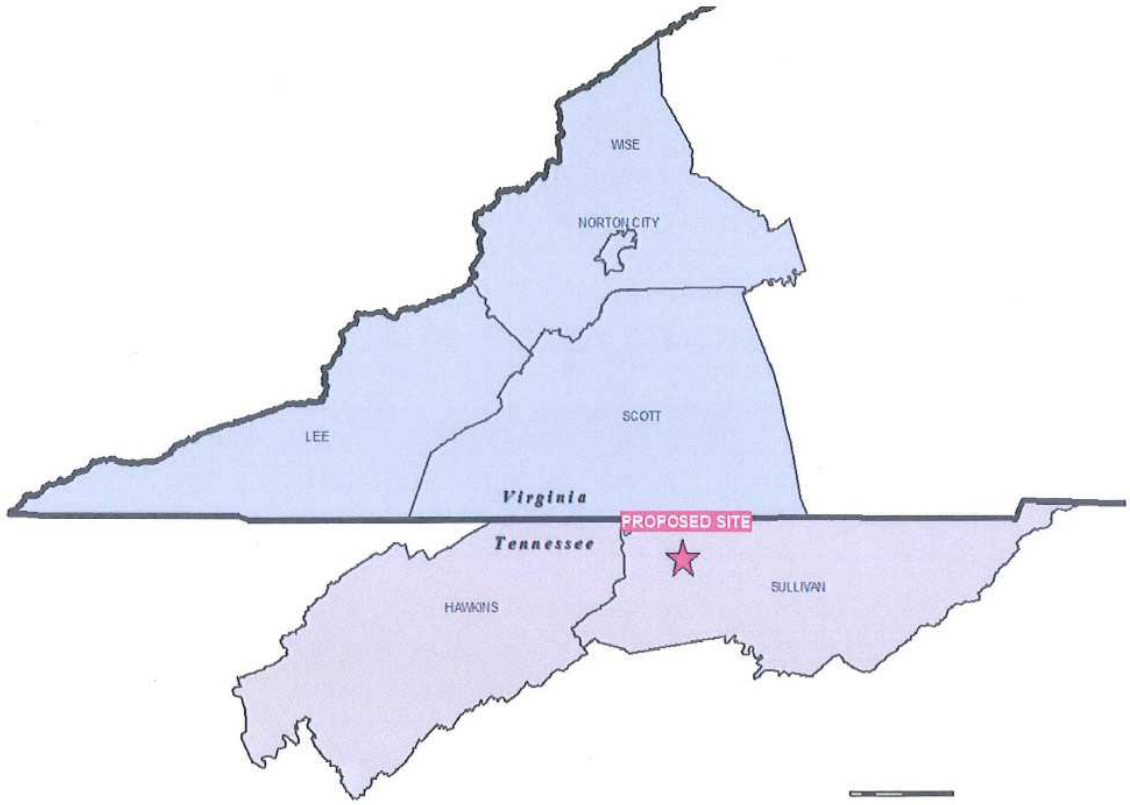
HSDA Chapter 0720-11-.01 (1).

1. <u>SBH's Gerrymandered Service Area Is Unreasonable and Should Be Rejected.</u>

The State Health Plan (*Guidelines for Growth*) includes a population-based need formula of 30 psychiatric beds per 100,000 population. The calculated need is then compared with existing staffed beds to determine whether there is any shortage of beds in a given area. For obvious reasons, in performing this analysis, the selection of the service area is critical—both in order to determine the appropriate population for the need calculation and in order to determine the number of existing beds. State guidelines provide that the service area should be "reasonable and based on an optimal balance between population density and service proximity or the

Community Service Agency." For CON purposes, health planning experts typically define a service area as the area from which vast majority (90-95%) of a project's patients will be drawn.

In the present case, SBH claims a service area consisting of five counties, Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee counties in Virginia as depicted on the following map:

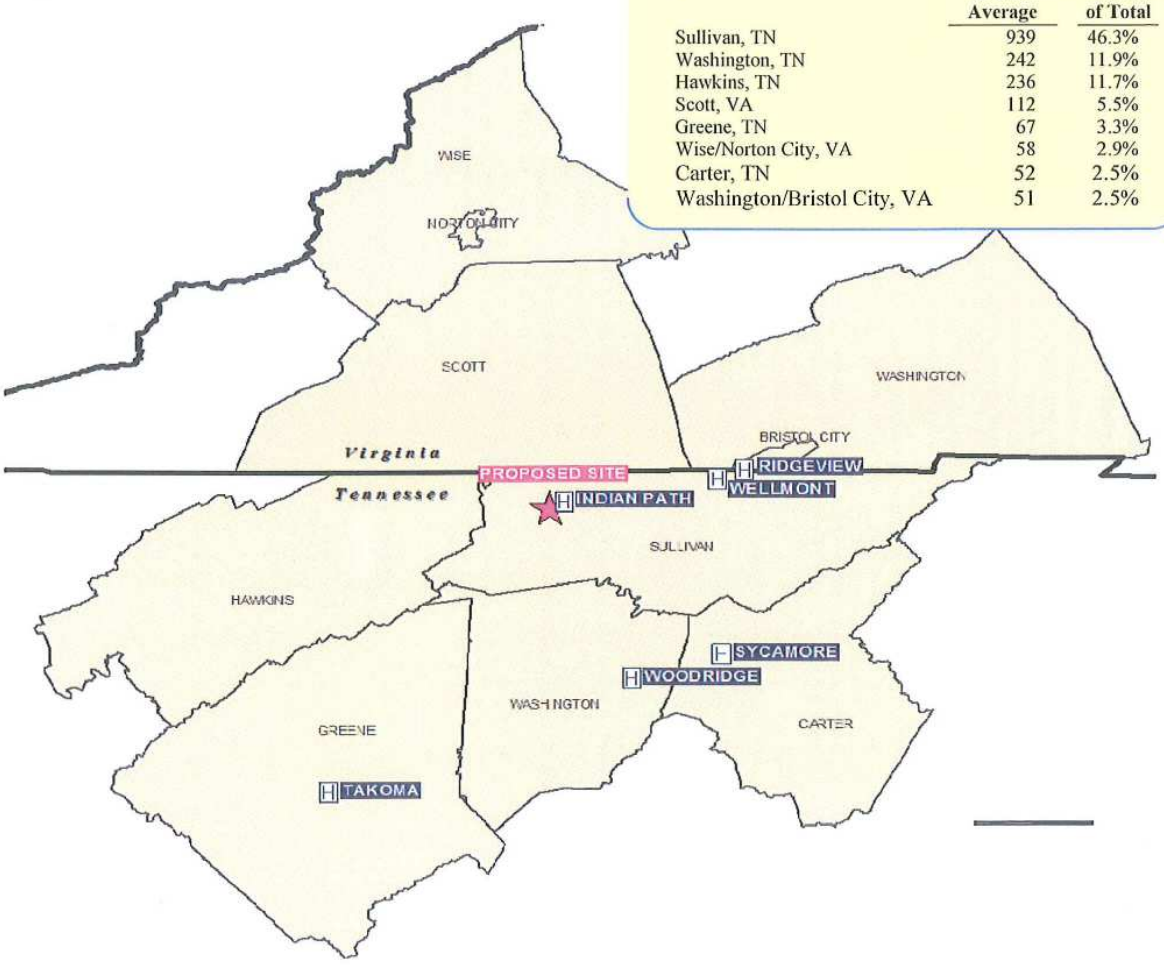


Washington County was excluded from SBH's claimed service area even though a substantial number of patients from Sullivan County currently receive psychiatric inpatient services in Johnson City. For example, in 2014, 24.9% of patients admitted to Woodridge were from Sullivan County, which represented the second highest volume from any one county. Patients

residing in other counties claimed as the service area by SBH also utilize Woodridge; in fact over a three-year period, residents of the SBH claimed service area constituted 36% of Woodridge's inpatients.

Interestingly, psychiatric services were offered at the Indian Path Psychiatric Pavilion in Kingsport until 2009, when it was closed due to declining patient census. Located essentially next door to the proposed SBH facility, Indian Path Pavilion can provide a comparative snapshot for what the true service area for a psychiatric hospital located in Kingsport would look like. The map below shows the Indian Path Pavilion service area with three year averages of patient origin:

	2007-2009 3-Year Average	Percent of Total
Sullivan, TN	939	46.3%
Washington, TN	242	11.9%
Hawkins, TN	236	11.7%
Scott, VA	112	5.5%
Greene, TN	67	3.3%
Wise/Norton City, VA	58	2.9%
Carter, TN	52	2.5%
Washington/Bristol City, VA	51	2.5%



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Not surprisingly considering their geographic proximity, Washington County was the second most common county of origin for patients at Indian Path Pavilion, accounting for almost 12% of admissions over a three-year period, and slightly more than Hawkins County, which SBH did include in its service area.

In light of the historical patient utilization patterns in Upper East Tennessee, the close economic and other ties among the Tri-Cities, SBH's own internal planning documents, and the history of this project, it is clear that a new psychiatric hospital in Kingsport would admit a substantial number of patients that otherwise would have been seen at Woodridge, including patients from Washington County and from other counties in Woodridge's service area. SBH's claimed service area is arbitrary, and was developed only in the hope of facilitating CON approval. Such obvious gerrymandering is not reasonable within the meaning of the HSDA rules and should not be countenanced.

SBH's health planning expert, Deborah Kolb Collier, Ph.D., whose report is attached hereto as Exhibit 1, has proposed a reasonable service area that includes Sullivan, Washington, Hawkins, Greene, Unicoi and Carter counties in Tennessee, and Scott, Wise, Lee, Russell and Washington Counties in Virginia. Using this service area, and applying the State's bed need methodology, yields a net need of 30 beds in the area (18 child/adolescent, 9 adult, and 3 geriatric).

2. **Woodridge and Other Local Providers Are Diligently Working To Strengthen Community-Based Behavioral Health Services**

Since a reasonable evaluation of SBH's service area fails to establish the need for a new 72 bed-hospital, SBH may argue that, based purely on anecdotes, that patients in the service area have difficulty accessing psychiatric and behavioral health services. Such anecdotes are stale, misleading, and fail to account for recent steps taken by Woodridge to improve service offerings.

When Lakeshore, the public psychiatric hospital for East Tennessee, shuttered its doors in mid-2012, Woodridge volunteered to become the service provider for those patients. As would be expected, Woodridge required time to adjust not only to an increase in patient census but also an increase in the acuity of the patients who were previously being treated at Lakeshore. This transition caused occasional operational issues and lag times for patient response. But beginning in late 2012 through today, Woodridge has taken a number of important steps to increase efficiencies and remove barriers to access. For instance, in 2013, Woodridge initiated a LEAN process review to transform the manner in which it triaged, evaluated, and admitted psychiatric patients from local emergency rooms into its facility. Through this and additional process improvements through 2014, Woodridge has seen a steady increase in inpatient admissions and an equally steady decrease in the number of patients who had to be deferred because of the lack of an available bed. Currently, Woodridge operates at or around 85% capacity on a routine basis, demonstrating efficient use of its existing resources.

While SBH might suggest that there is some percentage of the population in the Tri-Cities that needs psychiatric care but is not currently receiving it, SBH has never performed a statistical analysis to quantify the number of these patients. To the contrary, Sullivan County has a relatively high psychiatric use rate compared to the Tennessee average. In 2013, the state wide use rate was 938.6 per 100,000 population, compared to 1,026.8 for Sullivan Count residents. In other words, had SBH actually performed a statistical analysis of this suggested pent up demand, it would have discovered that there are no access problems preventing residents of Sullivan County or the surrounding areas from receiving psychiatric services.

Moreover, MSHA has increasingly devoted its financial resources to partnering with outpatient providers in its region to offer community-based psychiatric care alternatives to

inpatient hospitalization. For instance, MSHA has entered into a collaborative relationship with Frontier Health, the leading outpatient psychiatric service provider in Upper East Tennessee and Southwest Virginia, to construct a 12-bed Crisis Stabilization Unit (CSU) for adolescents. The CSU is on pace to be operational before the end of 2015.

A CSU is a non-hospital facility offering 24-hour, 7-days a week, intensive behavioral health treatment geared towards assessment, evaluation, early intervention, and stabilization within a 72 hour time period. While patients in a CSU can have the same or similar level of severity of psychiatric illness as an inpatient unit, care provided in a CSU setting tends to be less costly than an inpatient stay both in daily cost as well as overall cost due to shorter length of stay. This level of care is advantageous for those with specific psychosocial stressors (for example, loss of job or relationship issues) or readily mitigated treatment issues (for example, patient who is decompensating due to not taking psychotropic medications). Tennessee currently has some adult CSU beds but no pediatric CSU beds have previously been implemented. The availability of CSU beds can significantly impact the need for inpatient beds for patients of all ages by providing a less expensive alternative for patients in acute distress who do not warrant inpatient hospitalization. If more patients are appropriately treated as outpatients or in other treatment settings, then that will alleviate demand for existing licensed beds and will increase functional bed capacity in the area.

The CSU unit being developed by MSHA and Frontier is exactly the kind of new resource that is needed in the Tri-Cities. While adding a new 72-bed freestanding hospital simply duplicates existing resources, the adolescent CSU will be an important addition, which will help to free up more inpatient beds for the patients who truly need them.

B. **A New 72-Bed Psychiatric Facility in Kingsport Will Not Contribute to the Orderly Development of Healthcare**

The introduction of a new 72-bed psychiatric facility in Kingsport will not promote the orderly development of healthcare in Sullivan County and its environs. The proposed Project will simply duplicate existing services, and will damage existing health care providers.

In determining whether the Project will contribute to the orderly development of healthcare, the Court must look to HSDA Rule 0720-11-.01(3):

> (3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:
>
> (a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);
>
> (b) The positive or negative effects attributed to duplication or competition;
>
> (c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;
>
> (d) The quality of the proposed project in relation to applicable governmental or professional standards.

(emphasis added).

As discussed above, Woodridge serves an especially critical role as a safety-net hospital for psychiatric patients in the region. When Lakeshore closed, Woodridge made the commitment to provide mental health services to uninsured patients who otherwise would have no access to care. Woodridge has served over 3,000 uninsured patients since that time. Bad debt and charity care at Woodridge increased from about $700,000 annually in 2011 to approximately $15 million in 2014. Although Woodridge receives a grant from the State for these services, the grant covers substantially less than the costs associated with treating grant eligible patients. The

grant with the State of Tennessee is reviewed annually for renewal and is subject to change and reduction without notice. Furthermore, when Woodridge sees more indigent patients than are covered by the grant amount (which has occurred every year), Woodridge must petition the State to cover the remaining costs.

By contrast, SBH proposes to serve very few uninsured patients—the application projects only 70 charity care patients annually, while Woodridge served more than 1,250 such patients in FY 2014. Even this minimal participation by SBH to serve medically indigent patients, however, has been called into question by information obtained during discovery.

While SBH suggested in its application that 5% of charges would be accounted for by charity/indigent patients, SBH's historical performance does not support that claim. Notably, in response to MSHA's written discovery, SBH provided the payor mix for all current SBH non-residential psychiatric facilities, as follows:

Payor Percentage of Charges

Medicaid 19.5%
Medicare 29.3%
Commercial 7.0%
HMO/PPO 38.6%
Self pay 1.2%
Uncompensated care 4.5% (includes bad debt, denials, and administrative adjustments)

(SBH Response to First Set of Interrogatories from MSHA, #34, p. 27.) As can be seen from the table above, SBH did not identify indigent or charity care as one of its payers. While uncompensated care is described vaguely to include "bad debts, denials, and administrative adjustments", bad debt and denials clearly do not constitute charity. It is unclear what "administrative adjustments" are being referenced.

The SBH facility in Garner, North Carolina (SBH-Raleigh) provides an illuminating example of past performance. In its license renewal application for 2014, SBH-Raleigh reported that in the eight month period ended September 30, 20137, the facility had 277 acute care psychiatric discharges, **only 1** of which was self pay/indigent/charity. The remainder were Medicaid (10.8%) or commercial/managed care (88.8%) patients. Similarly, the SBH facility in Leland, North Carolina (SBH-Wilmington) submitted a license renewal application for 2015 (with data for twelve months ended September 2014). Out of 551 discharges, SBH disclosed that it had **zero** self pay/indigent/charity.

Based on the information from past SBH experience, the projection of 5% charity/indigent care is not credible. Furthermore, there is no means to enforce the 5% performance if the project moves forward. It is uncontested that Woodridge bears, by far, the largest share of the indigent psychiatric care in the region. In his deposition, Michael Garone, explained SBH's position on serving the indigent patients now being served by Woodridge:

> *Garone: To the best of my knowledge, the Woodridge Hospital has a contract for indigent care that's reimbursed by the State. And so obviously the closure of the Mental Health Institute, those patients need to go somewhere. So it's our understanding that the State kind of has this contingency plan for shutting down the hospital, that they would compensate one of the providers, being Woodridge, to see those patients.*
>
> *What we said was, if there - if that contract is in place, it would make sense for those patients to go to the facility with which they're compensated - their care is compensated. We would be happy to explore opportunities to replicate that contract in such a way that we would also be an option for those patients. But if that's [sic] an option, it wouldn't make sense for those patients to come to us without reimbursement when they could go to Woodridge with reimbursement.*

(Garone deposition, p. 89). The message is clear. SBH expects Woodridge to continue to be the destination for indigent patients, while SBH targets the insured patients for its new facility in

Kingsport. Apparently, SBH is willing to send indigent residents from its defined service area out of the service area to Woodridge for care.

Given SBH's location in the middle of Woodridge's service area, it is obvious that many if not most of the patients admitted to SBH would be patients that otherwise would have been treated at Woodridge. An analysis performed by Dr. Collier suggests that conservatively, the SBH project will result in 1,084 lost cases to Woodridge – 27% percent of its 2014 volume. The diversion of such a large number, including a disproportionately larger number of insured patients, from Woodridge to an SBH facility would have a devastating financial impact on Woodridge, again, conservatively estimated at between $1.51 and $1.92 million per year. Furthermore, this impact is based on the projected second year of operations for SBH-Kingsport, when the facility is operating at only 65% occupancy. As SBH's utilization increases in subsequent years (SBH uses 85% occupancy as its target metric), the impact on Woodridge can be expected to grow.

The loss of insured patients to a new SBH facility would have a significant adverse impact on Woodridge, given that it has accepted the additional financial burden of uninsured patients, only partially subsidized by the State. In the face of a new, for-profit competitor located in its service area, Woodridge would still be the facility receiving indigent cases from SBH's Tennessee service area (however defined), but would have a much smaller base of insured patients to support its operations.

In any scenario, the financial impact on Woodridge will be significant. In 2014, Woodridge experienced an operating income of approximately $99,121. For eleven months ended in May 2015, Woodridge has experienced a net operating loss of ($624,938). The loss of at least $1.51 to 1.91 million in contribution margin per year would represent a major challenge

to the ability of Woodridge to support the full range of its current services, especially in today's environment of federal and state budgetary pressures to reduce/control health care payments. An impact of this magnitude would cause serious financial stress on Woodridge and might result in the elimination or reduction of needed services or investment. Such a result would be contrary to the orderly development of health care, particularly in light of the fact that a new 72-bed inpatient psychiatric hospital is simply not needed in the service area.

Respectfully Submitted,



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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

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dkc consulting

REPORT ON SBH – KINGSPORT, LLC
PROPOSED CON FOR PSYCHIATRIC HOSPITAL
CN1312-050

Deborah K. Collier
DKC Consulting, LLC
July 10, 2015

REPORT ON SBH – KINGSPORT, LLC
PROPOSED CON FOR PSYCHIATRIC HOSPITAL

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INTRODUCTION

This report assesses the Certificate of Need ("CON") project (CN1312-050) for SBH - Kingsport, LLC ("SBH") in light of the statutory requirements of the Tennessee Code Annotated ("T.C.A.") and applicable criteria and standards of the Tennessee Health Services Development Agency ("HSDA" or the "Agency"). According to T.C.A. § 68-11-1609(b):

> No certificate of need shall be granted unless the action proposed in the application (1) is necessary to provide needed health care in the area to be served, (2) can be economically accomplished and maintained, and (3) will contribute to the orderly development of adequate and effective health care facilities or services.

SBH filed a Certificate of Need application on December 3, 2013 to build a 72-bed mental health hospital to be located in Kingsport, in Sullivan County. The total project cost was estimated as $11,717,915. The proposed hospital would include:

- 28 beds for children and adolescents
- 18 beds for adult psychiatric patients
- 16 beds for gero-psychiatric patients
- 10 beds for adult chemical dependency patients

This analysis examines the need for and the economic feasibility of the project, as well as the potential negative impact of the project on the existing health care delivery system, including the financial impact on Woodridge Hospital ("Woodridge"). Woodridge Hospital is owned by Mountain States Health Alliance ("MSHA").

This report was prepared by Deborah Kolb Collier, Ph.D., M.B.A. Dr. Collier has more than 36 years of consulting experience in the health care industry. She has been accepted as an expert witness in the fields of health care planning and health care finance in numerous CON administrative hearings, including those for psychiatric services. She has testified as an expert in administrative hearings in Tennessee, as well as in Georgia, Alabama, Florida, and other states. Her resume can be found in Appendix A of this report.

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CRITERION 1: NEED FOR THE PROJECT

There is no documented need for the project.

Under the HSDA rules, Chapter 0720-11-.01 (1)(a-g), the need for the proposed service is to be evaluated upon the following factors:

1.a. The relationship of the proposal to any existing applicable plans (e.g., the State Health Plan);

1.b. The population to be served by the proposal;

1.c. The existing or certified services or institutions in the area;

1.d. The reasonableness of the service area;

1.e. The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities and low-income groups;

1.f. Comparison of utilization/occupancy trends and services offered by other area providers;

1.g. The extent to which Medicare, Medicaid (TennCare) and medically indigent patients will be served by the project.

Examination of the SBH CON application in light of these factors indicates that there is no need for this project, as shown below.

1.a. The relationship of the proposal to any existing applicable plans (e.g., the State Health Plan);

There is no need for the project under the applicable State Health Plan, *Guidelines for Growth, 2000 Edition*, which includes service-specific rules for psychiatric inpatient services. The project satisfies neither the service-specific nor the general criteria related to need, as discussed below.

RELATIONSHIP TO THE SERVICE-SPECIFIC CRITERIA:

The following passage presents the service-specific criteria for psychiatric inpatient services found in the Guidelines for Growth, 2000 Edition.

A. Need

1. **The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).**

2. **For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.**

3. **For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.**

4. **These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.**

B. Service Area

1. **The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.**

2. **The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.**

C. Relationship to Existing Applicable Plans

1. **The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.**

2. **The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.**

3. **The impact of the proposal on similar services supported by state appropriations should be assessed and considered.**

4. **The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.**

5. **The degree of projected financial participation in the Medicare and TennCare programs should be considered.**

D. Relationship to Existing Similar Services in the Area

1. **The area's trends in occupancy and utilization of similar services should be considered.**

2. **Accessibility to specific special needs groups should be an important factor.**

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

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Service-specific Criteria A. Need and B. Service Area

As noted above, the State of Tennessee has adopted a population-based rule for the estimate of the need for psychiatric inpatient services, as set forth in the State Health Plan, *The Guidelines for Growth.* Total need is calculated as 30 psychiatric beds per 100,000 general population. This measure is also applied to subsets of the population, i.e., adults, adolescents, or children. The estimates of total need are to be adjusted by the number of existing staffed beds operating in the area, as inventoried in the Joint Annual Reports of providers. The identification of the appropriate area to use in these calculations, of course, is critical to the health planning analysis. The State's guidelines call for the applicant's geographic service area to be "reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency."[1]

SBH's argument for need, however, is based on an arbitrary and unreasonable definition of its proposed 5-county service area: Sullivan and Hawkins counties in Tennessee, and Wise, Scott and Lee counties in Virginia. This proposed service area is shown on **Map 1**, in Appendix B which contains exhibits for this report. The proposed facility would be situated in Kingsport, in Sullivan County. As can be seen, the service area is drawn to include a larger geographical area in Virginia than in Tennessee. Furthermore, it reaches two counties beyond Sullivan County into Lee and Wise Counties in Virginia, but does not include counties contiguous to Sullivan County to the south in Tennessee or to the northeast in Virginia.

By excluding Washington County from the defined service area, the applicant excluded a significant number of beds that are available to meet psychiatric needs of area residents. The applicant's proposed service area is arbitrary and unreasonable, and it does not represent the likely service area of an inpatient facility to be built in Kingsport, as shown below.

Arbitrary Exclusion of Washington County

Adjacent to Sullivan County, Washington County cannot be legitimately excluded from the analysis of psychiatric bed need in the area. By excluding Washington County, the applicant ignores a large population center and its proximity just to the south of Sullivan County. Furthermore, Woodridge Psychiatric Hospital, located in Washington County, is the primary provider of inpatient psychiatric services to residents of SBH's defined service area.

There is a demonstrable flow of patients between Washington and Sullivan Counties for services. As an example, in 2014, Woodridge Psychiatric Hospital ("Woodridge") reported 4,081 psychiatric admissions on its Joint Annual Report ("JAR"), 32.4% of whom were from Washington County where the facility is located. The second highest volume of patients at Woodridge came from Sullivan County, accounting for 24.9% of the total. An additional 5 counties in Tennessee contributed more than 100 admissions each. Virginia patients accounted for 7.8% of the total. Based on an average of the last three years of JAR data (2012, 2013, and 2014) for patient origin for Woodridge, the facility's service area includes Washington, Sullivan Carter, Greene, Hawkins, Unicoi, and Johnson counties in TN, and Scott and Washington Counties in VA. In addition, approximately 10% of Woodridge patients come from a multitude

[1] *Guidelines for Growth*, p. 25, B 1.

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(more than 20) of other counties in TN and VA, as well as from other states. Altogether, over the three year period, residents of counties in the proposed five county service area of SBH accounted for 36% of Woodridge's inpatients. Thus, patients originating in Sullivan and Hawkins counties and the defined Virginia counties can and do utilize Woodridge Psychiatric Hospital in Washington County. **Map 2** depicts the historical service area of Woodridge.

Furthermore, patient flow data from Indian Path Pavilion ("Indian Path") during the last full three years of operation of its mental health services demonstrate that a facility located in Kingsport could reasonably be expected to serve not only the counties defined by SBH but Washington County, TN, and other contiguous counties as well. **Map 3** depicts the historical service area for Indian Path, which includes Sullivan, Washington, Hawkins, and Greene counties in TN and Washington (including Bristol City), Scott, and Wise (including Norton City) counties in VA. This service area, based on a ranking of admissions by county, accounted for approximately 90% of admissions, with an additional 10% coming from a large number of surrounding counties in TN and VA, as well as from other states.

Information revealed in the discovery process shows that SBH considered the larger northeastern Tennessee/southwestern Virginia, commonly referred to as the Tri-Cities area for the population centers of Kingsport, Bristol, and Johnson City, as the target "catchment" area for its planned facility. The U. S. Census Bureau has defined the Johnson City-Kingsport-Bristol, TN-VA (Tri-Cities) Combined Statistical Area to include the counties of Sullivan, Hawkins, Washington, Unicoi, and Carter in Tennessee and Washington and Scott counties in Virginia, as well as the City of Bristol, Virginia. The designation as a Combined Statistical Area indicates that there is significant commercial traffic and business commuting between and among these cities and the surrounding areas.[2] The Tri-Cities area was included in the initial assessment of potential markets for SBH's management's review. (See P 3143-3155 and deposition of Mike Garone, pp. 110 - 111.)

In fact, there is also evidence that SBH first wanted to place its facility in Washington County in Johnson City. Mike Garone of SBH completed an Industrial Development Bond Board Incentive Application in October to locate the hospital in Johnson City.[3] Its first Supplemental Response to HSDA questions revealed that SBH, as late as October 10, 2013, when it met with representatives of Frontier Health, "had not excluded Washington County from its service area...." (Bates stamp 094)

On November 4, 2013, Mike Garone of SBH wrote in an e-mail: "You will notice that we have switched the physical location of the project from Johnson City to Kingsport in an attempt to avoid Mountain States Health Alliance from contesting our application." (P-0037) It is clear that Washington County was an important part of SBH's strategy for its project from the beginning;

[2] Combinations for adjacent areas with an employment interchange of 25% or more are automatic. Combinations for adjacent areas with an employment interchange of at least 15% but less than 25% are based on local opinion as expressed through the Congressional delegations. The Office of Management and Budget (OMB) defines the "employment interchange measure" as "the sum of the percentage of employed residents of the smaller entity who work in the larger entity and the percentage of the employment in the smaller entity that is accounted for by workers in the larger entity." www.census.gov/econ/census/help/geography

[3] See Garone deposition, p.72 and P-1763.

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yet Washington County was excluded from its need analysis or discussion of similar services in the area.

Evidence shows that, even after the filing of its CON in December 2013, SBH still considered Johnson City and Washington County to be part of the proposed hospital's catchment area. On January 10, 2014, SBH executive management reviewed a document about the proposed hospital project that depicted catchment areas with 25 mile and 50 mile radii around Kingsport, which would have included Woodridge as well as other psychiatric beds. (See P-0158) Mike Garone, who prepared the catchment area presentation slide was asked in deposition about the meaning of "catchment area."

> ***Q:*** *And what is a 'catchment area'?*
>
> ***Garone:*** *A 'catchment area' is one of the things that we looked at for how we might be able to access staff, possible patients. It's one way for us to look at the greater region.*
>
> ***Q:*** *Sort of the area where you're doing business, if you will?*
>
> ***Garone:*** *The area where we're doing business and our accessibility to staff and potential patients. (Garone deposition, pp. 112 – 113)*

The discussion document for the meeting noted the "limited competition" in the area, including "Only 2 facilities (40 beds) within 25 miles and 3 facilities (112) beds within 50 miles," and "Only 1 substance abuse provider (19 beds) in the entire market." (P-0155) It is clear that management was presented with and was aware of additional beds, including 28 beds at Ridgeview Pavilion and 84 beds at Woodridge. (P-0160) Thus even after the CON application had been filed, it appears that SBH knew that the target market for the project was much larger than its defined service area in the application.

Given the data on patient flow across Sullivan and Washington counties in Tennessee and the surrounding counties, as well as the evidence of commercial and commuting traffic across the Tri-Cities area, it is clear that if SBH builds a hospital in Kingsport, it is likely to market to and accept patients from Tennessee counties beyond Sullivan and Hawkins. Even SBH's health planning expert, Dan Sullivan, acknowledged in his report (p. 14): "Population growth in SBH's service area is expected to be modest." In fact, Washington County is experiencing more growth than Sullivan County (as will be shown later in this report).

It is not reasonable to believe that SBH, given its plan to build a large unit for children and adolescents, would ignore the growing market in Washington County and limit itself to the shrinking market of children and adolescents in its defined service area. James Shaheen, CEO of SBH, confirmed in deposition, that there would be no geographical restrictions on patients accepted at the Kingsport facility:

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Q: Is it your plan at the facility in Kingsport, if it's approved, to restrict geographically where your patients originate from?

Shaheen: *No, we wouldn't. (Garone deposition, p. 27)*

Even if it were possible to limit marketing to the defined service area, it is unlikely that SBH would do so, given the need to meet corporate utilization/census targets and achieve profitability goals. SBH can be expected to look for staff and patients in the larger Tri-Cities catchment area.

The applicant has arbitrarily drawn a service area to exclude competitors from its analysis of need and impact on the existing health care system. The primary, if not only, reason for excluding Washington County was to reduce the chance that MSHA would oppose the project. As shown by discovery documents, such as Mr. Garone's e-mail cited above and the meeting document from January 10, 2014, post-filing, SBH was well aware that it would be competing for the same patients that MSHA serves, including Washington County residents. Thus the applicant has not defined a reasonable service area.

Alternate Service Area

A more reasonable likely service area for a 72-bed behavioral health inpatient facility located in Kingsport in Sullivan County would include the counties identified by SBH plus several additional counties that are within an approximate one-hour driving radius of the proposed SBH facility in Kingsport. A radius of 35 miles was used to approximate a one-hour drive time range, as depicted in **Map 4**. Drive times to several of the outlying communities within the area were checked with MapQuest to confirm that the area represented approximately a one-hour drive time radius. **Exhibit 1** shows drive times between the proposed SBH facility and several outlying communities. **Maps 5 and 6** illustrate the relative locations of the various sites used for the travel time analysis in **Exhibit 1**.

Although Tennessee does not use a specific drive-time standard in its psychiatric bed need methodology, a 60-minute drive time benchmark is a reasonable one. In fact, the State of Virginia uses such a standard in its State Medical Facilities Plan for inpatient mental health services: "Acute psychiatric and acute substance abuse disorder treatment services should be available within 60 minutes driving time one way under normal conditions of 95% of the population using mapping software as determined by the commissioner."[4] Notably, a large portion of the applicant's proposed service area (3 of 5 counties) lies within Virginia.

South Carolina also developed its standards for psychiatric facilities with a one-hour geographic accessibility target in mind. The South Carolina Health Plan notes: "Psychiatric beds are planned for and located within sixty (60) minutes travel time for the majority of residents in the State. In addition, current utilization and population growth are factored into the methodology for determining psychiatric bed need."[5]

[4] Virginia Department of Health, Office of Licensure and Certification, State Medical Facilities Plan. Part XII, Article 1, 12VAC5-230-840, Travel time.
[5] 2012-2013 South Carolina Health Plan, p. IV-5 and The South Carolina Draft State Health Plan, 4/13/15, p. IV-3.

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As can be seen on **Map 4**, there is a large portion of the area within the 35-mile range that was excluded by SBH from its defined service area. Most notably, the defined SBH service area extends 35+ miles to the north and northwest, but only about 8-10 miles south, even though the northern area is mountainous and has fewer routes into Kingsport, as indicated on **Map 4** and the satellite map showing topography, **Map 7**.

Map 8 depicts the alternate, more reasonable service area comprising counties that are wholly or largely within an hour's drive of Kingsport. The alternate service area includes:

Tennessee	Virginia
Sullivan	Scott
Washington	Wise (plus Norton City)
Hawkins	Lee
Greene	Russell
Unicoi	Washington (plus Bristol City)
Carter	

Within this total service area, Sullivan and Washington counties in TN would be expected to account for the majority of cases in a psychiatric facility in Kingsport, due in part to two factors:

1) These two counties account for more than 40% of all the population in the alternate service area, and
2) Geographic accessibility to Kingsport is relatively easier from these two counties, given the existing highway infrastructure and topography.

The reasonableness of this alternate service area definition is borne out by the historical experience of Indian Path and Woodridge, as set forth above. Both Woodridge and Indian Path data show a broad service area with a heavy reliance on Sullivan and Washington counties in Tennessee, with secondary reliance on surrounding counties in Tennessee and Virginia.

Service Area Total Population

The alternate service area described above contains six counties in Tennessee and five counties in Virginia. As shown on **Exhibit 2**, the total population of the alternate service area was estimated at 686,499 in 2014 and projected to grow to 705,646 by 2019. The SBH proposed service area was estimated at 308,983 in 2014 and projected to grow to 312,916 by 2019. As is evident on the exhibit, the SBH proposed service area has a lower rate of growth (1.3%) than the additional area contained in the alternate service area (4.0%). Washington Co., TN, adjacent to Sullivan County, has the highest rate of growth (7.3%), with a projected increase of 9,598 people between 2014 and 2019, bringing its total population to more than 140,000 by 2019.

Exhibit 3 compares the change in total population for Sullivan County, the SBH proposed service area as a whole and Washington County, TN. Washington County, TN, is projected to add 3.5 times as many residents (9,598) as Sullivan County (2,732) and almost 2.5 times as many residents as the entire SBH proposed service area (3,933) over a five-year horizon. It seems reasonable to assume that a corporation planning a new hospital venture in Sullivan County

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would expect and make every effort to serve patients from the neighboring, faster growing Washington County. In fact, it is clear that SBH originally planned to locate its facility in Washington County (as shown previously), but chose to locate it in Sullivan County to reduce the chance that Woodridge would oppose the venture. Arbitrarily carving Washington County out of its service area, however, creates an unreasonable and unsupportable service area for SBH.

Population Subgroups

The Tennessee CON criteria for psychiatric bed need allow for analysis of population subgroups, namely children under 13, adolescents ages 13-17, and adults ages 18 and over. Given the limitations of the information available from Virginia's demographic source (the Weldon Cooper Center at the University of Virginia), it was not possible to use the exact age breakouts specified in the Tennessee CON Criteria for psychiatric bed need for the Virginia portion of the service area. Accordingly, the Virginia age breakouts are as close as possible to the age groupings used for Tennessee counties.

Child and Adolescent Population

Exhibit 4 provides underlying demographic data for the child and adolescent population by county for the proposed SBH service area and the alternate service area. SBH has emphasized child and adolescent behavioral health services in its CON application, although the demographic analysis shows that the child and adolescent population in SBH's proposed service area is projected to decline by 13.3% overall between 2014 and 2019. Notably, Sullivan and Hawkins counties, which make up the Tennessee portion of the SBH service area, are projected to experience a decrease of 20.1% of their child and adolescent population by 2019. Overall, there are projected to be 8,140 fewer children and adolescents in SBH's proposed service area in 2019 compared to 2014.

In contrast to the 20% decrease in children and adolescents projected for Sullivan County, Washington County, TN, is expected to have 11.9% increase in this population cohort by 2019, as shown on **Exhibit 4.** By 2019, Sullivan County's child and adolescent population will have shrunk to 23,553, while Washington County's will have grown to 29,342, as depicted on **Exhibit 5.**

The changes in the size of child/adolescent population for Sullivan County, the SBH service area, Washington Co., TN, and the total alternate service area are compared on **Exhibit 6.** Even with the growth in Washington County's child/adolescent population, there is still a projected net decrease in child/adolescent population in the alternate service area overall. *It seems disingenuous for SBH to ignore virtually the only area of growth in the child/adolescent population, Washington County, TN, immediately adjacent to its proposed home county.*

Adult Population

Exhibit 7 provides demographic data for the adult populations of SBH's proposed service area and for the alternate service area. Not surprisingly, the population of elderly 65+ is growing more rapidly than other cohorts. Washington County, TN, has a slightly higher rate of growth for

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adults ages 18-64 and a slightly lower rate for elderly 65+ compared to Sullivan County. Overall, the adult growth rate is projected at 6.6% for Sullivan and 6.2% for Washington. The total adult population of Washington County is projected to be 110,842 in 2019, a large population that is not likely to be ignored by SBH in its need to fill its beds.

BED NEED CALCULATION

For the alternate service area, bed need calculations were prepared for each county and age cohort using the State's planning standard of 30 beds per hundred thousand population.

Child and Adolescent Gross Bed Need

Exhibit 8 sets forth the calculated gross bed need (before adjustments for bed inventory) for child and adolescent psychiatric beds for 2014 and 2019 for the counties in the alternate service area. The bed need for children under 5 years old was broken out for two reasons:

1) SBH does not propose to serve this population and excluded it from the CON calculations.
2) Hospitalization of babies and toddlers for psychiatric reasons is extremely rare and generally considered inappropriate.

Because SBH would not be serving the under five population, the bed need calculated for that age cohort should not be considered in this CON review process.

As calculated from **Exhibit 8**, exclusive of the under 5 population, the total number of beds needed for children and adolescents in the alternate service area is 31.2 in 2014, declining to 30.1 by 2019. This decline reflects the declining population of children and adolescents overall. ***Looking specifically at the counties identified in the SBH proposed service area, the gross need for child and adolescent beds (exclusive of the under 5 population) drops from 14.1 to 12.4 between 2014 and 2019. Thus there is no way for SBH to defend the proposed 28 bed child and adolescent program based on its defined service area.***

In his expert report for SBH, Dan Sullivan acknowledges that the bed need methodology does not support 28 child and adolescent beds. (Sullivan Report, p. 12) He calculates a need for 15 child and adolescent beds in 2019: however, he includes the under 5 population, thereby overstating the need that SBH proposed to serve. (Sullivan Exhibit #20) To try to justify the surplus beds, Sullivan refers to the relatively high occupancy at Woodridge, even though he and SBH are claiming that Woodridge is not in their service area: "The need is confirmed by the practical limitations of Woodridge's 12-bed child and adolescent unit, detailed above." (Sullivan Report, p. 13)

It is logically inconsistent for Mr. Sullivan to claim that Woodridge is outside the SBH service area (and hence irrelevant to the need consideration as well as unaffected by SBH's project) and, at the same time, argue that SBH's "extra" beds beyond the calculated need are needed to serve the broader region served by Woodridge. It is clear that SBH would have to reach beyond the defined service area for patients to fill a 28-bed unit.

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Adult Gross Bed Need

Exhibit 9 presents the calculated gross bed need (again, before adjustments for bed inventory) for adult psychiatric beds for 2014 and 2019. As shown on the exhibit, for the larger alternate service area, the total adult bed need is estimated at 164.4 in 2014, increasing to 171.5 in 2019. Approximately one-fourth of the adult bed need is attributable to the 65+ population.

Exhibit 10 summarizes the gross bed need calculations by major category for the alternate service area. As shown, excluding beds for children under 5, there is a need for 196 beds increasing to 202 by 2019.

Adjustment for Existing Bed Inventory

As stated in the State's methodology, the calculated bed need is to be reduced by the existing supply of beds in the area. **Exhibit 11** identifies the current inventory of beds by facility and county. The total supply of 172 beds includes 12 for children and adolescents, 118 for adults under 65, and 42 designated for elderly patients.

Map 8, referenced earlier, shows the location of the acute inpatient psychiatric services within the alternate service area. The applicant ignored all of these facilities except for Wellmont Bristol Regional Medical Center ("WBRMC") in its analysis of need in the application. The applicant even ignored Ridgeview Pavilion, located only 3 miles and 6 minutes driving time from WBRMC, whose beds were included in the SBH analysis. [6]

NET BED NEED

A comparison of the gross number of beds needed to the inventory of current beds yields the net number of beds needed, as set forth in **Exhibit 12**. In 2019, there is a net need shown for 18 beds for children (5+) and adolescents, 9 beds for adults under 65, and 3 beds for adults 65+, for a total of 30 beds. *This net need is fewer than half of the 72 beds proposed by SBH.*

It should also be noted that the finding under the population-based formula for 18 child and adolescent beds in the alternate service area does not take into account the planned implementation of a child/adolescent Crisis Stabilization Unit (CSU) in the area. The availability of the CSU is expected to add functional capacity to the existing inpatient beds and thus potentially reduce the need for additional beds.

Given that the service area defined by the applicant is unreasonable, then the subsequent analysis of the population demographics in the application is necessarily deficient. Furthermore, the applicant did not size its facility to fit the population needs of its own proposed service area.

As the need calculation shows, the applicant did not adequately assess the "socio-demographics of the service area and the projected population to receive services," as called for in the service-specific rules. The applicant does not present information to support the need based on any identified underserved populations or in-depth demographic analysis. In fact, the applicant

[6] Based on MapQuest search.

provides minimal socio-demographic data in the application, and does not address where underserved populations reside within the service area or how the SBH facility would alleviate any specific needs of underserved populations such as minorities, women, former military with PTSD (post traumatic stress disorder), homeless or impoverished residents.

The applicant has stated that it would accept involuntary admissions, but based much of its argument on the needs of patients from Virginia, who could only be accepted as voluntary admissions under current regulations. Thus the portion of Mr. Sullivan's need calculation based on Virginia population is also overstated to the extent it includes the need for serving involuntary cases as well as voluntary.

Substance Abuse/ Chemical Dependency

There are no separate CON rules for determining the need for inpatient substance abuse and chemical dependency beds. Such beds are subsumed within the overall psychiatric bed need methodology. In this case, SBH is proposing a 10-bed adult substance abuse and chemical dependency unit as part of its 72-bed project. It should be noted that Woodridge maintains a 26-bed unit (the Poplar unit) that serves adult chemical dependency patients, as well as units for child and adolescent psychiatric patients, and units for general adult and gero-psychiatric patients.

Service-specific Criteria C. Relationship to Existing Applicable Plans

It is clear that the applicant did not engage with or consult with representatives of the Tennessee HSDA or the Department of Mental Health and Substance Abuse Services ("TDMHSAS") concerning the need for the project prior to filing its CON application. In its Supplemental Response #1 to HSDA questions, the applicant states: "Prior to the submitting of our CON Application, a discussion with the Tennessee Department of Mental Health and Substance Abuse Services had not yet taken place." (Bates 92) The applicant also did not communicate with representatives of TennCare prior to filing the application: "Prior to the submitting of our CON Application, a discussion with the Bureau of TennCare and the contracted TennCare managed care organizations had not yet taken place." (Bates 92)

The Applicant's planning process, as revealed in discovery documents, was based largely on a high-level screening process to locate areas that could be commercially successful while minimizing potential opposition. (Garone deposition and P-3143-3155)

Service-specific Criteria D. Relationship to Existing Similar Services in the Area

The State's CON guidelines for inpatient psychiatric services call for a consideration of the occupancy and utilization of existing similar services. The applicant's choice of an unreasonable service area excluded facilities that provide similar services to residents of the defined service area. In fact, facilities ignored by SBH account for the vast majority of care provided to residents of SBH's defined service area.

Market Share

Exhibit 13 presents data on psychiatric patients who were residents of the SBH proposed service area, including the number of discharges of these residents to any Tennessee hospital captured in the Hospital Discharge Data System (HDDS) from 2011 through 2013. HDDS data were supplemented by patient origin data from JAR reports for hospitals that did not participate in HDDS. Also shown is the resulting market share of discharges for these facilities. As is clear from the Exhibit, Woodridge is the primary source of inpatient care for the residents of the SBH proposed service area, with a market share of 52.0% in 2013. WBRMC, the only facility SBH acknowledged in its need assessment, accounted for only 24.1% of care in 2013.

Exhibit 14 provides similar data on the destination of care for residents of the alternate service area, which, of course, includes all of the SBH-defined service area. Once again, Woodridge is the primary source of care, with a market share of 57.2% in 2013, and WBRMC has the second highest market share, at 19.1%. As can be seen from the market share exhibits, patients with psychiatric diagnoses are also treated in hospitals that do not have designated psychiatric beds, for example, Johnson City Medical Center. Typically such patients also have a medical condition or complication that warrants an acute care hospital stay.

Utilization

Exhibit 15 provides an overview of discharges, average length of stay ("ALOS") and occupancy rates for 2011 through 2013 for psychiatric service providers in the alternate service area. Overall, for the 172 beds in the alternate service area, occupancy was 63.1% in 2013, indicating that there was capacity for additional admissions. Occupancy of the 12-bed child and adolescent beds at Woodridge was 56.8% in 2013, and based on the 2014 JAR, it was 64.9% in 2014.

In his deposition, Michael Garone of SBH was asked about the corporate standard or target or optimal occupancy of SBH facilities:

> ***Q:*** *Okay. What is your corporate standard for target or optimal occupancy at SBH facilities?*
>
> ***Garone:*** *Target occupancy, I think it probably depends on when you're talking about. Our facilities across the country that are fully ramped up and operational are averaging anywhere from 80 to 90 percent occupancy.* (Garone deposition, p. 138)

As noted in discovery, Woodridge has taken steps to increase the effective capacity of its child and adolescent program and reduce deferrals. SBH is aware of the trend in reduced deferrals, as evidenced by correspondence with Youth Villages (See P – 0343). The Sullivan Report, p. 17, also acknowledged that the number of deferrals at Woodridge declined in 2014.

The available capacity in existing facilities, coupled with a finding of net need for fewer than half of the beds proposed by the applicant, means that the 72-bed hospital proposed by SBH would unnecessarily duplicate existing resources.

The service-specific criteria also state that accessibility to specific special need groups should be an important factor. The applicant's response to this criterion (D.2.), was to restate that it would accept involuntary admissions. As noted previously, the applicant would not be able to take involuntary admissions from Virginia. Furthermore, the applicant makes no specific commitment to any special needs groups that are uninsured, nor does it identify or quantify any specific special needs group. Furthermore, the applicant does not propose to add any services that are not already available for area residents.

Use Rates

The applicant has not demonstrated that there are access problems that prevent residents of Sullivan County or the surrounding area from receiving psychiatric services. In fact, Sullivan County has a relatively high psychiatric use rate (discharges per 100,000 population) compared to the statewide average, as shown on **Exhibit 16**. In 2013, the statewide use rate was 938.6, compared to 1,026.8 for Sullivan County residents. The rate for Sullivan and Hawkins counties combined was 961.9, slightly above the statewide rate. For the six Tennessee counties in the alternate service area, the overall rate was 981.0, also above the statewide rate in 2013.

Service-specific Criteria E. Feasibility

The service-specific criterion for feasibility only references the applicant's ability to meet licensure requirements related to personnel and staffing. There is no basis to dispute the applicant's intent or ability to meet all licensure requirements related to personnel. The overall feasibility of the proposal will be addressed under the General Criterion of Economic Feasibility in this report.

GENERAL CRITERIA RELATED TO NEED

The general criteria for CON review call for an evaluation of need based on six factors (in addition to the service-specific criteria). These factors are covered by the discussion of the service-specific factors above.

1.b. The population to be served by the proposal;

As noted previously, the applicant's service area definition is flawed and necessarily leads to an inadequate presentation of the population to be served.

1.c. The existing or certified services or institutions in the area;

The applicant arbitrarily excludes several existing institutions from its analysis.

1.d. The reasonableness of the service area;

The applicant's 5-county service area is unreasonable, as discussed in detail under the service-specific rules section of this report. The arbitrarily limited service area definition leads to

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deficiencies in the applicant's analysis of population, existing providers, area utilization, and economic impact.

1.e. The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities and low-income groups;

The Applicant provided no documentation beyond unverified anecdotes of any accessibility issues for consumers and patients in the service area, particularly women, racial or ethnic minorities, or low-income groups.

1.f. Comparison of utilization/occupancy trends and services offered by other area providers;

The applicant tried to limit its analysis of other area providers by drawing an unreasonable service area.

1.g. The extent to which Medicare, Medicaid (TennCare) and medically indigent patients will be served by the project.

Although SBH proposes to serve Medicare, TennCare, and medically indigent patients, information received during discovery weakens the credibility of this claim. The applicant has projected that 5% of charges would be accounted for by charity/indigent patients. SBH's historical performance does not support that claim.

Notably, in response to MSHA's First Set of Interrogatories, SBH provided the payor mix for all current SBH non-residential psychiatric facilities, as follows:

Payor	Percentage of Charges
Medicaid	19.5%
Medicare	29.3%
Commercial	7.0%
HMO/PPO	38.6%
Self pay	1.2%
Uncompensated care	4.5% (includes bad debt, denials, and administrative adjustments)

Source: SBH Response to First Set of Interrogatories from MSHA, #34, p. 27.

As can be seen from the table above, SBH did not identify indigent or charity care as one of the payor classifications, although the interrogatory requested that information. The self pay category may include individuals who self insure as well as those who cannot pay. Uncompensated care is described vaguely to include bad debts, denials, and administrative adjustments. Certainly, bad debt and denials do not constitute charity. It is unclear what "administrative adjustments" are being referenced. In its response to this request, SBH failed to provide any indication or evidence of charity or indigent care or to point to a corporate policy on charity or indigent care.

The SBH facility in Garner, North Carolina (SBH-Raleigh) provides an illuminating example of past performance. In its license renewal application for 2014, SBH-Raleigh reported that in the

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eight month period ended September 30, 2013[7], the facility had 277 acute care psychiatric discharges, only 1 (0.4%) of which was self pay/indigent/charity. The remainder were Medicaid (10.8%) or commercial/managed care (88.8%) patients.

The SBH facility in Leland, North Carolina (SBH-Wilmington) provides another example. In its license renewal application for 2015 (with data for twelve months ended September 2014), SBH-Wilmington reported 551 discharges, none of which was listed as self pay/indigent/charity.

Based on the information about SBH experience, the projection of 5% charity/indigent care is not credible. Furthermore, there is no means to enforce the 5% performance if the project moves forward. It is uncontested that Woodridge bears, by far, the largest share of the indigent psychiatric care in the region. In deposition, Michael Garone, explained SBH's position on serving the indigent patients now being served by Woodridge:

> ***Garone:*** *To the best of my knowledge, the Woodridge Hospital has a contract for indigent care that's reimbursed by the State. And so obviously the closure of the Mental Health Institute, those patients need to go somewhere. So it's our understanding that the State kind of has this contingency plan for shutting down the hospital, that they would compensate one of the providers, being Woodridge, to see those patients.*
>
> *What we said was, if there – if that contract is in place, it would make sense for those patients to go to the facility with which they're compensated -- their care is compensated. We would be happy to explore opportunities to replicate that contract in such a way that we would also be an option for those patients. But if that's [sic][8] an option, it wouldn't make sense for those patients to come to us without reimbursement when they could go to Woodridge with reimbursement. (Garone deposition, p. 89)*

The message is clear. SBH expects Woodridge to continue to be the destination for indigent patients, while SBH targets the insured patients for its new facility in Kingsport. Apparently, SBH is willing to send indigent residents from its defined service area out of the service area to Woodridge for care.

[7] According to SBH's Responses to MSHA's First Set of Interrogatories, #39 (a), p. 29, the acute care portion of this facility opened in February2013.
[8] The word "not" appears to have been left out in the transcript.

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CRITERION 2: ECONOMIC FEASIBILITY

The Applicant did not adequately document economic feasibility.

According to HSDA Rule 0720-11-.01(2)(a-f), factors to evaluate whether the proposal can be economically accomplished and maintained include:

2.a. Whether adequate funds are available to the applicant to complete the project;

It appears that SBH has a sufficient line of credit to carry out its project development.

2.b The reasonableness of the proposed project costs;

No opinion.

2.c. Anticipated revenue from the proposed project and the impact on existing patient charges;

The applicant does not provide a credible utilization projection or identify any underlying assumptions for market share or volume of cases by county; consequently, there is no basis for deeming the projections feasible. As another example of its deficient utilization modeling, SBH first used a 12-day average length of stay, well above area averages (as shown on Exhibit 15), only to reduce it to 9.2 days in the face of questions about the unusually long stay assumption. SBH then simply increased the number of admissions in order to keep the same number of patient days for its financial projection, as documented in the SBH – Kingsport Response to MSHA's First Set of Interrogatories, page 25.

Such a major change in assumptions to produce a desired result undermines the credibility of the utilization projection. Specifically, increasing the projected admissions from 1,425 to 1,859 in the second year would mean that SBH would have to capture a market share of approximately 74% of all cases from its defined service area market, based on a 2013 total market size of 2,527 cases, as shown on Exhibit 13. Such an assumption would be unreasonable. Given that 20%, or more than 500, of the cases from that area are indigent or self pay, it would mean that SBH would have to capture virtually all the insured cases.

SBH admits that its utilization projection is not based on any in depth market analysis. In its Response to MSHA's First Set of Interrogatories, p. 24, the applicant states, "SBH built its projected utilization around its ability to ramp up and staff the Project. SBH's ramp-up average daily census is controlled by its pace of development, not by any other factor." In other words, the project could be in Kingsport, TN, or Mobile, AL, or some other market and the utilization projection would be the same, regardless of number of competitors, competitors' market share positions, use rates, area length of stay, or other factors that health care planners, including SBH's expert witness, typically analyze and incorporate into the development of CON applications.

The unreasonable service area assumption coupled with the arbitrary change in length of stay and discharge numbers demonstrate the lack of credibility of the application's utilization projections. *Given the unreliable utilization projection, the financial projections cannot be considered reliable.*

2.d. Participation in state/federal revenue programs;

SBH proposes to participate in Medicare and TennCare, but as noted above, there is no evidence cited by the applicant that these patients are not being served well by the existing providers in the area. Moreover, Medicare and TennCare are, in fact, well served by existing providers, including Woodridge.

2.e. Alternatives considered; and

2.f. The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

The applicant did not reach out to Woodridge or WBRMC prior to filing its application to determine if there was a possible alternative to meet child and adolescent psychiatric need through a cooperative or joint venture with existing providers. In his deposition, Mr. Garone is asked about the alternative of a sharing arrangement:

> ***Q:*** *Question 11 (B), part of the formal application asked the applicant to consider – or whether consideration has been given to alternatives to new construction, for example, modernization or sharing arrangements. And your response is, the applicant has no facilities in east Tennessee to modernize. It does not believe that there are any other providers in east Tennessee [that] would engage in sharing arrangements with it, since it is a new provider in the area. Do you see that?*
>
> ***Garone:*** *Correct.*
>
> ***Q:*** *That's not accurate, is it?*
>
> ***Garone:*** *It's absolutely accurate when it was written. We had not had any conversations with Mountain States, nor their willingness to do any of that. So at the time our application was turned in, that's exactly what we believed.*
>
> ***Q:*** *So you state disbelief, but you had not had any conversations with any providers to actually determine whether or not that's true or not?*
>
> ***Garone:*** *With Mountain States? The only other provider you mean?*
>
> ***Q:*** *Or Wellmont.*
>
> ***Garone:*** *Right. Correct. (Garone deposition, pp. 188-189.)*

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Failing a cooperative venture or acquisition, an alternative would be to right-size the proposed facility to align with the identified need in a reasonably drawn service area. It appears that SBH made a decision in early October to build one of its standard prototype facilities in the Tri-Cities area, preferably in Johnson City, then dropped that choice in favor of Kingsport to reduce the chance of opposition from MSHA.

Even though SBH develops and operates several residential treatment centers for children and adolescents, there is no evidence that they investigated or considered that alternative for the area. A residential treatment center with a small acute care unit for children and adolescents, such as SBH's Garner, NC, facility, is one such alternative possibility.

Certainly, an alternative would have been to conduct more objective market research, conferring with HSDA and TMHSAS officials as well as with local inpatient and outpatient mental health providers, along with gathering data on patient flow, market share, length of stay, and payor issues.

A statistically valid market research survey of healthcare consumers in the region would have been a better alternative than relying solely on anecdotal reports. Furthermore, it does not appear that SBH tried to confirm or test the anecdotal reports it received concerning MSHA.

All in all, the project appears to have been hastily planned and submitted, with little thought given to alternative options for the Tri-Cities region.

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CRITERION 3: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF ADEQUATE AND EFFECTIVE HEALTH CARE FACILITIES AND/OR SERVICES

Unnecessary duplication of services will negatively affect existing providers and area patients.

The contribution which the project proposes to make to the orderly development of an adequate and effective health care system is to be judged based on the following factors, set forth in HSDA Rule 0720-11-.01(3)(a-d):

3.a. The relationship of the proposal to the existing health care system;

The project was developed and submitted for CON review without consideration of or consultation with key agencies concerned with the mental health system in the region that would be served. The project is not appropriately sized and would unnecessarily duplicate some services. Although there is some net need for additional child and adolescent beds in the region, there is not sufficient need to support the size of the proposed project.

As shown previously, Woodridge has a high market share of the patients originating in either the SBH defined service area or the more reasonable alternate service area. Specifically, in 2013, Woodridge provided care for 52.0% of all cases originating in the SBH defined service area and 57.2% of all cases originating in the alternate service area.[9]

Not only does Woodridge serve a large percentage of the patients from the SBH-defined service area, but Woodridge also relies heavily on the patient volume from the proposed SBH-service area. In 2014, patients from the SBH proposed service area represented approximately 37% of Woodridge's 4,081 inpatients, or 1,497 patients.

Assuming that SBH achieves its utilization projection of 946 cases in the first year and 1,859 cases in the second year,[10] it is reasonable to assume that a large portion of the cases would have otherwise been treated at Woodridge.

3.b. The positive or negative effects attributed to duplication or competition;

The proposed project would represent unnecessary duplication.

Volume Impact

To more precisely quantify the volume of cases lost, an analysis of market share by payor was developed using the State's Hospital Discharge Data Set ("HDDS").[11] As shown on **Exhibit 17**, Woodridge's market share by payor varies significantly. **Exhibit 18** shows a similar pattern for market share by payor within the alternate service area. A payor-level analysis is important, because of the small number of indigent cases that SBH is expected to serve, and because the lost

[9] As noted previously, market share analysis is based on data from hospitals reporting to the Hospital Discharge Data System (HDDS), supplemented by JAR data for hospitals not reporting on HDDS

[10] SBH revised its utilization projection in the discovery process. See SBH – Kingsport, LLC's Responses to MSHA's First Set of Interrogatories, p.24.

[11] Because some hospitals do not report through HDDS, totals do not tie to JAR reports. JAR reports cannot be used for this level of analysis, as they do not include patient origin at the payor level.

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contribution for cases shifted from Woodridge to SBH varies significantly by payor. **Exhibit 19** presents the payor distribution of cases for Woodridge from the SBH-defined service area and the alternate service area, along with the market share for each payor category.

One underlying assumption of the volume impact analysis is that SBH would draw patients from existing providers in proportion to the existing providers' relative current market share. This approach using a proportionate draw assumption is a common one used in CON impact analyses. In effect, it assumes that the existing providers who are currently serving the largest share of the market would be the ones most affected by the addition of a new competitor in the market, i.e., lose the most volume.

The volume impact analysis focuses on the second year of operations for SBH, when it has achieved a utilization rate of 17,100 patient days, or 65% of 72 beds. SBH has indicated that it would expect higher utilization in the third year, but did not provide a third year projection[12]. Of course, to the extent that utilization of SBH is higher than the second year projection in the second or subsequent years, the impact would be greater.

Because the applicant did not provide a projection of cases by payor,[13] this analysis makes a couple of assumptions to derive an estimate of SBH cases by payor. Because SBH used the same charge per day for all payors ($1,578) and provided a breakout of charges by payor, it was possible to derive an estimate of the number of patient days by payor. To convert patient days by payor to cases by payor, an estimate of average length of stay by payor is needed. For this average length of stay by payor, the nationwide SBH average length of stay by payor was used.[14] There was also a slight adjustment required to tie to the 1,859 total cases projected by SBH in Year Two.[15] The resulting estimate of SBH Year Two cases by payor appears in **Exhibit 20**.

Exhibit 21 presents the estimate of lost cases from Woodridge under the assumption that cases are lost by existing providers in proportion to existing market share by payor across either the SBH defined service area or the larger alternate service area. As shown, the total number of cases lost is estimated at 1,084. Thus even if SBH were to draw patients only from its defined service area, the number of cases lost by Woodridge would be large, almost 27% percent, of the 2014 volume of 4,081 cases.

If the alternate service area is used for the analysis, the volume impact on Woodridge is 1,185 lost cases.

Financial Impact

The applicant did not adequately assess or consider the impact of the proposal on similar services supported by state appropriations. SBH noted that the State closed Lakeshore Mental Health Institute in Knoxville in 2012, which served northeast Tennessee, including Sullivan and

[12] See Garone deposition, p.138-139, and Shaheen deposition, p. 111.
[13] Based on discovery documents and depositions of Garone and Sheehan, it is clear that the applicant did not perform any such analysis, nor did its expert witness. See SBH Response to MSHA's First Set of Interrogatories, #8(b), p. 8.
[14] See SBH Response to MSHA's First Set of Interrogatories, #10, p. 8.
[15] SBH Response to MSHA's First Set of Interrogatories, #11, p. 9.

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Hawkins counties in the proposed SBH service area. However, SBH failed to acknowledge that the State then expanded its contracts with Woodridge and two other facilities (Ridgeview Psychiatric Hospital in Oak Ridge and Peninsula Hospital in Louisville) to provide services for uninsured patients. SBH should have assessed the likely impact on Woodridge of its proposed facility.

Because it carved Woodridge out of its defined service area, the applicant ignored the significant impact on Woodridge. The loss of insured patients to a new SBH facility would have a significant adverse impact on Woodridge, given that it has accepted an additional financial burden of uninsured patients, only partially subsidized by the State. In the face of a new, for-profit competitor located in its service area, Woodridge would still be the facility receiving indigent cases from SBH's Tennessee service area (however defined), but would have a much smaller base of insured patients to support its operations.

To quantify the potential negative impact on Woodridge, a contribution margin analysis was developed, based on cost accounting information from Woodridge. ***By definition, contribution margin per unit is equal to the net revenue per unit minus the variable cost of producing the unit of service.*** This standard business concept is useful in assessing the impact of the loss of a portion of service volume. While the loss of volume would reduce a provider's net revenue, it could, theoretically at least, result in savings for costs that vary with volume, i.e., variable costs. Such costs could include a portion of labor costs (assuming staffing could be reduced) and a portion of supply or other costs that are directly related to patient volume.

The contribution margin is the amount that is available to help cover the fixed costs of providing the service or of covering costs for other services. Fixed costs include such categories as fixed staffing requirements, insurance, depreciation, rent, utilities, and other costs that do not vary, over a reasonable range, with patient volume. In summary, the higher the net revenue and the lower the variable cost, the higher the contribution margin will be.

For psychiatric services, fixed costs are typically a large percentage of total costs. For example, there are significant staffing costs, including management and clinical staff to operate even at minimal patient volume. Certain staffing costs were fixed in the SBH CON application, for example, because they represent a core staffing level required to operate the facility on a full-time basis. On the other hand, supply expense was assumed to be variable in the pro formas. Overall, between Year One and Year Two of the CON pro forma, total expenses increased by 49.1%, while the volume of patient days nearly doubled, at 96.6%. This relationship suggests approximately 50% of expenses were projected as variable for CON purposes.

For the analysis of contribution margin for Woodridge, FY 2014 reports (the most recent available) from the hospital's cost accounting system were used as a foundation. These reports were run to aggregate inpatient cases and costs by payor so that a payor level analysis could be performed. Costs in the report were identified as direct (can be associated with patient care directly) or indirect (typically overhead, administrative or other costs that are difficult to tie directly to patient care). With further analysis and discussion with MSHA staff, DKC Consulting identified the portion of direct and indirect costs that could reasonably be considered variable. In summary, variable costs included:

- Variable portion of direct salaries with associated benefits, with variable at 68.1% of total direct salaries
- Direct supplies at 100% variable
- Variable portion of direct other expenses (e.g., insurance, maintenance, travel, recruitment, utilities, food) at 54.5% of total direct other expenses
- Variable portion of indirect salaries and nonsalaries at 27.5% of indirect salaries and nonsalaries

Costs that were considered fixed, i.e., not likely to decline with volume changes included:

- Direct depreciation
- Direct professional fees
- Indirect depreciation, amortization, interest
- Indirect hospital-supported clinic expense

The resulting cost allocation between fixed and variable is shown on **Exhibit 22** and indicates that approximately 45% of total inpatient costs were assigned as variable. It should be noted that cost behavior in the face of a loss of volume is likely to vary from one organization to the next. In general, costs can be described as "slippery" on the upside and "sticky" on the downside." In other words, organizations may be quicker to take on costs as volume increases than to cut costs as volume declines. Hospitals are often reluctant to cut back on staffing, in particular, because of the potential difficulty of replacing staff if volume increases and because of the negative community reaction to any cutbacks. Assigning 68% of direct salary costs as variable is a "liberal" assumption, in that it suggests that direct staffing, including nurses and techs, is largely variable. In reality, it would be very difficult to flex staffing with that degree of precision, and the organization would risk permanently losing staff whose hours decreased.

The product of the cost allocation analysis is an estimate of the contribution margin per case by payor as shown on **Exhibit 23**. As can be seen on the exhibit, indigent patients have a negative contribution margin, meaning that the minimal revenue received does not cover even the variable cost of caring for the patient. Commercially insured patients, of course, have a much higher contribution margin than others.

The estimated financial impact is calculated by multiplying the number of cases assumed to be shifted to Woodridge by the average contribution margin per case for Woodridge. **Exhibit 24** presents the financial impact calculations based on the second year volume of SBH - Kingsport, assuming the proportional distribution of impact described above. There are four scenarios presented in the exhibit:

A.1. Assumes cases come from the SBH-defined service area with payor mix per the CON (5% indigent)

A.2. Assumes cases come from the SBH-defined service area with 0% indigent care

B.1. Assumes cases come from alternate service area with payor mix per CON (5% indigent)

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B.2. Assumes cases come from alternate service area with 0% indigent care

As shown, the impact ranges from approximately $1.51m to $1.92m under these scenarios. It is important to note the following:

1) The impact shown is an annual impact. The full impact would be cumulative over time.

2) The impact analysis is based on the second year of operations for SBH-Kingsport, when the facility is operating at only 65% occupancy. As its utilization increases in subsequent years, as SBH expects it to do, the impact on Woodridge can be expected to grow.

3) The analysis assumes that any indigent cases taken from Woodridge would reduce the negative impact because of their negative contribution margin. Because there is reason to question SBH's projection of 5% indigent care, scenarios A.2. and B.2. were included to show the even greater impact each year if SBH provides no indigent care.

In any scenario, the financial impact on Woodridge will be significant. In 2014, Woodridge experienced an operating income of approximately $99,121. For eleven months ended in May 2015, Woodridge has experienced a net operating loss of ($624,938). The loss of at least $1.51 to 1.91 million in contribution margin per year would represent a major challenge to the ability of Woodridge to support the full range of its current services, especially in today's environment of federal and state budgetary pressures to reduce/control health care payments.

SBH's expert maintains that "MSHA and Johnson City Medical Center have the financial strength to absorb the limited loss of patients and revenues that MSHA assumes will result from SBH's operations."[16] Mr. Sullivan points to the asset base of MSHA to support his argument, but fails to note that MSHA has a high debt load and is considered highly leveraged by the ratings agencies. The financial statement for the first nine months of FY 2015 for MSHA, included as Exhibit 26b of Mr. Sullivan's submission, shows long term debt of more than $1 billion, total liabilities of $1.3 billion, and net assets of only $761 million, a debt to equity ratio of approximately 1.7 X.

In March 2015, Moody's Investor Services affirmed a Baa1 rating on MSHA's outstanding debt. Moody's summarized the rating rationale as follows:

> *The Baa1 rating reflects improved financial performance demonstrated by this large multi-hospital system in eastern Tennessee and southeastern Virginia. Performance is showing good momentum with stronger results through the first half of FY 2015 given a re-invigorated focus on operations, expense management and physician relations under the direction of a new CEO and engaged Board. The rating also incorporates the organization's leading market position in Johnson City and the expansive 29-county service area.*

[16] Sullivan Report, p. 32.

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> *These attributes are mitigated by the organization's leverage position which is very high and unfavorable to Moody's medians. Management is endeavoring over the next several years to de-leverage the system with increased cash flow and a new debt reduction strategy. Above average exposure to Medicare and Medicaid is also a credit risk.*[17]

Although MSHA has demonstrated improved performance, this does not mean that Woodridge can absorb a negative impact of the magnitude estimated here without serious adverse consequences, including the possibility of cutting back subsidized services within Woodridge or elsewhere in MSHA.

Summary

The proposed SBH project does not conform to the standards and criteria for need found in the *Guidelines for Growth, 2000 Edition.* The proposed service area is unreasonable and arbitrarily excludes Woodridge and other providers from its assessment of need. The project is not sized appropriately for the need that exists within the larger, more reasonable, alternate service area.

The project would not improve accessibility of services for underserved populations. In fact, to the extent that SBH targets insured patients that would otherwise have utilized Woodridge, it could reduce Woodridge's ability to subsidize its uninsured patients.

The utilization projections for the proposed facility are not supported by an appropriate service area market analysis; consequently, the utilization projections remain unsupported and economic feasibility cannot be demonstrated.

The project would not contribute to the orderly development of adequate and effective health care services and facilities. Finally, the proposed hospital represents an unnecessary and duplicative service that would have a significant adverse impact on Woodridge.

[17] Moody's Investors Service, Rating Action: Moody's affirms Mountain States Health Alliance's (TN) Baa1, www.moodys.com/research.

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Appendix A:

Resume

dkc consulting

DEBORAH KOLB COLLIER, PH.D.
DKC CONSULTING L.L.C.

WORK EXPERIENCE

2009-present	*Owner* DKC Consulting L.L.C. Atlanta, Georgia	1985-2002	*Executive Vice President* Jennings Ryan & Kolb Atlanta, Georgia
2004-2009	*Senior Principal* Noblis Norcross, Georgia	1979-1985	*Vice President, Manager of Consulting Services* Amherst Associates Inc. Atlanta, Georgia
2002-2004	*Executive Vice President* Cross Country Healthcare - Jennings Ryan & Kolb Atlanta, Georgia	1976-1977	*Instructor* University of North Carolina Department of English Chapel Hill, North Carolina

EDUCATION

- Master of Business Administration, *University of North Carolina at Chapel Hill*
- Doctor of Philosophy, English, *University of North Carolina at Chapel Hill*
- Bachelor of Arts, English, Summa Cum Laude, *University of Georgia, Athens, Georgia*

ORGANIZATIONS AND AWARDS

- Beta Gamma Sigma (Honorary Business)
- Phi Beta Kappa
- Recipient of Follmer Bronze, Reeves Silver, and Muncie Gold Merit Awards, presented by Healthcare Financial Management Association and Former Board Member, GA Chapter, HFMA

PROFESSIONAL EXPERIENCE

- Testified as expert witness in many Certificate of Need hearings. Accepted as an expert in health care planning and health care finance.
- Facilitated retreats for hospitals, physicians and boards of trustees, for the purpose of establishing mission, vision, and goal statements, and other strategic planning purposes.
- Conducted many educational sessions for Trustees, physicians, and hospital leader on industry trends and the future of health care.
- Led scenario planning and other planning exercises to engage Trustees and health care leaders in competitive strategy development.
- Assisted clients by clarifying and helping to structure the decision-making process in complex and difficult situations.
- Advised affiliation/acquisition/merger processes for clients in the Southeast.

PROFESSIONAL EXPERIENCE (CONTINUED)

- Directed the development of strategic plans for community hospitals and systems. Activities in the planning process have included:
  - Strategic issue identification, conceptualization of approach for identifying potential solutions
  - Market analysis and demand forecasting
  - Interviewing key stakeholders including senior management, board members, physicians, community leaders
  - Online surveys of key stakeholders
  - Portfolio assessment
  - Financial assessment
  - Formulation of vision and priorities
  - Definition of goals
  - Identification of measures of success
  - Development of action plans and resource requirements
  - Delineation of available strategies
  - Evaluation of alternative organizational structures
  - Facilitation of client meetings throughout the planning process (management groups, Board committees, steering committees, etc.)
  - Development of effective materials and frameworks to support key decisions
- Directed physician workforce assessments to determine community and organizational need for primary care and specialty services.
- Prepared more than 100 Certificate of Need applications for hospital services, including:
  - bed expansions and relocations
  - new hospitals
  - rehabilitation
  - home health
  - obstetrics and neonatal services
  - psychiatric
  - CT, MRI, and PET scanners
  - ambulatory surgery
  - cardiac catheterization
  - open heart surgery
  - CyberKnife™ and other radiation oncology services
  - Long Term Acute Care Hospitals

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Professional Experience (Continued)

- Advised hospitals in the development of diversification options including surgi-centers, urgent care centers, extended care, and home health.
- Prepared financial feasibility studies for hospitals involved in major capital financing projects.
- Served on the following Technical Advisory Committees by the Georgia State Health Planning Agency (now Division of Health Planning) and the Georgia State Health Policy Council:
  - Acute Care Hospital Services
  - Cardiovascular Services
  - Perinatal Services
- Provided strategic and business planning assistance for a variety of product lines, including:

- oncology	- orthopaedics
- home health	- neurosciences
- hospice	- obstetrical and neonatal services
- ambulatory surgery	- primary care networks
- laser surgery	- MRI and other diagnostic imaging
- cardiac and vascular services	- rehabilitation
- psychiatric services	- diabetes
- pediatrics	- transplant services

Selected Publications

- Collier, Deborah K., Dennis Kennedy, and Scott Clay, "Financial Implications of Moving to a Physician Employment Model," *Healthcare Financial Management,* April 2009.
- Collier, Deborah K., Scott Clay, and Peter Bruton, "Beyond and Behind the Ratios: How to Manage Your Credit Ratings," Strategic Financial Planning, HFMA, Fall 2008.
- Collier, Deborah K. and Kathleen Henchey, "Medical Staff Recruitment Planning under Stark," *Hospitals and Health Networks* On-Line, July 29, 2008.
- Collier, Deborah K., Scott Clay, and Peter Bruton, "What Hospital Systems Can Do to Ride Out the Financial Market Turbulence," HealthLeaders Media, March 17, 2008.
- Collier, Deborah K., Scott Clay, and Ed Ollie, "Defending A+: How to Maintain a High Credit Rating During a Facilities Overhaul," *Healthcare Financial Management*, November 2007.
- Kolb, Deborah, "Financial Planning in An Era of Uncertainty," *Georgia Scroll*, July 2002.
- Kolb, Deborah, co-author of a chapter in *Health Care Strategy for Uncertain Times*, AHA Press/Jossey-Bass, October 2000.
- Kolb, Deborah, and Scott Clay, "Scenario Planning," *The Alliance Report,* August 2000.
- Kolb, Deborah, and Scott Clay, "Clinical Staffing Needs in a Managed Care Environment," *Managed Care Perspectives: A Series of Reference Tools for the Healthcare Professional*, 1998.
- Kolb, Deborah, and Judith E. Belt, "Is the Medicare SELECT program a Stepping Stone to Managed Care," *Healthcare Financial Management*, October, 1997.

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Selected Publications (Continued)

- Kolb, Deborah, J. Bruce Ryan, Peter F. Straley, and Lou Gapenski, "Capitation and Risk Sharing," *Understanding Healthcare Financial Management*, 2nd edition, 1996.
- Kolb, Deborah, Editor, Assessing Organizational Readiness for Capitation, American Hospital Publishing Company, 1996.
- Kolb, Deborah, and Judith L. Horowitz, "Managing the Transition to Capitation," *Healthcare Financial Management*, February 1995, pp 64-69.
- Kolb, Deborah, "Managing the PHO Enrollment Process," *Developing a Successful Physician-Hospital Organization*, American Hospital Publishing Company, 1995.
- Kolb, Deborah, and Scott Baker Clay, "Ambulatory Care Groupings: When, How, and the Impact on Managed Care," *The Journal of Ambulatory Care Management*, Volume 17, Number 1, January 1994.
- Kolb, Deborah, Randall S. Hughes, Esq. and C. Edward Young, Esq. "Economic Credentialing," *Topics in Health Care Financing*, Volume 19, Number 3, Spring 1993, pp. 58-66. (Article also excerpted in Hospital Legal Forms, Checklists, and Guidelines, 1993.)
- Kolb, Deborah, Peter J. Veysey, and Joseph L. Gocke, "Private Long-Term Care Insurance: Will It Work?" *Topics in Health Care Financing*, Volume 15, Number 4, Summer 1991, pp. 9-21.
- Ryan, J. Bruce, Matthews E. Ward, and Deborah S. Kolb. "Capital Management Balances Charitable & Financial Goals," *Healthcare Financial Management*, March 1990 (Winner of the Helen Yerger/L. Vann Seawell Best Article Award for 1989-1990).
- Kolb, Deborah, and Denise H. Jones, "Determining The Feasibility of a Heart Transplant Program," *Healthcare Financial Management*, September 1988, pp. 102-106.
- Kolb, Deborah, and Glenn J. Black, Jr. "The Use of Incremental Financial Analysis to Evaluate Strategies: A Case Study." *Topics in Health Care Financing*, Volume 15, Number 1, Fall 1988, pp. 82-92.
- Kolb, Deborah, "Using Financial Ratio Analysis," *The Georgia Scroll*, July 1988, p. 7.
- Kolb, Deborah, and Armand E. Balsano, "Balancing Efficiency and Effectiveness in Elderly Day Care Programs." *Journal of Ambulatory Care Management*, Volume 11, Number 1, February 1988, pp. 53-62.
- Kolb, Deborah, "Developing a Pricing Strategy for ER Services," *Healthcare Financial Management*, June 1987, pp. 133-134.
- Kolb, Deborah, "Targeting the Elderly," *The Georgia Scroll*, May 1987, pp. 6-8.
- Kolb, Deborah, "Emergency Room Services: A Case Study in Pricing." *The Georgia Scroll*, December 1986, pp. 5-6.
- Kolb, Deborah, and Deborah J. Krueger. "Controlling the Expansion of the Nursing Home Industry: The Effects of Prospective Payment Systems on Capital Formation." *Topics in Health Care Financing*, Volume 10, Number 3 (1984), pp. 77-87.

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Selected Seminars and Presentations

- Louisiana Society for Hospital Public Relations and Marketing, "Strengthening Physician-Hospital Relationships," 2008.
- South Carolina HFMA, "Health Care Industry Trends," 2008.
- Georgia VHA Trustees Institute, "Strategies for Successful Hospital-Physician Alignment," 2006.
- Georgia Hospital Association, Webinar, "Strategies for Successful Hospital-Physician Alignment," 2006.
- Society for Healthcare and Market Development, "Round-Table Leaders: Physician-Hospital Joint Ventures," 2005.
- Alabama HFMA, "Got Money? Integrating Facility, Financial, and Strategic Planning," 2005.
- Virginia HFMA, "Ensuring Long Term Financial Viability," 2003.
- American Association of Integrated Healthcare Delivery Systems, "Managed Care Strategic Planning: A Consultant's Approach," 2003.
- Georgia Hospital Association TelNet, "Service Line Planning," 2003.
- Carolinas Society for Healthcare Planning and Marketing, "Understanding the CFO's Language," 2003.
- Kentucky HFMA, "Is Your Financial Plan Consistent with Your Strategic Plan?" 2003.
- Kentucky HFMA, "Developing Winning Strategies for Service Line Planning," 2003.
- Georgia HFMA, "Are You Headed for a Capital Crisis?" 2002.
- Birmingham Regional Health Executive Forum (ACHE), "Service Line Planning," 2002.
- Alabama HFMA, "Health Care Strategy in Uncertain Times," 2002.
- American College of Healthcare Executives, "Service Line Planning: The Case of the Miami Cardiac and Vascular Institute," 2001.
- Society of Cardiovascular and Interventional Radiology, "Designing a Business Plan to Gain Organizational Support," and "Promoting Your Center Internally and Externally," 2001.
- Georgia Healthcare Financial Management Association, "In Search of Profits: Revenue Returns to the Forefront," 2000.
- National Symposium for Healthcare Executives, "Strategy in the 21st Century: The Reality of Uncertainty," 2000.
- The Duke Endowment, H. Carl Rowland Memorial Library Health Planning Seminar, "Strategy in the 21st Century: The Reality of Uncertainty," 2000.
- South Carolina Health Alliance, "Millennium Trends: Work Force Implications," 2000.
- Dixie Institute, "Millennium Trends: Health Care Industry Trends and the Reality of Uncertainty," 2000.
- UAB National Symposium for Healthcare Executives, "Strategy in the 21st Century: The Reality of Uncertainty," 2000.
- North Carolina Hospital Association, "Co-opetition: A New Attitude," 1999.
- Southeastern Health Law and Policy Forum, "Gainsharing," 1999.
- Healthcare Financial Management Association, Annual National Institute, "Market Positioning Strategies for PSOs," 1998.
- Healthcare Financial Management Association, Annual National Institute, "Remaining Profitable after Acquiring Physician Practices," 1998.

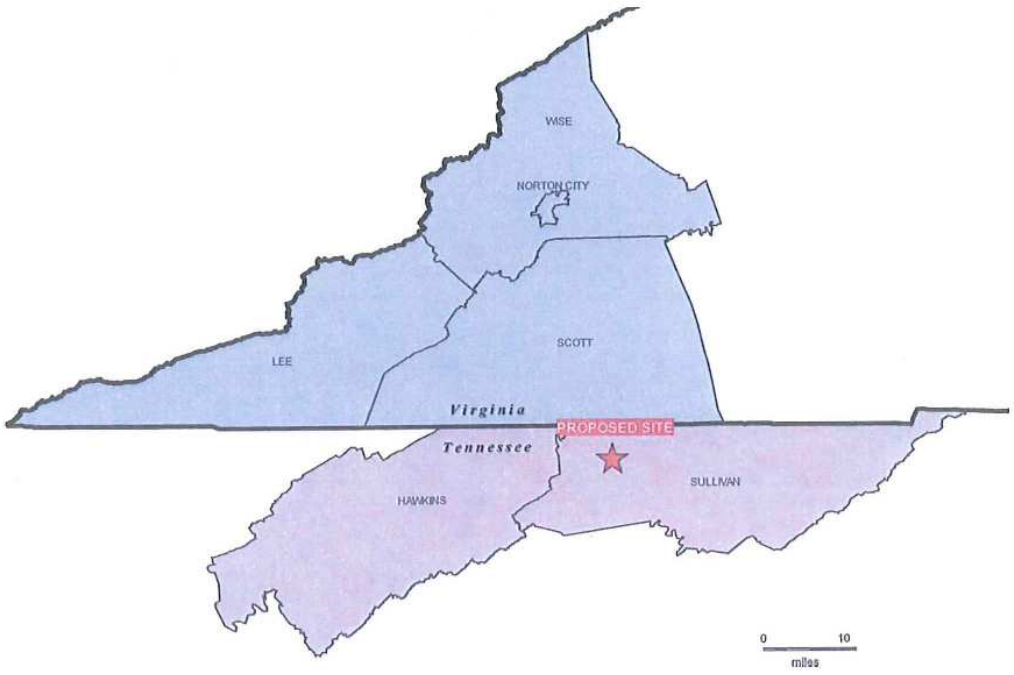
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Appendix B:

Exhibits and Maps

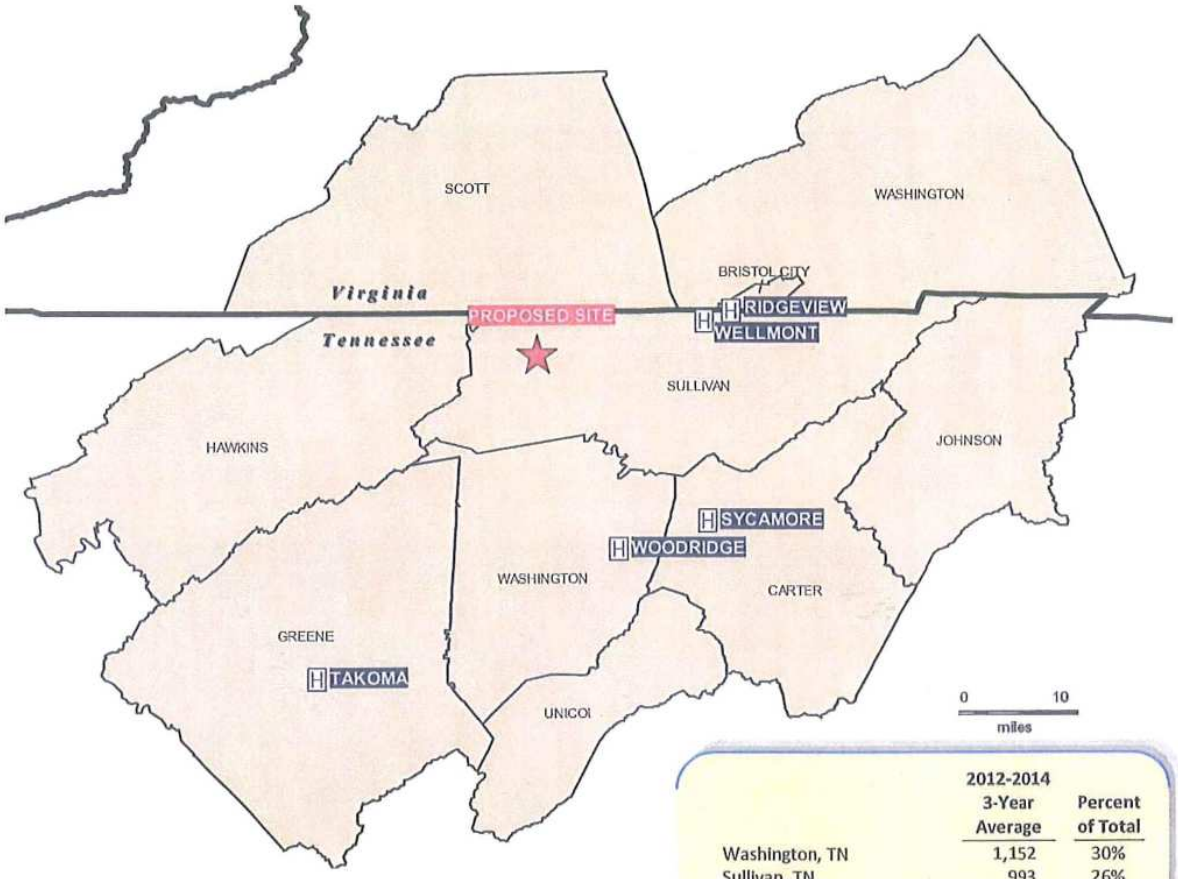
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MAP 1
SBH Proposed Service Area



1

MAP 2
Historical Service Area
Woodridge Psychiatric Hospital



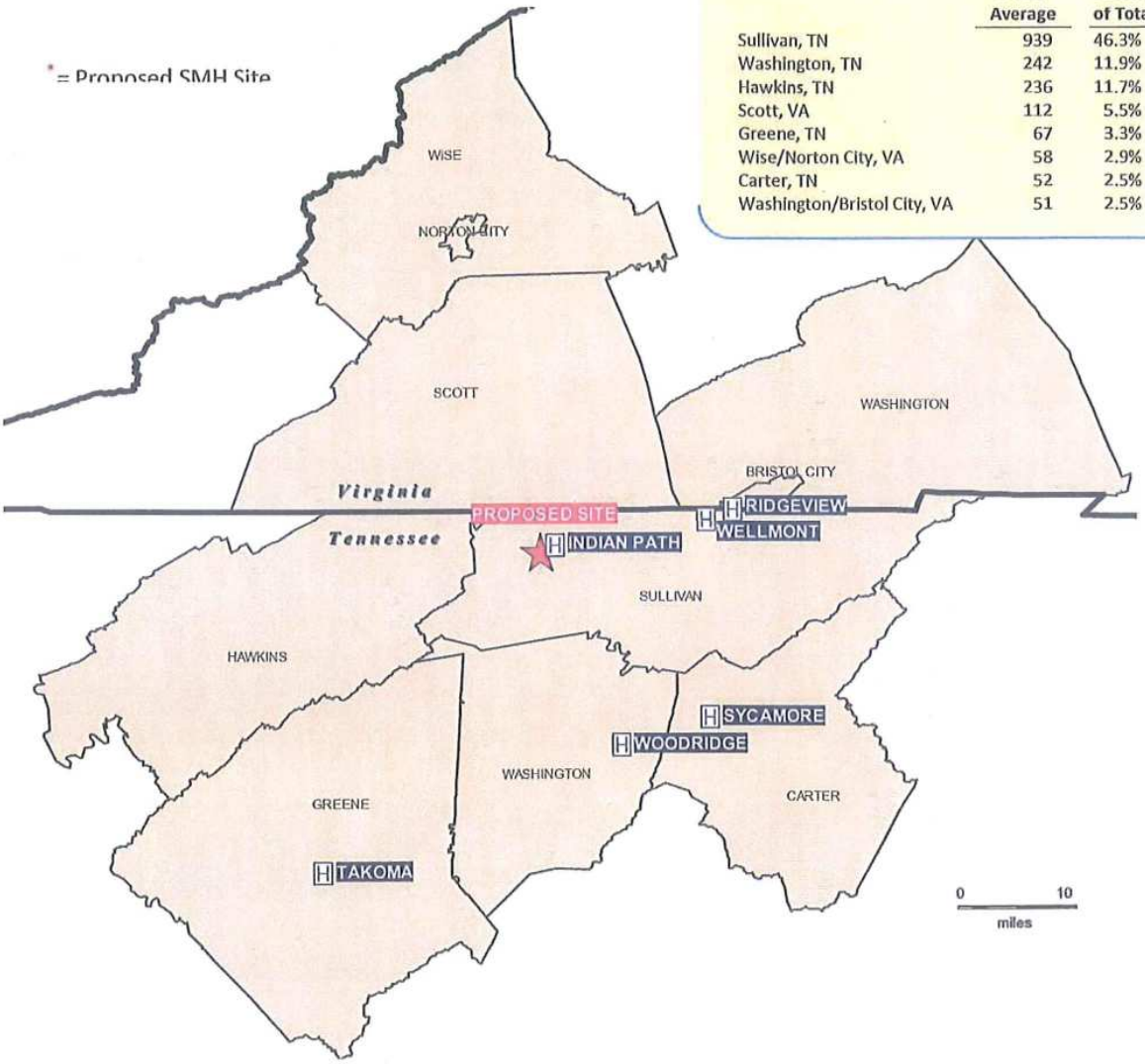
	2012-2014 3-Year Average	Percent of Total
Washington, TN	1,152	30%
Sullivan, TN	993	26%
Carter, TN	363	9%
Greene, TN	291	7%
Hawkins, TN	254	7%
Unicoi, TN	139	4%
Johnson, TN	122	3%
Bristol City/Washington, VA	96	2%
Scott, VA	81	2%

Source: Tennessee Department of Health, Joint Annual Report (JAR), 2012-2014, supplemented by internal MSHA data for "other" Virginia counties on JAR reports.

SBH-KINGSPORT 000162

Map 3
Historical Service Area
Indian Path Psychiatric Pavilion

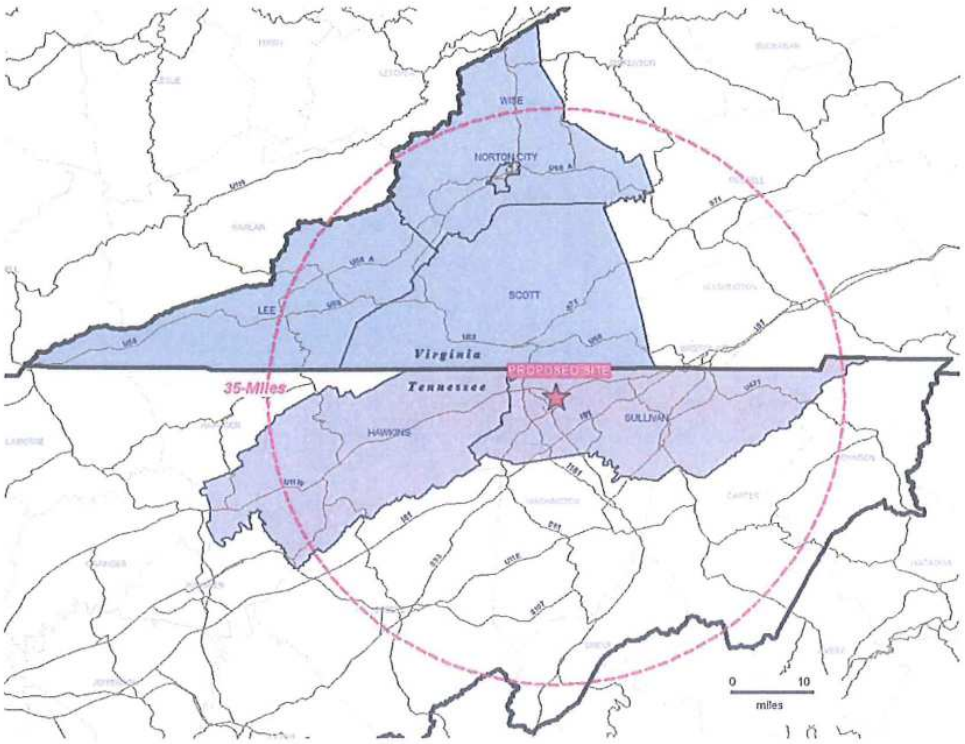
	2007-2009 3-Year Average	Percent of Total
Sullivan, TN	939	46.3%
Washington, TN	242	11.9%
Hawkins, TN	236	11.7%
Scott, VA	112	5.5%
Greene, TN	67	3.3%
Wise/Norton City, VA	58	2.9%
Carter, TN	52	2.5%
Washington/Bristol City, VA	51	2.5%



Source: Tennessee Department of Health, Joint Annual Report (JAR), 2007-2009, supplemented by internal MSHA data for "other" Virginia counties on JAR reports

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MAP 4
SBH Proposed Site
35-Mile Radius Map



4

EXHIBIT 1
Drive Times and Distance to SBH Proposed Site

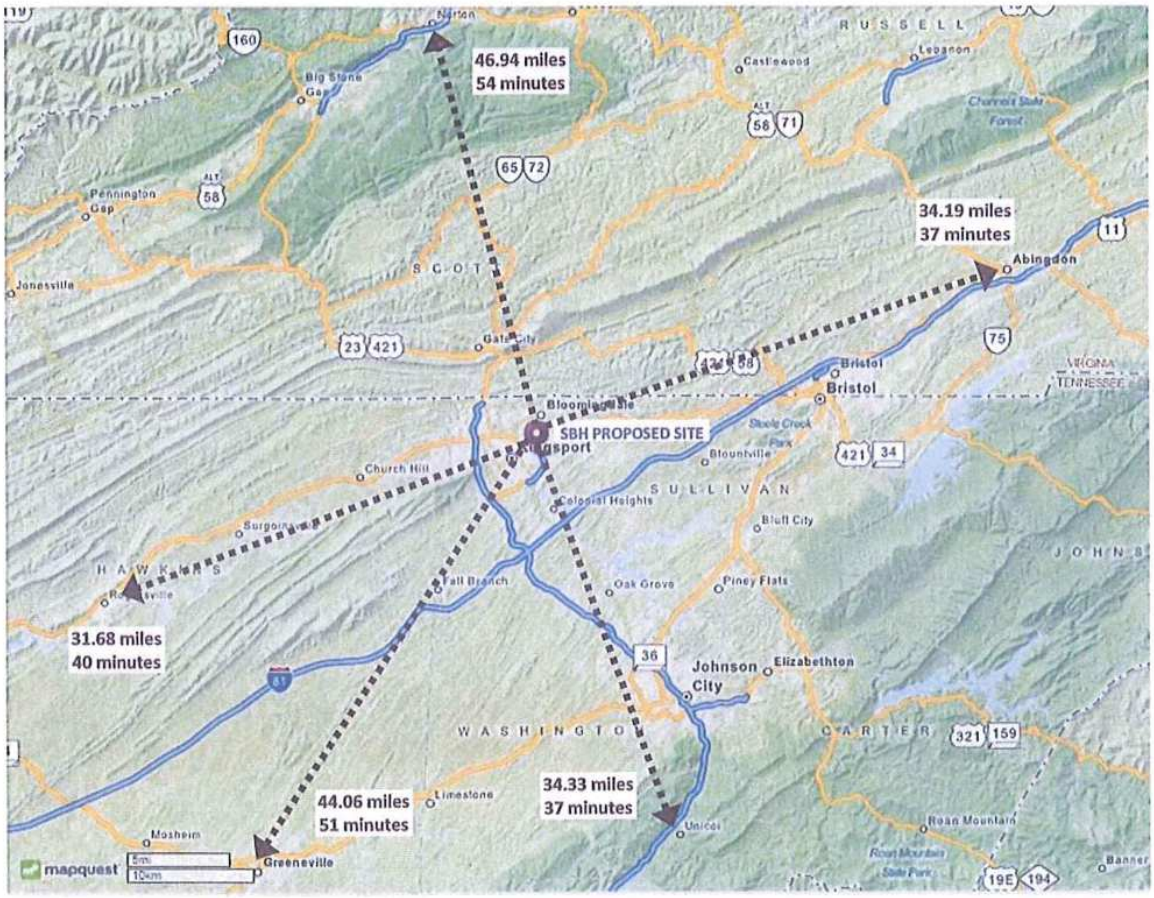
Site		Straight-line Distance	Driving Distance	Drive Time
From:	***Existing Psychiatric Providers in Alternate Service Area:***			
	Clearview Psychiatric Center at RCMC	34.40	52.49	1 hour
	Ridgeview Pavilion	16.86	17.98	22 minutes
	Sycamore Shoals Hospital	20.03	31.01	34 minutes
	Takoma Regional Hospital	32.70	44.62	53 minutes
	Woodridge Psych Hospital	17.65	24.52	29 minutes
From:	***Outlying Cities within the Radius:***			
	Abingdon, VA	31.68	34.19	37 minutes
	Greenville, TN	32.11	44.06	51 minutes
	Norton, VA	27.39	46.94	54 minutes
	Rogersville, TN	29.13	31.68	40 minutes
	Unicoi, TN	25.99	34.33	37 minutes

Source: MapQuest, 2015.

MAP 5

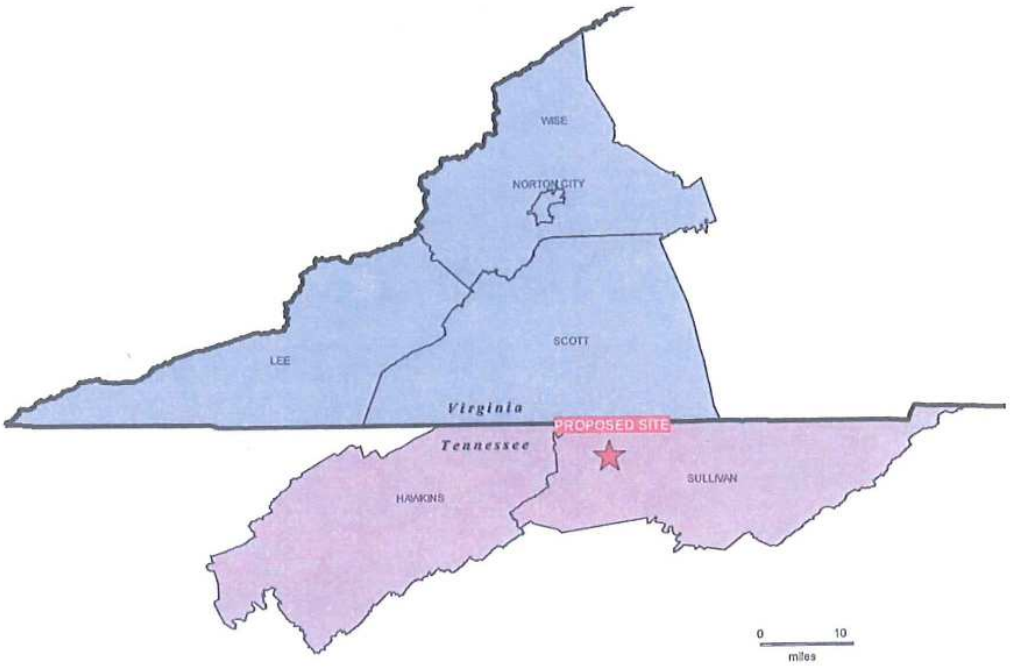
Drive Times

from Outlying Cities within the Radius to SBH Proposed Site



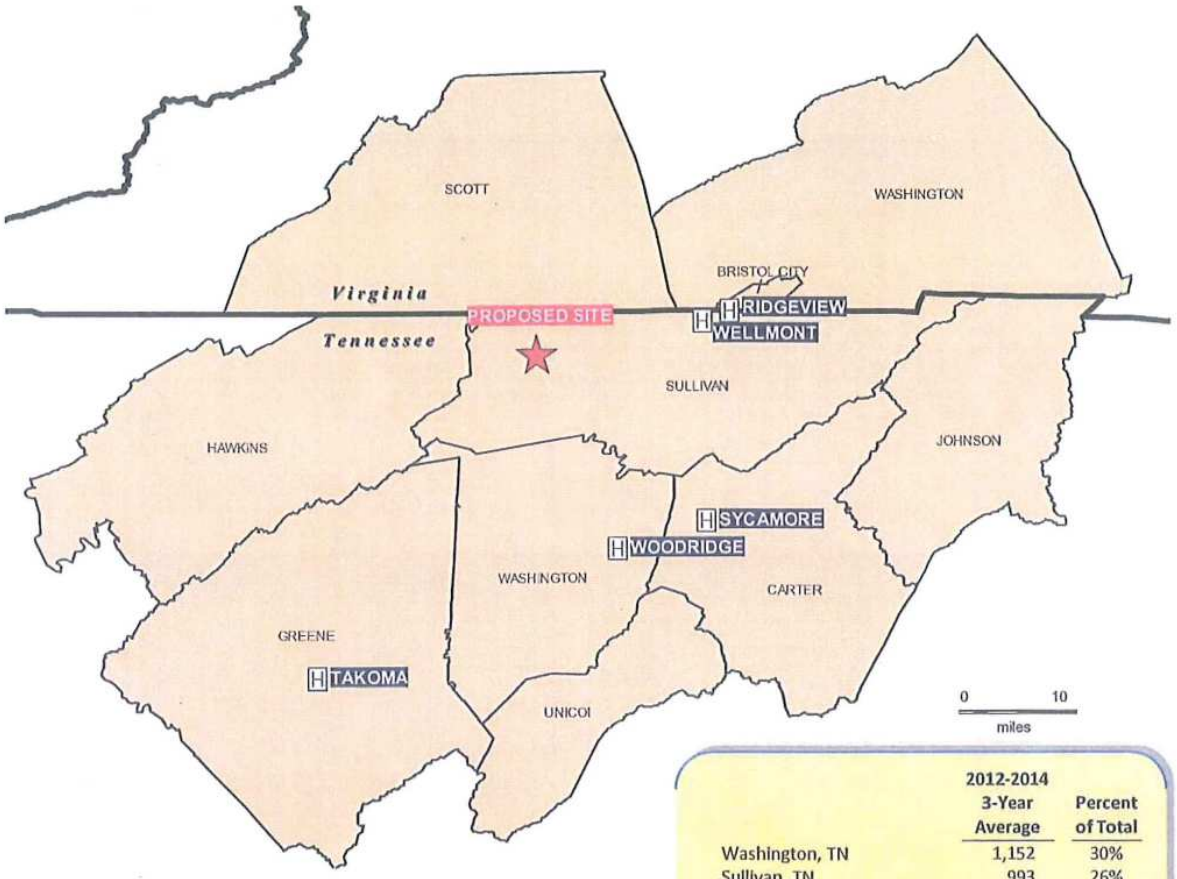
MAP 1

SBH Proposed Service Area



1

MAP 2
Historical Service Area
Woodridge Psychiatric Hospital



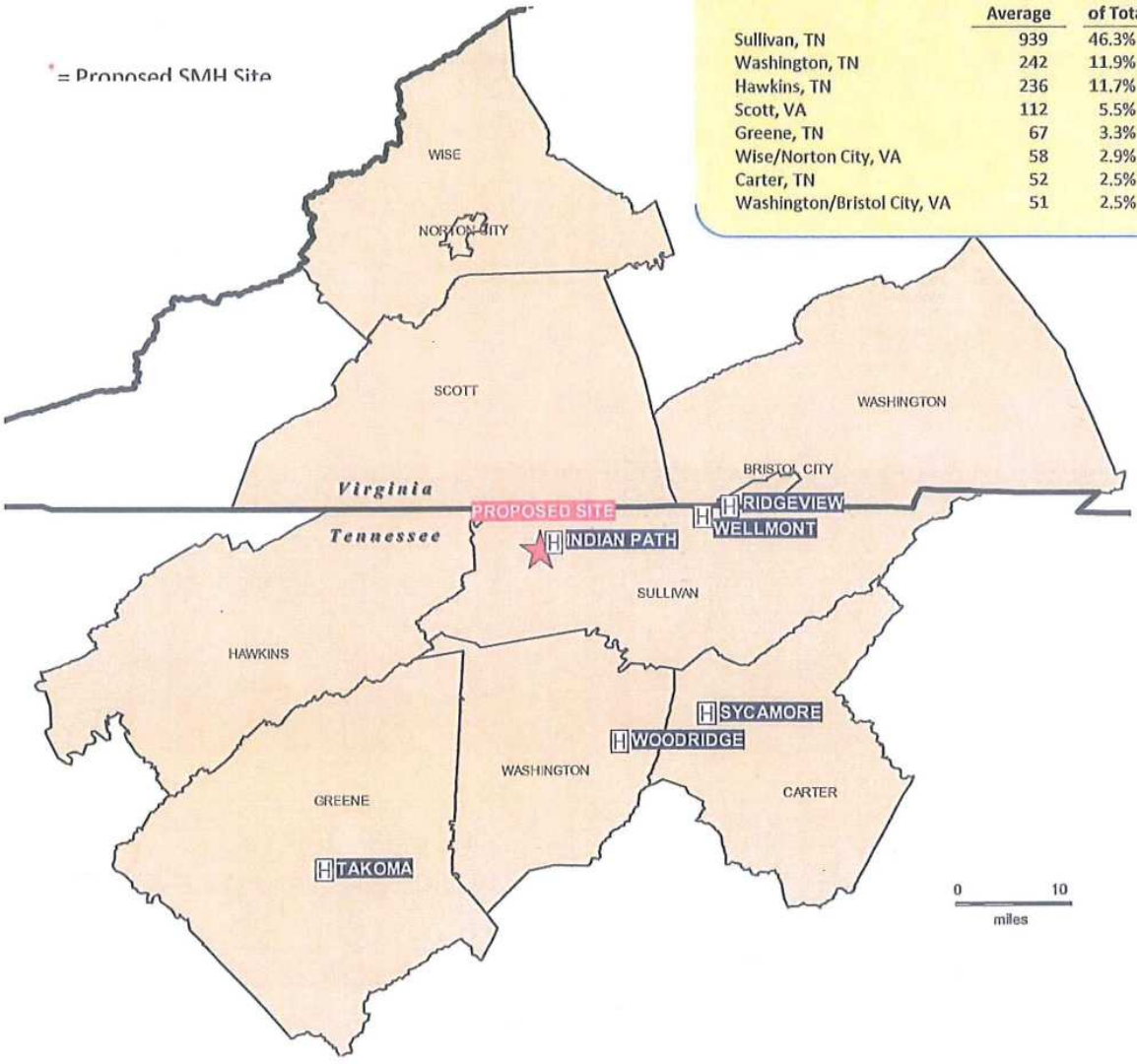
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Source: Tennessee Department of Health, Joint Annual Report (JAR), 2012-2014, supplemented by internal MSHA data for "other" Virginia counties on JAR reports.

SBH-KINGSPORT 000168

Map 3
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Indian Path Psychiatric Pavilion

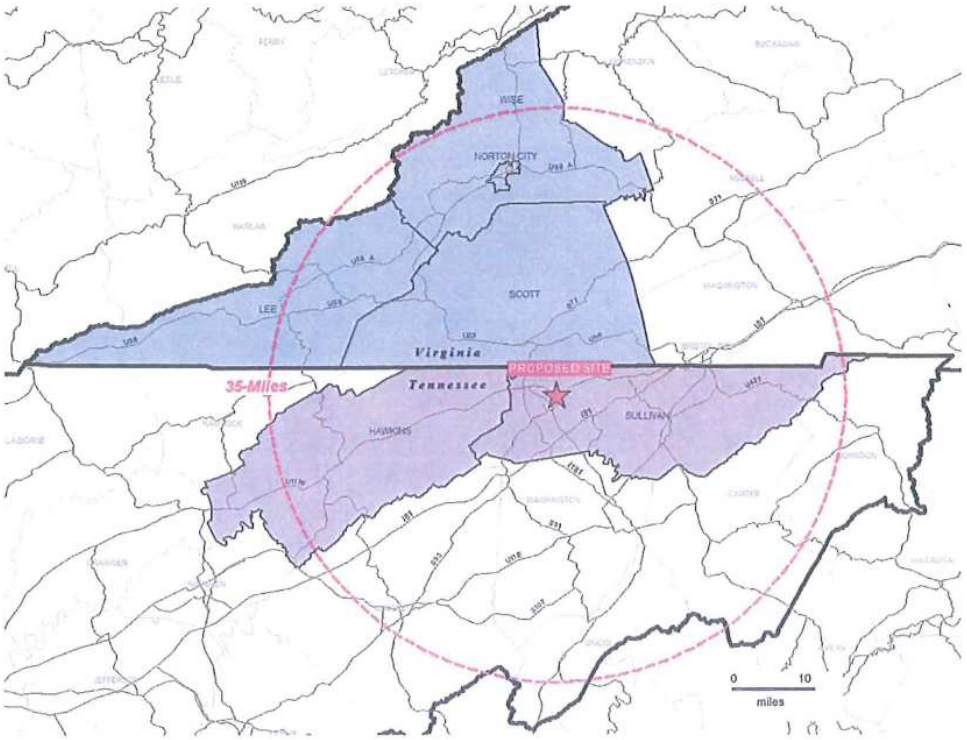
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Washington/Bristol City, VA	51	2.5%



Source: Tennessee Department of Health, Joint Annual Report (JAR), 2007-2009, supplemented by internal MSHA data for "other" Virginia counties on JAR reports

SBH-KINGSPORT 000169

MAP 4
SBH Proposed Site
35-Mile Radius Map



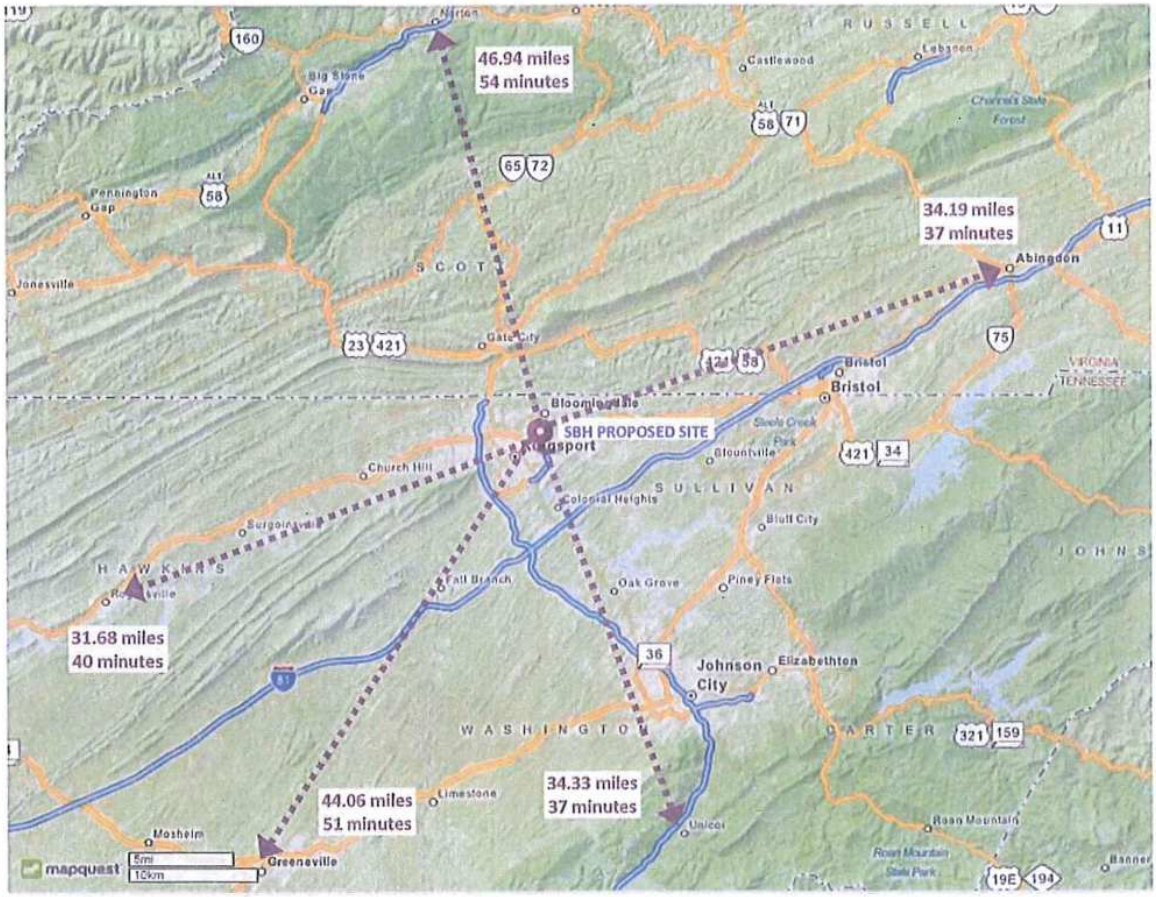
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EXHIBIT 1
Drive Times and Distance to SBH Proposed Site

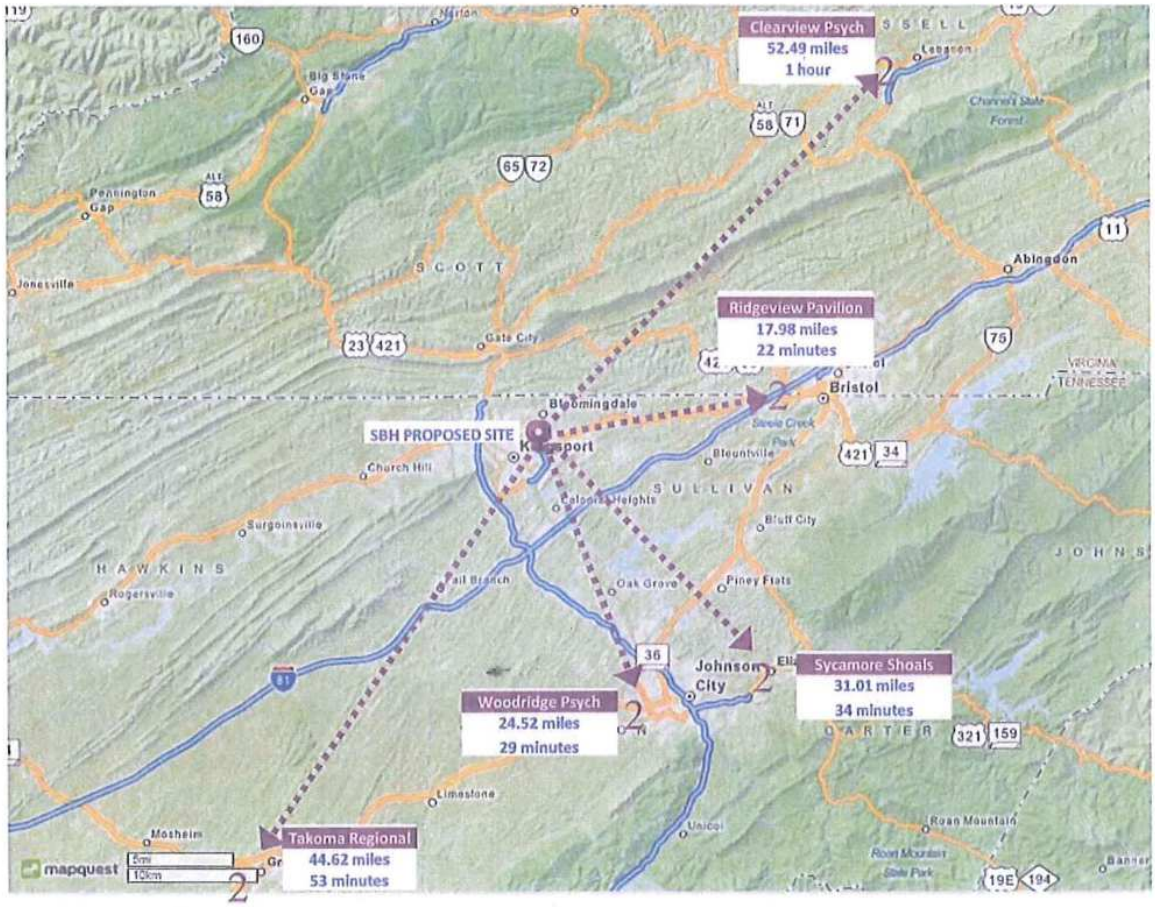
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	Unicoi, TN	25.99	34.33	37 minutes

Source: MapQuest, 2015.

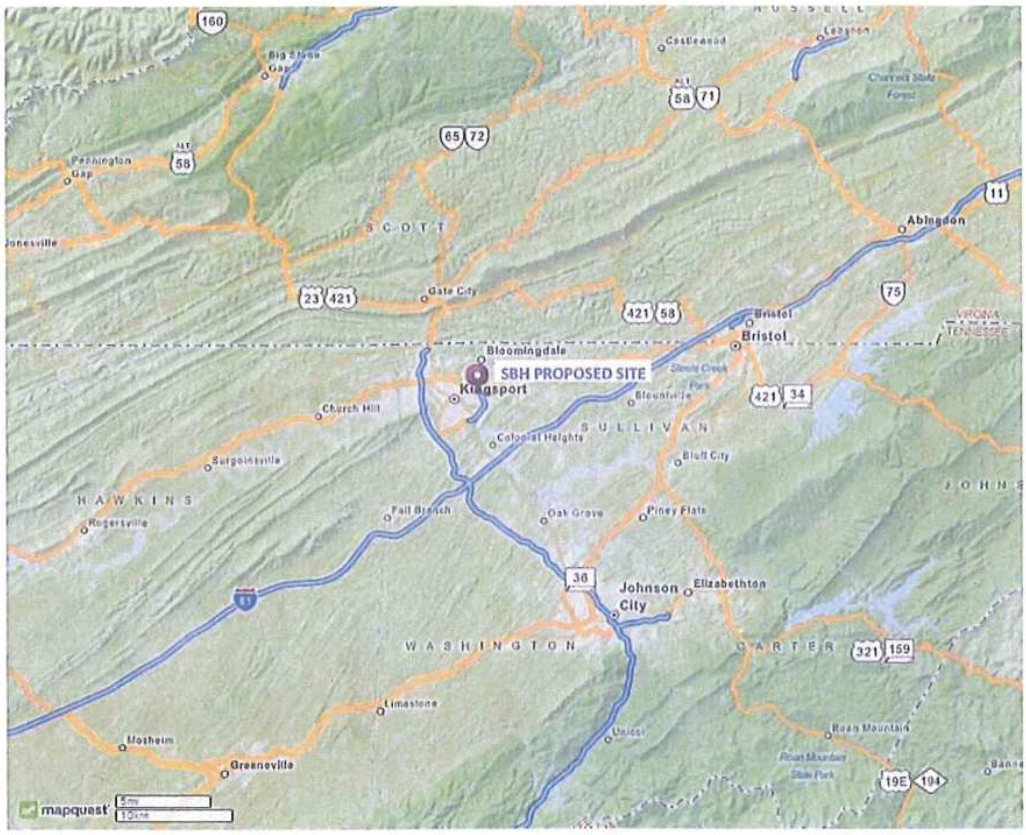
MAP 5
Drive Times
from Outlying Cities within the Radius to SBH Proposed Site



MAP 6
Drive Times
from Existing Psychiatric Providers to SBH Proposed Site

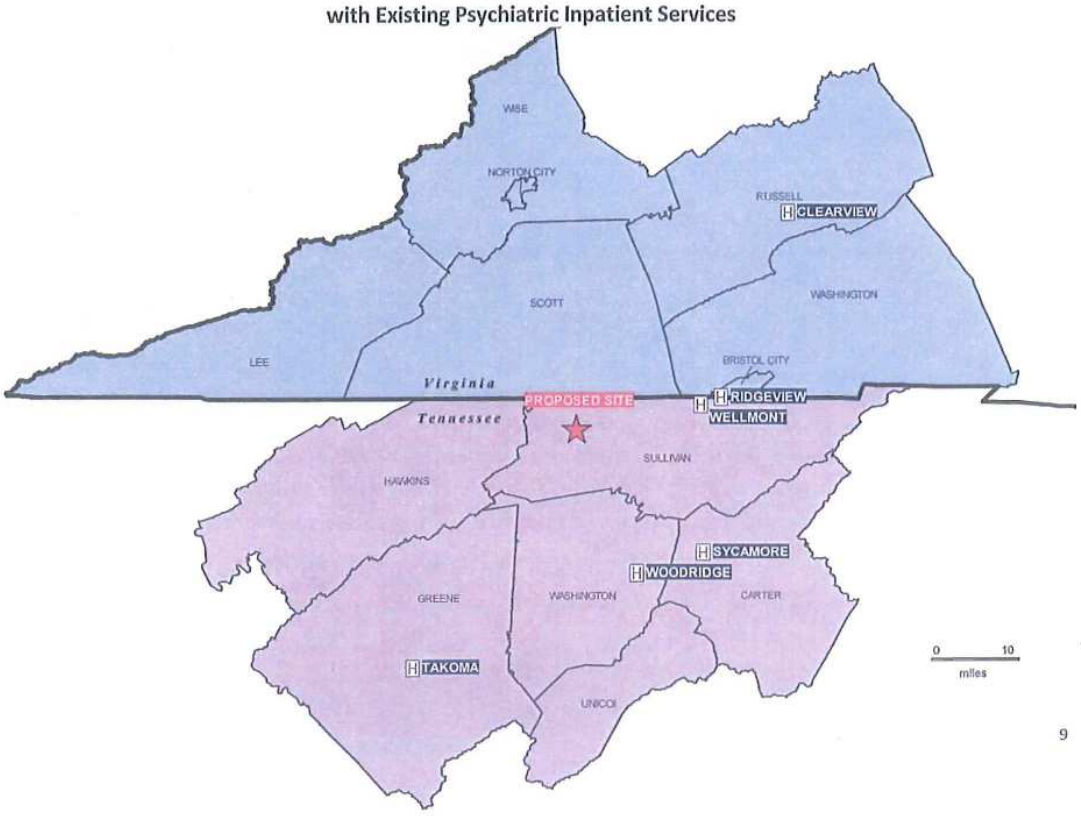


MAP 7
SBH Proposed Site
and Surrounding Topography



Source: MapQuest, 2015.

MAP 8
Alternate Service Area Map
with Existing Psychiatric Inpatient Services



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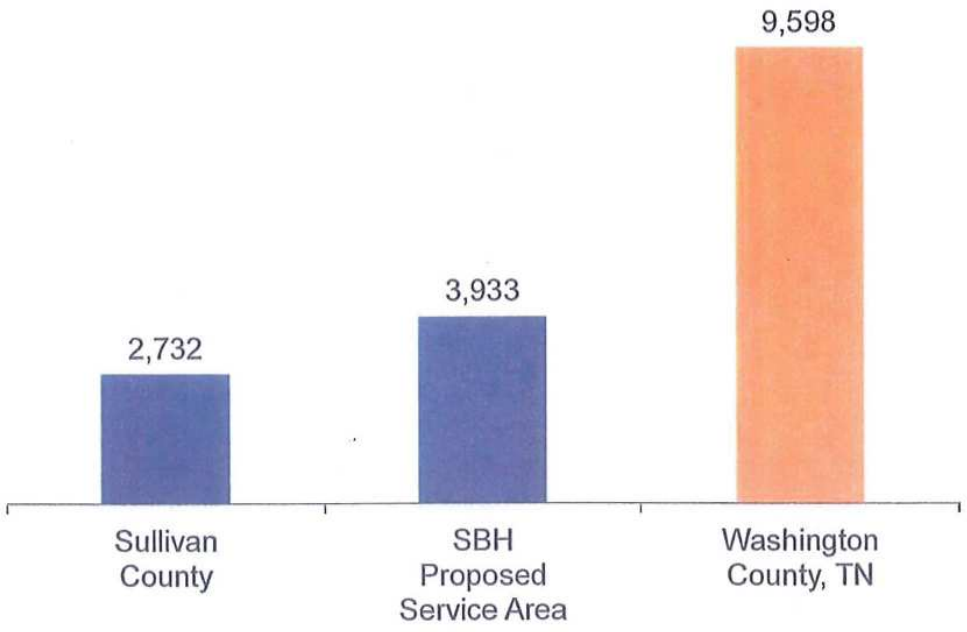
EXHIBIT 2
Area Population Trends
Total Population by County

County	2014	2019	Increase	Percent Change
SBH Proposed SA				
Sullivan	158,975	161,707	2,732	1.7%
Hawkins	57,509	58,241	732	1.3%
Subtotal TN	**216,484**	**219,948**	**3,464**	**1.6%**
Scott	22,682	22,927	245	1.1%
Lee	25,166	25,078	(88)	(0.3%)
Wise*	44,651	44,963	312	0.7%
Subtotal VA	**92,499**	**92,968**	**469**	**0.5%**
TOTAL SBH PROPOSED SERVICE AREA	**308,983**	**312,916**	**3,933**	**1.3%**
Additional Counties in Alternate SA				
Washington	130,586	140,184	9,598	7.3%
Carter	57,284	57,828	544	0.9%
Greene	70,187	71,989	1,802	2.6%
Unicoi	18,376	18,558	182	1.0%
Subtotal Additional TN	**276,433**	**288,559**	**12,126**	**4.4%**
Washington**	72,721	75,249	2,528	3.5%
Russell	28,362	28,922	560	2.0%
Subtotal Additional VA	**101,083**	**104,171**	**3,088**	**3.1%**
TOTAL ADDITIONAL SERVICE AREA	**377,516**	**392,730**	**15,214**	**4.0%**
TOTAL ALTERNATE SERVICE AREA	**686,499**	**705,646**	**19,147**	**2.8%**

*including Norton City
**including Bristol City
Note: Virginia population interpolated based on 2013-2020 AAGR.
Sources: Tennessee Department of Health Statistics, Population Estimates and Projections, 2010-2020.
Weldon Cooper Center for Public Service, University of Virginia, Population Estimates and Projections, 2010-2013 and 2020.

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EXHIBIT 3
Comparison of Changes in Total Population between 2014 and 2019



Note: Virginia population interpolated based on 2013-2020 AAGR.
Sources: Tennessee Department of Health Statistics, Population Estimates and Projections, 2010-2020.
Weldon Cooper Center for Public Service, University of Virginia, Population Estimates and Projections, 2010-2013 and 2020.

EXHIBIT 4
Area Population Trends
Child and Adolescent Population

County	2014	2019	Increase (Decrease)	Percent Change
SBH Proposed SA				
Sullivan				
0-4	6,826	5,203	(1,623)	(23.8%)
5-12	13,018	9,807	(3,211)	(24.7%)
13-17	9,575	8,543	(1,032)	(10.8%)
Total Child/Adoles.	**29,419**	**23,553**	**(5,866)**	**(19.9%)**
Hawkins				
0-4	2,454	1,877	(577)	(23.5%)
5-12	5,096	3,733	(1,363)	(26.7%)
13-17	3,751	3,379	(372)	(9.9%)
Total Child/Adoles.	**11,301**	**8,989**	**(2,312)**	**(20.5%)**
Scott				
0-4	1,100	1,032	(68)	(6.2%)
5-14	2,398	2,438	40	1.7%
15-19	1,218	1,206	(12)	(1.0%)
Total Child/Adoles.	**4,716**	**4,676**	**(40)**	**(0.8%)**
Lee				
0-4	1,304	1,259	(45)	(3.5%)
5-14	2,723	2,743	20	0.7%
15-19	1,320	1,340	20	1.5%
Total Child/Adoles.	**5,347**	**5,342**	**(5)**	**(0.1%)**
Wise*				
0-4	2,369	2,369	0	0.0%
5-14	5,120	5,188	68	1.3%
15-19	2,845	2,860	15	0.5%
Total Child/Adoles.	**10,334**	**10,417**	**83**	**0.8%**
TOTAL SBH PROPOSED SERVICE AREA				
0-4	14,053	11,740	(2,313)	(16.5%)
TN 5-12	18,114	13,540	(4,574)	(25.3%)
13-17	13,326	11,922	(1,404)	(10.5%)
VA 5-14	10,241	10,369	128	1.2%
15-19	5,383	5,406	23	0.4%
Total Child/Adoles.	**61,117**	**52,977**	**(8,140)**	**(13.3%)**
Additional Counties in Alternate SA				
Washington				
0-4	7,850	8,682	832	10.6%
5-12	11,580	13,682	2,102	18.2%
13-17	6,784	6,978	194	2.9%
Total Child/Adoles.	**26,214**	**29,342**	**3,128**	**11.9%**
Carter				
0-4	2,964	3,112	148	5.0%
5-12	4,975	4,877	(98)	(2.0%)
13-17	3,283	3,198	(85)	(2.6%)
Total Child/Adoles.	**11,222**	**11,187**	**(35)**	**(0.3%)**

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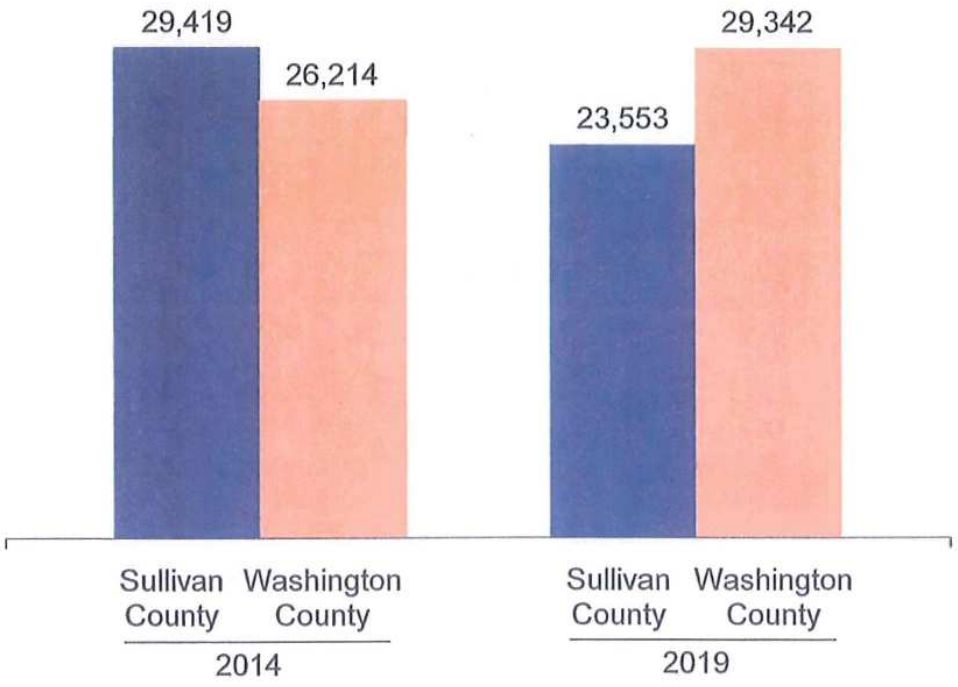
EXHIBIT 4 (Continued)

County	2014	2019	Increase (Decrease)	Percent Change
Greene				
0-4	3,744	4,159	415	11.1%
5-12	6,257	6,175	(82)	(1.3%)
13-17	4,304	4,171	(133)	(3.1%)
Total Child/Adoles.	**14,305**	**14,505**	**200**	**1.4%**
Unicoi				
0-4	847	908	61	7.2%
5-12	1,614	1,450	(164)	(10.2%)
13-17	1,148	1,087	(61)	(5.3%)
Total Child/Adoles.	**3,609**	**3,445**	**(164)**	**(4.5%)**
Washington**				
0-4	3,506	3,560	54	1.5%
5-14	8,135	8,245	110	1.4%
15-19	4,193	4,554	361	8.6%
Total Child/Adoles.	**15,834**	**16,359**	**525**	**3.3%**
Russell				
0-4	1,425	1,343	(82)	(5.8%)
5-14	3,125	3,120	(5)	(0.2%)
15-19	1,533	1,645	112	7.3%
Total Child/Adoles.	**6,083**	**6,108**	**25**	**0.4%**
TOTAL ADDITIONAL SERVICE AREA				
0-4	20,336	21,764	1,428	7.0%
TN 5-12	24,426	26,184	1,758	7.2%
13-17	15,519	15,434	(85)	(0.5%)
VA 5-14	11,260	11,365	105	0.9%
15-19	5,726	6,199	473	8.3%
Total Child/Adoles.	**77,267**	**80,946**	**3,679**	**4.8%**
TOTAL ALTERNATE SERVICE AREA				
0-4	34,389	33,504	(885)	(2.6%)
TN 5-12	42,540	39,724	(2,816)	(6.6%)
13-17	28,845	27,356	(1,489)	(5.2%)
VA 5-14	21,501	21,734	233	1.1%
15-19	11,109	11,605	496	4.5%
Total Child/Adoles.	**138,384**	**133,923**	**(4,461)**	**(3.2%)**

*including Norton City
**including Bristol City
Notes: VA population estimates and projections were not available for the same age cohort groupings as in TN.
Virginia population interpolated based on 2013-2020 AAGR.
Sources: Tennessee Department of Health Statistics, Population Estimates and Projections, 2010-2020.
Weldon Cooper Center for Public Service, University of Virginia, Population Estimates and Projections, 2010-2013 and 2020.

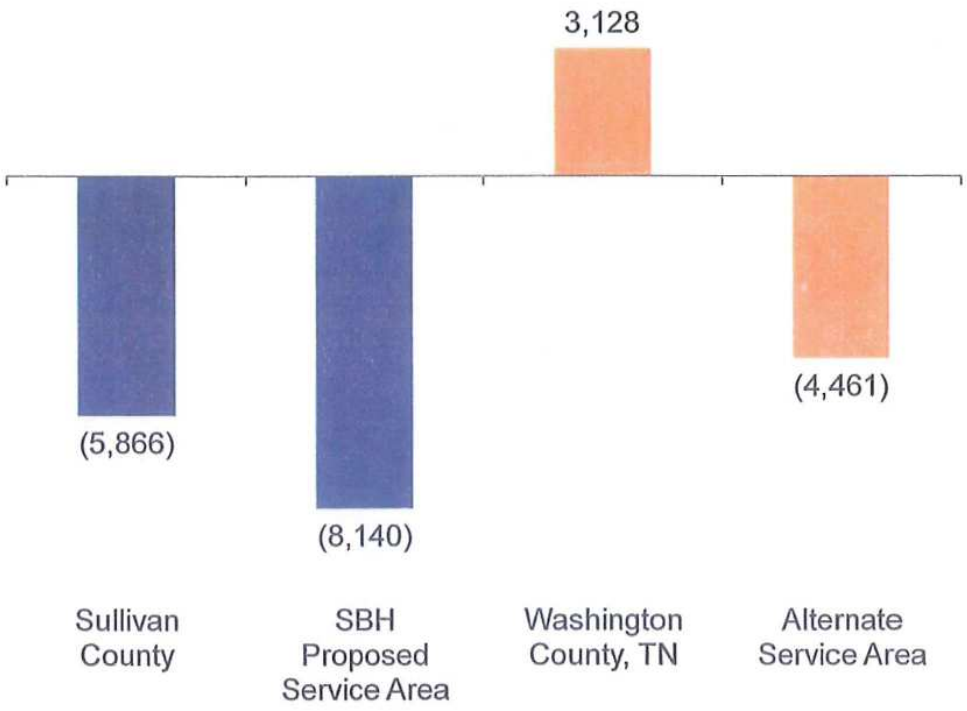
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EXHIBIT 5
Comparison of Child and Adolescent Population
2014 and 2019



Notes: Child/Adolescent includes ages 0-17.
Virginia population interpolated based on 2013-2020 AAGR.
Sources: Tennessee Department of Health Statistics, Population Estimates and Projections, 2010-2020.

EXHIBIT 6
Comparison of Changes in Child and Adolescent Population
2014 and 2019



Note: Virginia population interpolated based on 2013-2020 AAGR.
Sources: Tennessee Department of Health Statistics, Population Estimates and Projections, 2010-2020.
Weldon Cooper Center for Public Service, University of Virginia, Population Estimates and Projections, 2010-2013 and 2020.

EXHIBIT 7
Area Population Trends
Adult Population

County	2014	2019	Increase (Decrease)	Percent Change
SBH Proposed SA				
Sullivan				
18-64	96,231	99,677	3,446	3.6%
65+	33,325	38,477	5,152	15.5%
Total Adult	**129,556**	**138,154**	**8,598**	**6.6%**
Hawkins				
18-64	34,949	35,827	878	2.5%
65+	11,259	13,425	2,166	19.2%
Total Adult	**46,208**	**49,252**	**3,044**	**6.6%**
Scott				
20-64	13,142	12,927	(215)	(1.6%)
65+	4,824	5,324	500	10.4%
Total Adult	**17,966**	**18,251**	**285**	**1.6%**
Lee				
20-64	15,194	14,913	(281)	(1.8%)
65+	4,625	4,823	198	4.3%
Total Adult	**19,819**	**19,736**	**(83)**	**(0.4%)**
Wise*				
20-64	27,381	26,641	(740)	(2.7%)
65+	6,936	7,905	969	14.0%
Total Adult	**34,317**	**34,546**	**229**	**0.7%**
TOTAL SBH PROPOSED SERVICE AREA				
18-64, 20-64	186,897	189,985	3,088	1.7%
65+	60,969	69,954	8,985	14.7%
Total Adult	**247,866**	**259,939**	**12,073**	**4.9%**

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EXHIBIT 7 (Continued)

County	2014	2019	Increase (Decrease)	Percent Change
Additional Counties in Alternate SA				
Washington				
18-64	82,641	85,971	3,330	4.0%
65+	21,731	24,871	3,140	14.4%
Total Adult	**104,372**	**110,842**	**6,470**	**6.2%**
Carter				
18-64	35,013	34,433	(580)	(1.7%)
65+	11,049	12,208	1,159	10.5%
Total Adult	**46,062**	**46,641**	**579**	**1.3%**
Greene				
18-64	42,066	42,364	298	0.7%
65+	13,816	15,120	1,304	9.4%
Total Adult	**55,882**	**57,484**	**1,602**	**2.9%**
Unicoi				
18-64	10,822	10,795	(27)	(0.2%)
65+	3,945	4,318	373	9.5%
Total Adult	**14,767**	**15,113**	**346**	**2.3%**
Washington**				
20-64	42,471	42,790	319	0.8%
65+	14,416	16,100	1,684	11.7%
Total Adult	**56,887**	**58,890**	**2,003**	**3.5%**
Russell				
20-64	17,017	16,787	(230)	(1.4%)
65+	5,262	6,027	765	14.5%
Total Adult	**22,279**	**22,814**	**535**	**2.4%**
TOTAL ADDITIONAL SERVICE AREA				
18-64, 20-64	230,030	233,140	3,110	1.4%
65+	70,219	78,644	8,425	12.0%
Total Adult	**300,249**	**311,784**	**11,535**	**3.8%**
TOTAL ALTERNATE SERVICE AREA				
18-64, 20-64	416,927	423,125	6,198	1.5%
65+	131,188	148,598	17,410	13.3%
Total Adult	**548,115**	**571,723**	**23,608**	**4.3%**

*including Norton City
**including Bristol City
Notes: VA population estimates and projections were not available for the same age cohort groupings as in TN.
Virginia population interpolated based on 2013-2020 AAGR.
Sources: Tennessee Department of Health Statistics, Population Estimates and Projections, 2010-2020.
Weldon Cooper Center for Public Service, University of Virginia, Population Estimates and Projections, 2010-2013 and 2020.

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EXHIBIT 8
Child/ Adolescent Psychiatric Inpatient Bed Need - 2014 and 2019
Alternate Service Area
(Calculated using 30 Beds per 100,000 Population)

	2014				2019			
Age Cohort	0 - 4	5 – 12 (TN) 5 – 14 (VA)	13 – 17 (TN) 15 – 19 (VA)	Total Child/Adoles.	0 – 4	5 – 12 (TN) 5 – 14 (VA)	13 – 17 (TN) 15 – 19 (VA)	Total Child/Adoles.
County								
Sullivan	2.0	3.9	2.9	8.8	1.6	2.9	2.6	7.1
Hawkins	0.7	1.5	1.1	3.4	0.6	1.1	1.0	2.7
Scott	0.3	0.7	0.4	1.4	0.3	0.7	0.4	1.4
Lee	0.4	0.8	0.4	1.6	0.4	0.8	0.4	1.6
Wise*	0.7	1.5	0.9	3.1	0.7	1.6	0.9	3.1
SBH Service Area Total	4.2	8.5	5.6	18.3	3.5	7.2	5.2	15.9
Excluding Age 0-4	***0.0***	***8.5***	***5.6***	***14.1***	***0.0***	***7.2***	***5.2***	***12.4***
Washington	2.4	3.5	2.0	7.9	2.6	4.1	2.1	8.8
Carter	0.9	1.5	1.0	3.4	0.9	1.5	1.0	3.4
Greene	1.1	1.9	1.3	4.3	1.2	1.9	1.3	4.4
Unicoi	0.3	0.5	0.3	1.1	0.3	0.4	0.3	1.0
Russell	0.4	0.9	0.5	1.8	0.4	0.9	0.5	1.8
Washington**	1.1	2.4	1.3	4.8	1.1	2.5	1.4	4.9
ALTERNATE SERVICE AREA	10.3	19.2	12.0	41.5	10.1	18.4	11.7	40.2
Excluding Age 0-4	**0.0**	**19.2**	**12.0**	**31.2**	**0.0**	**18.4**	**11.7**	**30.1**

*including Norton City
**including Bristol City

Notes: VA population estimates and projections were not available for the same age cohort groupings as in TN.
Virginia population interpolated based on 2013-2020 AAGR.

Sources: Tennessee Department of Health Statistics, Population Estimates and Projections, 2010-2020.
Weldon Cooper Center for Public Service, University of Virginia, Population Estimates and Projections, 2010-2013 and 2020.

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EXHIBIT 9
Adult Psychiatric Inpatient Bed Need - 2014 and 2019
Alternate Service Area
(Calculated using 30 Beds per 100,000 Population)

	2014			2019		
Age Cohort	18 - 64 (TN) 20 – 64 (VA)	65+	Total Adult	18 - 64 (TN) 20 – 64 (VA)	65+	Total Adult
County						
Sullivan	28.9	10.0	38.9	29.9	11.5	41.4
Hawkins	10.5	3.4	13.9	10.7	4.0	14.8
Scott	3.9	1.4	5.4	3.9	1.6	5.5
Lee	4.6	1.4	5.9	4.5	1.4	5.9
Wise*	8.2	2.1	10.3	8.0	2.4	10.4
SBH Service Area Total	**56.1**	**18.3**	**74.4**	**57.0**	**21.0**	**78.0**
Washington	24.8	6.5	31.3	25.8	7.5	33.3
Carter	10.5	3.3	13.8	10.3	3.7	14.0
Greene	12.6	4.1	16.8	12.7	4.5	17.2
Unicoi	3.2	1.2	4.4	3.2	1.3	4.5
Russell	5.1	1.6	6.7	5.0	1.8	6.8
Washington**	12.7	4.3	17.1	12.8	4.8	17.7
ALTERNATE SERVICE AREA	**125.1**	**39.4**	**164.4**	**126.9**	**44.6**	**171.5**

*including Norton City
**including Bristol City
Notes: VA population estimates and projections were not available for the same age cohort groupings as in TN.
Virginia population interpolated based on 2013-2020 AAGR.
Sources: Tennessee Department of Health Statistics, Population Estimates and Projections, 2010-2020.
Weldon Cooper Center for Public Service, University of Virginia, Population Estimates and Projections, 2010-2013 and 2020.

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EXHIBIT 10
Summary Gross Bed Need
Alternate Service Area

Age Group	2014	2019
Under 5	10.3	10.1
Child 5+/Adolescent	31.2	30.1
Adult <65	125.1	126.9
Adult 65+	39.4	44.6
TOTAL	**206.0**	**211.7**
Total Excluding Under 5	***195.7***	***201.6***

EXHIBIT 11
Supply of Psychiatric Beds
Alternate Service Area

County	Facility Name	Child/Adoles. Beds	Adult Beds		Total Beds
			Non-Age Specific	65+	
Washington	Woodridge	12	58	14	84
Sullivan	WBRMC		12		12
Greene	Takoma			16	16
Carter	Sycamore Shoals			12	12
Bristol City, VA	Ridgeview Pavilion		28		28
Russell, VA	Clearview Center at Russell Co. Med. Ctr.	—	20	—	20
TOTAL		12	118	42	172

Source: Joint Annual Reports for Takoma and Sycamore Shoals. Clearview Center and Woodridge information provided by Woodridge. WBRMC and Ridgeview Pavilion based on WBRMC Cost Report and JAR.

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EXHIBIT 12
Net Bed Need
Alternate Service Area

Gross Bed Need by Age Group	2014	2019
Under 5	10.3	10.1
Child 5+/Adolescent	31.2	30.1
Adult <65	125.1	126.9
Adult 65+	39.4	44.6
TOTAL	**206.0**	**211.7**
Total Excluding Under 5	***195.7***	***201.6***
Existing Service Area Beds by Age Group		
Under 5	0	0
Child 5+/Adolescent	12	12
Non-Age Specific	118	118
Adult 65+	42	42
TOTAL	*172*	*172*
Net Beds Needed by Age Group		
Under 5	10.3	10.1
Child 5+/Adolescent	19.2	18.1
Adult <65	7.1	8.9
Adult 65+	(2.6)	2.6
TOTAL	**34.0**	**39.7**
Total Net Beds Needed Excluding Under 5	***24***	***30***

EXHIBIT 13
Psychiatric Patient Market Share
Residents of SBH Proposed Service Area

Destination Facility	Discharges			Market Share		
	2011	2012	2013	2011	2012	2013
MSHA						
Woodridge Psychiatric Hospital	1,298	1,375	1,315	51.3%	53.8%	52.0%
Sycamore Shoals Hospital	75	87	52	3.0%	3.4%	2.1%
Indian Path Medical Center	29	25	35	1.1%	1.0%	1.4%
Johnson City Medical Center	33	44	24	1.3%	1.7%	0.9%
Franklin Woods Community Hospital	1	1	0	0.0%	0.0%	0.0%
MSHA Total	**1,436**	**1,532**	**1,426**	**56.8%**	**59.9%**	**56.4%**
Wellmont						
Wellmont Bristol Regional Medical Center	549	588	609	21.7%	23.0%	24.1%
Wellmont Holston Valley Medical Center	86	91	86	3.4%	3.6%	3.4%
Wellmont Hawkins County Memorial Hospital	18	9	6	0.7%	0.4%	0.2%
Wellmont Total	**653**	**688**	**701**	**25.8%**	**26.9%**	**27.7%**
All Other						
Peninsula Hospital	200	262	296	7.9%	10.3%	11.7%
Lakeshore Mental Health Institute	170	0	0	6.7%	0.0%	0.0%
Takoma Regional Hospital	24	17	27	0.9%	0.7%	1.1%
Parkridge Valley Child & Adolescent Campus	8	8	9	0.3%	0.3%	0.4%
Vanderbilt University Hospitals	4	7	7	0.2%	0.3%	0.3%
Other Facilities	26	26	16	1.3%	1.6%	2.4%
All Other Total	**439**	**336**	**400**	**17.4%**	**13.1%**	**15.8%**
TOTAL	**2,528**	**2,556**	**2,527**	**100.0%**	**100.0%**	**100.0%**

Sources: Tennessee Department of Health, Hospital Discharge Data System (HDDS), 2011-2013.
Tennessee Department of Health Statistics, Joint Annual Reports, 2011-2013, for hospitals not reporting on HDDS.

EXHIBIT 14
Psychiatric Patient Market Share
Residents of Alternate Service Area

Destination Facility	Discharges			Market Share		
	2011	2012	2013	2011	2012	2013
MSHA						
Woodridge Psychiatric Hospital	3,099	3,314	3,387	54.8%	57.0%	57.2%
Sycamore Shoals Hospital	237	267	222	4.2%	4.6%	3.8%
Johnson City Medical Center	234	267	203	4.1%	4.6%	3.4%
Indian Path Medical Center	30	28	38	0.5%	0.5%	0.6%
Franklin Woods Community Hospital	23	17	10	0.4%	0.3%	0.2%
Unicoi County Memorial Hospital, Inc.	2	4	4	0.0%	0.1%	0.1%
MSHA Total	**3,625**	**3,897**	**3,864**	**64.1%**	**67.1%**	**65.3%**
Wellmont						
Wellmont Bristol Regional Medical Center	928	1,043	1,133	16.4%	17.9%	19.1%
Wellmont Holston Valley Medical Center	95	95	90	1.7%	1.6%	1.5%
Wellmont Hawkins County Memorial Hospital	18	9	6	0.3%	0.2%	0.1%
Wellmont Total	**1,041**	**1,147**	**1,229**	**18.4%**	**19.7%**	**20.8%**
All Other						
Peninsula Hospital	385	505	495	6.8%	8.7%	8.4%
Lakeshore Mental Health Institute	349	0	0	6.2%	0.0%	0.0%
Takoma Regional Hospital	142	141	129	2.5%	2.4%	2.2%
Parkridge Valley Child & Adolescent Campus	18	21	23	0.3%	0.4%	0.4%
Vanderbilt University Hospitals	11	12	20	0.2%	0.2%	0.3%
Other Facilities	51	55	47	1.5%	1.5%	2.7%
All Other Total	**989**	**768**	**826**	**17.5%**	**13.2%**	**14.0%**
TOTAL	**5,655**	**5,812**	**5,919**	**100.0%**	**100.0%**	**100.0%**

Sources: Tennessee Department of Health, Hospital Discharge Data System (HDDS), 2011-2013.
Tennessee Department of Health Statistics, Joint Annual Reports, 2011-2013 for hospitals not reporting on HDDS.

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EXHIBIT 15
Utilization for Inpatient Psychiatric Services in Alternate Service Area

Facility	Child/ Adolescent Beds	Discharges			ALOS			Percent Occupancy		
		2011	2012	2013	2011	2012	2013	2011	2012	2013
Woodridge Psychiatric Hospital	12	319	325	367	5.8	6.0	6.8	42.2%	44.2%	56.8%
TOTAL	**12**	**319**	**325**	**367**	**5.8**	**6.0**	**6.8**	**42.2%**	**44.2%**	**56.8%**

Facility	Adult/65+ Beds	Discharges			ALOS			Percent Occupancy		
		2011	2012	2013	2011	2012	2013	2011	2012	2013
Clearview	20	N/A	N/A	708	N/A	N/A	5.9	N/A	N/A	57.6%
Ridgeview[1]	28	823	855	947	4.8	4.9	6.1	38.9%	41.4%	49.6%
Sycamore	12	260	282	313	12.6	12.0	10.7	74.8%	77.1%	76.5%
Takoma Regional Hospital	16	187	218	207	9.6	10.2	10.0	30.8%	38.0%	35.6%
Wellmont Bristol Regional Med Ctr	12	335	431	427	7.3	6.4	6.8	56.0%	62.7%	66.0%
Woodridge Psychiatric Hospital	72	3,111	3,248	3,457	5.8	6.0	5.7	68.6%	73.8%	75.2%
TOTAL[2]	**160**	**4,716**	**5,034**	**6,059**	**6.2**	**6.4**	**6.3**	**50.6%**	**54.7%**	**63.6%**
Adult Subtotal[2]	*118*	*4,021*	*4,248*	*5,187*	*5.7*	*5.8*	*5.8*	*53.3%*	*57.5%*	*67.5%*
65+ Subtotal	*42*	*695*	*786*	*872*	*9.5*	*9.2*	*9.2*	*43.0%*	*47.0%*	*52.4%*

Facility	Total Beds	Discharges			ALOS			Percent Occupancy		
		2011	2012	2013	2011	2012	2013	2011	2012	2013
Clearview	20	N/A	N/A	708	N/A	N/A	5.9	N/A	N/A	57.6%
Ridgeview[1]	28	823	855	947	4.8	4.9	6.1	38.9%	41.4%	49.6%
Sycamore	12	260	282	313	12.6	12.0	10.7	74.8%	77.1%	76.5%
Takoma Regional Hospital	16	187	218	207	9.6	10.2	10.0	30.8%	38.0%	35.6%
Wellmont Bristol Regional Med Ctr	12	335	431	427	7.3	6.4	6.8	56.0%	62.7%	66.0%
Woodridge Psychiatric Hospital	84	3,430	3,573	3,824	5.8	6.0	5.8	64.8%	69.6%	72.5%
TOTAL[2]	**172**	**5,035**	**5,359**	**6,426**	**6.2**	**6.3**	**6.3**	**50.0%**	**54.0%**	**63.1%**

[1] Ridgeview's 2013 occupancy based on 32-beds; however, Ridgeview's 2013 utilization for 28-beds would be 56.7%.
[2] 2013 occupancy based on Ridgeview's 32-beds. Alternatively, 2013 occupancy would be 69.8% for Adults, 65.2% for Adult/65+ and 64.6% overall based on Ridgeview's 28-beds.

Note: Cost report for WBRMC shows 44 psychiatric beds for 2013, including Ridgeview Pavilion. Previously WBRMC reported 40-beds (12 at WBRMC and 28 at Ridgeview). For purposes of this analysis, it is assumed that Ridgeview operated 4 additional beds in 2013, or a total of 32-beds.

Source: Tennessee Department of Health Statistics, Joint Annual Reports, 2011-2013.

SBH-KINGSPORT 000191

EXHIBIT 16
Use Rate Comparison
State and Select Tennessee Counties

	Discharges per 100,000		
	2011	2012	2013
Tennessee	*903.9*	*958.3*	*938.6*
Sullivan	980.2	1,038.4	1,026.8
Hawkins	824.0	729.8	782.2
TN Portion of SBH defined SA	**938.9**	**956.5**	**961.9**
Washington	1,204.6	1,124.4	1,192.7
Greene	816.3	782.9	748.3
Carter	778.0	893.4	912.1
Unicoi	761.5	1,164.1	878.1
Additional TN Counties in Alt. SA	**983.9**	**990.9**	**999.7**
TOTAL 6 TN COUNTIES IN ALT. SA	**963.9**	**975.7**	**983.0**

Source: Tennessee Department of Health Statistics, Joint Annual Reports, 2011-2013.

EXHIBIT 17
2013 Psychiatric Market Share by Payor
Residents of SBH Proposed Service Area

Hospital	Medicare	TennCare/ Medicaid	Indigent/ Charity	Blue Cross/ Commercial/ Managed Care	Self Pay	All Other
Woodridge	41.6%	58.1%	79.3%	60.7%	2.8%	66.1%
WBRMC	32.0%	23.6%	0.0%	20.9%	64.0%	17.9%
Peninsula[1]	6.8%	14.7%	20.7%	10.0%	11.3%	0.0%
Sycamore Shoals	6.1%	0.2%	0.0%	0.0%	0.0%	1.8%
Takoma Regional	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Wellmont Holston Valley	4.6%	1.3%	0.0%	5.2%	12.4%	0.0%
Indian Path Medical Center	2.9%	0.3%	0.0%	0.6%	3.9%	0.0%
Johnson City Medical Center	1.2%	0.2%	0.0%	1.2%	3.9%	3.6%
All Others	1.6%	1.7%	0.0%	1.4%	1.7%	10.7%

Notes: 1. Peninsula Hospital reported no cases as "indigent" in its HDDS data, but reported a large number of cases in the "all other" category in 2012 and 2013. For the purposes of this analysis, the cases in "all other" are treated as "indigent." Peninsula, like Woodridge, has a state contract to care for indigent patients.
2. A few hospitals, including the State Mental Health Institutes, do not report HDDS data.

Sources: Tennessee Department of Health, Hospital Discharge Data System (HDDS), 2013.

SBH-KINGSPORT 000193

EXHIBIT 18
Psychiatric Market Share by Payor
Residents of Alternate Service Area

Hospital	Medicare	TennCare/ Medicaid	Indigent/ Charity	Blue Cross/ Commercial/ Managed Care	Self Pay	All Other
Woodridge	44.3%	62.6%	86.7%	67.2%	4.4%	77.4%
WBRMC	24.8%	20.7%	0.0%	17.2%	56.3%	6.9%
Peninsula[1]	4.7%	12.4%	13.3%	5.6%	9.5%	0.0%
Sycamore Shoals	10.1%	0.1%	0.0%	1.2%	2.3%	2.5%
Takoma Regional	6.5%	0.1%	0.0%	0.0%	0.0%	0.6%
Wellmont Holston Valley	2.1%	0.6%	0.0%	2.3%	5.7%	0.0%
Indian Path Medical Center	1.3%	0.1%	0.0%	0.2%	2.1%	0.0%
Johnson City Medical Center	4.2%	1.8%	0.0%	3.4%	16.7%	3.1%
All Others	2.0%	1.6%	0.0%	2.7%	3.1%	9.4%

Notes: 1. Peninsula Hospital reported no cases as "indigent" in its HDDS data, but reported a large number of cases in the "all other" category in 2012 and 2013. For the purposes of this analysis, the cases in "all other" are treated as "indigent." Peninsula, like Woodridge, has a state contract to care for indigent patients.
2. A few hospitals, including the State Mental Health Institutes, do not report HDDS data.

Sources: Tennessee Department of Health, Hospital Discharge Data System (HDDS), 2013.

SBH-KINGSPORT 000194

EXHIBIT 19
Woodridge Market Share of Cases by Payor

Payor	SBH Proposed Service Area			Alternate Service Area		
	Total 2013 Discharges	WPH 2013 Discharges	WPH 2013 SA Mkt. Share	Total 2013 Alternate SA Discharges	WPH 2013 Discharges	WPH 2013 Alternate SA Mkt. Share
Medicare	823	342	41.6%	1,949	863	44.3%
TennCare/Medicaid	632	367	58.1%	1,354	847	62.6%
Commercial	349	212	60.7%	815	548	67.2%
Charity/Indigent	452	352	77.9	989	989	86.7%
Self Pay	178	5	2.8%	389	17	4.4%
All others	148	37	25.1%	309	123	77.4%
TOTAL	2,482	1,315	53.0%	**5,809**	**3,387**	**58.3%**

Source: Tennessee Department of Health, Hospital Discharge Data System (HDDS), 2011-2013. Payor level patient origin data not available for nonreporting hospitals.

SBH-KINGSPORT 000195

EXHIBIT 20
SBH Projected Payor Mix and Cases by Payor

Payor	Percentage of Patient Days SBH - Kingsport	Patient Days based on Projected distribution	Avg. Length of Stay	Cases	Cases Adjusted to 1,859
Commercial	35%	5,985	7.6	788	769
TennCare/Medicaid	38%	6,498	9.8	663	648
Medicare	20%	3,420	12.2	280	274
Charity/Indigent	5%	855	6.7	128	125
Other	2%	342	7.7	44	43
TOTAL	**100%**	**17,100**	**9.2**	**1,903**	**1,859**

Notes:
1. Patient Day distribution by payor from Response to MSHA's First Set of Interrogatories #11 (d) with assumption that 5% charity/indigent = 5% self pay to tie to 100% of cases.
2. ALOS based on SBH Response to MSHA's First Set of Interrogatories, #35. Commercial/HMO/PPO is average of commercial and HMO/PPO. Other was assumed to be same as HMO/PPO.
3. Total cases from SBH Response to MSHA's First Set of Interrogatories, #25.

EXHIBIT 21
Estimate of Cases Taken from Woodridge by SBH-Kingsport Assuming Payor Mix per SBH

Payor	SBH Projected Payor Mix[1]	Projected YR 2 Cases[2]	WPH's Mkt Share of SA by Payor	SA Cases Taken from WPH	WPH's Mkt. Share of Alternate SA by Payor	Alternate SA Cases Taken from WPH
Medicare	20%	372	32.6%	114	44.3%	121
TennCare	38%	706	58.1%	376	62.6%	406
Commercial	35%	651	60.7%	467	67.2%	517
Indigent/Self pay	5%	93	79.3%	99	86.7%	108
Other	2%	37	66.1%	28	77.4%	33
TOTAL	**100%**	**1,859**	**57.1%**	**1,084**	**62.0%**	**1,185**

[1] From Response to MSHA's First Set of Interrogatories #11(d), with assumption that 5% charity/indigent = 5% self pay to tie to 100% of cases.
[2] Payor distribution applied to total cases from Response to MSHA's First Set of Interrogatories #29.
Source: Tennessee Department of Health, Hospital Discharge Data System (HDDS), 2011-2013.

SBH-KINGSPORT 000197

EXHIBIT 22
Woodridge Fixed and Variable Cost Allocation

Variable Direct Salaries	$	3,695,833	
Variable Benefits from Ind		554,375	
Variable Direct Supplies		452,694	
Variable Direct Other		1,717,311	
Variable Indirect Salaries		726,948	
Variable Indirect Supplies /Other		559,379	
TOTAL VARIABLE	**$**	**7,706,540**	**45.1%**
Fixed Direct Other	$	1,434,905	
Fixed Indirect Salaries		1,914,642	
Fixed Indirect NonSalary/Other		1,473,296	
Direct Depreciation		20,483	
Fixed Direct Salaries		1,728,386	
Direct Professional Fees		99,570	
Indirect Depreciation/Interest		1,335,358	
Hospital supported clinic		1,372,646	
TOTAL FIXED	**$**	**9,379,286**	**54.9%**
TOTAL EXPENSE	**$**	**17,085,826**	**100.0%**

Sources: MSHA's TrendStar cost accounting data for FY 2014 and fixed and variable allocations based on DKC assumptions and discussions with MSHA staff.

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SBH-KINGSPORT 000198

EXHIBIT 23
Woodridge FY 2014 Contribution Margin Per Case

Payor	Cases	Net Rev/Case	Var Cost/Case	Contribution Margin/Case
Medicare	1,060	$4,750	$2,422	$2,328
TennCare/Medicaid	1,074	$2,763	$1,873	$891
Commercial	672	$3,907	$1,724	$2,183
Other/Self Pay	29	$2,322	$1,470	$851
Indigent	1,241	$222	$1,553	($1,331)
TOTAL	**4,076**	**$2,691**	**$1,891**	**$801**

Sources: MSHA's TrendStar cost accounting data for FY 2014 and fixed and variable allocations based on DKC assumptions and discussions with MSHA staff.

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SBH-KINGSPORT 000199

EXHIBIT 24
Estimated Financial Impact of SBH on Woodridge

Scenario A.1: *Assumes SBH Service Area and 5% Indigent Care*			
Payor	**Woodridge Cases Lost**	**Contribution per Case**	**Lost Contribution Margin**
Medicare	114	$2,328	$265,344
TennCare/Medicaid	376	$891	$334,839
Commercial	467	$2,183	$1,019,438
Other/Self Pay	28	$851	$23,839
Indigent	99	$(1,331)	$(131,762)
TOTAL	**1,084**	**$1,395**	**$1,511,699**
Scenario A.2: *Assumes SBH Service Area and 0% Indigent Care*			
Payor	**Woodridge Cases Lost**	**Contribution per Case**	**Lost Contribution Margin**
Medicare	123	$2,328	$286,292
TennCare/Medicaid	407	$891	$362,445
Commercial	495	$2,183	$1,080,561
Other/Self Pay	31	$851	$26,393
Indigent	0	$(1,331)	$0
TOTAL	**1,056**	**$1,663**	**$1,755,692**
Scenario B.1: *Assumes Alternate Service Area and 5% Indigent Care*			
Payor	**Woodridge Cases Lost**	**Contribution per Case**	**Lost Contribution Margin**
Medicare	121	$2,328	$281,637
TennCare/Medicaid	406	$891	$361,555
Commercial	517	$2,183	$1,128,586
Other/Self Pay	33	$851	$28,096
Indigent	108	$(1,331)	$(143,740)
TOTAL	**1,185**	**$1,395**	**$1,656,134**
Scenario B.2: *Assumes Alternate Service Area and 0% Indigent Care*			
Payor	**Woodridge Cases Lost**	**Contribution per Case**	**Lost Contribution Margin**
Medicare	131	$2,328	$304,913
TennCare/Medicaid	438	$891	$390,052
Commercial	548	$2,183	$1,196,257
Other/Self Pay	36	$851	$30,650
Indigent	0	$(1,331)	$0
TOTAL	**1,153**	**$1,663**	**$1,921,872**

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SBH-KINGSPORT 000200

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

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IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	
	)	**Docket No. 25.00-126908J**
Petitioner/Applicant	)	
	)	
	)	
CON Application No. CN1312-050	)	

PETITION TO INTERVENE

Mountain States Health Alliance ("MSHA"), through its undersigned counsel, seeks to intervene in the above contested-case proceeding as a Respondent, and in support of such intervention, states as follows:

1. On June 25, 2014, the Tennessee Health Services and Development Agency considered the application of Petitioner SBH-Kingsport, LLC ("SBH-Kingsport") for a certificate of need to establish a new 72-bed mental health hospital and to initiate inpatient psychiatric services in Kingsport, Sullivan County, Tennessee.

2. Through its representatives, MSHA appeared before the Agency and objected to the granting of a certificate of need to Petitioner for the new hospital and the initiation of the inpatient psychiatric services. MSHA opposed Petitioner's application because it fails to satisfy any of the criteria that govern CON applications in Tennessee—that is, the project is not needed, is not economically feasible and will not contribute to the orderly development of adequate and effective health care services.

3. At its meeting on June 25, 2014, the Agency voted to deny the Petitioner's certificate of need application by a vote of 4-4. SBH-Kingsport subsequently filed its Petition for Contested Case pursuant to Tenn. Code Ann. §§ 68-11-1601, *et seq.*

SBH-KINGSPORT 000201

4. This Petition to Intervene has been filed in a timely manner in accordance with Tenn. Code Ann. § 4-5-310.

5. The extent of intervention sought includes appearance in all stages of the proceeding, participation in discovery, the presentation of proof, the examination and cross-examination of witnesses, and receipt of all pleadings, orders and other documents.

Based on the foregoing, Mountain States Health Alliance respectfully requests that this Petition to Intervene be granted.

Respectfully submitted,

G. Brian Jackson (Tenn. BPR No. 015497)
Travis B. Swearingen (Tenn. BPR No. 025717)
BUTLER SNOW LLP
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Attorneys for Mountain States Health Alliance

SBH-KINGSPORT 000202

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent via electronic mail and First Class Mail to the following counsel of record:

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BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

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MOUNTAIN STATES HEALTH ALLIANCE'S
MOTION IN LIMINE NO. 1
TO PRECLUDE EVIDENCE OF THE POTENTIAL WELLMONT/MSHA MERGER

Mountain States Health Alliance ("MSHA") moves the Court to preclude SBH-Kingsport, LLC ("SBH") from presenting evidence or making references to the potential merger between MHSA and Wellmont Health System ("Wellmont") and asks the Court not consider any such evidence. Any such information is completely speculative and irrelevant to this contested case proceeding.

LAW

No evidence is admissible unless it is relevant. Tenn. R. Evid. 402. Evidence is relevant only if it has a "tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the

evidence." Tenn. R. Evid. 401. "Evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or...waste of time..." Tenn R. Evid 403.

Argument

Wellmont Health System and MSHA are the two primary providers of healthcare services in Upper East Tennessee and Southwest Virginia. Wellmont and MHSA have recently announced their decision to explore the creation of a new, integrated health system. Moving forward, representatives from each organization, along with their attorneys, will enter into a lengthy negotiation period during which they will attempt to come to a definitive agreement establishing the terms of the proposed merger. The two companies will then be required to submit their proposed merger plan in an application for a Certificate of Public Advantage ("COPA") with the State of Tennessee and a similar regulatory process with the Commonwealth of Virginia. While the merger has been generally discussed, most of the details of the potential combination have not yet been even negotiated, let alone finalized.

The possible merger of Wellmont and MSHA is irrelevant to this proceeding. Negotiations are in their infancy. Those negotiations are highly sensitive, both economically and legally. What the final proposed merger plan will look like, it if it is even reached, is unknown. Moreover, the requisite COPA for this merger has not been filed and is not even finalized. As such, it is not known what the final COPA filing will look like, if it will be approved, and what conditions might accompany the approval. It may be denied, which would effectively terminate the merger. It may be approved with any number of conditions which could terminate the merger, or require further concessions, alterations, and divestitures of service lines. At this point, not only would such discussions at the trial of this contested case delve into highly

sensitive matters, but whether any merger will ever happen is completely speculative and irrelevant to this proceeding.

CONCLUSION

Based on the foregoing, MSHA respectfully requests the Court to instruct SBH not to mention, refer to, interrogate concerning, or attempt to convey before the Court, at any time during these proceedings in any manner either directly or indirectly, the above information or similar information. MSHA further requests that SBH's counsel be instructed to warn and caution each and every witness appearing in support of their cases to comply strictly with the ruling of this Court. Lastly, MSHA respectfully requests the Court not consider any such evidence in determining approval or denial of the requested CON.

Respectfully Submitted,

G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
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Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services &
Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 20th day of July, 2015.



SBH-KINGSPORT 000207

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

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MOUNTAIN STATES HEALTH ALLIANCE'S
MOTION IN LIMINE NO. 2
TO PRECLUDE EVIDENCE OF LETTERS OF SUPPORT AND OPPOSITION

Mountain States Health Alliance ("MSHA") moves the Court to preclude SBH-Kingsport, LLC ("SBH") from presenting evidence or making references to letters of support or letters of opposition that were submitted to the Health Services and Development Agency ("HSDA").

SBH seeks a Certificate of Need to build a new, freestanding 72-bed psychiatric hospital in Kingsport, Tennessee. Although the HSDA has never codified the practice in any rule or regulation, typically, interested parties may submit letters in support of and letters in opposition to the project for the HSDA's consideration. The letters are not sworn under oath, they are not verified or authenticated by the HSDA's staff, and the authors are not subjected to cross-

examination or tested in any way. In this case, several letters were submitted both in support of and in opposition to the Project. Most of the letters were authored between January 2014 and June 2014. These letters are hearsay for which no exception applies. Even if the letters were not hearsay, they were authored in many cases over a year and a half ago. Accordingly, any limited probative value they may have once had, has since expired.

LAW

Tennessee Rule of Evidence 801(c) defines hearsay as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." Rule 802 provides that "[h]earsay is not admissible except as provided by these rules or otherwise by law." "The determination of whether a statement is hearsay and whether it is admissible through an exception to the hearsay rule is left to the sound discretion of the trial court." *State v. Stout*, 46 S.W.3d 689, 697 (Tenn.2001).

In addition, no evidence is admissible unless it is relevant. Tenn. R. Evid. 402. Evidence is relevant only if it has a "tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." Tenn. R. Evid. 401. "Evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or…waste of time…" Tenn R. Evid 403.

Argument

Letters of support and opposition submitted to the HSDA are hearsay for which no exception applies and should be excluded. First, the letters are clearly hearsay – out of court statements, that would be offered by either party to establish the matters asserted in the particular letter, i.e., that there is (or is not) a need for the proposed project. Second, the letters do not fall

within any exception to the hearsay rules. The letters are not contemporaneous "business records" subject to exception under Tenn. R. Evid. 802(6). Similarly, they would not qualify as a "public record" under Tenn. R. Evid. 802(8), because they are not "statements...setting forth the activities of the office or agency." To point, these letters are simply received in by the HSDA staff in whatever form they are presented, packaged together, and then presented to the HSDA members to be given whatever weight the members see fit. The HSDA staff does not contact the authors to verify their credentials or determine if they actually signed the letter. No research is completed by the staff to corroborate the claims made. Moreover, an opposing party is not given an opportunity to cross examine the authors.

If a party wishes to introduce the testimony of an interested party into a contested case, the UAPA provides a process by which a party can submit affidavits. Tenn. Code Ann. § 4-5-313(2). Unlike letters of support, the affidavits have to be signed and notarized and, most importantly, made under oath. Moreover, the UAPA permits the party opposing the affidavit an opportunity to request to cross-examine the affiant, and test the statements made. Tenn. Code Ann. § 4-5-313(2). These affidavits, not unverified letters of support, are the proper way to introduce third-party testimony.

Even if they were not hearsay, the letters should still be excluded on relevancy grounds. This contested case proceeding is heard by the Court *de novo* without consideration for the proof presented before the HSDA. As it has been over a year since the original hearing before the HSDA, the matters referred to in the letters most likely no longer represent the true nature of the care and psychiatric services being provided in the region. Moreover, the authors may have learned additional information in the interim that would have led them to change the opinions authored in their letters. As such, the letters of support and opposition should not be relied on as

substantive evidence in this matter.

CONCLUSION

Based on the foregoing, MSHA respectfully requests the Court to instruct SBH not to mention, refer to, interrogate concerning, or attempt to convey before the Court, at any time during these proceedings in any manner either directly or indirectly, the above information or similar information. MSHA further requests that SBH's counsel be instructed to warn and caution each and every witness appearing in support of their cases to comply strictly with the ruling of this Court. Lastly, MSHA respectfully requests the Court not consider any such evidence in determining approval or denial of the requested CON.

Respectfully Submitted,

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Counsel for Mountain States Health Alliance

SBH-KINGSPORT 000211

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services &
Development Agency
500 Deaderick Street, 9th Floor
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Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 20th day of July, 2015.



LPP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

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SECRETARY OF STATE

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	
	)	

APPLICANT'S PREHEARING MEMORANDUM OF LAW

Pursuant to the amended scheduling order herein, the Applicant/Petitioner in this matter, SBH-Kingsport, LLC (hereinafter "Applicant"), hereby files its pretrial brief in this proceeding. This proceeding is a contested case proceeding pursuant to T.C.A. § 68-11-1610, and the provisions of the Tennessee Uniform Administrative Procedures Act, particularly those pertaining to contested case proceedings, T.C.A. § 4-5-301, *et seq.*

I. FACTUAL BACKGROUND

This case involves the Applicant's "appeal", or Petition for a Contested Case Proceeding, regarding the denial of its certificate of need application, CON number CN1312-050, which took

place on June 25, 2014, at the meeting of the Tennessee Health Services and Development Agency ("HSDA"). As the CON number indicates, the Applicant filed CON application number CN1312-050 for the establishment of a 72-bed psychiatric hospital in Kingsport, Tennessee, and the initiation of psychiatric services therein, in December 2013.

At the June 25, 2014 meeting of the HSDA, at the conclusion of its consideration of the CON application number CN1312-050, a motion by an HSDA member to approve the certificate of need failed by a vote of four in favor to four opposed. A tie vote at the HSDA means that the motion is denied. Therefore, the Applicant's CON application was denied by this tie vote.

The Applicant timely perfected its petition for a contested case proceeding on the denial of its CON application by filing its petition for a contested case proceeding in July 2014, pursuant to T.C.A. § 68-11-1610(a). Shortly thereafter, Mountain States Health Alliance, which had opposed the SBH-Kingsport CON application before the HSDA, was permitted to intervene in opposition to the Applicant and CON application CN1312-050 in this contested case proceeding.

The Applicant in this matter, SBH-Kingsport, LLC, is an entity formed to build and operate this proposed psychiatric hospital in Sullivan County by Strategic Behavioral Health, Inc., a Memphis-based psychiatric hospital company. Strategic Behavioral Health has acquired, developed, and operates numerous psychiatric hospitals. It operates such facilities in North Carolina, Texas, Colorado and Nevada. SBH-Kingsport, LLC will be its first psychiatric hospital in Tennessee, if it is permitted to be built, even though Strategic Behavioral Health, Inc. has its corporate headquarters in Memphis, Shelby County, Tennessee.

SBH-Kingsport, LLC needed to seek a certificate of need in order to establish a psychiatric hospital in Tennessee, with 72 beds, and deliver inpatient psychiatric services therein.

Such actions require a grant of a certificate of need by the HSDA, pursuant to T.C.A. § 68-11-1607.

The Applicant's certificate of need application at issue in this hearing seeks to establish a free-standing psychiatric hospital in Kingsport, Sullivan County, Tennessee. It proposes that this hospital will have the following inpatient psychiatric bed components: 18 adult psychiatric beds, 28 child and adolescent psychiatric beds, 16 gero-psychiatric psychiatric beds, and 10 chemical dependency beds.

MSHA, through Johnson City Medical Center's service known as Woodridge Psychiatric Hospital, operates a psychiatric hospital that has 12 child and adolescent beds, 14 gero-psychiatric beds, and 58 adult psychiatric beds. It provides chemical dependency services in some of the adult psychiatric beds.

II. STATUTORY AND REGULATORY BACKGROUND:

The statutory criteria for the grant of a certificate of need are set forth in the HSDA's statute, the Tennessee Health Services and Planning Act of 2002, which states the criteria for the grant of a certificate of need at T.C.A. § 68-11-1609(b). This provision of the HSDA's act states as follows, in relevant part:

> No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed healthcare in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective healthcare facilities or services. In making such determinations, the Agency shall use as guidelines the goals, objectives, criteria, and standards in the state health plan. . . . Additional criteria for review of application shall also be prescribed by the rules of the Agency.

The rules of the Agency specify additional "criteria" as set forth below, and published in HSDA Rule 0720-11-.01. These criteria state as follows:

> 0720-11-.01 - General Criteria for a Certificate of Need. The Agency will consider the following general criteria in determining whether an application for a certificate of need shall be granted:

(1) Need. The healthcare needed in the area to be served may be evaluated upon the following factors:

(a) the relationship of their proposal to any existing applicable plan;
(b) the population served by the proposal;
(c) the existing or certified services or institutions in the area;
(d) the reasonableness of the service area;
(e) the special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants and low income groups;
(f) comparison of utilization/occupancy trends and services provided by other area providers;
(g) the extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of the services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) whether adequate funds are available to the applicant to complete the project;
(b) the reasonableness of the proposed project costs;
(c) anticipated revenue from the proposed project and the impact on existing patient charges;
(d) participation in state/federal revenue programs;
(e) alternatives considered; and
(f) the availability of less costly or more effective methods of providing the benefits intended by the proposal.

(3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make the orderly development of an adequate and effective healthcare system may be evaluated upon the following factors:

(a) the relationship of the proposal to the existing healthcare system (for example, transfer agreements, contractual agreements for health services, the applicant's proposal TennCare participation, affiliation of the project with health professional schools);
(b) the positive or negative effects attributed to duplication or competition;
(c) the availability and accessibility of human resources required by the proposal, including consumers and related providers;

(d) the quality of the proposed project in relation to applicable governmental or professional standards.

The applicable current state health plan standards for inpatient psychiatric hospital facilities is set forth in the state health plan document known historically as the "Guidelines for Growth". The applicable Guidelines for Growth section provides as follows (2000 edition) as to "Psychiatric Inpatient Services":

A. Need.

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

3. For child inpatient under age 13 and if adolescent program the age group of 13-17 should be used.

4. These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.

2. Accessibility to specific special needs groups should be an important factor.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

For the convenience of this tribunal, a copy of T.C.A. § 68-11-1609 is attached hereto as Exhibit A. A copy of HSDA Rule 0720-11-.01 is attached hereto as Exhibit B, and a copy of the "Psychiatric Inpatient Services" section of the Guidelines for Growth is attached hereto as Exhibit C.

The certificate of need application filed by SBH-Kingsport, LLC addressed the factors listed in T.C.A. § 68-11-1609(b), as well as the factors set forth in the HSDA's rules described above and the provisions of the Guidelines for Growth also specified above. The specifics of the proposals by the petitioner to satisfy these criteria will be addressed more fully in proof at trial, but, as an example, the CON application for this project proposed by SBH-Kingsport, LLC states

that it will admit involuntarily committed mental health patients. It will also participate in both the Medicare and TennCare programs, according to the certificate of need application.

At least as set forth in the discovery in this matter, experts for both SBH-Kingsport, LLC and MSHA agree that there is a numerical need under the state health plan's population formula for additional inpatient psychiatric beds in the service area described by the CON application. However, there is expert witness disagreement as to how many beds are needed, and also as to whether the service area the applicant has proposed has been properly defined by the Applicant.

III. INTERVENOR ISSUES:

The only entity pursuing intervention in this contested case proceeding in opposition to this certificate of need application is Mountain States Health Alliance ("MSHA"), the Intervenor in this matter. MSHA is a single corporate entity that does business as its various hospitals.

In Johnson City, Tennessee, MSHA operates a large multi-specialty hospital known as Johnson City Medical Center. Johnson City Medical Center has a "satellite" hospital, Woodridge Psychiatric Hospital, which is across the street from Johnson City Medical Center. However, the Intervenor in this matter is not Woodridge Psychiatric Hospital or Johnson City Medical Center. Rather, the Intervenor in this matter is Mountain States Health Alliance. Data regarding Woodridge Psychiatric Hospital has been an issue in discovery, as has certain data related to Johnson City Medical Center.

A legal issue that may arise in this matter is the impact of the status of Woodridge Psychiatric Hospital as a "satellite" of Johnson City Medical Center. Tennessee hospital regulations recognize and permit such satellite hospital designations. Medicare also recognizes satellite hospital status for certain hospital facilities, and it imposes significant requirements that such a hospital must satisfy in order to be considered by Medicare as a "satellite" of another hospital. These are found at 42 CFR § 413.65(d). 42 CFR § 413.65(d) lists four basic

requirements, applicable to Woodridge's situation that Woodridge must satisfy to maintain its status as a "satellite" of JCMC. These four requirements can be summarized as follows: in order to be considered by Medicare as a satellite of JCMC, Woodridge must: be operated under the same license as JCMC; integrate its clinical services and medical staff with those of JCMC; share income and expenses with JCMC; and it must hold itself out to the public and payors as being a part of JCMC. Woodridge's sharing of revenue and expenses with JCMC will be a legal and factual issue in this proceeding. A copy of the relevant sections of 42 CFR §413.65 are attached hereto as Exhibit D. If Woodridge shares revenues and expenses with JCMC, any projected negative financial impact of SBH-Kingsport's psychiatric hospital on Woodridge will be diminished significantly.

In 2009, MSHA closed down a psychiatric hospital facility in Kingsport in Sullivan County that was known as Indian Path Pavilion. Through this action, 52 inpatient psychiatric beds were taken out of service, while another nine of the beds formerly at Indian Path Pavilion were transferred to Woodridge Psychiatric Hospital in Johnson City in Washington County. This gave Woodridge Psychiatric Hospital a total of 84 inpatient psychiatric beds, which is its current bed complement. Over the past two years, the utilization of Woodridge has been high and rising and it continued to rise in its 2015 fiscal year.

IV. SERVICE AREA ISSUES

Much of the proof and testimony in this matter will focus on issues regarding the service area proposed by SBH-Kingsport, LLC in its CON application. This proposed service area, as noted above, consists of Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. The proposed project is to be located in Kingsport, in western Sullivan County, Tennessee. As noted above, Indian Path Pavilion formerly operated 61 psychiatric hospital beds in Kingsport, Tennessee, until it was closed by MSHA in 2009.

The reason this issue is contentious in this matter is that if the definition of the service area proposed by SBH-Kingsport is accepted by this tribunal, a mathematical need under the state health plan ("Guidelines for Growth") exists for more beds in this particular service area than have been proposed by SBH-Kingsport. Therefore, based on this criterion alone, there would be a need for SBH-Kingsport, LLC's proposed psychiatric hospital facility to be located in Kingsport, Sullivan County, Tennessee.

The Intervenor argues that the Applicant/Applicant should have used a larger service area, to include Washington County, Tennessee, as well as other counties. This would have caused Woodridge Psychiatric Hospital, operated by MSHA in Johnson City in Washington County to be included in the bed need analysis. As noted, it is a satellite hospital facility of Johnson City Medical Center, and operates under the Johnson City Medical Center license. This would increase the number of available beds in the service area if the Applicant's service area were enlarged to include the enlarged service area.

In the five-county service area proposed by the applicant in this matter, there are only 12 inpatient psychiatric hospital beds currently. These 12 beds are located in Bristol, Tennessee, in eastern Sullivan County.

V. ISSUES OF LAW

This case arises under the Tennessee Uniform Administrative Procedures Act, T.C.A. § 4-5-301, *et seq.*, because it is a contested case proceeding.

Tennessee cases under the UAPA provide that in administrative proceedings such as this one, the burden of proof ordinarily rests on the one seeking the relief, benefits or privilege. See *Big Fork Mining Co. v. Tennessee Water Quality Control Board*, 620 S.W.2d 515, 520 (Tenn. App. 1981).

In *Big Fork*, the court also held that proceedings such as this one are *de novo* hearings; thus, evidence not previously submitted to the Agency can be offered. Also, it held further as to the burden of proof that the burden of proof rests on the party having the affirmative of an issue, that burden does not shift. In the instant case, the burden of proof is on the Applicant, SBH-Kingsport, LLC.

This proceeding also involves testimony of expert witnesses. Based on reports generated in discovery by the expert witnesses so far, there will be conflicts in expert testimony. Tennessee courts have also held that when there are conflicts in expert testimony in a proceeding, it is "the Agency's prerogative to resolve them, . . .". *Wayne Co. v. Tennessee Solid Water Disposal Control Board*, 756 S.W.2d 274, 281 (Tenn. App. 1988).

Applicant bears the burden of proving that the project it proposes in CON application number CN1312-050, for the establishment of a 72-bed psychiatric hospital in Kingsport, Sullivan County, Tennessee, and the initiation of psychiatric services therein, is, as required by T.C.A. § 68-11-1609(d), "necessary to provide needed healthcare in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective healthcare facilities or services."

It is the Applicant's assertion that, as also shown by the proof that will be presented at the hearing, the action it proposes in certificate of need application CN1312-050, is necessary to provide needed healthcare in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective healthcare facilities or services. Thus, the Applicant asserts that the CON it seeks should be granted.

The Applicant further asserts that the evidence presented at the hearing will clearly establish that the project proposed in CON application number CN1312-050 will satisfy the

criteria set forth in the state health plan, also known as the Guidelines for Growth, for the establishment for the addition of facilities and beds to provide psychiatric inpatient services. These provisions of the Guidelines for Growth, are, by statute (T.C.A. § 68-11-1609(b)), to be used as "guidelines" by the HSDA in CON matters such as this one.

The Applicant asserts that the actions it proposes in CON application CN1312-050 will also satisfy any applicable criteria set forth in the rules of the HSDA itself, particularly Rule 0720-11-.01. The provisions of this rule, as the rule text itself indicates, "may" be utilized by the HSDA in making its decision.

The Intervenor generally disputes any assertion that the project proposed in CON application number CN1312-050 satisfies the statutory criteria for the grant of a CON, or the applicable provisions of the Guidelines for Growth or applicable HSDA rules. The Intervenor disputes in particular the scope of the service area proposed by the applicant for this project, as well as the need for this project.

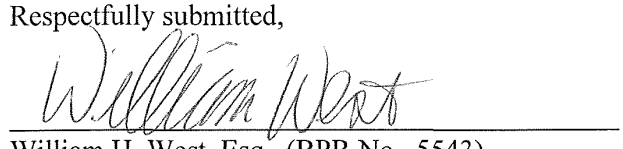
While T.C.A. § 68-11-1609 specifies that the state health plan shall be used by the HSDA as "guidelines", and the Agency's own rules assert that the criteria listed therein "may" be utilized by the HSDA in making its decisions, the criteria generally known as "need, economic feasibility and contributions of orderly development of healthcare", as set forth in the first sentence of T.C.A. § 68-11-1609 above, are mandatory. Thus, the statutory criteria of need, economic feasibility, and contribution to the orderly development of healthcare control over any non-mandatory provisions of the state health plan and the rules of the HSDA. However, the Applicant asserts that its CON application and the proof it presents in this proceeding will establish that all of the concerns set forth in the Guidelines in the Growth and the rules of the Agency are satisfied by the project proposed in CON application CN1312-050, and that it will

also, as noted above, satisfy the statutory criteria set forth in the first sentence of T.C.A. § 68-11-1609(b), otherwise known as "need, economic feasibility, and contribution to the orderly development of healthcare."

VI. RELIEF REQUESTED

The Applicant respectfully requests that, after hearing and considering the proof presented in this proceeding, and review of the record arising therefrom, this tribunal issue an initial order finding for the Applicant and concluding that, as a matter of fact and law, the project set forth in CON application number CN1312-050 satisfies the statutory criteria for the grant of a CON set forth in T.C.A. § 68-11-1609(b) and all other relevant criteria, and that the requested CON should be granted. Upon reaching such a conclusion as set forth in this tribunal's findings of fact and conclusions of law, the Applicant respectfully requests that the initial order so issued also direct the HSDA to issue the CON requested in CON application number CN1312-050 to SBH-Kingsport, LLC.

Respectfully submitted,



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Applicant/Petitioner

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been delivered via email to:

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and

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

this 20 day of July, 2015.

William West

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Tenn. Code Ann. § 68-11-1609 (Copy w/ Cite) Pages: **3**

Tenn. Code Ann. § 68-11-1609

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*** Current through the 2014 Regular Session and amendments approved at the November 4, 2014 General Election ***

Title 68 Health, Safety and Environmental Protection
Health
Chapter 11 Health Facilities and Resources
Part 16 Tennessee Health Services and Planning Act of 2002

Tenn. Code Ann. § 68-11-1609 (2014)

68-11-1609. Decision on application.

(a) The agency shall, upon consideration of an application and review of the evaluation and other relevant information:

(1) Approve part or all of the application and grant a certificate of need, upon any lawful conditions that the agency deems appropriate and enforceable on the grounds that those parts of the proposal appear to meet applicable criteria;

(A) Any condition or conditions that are placed on a certificate of need, and that appear on the face of the certificate of need when issued, shall also be made a condition or conditions of any corresponding license issued by the department of health or department of mental health and substance abuse services. Notwithstanding any law to the contrary, any such conditions survive the expiration of the certificate of need, and remain effective until removed or modified by the agency. Such conditions shall become a requirement of licensure and shall be enforced by the respective licensing entity;

(B) The holder of a license or certificate of need that has a condition placed on it by the agency may subsequently request that the condition be removed or modified, for good cause shown. The agency shall consider the request and determine whether or not to remove or modify the condition. The procedure for requesting such a determination shall be as provided by agency rules. If the holder of the license or certificate of need is aggrieved by the agency's decision, it may request a contested case hearing as permitted by this part;

(2) Disapprove part or all of the application and deny a certificate of need on the grounds that the applicant has not affirmatively demonstrated that those parts of the proposal meet the applicable criteria; or

(3) Defer decisions for no more than ninety (90) days to obtain a clarification of information concerning applications properly before the agency, if there are no simultaneous review applications being concurrently considered by the agency with the deferred application.

(b) No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically

Ex. A

accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services. In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. Until the state health plan is approved and adopted, the agency shall use as guidelines the current criteria and standards adopted by the state health planning and advisory board, and any changes implemented by the planning division pursuant to § 68-11-1625. Additional criteria for review of applications shall also be prescribed by the rules of the agency. Notwithstanding any other provision of this subsection (b), when considering applications for new nursing home beds from the one hundred twenty-five (125) bed medicare skilled nursing facility (SNF) bed pool authorized in § 68-11-1622, the agency shall apply the criteria in this subsection (b). All other applications for new nursing home beds shall be governed solely by § 68-11-1621. During the fiscal year of July 1, 2014, to June 30, 2015, the agency shall issue no certificates of need for new nursing home beds other than the one hundred twenty-five (125) medicare SNF beds authorized in § 68-11-1622.

(c) A certificate of need is valid for a period not to exceed three (3) years for hospital projects, and two (2) years for all other projects, from the date of its issuance and after such time shall expire; provided, however, 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 nonrefundable reasonable filing fee, as prescribed by rule. An extension cannot be issued to any applicant, unless substantial progress has been demonstrated. A certificate of need that 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.

(d) A certificate of need that has expired is null and void, and of no effect. No revocation proceeding is required. No license or occupancy approval may be issued by the department of health or the department of mental health and substance abuse services for any activity for which a certificate of need has become null and void.

(e) The agency's decision to approve or deny an application shall be final and shall not be reconsidered after the adjournment of the meeting in which the matter was considered. This subsection (e) does not limit the right to file a petition for a contested case hearing pursuant to § 68-11-1610, nor does it limit the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, part 3, pertaining to contested case hearings.

(f) Written notice of the decision of the agency approving, disapproving, or deferring an application, or parts of an application, shall be transmitted to the applicant, simultaneous review applicants, the department of health, the department of mental health and substance abuse services, the department of intellectual and developmental disabilities, and others upon request.

(g) (1) Subject to subdivision (g)(2), any health care institution wishing to oppose a certificate of need application must file a written objection with the agency and serve a copy on the contact person for the applicant, not later than fifteen (15) days before the agency meeting at which the application is originally scheduled. An application for which the agency has received opposition shall be designated on the agency's agenda as an opposed application.

(2) A health care institution or other person may appear before the agency and express opposition to an application without complying with the requirements of subdivision (g)(1); provided, that if a health care institution does not provide notice of its opposition as required by subdivision (g)(1), and if such health care institution initiates a contested case pursuant to § 68-11-1610, then such health care institution shall be solely responsible for the agency's costs of the contested case proceeding and shall reimburse to the applicant the filing fee paid by the applicant, notwithstanding any other law. Noncompliance with subdivision (g)(1) shall not preclude a health care institution from intervening in a contested case proceeding initiated by

the applicant.

HISTORY: Acts 2002, ch. 780, § 4; 2004, ch. 942, § 6; 2005, ch. 237, § 1; 2007, ch. 347, § 1; 2009, ch. 461, § 1; 2010, ch. 1100, §§ 119-121; 2011, ch. 479, § 1; 2012, ch. 575, § 1; 2013, ch. 311, § 1; 2014, ch. 874, § 1.

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RULES
OF
HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-11
CERTIFICATE OF NEED PROGRAM – GENERAL CRITERIA

TABLE OF CONTENTS

0720-11-.01 General Criteria for Certificate of Need

0720-11-.01 GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

(a) The relationship of the proposal to any existing applicable plans;

(b) The population served by the proposal;

(c) The existing or certified services or institutions in the area;

(d) The reasonableness of the service area;

(e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;

(f) Comparison of utilization/occupancy trends and services offered by other area providers;

(g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

Ex. B

SBH-KINGSPORT 000229

(Rule 0720-11-.01, continued)

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition;

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;

(d) The quality of the proposed project in relation to applicable governmental or professional standards.

(4) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, The Agency may consider, in addition to the foregoing factors, the following factors:

(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change to the proposed new site.

(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

(c) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.

(5) Certificate of need conditions. In accordance with T.C.A. § 68-11-1609, The Agency, in its discretion, may place such conditions upon a certificate of need it deems appropriate and enforceable to meet the applicable criteria as defined in statute and in these rules.

Authority: *T.C.A. §§ 4-5-202, 68-11-1605, and 68-11-1609.* ***Administrative History:*** *Original rule filed August 31, 2005; effective November 14, 2005.*

SBH-KINGSPORT 000230

PSYCHIATRIC INPATIENT SERVICES

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

3. For child inpatient under age 13, and if adolescent program the age group of 13-17 should be used.

4. These estimates for total need should be adjusted by the existent staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.

2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

Ex. C

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.

2. Accessibility to specific special need groups should be an important factor.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

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for the month in which the civil action is commenced.

Example: An contractor made a final determination on the amount of Medicare program reimbursement on June 15, 1974, and the provider appealed that determination to the Provider Reimbursement Review Board. The Board heard the appeal and rendered a decision adverse to the provider. On October 28, 1974, the provider commenced civil action to have such decision reviewed. The rate of return on equity capital for the month of October 1974 was 11.625 percent. The period for which interest is computed begins on January 1, 1975, and the interest beginning January 1, 1975, would be at the rate of 11.625 percent per annum.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 42238, Nov. 24, 1986; 53 FR 1628, Jan. 21, 1988; 57 FR 39830, Sept. 1, 1992; 59 FR 36713, July 19, 1994; 64 FR 41682, July 30, 1999; 65 FR 41211, July 3, 2000; 66 FR 41394, Aug. 7, 2001; 67 FR 56056, Aug. 30, 2002; 69 FR 49252, Aug. 11, 2004; 69 FR 66981, Nov. 15, 2004; 73 FR 30267, May 23, 2008]

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* (1) *Scope.* (i) This section applies to all facilities for which provider-based status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in §§ 412.22(h)(1) and 412.25(e)(1) of this chapter, other than facilities described in paragraph (a)(1)(ii) of this section.

(ii) The determinations of provider-based status for payment purposes described in this section are not made as to whether the following facilities are provider-based:

(A) Ambulatory surgical centers (ASCs).

(B) Comprehensive outpatient rehabilitation facilities (CORFs).

(C) Home health agencies (HHAs).

(D) Skilled nursing facilities (SNFs) (determinations for SNFs are made in accordance with the criteria set forth in § 483.5 of this chapter).

(E) Hospices.

(F) Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services.

(G) Independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities that furnish only screening mammography services (as defined in section 1861(jj) of the Act), facilities that furnish only clinical diagnostic laboratory tests, other than those clinical diagnostic laboratories operating as parts of CAHs on or after October 1, 2010, or facilities that furnish only some combination of these services.

(H) Facilities, other than those operating as parts of CAHs, furnishing only physical, occupational, or speech therapy to ambulatory patients, throughout any period during which the annual financial cap amount on payment for coverage of physical, occupational, or speech therapy, as described in section 1833(g)(2) of the Act, is suspended by legislation.

(I) ESRD facilities (determinations for ESRD facilities are made under § 413.174 of this chapter).

(J) Departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid (for example, laundry or medical records departments).

(K) Ambulances.

(L) Rural health clinics (RHCs) affiliated with hospitals having 50 or more beds.

(2) *Definitions.* In this subpart E, unless the context indicates otherwise—

Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Department of a provider means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the

Ex. D

SBH-KINGSPORT 000233

Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A department of a provider may not by itself be qualified to participate in Medicare as a provider under §489.2 of this chapter, and the Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term "department of a provider" does not include an RHC or, except as specified in paragraph (n) of this section, an FQHC.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity.

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider of health care services, or an RHC as defined in §405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider, in accordance with the provisions of this section. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. A provider-based entity may, by itself, be qualified to participate in Medicare as a provider under §489.2 of this chapter, and the Medicare conditions of participation do apply to a provider-based entity as an independent entity.

Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.

Remote location of a hospital means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital comprises both the specific physical facility that serves as the site of services for which separate payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. The Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term "remote location of a hospital" does not include a satellite facility as defined in §§412.22(h)(1) and 412.25(e)(1) of this chapter.

(b) *Provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) If a facility was treated as provider-based in relation to a hospital or CAH on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. The requirements, limitations, and exclusions specified in paragraphs (d), (e), (f), (h), and (i) of this section will not apply to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. For purposes of this paragraph (b)(2), a facility is considered as provider-based on October 1, 2000 if, on that date, it either had a written determination from CMS that it was provider-based, or was billing and being paid as a provider-based department or entity of the hospital.

(3)(i) Except as specified in paragraphs (b)(2) and (b)(5) of this section, if a potential main provider seeks a determination of provider-based status for a facility that is located on the campus of the potential main provider, the provider would be required to submit an attestation stating that the facility meets the criteria in paragraph

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(d) of this section and, if it is a hospital, also attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider seeking such a determination would also be required to maintain documentation of the basis for its attestations and to make that documentation available to CMS and to CMS contractors upon request. If the facility is operated as a joint venture, the provider would also have to attest that it will comply with the requirements of paragraph (f) of this section.

(ii) If the facility is not located on the campus of the potential main provider, the provider seeking a determination would be required to submit an attestation stating that the facility meets the criteria in paragraphs (d) and (e) of this section, and if the facility is operated under a management contract, the requirements of paragraph (h) of this section. If the potential main provider is a hospital, the hospital also would be required to attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section. The provider would be required to supply documentation of the basis for its attestations to CMS at the time it submits its attestations.

(iii) Whenever a provider submits an attestation of provider-based status for an on-campus facility or organization, as described in paragraph (b)(3)(i) of this section, CMS will send the provider written acknowledgment of receipt of the attestation, review the attestation for completeness, consistency with the criteria in this section, and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based.

(iv) Whenever a provider submits an attestation of provider-based status for an off-campus facility or organization, as described in paragraph (b)(3)(ii) of this section, CMS will send the provider written acknowledgment of receipt of the attestation, review the attestation for completeness, consistency with the documentation submitted with the attestation and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility or organization is provider-based.

(4) A facility that is not located on the campus of a hospital and that is used as a site where physician services of the kind ordinarily furnished in physician offices are furnished is presumed as a free-standing facility, unless CMS determines the facility has provider-based status.

(5) A facility that has requested provider-based status in relation to a hospital or CAH on or after October 1, 2000 and before October 1, 2002 will be treated as provider-based in relation to the hospital or CAH from the first date on or after October 1, 2000 on which the facility was licensed (to the extent required by the State), staffed and equipped to treat patients until the date on which CMS determines that the facility does not qualify for provider-based status.

(c) *Reporting of material changes in relationships.* A main provider that has had one or more facilities or organizations considered provider-based also may report to CMS any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that would affect the provider-based status of the facility or organization.

(d) *Requirements applicable to all facilities or organizations.* Any facility or organization for which provider-based status is sought, whether located on or off the campus of a potential main provider, must meet all of the following requirements to be determined by CMS to have provider-based status:

(1) *Licensure.* The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the

SBH-KINGSPORT 000235

provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, CMS will determine that the facility or organization does not have provider-based status.

(2) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(3) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.

(4) *Public awareness.* The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(5) *Obligations of hospital outpatient departments and hospital-based entities.* In the case of a hospital outpatient department or a hospital-based entity, the facility or organization must fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph (g) of this section.

(e) *Additional requirements applicable to off-campus facilities or organizations.* Except as described in paragraphs (b)(2) and (b)(5) of this section, any facility or organization for which provider-based status is sought that is not located on the campus of a potential main provider must meet both the requirements in paragraph (d) of this section and all of the following additional requirements, in order to be determined by CMS to have provider-based status.

(1) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based

SBH-KINGSPORT 000236

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
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Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

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SECRETARY OF STATE

MOUNTAIN STATES HEALTH ALLIANCE'S NOTICE OF INTENT TO INTRODUCE AFFIDAVIT

The accompanying affidavit of Teresa M. Kidd, Ph.D will be introduced as evidence at the hearing in the matter of *SBH-Kingsport, LLC v. Tennessee Health Services and Development Agency and Mountain States Health Alliance.*

Teresa M. Kidd, Ph.D. will not be called to testify orally and you will not be entitled to question her unless you notify Brian Jackson and Travis Swearingen at Butler Snow LLP, 150 Third Ave South, Suite 1600, Nashville TN 37201. To be effective, your request must be mailed or delivered to Brian Jackson and Travis Swearingen on or before July 23, 2015.

G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services & Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 16th day of July, 2015.

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
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Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
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Respondent,	)	
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and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

AFFIDAVIT OF TERESA M. KIDD, PH.D.

Having been duly sworn, I, Teresa M. Kidd, Ph.D., attest as follows:

1. I am of majority age, am competent to provide testimony, and have personal knowledge of the facts set forth herein.

2. That the statements contained herein are true, accurate, and correct to the best of my knowledge and belief.

3. I am a psychologist licensed to provide mental health and substance abuse services in Tennessee. I received my undergraduate degree in psychology from Marietta College

in Marietta, Ohio, in 1975. I earned my master's degree in school psychology in 1977 and my Ph.D. in psychology in 1980, both from the University of Tennessee.

4. For the past 33 years, I have been actively involved in providing mental health and substance abuse services in Northeast Tennessee. In addition, since 1991, I have served in a leadership capacity with Frontier Health and its predecessor entities. Today, I am President and Chief Executive Officer of Frontier Health.

5. Frontier Health, headquartered in Gray, Tennessee, is the leading provider of outpatient psychiatric services in Northeast Tennessee and Southwest Virginia. We operate approximately 25 outpatient access points, including comprehensive intensive outpatient treatment programs, residential programs for individuals with serious or persistent mental illness, community-based child and adolescent services, assessment and forensic services, and crisis management. Twenty of Frontier Health's program areas are currently accredited through the Commission on the Accreditation of Rehabilitation Facilities.

6. In conjunction with the outpatient services offered by Frontier Health, Woodridge Psychiatric Hospital ("Woodridge") plays a critical role as the non-profit, public psychiatric facility for eight (8) counties of Region One in Northeast Tennessee and portions of Southwest Virginia. Woodridge accepts walk-in individuals and community referrals regardless of their ability to pay and serves as a safety-net for those individuals. In addition, Woodridge works cooperatively with Frontier Health in efforts to reduce hospitalization recidivism, and in the coordination of care with patients; interacting with multiple healthcare systems. The long standing effective communication between Woodridge and regional providers promotes increasing positive outcomes in the treatment of highly complex co-occurring disorders (which represents more than sixty percent (60%) of all presenting patients).

7. Woodridge Psychiatric Hospital, Mountain States Health Alliance, and Frontier Health have a longstanding commitment to serving those in acute and chronic conditions; and each consistently has given significant uncompensated care to the citizens of our region. This community partnership has increased access to care and improved the local quality of care for many years.

8. Consistent with this commitment, Mountain States Health Alliance and Frontier Health are in the final stages of collaborating to create a 12-bed adolescent crisis stabilization unit to be based in Gray, Tennessee. CSUs are an important level of care as they provide 72-96 hours of acute therapeutic intervention for patients who have the same or similar level of severity of psychiatric illness as an inpatient unit. The availability of CSU beds can significantly impact the need for inpatient beds by providing a less expensive alternative for patients in acute distress who do not warrant inpatient hospitalization.

9. It is my expectation that once the new adolescent CSU is operational, it will be able to handle a significant number of our acute patients who currently have no other option but to be admitted on an inpatient basis. As a result, the CSU will free up inpatient beds at Woodridge and other surrounding providers to handle the most critical patients.

10. Frontier Health would be deeply concerned about any new project that, if approved, would impact Woodridge's ability to continue serving as our partner in providing a comprehensive array of psychiatric services to our community. I fear that the addition of a new 72-bed psychiatric hospital, particularly a for-profit provider with no history in this community of caring for those without the ability to pay, would disrupt the efforts currently being made to address the needs of our patients. Moreover, the continued viability of Woodridge is critical to the health of our medical community, which would be irreparably harmed if Woodridge were

forced to revise or reconstitute its mission as the regional inpatient psychiatric provider because it economically could no longer afford to offer the services it does.

FURTHER THE AFFIANT SAYETH NOT

Teresa M. Kidd, Ph.D.,

Sworn to the subscribed before me
this 7th day of July, 2015.

NOTARY PUBLIC
My Commission Expires: 8/29/17

TERRI MARTIN
STATE OF TENNESSEE NOTARY PUBLIC
WASHINGTON COUNTY

LFP

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2015 JUL 21 PM 4:25
SECRETARY OF STATE

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
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and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

MOUNTAIN STATES HEALTH ALLIANCE'S NOTICE OF INTENT TO INTRODUCE AFFIDAVIT

The accompanying affidavit of Karl Goodkin, MD, PhD, DFAPA will be introduced as evidence at the hearing in the matter of *SBH-Kingsport, LLC v. Tennessee Health Services and Development Agency and Mountain States Health Alliance.*

Karl Goodkin, MD, PhD, DFAPA will not be called to testify orally and you will not be entitled to question him unless you notify Brian Jackson and Travis Swearingen at Butler Snow LLP, 150 Third Ave South, Suite 1600, Nashville TN 37201. To be effective, your request must be mailed or delivered to Brian Jackson and Travis Swearingen on or before July 28, 2015.

G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services &
Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 21st day of July, 2015.

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
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Applicant,	)	
	)	
v.	)	
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TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
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Respondent,	)	
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and	)	
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MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

AFFIDAVIT OF KARL GOODKIN, MD, PhD, DFAPA

Having been duly sworn, I, Karl Goodkin, MD, PhD, DFAPA attest as follows:

1. I am of majority age, am competent to provide testimony, and have personal knowledge of the facts set forth herein.

2. That the statements contained herein are true, accurate, and correct to the best of my knowledge and belief.

3. I am a medical doctor currently licensed to practice medicine in the State of Tennessee and previously licensed in the States of California, Texas, and Florida. I received my

medical degree from the University of Miami Miller School of Medicine in 1982. I completed my residency in psychiatry at Stanford University in 1986 and a research fellowship there in 1987. I am board-certified in psychiatry by the American Board of Psychiatry and Neurology. I have also been trained as a clinical psychologist with a PhD in that field obtained from the University of Miami in 1983.

4. I currently serve as Professor and Chair of the Department of Psychiatry and Behavioral Sciences at James H. Quillen College of Medicine at East Tennessee University State ("ETSU"). I am a distinguished fellow of the American Psychiatric Association and a member of the American College of Psychiatrists.

5. ETSU is located in Johnson City. The Quillen College of Medicine was founded in 1974 and has successfully graduated more than 1,500 physicians in that time. It is the only medical school in the Tennessee Board of Regents System and, with the College of Nursing, College of Clinical and Rehabilitative Health Sciences, Gatton College of Pharmacy, and College of Public Health, serves as the system's health sciences center. In just three decades, the College has developed into one of the nation's leading schools for rural medicine and primary care training, an honor consistently recognized by U.S. News & World Report.

6. The Department of Psychiatry and Behavioral Sciences is an important component of the College of Medicine. The ETSU psychiatry training program is broad-based so as to give a strong foundation in the full spectrum of psychiatric disorders, treatment approaches and treatment sites. The physicians in the ETSU psychiatry training program are firm believers in a comprehensive, bio-psychosocial approach to psychiatry. This provides trainees a comprehensive basis for their future practice of psychiatry, as well as clinical experience from which they can choose later career preferences.

7. Woodridge Psychiatric Hospital ("Woodridge") is a critical component of the ETSU ongoing psychiatry and behavioral science programs as Woodridge provides both financial and educational support to the ETSU psychiatry residency training program.

8. Woodridge currently subsidizes 10 residency slots at an annual cost of $450,000 to the hospital. Additionally, Woodridge annually provides $47,500 to help support two faculty positions. Without this support, the Department of Psychiatry and Behavioral Sciences would face increased financial pressure which would hinder its ability to offer the most effective and successful psychiatry residency training program possible.

9. Furthermore, Woodridge offers ETSU residents with the opportunity to achieve hundreds of hours of face-to-face patient interaction per month. This clinical experience is invaluable to ETSU residents as they continue to hone their education, knowledge and skill set. As the primary psychiatric hospital in this region offering a full spectrum of mental health services, Woodridge is a unique and invaluable educational tool to help train the next generation of psychiatrists.

10. In addition to the training opportunities Woodridge affords, ETSU serves in a critical role in the management of Woodridge. Specifically, ETSU professors provide psychiatric care and services for the "Spruce" unit at Woodridge, a 12-bed unit focused primarily on older adult and geriatric patients. For all TennCare patients that ETSU psychiatry sees through these programs, Woodridge subsidizes each service at a rate of $45 per treatment. Approximately 80% of the patients served at Woodridge have governmental insurance (Medicare, Tenncare/Medicaid) or are uninsured.

11. In conjunction with their responsibilities as the attending physicians for the Spruce unit, ETSU psychiatrists provide input into treatment policies and procedures at Woodridge. Through this partnership, I have seen first-hand how Woodridge serves as the

psychiatric safety-net provider for East Tennessee. Woodridge offers first rate care to the most vulnerable members of our community without regard to the ability to pay. Not only is the partnership between the ETSU Department of Psychiatry and Behavioral Sciences and Woodridge crucial to the well-being of the ETSU psychiatric residency training program, but Woodridge is also crucial to the well-being of our community.

12. I would be deeply concerned about any new project that, if approved, would impact Woodridge's ability to continue serving as an academic partner with the ETSU Department of Psychiatry and Behavioral Sciences. The continued viability of Woodridge is critical to the function of our psychiatric residency program, which is the only source to train psychiatry residents at East Tennessee State University. Furthermore, our medical community would be irreparably harmed if Woodridge were forced to revise or reconstitute its mission as the regional psychiatric provider because it economically could no longer afford to offer the services it does.

FURTHER THE AFFIANT SAYETH NOT

Karl Goodkin, MD, PhD, DFAPA

Sworn to the subscribed before me this 21st day of July 2015.

Christine H. Loveday
NOTARY PUBLIC
My Commission Expires: September 25, 2018

CHRISTINE H. LOVEDAY
STATE OF TENNESSEE NOTARY PUBLIC
WASHINGTON COUNTY

LFP

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

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July 20, 2015

Leonard Pogue, Administrative Judge
Department of State
Administrative Procedures Division
312 Eighth Avenue North
8th Floor, William R. Snodgrass Tower
Nashville, Tennessee 37243

Re: SBH-Kingsport, LLC
Certificate of Need Application No.: CN1312-050D
Docket No.: 25.00-126908J

Dear Judge Pogue:

Please be advised that respondent, the Health Services and Development Agency [HSDA], does not intend to file a pre-trial brief in this matter. On June 25, 2014, the HSDA considered the above-referenced CON application; the motion to approve failed by a 4-4 vote because a motion only carries if supported by a majority of members present and voting. The vote affects this contested case in two ways: the applicant still has the burden of proof in this *de novo* proceeding, and HSDA counsel does not intend to take a position regarding whether the proposed project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services. However, HSDA counsel will participate in this contested case to the extent necessary to protect the HSDA's interest regarding questions of law, procedure, evidence, and the CON process, generally.

Please do not hesitate to contact me if you have any questions.

Sincerely,

James B. Christoffersen
General Counsel

cc: William H. West, attorney for SBH-Kingsport, LLC (via email)
G. Brian Jackson, attorney for Mountain States Health Alliance (via email)

LFP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	
	)	

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SBH-KINGSPORT, LLC'S MEMORANDUM IN OPPOSITION TO MSHA'S MOTION IN LIMINE NO. 2 TO PRECLUDE EVIDENCE OF LETTERS OF SUPPORT AND OPPOSITION

SBH-Kingsport, LLC, the Applicant herein, hereby files this memorandum in opposition to Intervenor's MSHA's Motion in Limine No. 2 ("MIL No. 2") the purpose of which is to preclude Applicant "from presenting evidence or making references to letters of support or letters of opposition that were submitted" to the Health Services and Development Agency ("HSDA").

SBH-KINGSPORT 000254

This motion is not well taken and should be denied for the reasons set forth below. Strict adherence to the Tennessee Rules of Evidence is not required in proceedings before administrative bodies. *See*, *Davis v. Shelby County Sheriff's Dept.*, 278 S.W.3d 256, 266 (2009). By their own terms, the Tennessee Rules of Evidence do not apply to administrative hearings, but rather to court appearances. *Id.*; Tenn. R. Evid. 101 ("These rules shall govern evidence rulings in all trial courts of Tennessee except as otherwise provided by statute or rules of the Supreme Court of Tennessee."); s*ee Goodwin v. Metro. Bd. of Health,* 656 S.W.2d 383, 388 (Tenn. Ct. App.1983) ("[N]either the technicalities of the Civil Rules of Procedure nor the common law rules of evidence necessarily apply before nonjudicial bodies *unless the rules of that body so require.*") (emphasis added) (citing *Big Fork Mining Co. v. Tenn. Water Quality Control Bd.,* 620 S.W.2d 515 (Tenn. Ct. App.1981); *L & N Railroad Co. v. Fowler,* 197 Tenn. 266, 271 S.W.2d 188 (1954)). Unlike a court proceeding, the agency can rely on other evidence if it is "of a type commonly relied upon by reasonably prudent men in the conduct of their affairs." Tenn. Code Ann. § 4-5-313 (1). So, in some cases, hearsay, for example, could be admitted.

First, Intervenor does not specifically identify the letters about which MSHA complains. For this reason alone MIL No. 2 should be denied.

Second, depending on the letter in question, it may be the subject of a proper hearsay objection, or it may be admissible for other purposes for which there is a hearsay exception or the letter may be admitted as nonhearsay. It is premature to rule on the admissibility of such letters until they are offered in evidence.

More importantly, Intervenor acknowledges that interested parties may submit letters in support of and letters in opposition to the project for the HSDA's consideration. (MSHA's MIL

No. 2, p. 1). The letters of support are part of the CON application. The letters were reviewed and considered by the Agency members. The letters are now part of the Agency record. Any weight to be given the letters should be for the Administrative Law Judge to decide and the Judge should decline to rule until they are offered in evidence.

CONCLUSION

For the reasons set forth above, MSHA's Motion in Limine No. 2 should be denied.

Respectfully submitted,

William H. West, Esq. (BPR No. 5543)
Charles K. Grant (BPR No. 017081)
Baker Donelson Bearman Caldwell & Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
615-726-5561
Counsel for SBH-Kingsport, LLC, Applicant/Petitioner

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 24th day of July, 2015, a copy of the foregoing has been delivered via email to:

Travis Swearingen, Esq.
Brian Jackson, Esq.
Butler Snow LLP
150 Third Avenue South, Suite 1600
Nashville, TN 37201

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

Charles K. Grant

SBH-KINGSPORT 000256

LFP

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BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	
	)	

SBH-KINGSPORT, LLC'S MEMORANDUM IN OPPOSITION TO MSHA'S MOTION IN LIMINE NO. 1

SBH-Kingsport, LLC, the Applicant herein, hereby files this memorandum in opposition to Intervenor's MSHA's motion in limine number 1 that is aimed at "precluding evidence of the potential Wellmont/MSHA merger."

This motion is not well taken and should be denied for the reasons set forth below.

Evidence regarding the potential Wellmont/MSHA merger, accomplished by gaining state approval of their application pursuant to T.C.A. § 68-11-1301, *et seq.*, for a "certificate of public advantage" ("COPA") is relevant to the issue of the need for more psychiatric beds as

proposed by the Applicant's CON application. One of the purposes of the proposed merger that MSHA executives have publicly asserted concerns the need for northeast Tennessee and southwest Virginia to address the "serious health issues" of addiction care and increased access to mental health services, which are core issues in this proceeding. According to Alan Levine, the CEO of Intervenor, Mountain States Health Alliance ("MSHA"), addiction care and increased access to mental health services are among the top three "serious health issues" facing northeast Tennessee and southwest Virginia. These issues have been central to MSHA's public expressions of the reasons for MSHA's plan to file a Certificate of Public Advantage application in the near future. Thus, evidence of the COPA is directly relevant because the Applicant's CON project at issue seeks to provide 72 beds in Kingsport to treat mental health and addiction (chemical dependency) patients from northeast Tennessee and southwest Virginia. Any testimony concerning the proposed merger would be relevant to the core issues in this proceeding.

Furthermore, the documents concerning the proposed merger are all admissible for various reasons. The documents concerning the merger are as follows:

1. Wellmont Health System and MSHA's April 2, 2015 Press Release (Exh. A);

2. Copy of webpage from the Municipal Securities Rulemaking Board regarding the proposed merger (Exh. B);

3. Three pages from MSHA's webpage, which discusses the proposed merger (Exh. C);

4. Newspaper article from the *Herald Courier* (local newspaper in northeast Tennessee) reporting on the merger (Exh. D); and

5. Copy of Emergency COPA Rules 1200-38-01-.01, *et seq*.

As a general proposition, the Tennessee Rules of Evidence are used as guidance in agency proceedings, but are not mandatory. See *Armstrong v. Magill,* 2004 Tenn. App. LEXIS 430 (Tenn. Ct. App. 2004). Unlike a court proceeding, the agency can rely on other evidence if it is "of a type commonly relied upon by reasonably prudent men in the conduct of their affairs." See, Tenn. Code Ann. § 4-5-313 (1). So, in some cases, hearsay, for example, could be admitted.

Nevertheless, information a party disseminates on its own website is admissible as admissions of the party-opponent under Tenn.R.Evid. 8.03 (1.2) (Admission by Party-Opponent); *see, e.g., Van Westrienen v. Americontinental Collection Corp.,* 94 F.Supp.2d 1087, 1109 (D. Or. 2000) ("the representations made by defendants on the websites are admissible as admissions of the party-opponent under FRE 801(d)(2)(A)"). A court may take judicial notice of information publicly announced on a party's website (citing Fed.R.Evid. 201). *Doron Precision Sys., Inc. v. FAAC, Inc.*, 423 F.Supp.2d 173 (S.D.N.Y. 2006); *Town of Southold v. Town of East Hampton,* 406 F.Supp.2d 227 (E.D. N.Y. 2005). Thus, the press release found on MSHA's website is admissible.

Likewise, a court may take judicial notice of information found on a public website. *See, e.g., Lan Lan Wang v. Pataki,* 396 F.Supp.2d 446 (S.D.N.Y. 2005) (taking judicial notice of the contents of a website). The information found on the Municipal Securities Rulemaking Board website would be admissible.

Further, this press release is publicly available on the Municipal Securities Rulemaking Board's "EMMA" website, and denoted as Exh. B attached hereto. MSHA's press release also is also an exhibit to Mr. Levine's deposition.

Furthermore, Mr. Levine voluntarily gave interviews to the *Herald Courier*, a local newspaper in northeast Tennessee at which he spoke at length about the need for mental health

and addiction services in southwest Virginia. This newspaper article is Exh. D to this memorandum, and was also an exhibit in Mr. Levine's deposition. The headline for this article is: "Mental health, drug addiction targets of Wellmont/MSHA merger."

If Mr. Levine, the CEO of MSHA, believes that northeast Tennessee and southwest Virginia have significant need for more addiction services and improved access to mental health services -- statements he expressed while justifying MSHA's plans to pursue the COPA -- such statements by the CEO of MSHA surely and inescapably have the "tendency" to make the existence of the need for more psychiatric hospital services and chemical dependency services (as proposed by the Applicant) in Kingsport "more probable" than it would be without the evidence. Thus, these satisfy Rules 401 and 402 of the Tennessee Rules of Evidence and should be admitted into the record hearing herein.

It is highly inappropriate and unjust for MSHA to seek to prevent the presentation of publicly available relevant information to this tribunal, almost all of which MSHA itself has broadcast, and continues to broadcast, to the world. This would not only unfairly prejudice the case of the Applicant in this matter, but it is contrary to law. The United States Supreme Court itself has held in the case of *Ruckelshaus v. Monsanto*, 467 U.S. 986, 1011-1012 (1984), that once information is not secret it can never be returned to "secret" status, but is in the public domain. The information MSHA seeks to exclude is relevant, public domain information. Therefore, publicly available information, still being propounded by MSHA itself to the public, to its hospitals, to its employees and to the legislature of Tennessee, should not be excluded from this proceeding, especially when it is relevant directly relevant thereto and otherwise admissible.

MSHA sought and obtained, along with Wellmont, significant changes to the Tennessee certificate of public advantage statute, T.C.A. § 68-11-1301, *et seq.* These changes are found in

Public Chapter 464 of the Public Acts of 2015, which is an exhibit to Mr. Levine's deposition. Furthermore, on July 14, 2015, the Commissioner of Health propounded rules regarding the COPA process as emergency rules on the Secretary of State's website. Administrative agencies may take official notice of the rules of state agencies, have statewide application, and are easily ascertainable. *Acuff v. Comm'r of Tennessee Dep't of Labor,* 554 S.W.2d 627 (Tenn. 1977). Thus, the COPA issues are public both as to the contents of the COPA statutory changes and as to emergency rules which have just been issued by the Commissioner of Health and published as emergency rules in the Secretary of State's Administrative Register. As stated above, a copy of these rules is attached hereto as Exh. E.

Based on these rules, and the COPA statute, the factors available to be considered in the CON process sometimes resemble those set forth in the emergency rules for the COPA process. For example, HSDA Rule 0720-11-.01(3)(b) states that the HSDA may consider "the positive or negative effects attributable to duplication or competition". Similarly, the COPA emergency rules direct the COPA process to address "the extent of any reduction in competition among . . . hospitals that is likely to result from the Cooperative Agreement." See Emergency COPA Rule 1200-38-01-.03(b)(2). The new COPA statute also contains a virtually identical directive at T.C.A. § 68-11-1303(d)(3)(B). Thus, the relevant evidence for both this CON process and the COPA process overlap. In fact, the COPA regulations specify at COPA Rule 12-38-01-.02(2)(a)(13)(v)(IV) that the Cooperative Agreement filed for the COPA must include a statement "regarding the requirements for any Certificate(s) of Need resulting from the Cooperative Agreement". It is surely relevant to this proceeding if the proposed COPA project will result in any CON filings for any addiction care or behavioral health CON projects in

northeast Tennessee or southwest Virginia. MSHA's efforts to distort the evidence relevant to this matter are erroneous as a matter of fact and law.

Given the fact that the COPA issues are public all around -- whether at the General Assembly, the Secretary of State's office, the Department of Health, local newspapers, MSHA's own website, or the Municipal Securities Financing Board -- it is inappropriate and in bad faith for Mountain States to seek to prevent the Petitioner from "presenting evidence or making references to the potential merger between MSHA and Wellmont." This tribunal would be deprived of significant relevant evidence, necessary for its decision, should it grant MSHA's motion and the rights of the Applicant to a full and fair hearing would be impaired.

MSHA cannot complain of any danger of undue prejudice or confusion from Applicant's or this tribunal's use of Mr. Levine's statements and the documents that contain them or testimony related thereto. If such risks exist, MSHA would surely not have broadcast them to the world.

Furthermore, if the COPA negotiations or meetings between MSHA and Wellmont have addressed, or will address, the addition of any psychiatric hospital beds in northeast Tennessee or southwest Virginia, evidence of such negotiations are directly relevant to this case. If MSHA or Wellmont believes that more inpatient psychiatric hospital beds should be developed, whether by conversion of nonpsychiatric beds to psychiatric hospital beds or by construction of new psychiatric hospital beds (both of which actions require the grant of a CON in Tennessee), such information satisfies the relevancy tests of Rules 401-403 of the Tennessee Rules of Evidence by making it more probable, as a matter of fact, that the need for the Applicant's project exists. It would be error for such evidence to be excluded in this proceeding.

CONCLUSION

For the reasons set forth above, MSHA's motion in limine number 1 should be denied.

Respectfully submitted,

William H. West, Esq. (BPR No. 5543)
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615-726-5561
Counsel for SBH-Kingsport, LLC, Applicant/Petitioner

SBH-KINGSPORT 000263

FOR IMMEDIATE RELEASE:

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WELLMONT HEALTH SYSTEM, MOUNTAIN STATES HEALTH ALLIANCE ANNOUNCE PLANS TO PURSUE AN INTEGRATED HEALTH SYSTEM

New organization would make health care more affordable, redirect resources toward improving health of region

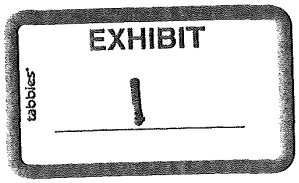
KINGSPORT and JOHNSON CITY, Tenn. – (April 2, 2015) – Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a new, integrated and locally governed health system designed to address the serious health issues affecting the region and to be among the best in the nation in terms of quality, affordability and patient satisfaction.

In a term sheet signed Wednesday, the boards of directors of both organizations agree to explore combining the assets and operations of Wellmont and Mountain States into a new health system. This decision follows more than a year of merger discussions, internal analysis within each system, thoughtful conversations in the community and unanimous votes by both boards to examine this option.

"We are excited about this proposed combination that will bring together the capabilities of both Wellmont and Mountain States, combined with a partnership in academics and with our states, to serve the region and result in unprecedented quality and value," said Roger Leonard, chair of Wellmont's board. "We are grateful to the thousands of community and business leaders, physicians, employees and patients who have shared their thoughts throughout this process. It was deliberative and methodical, which led us unanimously to the right conclusion."

"Our board is enthusiastic about this potential partnership," said Barbara Allen, chair of the board for Mountain States. "We and the leadership of Wellmont all care deeply about the region we serve. We share a passion for improving our region's health and our region's economy. We look forward to working closely with the state of Tennessee and the Commonwealth of Virginia, as well as with our payors, to focus on the real drivers of cost reduction and quality-enhancement."

A new board will be created, which will have equal representation from Wellmont and Mountain States, as well as two new independent, jointly appointed members. The board will also include a lead independent director who will be a Wellmont board appointee who will work with the board in coordination with the executive chairman. This is a best practice model frequently used by companies who have an executive chairman.



The president of East Tennessee State University will serve as an ex-officio nonvoting member of the board. The involvement of ETSU will focus on expanding opportunities to compete for research investment in our region, as well as enhancing physician and allied health training for the future.

This new board would direct the proposed health system, which would also have a new name. One leadership team, composed of current executives from both organizations, would lead the combined system. The CEOs of both organizations would share leadership responsibilities.

"Northeast Tennessee and Southwest Virginia disproportionately suffer from serious health issues – cardiovascular disease, diabetes, addiction and access to mental health services, to name a few – and they must be addressed," said Alan Levine, president and CEO of Mountain States, who would become executive chairman and president of the combined system. "The cost of this poor health is not sustainable. By integrating, we can refocus our efforts from being measured based on how many patients we can admit to the hospital and how many ways we can duplicate these efforts, to how we measurably improve the health of our region while eliminating unnecessary costs and making health care more affordable. The people of this region deserve nothing less. We intend to demonstrate the merger's substantial specific potential in these areas."

An integration council with executive and physician leaders from both systems will be formed to further develop plans for a combined system during the next several months. Those plans will be in the best interest of clinical quality and the patients served, will demonstrate shared values and will honor commitments to employees and physicians.

"Together, we'll work alongside our employed and independent physicians to shape the future of health care by modeling effective clinical collaboration, building new community health solutions and becoming a national model for rural health care delivery," said Bart Hove, president and CEO of Wellmont, who would be CEO of the new system. "As one system, our physicians would share best practices, collaborate to benchmark our outcomes against the nation's best and develop new high-level services closer to home."

The systems now enter a due diligence period and will work toward developing a definitive agreement. The definitive agreement will be followed by a process to obtain, among other regulatory requirements, Tennessee and Virginia approvals of the merger, which will likely take through the end of 2015.

In Tennessee, the organizations will pursue approval under the state's COPA (Certificate of Public Advantage) statute. A COPA authorizes the parties to merge and directs the state to actively supervise the new health system to ensure that it continues to benefit the community by providing health care that is affordable, accessible, cost-efficient and high in quality. In Virginia, the health systems will

pursue a process similar to a COPA that is defined by a proposed statute that has been passed by the legislature and awaits the governor's signature.

During the next phases of due diligence, integration analysis, planning for potential integration and government approval, both Mountain States and Wellmont will continue "business as usual" as two separate and independent organizations.

For more information, please visit www.becomingbettertogether.org.

About Wellmont Health System

Wellmont Health System is a leading provider of health care services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive health care, wellness, and long-term care services across the region. Wellmont facilities include Holston Valley Medical Center in Kingsport, Tenn.; Bristol Regional Medical Center in Bristol, Tenn.; Mountain View Regional Medical Center in Norton, Va.; Lonesome Pine Hospital in Big Stone Gap, Va.; Hawkins County Memorial Hospital in Rogersville, Tenn.; and Hancock County Hospital in Sneedville, Tenn. For more information about Wellmont, please visit www.wellmont.org.

About Mountain States Health Alliance

Since 1998, Mountain States Health Alliance has been bringing the nation's best health care close to home to serve the residents of Northeast Tennessee, Southwest Virginia, Southeastern Kentucky and Western North Carolina. This not-for-profit health care organization based in Johnson City, Tenn., operates family of 13 hospitals serving a 29-county region. Mountain States offers a large tertiary hospital with level 1 trauma center, a dedicated children's hospital, several community hospitals, two critical access hospitals, a behavioral health hospital, two long-term care facilities, home care and hospice services, retail pharmacies, a comprehensive medical management corporation, and the region's only provider-owned health insurance company. The team members, physicians and volunteers who make up Mountain States Health Alliance are committed to caring for you and earning your trust. For more information, visit www.mountainstateshealth.com.

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Issue Details

THE HEALTH AND EDUCATIONAL FACILITIES BOARD OF THE CITY OF JOHNSON CITY, TENNESSEE (MOUNTAIN STATES HEALTH ALLIANCE) HOSPITAL REVENUE BONDS SERIES 2013 A, TAXABLE HOSPITAL REFUNDING REVENUE BONDS, SERIES 2013 B (TN)

JOHNSON CITY TENN HEALTH & EDL FACS BRD HOSP REV VAR-MOUNTAIN ST HEALTH (TN)*

Dated Date: 07/30/2013
Underwriting Spread Amount: Disclosed in Official Statement
Closing Date: 07/30/2013
Time of Formal Award: 07/29/2013 05:00 PM
Time of First Execution: 07/30/2013 09:00 AM

Maturities and issue-related documents
View all maturities of an issue and download the official statement and other documents available from EMMA for this issue. Click on a CUSIP number for security-specific data, including trade price data.

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FINANCIAL INFORMATION & DOCUMENTS Collapse

Most Recent | Management Discussion For the Quarter Ended March 31, 2015 and Nine Months Fiscal Year to Date 2015 for the quarter ended 03/31/2015 posted 06/09/2015 (215 KB) details

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2

Annual Financial Information and Operating Data for the year ended 06/30/2014 posted 10/31/2014 (237 KB)	details
Annual Financial, Operating Data, and Maximum Annual Debt Service Coverage for the year ended 06/30/2013 posted 01/27/2014 (266 KB)	details

Audited Financial Statements or CAFR

Audited Consolidated Financial Statements for the year ended 06/30/2014 posted 10/31/2014 (4.4 MB)	details
Consolidated Audited Financials for the year ended 06/30/2013 posted 01/27/2014 (266 KB)	details
Consolidated Audited Financials for the year ended 06/30/2013 posted 10/31/2013 (5.5 MB)	details

Other Financial / Operating Data

Management Discussion For the Quarter Ended March 31, 2015 and Nine Months Fiscal Year to Date 2015 for the quarter ended 03/31/2015 posted 06/09/2015 (215 KB)	details

Quarterly / Monthly Financial Information

Quarterly Financial Information and Maximum Annual Debt Service Coverage for the quarter ended 03/31/2015 posted 05/14/2015 (305 KB)	details
Quarterly Financial Information and Historical Maximum Annual Debt Service Coverage for the quarter ended 12/31/2014 posted 02/10/2015 (587 KB)	details
Quarterly Financial Information and Maximum Annual Debt Service Coverage for the quarter ended 09/30/2014 posted 11/14/2014 (369 KB)	details
Quarterly Financial Information and Maximum Annual Debt Service Coverage for the quarter ended 06/30/2014 posted 08/14/2014 (326 KB)	details
Quarterly Financial Information and Maximum Annual Debt Service Coverage for the quarter ended 03/31/2014 posted 05/13/2014 (323 KB)	details
Quarterly Financial Information and Maximum Annual Debt Service Coverage for the quarter ended 12/31/2013 posted 02/13/2014 (250 KB)	details
Quarterly financial information and historical maximum annual debt service coverage ratio for the quarter ended 09/30/2013 posted 11/14/2013 (890 KB)	details
Quarterly Financial Information and Historical Maximum Annual Debt Service Coverage for the quarter ended 06/30/2013 posted 08/13/2013 (809 KB)	details

EVENT NOTICES

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Most Recent: Press Release re MSHA and WHS, dated 04/02/2015 dated 04/02/2015 posted 04/02/2015 (228 KB) details

Other Event-based Disclosures

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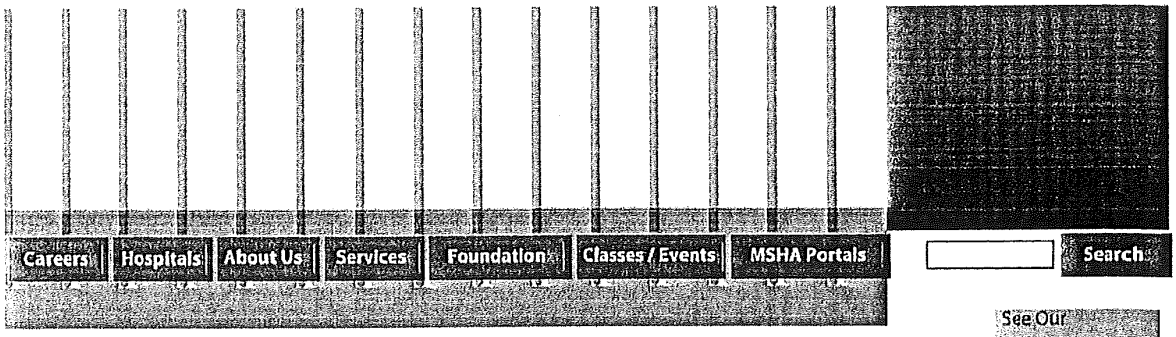
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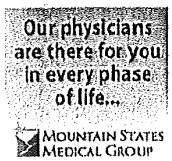

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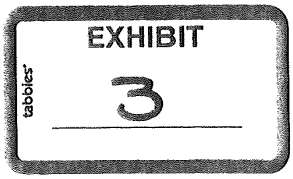

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Wellmont, Mountain States announce plans to pursue an integrated health system

4/2/2015

New organization would make health care more affordable, redirect resources toward improving health of region



Wellmont Health System and Mountain States Health Alliance have agreed to exclusively explore the creation of a new, integrated and locally governed health system designed to address the serious health issues affecting the region and to be among the best in the nation in terms of quality, affordability and patient satisfaction.

In a term sheet signed Wednesday, the boards of directors of both organizations agree to explore combining the assets and operations of Wellmont and Mountain States into a new health system. This decision follows more than a year of merger discussions, internal analysis within each system, thoughtful conversations in the community and unanimous votes by both boards to examine this option.

"We are excited about this proposed combination that will bring together the capabilities of both Wellmont and Mountain States, combined with a partnership in academics and with our states, to serve the region and result in unprecedented quality and value," said Roger Leonard, chair of Wellmont's board. "We are grateful to the thousands of community and business leaders, physicians, employees and patients who have shared their thoughts throughout this process. It was deliberative and methodical, which led us unanimously to the right conclusion."

"Our board is enthusiastic about this potential partnership," said Barbara Allen, chair of the board for Mountain States. "We and the leadership of Wellmont all care deeply about the region we serve. We share a passion for improving our region's health and our region's economy. We look forward to working closely with the state of Tennessee and the Commonwealth of Virginia, as well as with our payors, to focus on the real drivers of cost reduction and quality-enhancement."

A new board will be created, which will have equal representation from Wellmont and Mountain States, as well as two new independent, jointly appointed members. The board will also include a lead independent director who will be a Wellmont board appointee who will work with the board in coordination with the executive chairman. This is a best practice model frequently used by companies who have an executive chairman.

The president of East Tennessee State University will serve as an ex-officio nonvoting member of the board. The involvement of ETSU will focus on expanding opportunities to compete for research investment in our region, as well as enhancing physician and allied health training for the future.

This new board would direct the proposed health system, which would also have a new name. One leadership team, composed of current executives from both organizations, would lead the combined system. The CEOs of both organizations would share leadership responsibilities.

"Northeast Tennessee and Southwest Virginia disproportionately suffer from serious health issues – cardiovascular disease, diabetes, addiction and access to mental health services, to name a few – and they must be addressed," said Alan Levine, president and CEO of Mountain States, who would become executive chairman and president of the combined system. "The cost of this poor health is not sustainable. By integrating, we can refocus our efforts from being measured based on how many patients we can admit to the hospital and how many ways we can duplicate these efforts, to how we measurably improve the health of our region while eliminating unnecessary costs and making health care more affordable. The people of this region deserve nothing less. We intend to demonstrate the merger's substantial specific potential in these areas."

An integration council with executive and physician leaders from both systems will be formed to further develop plans for a combined system during the next several months. Those plans will be in the best interest of clinical quality and the patients served, will demonstrate shared values and will honor commitments to employees and physicians.

"Together, we'll work alongside our employed and independent physicians to shape the future of health care by modeling effective clinical collaboration, building new community health solutions and becoming a national model for rural health care delivery," saidBart Hove, president and CEO of Wellmont, who would be CEO of the new system. "As one system, our physicians would share best practices, collaborate to benchmark our outcomes against the nation's best and develop new high-level services closer to home."

The systems now enter a due diligence period and will work toward developing a definitive agreement. The definitive agreement will be followed by a process to obtain, among other regulatory requirements, Tennessee and Virginia approvals of the merger, which will likely take through the end of 2015.

In Tennessee, the organizations will pursue approval under the state's COPA (Certificate of Public Advantage) statute. A COPA authorizes the parties to merge and directs the state to actively supervise the new health system to ensure that it continues to benefit the community by providing health care that is affordable, accessible, cost-efficient and high in quality. In Virginia, the health systems will pursue a process similar to a COPA that is defined by a proposed statute that has been passed by the legislature and awaits the governor's signature.

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During the next phases of due diligence, integration analysis, planning for potential integration and government approval, both Mountain States and Wellmont will continue "business as usual" as two separate and independent organizations.

For more information, please visit www.becomingbettertogether.org.

About Wellmont Health System

Wellmont Health System is a leading provider of health care services for Northeast Tennessee and Southwest Virginia, delivering top-quality, comprehensive health care, wellness, and long-term care services across the region. Wellmont facilities include Holston Valley Medical Center in Kingsport, Tenn.; Bristol Regional Medical Center in Bristol, Tenn.; Mountain View Regional Medical Center in Norton, Va.; Lonesome Pine Hospital in Big Stone Gap, Va.; Hawkins County Memorial Hospital in Rogersville, Tenn.; and Hancock County Hospital in Sneedville, Tenn. For more information about Wellmont, please visit www.wellmont.org.

About Mountain States Health Alliance

Since 1998, Mountain States Health Alliance has been bringing the nation's best health care close to home to serve the residents of Northeast Tennessee, Southwest Virginia, Southeastern Kentucky and Western North Carolina. This not-for-profit health care organization based in Johnson City, Tenn., operates family of 13 hospitals serving a 29-county region. Mountain States offers a large tertiary hospital with level 1 trauma center, a dedicated children's hospital, several community hospitals, two critical access hospitals, a behavioral health hospital, two long-term care facilities, home care and hospice services, retail pharmacies, a comprehensive medical management corporation, and the region's only provider-owned health insurance company. The team members, physicians and volunteers who make up Mountain States Health Alliance are committed to caring for you and earning your trust. For more information, visit www.mountainstateshealth.com.

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Mental health, drug addiction targets of Wellmont/MSHA merger

BY ALLIE ROBINSON GIBSON | BRISTOL HERALD COURIER | Posted: Saturday, April 4, 2015 11:30 pm

Part of a proposed merged health system's goals going forward is to provide more access for mental health and drug-addicted patients, the leaders of the region's largest two health care systems said last week.



Regional drug addictions/mental health needs

MSHA president and CEO Alan Levine, right, and Wellmont president and CEO Bart Hove discuss the need for additional drug addiction treatment facilities and mental health needs within the region following Thursday's merger announcement.

Alan Levine, president and CEO of Mountain States Health Alliance, and Bart Hove, president and CEO of Wellmont Health System, outlined some plans for a future combined health system at a press event Thursday afternoon.

"We look to expand and grow needed services — for instance, if you go into Southwest Virginia, there's a true need for mental health and addiction recovery," Levine said. "It's something we've heard from the state, it's something we've heard from our doctors. So there's an opportunity to take some of the assets that we do have and infuse new and exciting opportunities to bring those services to the communities. We think this is a very positive move in helping sustain those communities, and those facilities."

Hove agreed.

"Part of [the plan] is to provide mental access close by so that patients can receive the services they need ... in a quick fashion," he said, echoing Levine's thought to potentially take current facilities and use them for those services. "Maintaining those facilities and those locations and utilizing them appropriately is really in our best interest going forward."

East Tennessee State University's Quillen College of Medicine will lead the charge in determining exactly what services are needed throughout the region, as faculty there lead a patient assessment survey. After that, ETSU President Brian Noland said work can begin to treat those health needs.

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"I think all of us in this room understand — this was part of Alan [Levine]'s proposal that got us excited — was to create a new focus on mental health and substance abuse," said Roger Leonard, Wellmont's board chairman. "We know that's not just difficult for employers, but the burden is on families in the region."

Currently, Mountain States has 116 beds dedicated to mental health patients — 84 at Woodridge Hospital in Johnson City, 20 at Russell County Medical Center and 12 beds dedicated to geriatric patients at Sycamore Shoals Hospital in Elizabethton, said MSHA spokeswoman Teresa Hicks.

Wellmont has a 40-bed capacity to address mental health and addiction services, according to Wellmont spokesman Jim Wozniak.

There are other facilities that offer those overnight services in the region, as well. Frontier Health, based in Gray, Tennessee, staffs two residential drug and alcohol recovery facilities, as well as several outpatient facilities and psychiatric treatment facilities.

The state-run Southwest Virginia Mental Health Institute has 162 beds for adult and geriatric patients, and is operated by the Department of Behavioral Health and Developmental Services.

Highlands Community Services in Abingdon, Virginia, offers outpatient facilities and Clinical Director Rebecca Holmes said Friday that she sees an increased need for closer bed capacity for both mental health and addiction recovery services in Southwest Virginia.

"Having beds would be extremely beneficial for the region to get qualified services for folks, particularly so they can get services at home and not have to drive so far," Holmes said.

She said it is particularly difficult to find space for children's services — the state facility for children, the Commonwealth Center for Children and Adolescents, is in Staunton, Virginia, a three-hour drive from Abingdon. There are private facilities that are closer, but they are still at least an hour away, she said.

There are some spots for adults in a facility in Bristol and Lebanon, Holmes said, and beds for substance abuse recovery in Galax and Lebanon. But, she said, one day this past week she was trying to find a spot at one of the recovery centers, which were both full. She said it's the first time in a while she's had trouble getting a placement for someone, but demand for those facilities is increasing.

A statewide bed registry instituted last year, following the tragic death of Sen. Creigh Deeds' son, who attacked Deeds with a knife and then shot himself after a psychiatric bed couldn't be found for him, has helped open up placement options, even if they're further away, Holmes said. She said the tragedy resulted in more awareness across the state and bed capacity is no longer quite so scarce.

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But it's still needed here, she said.

"I think any capacity for service options we can make accessible for the people in our region is beneficial and worth pursuing," she said.

She said she thinks the proposed merger between Mountain States and Wellmont would be good for behavioral health.

"I think both sides of the aisle have long known they don't operate independently of one another," she said. "Integrated care, simultaneously addressing all needs and issues in the region is beneficial. ... I'm excited this is a direction they are considering."

Another part of patient health services going forward would be a new integrated patient data platform, officials said.

"It will be great for patients, because no matter where you go, whatever system they choose to use, whichever doctor they choose to see, their information will be available to that doctor," Levine said. "This will be particularly important for patients who show up at the emergency department and may not have that information in critical care. That's a really important thing to address."

Doctors said they think that integrated system, once implemented, would improve patient care.

"That will not only help direct patient care, but is the framework for being able to look at a lot of patients and get that data to see improvements," said Nelson Gwaltney, a physician at Elmont Health System. "It also is easier to get the information, as opposed to going to 50 different places and looking at a paper chart."

The merger process is expected to take the remainder of the year to complete. During that time, the two health systems will function separately.

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Chapter 1200-38-01
Hospital Cooperation Act of 1993

New Chapter

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1200-38-01-.01 Purpose and Definitions.

The rules in this chapter implement the law relative to Cooperative Agreements and the granting of Certificates of Public Advantage pursuant to the Hospital Cooperation Act of 1993, T.C.A. §§ 68-11-1301 through 68-11-1309.

Pursuant to the Act, the Department is responsible for active state supervision to protect the public interest and to assure that the reduction in competition of health care and related services continues to be outweighed by clear and convincing evidence of the likely benefits of the Cooperative Agreement, including but not limited to improvements to population health, access to services and economic advantages to the public. The COPA will be denied or terminated if the likely benefits of the Cooperative Agreement fail to outweigh any disadvantages attributable to a potential reduction in competition resulting from the Cooperative Agreement by clear and convincing evidence.

(1) "Advisory Group" means the group of stakeholders from Applicants geographic service area, as specified in the Application, appointed by the Commissioner, in consultation with appropriate constituencies and government agencies, to recommend Measures to be considered for inclusion in an Index to objectively track Public Advantage of a single Cooperative Agreement.

(2) "Applicant" means the parties to a Cooperative Agreement who submit an Application to the Department in accordance with 1200-38-01.02.

(3) "Application" means the written materials submitted to the Department in accordance with 1200-38-01.02, by entities who desire to apply for a Certificate of Public Advantage.

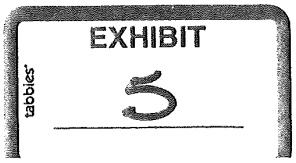
(4) "Attorney General" means the Attorney General and Reporter for the State of Tennessee.

(5) "Certificate of Public Advantage ("COPA" or the "Certificate")" means the written approval by the Department which governs the Cooperative Agreement.

(6) "Certificate Holder" means the entity holding the Certificate of Public Advantage issued by the Department.

(7) "Commissioner" means the Commissioner of the Department of Health.

(8) "Cooperative Agreement" means an agreement among two (2) or more hospitals for the consolidation by merger or other combination of assets, offering, provision, operation, planning, funding, pricing, contracting, utilization review or management of health services or for the sharing, allocation or referral of patients, personnel, instructional programs, support services and facilities or medical, diagnostic or



laboratory facilities or procedures or other services traditionally offered by hospitals, including any parent or subsidiary at the time the transaction occurs or at any time thereafter.

(9) "Department" means the Department of Health.

(10) "Hospital" means an institution required to be licensed as a hospital pursuant to § 68-11-201, or defined as a psychiatric hospital in § 68-11-102; or any parent of a hospital, hospital subsidiary or hospital affiliate that provides medical or medically-related diagnostic and laboratory services or engages in ancillary activities supporting those services.

(11) "Index" means a set of Measures used to objectively track the progress of a Cooperative Agreement over time to ensure Public Advantage. The components of the Index may be assigned differential weightings and modified from time to time as determined by the Department.

(12) "Intervenor" means any hospital, physician, allied health professional, healthcare provider or other person furnishing goods or services to, or in competition with, a hospital, insurer, hospital service corporation, medical service corporation, hospital and medical services corporation, preferred provider organization, health maintenance organization or any employer or association that directly or indirectly provides health care benefits to its employees or members.

(13) "Measure" means some number of factors or benchmarks, which may be binary, a range or continuous factors.

(14) "Plan of Separation" means the written proposal submitted with an Application to return the parties to a Cooperative Agreement to a pre-consolidation state, which includes a plan for separation of any combined assets, offering, provision, operation, planning, funding, pricing, contracting, utilization review or management of health services or any combined sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities or medical, diagnostic or laboratory facilities or procedures or other services traditionally offered by hospitals, including any parent or subsidiary at the time the consolidation occurs or thereafter.

(15) "Population" means the entirety of the human population residing or domiciled in the geographic service area set out in the proposed Cooperative Agreement unless otherwise defined.

(16) "Public Advantage" means the likely benefits accruing from a Cooperative Agreement which outweigh, by clear and convincing evidence, the likely disadvantages attributable to a reduction in competition likely to result from the Cooperative Agreement.

Authority: T.C.A. §§ 68-11-1301 through 68-11-1309.

1200-38-01-.02 Application Process.

(1) Letter of Intent. At least forty-five (45) days prior to filing an Application, the parties to the proposed Cooperative Agreement shall file a letter of intent with the Department.

(a) Contents. A letter of intent shall contain the following:

1. A brief description of the proposed Cooperative Agreement, including the physical location of the entities and parties to the Cooperative Agreement;

2. A list that includes all assets, ownership interests, subsidiaries and affiliated businesses currently owned or operated, in whole or in part, directly or indirectly, by any party to the Cooperative Agreement that the parties propose to be included in the COPA or any assets, ownership interests, subsidiaries and affiliated businesses currently owned or operated, in whole or part, by any party to the Cooperative Agreement that will be divested, sold or affected as a result of the Cooperative Agreement;

3. A list of all business interests or units for which each party to the Cooperative Agreement has any ownership interest or a management contract that is not proposed to be included in the Cooperative Agreement;

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4. The name, address and contact information of the parties to the proposed Cooperative Agreement including the executive officers, each party's respective board members and each party's general counsel;

5. A description of the entities' governing structure under the Cooperative Agreement;

6. The anticipated date of submission of the Application; and the anticipated effective date of the proposed Cooperative Agreement; and

7. The geographic service area and Population covered by the Cooperative Agreement.

(b) Amendment. The parties shall amend the letter of intent if material changes occur prior to submission of the parties' Application.

(c) Expiration. A letter of intent expires six (6) months after the date of receipt by the Department, if no Application is filed with the Department within that period.

(d) Public Record. The Department shall post letters of intent on the Department's website until an Application is filed or until the letter of intent expires.

(2) Application.

(a) Parties seeking a COPA shall apply to the Department in writing. Parties shall submit the following information in the Application:

1. A descriptive title;

2. A table of contents;

3. An executive summary which includes:

(i) Goals for change to be achieved by the Cooperative Agreement;

(ii) Benefits and advantages to parties and the public including but not limited to:

(I) Population health;

(II) Access to health care and prevention services; and

(III) Healthcare operating costs, including avoidance of capital expenditures, reduction in operating expenditures and improvements in patient outcomes.

(iii) Description of how the Cooperative Agreement better prepares and positions the parties to address anticipated future changes in health care financing, organization and accountability initiatives; and

(iv) Potential disadvantages of the Cooperative Agreement.

4. The names of each party to the Application and the address of the principal business office of each party;

5. A verified statement signed by the Chairperson of the Board of Directors and Chief Executive Officer of each party to the Application; or, if one or more of the Applicants is an individual, signed by the individual Applicant; attesting to the accuracy and completeness of the enclosed information;

6. A description of the prior history of dealings between the parties to the Application, including, but not limited to, their relationship as competitors and any prior joint ventures

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or other collaborative arrangements between the parties;

7. A detailed description of the proposed geographic service area, not limited to the boundaries of the State of Tennessee. If the proposed geographic service area differs from the service areas where the parties have conducted business over the five (5) years preceding the Application, a description of how and why the proposed geographic service area differs and why changes are proposed;

8. Identification of whether any services or products of the proposed Cooperative Agreement are currently being offered or capable of being offered by other providers or purchasers in the geographic service area described in the Application;

9. Explanation of how the Cooperative Agreement will assure continued competitive and independent operation of the services or products of entities not a party to the Cooperative Agreement;

10. A statement of whether there will be a Public Advantage or adverse impact on Population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement;

11. A statement of whether the projected levels of cost, access to health care or quality of health care could be achieved in the existing market without the granting of a COPA; and, for each of the above, an explanation of why or why not;

12. A report used for public information and education that is documented to have been disseminated prior to submission of the Application and submitted as part of the Application. The report must include the following:

    (i) A description of the proposed geographic service area, services and facilities to be included in the Cooperative Agreement;

    (ii) A description of how health services will change if the Application is accepted;

    (iii) A description of improvements in patient access to health care including prevention services for all categories of payers and advantages patients will experience across the entire service area regarding costs, availability or accessibility upon initiation of the Cooperative Agreement and/or findings from studies conducted by hospitals and other external entities, including health economists, clinical services and population health experts, that describe how implementation of the proposed Cooperative Agreement plans will be: effective with respect to resource allocation implications; efficient with respect to fostering cost containment, including, but not limited to, eliminating duplicate services and future plans; and equitable with respect to maintaining quality and competition in health services within the service area, assuring patient access to and choice of insurers and providers within the health care system;

    (iv) Findings from service area assessments that describe major health issues and trends, specific population health disparities and comparisons to state and other similar regional areas proposed to be addressed;

    (v) Impact on the health professions workforce including long-term employment and wage levels and recruitment and retention of health professionals; and

    (vi) A record of community stakeholder and consumer views of the proposed Cooperative Agreement collected through a public participatory process including meetings and correspondence in which this report or its components were used.

13. A signed copy of the Cooperative Agreement, including:

    (i) A description of any consideration passing to any individual or entity under the

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Cooperative Agreement including the amount, nature, source and recipient;

(ii) A detailed description of any merger, lease, operating or management contract, change of control or other acquisition or change, direct or indirect, in ownership of the assets of any party to the Cooperative Agreement;

(iii) A list of all services and products and of all service locations that are the subject of the Cooperative Agreement, including those not occurring within the boundaries of the State of Tennessee, and including, but not limited to, hospitals or other inpatient facilities, insurance products, physician practices, pharmacies, accountable care organizations, psychiatric facilities, nursing homes, physical therapy and rehabilitation units, home care agencies, wellness centers or services, surgical centers or services, dialysis centers or services, cancer centers or services, imaging centers or services, support services or any other product, facility or service;

(iv) A description of each party's contribution of capital, equipment, labor, services or other value to the transaction;

(v) A description of the competitive environment in the parties' geographic service area, including:

(I) Identification of all services and products likely to be affected by the Cooperative Agreement and the locations of the affected services and products;

(II) The parties' estimate of their current market shares for services and products and the projected market shares if the COPA is granted;

(III) A statement of how competition among health care providers or health care facilities will be reduced for the services and products included in the Cooperative Agreement; and

(IV) A statement regarding the requirement(s) for any Certificate(s) of Need resulting from the Cooperative Agreement.

(vi) Impact on the service area's health care industry workforce, including long-term employment and wage levels and recruitment and retention of health professionals;

(vii) Description of financial performance, including:

(I) A description and summary of all aspects of the financial performance of each party to the transaction for the preceding five (5) fiscal years including debt, bond rating and debt service and copies of offering materials, subsequent filings such as continuing disclosure agreements and material event disclosures, and financial statements prepared by external certified public accountants, including management reports;

(II) A copy of the current annual budget for each party to the Cooperative Agreement and a three (3) year projected budget for all parties after the initiation of the Cooperative Agreement. The budgets must be in sufficient detail so as to determine the fiscal impact of the Cooperative Agreement on each party. The budgets must be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used must be documented;

(III) A detailed explanation of the projected effects including expected change in volume, price and revenue as a result of the Cooperative Agreement, including;

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I. Identification of all insurance contracts and payer agreements in place at the time of the Application and a description of pending or anticipated changes that would require or enable the parties to amend their current insurance and payer agreements;

II. A description of how pricing for provider insurance contracts are calculated and the financial advantages accruing to insurers, insured consumers and the parties to the Cooperative Agreement, if the COPA is granted including changes in percentage of risk-bearing contracts;

III. The following policies:

A. Policy that assures no restrictions to Medicare and/or Medicaid patients,

B. Policies for free or reduced fee care for the uninsured and indigent,

C. Policies for bad debt write-off; and

D. Policies that assure parties to the Cooperative Agreement will maintain or exceed the existing level of charitable programs and services.

(IV) Identification of existing or future business plans, reports, studies or other documents of each party that:

I. Discuss each party's projected performance in the market, business strategies, capital investment plans, competitive analyses and financial projections including any documents prepared in anticipation of the Cooperative Agreement; and

II. Identification of plans that will be altered, eliminated or combined under the Cooperative Agreement or subsequent COPA.

(viii) A description of the plan to systematically integrate health care and preventive services among the parties to the Cooperative Agreement, in the proposed geographic service area, that addresses the following:

(I) A streamlined management structure, including a description of a single board of directors, centralized leadership and operating structure;

(II) Alignment of the care delivery decisions of the system with the interest of the community;

(III) Clinical standardization;

(IV) Alignment of cultural identities of the parties to the Cooperative Agreement; and

(V) Implementation of risk-based payment models to include risk, a schedule of risk assumptions and proposed performance metrics to demonstrate movement toward risk assumption and a proposed global spending cap for hospital services.

(ix) A description of the plan, including economic metrics, that details anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement including:

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(I) Proposed use of any cost savings to reduce prices borne by insurers and consumers;

(II) Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term Population health improvements; and

(III) Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

(x) Proposed Measures and suggested baseline values with rationale for each Measure to be considered by the Department in development of an Index. Proposed Measures are to be used to continuously evaluate the Public Advantage of the results of actions approved in the COPA through the Cooperative Agreements under active supervision of the Department. Measures should include source and projected trajectory over each of the first five (5) years of the Cooperative Agreement and the trajectory if the COPA was not granted; Proposed Measures may include:

(I) Improvements in the Population's health that exceed Measures of national and state improvement;

(II) Continuity in availability of services throughout the service area;

(III) Access and use of preventive and treatment health care services throughout the service area;

(IV) Operational savings projected to lower health care costs to payers and consumers; and

(V) Improvements in quality of services as defined by surveys of the Joint Commission.

14. An explanation of the reasons for the exclusion of any information set forth in section 1200-38-01-.02, the Application Process, including an explanation of why the item is not applicable to the Cooperative Agreement or to the parties;

15. A detailed description of the total cost resulting from the Cooperative Agreement, including, but not limited to, costs for consultant and professional services, capital costs, financing costs and management costs. The description should identify costs associated with the implementation of the Cooperative Agreement, including documentation of the availability of the necessary funds. The description should identify which costs are borne by each party;

16. A timetable for implementing all components of the Cooperative Agreement;

17. The Department shall require a Plan of Separation be submitted with the Application. The Plan of Separation shall be updated annually by the parties to the Cooperative Agreement. The parties shall provide an independent opinion from a qualified organization verifying the Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the parties; and

18. The name, address and telephone number of the person(s) authorized to receive notices, reports and communications with respect to the Application.

(3) Additional Department Requirements.

(a) The Department may request additional information from the parties prior to deeming the

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Application complete or issuing a final decision. The Application shall not be deemed complete nor shall the one hundred twenty (120) day review period commence until all information is received by the Department.

(b) The Department shall notify the parties in writing when the Application is deemed complete.

(c) The parties shall submit simultaneously a copy of the Application and copies of all additional related materials to the Attorney General and to the Department. The Department and the Attorney General are vested with the active and continuing oversight of all Cooperative Agreements.

(d) The Department may waive any of the requirements or timeframes that it finds, at its sole discretion, due to the nature of a particular Cooperative Agreement, are inapplicable to its analysis of the Cooperative Agreement.

(e) The Application and accompanying documents are public records pursuant to T.C.A. § 10-7-503 and are subject to public inspection in accordance with § 10-7-503, except for records which are confidential pursuant to state or federal law. The parties shall specify any portion of the Application which the parties contend is exempt from the Public Records Act. The parties shall include the specific authority for said exemption. Applicants shall submit two (2) copies of the Application. The first copy shall include all requested information. The second copy shall contain all requested information; however, the parties shall redact confidential information wherever possible. Nothing in this subsection shall limit or deny access to otherwise public information because an Application or accompanying document contains confidential information.

Authority: T.C.A. § 68-11-1303.

1200-38-01-.03 Terms of Certification. All COPAs shall be governed by terms of certification. The terms of certification shall include:

(1) Charges.

(a) Parties to a Cooperative Agreement who have applied to the Department for a COPA shall pay all charges incurred in the examination of the Application and, in the event the COPA is approved, all charges incurred for the review and ongoing supervision of the Cooperative Agreement. The charges shall include all expenses of the Department, including, but not limited to, the fees and expenses of experts and examiners employed in the review and ongoing supervision of the Application and COPA.

(b) The charges assessed by the Department, and the fees and expenses of experts and examiners contracted by the Commissioner to examine and review the Cooperative Agreement and all records shall be fixed by the Commissioner at an amount commensurate with usual compensation for like services.

(c) The Department shall develop a formula to include charges incurred in the examination of the Application and charges incurred for review and ongoing supervision and invoice COPA Applicants and holders Department's costs at a regular interval.

(d) The obligation to pay charges assessed under this section shall be the joint and several obligation of the parties to the Cooperative Agreement.

(2) Evaluation by the Department that demonstrates Public Advantage in accordance with the standards set forth in these rules.

(a) Benefits to include:

1. Enhancement of the quality of Hospital and hospital-related care provided to Tennessee citizens;

2. Preservation of hospital facilities in geographical proximity to the communities

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traditionally served by those facilities;

3. Gains in the cost containment and cost-efficiency of services provided by the Hospitals involved;

4. Improvements in the utilization of hospital resources and equipment;

5. Avoidance of duplication of Hospital resources;

6. Demonstration of Population health improvement of the region served according to criteria set forth in the Cooperative Agreement and approved by the Department;

7. The extent to which medically underserved populations have access to, and are projected to utilize, the proposed services; and

8. Any other benefits that may be identified.

(b) Disadvantages to include:

1. The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other healthcare payers to negotiate appropriate payment and service arrangements with Hospitals, physicians, allied healthcare professionals or other healthcare providers;

2. The extent of any reduction in competition among physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the Cooperative Agreement;

3. The extent of any likely adverse impact on (i) patients in the quality and availability of healthcare services and (ii) patients and payers in the price of healthcare services; and

4. The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the Cooperative Agreement.

(3) Ongoing Supervision through the use of an Index tracking demonstration of Public Advantage.

(a) An Index will be created and used by the Department to evaluate the proposed and continuing Public Advantage of the COPA.

(b) The Index will include measures of the cognizable benefits in the following categories:

1. population health;

2. access to health services;

3. economic; and

4. other cognizable benefits.

(c) Each category may be comprised of Measures for subcategories of the Index which shall be recommended separately by the Advisory Group and the parties to the Cooperative Agreement for the COPA. The Department retains exclusive authority to add to, modify, or to accept or reject recommendations when creating the Index.

(d) The Department shall establish a baseline score at the outset of the Index composition to allow for the future demonstration of a Public Advantage. Subsequently, established ranges for the score should demonstrate whether:

1. The advantage is clear and convincing, in which event the COPA will continue in effect,

2. The advantage is not clear and convincing in which event a modification to the Cooperative Agreement under the terms of certification will be necessary,

3. The advantage is not evident, in which event COPA will be terminated in accordance with 1200-38-01-.07.

(e) Advisory Group

1. Recommendations. The Advisory Group shall recommend to the Commissioner Measures to be considered for inclusion in an Index to objectively track the Public Advantage of a Cooperative Agreement.

2. Meetings. The Advisory Group shall hold at least four (4) meetings with stakeholders to obtain community input and comment, with guidance from the Department.

(i) All meetings shall be open in accordance with T.C.A. §§ 8-44-101 through 8-44-111.

(ii) One (1) meeting shall provide for comment from internal stakeholders, such as persons employed by, or agents, of the parties to the Cooperative Agreement, affiliates, contractors or vendors, staff clinicians and other persons deriving income from their activities with any of the parties to the Cooperative Agreement.

(iii) One (1) meeting shall provide for comment from external stakeholders, such as competing health care providers, non-staff clinicians, payers including self-insured employers, governmental agencies, and non-governmental agencies, and other parties who derive income from health or health care services or are who are not employed or affiliated with and do not derive income from the parties to the Cooperative Agreement.

(iv) One (1) meeting shall provide for comment from other members of the community not represented in the internal or external stakeholder groups, including, current or potential patients, customers or other entities who are not affiliated, competing, or otherwise contracting with the parties to the Cooperative Agreement.

(v) The final meeting shall be open to all persons expressing an interest in the Cooperative Agreement and shall be held following the completion of the Advisory Group's recommendation of Measures to be considered for inclusion in the Index.

(vi) The Advisory Group, in consultation with, and with the approval of, the Department, may elect to alter the number and composition of the meetings previously described.

(vii) The Department may provide guidance to the Advisory Group.

3. Completion of Duties.

(i) The Advisory Group's service shall conclude when the Department receives the Advisory Group's recommendation of Measures proposed for inclusion in the Index.

(ii) The Commissioner shall have the authority to reconvene the Advisory Group if necessary.

(4) Additional conditions of reporting and operations determined by the Department to demonstrate Public Advantage.

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Authority: T.C.A. §§ 68-11-1303 and 68-11-1307.

1200-38-01-.04 Notice and Hearing.

(1) Prior to acting on an Application for a Certificate, the Department shall hold at least one (1) public hearing which will afford the right to any interested parties to express their views regarding an Application, and may gather additional feedback through other means from the community as needed.

(2) The Department shall give notice of the completed Application to interested parties by publishing a notice in the Tennessee administrative register in accordance with the Uniform Administrative Procedures Act, compiled in T.C.A., title 4, chapter 5. The notice shall include a brief summary of the requested action, how to access the Application and information concerning the time and place of the public hearing. The notice shall be published at least forty-five (45) days prior to the date set for the public hearing and shall be deemed given five (5) business days from the date notice was transmitted to the secretary of state for publication.

Authority: T.C.A. § 68-11-1303.

1200-38-01-.05 Issuance and Maintenance of COPA.

(1) After consultation with and agreement from the Attorney General, the Department shall issue a Certificate for a Cooperative Agreement if it determines the Applicants have demonstrated by clear and convincing evidence that the likely benefits resulting from the Cooperative Agreement outweigh any disadvantages attributable to a reduction in competition that may result from the Cooperative Agreement.

(2) The Department shall grant or deny the Application within one hundred twenty (120) days after the date of filing of the Application. An Application shall not be deemed filed until the Application is complete. The Department shall act promptly to determine whether the Application is complete and may request additional documents or information from the Applicants necessary to make the Application complete. The Department's decision whether the Application should be granted or denied shall be in writing and shall set forth the basis for the decision. The Department shall furnish a copy of the decision to the Applicants, the Attorney General and any Intervenor. Prior to granting the COPA, the parties and the Department will agree upon terms of certification and specific conditions that assure Public Advantage.

(3) The Department shall maintain on file all effective COPAs.

Authority: T.C.A. § 68-11-1303 and 68-11-1.

1200-38-01-.06 Active Supervision by Terms of Certification.

(1) The Department shall maintain active supervision in accordance with the terms of certification described in 1200-38-01-.03. The Department shall not be bound by measures, indices or other conditions found outside of the COPA.

(2) Periodic Reports. The Department shall maintain active supervision in addition to requesting COPA holders to submit periodic reports to the Department in a format determined by the Department. The periodic reports shall be filed with the Department on January 1 and July 1 (or the following business day) each year. The reports shall include the name, address, telephone number and other contact information for the party responsible for completing future reports, who may be contacted by the Department to monitor the implementation of the Cooperative Agreement.

(3) Update Plan of Separation. The parties to the Cooperative Agreement shall update the parties' Plan of Separation annually and submit the updated Plan of Separation to the Department. The parties shall provide an independent opinion from a qualified organization which states the Plan of Separation may be operationally implemented without undue disruption to essential health services provided by the parties.

(4) Modification of Index. The Department retains the right to modify any Measure, Index or condition under the COPA at any time.

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(5) The Department shall conduct a public hearing in the geographic service area where a COPA is in effect at least once every three (3) years.

(6) Departmental Review. At least annually, the Department shall review such documents necessary to determine compliance with the terms of the COPA and calculate the Index. In addition to any required documents, the parties shall provide the Department with the most recent verifiable values available for those Measures that are included in the Index (except any Measures or factors which the Department itself regularly generates, receives or holds). The Department reserves the right to request supplemental information when needed, as determined by the Department.

(7) Parties to the Cooperative Agreement must timely pay all applicable fees and invoices for initiation and maintenance of the COPA.

(8) The Department shall make public its determinations of compliance, and the Index score and trends.

(9) Failure to meet any of the terms of the COPA shall result in termination or modification of the COPA.

Authority: T.C.A. § 68-11-1303.

1200-38-01-.07 Modification/Termination.

(1) If the Department determines that the benefits no longer outweigh the disadvantages by clear and convincing evidence, the Department may first seek modification of the Cooperative Agreement with the consent of the parties.

(2) If modification is not obtained, the Department may terminate the COPA by written notice to the Certificate Holder and the Certificate Holder may appeal in the same manner as if the COPA were denied.

(3) The COPA shall remain in effect until such time as the Certificate Holder has submitted, the Department has approved, and the Certificate Holder has completed, the Plan of Separation.

(4) Voluntary Termination. The Certificate Holder shall notify the Department at least forty-five (45) days prior to voluntary termination of the Cooperative Agreement.

Authority: T.C.A. §§ 68-11-1303 and 68-11-1306.

1200-38-01-.08 Hearing and Appeals.

(1) Applicant or Certificate Holder. Any Applicant or Certificate Holder aggrieved by a decision of the Department denying an Application, refusing to act on an Application or terminating a Certificate is entitled to judicial review of the Department's decision by the Chancery Court of Davidson County, as specified in T.C.A. 68-11-1303.

(2) Intervenor. An Intervenor aggrieved by a decision of the Department to grant or deny the Application shall have the right to appeal the Department's decision, except that there shall be no stay of the Department's decision granting an Application unless the Chancery Court of Davidson County shall have issued a stay of the Department's decision in accordance with § 68-11-1304, which shall be accompanied by an appeal bond from the Intervenor. If the Intervenor shall appeal the Department's decision and the appeal is unsuccessful, the Intervenor shall be responsible for the costs of the appeal and attorneys' fees of the Applicants.

Authority: T.C.A. § 68-11-1303.

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* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
N/A					

I certify that this is an accurate and complete copy of an emergency rule(s), lawfully promulgated and adopted.

Date: July 14, 2015

Signature: Malaka Watson

Name of Officer: Malaka Watson

Title of Officer: Assistant General Counsel, Department of Health

LUVENIA HARRISON
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

Subscribed and sworn to before me on: 7/14/2015

Notary Public Signature: Luvenia Harrison

My commission expires on: September 10, 2018

All emergency rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III

Herbert H. Slatery III
Attorney General and Reporter

7/14/2015
Date

Department of State Use Only

Filed with the Department of State on: 7/14/15

Effective for: 180 *days

Effective through: 1/10/16

** Emergency rule(s) may be effective for up to 180 days from the date of filing.*

Tre Hargett

Tre Hargett
Secretary of State

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PUBLICATIONS

SBH-KINGSPORT 000287

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been delivered via email to:

Travis Swearingen, Esq.
Brian Jackson, Esq.
Butler Snow LLP
150 Third Avenue South, Suite 1600
Nashville, TN 37201

and

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

this 24 day of July, 2015.

William West

LFP

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

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MOUNTAIN STATES HEALTH ALLIANCE'S WITNESS AND EXHIBIT LIST

Witness List

Mountain States Health Alliance hereby gives notice that it reserves the right to call any or all of the witnesses listed below to testify at either live or by deposition

1. Marlene Bailey
2. Deborah Collier, PhD
3. Dr. Karl Goodkin
4. Shane Hilton
5. Dr. Randy Jesse
6. Dr. Teresa Kidd

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7. Alan Levine

8. Kasey McDevitt

9. Allison Rogers

10. Dr. Harsh Trivedi

Exhibit List

Mountain States Health Alliance hereby gives notice that it reserves the right to offer into evidence any or all of the items or things listed below as well as documents, charts, pictures, diagrams, illustrations or computations that are created in the courtroom during the trial of this case. Mountain States Health Alliance also gives notice of its intention to use models, charts or diagrams for illustrative or demonstrative purposes which may not be offered into evidence as exhibits. All documents identified below have either previously been furnished to Respondent's counsel, are equally available to Respondent's counsel, or will be made available to Respondent's counsel for inspection upon request. Just because a certain document, model or thing is identified below does not mean it will be offered into evidence at trial.

1. All pleadings in case.

2. All depositions taken in this case.

3. All deposition exhibits whether exhibited at the deposition or produced informally thereafter.

4. All discovery responses whether by formal interrogatory responses, response to requests for productions, letters/faxes from counsel, or otherwise.

5. All documents produced in discovery.

6. All certificate of need application filed by Applicant or any of its subsidiaries, parent companies, sister companies, affiliates, or related business entities.

7. All documents, slides, boards, videos, or transcripts produces or shown during any HSDA hearings on the certificate of need applications filed by the Applicant

or any of its subsidiaries, parent companies, sister companies, affiliates, or related business entities.

8. Minute of hearing dated 6/25/2014

9. Transcript of HSDA Hearing dated 6/25/2014

10. Expert Report of Deborah Collier.

11. All exhibits, statistics and information sources cited in expert report of Deborah Collier.

12. CV of Deborah Collier

13. Expert Report of Harsh Trivedi with exhibits.

14. All exhibits, statistics and information sources cited in expert report of Harsh Trivedi.

15. CV of Harsh Trivedi

16. Expert Report of Daniel J. Sullivan

17. All exhibits, statistics and information sources cited in expert report of Daniel Sullivan

18. CV of Daniel Sullivan

19. Mountain States Health Alliance 2014 Annual Community Benefit Report

20. 2015 Mental Health/Substance Abuse Hospital License Renewal Application – Strategic Behavioral Center – SBH-Wilmington, LLC

21. 2014 Mental Health/substance Abuse Hospital License Renewal Application – Strategic Behavioral Center – SBH - Raleigh, LLC

22. 2015 Mental Health/Substance Abuse Hospital License Renewal Application – Strategic Behavioral Center – SBH –Raleigh, LLC

23. TennCare II Operational Protocol Revised February 2015

24. Markowitz, F.E. (2006), Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates. Criminology, 44: 45-72.

25. 2014 Total Population by Zip Code SBH Proposed Service Area and Washington County

26. Demonstrative Map 2 Historical Service Area Woodridge Psychiatric Hospital

27. Demonstrative Map 3 Historical Area Indian Path Psychiatric Pavilion

28. Demonstrative Map 8 Alternate Service Area Map with Existing Psychiatric Services

29. Affidavit of Karl Goodkin, MD, Ph.D, DFAPA

30. Affidavit of Teresa M. Kidd, Ph.D

31. Mountain States Health Alliance reserves the right to offer into evidence any or all exhibits disclosed by the Applicant

32. Mountain States Health Alliance reserves the right to offer into evidence information or documents necessary to rebut proof presented by the Applicant, including but not limited to rebuttal exhibits.

33. SBH-Kingsport, LLC CON Application Packet CN1312-050 dated December 13, 2013.

34. State of Tennessee Department of Mental Health and Substance Abuse Services Review and Analysis of Certificate of Need – Strategic Behavioral Health (SBH) – Kingsport – CN1312-050 Amended June 20, 2014.

35. Demonstrative exhibit Kingsport Catchment Area (P-0543).

36. Demonstrative exhibit Sullivan County Map.

Respectfully Submitted,

G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

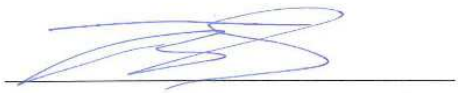
CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
James B. Christoffersen, Esq.
Tennessee Health Services &
Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243
E-mail: jim.christoffersen@state.tn.us

Via e-mail
William H. West, Esq.
Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 24th day of July, 2015.



SBH-KINGSPORT 000293

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

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SECRETARY OF STATE

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	
	)	

APPLICANT SBH-KINGSPORT, LLC'S MOTION FOR EXTENSION OF TIME WITHIN WHICH TO FILE ITS PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

Applicant SBH-Kingsport, LLC (hereinafter "Applicant") hereby moves for an extension of time to and including Wednesday, October 28, 2015 within which to file its Proposed Findings of Fact and Conclusions of Law. The contested case hearing in this matter lasted nearly a week. The record is extensive, with approximately 10 witnesses having testified, including three experts, and over 62 exhibits (many of which are multi-paged) filed. The hearing transcript is over 1,000 pages.

Thus, due to the density of the record, the brief is taking longer than expected to finalize. Previously, co-counsel for Applicant, Bill West, and co-counsel Intervenor Mountain States Health Alliance, Travis Swearingen, agreed to an extension from Monday, October 19 to Friday, October 23. The new requested extension would only add ten days to the original filing deadline. At the conclusion of the contested case hearing, the Administrative Law Judge and the parties' counsel anticipated that such an extension might be in order.

Applicant's co-counsel, Charles Grant, telephoned and emailed Intervenor's counsel, Travis Swearingen, and Tennessee Health Services and Development Agency's counsel, Jim Christoffersen, to determine their positions with respect to this motion but as of the filing of this motion Applicant's counsel has not heard from the attorneys for the other parties.

No parties will be prejudiced by this short extension.

WHEREFORE, Applicant moves for an extension to and including October 28, 2015 to file its Proposed Findings of Fact and Conclusions of Law.

Respectfully submitted,

William H. West, Esq. (BPR No. 5543)
Charles K. Grant (BRP 017081)
BAKER DONELSON BEARMAN
CALDWELL & BERKOWITZ, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201
615-726-5561
Counsel for SBH-Kingsport, LLC,
Applicant/Petitioner

SBH-KINGSPORT 000295

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 23rd day of October, 2015, a copy of the foregoing has been delivered via email to:

Travis Swearingen, Esq.
Brian Jackson, Esq.
Butler Snow LLP
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Nashville, TN 37201

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243



Charles K. Grant

SBH-KINGSPORT 000296

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BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

MOUNTAIN STATE HEALTH ALLIANCE'S PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Respondent, Mountain States Health Alliance, submits these proposed Findings of Fact and Conclusions of Law:

I. The Parties

A. Mountain States Health Alliance

1. Mountain States Health Alliance ("MSHA") is a Tennessee non-profit health care system with its principal offices in Johnson City, Tennessee. (Levine, Vol. 5, p. 880:5-884:1). MSHA provides comprehensive medical care to people in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. (*Id.*) MSHA owns and operates 13 hospitals, including Johnson City Medical Center, a 501-bed regional tertiary referral and Level I trauma center, Indian Path Medical Center, a 239-bed hospital in Kingsport, and Niswonger Children's Hospital, a 69-bed

children's hospital in Johnson City that is one of only six St. Jude Affiliate Clinics and serves more than 200,000 children in the area. (*Id.*)

2. MSHA provides vital health care services, including in many rural areas that are traditionally underserved, and to patients with limited financial resources. (Levine, Vol. 5, p. 880:5-884:1). As one of the largest TennCare providers in the State, MSHA plays an essential role in supporting the TennCare program. (*Id.*) In Fiscal Year 2014, MSHA provided more than $40 million in unreimbursed care to Medicaid and TennCare patients, and more than $20 million in charity care, as well as subsidized health care services and community health improvement services totaling approximately $90 million. (Levine, Vol. 5, p. 881:25-882:18). Because it is the largest system in a region that is predominantly rural, MHSA focuses on providing widely dispersed access points for healthcare services. (Levine, Vol. 5, p. 880:5-884:1).

3. MSHA's hospitals also include Woodridge Psychiatric Hospital ("Woodridge"), an 84-bed facility in Johnson City which treats over 4,000 inpatients annually. (Levine, Vol. 5, p. 880:5-884:1; Ex. 250, p. 1666). In conjunction with the psychiatric services offered at Woodridge, MHSA is actively promoting intensive outpatient mental health programs in outlying communities so patients can avoid the time, expense, and inconvenience associated with centralized inpatient care. (Levine, Vol. 5, pp. 882:19-884:1). Woodridge has partnered with the Department of Psychiatry and Behavioral Sciences at James H. Quillen College of Medicine at East Tennessee University State ("ETSU"), providing both financial and educational support to the ETSU program. (Elliott, Vol. 1, p. 144:2-145:23). Woodridge currently subsidizes up to 10 residency slots at an annual cost of $450,000. (*Id.*) Additionally, Woodridge annually provides $45,000 to support faculty positions. (*Id.*)

B. Strategic Behavioral Health

4. Strategic Behavioral Health ("SBH") is a privately-owned, closely-held, for-profit company that develops, owns and operates psychiatric hospitals, including residential facilities for child and adolescent patients. (Shaheen, Vol. 1, p. 79:16-83:1). SBH currently operates eight facilities in Nevada, New Mexico, North Carolina, and Texas. (*Id.*) SBH does not currently own or operate any hospitals in Tennessee. (*Id.*)

II. Tennessee CON Process — Background, Purpose and Policy

5. Beginning in the 1970s, the federal government urged states to control rising health care costs by using health planning to manage the escalating growth of health care services and facilities. To this end, in 1973, the Tennessee General Assembly enacted legislation creating the Tennessee Health Facilities Commission (the predecessor of the HSDA) and Tennessee's Certificate of Need ("CON") process. *See East Tenn. Health Improvement Council, Inc. v. Tenn. Health Facilities Comm.*, 626 S.W.2d 272, 274 (Tenn. Ct. Ap. 1981). Approximately 35 states, including Tennessee, use CONs to regulate capital expenditures on health care facilities. The Tennessee Legislature reaffirmed the State's commitment to the CON program in 2002, when it enacted the "Tennessee Health Services and Planning Act of 2002," Tenn. Code Ann. §§ 68-11-1601, et seq. (hereafter referred to as "Health Planning Act"), and again in 2013 when it reauthorized the HSDA. Tenn. Code Ann. § 4-29-238.

6. Tennessee CON law is designed to prevent the harmful effects caused by unnecessary, costly and duplicative healthcare services. As such, prospective health care providers must obtain approval of the HSDA before initiating certain new medical services. Tenn. Code Ann. §§ 68-11-1605, -1607. Under the CON system, an applicant seeking to initiate new services must show that the medical services are needed, can be economically accomplished

and maintained, and will contribute to the orderly development of adequate and effective health care. Tenn. Code Ann. § 68-11-1609(b).

7. The Tennessee Legislature has adopted three primary criteria that must be considered in determining whether a Certificate of Need should be granted:

> No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services.

Tenn. Code Ann. § 68-11-1609(b). In addition to the three general criteria, the Agency is also directed to consider the State Health Plan:

> In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. Until the state health plan is approved and adopted, the agency shall use as guidelines the current criteria and standards adopted by the state health planning and advisory board, and any changes implemented by the planning division pursuant to § 68-11-1625.

Id.

8. The "current criteria and standards" referred to in the statute are set forth in the State Health Plan, which incorporates the three general statutory criteria of need, economic feasibility and contribution to the orderly development of healthcare. The State Health Plan also contains additional considerations stemming from the three general criteria.[1] The State Health Plan contains a specific methodology for determining need for select regulated healthcare services, including psychiatric inpatient services. *See* State Health Plan, *available at* https://www.tn.gov/assets/entities/hsda/attachments/Psychiatric_Inptatient_Services.pdf. To award a CON to a party that does not satisfy the objective criteria in the State Health Plan and

[1] T.C.A. §68-11-1609(b) also authorized the Agency to set out additional criteria for consideration in its Rules. These additional general criteria are promulgated at Tenn. Comp. Rules & Regs. 0720-4-.01. *Id.*

that has not offered any compelling reason for disregarding those criteria, would constitute a "clear error in judgment."[2]

III. Proposed Project and Procedural History

9. SBH filed a Certificate of Need application on December 3, 2013, to build a 72-bed mental health hospital in Kingsport, Sullivan County, Tennessee (the "Project"). (Ex. 9). The total project cost was estimated to be $11,717,915. (*Id.*) The proposed hospital would include 28 child and adolescent psychiatric beds, 18 adult psychiatric beds, 16 gero-psychiatric beds, and 10 beds for adult chemical dependency patients. (*Id.*) The facility was planned as a 72-bed facility, not because of any health planning analysis, but because SBH had previously developed two facility prototypes - a 72-bed hospital prototype and a 92-bed hospital prototype – for use in projects across the country. (Shaheen, Vol. 1, p. 225:14-226:15).

10. On June 25, 2014, the HSDA considered the SBH application. The HSDA heard presentations both for and against the proposed new psychiatric hospital. At the conclusion of these presentations, the HSDA voted to deny the SBH Certificate of Need by a vote of 4 to 4. Thereafter, SBH timely perfected its petition for a contested case proceeding on the denial of its CON application. MHSA, which had presented in opposition to the Project before the HSDA, was granted permission to intervene in the contested case.

11. The purpose of this contested case is to determine whether the SBH Project satisfies the criteria for a Certificate of Need set forth in Tenn. Code Ann.§ 68-11-1609(b) and in Rules 0720-11-.01(1)-(3) of the HSDA. The general criteria of need, economic feasibility, and orderly development of health care are discussed below in more detail. With respect to this proceeding, the HSDA's initial vote to deny SBH's application allocates the burden of proof in

[2] *See Maury Regional Hospital v. Tennessee Health Services and Development Agency and Spring Hill Hospital*, Case No. 08-1133-I, at 22-23. (Chancery Court of Davidson County, Sept. 3, 2009).

the contested case. Because the HSDA voted to deny SBH's application, SBH has the burden of proof here to establish that its Project meets the applicable statutory criteria. This Court is charged with making the determination *de novo*. In making its determination, this Court sits for and on behalf of the HSDA. (Tenn. Comp. R. & Regs. R. 0720-6-.02).

IV. Service Area

12. The State of Tennessee has adopted a population-based rule to estimate the need for psychiatric inpatient services. *See* State Health Plan, Psychiatric Inpatient Services Criteria. Total bed need is calculated as 30 psychiatric beds per 100,000 general population. (*Id.*) This total bed need is then reduced by the number of existing staffed beds operating and providing psychiatric services in the area. (*Id.*) The HSDA's regulatory criteria also require that the impact to other providers in the proposed service area be measured when determining whether a project will contribute to the orderly development of healthcare. (Tenn. Comp. R. & Regs. R. 0720-11-.01(3)). Thus, in order to evaluate the Project under the State Health Plan, the Court first must determine a reasonable service area for the Project. The service area will then be used to determine the appropriate population for the bed need calculation, to determine the number of existing beds serving that population, and to identify the existing providers against whom the impact of the Project should be gauged.

13. HSDA guidelines define a project's "Service Area" as the county or counties "representing a reasonable area in which a health care institution intends to provide services and in which the majority of its service recipients reside." Tenn. Comp. R. & Regs. R. 0720-6-.01. Specifically as to psychiatric services, the State Health Plan requires that the service area be "reasonable and based on an optimal balance between population density and service proximity..." The health planning experts in this case agree that a reasonable total service area

of a health care facility is the geographic area from which the facility can expect to receive 90 to 95 percent of its patients. (Sullivan, Vol. 2, p. 444:10-13; Collier, Vol. 4, 699:11-699:19).

14. In the present case, SBH claims a service area consisting of five counties, Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee counties in Virginia. MHSA contends that a reasonable service area for the Project is substantially broader and should, at the very least, include Washington County, directly to the south. (*See* Ex. 381, Maps 3 and 8). MHSA argues that inpatient psychiatric services are regional in nature and typically draw from a wide geographic area. (Collier, Vol. 4, p. 703:14-704:7). Moreover, the psychiatric hospital previously located across the street from SBH's proposed facility drew from a much broader geographic area than the service area claimed by SBH. (Ex. 381, Map 3). The evidence presented at the contested case included facts relevant to the issue of whether the claimed service area is reasonable.

A. <u>Project Origins</u>

15. In the summer of 2012, SBH hired a graduate student in statistics, Mr. Thompson, to evaluate 95 potential expansion markets across the United States where the company might want to construct a new psychiatric hospital. (Shaheen, Vol. 1, p. 202:16-204:9; Ex. 6). Mr. Thompson prepared a series of spreadsheets in connection with this assignment. (*Id.*) One of the 95 potential locations identified by SBH was the "Tri-Cities." (Shaheen, Vol. 1, p. 204:20-205:4; Ex. 6).

16. The Tri-Cities service market was defined by Mr. Thompson to include both Johnson City and Kingsport. (Shaheen, Vol. 1, p. 205:11-205:16; Ex. 6). Mr. Thompson was the first SBH representative to conduct any analysis of psychiatric need, and he did so by examining the need for the entire Tri-Cities area. (*Id.* at p. 205:17-206:16). In fact, prior to the

submission of the CON application in this case, SBH never evaluated the need for new psychiatric services in Kingsport as distinct from the entire Tri-Cities area. (Shaheen, Vol. 1, p. 206:1-206:22).

17. To evaluate these 95 markets for need, SBH instructed Mr. Thompson to identify all psychiatric providers located in a 60-mile radius. (Shaheen, Vol. 1, p. 207:2-209:7; Ex. 6). Mr. Thompson identified Woodridge as the primary provider in the Tri-Cities service area. (Shaheen, Vol. 1, p. 208:7-208:15; Ex. 6). Woodridge is located within 25 miles of all major Tri-Cities population centers. (*Id.*) Additionally, Mr. Thompson considered a number of other existing providers in the area including Wellmont Bristol, Ridgeview, Takoma Regional, and Sycamore Shoals. (*Id.*)

18. In light of these existing resources in the Tri-Cities, Mr. Thompson was tasked with evaluating the need for new psychiatric services. (*Id.* at 207:2-208:2) To project need, SBH directed Mr. Thompson to apply a 30-bed-per-100,000 population formula to these markets, the same formula dictated by the State Health Plan. (*Id.*) Based on his analysis, SBH concluded that the Tri-Cities region ranked 34th in need for new psychiatric beds. (*Id.* at 209:8-209:18). The analysis did not identify any specific gaps in psychiatric services in the Tri-Cities. (*Id.* at 209:19-210:1).

19. SBH's President, Jim Shaheen, identified a number of other criteria to evaluate the various potential service areas, and asked Mr. Thompson to apply them. (Shaheen, Vol. 1, p. 210:2-211:8; Ex. 6). SBH determined that the Tri-Cities region had plentiful access to psychiatric services with robust competition among providers. For example, the Tri-Cities area was 23rd out of 27 regions for "Market Demand" which gauged bed need. (Shaheen, Vol. 1, p. 211:15-213:2; Ex. 6, p. 3145). The Tri-Cities area was ranked 21st out of 27 regions for

"Competition," which gauged the number and diversity of existing providers. (*Id.* at 213:3-22; Ex. 6, p. 3146).

20. While there was no demonstrated need, the Tri-Cities did perform better in financial metrics. The Tri-Cities was tenth best in building costs and second best in staffing costs. (*Id.* at 213:23-216:10; Ex. 6, p. 3146). In the final weighted analysis, the Tri-Cities ranked 15th out of 27 potential locations for a new psychiatric hospital. (*Id.* at 211:4-14).

21. In early September 2013, Mr. Shaheen chose to proceed with the Project, not because of any documented need for additional psychiatric services in the Tri-Cities, but because there was plenty of staff available and staff wages were comparatively low. (Shaheen, Vol. 1, p. 92:20 – 93:20). Mr. Shaheen designated Michael Garone, SBH's new Director of Development, to take charge of the Project. (*Id.* at 216:22-217:16). Mr. Garone's expertise is in marketing, not clinical health care. (*Id.*) He had never operated or been involved with psychiatric care in Upper East Tennessee, he had no experience in preparing a CON application in Tennessee, and he had never been to the Tri-Cities. (*Id.*)

22. Initially, SBH planned to locate the new hospital in Johnson City, not Kingsport. (Garone, Vol. 3, p. 541:5-541:15). In fact, on October 1, 2013, SBH submitted an application for economic development incentives from the Johnson City Industrial Bond Board. (Shaheen, Vol. 1, p. 217:22-219:18; Ex. 380; Garone, Vol. 3, p. 541:5-541:15). SBH never submitted a similar application to the Kingsport government. (*Id.*) In early October, Mr. Garone made his only visit to the Tri-Cities prior to the filing of the application. (Shaheen, Vol. 1, p. 220:17-224:12; Ex. 14). While there, he met with seven people, six of whom worked in Johnson City. (Shaheen, Vol. 1, p. 220:17-224:12; Ex. 14).

23. By early November, SBH executives had decided to place their proposed new hospital in Kingsport instead of Johnson City. SBH did not create a single document analyzing or setting out the need for a new psychiatric hospital in Kingsport versus the case for need in Johnson City. (Garone, Vol. 3, p. 542:6-10.) Moreover, none of the educational institutions that would be providing staff for the new facility were located in Kingsport. (Shaheen, Vol. 1, p. 235:1-10). SBH moved the Project from Johnson City to Kingsport for CON purposes, and in an effort to avoid a "political war with Mountain States." (Garone, Vol. 3., p. 547:19-23; Exhibit 378). As stated in an email from Mr. Garone:

> You will notice that we have switched the physical location of the project from Johnson City to Kingsport in an attempt to avoid Mountain States Health Alliance from contesting our application.

(Garone, Vol. 3, p. 543:6-17; Ex. 325).

24. SBH filed its application for a CON in December 2013, less than 60 days after the company first visited the Tri-Cities. (Ex. 9). The CON application not only moved the location of the hospital to Kingsport, but SBH's service area excluded Johnson City and Washington County and instead claimed a number of rural Virginia counties to the Northwest of the Tri-Cities. (Ex. 9).

25. Typically, CON applicants present assumptions in an application that divide the service area into county units or zip codes, demonstrating the size of the market, the projected market share, and patient volumes that the applicant expects to receive from each area. (Collier, Vol. 4, p. 700:14-701:5). In this instance, SBH did not provide any projections of how many patients would come from any particular county or zip code within its claimed service area. (Collier, Vol. 4, p. 700:14-701:5). In choosing its service area, SBH never examined historical patient origins for existing medical providers in Kingsport to extrapolate a reasonable proxy for

its own service area. (Garone, Vol. 3, p. 548:10-549:3; Collier, Vol. 4, p. 711:2-10). SBH never performed a written analysis of where patients in its proposed service area are currently receiving their psychiatric care. (Garone, Vol. 3, p. 549:11-15). Although its application projected approximately 2,000 cases by year two, SBH never determined where those cases would originate. (Garone, Vol. 3, p. 550:2-20). Furthermore, although Mr. Garone had no experience in drafting a Tennessee CON application, SBH did not engage a health planning expert to assist in determining a reasonable service area for the application. (Garone, Vol. 3, p. 549:16-18; Sullivan, Vol. 2, p. 436:6-438:12).[3] In other words, none of the post hoc rationales presented at trial by SBH's litigation-retained health planner were ever actually used by the Applicant to determine a reasonable service area. (Collier, Vol. 4, p. 711:2-10).

26. Although SBH's claimed service area in its application excluded Washington County, for internal purposes SBH continued to evaluate the Project in the context of the larger Tri-Cities region. For example, on January 10, 2014, SBH executives made an internal presentation to representatives of the company's owners, Dobbs Management Services, setting forth the financial rationale and anticipated return on investment for the proposed Project. (Shaheen, Vol. 1, p. 229:23-239:5; Ex. 10). As part of the proposal, SBH identified a "catchment area" consisting of 25-mile and 50-mile radii around Kingsport, which included Woodridge, Washington County, and other psychiatric providers. (*Id.* at p. 233:18-236:2; Ex. 10, p. 543). SBH further identified its "immediate market" as the area within 25 miles of the facility that included Woodridge, Ridgeview Pavilion and Magnolia Ridge. (*Id.* at p. 237:5-238:19; Ex. 10, p. 545, 546). SBH's proposed catchment area used for its internal business analysis is nearly identical to the service area MHSA has argued is appropriate for CON

[3] SBH's litigation expert, Dan Sullivan, had previously performed health planning work for SBH. (Sullivan, Vol. 2, p. 436:6-437:13). SBH never contacted Mr. Sullivan prior to filing its application. (*Id.*)

purposes. (Ex. 381, Map 8). Contrarily, the SBH executives never used the application's proposed service area as a basis for evaluating the financial return on investment for the project. (*Id.* at 238:24-239:5; Ex. 10).

B. <u>The Proposed Service Area in the Application Is Not Reasonable Or Consistent With Historical Patient Origin Patterns.</u>

27. Both SBH and Covenant offered testimony regarding the reasonableness of SBH's proposed service area. MHSA offered the testimony of Dr. Deborah Kolb Collier, a health planner with more than 36 years of experience. (Collier, Vol. 4, p. 692:9-695:24; Ex. 381, Appendix A). Dr. Collier has a Ph.D. in English and a Masters in Business Administration from the University of North Carolina, Chapel Hill. (*Id.*) Dr. Collier's health planning experience has included preparing Certificate of Need applications, strategic and financial health planning, financial feasibility analyses, and medical staffing planning. (*Id.*) She has performed strategic health planning for several major hospital systems in Tennessee including Vanderbilt University Medical Center, Wellmont Health System, Baptist Hospital in Nashville, Saint Thomas Hospital System, Middle Tennessee Medical Center, West Tennessee Health, Maury Regional Medical Center, Williamson Medical Center, and Covenant Health. (*Id.*) Specifically as it relates to psychiatric health planning, Dr. Collier has performed strategic business forecasting and feasibility studies for both free-standing psychiatric hospitals and psychiatric service lines for existing medical centers. (*Id.*)

28. Dr. Collier testified that SBH intentionally gerrymandered its proposed service area to exclude consideration of existing psychiatric beds in the surrounding area. (Collier, Vol. 4, p. 699:23-700:13). Essentially, SBH attempted to game the State Health Plan's need formula, while providing no quantitative basis for the service area that was claimed. (*Id.*) The proposed service area stretches more than 35 miles northwest, deep into a large area of Virginia which is

mountainous and sparsely populated, while it extends only a few miles to the south, excluding Washington County and its very large population base. (Collier, Vol. 4, p. 703:21-704:17). In other words, SBH's service area excludes Washington County, which is directly adjacent, connected to Sullivan County by a major interstate and contains 150,000 people, but includes Lee County, Virginia, which is two counties away, separated from Kingsport by a large mountain range, and contains 25,000 people. (Sullivan, Vol. 2, p. 451:13-452:11). Simply put, in Dr. Collier's opinion, SBH's service area is arbitrary, unreasonable, and ignores historic and existing patient flow and origin patterns. (Collier, Vol. 4, p. 701:6-702:5).

29. Both Dr. Collier and SBH's health planning expert, Daniel Sullivan, agree that the first step in formulating a reasonable service area (if a provider does not already offer services in the area) is to identify a surrogate or proxy facility which can be used as a reasonable approximation of the proposed project. (Sullivan, Vol. 2, p. 432:17-25; Collier, Vol. 3, p. 700:14-702:5).

30. Dr. Collier opined that Indian Path Psychiatric Pavilion, a 61-bed psychiatric hospital in Kingsport that operated until 2009, was the most reasonable proxy for SBH's proposed facility. (Collier, Vol. 4, p. 710:13-712:2, Ex. 381). Geographically, the two facilities are located less than a mile apart. (Collier, Vol. 4, p. 710:13-712:2, Ex. 381). Indian Path Pavilion was a full-service psychiatric hospital with a similar size to SBH's Project. (Bailey, Vol. 3, p. 562:4-563:18). Moreover, Indian Path Pavilion primarily targeted commercially insured and other profitable payer mixes similar to SBH's proposed business plan. (Bailey, Vol. 3, p. 562:4-563:18).

31. Dr. Collier analyzed Indian Path Pavilion's historic patient origin mix to identify its service area. (Collier, Vol. 4, p. 708:19-710:7, Ex. 381, Map 8). Not surprisingly considering

its geographic proximity, Washington County was the second highest county of origin for patients at Indian Path Pavilion, accounting for almost 12% of admissions over its last three-years of operation. (*Id.*) Washington County patients exceeded those from Hawkins, Scott, Wise, and Lee Counties, all of which SBH included in its service area. (*Id.*) In fact, more patients originated from Washington County than Scott, Wise and Lee Counties combined. (*Id.*)

32. Despite their geographic proximity and service line similarities, Mr. Sullivan did not use Indian Path Pavilion to develop his service area for the Project. (Sullivan, Vol. 2, p. 449:2-5). Mr. Sullivan suggested that Indian Path Pavilion should not be considered as a proxy because 2007-2009 was a "different competitive marketplace" than 2015. (Sullivan, Vol. 2, p. 449:2-25). Specifically, Mr. Sullivan seemed to suggest that in 2007-2009, Woodridge was not really an effective competitor, which prompted patients to leave Washington County to obtain psychiatric care at Indian Path Pavilion in Kingsport. (Sullivan, Vol. 2, p. 460:10-462:5, Ex. 246). Mr. Sullivan argued that in 2015 Woodridge was a better run, more desirable facility and now, few patients would leave Washington County for psychiatric care in Sullivan County. (*Id.*) Mr. Sullivan's opinion was based on a single page of Woodridge's historical inpatient data from 2005 and ambiguous testimony he attributed to a Woodridge administrator. (*Id.*)

33. Mr. Sullivan's explanation for ignoring Indian Path Pavilion's historical experience did not withstand scrutiny. The "data" on which Mr. Sullivan so heavily relied was determined to be erroneous – it only reported approximately half of Woodridge's discharges during the relevant time period. (Bailey, Vol. 3, p. 561:13-566:6; Sullivan, Vol. 5, 958:25-959:21). Furthermore, administrators who were actually working at Woodridge from 2005-2009 rejected any suggestion that Woodridge was weak or uncompetitive. (Bailey, Vol. 3, p. 561:13-566:6; Jessee, Vol. 4, p. 654:4-656:17). Instead, patients were leaving Washington County to

receive care in Sullivan County because Indian Path Pavilion was perceived as being a nicer, more upscale facility, just as SBH will market itself. (*Id.*)

34. Instead of using a recent, similarly-sized, psychiatric hospital located across the street as a proxy, Mr. Sullivan suggested that it would be more reasonable to use as a proxy either Indian Path Medical Center, an acute care hospital, or HealthSouth, a rehabilitation center, both located in Kingsport. (Sullivan, Vol. 2, p. 299:18-300:17). Mr. Sullivan conceded, however, that acute care services are localized in nature and, thus, typically have smaller service areas. (Sullivan, Vol. 2, p. 441:13-17). Psychiatric services, on the other hand, are more regional in nature, with much broader geographic service areas. (Sullivan, Vol. 2, p. 442:7-23). In fact, there are currently only 15 freestanding psychiatric hospitals in Tennessee. (*Id.*)

35. In addition to historical trends, Dr. Collier examined existing patient origin data in determining a reasonable service area for SBH's project. Dr. Collier concluded that there is demonstrable flow of patients between Washington and Sullivan counties for health services, including psychiatric services. (Collier, Vol. 4, p. 706:3-706:17). For example, in 2014, 24.9% of patients admitted to Woodridge were from Sullivan County, which represented the second highest volume from any one county. (Collier, Vol. 4, p. 706:3-706:17). Patients residing in other counties claimed as the service area by SBH also utilize Woodridge; in fact over a three-year period, residents of the SBH claimed service area constituted 36% of Woodridge's inpatients. (Collier, Vol. 4, p. 706:3-706:17).

36. In Dr. Collier's opinion, the free movement of patients between Sullivan and Washington County would likely continue if SBH's project is approved. This is especially true considering that Washington County is experiencing more growth than Sullivan County. (Collier, Vol. 4, p. 706:3:707:15). Specifically as it relates to child and adolescent patients – the

claimed focus of SBH's proposed Project – Washington County is the only county in the area with a growing pediatric population, while Sullivan County has a projected 20 percent decline. (Collier, Vol. 4, p. 706:3:707:15; Levine, Vol. 5, p. 893:18-894:2). Furthermore, thousands of people living in Washington County live in closer proximity to the new SBH facility than Woodridge. (Sullivan, Vol. 2, p. 453:8-17; Collier, Vol. 4, 744:3-745:5).

37. Moreover, SBH's financial and volume projections will require it to capture a significant number of patients from Johnson City. (Collier, Vol. 4, p. 706:3:710:7). SBH conservatively estimates that it will treat nearly 2,000 patients by Year 2. (*Id.*) As it will be primarily targeting insured patients, SBH will essentially have to capture all of the insured patients from its proposed service area to reach its volume projections, a highly improbable scenario. (*Id.*) It is more likely that SBH will market its new facility aggressively throughout the region and will not simply limit its marketing efforts to Sullivan County only. (Collier, Vol. 4, p. 706:18-707:15). Furthermore, SBH will not have any restrictions on its admission criteria prohibiting or deterring patients from Washington County from seeking treatment at the SBH facility. (Shaheen, Vol. 1, p. 243:5-16).

38. Considering both historical utilization patterns and existing patient trends for the use of psychiatric services, Dr. Collier concluded that a service area that included Washington County and other counties contiguous to Kingsport, is a much more reasonable approximation of where SBH's patients will likely originate. (Collier, Vol. 4, p. 710:8-21).

NEED FOR SBH'S PROPOSED PSYCHIATRIC HOSPITAL

39. Under the HSDA rules, Chapter 0720-11-.01 (1)(a-g), the need for the proposed service is to be evaluated upon the following factors:

> 1.a. The relationship of the proposal to any existing applicable plans (e.g., the State Health Plan);

1.b. The population to be served by the proposal;

1.c. The existing or certified services or institutions in the area;

1.d. The reasonableness of the service area;

1.e. The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities and low-income groups;

1.f. Comparison of utilization/occupancy trends and services offered by other area providers;

1.g. The extent to which Medicare, Medicaid (TennCare) and medically indigent patients will be served by the project.

40. As discussed above, the State Health Plan contains specific, objective criteria to be used to determine when inpatient psychiatric services should be approved in a particular service area. The State Health Plan applies a 30 beds per 100,000 general population formula. (Collier, Vol. 713:12-715:22). The State Health Plan also requires that adult and child psychiatric needs be evaluated separately. (*Id.*) Even using SBH's proposed service area, there is not a need for the 28 new child and adolescent psychiatric beds offered in the Project. (*Id.*) Using Dr. Collier's alternative, more reasonable service area, there will be a net bed need of approximately 30 total psychiatric beds in 2009, fewer than half of the 72 beds proposed by SBH. (*Id.*)

41. SBH argued that patients in the service area have difficulty accessing psychiatric and behavioral health services. However, SBH did not call a single patient or medical provider practicing in the Tri-Cities to establish that there are any access issues in the community.[4] Instead, SBH relied on the increasing census at Woodridge, as evidenced by patient flow sheets,

[4] SBH did call Dr. Hal Elliott, a former director of the ETSU psychiatry residency program. (Elliott, Vol. 1, p. 128:9-128:21). At the time he testified, Dr. Elliott was in the middle of moving from the Tri-Cities to Michigan. (*Id.*) Dr. Elliott gave several opinions about deficiencies in the ETSU psychiatry residency program but had little to offer as it relates to patient needs in the Tri-Cities.

to demonstrate that Woodridge was operating at or near 85% capacity and that on several days during the year, Woodridge was full and had to defer patients to other facilities.[5]

42. In response, Marlene Bailey, the current director of behavioral health programs at Woodridge, where she has worked for the last 26 years, testified that existing providers are meeting the psychiatric care needs of the Tri-Cities region. (Bailey, Vol. 3, p. 557:24-559:12.) Ms. Bailey explained that when Lakeshore, the public psychiatric hospital for East Tennessee, shuttered its doors in mid-2012, Woodridge volunteered to become the primary provider for patients who typically are cared for in State psychiatric hospitals. (Bailey, Vol. 3, p. 566:7-570:13). As would be expected, Woodridge required time to adjust not only to an increase in patient census but also an increase in the acuity of the patients who were previously being treated at Lakeshore. (Bailey, Vol. 3, p. 575:5-576:5). This transition caused occasional operational issues which resulted in lag between patients presenting for psychiatric treatment and admission to Woodridge. (*Id.*)

43. But beginning in late 2012 through today, Woodridge has taken a number of important steps to increase efficiencies and remove barriers to access. (Bailey, Vol. 3, p. 577:24-580:21). For instance, in 2013, Woodridge initiated a LEAN process review to transform the manner in which it triaged, evaluated, and admitted psychiatric patients from local emergency rooms into its facility. (*Id.*) As a result of these process improvements, Woodridge has seen a steady increase in inpatient admissions and an equally steady decrease in the number of patients who had to be deferred because of the lack of an available bed. (*Id.*)

44. Ms. Bailey further explained that the "patient flow sheets" were not the Woodridge census nor are they an accurate representation of the availability of psychiatric

[5] While SBH critiques Woodridge as being too full because it has recently operated at 85% capacity, SBH concedes that its **goal** is to operate at 85% capacity. (Shaheen, Vol. 1, p. 242:9 – 243:4).

services at Woodridge or in the Tri-Cities. (Bailey, Vol. 3, 580:22 – 583:6). Patient flow sheets are "snapshots" of occupancy levels at Woodridge, most commonly filled out before discharges have been made on a particular day. (*Id.*) If a patient is listed as "deferred" on a patient flow sheet, it means that Woodridge cannot take that patient at that particular moment in time for a variety of reasons.[6] (Bailey, Vol. 3, p. 575:19-576). Deferred patients often are admitted to Woodridge later on in the day after morning discharges occur. (Bailey, Vol. 3, p. 576:19-577:23). If a bed does not open at Woodridge, the deferred patient will be transferred to another available bed in the Tri-Cities region for care. (*Id.*) While a patient is deferred, they continue to receive psychiatric treatment in a hospital setting until an appropriate psychiatric bed becomes available. (Bailey, Vol. 3, p. 585:25-586:8, Trivedi, Vol. 4, p. 851:3-852:10).

45. SBH was simply unable to point to any evidence that a significant number of patients from its service area are unable to access care or are out-migrating (leaving the region for treatment). (Ex. 9, p. 12; Sullivan, Vol. 2, p. 465:9-471:22). To the contrary, data produced as part of SBH's application suggested that the small number of patients leaving the region were receiving psychiatric treatment at Peninsula Hospital outside of Knoxville and Moccasin Bend in Chattanooga, both State institutions that specialize in treating chronically and severely sick indigent patients on a long term basis. (*Id.*) In other words, the only patients leaving the region for treatment are patients that SBH cannot treat (chronic long-term patients) or will not treat (indigent patients without the ability to pay).

46. While Woodridge operates at or around 85% capacity on a routine basis, Ms. Bailey testified that Woodridge is meeting the current needs of patients and providers. (Bailey, Vol. 3, p. 583:7-585:20.) Since Woodridge implemented its numerous process improvements,

[6] Often times, patients are deferred for medical reasons – they are in a medical condition that cannot be treated in a psychiatric unit. (Bailey, Vol. 3, p. 575:23-576:18). Once that medical condition clears, those patients are often reevaluated by Woodridge's response team and admitted at that time. (Bailey, Vol. 3, p. 575:23-576:18).

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Woodridge's deferrals have been reduced by half. (Bailey, Vol. 3, p. 585:21-24). Moreover, despite running at 85% capacity, Woodridge continues to excel at quality control measures including outstanding patient satisfaction surveys and very low restraint rates. (Bailey, Vol. 3, p. 583:15-585:25). Furthermore, while Woodridge has seen an increase in its daily census, the 172 psychiatric beds in the Tri-Cities Region operated at 64% occupancy in 2013, suggesting sufficient capacity in the community.[7] (Ex. 381, p. 13). Patients who need access to psychiatric services in the Tri-Cities are receiving high quality and timely care. (*Id.*)

47. Ms. Bailey's testimony is corroborated by the usage rates in the area. While SBH suggested that there is some percentage of the population in the Tri-Cities that needs psychiatric care but is not currently receiving it, SBH has never performed a statistical analysis to quantify such patients. (Sullivan, Vol. 2, p. 412:3-24). To the contrary, compared to the Tennessee average there is relatively high use of inpatient psychiatric services by Sullivan County residents, which contradicts the claim that access to such services is difficult.[8] (Collier, Vol. 4, p. 724:19-725:14). In 2013, the state wide use rate was 938.6 per 100,000 population, compared to 1,026.8 for Sullivan County residents.[9] (Collier, Vol. 4, p. 724:19-725:14). Based on Dr. Collier's statistical analysis, there is no pent up demand nor are there any obvious access problems to psychiatric services in the SBH-proposed service area. (Collier, Vol. 4, p. 724:19-725:14). Further, SBH admits that the population growth in the area is very modest, and will not be the

[7] Although inconsistent with his opinions in this case, Mr. Sullivan has previously testified in other CON matters that it is appropriate to look at psychiatric resources available in adjacent counties in assessing whether there is a need for psychiatric beds in a particular community. (Sullivan, Vol. 2, p. 491:12-497:18).

[8] Contrary to the suggestion of SBH that Tennessee is below its national peers in psychiatric health access, Tennessee has a middling use rate relative to other states. (Collier, Vol. 4, p. 726:18-726:25). Tennessee has 32.7 private psychiatric beds per 100,000, while the national average is 22.9 private psychiatric beds per 100,000. (Collier, Vol. 4, p. 727:1-727:19). Similarly, Tennessee has more private psychiatric beds than the standard for the State Health Plan. (*Id.*)

impetus for increased psychiatric service demand in the future. (Sullivan, Vol. 2, p. 455:7-456:3, 482:8-482:11).

48. Moreover, MSHA is working to drive down use rates by providing more community-based psychiatric services. (Levine, Vol. 5, p. 886:21-887:25). MSHA recently announced a task force to explore expanding treatment options for mental health and addiction. (Levine, Vol. 5, p. 886:21-887:25). The Quillen Psychiatric Department at East Tennessee State University has accepted responsibility for preforming an analytics-driven mental health assessment that will determine the actual psychiatric needs of Northeast Tennessee and Southwest Virginia. (Levine, Vol. 5, p. 906:3-907:12). The task force, in a pragmatic and thoughtful manner, will identify areas where MHSA can invest in additional community-based psychiatric services. (*Id.*)

49. While SBH repeatedly cited comments made by MHSA's CEO, Alan Levine, that the Tri-Cities region disproportionately suffers from mental health issues, that statement did not mean that there was a need for additional inpatient beds. (Levine, Vol. 5, 884:2-885:10). Instead, MHSA is focusing on an analytics-based approach to determine what gaps in service may exist and how best to push effective outpatient psychiatric services into the communities. (*Id.*) This community-based analysis with involvement of key stakeholders is the opposite of SBH's strategy, i.e., the assumption that one-size fits all and simply doubling down on centralized inpatient beds is the appropriate solution to any limited service gaps that may exist in the region. (Levine, Vol. 5, p. 886:21-887:25). MHSA performs annual community health assessments of Sullivan and Washington Counties. (Collier, Vol. 4, 824:3-824:9; Levine, Vol. 5., p. 886:11-886:20). In the course of those community health assessments, no stakeholder has

communicated that there is a need for a new 72-bed inpatient hospital for psychiatric services in the Tri-Cities. (Collier, Vol. 4, 824:3-824:9; Levine, Vol. 5., p. 886:11-886:20).

50. As an example of the community-based services described by Mr. Levine, MSHA has entered into a collaborative relationship with Frontier Health, the leading outpatient psychiatric service provider in Upper East Tennessee and Southwest Virginia, to construct a 12-bed Crisis Stabilization Unit (CSU) for adolescents. (Jessee, Vol. 4, p. 659:15-665:17; Levine, Vol 5, p. 882-884). Dr. Jessee, the Senior Vice President of Specialty Services at Frontier Health, testified at length about the progress being made to establish the CSU. (Jessee, Vol. 4, p. 659:15-665:17). The CSU is on pace to be operational before the end of 2015.[10] (*Id.*)

51. A CSU is a non-hospital facility offering 24-hour, 7-days a week, intensive behavioral health treatment geared towards assessment, evaluation, early intervention, and stabilization within a 72 hour time period. (Trivedi, Vol. 4, p. 846:13-949:9; Jessee, Vol. 4, p. 659:15-665:17). While patients in a CSU can have the same or similar level of severity of psychiatric illness as an inpatient unit, care provided in a CSU setting tends to be less costly than an inpatient stay both in daily cost as well as overall cost due to shorter length of stay. (Trivedi, Vol. 4, p. 846:13-949:9; Jessee, Vol. 4, p. 659:15-665:17). This level of care is advantageous for those with specific psychosocial stressors (for example, loss of job or relationship issues) or readily mitigated treatment issues (for example, a patient who is decompensating due to not taking psychotropic medications). (Trivedi, Vol. 4, p. 846:13-949:9; Jessee, Vol. 4, p. 659:15-665:17). Tennessee currently has some adult CSU beds but no pediatric CSU beds have previously been implemented. (Trivedi, Vol. 4, p. 846:13-848:2). The availability of CSU beds can significantly impact the need for inpatient beds for patients of all ages by providing a less

[10] In addition to his role at Frontier Health, Dr. Jessee is also the chair of the Department of Mental Health Substance Abuse Services Licensure Review Board. (Jessee, Vol. 4, p. 690:3-690:17). Dr. Jessee is confident that the license for the proposed adolescent CSU will be approved.

expensive alternative for patients in acute distress who do not warrant inpatient hospitalization. (Trivedi, Vol. 4, p. 846:13-949:9; Jessee, Vol. 4, p. 659:15-665:17). If more patients are appropriately treated as outpatients or in other treatment settings, then that will alleviate demand for existing licensed beds and will increase functional bed capacity in the area. (Trivedi, Vol. 4, p. 846:13-949:9; Jessee, Vol. 4, p. 659:15-665:17). In fact, adding a 12-bed CSU for adolescents, like the one that is being finalized by MHSA and Frontier Health for this area, has the same impact as adding 28 inpatient adolescent beds to the service area. (Trivedi, Vol. 4, p. 849:1-849:9).

52. Dr. Harsh Trivedi serves as the Executive Director and Chief Medical Officer for Vanderbilt Behavioral Health, the Vice Chair for Clinical Affairs at the Vanderbilt Department of Psychiatry and Vanderbilt, and Regional Chief Medical Officer for the Vanderbilt Affiliated Health Network. (Trivedi, Vol. 4, p. 828:14-829:7). In Dr. Trivedi's opinion, modern psychiatric care should focus on providing patient-centered treatment at the level of care most appropriate for that patient. (Trivedi, Vol. 4, p. 839:12-839:24). Patients do not want to be locked in an institution or deprived of their civil liberties, nor should that be the goal of the psychiatric health system. (*Id.*) From a health planning perspective, the appropriate goal is to replace inpatient psychiatric care with outpatient alternatives to ultimately reduce the necessity of inpatient beds. (Trivedi, Vol. 4, p. 839:12-839:24; Collier, Vol. 4, p. 720:5-721:17). In Dr. Trivedi's opinion, the further commitment of resources to inpatient psychiatric beds is an unsound health planning strategy contrary to the orderly development of the psychiatric service community in the Tri-Cities. (Trivedi, Vol. 4, 853:21-854:12).

FINANCIAL FEASIBILITY

53. A CON applicant must prove that its project can be economically accomplished and is evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits.

Health Services and Development Agency Rule 0720-11-.01(2).

54. In Dr. Collier's expert opinion, SBH has not set forth sufficient evidence that the project is economically feasible as proposed. (Collier, Vol. 4, p. 737:9-737:13). While it is uncontested that SBH has sufficient funds available to construct and operate the Project, this fact standing alone does not satisfy the financial feasibility criterion. (*Id.*)

55. Initially, it is impossible to assess the economic feasibility of the project because SBH failed to apply an accurate service area, and therefore, did not consider the appropriate socio-economic demographics and population density for the Project to make an adequate determination. (Collier, Vol. 4, p. 733:3-734:8). In addition, SBH did not perform a distinct financial feasibility analysis. (Collier, Vol. 4, p. 733:3-734:8; Sullivan, Vol. 2, p. 438:18-439:8). SBH simply took a previous pro forma used on other projects, plugged in population numbers and an average length of stay (which was admittedly incorrect), and reproduced that pro forma in

its application. (*Id.*) SBH would have made the same utilization and financial projections if the Project were in Mobile, Alabama or Green Bay, Wisconsin. (*Id.*)

56. Moreover, there has been no indication that SBH considered other, less expensive, non-duplicative alternatives to its prototype 72-bed hospital. (Collier, Vol. 4, p. 734:9-735:3). In evaluating the economic implications of a CON application, the regulations require a project to be evaluated to determine whether less costly or more effective alternatives are available. As set forth above, a smaller adolescent CSU will offer an alternative to inpatient hospitalization and meet any additional demand that may be in the market for adolescent psychiatric services.

ORDERLY DEVELOPMENT

57. In determining whether the Project will contribute to the orderly development of healthcare, the Court must look to HSDA Rule 0720-11-.01(3):

> (3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:
>
> (a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);
>
> (b) The positive or negative effects attributed to duplication or competition;
>
> (c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;
>
> (d) The quality of the proposed project in relation to applicable governmental or professional standards.

(emphasis added).

58. The proposed SBH facility will offer the same psychiatric services that are already being offered by numerous existing providers in the region, including Woodridge.

(Shaheen, Vol. 1, p. 227:18-228:3). SBH has never prepared any analysis examining the potential impact of its proposed duplicative psychiatric hospital on any existing provider. (Garone, Vol. 3, p. 552:1-6). Similarly, although he routinely performs impact analyses in cases where he is retained as a health planning expert, Mr. Sullivan chose not to do one in this case. (Sullivan, Vol. 2, p. 482:16-482:24).

59. Woodridge serves an especially critical role as a safety-net hospital for psychiatric patients in the region. (Bailey, Vol. 3, p. 560:17 – 561:8). When Lakeshore closed, Woodridge made the commitment to provide mental health services to uninsured patients who otherwise would have no access to care. (Bailey, Vol. 3, p. 566:7-570:13). Although Woodridge receives a grant from the State for these services, the grant covers substantially less than the costs associated with treating grant eligible patients. (*Id.*) The grant with the State of Tennessee is reviewed annually for renewal and is subject to change and reduction without notice. (*Id.*) Furthermore, when Woodridge sees more indigent patients than are covered by the grant amount (which has occurred every year), Woodridge must petition the State to cover the remaining costs. (*Id.*)

60. By contrast, SBH proposes to serve very few uninsured patients—the application projects only 70 charity care patients annually, while Woodridge served more than 1,250 such patients in FY 2014. (Collier, Vol. 4, p. 728:9-731:8). Even this minimal participation by SBH to serve medically indigent patients, however, was called into question by evidence presented at trial. (Collier, Vol. 4, p. 728:9-731:8). In written discovery, MHSA asked SBH to identify the percentage of charity and indigent patients that SBH treats at its existing operational facilities. Instead of providing a direct response to the straightforward question, SBH suggested 4.5 percent of its patients are "uncompensated." (Shaheen, Vol. 1, p. 197:17-198:25). SBH's definition of

"uncompensated" care, however, includes bad debt, denials, and administrative adjustments, i.e. patients with commercial insurance who were treated, but were later denied coverage. (Shaheen, Vol. 1, p. 197:17-198:25). When an independent auditor reviewed SBH's 2014 financials, however, it noted that SBH "maintains records to identify and monitor the level of charity care it provides" and that "[t]hese records include the amount of charges foregone for services and supplies furnished under its charity care policy." (Cagle, Vol. 2, p. 269:9-270:21; Exhibit 79, p. 17, n.8). No explanation was given for why SBH did not produce the requested charity care information in discovery. (Collier, Vol. 4, p. 729:8-730:18). According to the independent auditor's report, approximately one half of one percent (.53%) of SBH's expenses in 2014 was attributed to charity care. (Shaheen, Vol. 3, p. 202:4-202:15). Extrapolating this expense ratio, Dr. Collier was able to estimate that SBH saw 150 indigent patients in all 8 of its hospitals in the country in 2014. (Collier, Vol. 4, p. 728:9-731:8).

61. It is uncontested that Woodridge bears, by far, the largest share of the indigent psychiatric care in the region. Furthermore, SBH expects Woodridge to continue to be the destination for indigent patients. (Garone, Vol. 3, p. 552:7-16). SBH has not had any conversations with representatives from the State of Tennessee about caring for the indigent patients formerly seen at Lakeshore. (*Id.*) Moreover, SBH believes it makes sense for those patients to continue to be seen at Woodridge even after SBH opens. (*Id.*)

62. Given SBH's location in the middle of Woodridge's service area, it is obvious that many if not most of the patients admitted to SBH would be patients that otherwise would have been treated at Woodridge. An analysis performed by Dr. Collier suggests that conservatively, the SBH project will result in 1,084 lost cases to Woodridge – 27% percent of its 2014 volume. (Collier, Vol. 4, p. 741:13-743:2). Dr. Collier's conservative estimate was based

on SBH's application pro forma which projected a Year 2 occupancy rate of 72%. (Collier, Vol. 4, p. 741:13-743:2; Shaheen, Vol. 1, p. 242:9 – 242:17). SBH's goal and expectation, however, is to operate at 85% or above at all of its facilities. (*Id.* at p. 241:12-243:4.) In fact, SBH's most recently opened facility in College Station had hit 72% occupancy by the end of Year 1. (*Id.*) The diversion of such a large number, including a disproportionately larger number of insured patients, from Woodridge to an SBH facility would have a significant financial impact on Woodridge, conservatively estimated at between $1.51 and $1.92 million in lost net income per year. (Collier, Vol. 4, p. 741:13-743:2). As SBH's utilization increases in subsequent years, the impact on Woodridge can be expected to grow.

63. The loss of insured patients to a new SBH facility would have a significant adverse impact on Woodridge, given that it has accepted the additional financial burden of uninsured patients, only partially subsidized by the State. (Levine, Vol. 5, p. 888:1-893:2). In the face of a new, for-profit competitor located in its service area, Woodridge would still be the facility receiving indigent cases from SBH's Tennessee service area, but would have a much smaller base of insured patients to support its operations. (*Id.*)

64. In any scenario, the financial impact on Woodridge will be significant. (Levine, Vol. 5, p. 888:1-893:2). The loss of at least $1.51 to 1.91 million in contribution margin per year would represent a major challenge to the ability of Woodridge to support the full range of its current services, especially in today's environment of federal and state budgetary pressures to reduce/control health care payments. (Levine, Vol. 5, p. 888:1-893:2). An impact of this magnitude would cause serious financial stress on Woodridge and might result in the elimination or reduction of needed services or investment. (*Id.*)

65. To the extent the impact is shared with the MHSA system as a whole, the financial picture is not much brighter. In the last six years, MHSA has annually spent $30 million more than its cashflow on significant capital expenditures in an effort to maintain and improve its physical infrastructure. (Levine, Vol. 5., p. 888:1-892:13). Although MSHA has a BBB-plus bond rating, MHSA's financial performance metrics are below its bond class median in several respects, especially as it relates to MHSA' significant debt burden. (*Id.*) Because of its debt load, MSHA can only maintain its BBB-plus rating through successful management of its cash flow. (*Id.*)

66. SBH's project will threaten MHSA's bond rating in a number of ways. (Levine, Vol. 5, p. 888:1-893:2). If the volume of patients with commercial insurance goes down, the hospital will be forced to subsidize lost revenue for the physicians. (*Id.*) This increases the variable costs of providing services at that hospital, and could ultimately force the hospital to reallocate resources to another hospital or facility due to an obligation to be fiscally responsible. (*Id.*) If MSHA's bond rating was downgraded, MSHA would be faced with several million dollars per year in additional interest payments. (Levine, Vol. 5., p. 892:14-892:19).

Conclusions of Law

Based on all of the foregoing findings of fact, including the Court's assessment of the credibility and demeanor of all of the witnesses, the Court reaches the following Conclusions of Law:

1. In light of the historical patient utilization patterns in Upper East Tennessee, the close economic and other ties among the Tri-Cities, SBH's own internal planning documents, and the history of this Project, the Court concludes that a new psychiatric hospital in Kingsport would admit a substantial number of patients that otherwise would have been seen at Woodridge,

including patients from Washington County and from other counties in Woodridge's service area. SBH's claimed service area excluding Washington County is arbitrary and illogical, not only in terms of the well-established economic and community ties between Johnson City and Kingsport, but also in terms of the historical flow of patients from Sullivan County to Woodridge and other providers that were artificially excluded from the asserted service area.

2. The Court adopts the service area proposed by Dr. Collier as representing a reasonable expectation of where most of SBH's patients will originate. The reasonableness of this alternative service area is borne out by the historical experience of Indian Path Pavilion, the most appropriate proxy for the proposed SBH facility.

3. After adopting a reasonable service area for the proposed facility, which would necessarily include Washington County, the Court concludes that the Project does not satisfy the need criteria set forth in the State Health Plan. Using Dr. Collier's alternative service area, in 2019, there will be a net bed need of approximately 30 total beds according to the State Health Plan's quantitative criteria, fewer than half of the 72 beds proposed by SBH.

4. Even if the Court were to accept SBH's proposed service area, SBH has failed to demonstrate that there is a lack of access to psychiatric services in the region that would require the creation of a new 72-bed psychiatric hospital. At worst, SBH has demonstrated that there are transient operational bed shortages during peak times of demand. There are far more economical and efficient ways of addressing any such suggested shortages than simply creating more inpatient beds. The evidence demonstrated that Woodridge has taken and continues to take steps to provide additional community resources to help increase availability of inpatient beds, including the introduction of the joint venture with Frontier Health to establish a Crisis Stabilization Unit for children and adolescents. The Crisis Stabilization Unit will create

functional bed capacity and will help avoid the necessity of inpatient hospitalization for many patients.

5. The Court finds that there is insufficient evidence to establish that the Project is economically feasible as proposed. SBH failed to provide any analysis demonstrating its financial feasibility and failed to examine any less costly alternatives.

6. The introduction of a new 72-bed psychiatric hospital will not promote the orderly development of adequate and effective healthcare services in the Tri-Cities region. SBH's proposed Project will simply duplicate existing psychiatric services and will harm existing health care providers. The proposed Project would serve very few, if any, uninsured patients, leaving those patients to continue being cared for mostly at Woodridge. Although SBH has claimed it will provide 5% charity/indigent care at its new hospital, even that low estimate is simply not credible based the Court's review of SBH's discovery responses and the Court's examination of the historical performance of other SBH facilities, which treat few charity patients. SBH's executives admitted their intention is for uninsured patients to continue to be seen at Woodridge and SBH has taken no steps to offer services for those patients.

7. A substantial number of patients from Sullivan County receive psychiatric services at Woodridge, in Johnson City. It is obvious that many if not most of those patients who have insurance would be diverted from Woodridge to SBH if this project were approved. The impact of redirecting Sullivan County patients and other area patients from Woodridge to SBH would be substantial, and would result in Woodridge losing between $1.5 and $2 million in net income annually, using conservative assumptions. Woodridge currently operates at marginal profitability and MSHA, while operationally healthy, is burdened by substantial debt and faces formidable challenges in today's healthcare environment. The net loss of $2 million annually

would adversely affect MHSA's ability to continue to reinvest in community based services, including the provision of psychiatric services to the most vulnerable segments of the region's population. While the CON process does not create immunity from competition, it exists to prevent unnecessary duplicative services and to preclude the proliferation of new services in the absence of a genuine need.

8. SBH's Application to satisfy the criteria for a Certificate of Need set forth in Tenn. Code Ann.§ 68-11-1609(b) and in HSDA Rules 0720-11-.01(1)-(3) and therefore should be **DENIED.**

WHEREFORE, the Court **hereby ORDERS, ADJUDGES, AND DECREES** that Certificate of Need Application No. CN 1312-050 is denied.

So **ORDERED** this _day of _____, 2015.

_____

Leonard Pogue
Administrative Law Judge

Approved for Entry:



G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been sent to the following counsel of record by the means indicated to the addresses below:

Via e-mail.
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this 28th day of October, 2015.



SBH-KINGSPORT 000329

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November 19, 2015

The Honorable Leonard Pogue
Administrative Procedures Division
Secretary of State
8th Floor, Tennessee Tower
Nashville, TN 37243

Re: Paragraph Numbering Issues in SBH-Kingsport, LLC's Proposed Findings of Fact and Conclusions of Law

Dear Judge Pogue:

I wanted to apologize to you and to fellow counsel for a word processing paragraph numbering issue in the Applicant's Proposed Findings of Fact and Conclusions of Law in the SBH-Kingsport, LLC's CON matter. Last week I spoke to Mr. Swearingen about this issue and apologized to him for any difficulties it may have caused.

Basically, the numbers assigned by the word processing program to the paragraphs in the Applicant's Proposed Findings of Fact and Conclusions of Law are disordered in the first few pages of the document, as you may have already noticed. This numbering error does not affect the text in the paragraphs of our Proposed Findings of Fact and Conclusions of Law; it is strictly a number assignment issue.

The the numbers assigned to the paragraphs of our Proposed Findings of Fact and Conclusions of Law are essentially sequential and in order from paragraph 94 on page 5 through paragraph 295 on page 90, with the following small sets of duplications.

For some reason a first set of paragraph numbers from 94 through 102 are found on pages 2 through 4 of the document. However, the numbers 94 through 102 are repeated beginning with paragraph 94 on page 5, where the basically sequential numbering of the paragraphs begins. There are duplicate paragraph numbers 109-110 on pages 39-40, as well as duplicate paragraph numbers 131-132 on page 49. The final set of number duplications in the Findings is paragraph numbers 145-146 on page 54. In the Conclusions of Law, numbers 1 and 2 are duplicates of

paragraph numbers 1-2 on page 1. However, the remaining paragraph numbers 230-295 of the Conclusions of Law are not interrupted by any more duplications.

Also, as you may have noticed, the Roman numeral enumeration of the larger sections of the document are somewhat disordered, since they start with II and contain duplicate IIIs.

It appears that there was some corruption in the numbering process due to our having more than one word processor working on this large document. However, as far as we can tell, there are no duplications of text attributable to any duplications of numbers or other numeric problems in the Applicant's Proposed Findings of Fact and Conclusions of Law.

Once again, we regret any concern or difficulties this may have caused for the Court or any other party. We believe that our Reply Brief, which is also filed today, will have its sections in order, and we are double-checking the Roman numerals in it. If you have any questions about any of this, please let me know.

Sincerely,

William West

WHW/mhh

cc: Travis Swearingen, Esq.
Brian Jackson, Esq.
Jim Christoffersen, Esq.
Charles Grant, Esq.

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BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

APPLICANT'S PROPOSED FINDINGS OF FACT

I. INTRODUCTION

1. This contested case proceeding involves SBH-Kingsport, LLC/s ("the Applicant" or "SBHK") "appeal," or Petition for a Contested Case Proceeding, regarding the denial of its certificate of need application, CON number CN1312-050 ("CON application"). The Applicant sought the , SBH-Kingsport, LLC ("SBHK") filed CON application number CN1312-050 for the establishment of a 72-bed psychiatric hospital in Kingsport, Tennessee, and the initiation of psychiatric services therein, beginning in December 2013.[1]

[1] Petition for Contested Case Proceeding filed herein by SBH-Kingsport, LLC.

2. At the conclusion of the June 25, 2014 meeting of the Tennessee Health Services and Development Agency ("HSDA"), a motion by a HSDA member to approve the certificate of need failed by a vote of four in favor of approval and four opposed. A tie vote means that the motion was denied. Therefore, the Applicant's CON application was denied by this tie vote.[2]

3. In July 2014, the Applicant timely perfected its petition for a contested case proceeding on the denial of its CON application, pursuant to T.C.A. § 68-11-1610(a). Shortly thereafter, Mountain States Health Alliance ("MSHA"), which had opposed the SBH-Kingsport CON application before the HSDA, was permitted to intervene in opposition to the CON application.[3]

4. SBHK is an entity formed by its parent company Strategic Behavioral Health, LLC ("SBH"), a Memphis-based psychiatric hospital company, to build and operate the proposed psychiatric hospital. SBH has acquired, developed, and operates eight psychiatric hospitals in North Carolina, Texas, New Mexico, Colorado and Nevada. SBHK will be SBH's first psychiatric hospital in Tennessee.[4]

5. Pursuant to the statutory requirements of the Tennessee Health Services and Planning Act of 2002, SBH-Kingsport, LLC needs to obtain a certificate of need from the HSDA in order to establish and operate a psychiatric hospital in Tennessee, with 72 beds, and deliver inpatient psychiatric services therein. Such actions require a grant of a certificate of need by the HSDA, pursuant to T.C.A. § 68-11-1607.[5]

---

[2] Petition for Contested Case Proceeding, filed herein by SBHK.
[3] Petition to Intervene, filed herein by Mountain States Health Alliance.
[4] Ex. 9, CON application No. CN1312-050, pp. 29; Shaheen, TR 81-84.
[5] Ex. 9, p. 29.

6. SBHK proposes that its hospital will have the following inpatient psychiatric bed components: 18 adult psychiatric beds, 28 child and adolescent psychiatric beds, 16 gero-psychiatric beds, and 10 chemical dependency beds.[6]

7. MSHA, through Johnson City Medical Center's department known as Woodridge Psychiatric Hospital ("WPH"), operates a psychiatric hospital that has 12 child and adolescent beds, 14 geropsychiatric beds, and 58 adult psychiatric beds. WPH's beds are in five named separate buildings, which have the following bed complements: Willow-12 child and adolescent beds; Spruce-14 geropsychiatric beds; Cedar-16 adult beds; Laurel-16 adult bed; and Poplar-26 adult. It provides chemical dependency services in some of the adult psychiatric beds.[7]

8. James Shaheen is the President and founder of SBH, the parent of the applicant SBHK.[8]

9. SBH made the decision to pursue the establishment of a psychiatric hospital in northeast Tennessee, in Kingsport, Sullivan County, due to the results of a national survey of various areas around the country. The northeast Tennessee area was selected because it ranked number 2 in the country in terms of SBH's ability to staff the facility. SBH picked Kingsport as a location because Sullivan County is the most populated county in upper east Tennessee. Mr. Shaheen and Mr. Mike Garone, SBH director of development, met with mental health stakeholders in upper east Tennessee and determined that there was a significant need for adolescent and children's beds as well as a need for geropsychiatric and chemical dependency beds.[9]

10. Mr. Shaheen was involved directly in the development of the CON application.

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[6] Ex. 9 at 29.
[7] Bailey, TR 629-630, Ex. 221.
[8] Shaheen, TR 79-80.
[9] Shaheen, TR 91-93. SBH had originally considered locating this facility in Washington County.

11. In Tennessee, issues of certificate of need law are governed by the Tennessee Health Services and Planning Act of 2002. This law sets forth the statutory criteria for the grant of a certificate of need at T.C.A. § 68-11-1609(b). The text of subsection 1609(b) provides as follows in listing the three statutory criteria (generally called "need, economic feasibility, and orderly development") necessary to be satisfied before the HSDA can grant a certificate of need:

> No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed healthcare in the area to be served, can be economically accomplished and maintained and will contribute to the orderly development of adequate and effective healthcare facilities and/or services. In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. . . . Additional criteria for review of application shall also be prescribed by the rules of the agency. (Emphasis added.)

II. NEED - The psychiatric hospital proposed by SBHK in CON application CN1312-050 satisfies the statutory CON requirement of "need" set forth by T.C.A. § 68-11-1609(b): it is "necessary to provide needed healthcare in the area to be served" as a matter of fact.

A. The Applicant's proposed service area is reasonable, as a matter of fact.

12. The statutory description of what a "service area" is for purposes of a certificate of need application is set forth in T.C.A. § 68-11-1609(b) above. When that subsection states "no certificate of need shall be granted unless the action proposed in the application is necessary to provide needed healthcare in the area to be served, . . .", the factual question in terms of definition of a service area under the statute is basically whether the CON project is necessary in order to provide "needed healthcare in the area to be served." SBHK has asserted in this record that it has fully satisfied this criterion of the Tennessee certificate of need program's statutory requirements. This tribunal agrees, as set forth herein, with this assertion by SBH. This tribunal finds, as a matter of fact, that, based on the findings of fact made herein, that the 72-bed inpatient psychiatric hospital proposed by SBHK in CON application number CN1312-050 is necessary to provide needed healthcare in the area it proposes to serve.

13. SBHK described a service area of five counties in its CON application herein. As shown by the MSHA documents in Exhibits 211 and 212, regional referral hospitals operated by MSHA, such as IPMC and JCMC, define their service areas as being three and a half counties, in the case of IPMC, and six counties in the case of JCMC. Thus, when the CON application for the SBHK project describes its service area as consisting of five counties, it is, in terms of its claimed number of counties, well within the range which MSHA defines service areas in June 2015 for its regional referral center hospitals such as IPMC and JCMC. Thus, SBHK's claimed service area is "reasonable" from this standpoint[10], confirming the finding made herein that SBHK's service area definition satisfies the statutory criterion for a proper service area under T.C.A. § 68-11-1609(b).[11] This tribunal therefore finds that the service area proposed to be served by SBHK is "reasonable" as a matter of fact.

14. The "area to be served" by the project proposed by SBHK in CON application number CN1312-050, is described in the SBHK CON application itself and in hearing testimony as the "service area" of the SBHK project. This service area claimed by SBHK consists of Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. In this five-county service area, there are only 12 inpatient psychiatric beds, all for adults, at Bristol Regional Medical Center in Bristol, Tennessee.[12]

B. The testimony of SBHK's expert, Daniel Sullivan, persuasively supports SBHK's service area definition.

15. Daniel J. Sullivan testified as SBHK's expert witness. Highly qualified, Mr. Sullivan has testified in hundreds of CON cases around the country and frequently testifies as an

[10] The use of the adjective "reasonable" as a descriptor of an appropriate service area does not come from the statute, T.C.A. § 68-11-1609(b), but from the state health plan, the *Guidelines for Growth*, in its "Psychiatric Inpatient Services" section. It is also used in HSDA Rule 0720-11-.01(1)(d). Regardless of its source, this tribunal finds, as set forth herein, that the service area set forth by SBHK in CON application CN1312-050 is "reasonable."
[11] Ex. 211, p. 31; Ex. 212, p. 31.
[12] Ex. 9, p. 70; Ex. 80, p. 11.

expert witness on CON matters in Tennessee cases, including CON cases concerning psychiatric hospitals. The parties have stipulated, and this tribunal agrees, that Mr. Sullivan is an expert in the areas of Tennessee CON issues and health planning issues. Mr. Sullivan set forth his expert conclusions and supporting analyses regarding SBHK's service area definition, confirming in detail the reasonableness and appropriateness of SBHK's claimed service area.[13]

16. After analyzing the CON application and reviewing various comparable facilities, Mr. Sullivan concluded as follows:

> Based on all of these considerations, SBH's service area of Sullivan and Hawkins County in Tennessee and Lee, Scott and Wise Counties in Virginia is a reasonable basis on which to determine the need for a new behavioral health facility located in Kingsport.[14]

As set forth below, this tribunal agrees with Mr. Sullivan's expert opinion that the proposed service area is reasonable.

17. Mr. Sullivan reviewed the service area for HealthSouth Rehabilitation Hospital in Kingsport ("HealthSouth"). HealthSouth also is a specialty hospital. HealthSouth's service area consists of Sullivan and Hawkins Counties in Tennessee and certain Virginia counties, but does not include any other Tennessee counties.

18. Mr. Sullivan reviewed the service area of another acute care hospital located in Kingsport, Wellmont Holston Valley Medical Center ("Wellmont"), and testified that its service area consisted of Sullivan and Hawkins County in Tennessee and Scott, Wise and other counties in Virginia. He noted that Wellmont received only 5.7% of its patients from Washington County, Tennessee despite the fact that it is located in Kingsport.[15]

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[13] Ex. 81 (C.V. of Daniel J. Sullivan); TR 337.
[14] Ex. 80, pp. 9-11.
[15] *Id.*, p. 10; Ex. 230, HealthSouth 2013 Inpatient Origin; and Ex. 231, Wellmont Holston Valley Medical Center 2013 Inpatient Origin.

19. Mr. Sullivan noted that the only other provider of psychiatric inpatient services in the proposed SBH service area, Wellmont Bristol Regional Medical Center's 12-bed unit ("BRMC"), received less than one percent of its patients from Washington County, Tennessee, and only 42.1% of its patients were from any of the five counties (including Sullivan) in SBH's service area.[16]

20. Mr. Sullivan reviewed the service area of third psychiatric hospital that was located in Kingsport. Separately, when HCA owned Indian Path Pavilion, a psychiatric hospital formerly located in Kingsport, Tennessee and affiliated with Indian Path Medical Center ("IPMC"), it filed a certificate of need application, number CN9606-042, in a project that involved combining the IPMC and Indian Path Pavilion hospital licenses. In the Indian Path Pavilion at CON application, it described its primary service area as Hawkins and Sullivan Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia.[17]

C. HSDA generally accepts the CON applicant service area definitions.

21. Mr. Sullivan testified that, in reviewing and acting upon CON applications, the HSDA generally has accepted CON applicants' service area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients. Specifically, HSDA has approved such projects requesting additional psychiatric inpatient beds. Trustpoint Hospital ("Trustpoint"), in Rutherford County, Tennessee is an existing provider of both psychiatric and rehabilitation services. HSDA recently approved Trustpoint's recent application to expand its inpatient psychiatric bed capacity. In its application, TrustPoint defined its service area as including only two counties: Rutherford and Bedford. It excluded from its designated service area the contiguous counties of Davidson and Williamson. As Mr. Sullivan

[16] Ex. 80, p. 11.
[17] Ex. 7, p. 22; Ex. 80, p. 10.

testified, both Davidson and Williamson counties have other large and significant hospital providers of inpatient psychiatric services. Mr. Sullivan testified that Trustpoint's application even indicated that Davidson County itself was the second largest source of its admissions, yet its defined service area of Bedford and Rutherford Counties was utilized by the HSDA in analyzing the need for Trustpoint's additional psychiatric beds.

22. Another example concerning applicant's designation of service areas involves Rolling Hills Hospital's CON application CN1312-051. Mr. Sullivan testified that Rutherford and Bedford Counties were included as part of Rolling Hills Hospital's service area. Rolling Hills is the psychiatric hospital in Williamson County, Tennessee. HSDA approved its application. Williamson County is contiguous to both Rutherford County and Davidson County.[18]

23. Thus, HSDA accepted Trustpoint's two-county service area of Rutherford and Bedford Counties which were included in Rolling Hills Hospital's primary service area, and despite the fact that Davidson County was the second largest source of the admissions to Trustpoint for psychiatric hospital beds as defined in its certificate of need application. The HSDA also approved Trustpoint's certificate of need application to expand its psychiatric inpatient hospital bed count. MSHA's expert witness, Dr. Deborah Collier, agreed that Trustpoint's recently approved CON application referred to by Mr. Sullivan utilized a service area consisting of only two counties.[19] Thus, this tribunal finds as matters of fact that the following: the HSDA has recently granted a CON application for additional psychiatric hospital beds filed by Trustpoint Hospital in Rutherford County; Trustpoint's CON application claimed a service area of only two counties, both of which had been claimed by another psychiatric

[18] *Id.*, p. 11; TR 322-324.
[19] Sullivan, TR 322-324; Collier at TR 772.

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hospital as part of its service area, and Trustpoint's CON application excluded from its service area a contiguous county which was a significant source of admissions.

24. Mr. Sullivan opined further that how a psychiatric hospital provider in Kingsport, Tennessee defined its service area is not necessarily the same as how ("WPH") does so from its base in Johnson City. He testified that the definition of the service area depends on where the facility is located and its interconnections with the healthcare system. WPH is located in Washington County, and is affiliated with Mountain States Health Alliance, a formidable competitor for SBHK.[20]

25. Mr. Sullivan doubts that a psychiatric hospital in Kingsport, Tennessee would be able to draw a significant number of people from Washington County when Washington County residents already have excellent access to inpatient psychiatric care at WPH, a psychiatric hospital that is part of Johnson City Medical Center, the largest acute care hospital in the region. When an entrenched provider is located in the community, it is reasonable to conclude that the new provider will not be able to draw many patients from the established provider.[21]

26. Mr. Sullivan testified that in health planning the primary service area is the source of approximately 75% of the patients. He does not believe that Washington County's patients going to SBHK would be within the 75% of patients in the service area definition for a new hospital in Kingsport.[22]

27. Mr. Sullivan then examined the service area for Indian Path Medical Center, which is the MSHA-owned acute care facility in Kingsport, Tennessee. He noted further that its Community Health Needs Assessment ("CHNA"), performed on behalf of IPMC by MSHA and

[20] Sullivan, TR 297.
[21] Sullivan, TR 298-299.
[22] Sullivan, TR 299; Ex. 381, Map 3 shows that, in 2007-2009 time period, Indian Path Pavilion in Kingsport received less than 12% of its patients from Washington County, Tennessee.

published on June 29, 2015, sets forth a service area for IPMC. The service area for Indian Path Medical Center does not include all of Sullivan County, in which it is located. Rather, IPMC's claimed service area includes merely western Sullivan County and Hawkins County in Tennessee, plus Scott and Wise Counties in Virginia.[23]

D. Dr. Deborah Collier's "Alternate Service Area" analysis is flawed.

28. Dr. Deborah Collier is MSHA's expert witness. She proposed an "alternate service area" for SBHK. Mr. Sullivan disagrees with Dr. Collier's proposed "alternate service area" definition.[24]

29. Mr. Sullivan opined that the area Woodridge serves is not relevant to what the service area should be for a hospital located in Kingsport, Tennessee, which is in a different location and situation, is not part of a major medical center, and would be facing existing competition. Woodridge currently has no real competition in terms of another comprehensive psychiatric hospital provider. A hospital in Kingsport would thus have a significant competitive situation than does Woodridge, located in Washington County. Mr. Sullivan opined it would be very difficult for any psychiatric hospital in Kingsport to draw a large number of patients out of Washington County, Tennessee. He opined further that if Dr. Collier's proposed alternate service area were used for SBHK, and Washington County were excluded but everything else remained the same, there would be a need for even more beds than what was projected by SBHK.[25]

30. Dr. Collier included Russell County, Virginia in her "alternate service area." Mr. Sullivan has not seen any data that would indicate a provider in Sullivan County, Tennessee

[23] Sullivan, TR 309-313, Ex. 211, p. 31.
[24] Sullivan, TR 406.
[25] Sullivan, TR 406-407. Dr. Collier's report, Ex. 381, Map 3 indicates that Washington County, Tennessee provided on average of 242 patients per year to Indian Path Pavilion in Kingsport in the years 2007-2009, when MSHA owned both WPH and Indian Path Pavilion.

would serve a material number of patients from Russell County, Virginia. He noted that Russell County, Virginia is not in Johnson City Medical Center's service area. Furthermore, Russel County patients traveling to Kingsport would have to pass three psychiatric hospitals: Russell County, has a 20 inpatient bed facility; a 28-bed psychiatric hospital in Washington County, Virginia; and a 12-bed unit at Wellmont . Dr. Collier also included Washington County, Virginia. Mr. Sullivan testified that he doubts a significant number of people from Washington County, Virginia would leave to go to a provider located in western Sullivan County, Tennessee.[26]

31. Regarding potential patients from Russell County or Washington County, Virginia, Mr. Sullivan testified that there are approximately 60 beds in closer proximity to that population (20 in Russell County, 28 in Bristol, Virginia, and the 12 at Bristol Regional Medical Center in Bristol, Tennessee). Furthermore, he testified that neither Washington County, Virginia nor Russell County, Virginia has been a significant source of patients for the HealthSouth hospital in Kingsport.[27]

32. Concerning Carter County, Tennessee, Mr. Sullivan testified that there is not a significant patient flow from Carter County to Kingsport's hospitals. With regard to patient flow to Kingsport from Unicoi County, Mr. Sullivan testified that patients from Unicoi would have to drive past WPH and go a considerable distance farther to get to the SBHK facility in Kingsport, which he testified would not make a lot of sense. He testified that the same analysis applies to the Tacoma facility in Greene County.[28]

33. Mr. Sullivan opined that the "alternate service area" proposed by Dr. Collier shows a need for 30 to 38 beds in that area. He testified that if her alternate service area were

[26] Sullivan, TR 408-409; Ex. 212, p. 31.
[27] Sullivan, TR 409.
[28] Sullivan, TR 409-410.

drawn more reasonably and the bed need calculations were done as he had illustrated in his report, the need for a 72 bed psychiatric hospital would be readily clear.[29]

34. Mr. Sullivan pointed out that in Indian Path Medical Center's recent Community Health Needs Assessment for that facility, Indian Path Medical Center did not include Russell County or Washington County, Virginia as part of its service area, nor did it include Carter County, Unicoi County or Greene County in Tennessee. Indian Path Medical Center, which is in Kingsport, focuses in identifying its service area on the western half of Sullivan County and Hawkins County plus several Virginia counties. Mr. Sullivan testified that the orientation for the Kingsport area healthcare facilities is to the west and north in terms of where their patients come from.[30]

35. Mr. Sullivan testified that he did not perform the type of "impact analysis" that Dr. Collier performed, because he did not have access to the proprietary information available to him that had been available to Dr. Collier. Furthermore, with regard to Dr. Collier's "use rate analysis," Mr. Sullivan, unlike Dr. Collier, was not able to utilize the Tennessee Hospital Association's ("THA") detailed discharge data because only members of THA can have access to them. SBH is not a member of THA because it does not currently operate any hospitals in Tennessee.[31]

36. Johnson City Medical Center ("JCMC") is MSHA's flagship hospital. JCMC's "2015 Community Health Needs Assessment", published by MSHA on June 29, 2015, notes as follows:

> Johnson City Medical Center (JCMC), MSHA's flagship facility, is a 445-bed regional tertiary referral center for the entire service area. . . . JCMC also includes

[29] Sullivan, TR 410.
[30] Sullivan, TR 411; Ex. 211, p. 31.
[31] Sullivan, TR 411-412.

> Niswonger Children's Hospital and Woodridge Psychiatric Hospital. (Emphasis added.)[32]

37. MSHA listed JCMS's service area counties (all in Tennessee) as follows: Washington, Sullivan, Unicoi, Carter, Greene and Johnson. JCMC does not include Hawkins County in its service area.[33]

38. Similarly, MSHA described its Indian Path Medical Center hospital ("IPMC"), located in Kingsport, in its "2015 Community Health Needs Assessment" ("CHNA") as follows:

> Indian Path Medical Center (IPMC), Kingsport, Tenn., is a 261-bed, not-for-profit hospital. . . . This hospital serves as a regional referral center providing advanced care in the areas of orthopedics, oncology, cardiology and women's. (Emphasis added.)[34]

39. MSHA does not claim eastern Sullivan County as being part of IPMC's service area because the Wellmont acute care facility Bristol Regional Medical Center is located in Bristol, in eastern Sullivan County, Tennessee. Thus, IPMC claims a service area of only three and one-half counties, even though MSHA's documents assert that IPMC is a "regional referral center".[35]

40. On page 37 of the IPMC CHNA, there is a "2015 county snapshot" for Sullivan County which lists such things as "top health issues." Its list of "top health issues" specifies "substance abuse/NAS" as number 5. It also lists "behavioral health" as an "additional health issue" for Sullivan County. Wise County, Virginia and Norton City, Virginia (Norton is located in Wise County) also list their "top health issues" in the CHNA's 2015 county "snapshot" on page 56. Wise County lists as its top health issue number 5 the "lack of specialty care" and as issue number 6 "mental health."[36]

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[32] Ex. 212, p. 31.
[33] *Id.*, at 31.
[34] Ex. 211, p. 31.
[35] Ex. 211, p. 31.
[36] Ex. 211, pp. 37 and 56.

41. Through its expert, Dr. Deborah Collier, MSHA attacked SBH's definition of the service area it proposed to serve in the CON project at issue. Dr. Collier has been stipulated by the parties as being an expert in health planning issues, and this tribunal agrees that she is such an expert. In disagreeing with SBHK's service area definition, however, Dr. Collier's report and testimony failed to account for Johnson City Medical Center's ("JCMC") exclusion of Hawkins County from its own service area (while she admitted that WPH is a department of JCMC). Furthermore, Dr. Collier ignored MSHA's definition of its service area in JCMC's own CHNA, in which it excluded any Virginia counties whatsoever from its service area. In her testimony and expert report, Dr. Collier failed to account for, or analyze any impact, negative or otherwise, of SBHK's proposed psychiatric hospital on JCMC, even though she agreed that WPH is a department of JCMC.[37]

42. Dr. Collier emphasized that inpatient psychiatric hospital services are a "regional" service. However, she ignored the limited three and one-half county and six-county service areas designated by MSHA for its "regional referral center" IPMC and its "regional tertiary referral center" JCMC respectively.[38] Thus, the "regional" service provider, IPMC (for acute care specialties) is described by MSHA itself as having a service area much smaller than the five-county service area claimed by SBHK.

43. Dr. Collier asserted that SBHK chose a service area that was too small. She asserted that SBHK should have utilized a different service area, an "alternate service area." In Map 8 of her report (Ex. 381), she set forth a map of her proposed 11-county "alternate service area" for SBHK. She described the area so mapped as the "alternate service area" that SBHK should have utilized, in her view. The alternate service area she proposed contains 11 counties --

[37] Dr. Collier's Ph.D. is in American Literature; she also has an MBA and is accepted by all parties hereto as an expert in health planning and healthcare finance; Collier at TR 779; Ex. 212, p. 31; Ex. 381.
[38] Collier at TR 796; Ex. 381, p. 7; Ex. 211, p. 31; Ex. 212, p. 31.

far larger than the six-county service area of JCMC, which is a "major regional referral center", by MSHA's own account. Dr. Collier's "alternate service area" for SBH includes the following six counties in Tennessee: Hawkins, Sullivan, Greene, Washington, Carter and Unicoi. However, it also includes five counties in Virginia: Wise, Scott, Lee, Washington (Virginia), and Russell. Neither Washington County, Virginia or Russell County, Virginia were designated by MSHA as being part of IPMC's or JCMC's service areas. Dr. Collier also excluded Russell County, Virginia from her definition of WPH's own "Historical Service Area". Dr. Collier's analysis, in Map 3 of her report, of past patient flow to the now-closed (by MSHA) Indian Path Pavilion psychiatric hospital in Kingsport also failed to include Russell County, Virginia as an identifiable source of patients to Indian Path Pavilion, or even to include it as part of the historical service area ascribed to Indian Path Pavilion by Dr. Collier. Thus, even if SBHK's chosen service area were deemed to be too small, there is insufficient justification for including Russell County, Virginia as part of the service area for the SBHK psychiatric hospital in Kingsport, Tennessee.[39]

44. Thus, in attacking the service area defined by SBH in its own CON application, Dr. Collier recommends an "alternate service area" that includes 11 counties: almost twice the number of counties proposed for MSHA's flagship "regional referral center", JCMC, and more than three times the 3.5 county service area proposed for MSHA's regional referral hospital of Indian Path Medical Center, which is actually located in Kingsport in Sullivan County.[40]

45. Dr. Collier's 11-county "alternate service area" for SBHK is two counties larger than Woodridge's own "Historical Service Area" of only nine counties (Ex. 381, Map 2), even

[39] Ex. 381, Maps 2 and 8 thereto.
[40] Ex. 381, map 8; Ex. 212, p. 31, and Ex. 211, p. 31.

though, at 72 beds, SBH will be smaller than WPH, which has 84 beds.[41] This tribunal finds, as a matter of fact, that Dr. Collier's proposed "alternate service area" for SBHK is unreasonable and inappropriate. This tribunal rejects Dr. Collier's "alternate service area" for SBHK an appropriate basis for finding unreasonable the five-county service area proposed by SBHK in CON application CN1312-050.

46. Using Dr. Collier's definition of the proper size of a population appropriate to define a "primary" service area as being one which accounts for 60 to 75% of the facility's patients by origin, WPH has a primary service area definable by Dr. Collier's criteria as excluding Hawkins County, Tennessee and Scott County, Virginia. As redefined, it would instead consist of only four counties, Sullivan, Washington (TN), Unicoi, Carter and Greene, which were the source of 72% of WPH's average admissions for the years 2012-2014.[42] Utilizing the 2014 Joint Annual Report data for WPH, the four counties listed above, Sullivan, Washington (Tennessee), Carter and Greene, would account for 75% of all the admissions to WPH in fiscal year 2014.[43]

47. Using Dr. Collier's primary service area determination approach, Wise, Scott and Lee are not in WPH's primary service area. MSHA has also excluded all Virginia counties from JCMC's service area. See JCMC CHNA, p. 31, Ex. 212. According to WPH's 2014 Joint Annual Report ("JAR") to the Tennessee Department of Health, in 2014 the only Virginia county claimed by WPH as being in SBH's service area that WPH even lists specifically in the "Patient Origin" section of WPH's 2014 JAR is Wise County. WPH's JAR states that Wise County,

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[41] Ex. 381, map 2, Ex. 250.
[42] Neither the health planning statute, at T.C.A. § 68-11-1609, nor the state health plan, refer to a "primary" or "secondary" service area. The statute refers to "the area to be served" (see T.C.A. § 68-11-1609(b)), while the state health plan refers to "the geographic service area" or "the area". HSDA Rule 0720-11-.01(1) also refers to "the area" and "the service area", but does not mention or define "primary" or "secondary" service areas.
[43] Collier testimony at TR 784-785; Ex. 250 (WPH 2014 Joint Annual Report), pp. 27-30; Ex. 381, Map 2.

Virginia provided 41 "admissions or discharges" to WPH in 2014. This is 1% of all WPH's reported admissions or discharges in 2014. Thus, consistent with JCMC's claimed service area, Wise, Scott and Lee Counties in Virginia are not part of WPH's primary service area. Together, Scott and Lee Counties must account for less than 1% each of WPH's admissions. Thus, as a matter of fact, if most or all of the inpatient psychiatric utilization in these three Virginia counties went to SBHK, there would be virtually no impact on WPH. Otherwise, these Virginia counties would have been listed before Wise on p. 30 of Ex. 250. [44]

48. In any event, even assuming Scott and Lee account for 1% each of WPH's 2014 admissions, 97% of WPH's 2014 admissions come from counties other than these three. Therefore, the three Virginia Counties (Wise, Scott and Lee), claimed by SBH as being part of its five-county service area, are not part of WPH's primary service area.

49. Similarly, according to WPH's 2014 JAR, Hawkins County, Tennessee accounted for only 229 WPH admissions or discharges in 2014. This is only 5.6% of WPH's admissions or discharges in 2014. Since JCMC, of which WPH is a department (per Ms. Bailey's testimony at TR 588) excludes Hawkins County, Tennessee from its service area, it should also be excluded from WPH's service area. Assuming that Wise, Scott and Lee Counties account for 1% each of WPH's admissions or discharges (which appears unlikely, as noted above), excluding them and Hawkins County, Tennessee from WPH's service area still leaves WPH with approximately 91.4% of its 2014 admissions or discharges coming from other counties. Thus, four of the five counties claimed proposed as SBHK's service area are not part of WPH's primary service area, if Dr. Collier's primary service area designation analysis is used. These four counties are: Hawkins County in Tennessee, and Wise, Scott and Lee Counties in Virginia.[45]

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[44] Ex. 212, p. 31; Ex. 250, p. 30.
[45] Ex. 250, p. 27; Collier, TR 784-785.

50. Dr. Collier explained on cross-examination that she did not testify that a primary service area had to be the source for 90 to 95 percent of the patients to be described an as accurate primary service area.

Collier had testified on direct as follows, at TR 699:

Q: . . . When we say service area, what are we describing exactly?

A: Well, it's the area that accounts for the vast majority of the patients receiving service at an institution. . . ."

51. At TR 785 Dr. Collier stated on cross-examination that the "vast majority" of patients line she used to demarcate between the primary and secondary service areas was 60-75% of patients:

Q: And where would you make the cutoff between the primary and the secondary service area?

A: That's a matter of judgment. I typically look at the vast majority could be 60, 75 percent.

52. In light of this testimony by Dr. Collier, it is clear that Dr. Collier's report does not show the primary service area of WPH, which, per Dr. Collier's, can be identified as four counties, none of which are in Virginia: Washington (TN), Sullivan, Carter and Greene. These four counties yield 72% of WPH's patients for the 2012-2014 time period, on average. This analysis excludes Scott County, Virginia, and Hawkins County, Tennessee, both of which are also excluded by JCMC, of which WPH is a "department," from JCMC's service area. It also excludes Unicoi County, Tennessee and Washington County, Virginia from WPH's primary service area.[46]

53. Similarly, when applying Dr. Collier's description of the primary service area as being where the "vast majority", or "60, 75 percent" of a facility's patients originate, her report

[46] Ex. 381, Map2; Ex. 212, p. 31.

demonstrates that Indian Path Pavilion's primary service area could be defined (prior to its closure by MSHA in 2009) only Sullivan and Hawkins Counties, Tennessee, and Wise and Scott Counties in Virginia. According to Dr. Collier, these four counties accounted for 66.4% of Indian Path Pavilion's admissions in the 2007-2009 averaged data. This percentage of 66.4% is well within the 60-75% of patients that Dr. Collier specifies as being the cutoff for defining a facility's primary service area. The primary service area for Indian Path Pavilion is consistent with the service area claimed by SBH, with the exception of Lee County, Virginia.[47]

54. Dr. Collier's analysis of patient flow from her "alternate service area" does not take into account issues disclosed by this record with WPH's deferrals, nor does she take them into account in her assertions as to the purported impact of SBHK's hospital on WPH. The same is true of Dr. Collier's testimony at trial.[48]

E. WPH deferrals show the need for more psychiatric beds.

55. According to MSHA witness Bailey, a "deferral" at WPH "is a patient that we can't take at that moment in time for whatever reason, so we are trying to make other arrangements so they can get a bed." (Bailey, TR 574). Ms. Bailey testified (TR 607-609) that, prior to January 2014, WPH was not meeting the needs of the area, in her own view. WPH had 365 total adult deferrals from June 2013 through December 2013, which yields an annualized rate of 626 deferrals. Thus, during the time in which when Ms. Bailey concluded that WPH as not meeting its service area's needs, there were, on an annualized basis, 626 deferrals by WPH of potential adult patients. In calendar 2015, based upon reported 2015 WPH deferrals set forth in this record, there will be, on an annualized basis, 466 deferrals at WPH of potential adult patients. Thus, it appears, from Ms. Bailey's expressed view, that WPH continues to fail to meet

[47] Collier testimony, TR 785; Ex. 381, Map 3.
[48] Ex. 381.

the needs of the area in 2015. The area she referred to includes SBHK's chosen service area. This is also proof of a continuing unmet need in northeast Tennessee for inpatient psychiatric services despite WPH's improved admission processes and its continuing 86%-89.5% (or possibly higher) monthly occupancy rate in calendar 2015.[49]

56. Russell County, Virginia is not included by MSHA in IPMC's CHNA as being in its "Northwest Market," but is included in MSHA's "Northeast Market" which contains only Virginia MSHA facilities. This fact highlights why Dr. Collier's use of Russell County, Virginia as being part of any SBHK service area is unsupportable and illogical, as a matter of fact.[50]

F. MSHA's 2009 CON application showed need for more psychiatric beds.

57. In Ex. 7, SBH's interrogatory responses, on page 7 thereof, the following response is made to Interrogatory 28(a)(4):

> 4. In the CON application in which MSHA's CON application to relocate the nine beds from Indian Path Pavilion to Woodridge, CN0908-043, the HSDA staff reported in 2009 that:
>
> > If this CON is approved, with the addition of nine beds at Woodridge and the removal of 61 beds at Indian Path Pavilion, as calculated by the *Guidelines of Growth* psychiatric bed need formula, there will remain a need for 68 additional psychiatric beds within the applicant's two-state service area.

The *Guidelines for Growth* bed need formula for inpatient psychiatric beds has not changed since 2009. MSHA's closure of Indian Path Pavilion caused the need for psychiatric hospital beds in east Tennessee and southwest Virginia to grow dramatically.

58. The correctness of the HSDA staff's 2009 assertion that there was a significant need for more psychiatric hospital beds in northeast Tennessee and southwest Virginia has been

[49] 2013 deferral data, Ex. 65; 2014 deferral data, Ex. 65; 2015 deferral data, Exs. 239-242; Ex. 253; Bailey, TR 606.
[50] Ex. 211, p. 4.

buttressed by the repeated public assertions by Mr. Levine, MSHA's CEO, that these areas have significant needs for more addiction care and access to mental health services.[51]

59. Unlike residents of Russell County, Virginia, the residents of Lee County, Virginia do not have the option of driving past three psychiatric hospital facilities in order to reach Kingsport, Tennessee. As a matter of fact, there are no inpatient psychiatric facilities in Lee County, Virginia, or between Lee County, Virginia and Kingsport, Tennessee.[52]

60. According to Dr. Collier's report, the adolescent population of Sullivan and Hawkins Counties will decline from 2014 to 2019, but the adolescent population of Wise, Scott and Lee Counties in Virginia will actually increase from 2014 to 2019.[53]

61. Dr. Collier also admitted that, with Russell County, Virginia included in her designated "alternate service area" for SBHK a continuing need exists for at least 30 additional inpatient psychiatric hospital beds in 2019 in her proposed "alternate service area" for SBHK. Collier at TR 819. She admitted further that if Russell County, Virginia were excluded from her "alternate service area", "the bed need there would go up". Collier at TR 821. The reason the bed need would increase is that Russell County's 20 psychiatric hospital beds would be excluded from the bed need calculations, along with Russell County's population (which, for 2019, she estimates be only 28,922).

62. The elimination of Russell County's population from the "alternate service area" would cause the "alternate service area's" 2019 population to decline from 705,646 to 676,724, a decline of 4%. Ex. 2 of Collier report, Ex. 381. Under the *Guidelines for* Growth formula, 30 psychiatric beds per 100,000 inpatient population, and the subtraction of the other psychiatric beds in Dr. Collier's "alternate service area" would net a need for 51 new psychiatric beds. This

[51] Ex. 245; Levine, TR 884.
[52] Ex. 381, Map 8.
[53] Ex. 381, Ex. 4 thereof.

is shown by multiplying 30 beds per 100,000 population by 6.76724 units of 100,000 population (which yields a total need of 203 beds). When the 152 existing psychiatric hospital beds remaining in Dr. Collier's alternate service area (after Russell County's 20 beds are excluded), the net need for the "alternate service area" is 51 beds.[54]

142. Mr. Sullivan also analyzed the patient origin pattern for Bristol Regional Medical Center's facility that provides psychiatric and substance abuse services. Bristol Regional Medical Center is located in eastern Sullivan County near the Virginia border. Mr. Sullivan concluded that BRMC drew a very small percentage of its patients from Washington County, Tennessee.[55]

G. Application of the bed need formula for psychiatric inpatient service set forth in the State Health Plan's Guidelines for Growth to the Applicant's CON application establishes that there is a need for the Applicant's CON project, as a matter of Fact.

143. After establishing that the service area claimed by SBHK was reasonable, the next step in determining need, as testified to by Mr. Sullivan, is to evaluate the bed need using the *Guidelines for Growth* inpatient psychiatric bed need formula, which is 30 beds per 100,000 population in the service area.[56]

144. He described the application of the need formula as simple math, in which the population is multiplied by 30, and the result is then divided by 100,000, which indicates the gross number of inpatient psychiatric beds that are needed. The next step is to subtract the supply of existing inpatient psychiatric hospital beds in the service area. Applying these steps to the 2015 population for the proposed SBHK service area, which has slightly more than 300,000 people, Mr. Sullivan determined a total need of 92 beds in 2015, rising to 93 beds by 2020.

[54] Ex. 381, Ex. 2 thereof.
[55] Sullivan, TR 317-319; Ex. 232.
[56] Sullivan, TR 325-326.

Since the only inpatient psychiatric provider in the SBHK proposed service area is Bristol Regional Medical Center with its12 beds, the net inpatient psychiatric bed need is 81 in 2015, which increases to 82 beds by 2020. Therefore, after applying the *Guidelines for Growth* inpatient psychiatric bed need formula, Mr. Sullivan opined the 72 beds proposed by SBH is consistent with the overall net need for inpatient psychiatric beds, which is presently 81 and later 82.[57]

145. Mr. Sullivan also analyzed the bed need for the individual categories of beds at the proposed facility, which include geropsychiatric, children and adolescents, and adult. He determined a need for 44 additional beds for adult inpatient psychiatric patients, which is well in excess of SBHK's proposal for an 18-bed adult psychiatric unit and a 10-bed adult chemical dependency unit. No methodology exists for calculating chemical dependency bed need under the *Guidelines for Growth* formula, so Mr. Sullivan included the ten adult chemical dependency beds with the adult psychiatric beds. Thus, there is a need for both the ten adult chemical dependency beds and the 18 adult psychiatric proposed beds by SBHK, given that there is a net need for 44 additional adult inpatient psychiatric beds in the SBHK service area.[58]

146. Mr. Sullivan also analyzed the need for the 65 and older population to determine the geropsychiatric bed need. In his expert opinion, there is a need for that as well.[59]

147. With regard to the 17 and under age group population's bed need calculation, he determined that there was a need for 17 child and adolescent beds in 2015 and 15 such beds in 2019. Thus, while there is a significant need for these beds, SBH is proposing 28 beds. Concerning the children and adolescent beds, Mr. Sullivan noted that while SBHK's proposal for 28 beds is in excess of the bed needs guidelines for this age group, very few inpatient psychiatric

[57] Sullivan, TR 326.
[58] Sullivan, TR 329-330; Ex. 235.
[59] Sullivan, TR 331.

beds for this population exists in northeast Tennessee. Woodridge has only 12 beds for such a unit, and there are no such beds west of Kingsport before Nashville, according to Mr. Sullivan.[60]

148. Mr. Sullivan expects in-migration from outside the service area for child and adolescent patients to Kingsport, because of the paucity of inpatient psychiatric bed resources available for these patients in the wider northeast Tennessee and southwest Virginia area. He pointed out that the *Guidelines for Growth* are merely guidelines, and they are not "hard and fast standards that had to be met".[61]

149. Mr. Sullivan opined that it was prudent to have additional inpatient psychiatric bed capacity for child and adolescent services, given his expectation that there will be more migration from outside the service area for child and adolescent patients due to the shortage of beds in northeast Tennessee for those services.[62]

150. Mr. Sullivan analyzed whether there were any child and adolescent psychiatric units anywhere in the Johnson City medical area or anywhere in the JCMC or IPMC service area other than the 12 beds at Woodridge; he did not find any.[63]

151. Mr. Sullivan also analyzed the utilization at Wellmont Bristol Regional Medical Center's 12 inpatient psychiatric hospital beds for adults. He determined that their occupancy was approximately 66% in 2013, thereby indicating that about two-thirds of its beds were occupied during 2013.[64]

152. Dr. Collier's data indicates, in Ex. 13 to her report (Ex. 381), that 400 patients from SBHK's proposed service area went to facilities in Blount County and as far away as Vanderbilt in FY 2013. Of these 400, Peninsula Hospital in Blount County received 296 (74%).

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[60] Sullivan, TR 332.
[61] Sullivan, TR 332-333.
[62] Sullivan, TR 332-333.
[63] Sullivan, TR 333-334; Ex. 236.
[64] Sullivan, TR 335-336; Ex. 237.

These patients do not include SBHK service area patients who went to any MSHA or Wellmont facilities. Thus, as a matter of fact, the presence of SBHK in Kingsport should eliminate most, if not all, of this out-of-service-area inpatient psychiatric patient flow from SBHK's service area to Blount County, and will as a matter of fact diminish whatever impact on WPH there might otherwise be from the development of SBHK. In year 1 of its operations, SBHK projects that it will admit 946 cases. Thus, utilizing these 2013 data, approximately 42% of those year 1 SBHK cases (400 divided by 946 equals 42%) could be projected not to be "taken" from WPH patient flow. Peninsula Hospital is in Blount County, south of Knoxville. It is approximately 113 miles from the SBHK site in Kingsport. Ridgeview Hospital is in Oak Ridge in Anderson County, west of Knoxville. It is approximately 123 miles from the SBHK site in Kingsport.[65]

H. The Applicant's CON application satisfies the other need criteria set forth in the HSDA's Rules and the Guidelines for Growth, as a matter of fact.

153. Mr. Sullivan testified that Tennessee has seen a dramatic rise over the last ten to fifteen years in the number of inpatient psychiatric beds which have been closed, particularly as to state beds. He testified that the state regional mental health institute which had previously served northeastern Tennessee, Lakeshore Mental Health Institute, closed in 2012, thereby taking 250 licensed inpatient psychiatric hospital beds out of service in eastern Tennessee. The result is that the regional public mental health institute that now serves northeastern Tennessee is Moccasin Bend in Chattanooga, which is over 200 miles from the Tri-Cities area.[66]

154. Mr. Sullivan testified that there had been a psychiatric hospital, previously owned by MSHA and located in Kingsport, called Indian Path Pavilion. In 2009, Mountain States closed the hospital, moving nine of the inpatient psychiatric beds to Woodridge in Washington County and closing the remaining 52 inpatient psychiatric hospital beds. Thus, in Kingsport,

[65] Ex. 381, Ex. 13 thereto; Ex. 9, p. 99.
[66] Sullivan, TR 288.

Sullivan County, there has been a relatively recent significant decrease in the availability of inpatient psychiatric beds. After the closure of Indian Path Pavilion only 12 inpatient psychiatric hospital beds remain in Sullivan County. These are located in Bristol at the northeastern end of Sullivan County, and consist of only 12 adult beds. Thus, in SBHK's proposed five-county service area, the population has very limited access to inpatient psychiatric services. Therefore, Mr. Sullivan opined, there is a high need for additional inpatient psychiatric beds, especially given Tennessee's high incidence of mental health disease relative to other states.[67]

155. Sullivan County is the ninth largest county in Tennessee by population, but it contains only 12 inpatient psychiatric hospital beds.[68]

156. Mr. Sullivan testified that in the five-year period from 2005 to 2010, hospitals in Tennessee closed 462 psychiatric beds. These closures occurred prior to the loss of 250 inpatient psychiatric hospital beds with the closure of Lakeshore Mental Health Institute in 2012.[69]

157. Mr. Sullivan testified that, given the described inpatient psychiatric bed closures, the HSDA has recently approved new psychiatric hospital facilities such as a new inpatient psychiatric hospital facility in Memphis and a 25-bed new hospital facility in Madison County, Tennessee. As noted previously, the HSDA also approved additional psychiatric hospital beds in middle Tennessee in Williamson County at Rolling Hills Hospital, and in Rutherford County at TrustPoint Hospital.[70]

158. Mr. Sullivan also testified regarding the use of certain terms such as "ALOS" and "ADC." He testified that "ALOS" means "Average Length of Stay." It is calculated by taking the number of patient days at the psychiatric hospital and dividing it by the number of patients

[67] Sullivan, TR 290-291.
[68] Sullivan, TR 291 and Ex. 243.
[69] Sullivan, TR 293; Ex. 80, p. 3.
[70] Sullivan, TR 293-294.

admitted for any particular period of time. The result is, on average, how long each patient stayed in the hospital. With regard to "ADC," he testified that it meant "Average Daily Census." Average Daily Census is determined by dividing the number of patient days by the number of days in the year, which would give the result of how many beds would be full on average on any day.[71]

159. Mr. Sullivan opined that SBHK's proposal is consistent with the *Guidelines for Growth* both in terms of establishing a numerical need for beds, as well as satisfying the more qualitative aspects of CON requirements.[72]

160. Mr. Sullivan testified that the SBHK psychiatric hospital will differ in its bed complements from those served by WPH. While WPH has 84 beds, only 12 of which are child and adolescent beds. However, WPH proposes that 28 out of its 72 beds (approximately 37%) will be devoted to children and adolescents.[73]

161. Mr. Sullivan also testified that Allen Levine, the CEO of MSHA, had issued a press release in April 2015, in which he stated: "Northeast Tennessee and southwest Virginia disproportionately suffer from serious health issues," including, among the only three specifically listed, "addiction and access to mental health services" which need to be addressed, according to Mr. Levine.[74]

162. Mr. Sullivan opined further that another important factor limiting the impact of the SBHK project on Woodridge is that Woodridge is not a distinct hospital. Rather, it is a service, or "department", of Johnson City Medical Center. Mr. Sullivan believes that the more appropriate impact analysis would be to examine the impact of the SBHK project on Johnson

[71] Sullivan, TR 367-368; Ex. 244.
[72] Sullivan, TR 369-370; Ex. 9.
[73] Sullivan, TR 374; Ex. 80, p. 24.
[74] Sullivan, TR 375-376; Ex. 245; Levine, TR 884.

City Medical Center or on MSHA. He testified that the 2013 JAR report for Johnson City Medical Center indicated that JCMC had a bottom line profit of over $30 million in fiscal year 2013. Thus, Mr. Sullivan opined that even if the impact of SBHK were as large as was projected by Dr. Collier's projections, the large and profitable organization, JCMC, of which WPH is only a department, would not experience significantly detrimental impact from it. Anew psychiatric hospital would not require JCMC to discontinue any services. Mr. Sullivan opined that any impact of SBHK on JCMC would be that which results necessarily when a new facility is approved to enhance access to care. Furthermore, Mr. Sullivan opined that the weight of the health planning analysis favors the benefits that accrue to the community from SBHK's project over and above any monetary impact on WPH or JCMC.[75]

163. Dr. Collier's data indicates, in Ex. 13 to her report (Ex. 381), that 400 patients from SBHK's proposed service area went to facilities in Blount County and as far away as Vanderbilt in FY 2013. Of these 400, Peninsula Hospital in Blount County received 296 (74%). These patients do not include SBHK service area patients who went to any MSHA or Wellmont facilities. Thus, as a matter of fact, the presence of SBHK in Kingsport should eliminate most, if not all, of this out-of-service-area inpatient psychiatric patient flow from SBHK's service area to Blount County, and will as a matter of fact diminish whatever impact on WPH there might otherwise be from the development of SBHK. In year 1 of its operations, SBHK projects that it will admit 946 cases. Thus, utilizing these 2013 data, approximately 42% of those year 1 SBHK cases (400 divided by 946 equals 42%) could be projected not to be "taken" from WPH patient flow.[76]

[75] Sullivan, TR 397-398; Ex. 83 (2013 JCMC JAR), p. 19.
[76] Ex. 381, Ex. 13 thereto.

164. The experts for both SBHK and MSHA, Mr. Sullivan and Dr. Collier, agree that there is a need for more than 72 inpatient psychiatric hospital beds in the five-county service area defined by SBHK in its CON application, Ex. 7. These five counties are: Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia.[77]

165. Similarly, given that Dr. Collier's report indicates (at Map 3) that Washington County (with Bristol, Virginia), Virginia provided very few admissions to Indian Path Pavilion prior to its 2009 closure by MSHA (an average of 51 admissions per year, 2007-2009), it is also reasonable to exclude Bristol and Washington County in Virginia from Dr. Collier's "alternate service area". The remaining 2019 population of the alternate service area is 69,751. This population generates a total need of 181 beds under the 30 beds per 100,000 population formula. The remaining 'alternate service area" contains only 124 existing beds, if Washington County's beds are removed. Thus, under this approach, there is a net need in this area for 57 more inpatient psychiatric hospital beds.[78]

166. Mr. Shaheen testified that coverage changes under the federal Affordable Care Act, which became effective in insurance policy renewals after July 2014, have increased insurance coverage for inpatient psychiatric and substance abuse care.[79]

167. Mr. Shaheen testified further, without contradiction in this record, that since January 2015, SBH has seen significant increases in patients who have access to mental health and substance abuse care because of Affordable Care Act insurance requirements.[80]

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[77] Sullivan, TR 326; Collier, TR 790-791.
[78] Ex. 381, Map 3 and Exs. 7 and 11 thereof.
[79] Shaheen, TR 179-180.
[80] Shaheen, TR 179-180.

I. The trends in occupancy and utilization of other inpatient psychiatric hospitals both inside the Applicant's chosen service area and outside its border are rising.

168. As shown by the chart below, admissions at WPH have been growing at a steadily increasing rate since 2011, and patient days are up sharply, by almost 32% since 2011. Even since 2013, the year from which Dr. Collier gets much of the data for her report, Exhibit 381, admissions are higher at WPH in FY 2015 by more than 23%, and patient days are higher by 3,936 patient days, or 17.7%. WPH is now clearly approaching full occupancy, and its own reports indicate that it hit 89.5% occupancy for the month of May 2015 and 89.9% occupancy in November 2014. Ms. Bailey testified that WPH had experienced an occupancy rate of 88% for July 2015, the month of the hearing.[81]

[81] Ex. 253 (WPH 2011-2014 fiscal years' results); Ex. 85 (WPH FY 2015 operating indicators through 5/31/2015; Ex. 87, WPH monthly patient day totals by unit from September 2014 through June 2015; Bailey testimony at TR 606. The total number of admissions at WPH in FY 2015 has been derived as follows: Ex. 85, which is MSHA document 1905, shows that through May 31, 2015, WPH had admitted 4,320 in its FY 2015. It also shows that those patients had an average length of stay in FY 2015 of 5.54 days. Ex. 87, another MSHA document, shows that WPH experienced 2,185 patient days in June 2015. The number of admissions at WPH in June 2015 can be derived by dividing the total number of days, 2,185, by the average length of stay at WPH in FY 2015, or 5.54 days. The result is 394 June 2015 admissions. When the June 2015 total is added to the total admissions through May 2015, the sum is 4,714 admissions, as shown on the chart above. An alternate method would be to find monthly average of WPH admissions through May 31, 2015, which, per Ex. 85, is 4,320. Through 11 months, WPH averaged 392 monthly admissions. thus, when the monthly average of 392 is added to the 11 month total of 4,320, the total 2015 yearly admissions at WPH is projected to be 4,713.

	2011	2012	2013	2014	2015	Increases from 2011 to 2015
Occupancy	64.7%	69.4%	72.3%	76.4%	85.7%	21% higher
No. of Admits	3,430	3,577	3,825	4,081	4,714[81]	1,284 more
% admissions increase from prior year	3.6%	4.3%	6.5%	6.7%	15.4%	37.4% higher
No. of patient days	19,827	21,329	22,182	23,426	26,118	6,291 more
% increase in patient days from prior year	1.3%	7.8%	4%	5.6%	11.5%	31.7% higher

Data Sources: Exs. 85, 87 and 253. 2010 base data from Ex. 251, WPH 2010 JAR, p. 24. 2011-2014 utilization data from Ex. 253, MSHA document 000874.

169. MSHA witness Dr. Randall Jessee confirmed WPH's extremely high occupancy in recent months in his testimony at TR 686:

> Q: "What is your understanding of the current occupancy rate of the Woodridge Psychiatric Hospital in Johnson City? . . ."
>
> A: " . . . it's approaching being full on many occasions."

170. "Approaching being full" means that WPH is basically full on many occasions, causing many patients referred to WPH to be deferred by WPH itself. Ms. Bailey testified, at TR 583, that merely discharging current patients from WPH may not open up the beds formerly occupied by those persons to new admissions:

> p. 583: "Now, it's not simply I discharge one, I admit one. If you discharge one on Cedar, you can't admit one who needs Poplar to Cedar, because their units are very different and have very distinct identities; so we have to make sure that the person that's coming is getting to the right bed on the right unit."[82]

171. MSHA CEO Alan Levine testified that his goal is for MSHA to have fewer inpatient psychiatric admissions, yet WPH grew by 15.5% in inpatient admissions from FY 2014 to FY 2015. In MSHA's "Management Discussion" of March 2015 MSHA financial results (Ex. 219), MSHA's management touts the fact that MSHA's third quarter FY 2015 admissions were

[82] Ex. 239-242; TR 583 and 686.

up 8.4%, or 1,215, from those of the third quarter of FY 2014. These increased admissions include increased psychiatric admissions to WPH, a department of JCMC, in FY 2015.[83]

172. If Mr. Levine achieves his goal of fewer inpatient admissions at WPH, WPH will show larger losses, according to the analysis employed by Dr. Collier. Thus, Mr. Levine's goal of reducing inpatient psychiatric admissions, as he testified, is contrary to his claimed goal of maximizing MSHA revenues in order to raise its bond ratings. If Dr. Collier's analysis is accepted as accurate, Mr. Levine's goal of fewer psychiatric admissions at WPH will have the same kind of negative financial impact on MSHA that Mr. Levine claims to fear from the development of SBHK's CON project -- lower revenues for MSHA.[84]

173. Dr. Collier asserts on Ex. 23 of her report, Ex. 381, and in her testimony (TR 804-805), that virtually every single patient at WPH provided a significant financial contribution margin per case at WPH in 2014, regardless of whether they were Medicare, Medicaid or MSHA's state grant patients. According to Dr. Collier, WPH had virtually no free cases or cases for which WPH received no revenue in FY 2014, the WPH reporting period for which Dr. Collier determined the Woodridge FY 2014 "contribution margin per case". Dr. Collier testified on cross-examination that even the 1,241 "indigent" patients paid for by the Tennessee Department of Mental Health and Substance Abuse Services ("MHSAS") grant (Ex. 50) generated an average positive contribution margin of roughly $800 per case.[85]

[83] Levine testimony at TR 884-885; Ex. 219, Ex. 219. Ex. 85, MSHA doc. 001905, states that through 11 months of FY 2015, through May 31, 2015, WPH's admissions increased by 596 over the first 11 months of FY 2014, from 3,724 to 4,320 admissions.
[84] Ex. 381, p. 34; Levine, TR 899 and 890; Ex. 381, Exs. 23 and 24 thereto.
[85] Collier testimony at TR 804-805; Exs. 23 and 24 to Ex. 381.

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J. WPH's sharply increased omissions demonstrate that there is a need for more inpatient psychiatric beds in northeast Tennessee and southwest Virginia.

174. Collier's need assessment approach in her report could not predict WPH's 15.5% growth in admissions in 2015, following continuous years of consistent, but lower, growth. MSHA did not forecast this growth either: its budgetary projections in Ex. 85 show that, as of May 31, 2015, admissions at WPH were running more than 1,000 admissions higher than the number of admissions MSHA had budgeted for WPH for the first 11 months of FY 2015. Actual admissions at WPH through May 31, 2015 were 4,320, but MSHA had only budgeted for 3,318. Collier's report forecasts WPH's future results from a period of lower WPH utilization (2010-2013), which was significantly lower than the last half of FY 2014 and all of FY 2015. This basis of "under-utilization" of WPH reflected in Ex. 381 is contrary to the facts as shown in 2014 and 2015: WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally on a monthly basis, and on many days occupancy is 95% or more, as shown by Ex. 221. This tribunal finds as a fact that, at these current rates of utilization, on a monthly basis WPH has only 10-15% of its capacity open to take new patients, or for its admission volume to increase.[86]

175. As set forth in this record and summarized in the 2011-2015 data chart above, WPH's volume grew by 633 admissions in FY 2015 (WPH's 2015 fiscal year ended on June 30, 2015). If WPH's volume grows by a similar patient day utilization increase in FY 2016 (an increase of 2,692 patient days from the prior year), it will experience 28,810 patient days in FY 2016. The maximum number of patient days possible for WPH in any single fiscal year is 30,660 patient days (derived by multiplying 365 days by 84 beds for non-leap years--this

[86] Ex. 221; Ex. 87. In May, 2015, Ex. 85 reports that WPH recorded a total of 2,330 patient days and had an occupancy rate of 89.5%. The occupancy rate for a hospital is derived as follows, using WPH's May 2015 experience as a model: the maximum number of patient days possible at WPH in May is 2,604 (31 days x 84 beds). When 2,330 is divided by 2,604, the result is 89.5%. See budgetary forecasts in Ex. 85.

assumes every bed at WPH is occupied every single day of the year). If WPH experiences 28,810 patient days in any one year, such as FY 2016, its occupancy rate will be 94% for that year (94% equals 28,810 actual patient days divided by 30,660, the maximum possible patient days in a single non-leap year). If WPH experiences 28,810 patient days in FY 2016, then the utilization of WPH in subsequent FY 2017 then cannot physically increase by more than 1,850 patient days, which is an increase of only 6%, before it hits its maximum possible patient day total of 30,660 patient days in one fiscal year. Thus, if WPH's utilization increases (as measured by patient days) continue at the FY 2015 numeric volume of increase, WPH will be 100% full in less than two years from FY 2015.[87]

97. This record contains WPH internal documents in Ex. 238 called "Patient Flow Sheets," which contain patient "census" (a term used in each such daily sheet) data by day reported for the period from January 1, 2015 to May 31, 2015. These MSHA documents provide daily data for 27 of the 31 days in May, 2015 (omitting May 1 and May 25-29). The "census" data was described by Mr. Bailey at TR 581 as the number of beds occupied at approximately 7:00 a.m. on the day reported on. Ex. 283 demonstrates that on 22 of the 27 days reported on the census showed that 90% or more of the WPH beds were occupied, with occupancy rising as high as 83 of 84 beds, or 98.8% on May 5.[88]

98. Mr. Sullivan summarized four months' worth of flow sheet reports. In drawing data from the patient flow sheets, he entered the number of beds available on any given day in each of the units, which at WPH are the separate buildings called Cedar, Laurel, Poplar, Spruce and Willow. He noted that occupancy can be determined as follows: if WPH had 71 total

[87] Exs. 253, 85, and 87.
[88] Ex. 238, pp. MSHA 2022-MSHA 2050.

people in its beds, to determine its occupancy percentage that number is divided by the 84 total beds in the hospital, which would yield the occupancy rate the day in question.[89]

99. Mr. Sullivan testified that not many people are discharged from the psychiatric hospital between 12 midnight and 7:30 in the morning. Thus, the patient flow sheets provide a reasonably close count of the number of patients in the hospital on any given day. He testified that if 81 beds are occupied, the occupancy rate on that day at that time would be 96.4%. Mr. Sullivan testified that the highest levels in the four months he examined were as follows: on March 30, 2015, there were 82 patients, which is a 97.6% occupancy. This was repeated on April 26 and April 27. He noted that there was one day, May 5, 2015, when there were 83 patients listed on the patient flow sheet which resulted in an occupancy rate of 98.8%. He noted further that if 80 of WPH's 84 beds are filled, the percentage occupancy for WPH is 95.2%. He noted further that any occupancy at WPH of 76 beds or higher would constitute a WPH occupancy level in excess of 90% occupancy.[90]

100. The data set forth above demonstrate, as matters of fact, that any negative impact of SBHK on WPH projected by Collier in Ex. 381 or in her testimony will be significantly diminished by the continuing very high utilization of WPH foreseeable in the future, based upon high and increasing current and recent utilization levels at WPH. These findings are confirmed by MSHA's own internal financial analysis of the "impact" it foresaw internally of the SBHK project on WPH. Prior to the June 2014 HSDA meeting at which SBHK's CON application was denied, MSHA planning personnel projected that SBHK's financial impact on WPH in SBHK's second year of operation would be only about a $50,000 reduction in WPH's net income.[91]

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[89] Sullivan, TR 349-350.
[90] Sullivan, TR 351-353.
[91] Ex. 27, MSHA document 00074. See also Exs. 85, 87 and 253.

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101. Mr. Sullivan testified concerning the meaning and use of the term "deferral." "Deferral" means that if a patient was referred to WPH for admission to an inpatient psychiatric bed and could not be admitted, but was deferred for any reason, such action would be considered a "deferral." Deferral could mean that the patient was placed on a waiting list for later admission, or it could mean that the patient was referred to a different facility. He testified that MSHA has provided of documents indicating deferral information for various periods of time.[92]

102. Among other analyses of deferrals, Mr. Sullivan analyzed the adult deferrals for the period of June 2013 through December 2013. He testified that MSHA records show 365 deferrals of adults and that 242 of those deferrals were for the following reason: "appropriate bed not available."[93]

103. MSHA's documents demonstrate total deferrals and deferrals for the reasons "No Bed" or "Appropriate bed not available" are occurring at WPH at higher rates in FY 2015 than in FY 2014. The data are shown below:[94]

		Adult Deferrals		
Source:	**Time Period**	**Total Deferrals**	**Reason for Deferral: "appropriate bed not available"**	**Total 12 months of Deferrals**
Ex. 65	6/13 through 12/13	365	242	
Ex. 65	1/14 through 5/14	107	70	472
Exs. 240-241	1/15 through 5/15	194	126[95]	466[96]

[92] Sullivan, TR 354-355; Exs, 239-242..
[93] Sullivan, TR 360; Ex. 65.
[94] Exs. 65, 239-242.
[95] Annualized, equals 302.
[96] Annualized based on reported five months of utilization, 1/15 through 5/15, 2015.

Source: Exhibit	Time Period	Adolescent Deferrals	Reason for Deferral: "No Bed"	"No Bed" Annual Total
Ex. 65	6/13 through 12/13	75	27	
Ex. 65	1/14 through 5/14	43	26	118
Exs. 239-242	1/15 through 5/15	45	36	108[96]

104. Thus, the total of annualized deferrals in 2015 for reasons of no bed or "no appropriate bed" in 2015 is the sum of 302 adult deferrals plus 86 adolescent deferrals, which yields 388 total deferrals, annualized. This exceeds the 12-month actual total for June 2013 through May 2014 of 312 adult deferrals plus 53 adolescent deferrals, or 365, for an increase of 23 or 6.3% in FY 2015.

105. Thus, this record establishes factually that WPH's deferrals of potential patients because it has no bed available are increasing over the time period covered from 2014 to 2015. This tribunal finds as a matter of fact that when the data for the first five months of 2014 are compared to that for the first five months of 2015, it is clear that whatever effects the admissions process improvements WPH were in early 2014 when first carried out, they no longer restrain the rise in deferrals caused by the impact of high utilization at WPH, which is more often leading to deferrals because WPH has no beds available, or WPH does not have the right kind of beds available.[97]

106. The 2015 deferrals due to lack of appropriate beds at WPH establishes that Dr. Collier overstated any impact of SBHK's project on WPH. If WPH is unable to admit 388 deferred patients because it does not have a bed for them, then, as a matter of fact, the presence of another psychiatric hospital in upper East Tennessee that can admit them is unlikely to

[97] Bailey, TR 853.

meaningfully harm WPH financially. Stated another way, by admitting 388 patients, or any other number of patients that WPH cannot absorb, SBHK would not harm WPH.[98]

107. MSHA's documents factually establish that many of these deferred patients in 2015 have from Sullivan and Hawkins Counties. In the January 2015 through May 2015 2015 time period, 76 of the total of 194 adult deferrals were from Sullivan County, while 17 deferrals were from Hawkins County. Thus, 93 of the 194 adult deferrals were from Sullivan or Hawkins Counties. This amounts to 48% of all adult deferrals by WPH during this time period. Based upon these data, on an annualized basis, 223 deferrals of adults from WPH can be projected for calendar 2015 from Hawkins and Sullivan Counties. As a matter of fact, as WPH's utilization continues to increase in FY 2016 and later, these numbers can also be expected to increase.[99]

108. WPH's 2015 occupancy rate for January through May can be determined by using Ex. 87, which shows the total patient days by month for each of the first six months of 2015. Ex. 87 shows that WPH experienced 10,972 patient days during this five-month period, which resulted in an occupancy rate for that period of 86.5% (determined by dividing 10,972 patient days experienced by WPH in those five months by the total number of possible patient days in those five months (151 days multiplied by the 84 WPH beds) which is 12,684). If WPH's FY 2016 occupancy rate continues to run at July 2015's occupancy rate of 88% or higher, the number of deferrals can reasonably be projected to rise even higher.[100]

[98] Ex. 381, p. 34.
[99] Ex. 240.
[100] Ex. 87.

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III. ORDERLY DEVELOPMENT: The psychiatric hospital proposed by SBHK satisfies the statutory CON requirement of "orderly development" set forth by T.C.A. § 68-11-1609(b): it "will contribute to the orderly development of adequate and effective healthcare facilities or services" as a matter of fact.

A. The positive effects of competition arising from the Applicants's CON project significantly exceed any negative effects of duplication that might arise from the project.

109. With regard to the statutory CON criterion of orderly development of healthcare, Mr. Sullivan's opined was that the SBHK's project would contribute to the orderly development of healthcare. He testified that the CON application indicates the intent of SBHK to become an integral part of the healthcare delivery system within its service area by reaching out to community-based organizations involved in mental health treatment, such as schools, law enforcement agencies and other types of outpatient mental health providers, to try to integrate their services. Thus, Mr. Sullivan opined that the SBHK project will be an enhancement to the overall delivery of mental health in the service area.[101]

110. With regard to the orderly development HSDA rule criterion concerning evaluation of the positive or negative effects attributable to duplication or competition (HSDA Rule 0720-11-.01(3)(b)), Mr. Sullivan testified that the positive effects attributable to competition were a material consideration supporting the grant of a certificate of need for the proposed project. He opined that SBHK would provide a competitive alternative to Woodridge and to MSHA. He testified further that SBHK will attract additional healthcare professionals and specialized psychiatrists and other staff to the area. He also testified that SBHK would provide services in ways different from MSHA, giving patients increased choices in terms of where they want to go. Finally, he testified that the SBHK hospital could potentially stimulate price competition as it relates to contracting with third-party payors in the market. From these

[101] Sullivan, TR389-390.

standpoints, Mr. Sullivan opined that any duplication that might occur would be necessary duplication. He opined further that in health planning, duplication can be either "necessary" duplication or "unnecessary" duplication. "Unnecessary" duplication would occur where there is no need for what is being proposed and the applicant is merely duplicating what another facility already provides. However, Mr. Sullivan testified, in the case of SBHK any duplication that might occur would be "necessary" because more inpatient psychiatric beds are needed in the community.[102]

111. With regard to the project's impact on existing area providers, Mr. Sullivan opined that Bristol Regional Medical Center primarily serves a Virginia-focused population. No other providers in SBHK's proposed service area would be impacted. While the SBHK project may impact Woodridge, Mr. Sullivan's opinion, based in part on discovery documents such as Ex. 27, is that any claims by WPH of significant financial impact of the SBHK project upon WPH are overstated.[103]

112. Mr. Sullivan testified that MSHA personnel in April 2014 projected that the impact of SBHK's operation on WPH in the second year would be only about $50,000.[104]

113. Mr. Levine, MSHA's CEO, asserted that SBH's impact on MSHA's collected revenues, which for FY 2015 through March 31, 2015 already totaled nearly $800 million, could negatively affect MSHA. However, he also expects that WPH will lose revenues to the development of an adolescent CSU, the establishment of which he supports. Given Mr. Levine's testimony indicating his goal of fewer admissions at WPH and his lack of concern over adolescent admission losses to the proposed adolescent CSU, Mr. Levine and MSHA failed to provide any credible proof in this record of any significant or negative financial harm to MSHA

[102] Sullivan, TR 390-391.
[103] Sullivan, TR 392-399; Ex. 27; Ex. 80, pp. 29-32.
[104] Sullivan, TR 396; Ex. 27.

itself or to JCMC from the establishment of the proposed SBHK psychiatric hospital. If MSHA loses revenues to a new adolescent CSU, those revenues will be just as "lost" to MSHA as if they had been "lost" to SBHK: MSHA will not receive those revenues. Similarly, if Mr. Levine succeeds in reducing inpatient admissions at WPH, which he testified was one of his goals for MSHA, WPH (and, according to Mr. Levine's testimony, MSHA as well) will lose revenues.[105]

114. Mr. Levine's assertion that MSHA could lose a small amount of its annual EBITDA (which exceeded $103 million in the first nine months of FY 2015, up over a comparable FY 2014 level by 41.5%) relies upon Dr. Collier's report, Ex. 381. Yet, as shown herein, Dr. Collier's projections of WPH cases "lost" to SBHK contain significant math errors and fail to account for SBHK's potential receipt of cases now going to Blount County providers or elsewhere.[106]

115. An alternative explanation from this proof is that MSHA will not be "harmed" by the existence of SBHK, given the high levels of need for addiction care and mental health services in northeast Tennessee and southwest Virginia, as expressed by Mr. Levine himself, and the explosive growth in WPH's utilization in 2014 and 2015.[107]

116. As shown by its support of the proposed adolescent CSU, which MSHA clinical expert Dr. Harsh Trivedi stated would reduce adolescent admissions to WPH, MSHA does not oppose loss of revenues to another provider. Presumably MSHA credits as accurate Dr. Trivedi's testimony projecting adolescent psychiatric hospital admissions lost to the adolescent CSU, which will, if actually developed, be operated by Frontier, not MSHA. Dr. Trivedi testified that he believes the adolescent CSU will give adolescents "another way" to access psychiatric bed services that does not involve a hospital. Thus, according to Dr. Trivedi's view, the adolescent

[105] Levine testimony at TR 888 and 897; Ex. 245; Ex. 214, p. 3.
[106] Ex. 219, p. 2.
[107] Ex. 245, p. 1.

CSU will route Medicaid and other payments for adolescent psychiatric services away from inpatient psychiatric hospital providers. WPH is such a hospital provider. An alternative explanation for MSHA's lack of concern over the proposed development of the adolescent CSU is the one admitted by Ms. Bailey: CSUs serve needs different from those served by inpatient psychiatric facilities, so MSHA will not lose adolescent psychiatric hospital admissions to the adolescent CSU if and when it is ever established.[108]

117. Dr. Trivedi, MSHA's clinical expert, opined that adolescent CSU beds and inpatient psychiatric hospital beds are essentially equivalent at TR 855:

> Q: "But as far as the concerns you expressed with the development of a new crisis stabilization unit in Washington County, . . . that process can go forward regardless of whether SBH-Kingsport is constructed or not, is that correct?"
>
> A: "The process can go forward. But if we're talking about the orderly development of services, the requirements for as many child and adolescent beds would not exist because there would be another way to access those services."

If Dr. Trivedi is correct (MSHA witness Bailey disagrees: she testified that CSUs and psychiatric hospitals service different needs (Bailey at TR 612)), then the adolescent CSU's establishment will reduce the utilization by adolescents of inpatient psychiatric beds at WPH. Dr. Trivedi also testified at TR 849 that "A 12-bed unit is the same impact as adding 28 inpatient adolescent beds." This statement assumes 100% occupancy of the proposed CSU at all times. This statement by Dr. Trivedi also generally is not accurate; neither Dr. Collier nor Mr. Sullivan, who are both experienced health planning experts, made any similar conclusions or accounted for any CSU beds in any manner resembling Dr. Trivedi's statement. The presence of a 15-bed adult CSU since 2009 in Johnson City has not retarded WPH's dramatic growth of inpatient psychiatric admissions since 2010. (Bailey at TR 613). As Dr. Trivedi admitted in his testimony

[108] Trivedi, TR 865-867; Bailey, TR 612.

(TR 865), he is "not a health planning expert." Dr. Trivedi also testified that he is not a financial expert. (TR 864).[109]

Ms. Bailey's testimony established without any contradiction in the record that the presence of an adult crisis stabilization unit ("CSU") in Johnson City since 2009 has not limited significant growth in inpatient utilization at WPH since 2009, as shown by her testimony (TR 614) set forth below:

> Q. "And, the CSU, despite their function in preventing hospitalization though, hospitalization has been rapidly increasing at Woodridge, is that correct?
>
> "Yes."
>
> Bailey at 613:
>
> Q: "And how long has that CSU been operational?"
>
> A: "I think it opened up in 2009."
>
> *****
>
> Q: So the presence of this adult CSU in Johnson City in Washington County has not retarded the growth in Woodridge Psychiatric Hospital's utilization, has it?"
>
> A: No.

118. Ms. Bailey testified at TR 612 that Woodridge discharges adult psychiatric patients to the adult CSU in Johnson City. Dr. Jessee testified that the adult CSU in Johnson City had 15 beds and ran at a yearly occupancy rate of from 75-80%. Jessee at TR 674-683. In reality, this record establishes that MSHA opposes competition for hospital services. Thus, it seeks to enter into a Certificate of Public Advantage ("COPA") with its primary overall

[109] In his report, Ex. 88, Dr. Trivedi makes at page 5 a similar statement expressed in terms of "need": "The availability of CSU beds can significantly impact the need for inpatient beds for patients of all ages by providing a less expensive alternative for patients in acute distress who do not warrant inpatient hospitalization." Dr. Trivedi was not qualified as a health planning expert: he testified that he was "not a health planning expert" (TR 865), had never drafted a CON application, had never presented to, or appeared before, the HSDA, and had only been in Tennessee for five years. TR 857-858. This testimony as to "need" by Dr. Trivedi is therefore not accepted by this tribunal, and it is contradicted by MSHA witness Bailey. (TR 612). Dr. Trivedi repeatedly mistakenly stated that SBHK was seeking 77 beds, TR 856 and 866.

competitor in the area, Wellmont Health Systems, pursuant to T.C.A. §§ 68-11-1301, *et seq.* Mr. Levine's concern over revenues that might be "lost" by WPH to SBHK is undermined by Mr. Levine's lack of concern over the future "loss" of revenues to the adolescent CSU, as well as revenues "lost" by WPH if MSHA achieves Mr. Levine's goal of reducing inpatient psychiatric hospital revenues.[110]

119. Dr. Collier's "lost contribution margin" analysis, is inappropriate as a test of financial impact because it incorrectly assumes that inpatient psychiatric admissions are a zero-sum situation in the context of WPH. WPH's own documents, filed as exhibits in this record, prove the inappropriateness of her analysis in this case, especially given the dramatic and continuing increases in utilization at WPH. Furthermore, as noted above, Dr. Collier made no analysis whatsoever of the effects of SBHK's hospital at issue on JCMC, of which WPH is merely a "department." Thus, Dr. Collier's claims of significant "lost contribution margins" upon WPH itself are factually insufficient, and are not relied upon by this tribunal. Neither Dr. Collier nor MSHA offered any proof that WPH's 633 admissions increase in FY 2015 over of its FY 2014 level were "taken" (to use Dr. Collier's expression) by WPH from any other psychiatric hospital provider.[111]

120. Dr. Collier also incorrectly assumes that admissions WPH does not receive will cause a detrimental effect on WPH's financial results. WPH's own documents also prove, as a matter of fact, that this assumption is also erroneous, as set forth below.

[110] Ex. 245; Levine, TR 918.
[111] Ex. 381, Exs. 21 and 24 thereto; Exs. 253, 85 and 87.

121. MSHA document 1905, Ex. 85 in this record, contains the financial and utilization results for 11 months of WPH's FY 2014 and FY 2015. The relevant eleven-month results of both fiscal years are detailed in the following table:[112]

	Occupancy %	Patient Days	Admissions	Net Patient Svce Rev	Net Income Before OH Alloc.	EBITDA after OH Alloc.
FY 2015	85%	23,933	4,320	$13,583,824	397,195	577,324
FY 2014	75.7%	21,303	3,724	13,077,240	1,440,129	953,148

Source: Ex. 85. "OH Alloc" means "Overhead Cost Allocation."

122. WPH's financial information, set forth above, provide a basis to test whether any alleged loss of admissions by WPH to SBHK would result in a negative financial impact on WPH. If Dr. Collier's impact model in Ex. 34 to Ex. 381 is correct, an increase in WPH admissions should result in a financial benefit to WPH, just as she projects in Ex. 381 that a reduction in admissions would cause a negative financial result for WPH. As shown in the chart above, WPH's financial results before allocation of overhead costs (Net Operating Income Before Support Allocation) are much higher ($1,440,129) for a year (2014) with 596 fewer admissions (in 11 months for each year) than in FY 2015 ($397,195). Similarly, EBITDA, which measures funds available for purposes such as paying interest on bonds (a major concern for Mr. Levine), is 65% higher (at $953,148) in FY 2014 than in FY 2015 ($577,324) on 596 fewer admissions. This is true even though the amount of "support allocation" imposed on WPH's cash flow by MSHA was much higher in 2014 ($1,742,842) than in 2015 ($1,022,132).[113]

123. Thus, Dr. Collier's model is fundamentally flawed: it cannot account for WPH's different financial results and utilization levels when comparing WPH's FY 2015 results to its

[112] Ex. 85.
[113] Ex. 34 to Ex. 381; Levine testimony at TR 888. "EBITDA" is defined as "Earnings before interest, taxes, depreciation, and amortization."

FY 2014 results. In fact, as shown by its own documents, WPH had much more positive financial results with 3,724 patients in the first 11 months of FY 2014 than it had with 4,320 patients in the first 11 months of FY 2015.[114]

124. According to Dr. Collier's analysis in Ex. 24 of her report, those 596 additional cases should have generated a significant contribution margin leading to better financial results at WPH in FY 2015 than in FY 2014. This should be especially true since, as Dr. Collier testified (TR 804-805) and as shown in Ex. 23 of her report, virtually all patients at WPH generate a positive contribution margin per case, regardless of whether the source of payment is Medicare, TennCare, commercial or for indigent patients, MHSAS grant. (Collier testified at TR 804 that MHSAS grant patients generated approximately $800 per case in positive contribution margins). Also, as Ex. 85 demonstrates, inpatient revenues per patient day were higher in 2015 than in 2014, and operating expenses per adjusted patient day were lower in 2015 than in 2014. Despite these two facts, as a matter of fact, WPH's financial results through 11 months were better in WPH's FY 2014 than they were in WPH's FY 2015.[115]

125. While Dr. Jessee was not designated as an expert in this case, he is a Ph.D. psychologist who has worked at Frontier, the community mental health center for northeast Tennessee for many years. He did not express any opposition to the CON application, but he did testify that WPH is "approaching being full on many occasions." Also, in his testimony, Dr. Jessee, a Frontier executive, never expressed any opposition to SBHK's CON application by Frontier itself.[116]

126. Following Tennessee state governmental approval of any MSHA/Wellmont COPA application, assuming such approval occurs, there will not be any competition in

[114] Ex. 85.
[115] Collier, TR 804-805; Ex. 381, Exs. 23 and 24 thereof; Ex. 85.
[116] Jessee, TR 686.

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northeast Tennessee for acute inpatient hospital care. Mr. Levine's fear of competition is misplaced when it comes to psychiatric hospital care -- Strategic Behavioral Health, LLC does not operate any acute care hospitals. It will not compete with MSHA or Wellmont for any acute hospital business. Thus, unlike the case with pre-COPA Wellmont facilities, psychiatric revenues to SBHK cannot go to fund acute-care competition against MSHA.[117]

B. Dr. Collier's "contribution margin" analysis is fundamentally flawed.

127. Furthermore, Dr. Collier's data in Ex. 13 of her report indicate that, in 2013, WPH discharged only 1,315, or 52%, of the 2,527 psychiatric hospital discharges of SBHK proposed service area residents. (A few cases went to other MSHA facilities.) Thus, if SBHK drew its cases only from the non-MSHA cases, there will be 1,101 remaining "other" cases (not related to MSHA facilities at all) that could go to SBHK once it is built. This number is well in excess of the 946 admissions that SBHK projects for the first year of its operations.[118] These facts demonstrate that SBHK will not have the impact on WPH that Dr. Collier has projected in Ex. 381. This number also exceeds the projected "Woodridge cases lost" data set forth in scenarios A.1. and A.2. of Ex. 381's Ex. 24, which projects data for the second year of SBHK's operations.

128. A similar analysis of this type of data from Ex. 381 demonstrates that even if Dr. Collier's "alternate service area" analysis is used, Ex. 14 to Ex. 381 shows that Peninsula Hospital in Blount County received 495 patients in 2013 from the "alternate service area", and that MSHA facilities captured only 65.3% of all psychiatric inpatients from the "alternate service area". There were a total of 5,919 psychiatric discharges from the "alternate service area" in 2013, per Ex. 14. This means that non-MSHA facilities, including Peninsula, discharged 2,055 patients from the "alternate service area". This volume of patients who could be admitted to

[117] Shaheen, TR 80-83.
[118] Ex. 7, pp. 9 and 24.

SBHK once it is built far exceeds the maximum "Woodridge cases lost" number of 1,185 in scenario B.1. of Ex. 24 to Ex. 381, which covers the projected second year of SBHK's operations. This demonstrates that the number (2,055 patients) of 2013 discharges from non-MSHA facilities of patients from the "alternate service area" was 173% of the number of "Woodridge cases lost" (1,185 cases) projected by Dr. Collier. Thus, Dr. Collier's own data establish, as a matter of fact, that the number of "Woodridge cases lost" she projected in Ex. 381 is arbitrary, inaccurate and untrustworthy.[119]

129. Dr. Collier's "Market Share of Cases by Payor" analysis is inaccurate on its face, as a matter of fact. This fact calls into question the accuracy of her "financial impact" of SBHK's hospital project on WPH's case volume and lost contribution" analysis (Ex. 24 to her report, Ex. 281).

130. For example, in Ex. 21 to her report (p. 31 of her report), Dr. Collier asserts that WPH has a 60.7% market share of commercial payor cases from the SBHK service area. She projects in Ex. 21 that there will be 651 commercial payor cases from the five-county service area in Year 2 of SBHK's operations. She then projects that SBHK will take 467 commercial SBHK service area payor cases from WPH in Year 2 of SBHK's operations. Yet, 467 is actually 72% of 651, not 60.7% (the market share of such cases she has ascribed to WPH). Thus, Dr. Collier, by her own terms, has overstated WPH's projected "loss" of private payor cases to SBHK. A similar error affects her analysis of WPH's cases "lost" to SBHK from the "alternative service area": she projects a WPH loss of 517 out of 651 possible cases. This amounts to 79.4% of the 651 projected Year 2 commercial cases -- which exceeds WPH's market share, which she lists as 67.2%.[120]

[119] Ex. 381, Exs. 14 and 24 thereto.
[120] Ex. 381, p. 31 (Ex. 21 thereto).

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131. Similarly, Ex. 21 of Dr. Collier's report also projects that SBHK will take 99 indigent/self pay cases from WPH in Year 2 of its operations. However, she projects that there are only 93 such cases in the SBHK service area, and that WPH has a market share of 79.3% thereof. Thus, she projects in Ex. 21 that SBHK will take more of the cases she projects for this category than the total number of cases she projects that WPH would actually experience. This is illogical, and demonstrates basic flaws in Dr. Collier's analysis, rendering it untrustworthy as a matter of fact. A similar error is present in her projections for WPH's "lost" indigent/self pay cases from her alternate service area -- she projects that SBHK will take far more such cases from WPH than she projects that WPH itself will experience. Her projection is that WPH will take 86.7% of the 93 cases, which yields 81 cases. Yet her Ex. 21 table projects that SBHK will take 108 cases arising from the alternate service area from WPH. SBHK could not, in this analysis, "take" more cases from WPH than WPH would otherwise be expected, by Dr. Collier, to experience.[121]

C. MSHA's Woodridge Psychiatric Hospital is a department of Johnson City Medical Center; but MSHA's proof failed to account for the impact of this status.

132. As admitted at the contested case proceeding herein by MSHA witnesses Bailey and Levine, as well as by MSHA's expert witness, Dr. Deborah Collier, Woodridge Psychiatric Hospital in Johnson City is a department of the Johnson City Medical Center ("JCMC"). This is due in part to WPH's status as a "satellite" of Johnson City Medical Center, and the fact that WPH operates pursuant to the license of Johnson City Medical Center. In Ex. 83, the 2013 Joint Annual Report ("JAR") of JCMC to the Tennessee Department of Health, JCMC reports to the Tennessee Department of Health on page 1 thereof that JCMC owns and operates WPH.[122]

[121] Ex. 381, p. 31 (Ex. 21 thereto).
[122] Testimony of MSHA witnesses Bailey (TR 588), Levine (TR 913), and Collier (TR 779-781); Ex. 83, p. 1.

133. Federal Medicare regulations establish, at 42 C.F.R. § 413.65(d), that there are four basic federal requirements imposed on WPH and JCMC arising from Woodridge's status as a satellite of JCMC. In order to comply with these requirements and regulations to be considered by Medicare as a "satellite" hospital, Woodridge must be: operated under the same license as JCMC; integrate its clinical services and medical staff with those of JCMC; share income and expenses with JCMC; and hold itself out to the public and payors as being a part of JCMC. As the testimony of SBHK witness Dr. Harold Elliott indicates, the medical staff of JCMC and Woodridge are integrated. Dr. Elliott testified that he was on the medical staff of JCMC while he practiced at WPH. (Elliott, TR 130) As MSHA CEO Alan Levine testified, WPH is a department of JCMC, and it is under the same license as JCMC. (Levine, TR 915) Therefore, WPH is estopped from claiming that it is not a part of JCMC. None of the MSHA witnesses testified that WPH is not a department of JCMC; instead they generally affirmed that WPH is a department of JCMC. Despite WPH's status as a department of JCMC, MSHA failed to analyze the impact of the CON application on JCMC. Both its corporate witnesses, such as Ms. Bailey and Mr. Levine, as well as its expert witness, Dr. Collier, failed to analyze any impact by SBH's proposed psychiatric hospital on JCMC itself. No MSHA witness denied that WPH shares income and expenses with JCMC. Thus, as a matter of fact, MSHA is also estopped from denying that WPH shares income and expenses with JCMC. This tribunal hereby finds as a matter of fact that WPH is a department of Johnson City Medical Center and is a satellite of JCMC, thereby meeting all the Medicare regulatory requirements for satellite status. Thus, this tribunal finds as a matter of fact that WPH and JCMC share income and expenses. Yet, other than data drawn from the 2013 JAR filed by JCMC with the state, this record is devoid of any proof relating to financial results of JCMC's annual operations (Ex. 83). As a matter of fact,

there is no factual basis in this record upon which this tribunal can determine that SBHK's proposed psychiatric hospital has any negative effect on JCMC.[123]

D. The Applicant's CON project will provide positive benefits to the healthcare system in its service area.

134. Mr. Sullivan opined that the SBH Kingsport CON project was economically feasible. He found this to be true because SBH is an experienced operator of psychiatric hospitals and has the resources to fund the project. Even with projections of utilization of approximately 63% in the second year in the application, the project would generate revenues in excess of expenses. Thus, Mr. Sullivan opined that the SBHK project is economically feasible and is the best alternative to address the needs of the community.[124]

135. Mr. Sullivan also opined that he did not believe there would be an alternative to the SBHK CON project that was less costly or more effective, for many of the same reasons testified to and indicated immediately above.[125]

E. The human resources required by the Applicant's CON project are both available and accessible.

136. The treatment staff at SBH Kingsport will include licensed physicians who will be board-certified or board-eligible in adult or child and adolescent psychiatry. Medical surgical nurses will be on staff to serve on the geriatric units. Behavioral health therapy also will be delivered by masters level therapists, as well as some who are "license eligible", as well as case managers. At its hospitals, SBH also employs mental health technicians who are direct staff

[123] Elliott (TR 130); Levine (TR 915); Ex. 381. Dr. Elliott also testified, at TR 139, that he had heard nothing at all about the potential establishment of an adolescent CSU in Washington County. He was in the process of moving to Michigan on the day he testified herein. He had practiced psychiatry in Johnson City from 2011 to June 2015. TR 129.
[124] Sullivan, TR 282-283.
[125] Sullivan, TR 389.

working with the patients during the day. SBH treatment policy requires that patient whereabouts are recorded and documented as safe every 15 minutes.[126]

137. While SBH does not employ physicians, its facilities utilize the open medical staff model, as will SBHK. SBH is able to recruit new physicians into the community as well as to permit established physicians in the community to be on its medical staff.[127]

138. Mr. Shaheen testified, without contradiction, that at each of SBH's psychiatric hospitals, there are board-certified child and adolescent psychiatrists who work there. He testified each of Strategic Behavioral Health hospitals is doing child and adolescent work, there is at least one board-certified child and adolescent psychiatrist, and sometimes more. In North Carolina, Strategic Behavioral Health has 256 child and adolescent beds for inpatient hospital services and inpatient residential treatment facility services. In North Carolina all the psychiatrists working at those facilities are either board-eligible for child and adolescent or board-certified for child and adolescent.[128]

139. Mr. Shaheen stated that while there is a shortage of child and adolescent psychiatrists, as well as beds, the revenues SBH generates enables it to recruit board-certified child and adolescent psychiatrists to the communities in which its facilities are located.[129]

140. Mr. Shaheen testified that at all its facilities except those in North Carolina, Strategic Behavioral Health offers significant outpatient services as well as inpatient services. It offers intensive outpatient services where the patients come all day long and then return to their homes. They also offer partial hospitalization programs. In outpatient programs at SBH

[126] Shaheen, TR 99-100.
[127] Shaheen, TR 101.
[128] Shaheen, TR 101-102.
[129] Shaheen, TR 102-103.

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facilities, it is not necessary for a participant to have been an inpatient in any SBH hospital prior to utilizing the programs. SBH offers these outpatient programs to the public.[130]

F. The Applicant's CON project will satisfy all applicable governmental or professional standards.

141. Mr. Shaheen testified that a psychiatric hospital needs to be a therapeutic environment, so SBH hospitals are designed to be a therapeutic environment. SBH takes both voluntary and involuntary patients. SBH hospitals have a center courtyard to enable the patients to go outside and get fresh air but if they are involuntary patients they will be secure and restrained. The individual units in each hospital are designed for the types of patients that it serves. For example, the geriatric unit is designed as a square with a nursing station in the center.[131]

142. Mr. Shaheen testified that the physical environment of the SBH hospitals is designed and built to remove barriers so that the staff are safe and so that the patients feel safe and are able to deal with their clinical issues. He testified that SBH has found success in its designs and practices.[132]

143. Mr. Shaheen testified that after SBH enters a market with a new facility, response times by other providers improve and access to care for psychiatric patients also improves. Even though SBH performs outpatient "mobile assessment" of what type of psychiatric care is needed by any individuals who contact its mobile assessment teams, 70% of the callers to SBH needing states for mobile assessment do not require psychiatric hospitalization. Instead, mobile assessment callers are referred to other community agencies for services.[133]

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[130] Shaheen, TR 103-105.
[131] Shaheen, TR 96-97.
[132] Shaheen, TR 98.
[133] Shaheen, TR 112-113.

144. With regard to orderly development of healthcare, Mr. Shaheen testified that the project satisfies the statutory requirement to contribute to the orderly development of healthcare facilities. He and Mr. Mike Garone have met with local community leaders and listened to their concerns and views regarding the area's needs. Strategic Behavioral Health asks its physicians to participate in outpatient therapy. Strategic Behavioral Health shares its therapists with the communities, according to Mr. Shaheen's testimony. Mr. Shaheen also emphasized the availability of partial hospitalization and intensive outpatient treatment to people who have not previously been inpatients at the hospitals.[134]

IV. ECONOMIC FEASIBILITY: The psychiatric hospital proposed by SBHK satisfies the statutory criteria of "economic feasibility required by T.C.A. § 68-11-1609(b): the hospital "can be economically accomplished and maintained", as a matter of fact.

145. Mr. Sullivan testified that the five-county service area identified by SBH is currently underserved for inpatient psychiatric and substance abuse services. He also found that the major existing provider in that area, Woodridge Psychiatric Hospital, had limited available bed capacity to address needs, particularly due to its recent significant growth in utilization. He opined also that the levels of inpatient psychiatric hospital utilization in counties where such services are not readily accessible psychiatric inpatient services were lower than what they could be if accessible services were there. Therefore, he concluded that the proposed beds were needed and could be reasonably well utilized once constructed.[135]

146. Mr. Sullivan testified that he projected that approximately 20% of the patient volume at SBHK would likely come from outside the five-county service area.[136]

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[134] Shaheen, TR ___.
[135] Sullivan, TR 282; Ex. 80.
[136] Sullivan, TR 386.

147. With regard to the statutory CON criterion of economic feasibility, Mr. Sullivan opined that the SBHK project is economically feasible. He opined that SBH had demonstrated that it had adequate funds to complete the project. He further opined that SBHK's proposed project costs were reasonable. He testified that the SBHK CON project was "a very efficient project with only $12 million, approximately, to build a 72-bed facility. That's a very efficient price. . . . I think the construction costs and other costs are very reasonable."[137]

148. With regard to revenues for the proposed SBHK project, Mr. Sullivan opined that the projection of the revenues were reasonably developed by Mr. Shaheen. He testified further that SBHK plans to participate in state and federal programs in terms of reimbursement. Therefore, from the state health plan criteria regarding economic feasibility on those points, he opined that SBHK had demonstrated conformity with those criteria.[138]

149. With regard to the alternatives considered to the project, which he analyzed on pages 27 and 28 of Exhibit 80, Mr. Sullivan testified that he believed that not building a facility in Kingsport would not be the best alternative, because such inaction would do nothing to address the shortage of inpatient psychiatric services and the lack of access to care that currently exists in the area. He testified that it would be possible to build a facility smaller than 72 beds, but given that the *Guidelines for Growth* formula has identified a need for more than 72 beds and that the SBHK project would be serving a service area population of over 300,000 people, Mr. Sullivan opined that building a smaller facility would not be advantageous. Furthermore, he pointed out that an advantage of a larger psychiatric hospital facility is that it would enable the hospital to treat different patient segments within the populations it serves. An example would be apparent in the treatment of children and adolescents. A larger facility would create sufficient

[137] Sullivan, TR 386-387.
[138] Sullivan, TR 386-387.

space within the hospital separate the children from the adolescents. SBHK will treat children separately from adolescents. As Mr. Sullivan testified, Woodridge does not do so because it has only 12 child and adolescent beds. Mr. Sullivan opined that having a larger facility gives the hospital a clinical advantage in terms of being able to separate patients into different treatment tracks, depending on different diagnoses and patient needs. Therefore, he did not believe that a better alternative would be not to build the SBHK project or to make it smaller.[139]

150. Mr. Sullivan also opined that he did not believe there would be an alternative to the SBHK CON project that was less costly or more effective for this project, for many of the same reasons testified to and indicated immediately above.[140]

151. Mr. Shaheen testified that in 2015, after revenues of approximately $105 million in its FY 2014, SBH projected its revenues would be approximately $127 million in its FY 2015. In the month of the hearing herein, July 2015, he testified that SBH was on track to achieve that revenue figure of $127 million for 2015.[141]

152. The estimated project costs of SBHK's hospital is approximately $12 million. Mr. Shaheen testified that SBH has (at the time of the contested case proceeding) $70 million in its line of credit facility from commercial banks available to fund the SBHK project, as well as $25-30 million available in annual cash flow from the company. In sum, SBH has just under $100 million available to it to build this project. The total project costs for the SBHK is projected to be $11,717,915.[142]

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[139] Sullivan, TR 388-389; Ex. 80, pp. 13 and 27-28.
[140] Sullivan, TR 389.
[141] Shaheen, TR 159.
[142] Shaheen, TR 160-161, Ex. 9, p. 1.

153. MSHA produced no physicians or medical staff members of JCMC or WPH to testify at the hearing in support of MSHA's positions. Dr. Jessee, a psychologist at Frontier, did testify at the hearing, but he never said a word in opposition to SBHK's CON application.[143]

154. Mr. Shaheen also testified that the SBHK project is economically feasible. For example, because SBH has already developed the designs for these facilities, SBH's architectural fees are much lower than normal for the development of a new facility. Also, because of Strategic Behavioral Health's experience in its development and operation of its other hospitals, he believes that SBH can operate its facility efficiently.[144]

155. The project proposed by SBHK, a 72-bed psychiatric hospital, satisfies, as a matter of fact, the "economic feasibility" criterion of T.C.A. § 68-11-1609(b): it "can be economically established and maintained."

156. SBH's CFO, James Cagle, is licensed as a certified public accountant in Tennessee. Mr. Cagle testified that SBH's operating cash flows and credit availability establish that there is a very good likelihood that SBH can economically establish and maintain the SBHK CON project at issue in this proceeding.[145] This tribunal finds, as a matter of fact, that SBH can economically accomplish and maintain the psychiatric hospital applied for by SBHK in CON application CN1312-050.

[143] Dr. Jessee, at TR 651-690.
[144] Shaheen, TR 160-161.
[145] Cagle, TR 264-267.

SBH-KINGSPORT 000388

APPLICANT'S PROPOSED CONCLUSIONS OF LAW

1. The statutory criteria for the grant of a certificate of need are set forth in the HSDA's statute, the Tennessee Health Services and Planning Act of 2002, which sets forth the Legislature's criteria for the grant of a certificate of need by the HSDA at T.C.A. § 68-11-1609(b). This provision of the HSDA's act states as follows, in relevant part:

> No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed healthcare in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective healthcare facilities or services. In making such determinations, the Agency shall use as guidelines the goals, objectives, criteria, and standards in the state health plan. . . . Additional criteria for review of application shall also be prescribed by the rules of the Agency.

2. The applicable current state health plan guidelines for inpatient psychiatric hospital facilities is set forth in the state health plan document known historically as the "Guidelines for Growth". The applicable Guidelines for Growth section provides as follows (2000 edition) as to "Psychiatric Inpatient Services":

A. Need.

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).
2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.
3. For child inpatient under age 13 and if adolescent program the age group of 13-17 should be used.
4. These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.
2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.
2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration.
3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.
4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.
5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.
2. Accessibility to specific special needs groups should be an important factor.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

3. The rules of the Agency specify additional "criteria", set forth below, which are published in HSDA Rule 0720-11-.01. These criteria state as follows:

0720-11-.01 - General Criteria for a Certificate of Need. The Agency will consider the following general criteria in determining whether an application for a certificate of need shall be granted:

(1) Need. The healthcare needed in the area to be served may be evaluated upon the following factors:

(a) the relationship of their proposal to any existing applicable plan;
(b) the population served by the proposal;
(c) the existing or certified services or institutions in the area;
(d) the reasonableness of the service area;
(e) the special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants and low income groups;
(f) comparison of utilization/occupancy trends and services provided by other area providers;
(g) the extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of the services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) whether adequate funds are available to the applicant to complete the project;
(b) the reasonableness of the proposed project costs;
(c) anticipated revenue from the proposed project and the impact on existing patient charges;
(d) participation in state/federal revenue programs;
(e) alternatives considered; and
(f) the availability of less costly or more effective methods of providing the benefits intended by the proposal.

(3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective healthcare system may be evaluated upon the following factors:

(a) the relationship of the proposal to the existing healthcare system (for example, transfer agreements, contractual agreements for health services, the applicant's proposal TennCare participation, affiliation of the project with health professional schools);

(b) the positive or negative effects attributed to duplication or competition;
(c) the availability and accessibility of human resources required by the proposal, including consumers and related providers;
(d) the quality of the proposed project in relation to applicable governmental or professional standards.

4. The Applicant, SBHK, bears the burden of proof in this contested case proceeding. This tribunal hears this case *de novo*, and it is necessary for the Petitioner to establish that the three statutory criteria have been satisfied and that a certificate of need should therefore be granted.

5. The Applicant, SBHK, has established in this record, though the testimony of its witnesses and the exhibits in this record, that the project it proposes in certificate of need application CN1312-050 for the establishment of a 72-bed psychiatric hospital in Kingsport, Sullivan County, Tennessee, and the initiation of inpatient psychiatric hospital services therein, is necessary to provide needed healthcare in the area to be served ("Need"), can be economically accomplished and maintained ("Economic Feasibility"), and will contribute to the orderly development of adequate and effective healthcare facilities or services ("Contribution to the Orderly Development of Healthcare"). This tribunal concludes, as a matter of law, that the Petitioner herein, SBH-Kingport, LLC, in certificate of need application number CN1312-050, has satisfied its burden of proof by establishing in this record that each of these three statutory criteria from T.C.A. § 68-11-1609(b) have been satisfied as set forth more fully below. Therefore, as a matter of law, the requested certificate of need at issue should be granted.

6. The HSDA statute, the Tennessee Health Services and Planning Act of 2002, also provides, in T.C.A. § 68-11-1609(b) that "the Agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan."

7. The relevant state health plan provisions with regard to inpatient psychiatric services are set forth in the state health plan document historically known as the *Guidelines for Growth*. As to need, the applicable *Guidelines for Growth* sections provide the following provisions which require that CON application be assessed utilizing certain guideline criteria. The first of these guideline criteria is that the applicant establish a population-based estimate of the total need for psychiatric inpatient services utilizing the ratio of 30 psychiatric hospital beds per 100,000 general population. SBHK has done so in this process, by establishing that in its service area there is a population of slightly more than 300,000. Thus, as Mr. Sullivan, opined, utilizing the *Guidelines for Growth* 30 beds per 100,000 general population, there is a total need of 92 beds in 2015, rising to 93 beds in 2020, in the five-county service area proposed by SBHK (Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia). The *Guidelines for Growth* further direct that the estimates for total need should be adjusted by the existing staffed beds operating in the area, as indicated by the Joint Annual Reports of the Department of Health. As Mr. Sullivan testified, the only other provider of inpatient psychiatric care in the five-county SBHK service area is Bristol Regional Medical Center in Bristol, Tennessee (in Sullivan County), which operates 12 inpatient psychiatric beds for adults.

8. Therefore, assessing the net need for psychiatric hospital beds in the service area by applying the *Guidelines for Growth* formula, there is currently a net need for 80 inpatient beds in the service area proposed by SBHK in its service area, rising to 81 beds in 2020, according to Mr. Sullivan. Dr. Collier, the expert witness for the Intervenor, MSHA, provided a similar projection of bed needs utilizing the same formula. By Dr. Collier's analysis under the *Guidelines for Growth* formula, a total need in the service area of 90.4 beds in 2019, with the population under the age of five excluded. Thus, experts for both parties agree that there is a net

need in SBHK's claimed service area defined by SBHK for more beds than SBHK proposes to construct (72 beds). Thus, as matter of law net need for additional psychiatric hospital beds is greater in the SBHK service area than the number of psychiatric hospital beds that SBHK proposes to supply in its proposed Kingsport hospital.

9. The *Guidelines for Growth* also provides, as to Need, that applicants should analyze the number of beds needed for adult programs utilizing the population 18 and older, while child and adolescent programs should be evaluated using their appropriate age groups.

10. Mr. Sullivan testified and opined that the need for additional adult inpatient psychiatric beds in the service area defined by SBHK exceeds the number of adult inpatient psychiatric beds SBHK proposes. In its CON application (Ex. 9), SBHK proposes to construct 18 adult inpatient psychiatric beds and 10 chemical dependency beds, both of which Mr. Sullivan counted as adult beds in analyzing the application. Mr. Sullivan opined that there was actually a need for 44 inpatient psychiatric beds for adults in the service area defined by SBHK. Similarly, Dr. Collier found that there was a net need for 66 adult inpatient psychiatric beds in 2019. Thus, the experts for both parties agree that there is a need for additional adult inpatient psychiatric beds in the service area proposed by SBHK that exceeds the 28 beds SBHK proposes for general adult and chemical dependency beds. In fact, health planning experts for Applicant and Intervenor in this case both agree that, when geropsychiatric beds are included, the total net need in the service area proposed by SBH exceeds or matches the number of beds for those three respective categories of adult beds proposed by SBHK, which is 44 total adult beds (SBHK proposes to construct and operate 18 adult psychiatric beds, 16 geropsychiatric beds, and 10 chemical dependency beds).

11. The need provisions of the *Guidelines for Growth* also direct the CON applicant, if it plans to serve children and adolescent patients, to assess the child and adolescent population to determine the need for such beds in the service area. SBHK proposes to construct 28 child and adolescent beds. Currently, there are no child and adolescent beds in the service area proposed by SBHK. Mr. Sullivan found that there would be a need for 17 child and adolescent beds in the SBHK service area in 2015, falling to 15 such beds in 2019. Dr. Collier found that there would be a net need for 12 child and adolescent beds in the service area proposed by SBHK in 2019. Thus, the net need for child and adolescent beds as defined by the guideline of 30 beds per 100,000 population does not match or exceed the 28 such beds proposed by SBHK. Mr. Sullivan opined that, in this particular area of need for psychiatric beds, the request for 28 beds by SBHK was appropriate, given that in the broader area there are only 12 child and adolescent inpatient psychiatric beds in all of upper east Tennessee and southwest Virginia. These 12 beds are found at WPH in Washington County, Tennessee, outside the service area proposed by SBHK. Mr. Sullivan opined that there was a significant shortage generally of child and adolescent psychiatric beds in northeast Tennessee. Thus, even though the number of inpatient psychiatric beds proposed by SBHK exceeds the number projected as need by the *Guidelines for Growth*'s population based formula, this tribunal concludes that given the overall need in northeast Tennessee and southwest Virginia for additional child and adolescent inpatient psychiatric beds, and the shortage thereof (given that there are only 12, all in Washington County, in the broader northeast Tennessee area), there is a need for the 28 child and adolescent inpatient psychiatric beds proposed by SBHK in CON application number CN1312-050. This is especially true given the accessibility issues raised by WPH's child and adolescent unit, their

"Willow" building, due to frequently blocked rooms or beds in that unit, as shown by Ex. 238, the patient flow sheets for May and June, 2015.

12. Section "B" of the *Guidelines for Growth* provisions for "Psychiatric Inpatient Services" concerns the "service area" for this CON project. The first step in this analysis involves determining the reasonableness of the service area: "The geographic service area should be reasonable and based on an optimal balance between population density and service proximity . . .".

13. In CON application number CN1312-050, SBHK proposed a service area that will consist of five counties: Sullivan and Hawkins in Tennessee, and Wise, Scott and Lee in Virginia. As Mr. Sullivan noted, Sullivan County is the ninth largest county in Tennessee in terms of population, and it currently has only 12 inpatient psychiatric beds, all for adults. There are no inpatient psychiatric beds located anywhere else in the service area proposed by SBHK. Mr. Sullivan determined that the service area proposed by SBHK was, in fact, "reasonable". He provided a detailed analysis the service areas for other Kingsport providers, including specialty hospital providers, such as HealthSouth, in Kingsport. He testified that their service areas resembled the one chosen by SBHK in CON application number CN1312-050. Mr. Sullivan noted further that Mountain States' own inpatient acute hospital facility in Kingsport, Indian Path Medical Center ("IPMC"), is also a "regional referral hospital" as designated by MSHA itself. In Ex. 211, published in June 2015, the month before the hearing herein, MSHA specified that the service area for IPMC consisted of three and a half counties: Hawkins County and the western half of Sullivan County in Tennessee, and Wise and Scott Counties in Virginia. Mr. Sullivan also testified that Johnson City Medical Center, the flagship MSHA hospital which is also a

regional referral center and is located in Washington County, Tennessee, claims only six counties in its service area. MSHA excluded Hawkins County from JCMC's service area.[146]

14. The five-county service area designated by SBHK in its CON application falls, in size, between the three and a half county service area designated by MSHA for IPMC, and the six-county service area designated by MSHA for JCMC. Mr. Sullivan also testified, without contradiction, that the Bristol area Wellmont Health System facility, Wellmont Bristol Regional Medical Center, looks more toward Virginia counties north of it for its service area as well. Thus, Mr. Sullivan opined, and this tribunal concludes, as a matter of law, that the SBHK five-county service area is reasonable as a matter of law for this CON project. The "alternate service area" proposed by Dr. Collier is too large (larger than the one she designated for WPH, even though WPH has 12 more beds than SBHK proposes to build). It also involves counties such as Russell County, Virginia which are too remote from Kingsport to be included in a service area for SBHK.

15. The *Giudelines for Growth* also provides that the geographic service area should also be "based on an optimal balance between population density and service proximity. This tribunal concludes that the SBHK CON application satisfies this provision of the *Guidelines for Growth*, for the reasons set forth below. As Mr. Sullivan opined, there are very limited inpatient psychiatric hospital services available in the service area for the population, which exceeds 300,000. Furthermore, the most significant population density in the service area is in Sullivan County itself, in which the SBHK project will be located. As Mr. Sullivan demonstrated, Sullivan County is in the ninth largest county in Tennessee by population. Therefore, this tribunal concludes, as a matter of law, that SBHK's CON application satisfies the guideline set

[146] In this record, MSHA does not dispute SBHK's assertion and proof that Woodridge Psychiatric Hospital is merely a department of Johnson City Medical Center.

forth in the *Guidelines for Growth* for the Project's service area to be "based on an optimal balance between population density and service proximity." This tribunal notes further there are no inpatient psychiatric hospital services available either north or west of Sullivan County in the service area SBHK proposes. Provision (B)(2) of the *Guidelines for Growth*'s service area provisions stress the relationship of the projected population to receive services and its sociodemographics. It directs the applicant to consider the special needs of the service area, such as those needing services involuntarily, and the project's accessibility to consumers, low income groups, and others. This tribunal concludes, as matter of law, that the SBHK CON proposal satisfies the service area provision (B)(2) of the *Guidelines for Growth*. As Mr. Shaheen testified and as Mr. Sullivan opined, the SBHK psychiatric hospital will accept involuntary patient commitments. Furthermore, the SBHK inpatient psychiatric hospital will serve Medicaid and Medicare patients, thus serving low income groups and demonstrating accessibility to consumers and racial and ethnic minorities.

16. While the MSHA criticized SBHK's CON proposal for projecting only 5% of its charges as attributable indigent or charity care, the 5% projection by SBHK is entirely consistent with the budgetary projections made by MSHA's Woodridge Psychiatric Hospital itself. The record shows that, for WPH's fiscal years 2012 through 2014, its budgetary projections for charity/self pay for WPH ranged from 1.3% to 2.8% of gross revenues. Furthermore, Alan Levine, the CEO of MSHA, testified (TR 922-923) that his own view of "charity care" includes people who do not have insurance, people who have insurance but have used up their benefits, or people who are underinsured.

17. Therefore, given how MSHA views its own hospitals' charity care issues and budgets for them, the 5% budgeted by SBHK for similar matters is consistent with the budgetary

processes engaged in by MSHA. Therefore, this tribunal concludes as a matter of law that the SBHK CON application has appropriately shown sensitivity and responsiveness to low income groups in its CON application. Therefore, this tribunal concludes that section (B)(2) of the *Guidelines for Growth* as to service area has been satisfied by SBHK in its CON application, as a matter of law.

18. Subpart C. of the *Guidelines for Growth*'s provisions on inpatient psychiatric services provide a provision entitled, "Relationship to Existing Applicable Plans." The first part of this guideline's section focuses on the CON proposal's relationship to policy as formulated in various public plans and other documents. Tennessee's only applicable public plan in the health planning context is the state health plan. Its provisions on inpatient psychiatric services are drawn from the 2000 *Guidelines for Growth* and have been listed above at the start of these conclusions. Therefore, this tribunal concludes, as a matter of law, that SBHK's CON application, CN1312-050, properly considered the *Guidelines for Growth* and other state health plan provisions on inpatient psychiatric services, by addressing the bed need formula and applying it to the SBHK CON application. Thus, the only available public plan was dealt with at length by SBHK in its CON application, Ex. 9. This plan was also dealt with at great length by Mr. Sullivan both in his report, Ex. 80, and in his testimony at the hearing herein.

19. The second provision of subsection (C) of the *Guidelines for Growth* for inpatient psychiatric services requires consideration of the CON proposal's relationship to underserved geographic areas and underserved population groups that are identified in the state, city or county or regional plans, and "other documents". As concluded above, the SBHK CON application is designed to serve an underserved geographic area in this state. The service area proposed by SBHK shows significant needs for additional inpatient psychiatric beds that actually

exceed the number of beds requested for approval by SBHK (72). Furthermore, while there is no formal public "regional" plan that is identified in this record, both of the major hospital systems in northeast Tennessee and southwest Virginia, MSHA and Wellmont Health Systems, issued a joint press release in April 2015 (Ex. 245, p. 1) in which the representatives of those two entities, including Mr. Levine, stated as follows:

> Northeast Tennessee and southwest Virginia disproportionately suffer from serious health issues -- cardiovascular disease, diabetes, addiction and access to mental health services, to name a few -- and they must be addressed, said Alan Levine, president and CEO of Mountain States, who would become executive director and president of the combined system.

Given that both Mountain States and Wellmont have identified northeast Tennessee and southwest Virginia as "underserved geographic areas", especially as to addiction care and lack of access to mental health services, the SBHK CON proposal is designed to assist in meeting the identified needs of the underserved geographic service area they designated. SBHK proposes to have 10 chemical dependency beds, and 62 other inpatient psychiatric hospital beds. These will address the lack of access to addiction care and mental health services in northeast Tennessee and southwest Virginia identified by MSHA and Wellmont. Therefore, the SBHK CON application has a positive relationship to the underserved geographic areas identified by public statements made on behalf of MSHA and Wellmont, as shown in this record (Ex. 245). This tribunal concludes, as a matter of law, that SBHK's CON application CN1312-050 satisfies this provision of the *Guidelines for Growth.*

20. The third subsection, C.3, of the relationship to existing plans provisions of the *Guidelines for Growth*, calls for the applicant to assess "the impact of the proposal on similar services supported by state appropriations . . .". Mr. Sullivan provided significant testimony on this point. There is no regional mental health institute in East Tennessee north of Chattanooga. Lakeshore Regional Health Institute had been located in Knoxville, Tennessee, but was closed in

2012, causing a loss from the mental healthcare system of 250 beds. Prior to its closure, it was the designated state regional mental health institute for Sullivan and Hawkins County. Therefore, as Mr. Sullivan testified, now the only mental health institute for upper East Tennessee that is directly supported by state appropriations is Moccasin Bend, in Chattanooga. This tribunal concludes, as a matter of law, that, as testified to by Mr. Sullivan, the SBHK CON project will not have a significant or negative relationship on the state mental health institute known as Moccasin Bend in Chattanooga. Since there are no other state mental health institutes located in east Tennessee north of Moccasin Bend, there will be no impact on any others from the operations of the SBHK psychiatric hospital.

21. The Tennessee Department of Mental Health and Substance Abuse Services ("MHSAS") does have a contract for inpatient psychiatric services with Mountain States Health Alliance, which owns both Johnson City Medical Center and Woodridge Psychiatric Hospital, but MSHA does not receive a direct state appropriation from the General Assembly or the comptroller of the state of Tennessee for those services. Furthermore, Woodridge Psychiatric Hospital is not itself the party to the grant between MSHA and MHSAS; neither is JCMC. Therefore, the actual delivery of services under that grant contract is separated from the appropriations process even further: the grant money flows from MHSAS to MSHA and then presumably to JCMC and WPH (who must, under Medicare regulations, share expenses and revenues). Thus, this tribunal concludes, as a matter of law, that this provision of the *Guidelines for Growth* has been satisfied by the SBHK CON application.

22. The fourth provision of the "relationship to existing applicable plans" provisions of the *Guidelines for Growth*, directs the assessment of the CON's proposal's relationship to whether the facility takes voluntary and/or involuntary admissions. Mr. Sullivan testified, and

Mr. Shaheen and the CON application confirmed, that the SBHK psychiatric hospital proposed by CN1312-050 will take both voluntary and involuntary admissions. Therefore, this criterion of the *Guidelines for Growth* is satisfied.

23. The next provision of subpart 4 asks the CON process to consider whether the facility serves acute or long-term patients. It is clear, as Mr. Sullivan testified, that the applicant serves acute inpatient psychiatric patients, with its projected average length of stay per patient being 9.2 days. Therefore, it will not serve long-term patients. In light of the foregoing, this tribunal concludes that, as a matter of law, the SBHK CON application satisfies provision C.4 of the *Guidelines for Growth* criteria on inpatient psychiatric services.

24. The final provision of subsection C of the *Guidelines for Growth* for inpatient psychiatric services concerns "the degree of projected financial participation in the Medicare and TennCare programs should be considered." As Mr. Shaheen and Mr. Sullivan have testified in this record, and as CON application CN1312-050 itself makes clear, the SBHK psychiatric inpatient hospital will participate in both Medicare and TennCare programs. While SBHK will be considered under federal Medicaid regulations an "institute of mental disease" that will limit its capability to receive federal Medicaid funding for adult patients, it can receive both the federal and state shares of the Medicaid funding for child and adolescent patients. Furthermore, its geropsychiatric programs, as Mr. Shaheen testified, will be primarily Medicare-funded. Mr. Shaheen also testified, without contradiction in this record, that TennCare, through its contracting managed care organizations, has a process for funding adult inpatient psychiatric care with state funds. Therefore, this tribunal concludes, as a matter of law, that subsection C.5. of the *Guidelines for Growth* criteria on inpatient psychiatric services has been satisfied by SBHK in its CON application, CN1312-050.

25. The *Guidelines for Growth*'s criteria for inpatient psychiatric services, in subsection D. thereof, direct the CON inquiry to consider the "relationship to existing similar services in the area". Subsection 1 of section D. directs the CON inquiry to focus on "the area's trends in occupancy and utilization of similar services should be considered." This tribunal concludes, as a matter of law, that this reference to "the area" in this part of the *Guidelines for Growth* refers to the service area of the project. T.C.A. § 68-11-1609(b) uses the term "the area to be served." Logically and legally, that term refers to the service area reasonably chosen by the CON applicant, as occurred here.[147]

26. Therefore, as Mr. Sullivan and the CON application analyzed this process, they focused initially on the SBHK's proposed service area. Clearly, there is a need for the SBHK psychiatric hospital of 72 beds in the service area designated in the CON application. There are only 12 psychiatric hospital beds in the entire five-county area. Those are located at Bristol Regional Medical Center in Bristol, Tennessee. As Mr. Sullivan testified, and showed in his report, the 2013 utilization of those 12 beds was approximately 65%. Therefore, on average only four of those BRMC beds were available to the patients of the service area in 2013. Furthermore, BRMC's utilization has been increasing over the last three years (2011-2013). Mr. Sullivan demonstrated that BRMC's utilization increased from 55.9% in 2011 to 65.8% in 2013 (Ex. 237). Therefore, this tribunal concludes, as a matter of law, that the trends in occupancy and utilization of inpatient psychiatric services in the service area designated by SBHK in its CON application indicate that the psychiatric hospital proposed by SBHK in CON application CN1312-050 is clearly needed to provide inpatient psychiatric services to this service area.

27. Mr. Sullivan also analyzed the utilization of Woodridge Psychiatric Hospital ("WPH") in Johnson City in Washington County, Tennessee even though WPH is outside

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SBHK's chosen service area. . This 84-bed facility has seen a dramatic increase in utilization, as demonstrated in this record, in 2014 and 2015 from prior years. In fact, as this record demonstrates, in the first six months of calendar 2015, monthly utilization of WPH's 84 beds ranged generally from 85% to approximately 90% in occupancy, and remained at 88% occupancy in July 2015, the month of the hearing herein. As MSHA documents and MSHA witnesses such as Ms. Bailey demonstrated, there are often additional roadblocks to adding patients at WPH, such as "blocked" beds or rooms, because the type of bed needed (geropsychiatric or child and adolescent or adult) may not be available in the particular building in which WPH provides those services. The 84 beds at WPH are not fully interchangeable. Therefore, the effective occupancy rate, if rooms or beds are blocked or if certain units are full, is higher than the 85 to 90% it generally has shown utilization levels in 2015. Therefore, even assuming that this provision of the *Guidelines for Growth* directs SBHK and this tribunal to examine utilization and occupancy trends in providers not within the designated service area but close to it, those trends are significantly positive, as this record repeatedly demonstrates.

28. The general trend at WPH over the last several years has been that admissions have risen every year, but admissions dramatically increased in the second half of FY 2014 and all of 2015. Therefore, if the trends in occupancy and utilization of WPH are considered, those trends clearly demonstrate that there is a need for significant additional inpatient psychiatric hospital services and addiction care in northeast Tennessee and southwest Virginia. Furthermore, MSHA's CEO Levine stated in the press release in early 2015 (Ex. 245) referenced above, that he believed there were needs for increased care for addiction care and increased access to mental health services in northeast Tennessee and southwest Virginia. The extremely high levels of utilization at WPH in the first six months of 2015 clearly demonstrate that Mr.

Levine is correct. Therefore, even representatives of MSHA have confirmed, through public statements as well as by the utilization and occupancy figures for WPH, that there is a dramatic need for additional inpatient psychiatric hospital beds to provide addiction care and increased access to mental health services in northeast Tennessee and southwest Virginia. The SBHK psychiatric hospital proposed in CON application CN1312-050 is therefore necessary to provide needed services in the area to be served. Therefore, this tribunal concludes, as a matter of law, that SBHK CON application CN1312-050 satisfies the criteria set forth in *Guidelines for Growth* criterion D.1.4 inpatient psychiatric services.

29. The second subsection of section D of *Guidelines for Growth* on this topic direct the inquiry toward the project's "accessibility to specific special needs groups should be an important factor." The access issues of two specific special needs groups that are addressed by this CON application are the CON project's accessibility to chemical dependency patients as well as its accessibility to children and adolescents. Given that SBHK's psychiatric hospital will have a dedicated 10-bed unit for chemical dependency patients, it clearly will increase accessibility to services in the area for that special needs group.

30. Furthermore, SBHK's plan to have 28 child and adolescent inpatient psychiatric beds demonstrate that the SBHK psychiatric hospital will increase accessibility to inpatient psychiatric hospital care for children and adolescent patients to the service area. In SBHK's designated service area, as noted above, there are no children and adolescent psychiatric inpatient hospital beds. Even at WPH, there are only 12 such beds. Therefore, the general area lacks sufficient supply of these beds. The accessibility to these beds and these services by child and adolescent patients in the servce area will be significantly enhanced by the construction of SBHK psychiatric hospital. This tribunal concludes, as a matter of law, that SBHK's CON

application CN1312-050 satisfies section D.2. of the inpatient psychiatric services provisions of the *Guidelines for Growth.*

31. The final criterion that the *Guidelines for Growth* direct attention to under psychiatric inpatient services section is "feasibility" which it specifies to be "the ability of the applicant to meet Tennessee Department of Mental Health Licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) . . .". As Mr. Shaheen and Mr. Sullivan have demonstrated at length in their testimony, as does Mr. Sullivan's report also, SBHK will have access to Strategic Behavioral Health, LLC's revenue stream and corporate contacts with regard to recruiting child and adolescent board certified psychiatrists and other healthcare providers to assist SBHK in delivering its services in Kingsport, Sullivan County, Tennessee. Therefore, this record has established that SBHK has "the ability" to meet the personnel and staffing requirements of the Tennessee Department of Mental Health and Substance Abuse Services for licensure. Furthermore, there is no dispute in this record that Strategic Behavioral Health, LLC itself is an experienced operator of psychiatric hospitals and psychiatric hospital service delivery in its facilities in numerous states, including Nevada, Colorado, New Mexico, Texas and North Carolina. This demonstrates that SBHK, which will draw upon the resources of Strategic Behavioral Health, LLC for staffing and other purposes, has the ability, as a matter of fact and law, to meet the Tennessee Department of Mental Health and Substance Abuse Services licensure requirements, especially those for personnel and staffing for psychiatric inpatient facilities. This tribunal finds that, as a matter of law, the applicant has satisfied subsection E of the *Guidelines for Growth* criteria for inpatient psychiatric services.

32. The HSDA has issued additional "criteria" set forth in its rules for the review of CON applications. These are set forth above at the beginning of the conclusions of law in this

matter. Among these are a set of criteria for each of the three statutory criteria, the first set being that for the criterion of need. The rules are set forth in HSDA Rule 07-11-.01, and are addressed below.

33. With regard to subsection (1)(a) of the HSDA rule provisions on need, in CON application CN1312-050, SBHK applied the existing applicable state health plan, the psychiatric inpatient services provision of the *Guidelines for Growth*, both in its CON application and in the proof presented in this contested case proceeding. The relationship of the CON application to the plan is that certificate of need application CN1312-050 satisfies the 30 beds per 100,000 population bed need criterion in the *Guidelines for Growth* in establishing the need for the services and facility proposed. The individual subcategories of bed need analysis of the particular age groups served by the CON project also satisfy the state health plan guidelines, with the possible exception of the child and adolescent bed proposal for 28 beds. However, as concluded above, the general absence of inpatient psychiatric child and adolescent beds in upper east Tennessee and southwest Virginia generally (except for the 12 such beds at WPH in Washington County, Tennessee) support the addition of the significant new supply of inpatient child and adolescent inpatient psychiatric hospital beds proposed by the SBHK CON application CN1312-050.

34. With regard to subparagraph (1)(b), the population served by the proposal, both the CON application itself and Mr. Sullivan's testimony and report demonstrate that the service area proposed by SBHK, consisting of five counties, has a population of more than 300,000 people and shows a need for more than 72 inpatient psychiatric hospital beds under the 30 beds per 100,000 population formula.

35. With regard to subsection (1)(c), the existing services or institutions in the area, as both the CON application itself and Mr. Shaheen and Mr. Sullivan demonstrate, there is only a single supplier of inpatient psychiatric hospital beds in the five county service area designated by SBHK: the 12 adult psychiatric hospital bed unit located in Bristol Regional Medical Center in Bristol, Tennessee. Those beds, as demonstrated by Mr. Sullivan's testimony and supporting exhibits, had an occupancy rate of approximately 66% in 2013, leaving only four beds on average as the open psychiatric hospital beds available for additional patients in the service area chosen by SBHK. Therefore, given the size of the population of the proposed service area, and the paucity of available beds in the service area, the population served by the proposal supports this tribunal's conclusion as a matter of law that the SBHK 72-bed psychiatric hospital CON project is needed in the area to be served.

36. Even if utilization of Woodridge Psychiatric Hospital were to be assessed in this analysis, the record demonstrates, from Woodridge's own uncontested documentation that in calendar 2015 Woodridge's monthly utilization has generally been in the range of 85 to approximately 90%, with its monthly occupancy reaching more than 89% in May 2015 and 88% in the month of July 2015.

37. With regard to subsection 1(d) of the general criterion of the HSDA rules, "the reasonableness of the service area", the findings of fact and conclusions of law in this matter establish the reasonableness of the service area chosen by SBHK in detail. Mr. Sullivan opined that it was an appropriate service area for a 72-bed psychiatric inpatient hospital. There are only 12 inpatient psychiatric hospital beds currently in the five-county service area. As Mr. Sullivan's analysis demonstrates, even if a larger service area were utilized, there would still be a need for nearly 60 inpatient psychiatric hospital beds in a broader service area. Both Mr. Sullivan and the

MSHA's health planning expert, Dr. Collier, agree that the numerical need for additional inpatient psychiatric beds in the service area designated by SBHK exceeds the total of 72 beds sought by SBHK in the CON application at issue.

38. Furthermore, with regard to the reasonableness of the service area, MSHA itself has designated a smaller 3.5 county service area for its regional referral center, Indian Path Medical Center, located in Kingsport, Tennessee, and has designated a service area of only six Tennessee counties, excluding Hawkins County, in its service area designated for its flagship hospital, the regional referral center known as Johnson City Medical Center. Therefore, the five-county service area designated by SBHK for its service area is reasonable, as a matter of law. This tribunal concludes that the "reasonableness of the service area" criterion under subsection (1)(d) of the HSDA's general criteria rules is satisfied as a matter of law by the SBHK CON application, CN1312-050.

39. With regard to HSDA general criteria rule (1)(e), this provision directs the applicant to address the special needs of the service area population including accessibility to consumers, and women, racial and ethnic minorities, TennCare participants and low income groups. This tribunal finds, as a matter of law, that the SBHK CON application CN1312-050 satisfies this provision of the HSDA's general criteria rule. The applicant has established in this record, through the testimony of Mr. Shaheen and Mr. Sullivan, that the SBHK project will serve TennCare participants and low income groups. The applicant has established that it will be accessible to special needs of the service area population, such as the needs of the service area population for increased care for addiction, through its ten dedicated chemical dependency beds, and through increased access to children and adolescent inpatient psychiatric services through its 28 beds designated for children and adolescent patients.

40. HSDA general criterion rule 1(f) directs consideration of "comparison of utilization/occupancy trends and services provided by other area providers . . .". This analysis is very similar to comparison of utilization and occupancy trends noted in conclusions above related to the *Guidelines for Growth*, which address very similar issues. As noted there and elsewhere in this record, occupancy trends in the 12 beds in the SBHK service area having been rising, and reached approximately 66% in 2013. Similarly, those 12 beds at Bristol Regional Medical Center do not provide geropsychiatric or child and adolescent services; they are for the adult population generally. Therefore, there is a need for these child and adolescent beds and the geropsychiatric beds proposed by the SBHK CON application.

41. With regard to utilization of providers outside the designated service area, WPH's utilization has been rising over the last four years, and has generally hit monthly levels between 85 and 90% in the first seven months of calendar 2015, including nearly 90% in March and May 2015 and 88% in July 2015, the month of the hearing herein. Therefore, evaluation of this criterion supports the conclusion made by this tribunal that there is a need for the 72 bed inpatient psychiatric hospital proposed by SBHK in CON application CN1312-050. Therefore, this criterion of the HSDA rules has been satisfied, as a matter of law, by the applicant in this matter.

42. The final provision of the HSDA general criterion rule regarding need, which is subsection (g), directs the analysis of the extent to which Medicare, Medicaid, TennCare, medically indigent, charity patients and low income patients will be served by the project. The applicant has established that it will serve Medicare and TennCare patients. It also projects that 5% of its charges will be for charity care patients and low income patients, which is consistent with the budgetary amounts of charity care forecasted by Woodridge Psychiatric Hospital in its

recent budgets. Furthermore, Mr. Shaheen testified that he would welcome a contract for SBHK with the Tennessee Department of Mental Health and Substance Abuse Services to serve indigent and uninsured inpatient psychiatric patients at the SBHK facility, similar to the contract which MSHA currently has with MSHSAS.

43. This provision of the HSDA need criteria rule also directs consideration of how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet the needs. The CON application itself, along with the testimony of Mr. Shaheen and Mr. Sullivan, establish that the applicant has made contacts with the local community mental health agency, Frontier, and it has indicated that SBHK is willing to work with Frontier (the area's mental health center), and that Frontier is willing to work with it should its CON application be approved. Furthermore, Mr. Sullivan's testimony is supported by the CON application itself. Mr. Shaheen testified without contradiction in this record that SBH engages in significant community outreach at every hospital it operates, and that it will do so at the SBH Kingsport facility as well. Dr. Elliott has confirmed that ETSU's medical school needs additional residency sites, such as the SBHK hospital in Kingsport, to support its psychiatry residency program.

44. The HSDA general criteria rule provides, in its section number 2 for economic factors, that the CON application may be evaluated upon certain economic factors. The first two of these factors relate to whether adequate funds are available to the applicant to complete the project and to the reasonableness of the project costs. With regard to these two factors, this tribunal concludes, as a matter of law, that adequate funds are available to the applicant to complete this project and that the project costs of slightly under $12 million are reasonable for a project of this size. There does not appear to be any dispute in the record on these two points.

Thus, the applicant has moved its burden of proof on these points. The testimony of Mr. Shaheen, Mr. Cagle (the CFO of Strategic Behavioral Health, LLC), and Mr. Sullivan prove that there is funding under a $150 million line of credit available to Strategic Behavioral Health, LLC to fund this and other SBH projects, and that the operating revenues of Strategic Behavioral Health, LLC, as detailed by Mr. Shaheen and Mr. Cagle in their testimony, are also available and are in the annual range of $25 to 30 million per year. These facts establish that adequate funds are available, as a matter of law as well as fact, to the applicant to complete the project. Furthermore, as Mr. Sullivan testified, SBH's capability to complete a project for a 72-bed psychiatric hospital at a projected cost level of under $12 million is definitely reasonable. Mr. Shaheen testified at length as to how SBH is able to carry out such a hospital project in such a reasonable manner with regard to its cost. Therefore, this tribunal concludes, as a matter of law, that SBHK has adequate funds available to it to complete this project, and that the proposed project costs are reasonable.

45. The next two subsections of this section of this rule focus on the anticipated revenue from the proposed project and the impact on existing patient charges, as well as participation in state/federal revenue programs. With regard to these two provisions, this tribunal finds that, as a matter of law, the anticipated revenue from the proposed project is reasonable and supports the granting of the certificate of need. Since SBH-Kingsport, LLC does not currently exist; thus, it does not have any existing patient charges. Mr. Sullivan opined at length that the anticipated revenue from the proposed project was reasonable. Furthermore, the proof in this record makes clear that the SBH-Kingsport, LLC CON project will participate in Medicare and Medicaid programs, thus participating in state/federal programs. Therefore, as a matter of law, this tribunal concludes that sections (c) and (d) of the economic factors criteria

rule of the HSDA are satisfied by the CON application at issue filed by SBH-Kingsport, LLC in CON application CN1312-050.

46. The final two provisions of the economic factors rule, the alternatives considered and the availability of less costly or more effective methods of providing benefits intended by the proposal, were dealt with at length in the CON application and more particularly in the testimony of Mr. Sullivan at the hearing. Mr. Sullivan opined at trial and in Ex. 80, his expert report, that he did not believe that failing to build the SBHK facility would be the best alternative, because not building it would do nothing to address the shortage of inpatient psychiatric services and the lack of access to inpatient psychiatric and addiction care that currently exist in the service area of SBHK. He opined that it would be possible for SBHK to build a facility smaller than 72 beds, but given the scope of the need identified by the *Guidelines for Growth* formula application, he believes that in order for it to serve fully a population of over 300,000, that building a smaller facility would not be advantageous.

47. Furthermore, Mr. Sullivan opined, without contradiction in this record, that building the larger facility described in the CON application enabled the SBHK hospital to treat different patient populations within the segments of the population it serves. One example would be its services to children and adolescents. SBHK's larger complement of child and adolescent beds would let the hospital separate the children from the adolescents. SBH proposes to do just that, while, as Mr. Sullivan established, Woodridge is not able to do so because it has a limited number (12) of child and adolescent beds in a single building (Willow).[148]

48. Mr. Sullivan also testified that having a larger facility gives the hospital a clinical advantage in terms of being able to put various patients on different tracks of treatment depending on their different diagnoses and patient needs. Therefore, he did not believe it would

[148] Ex. 80, p. 13.

be a better alternative not to build the SBHK project or to make it smaller. For the same reasons, Mr. Sullivan could not identify an appropriate alternative to the SBHK project that was less costly or more effective for the need identified in this record and in the CON application itself. This tribunal concludes, therefore, as a matter of law, that the economic factors criteria of the HSDA's Rule 0720-11-.01(2) subsections (e) and (f), are satisfied, as a matter of law, by the SBHK CON application, CN1312-050, as supported also by this record.

49. The third part of the HSDA's general criteria for a certificate of need rule relates to the statutory criterion of contribution to the orderly development of adequate and effective healthcare facilities or services. This rule provision directs focus of the analysis to four factors. The first of these is the relationship of the proposal to the existing healthcare system. This tribunal concludes, as a matter of law, that the application of this factor to the analysis of SBHK CON application CN1312-050 favors the grant of the certificate of need. SBHK's CON application demonstrated that it proposes to participate in the TennCare program, as detailed by Mr. Shaheen's testimony and that of Mr. Sullivan as well. Both Mr. Shaheen and Mr. Sullivan testified that it was the intent of SBHK to contract with the medical school at ETSU to be a site for their psychiatric residency program. The testimony of Dr. Harold Elliott, the director of the residency program at the ETSU Medical School until June 2015, also factually supports this conclusion of law. There was no testimony to the contrary provided by MSHA.

50. Furthermore, Mr. Shaheen's testimony indicates that Strategic Behavioral Health, LLC has significant capability to develop contractual agreements for recruiting health services personnel, such as board certified child and adolescent psychiatrists and other healthcare professionals, to its facilities such as SBHK. Given the history and success of Strategic Behavioral Health, LLC in recruiting board-certified psychiatrists and other healthcare

professionals to its other hospitals, there is no contradiction in this record of Mr. Shaheen's assertion that it can do so, and will do, at SBHK if it is permitted to construct the facility. Furthermore, there is no question in this record that contradicts SBHK's assertions that it will be a TennCare participant.

51. The next criterion under this general criteria rule is subsection (b), which addresses the positive or negative effects attributed to duplication or competition. As has been addressed extensively in this record by Mr. Sullivan, the documents filed, and the testimony of Dr. Elliott and Mr. Shaheen, the positive effects attributable to competition outweigh, as proven in this record, any negative effects that might be attributable to duplication. There is no real duplication of services in the five-county service area designated by SBHK for this project. There are only 12 other inpatient psychiatric beds within the five counties and those have been running two-thirds full in 2013 at Bristol Regional Medical Center. Therefore, as Mr. Sullivan pointed out, given the level of BRMC utilization there are only four available beds in the service area. Therefore, there will be no duplication or significant competition in the service area designated by SBHK arising from the establishment of SBHK's hospital facility.

52. With regard to competition generally, Mr. Sullivan opined that the positive effects attributable to competition were material considerations supporting the grant of this certificate of need. He opined that SBHK would provide a competitive alternative to Woodridge and Mountain States. He opined further that SBHK would attract additional healthcare professionals and specialized psychiatrists and other staff to the service area. He also opined that SBHK could provide services differently from the ways MSHA has done at WPH, giving patients increased choices of where they want to go. Finally, Mr. Sullivan opined that SBHK could potentially stimulate price competition with MSHA as it relates to contracting with third-party payors in the

market. Mr. Sullivan opined that from these standpoints the benefits of competition outweigh any negative effects from duplication. Mr. Sullivan opined that his view of any "duplication" arising from SBHK project would be "necessary" duplication because more inpatient psychiatric beds are needed in the community.

53. Furthermore, Mr. Sullivan pointed out that MSHA's own internal personnel had, in April 2014, projected that the impact of SBHK's operation on WPH in the second year of SBHK's operation would be only $50,000.

54. Finally, Mr. Sullivan opined, as the record demonstrates, Woodridge is merely a department or service of Johnson City Medical Center. He testified that the more appropriate analysis would be to examine the impact of SBHK on Johnson City Medical Center itself or on MSHA itself. He pointed out that the 2013 Joint Annual Report for JCMC indicated that JCMC had a bottom line profit of over $30 million in fiscal year 2013. MSHA provided no proof of any form in the record to indicate that the impact of SBHK on Johnson City Medical Center would be negative to any degree. MSHA's public financial statements demonstrate that, through the first nine months of its FY 2015, MSHA's gross actual revenues were almost $$800 million. This tribunal concludes, as a matter of law, that the positive effects attributed to competition by SBHK far outweigh any negative effects attributable to duplication. Therefore, this tribunal finds, as a matter of law, that the application of HSDA Rule criterioin 3(b) as set forth above favors the grant of the certificate of need at issue in this matter. SBHK CON application CN1312-050 fully satisfies this criterion, as a matter of law.

55. As a matter of law, this tribunal concludes that, in this case, the competition with MSHA's facilities that will be provided by the applicant's project has many positive effects, and limited negative ones. This record establishes, without contradiction, that WPH, the only facility

operated by MSHA that does only psychiatric care, is, as Dr. Jessee testified and MSHA's own documents prove, "approaching being full on many occasions." This high level of utilization causes many deferrals as shown by this record, that could be accommodated immediately by the new SBHK facility -- this is a positive effect of competition. Another positive effect of competition documented by Ex. 13 to Dr. Collier's report, is the elimination of the need for hundreds of area psychiatric hospital patients to leave the SBHK service area to go to facilities like Peninsula Hospital in Blount County, south of Knoxville, or elsewhere outside northeast Tennessee to obtain psychiatric hospital services. Once the SBHK hospital facility is in operation, these hundreds of patients from the SBHK service area can obtain care much closer to their families and homes. Thus, this tribunal concludes, as a matter of law, as well as finding as a matter of fact, that the competition to MSHA provided by SBHK will have a number of positive effects that will contribute to the orderly development of adequate and defective healthcare facilities, servicing and systems.

56. MSHA itself designates its own facilities' service areas in a manner designed to avoid competing hospitals. Ex. 21, at p. 31 thereof, shows that MSHA designated IPMC's service area as including only the western party of Sullivan County, plus Hawkins County in Tennessee and Wise and Scott in Virginia. If MSHA can partition a single county in this way in designating IPMC's service area, it is clearly reasonable for SBHK to draw up the southern border of its service area at an actual county line, Sullivan County's southern border with Washington County, Tennessee.

57. The Tennessee Hospital Cooperation Act of 1993 does permit reduction of competition among hospitals acting pursuant to a certificate of public advantage ("COPA"), but only after the Tennessee Department of Health grants an application by those hospitals for a

COPA. The hospitals acting pursuant to the COPA also remain subject to ongoing regulation and review, by the TDOH, of their activities under the COPA. T.C.A. § 68-11-1303.

58. The COPA statute specifically provides at T.C.A. § 68-11-1306(c) that the COPA statute does not diminish the CON laws in Tennessee: "Nothing in this part exempts hospitals or other healthcare providers form compliance with laws governing certificates of need."

59. Regardless of MSHA's plans or activities pursuant to the COPA statute, the positive effects attributable to competition cited above remain, pursuant to the CON laws, to be a factor militating for the approval of CON application CN1312-050 for SBHK's establishment of a psychiatric hospital in Kingsport, Tennessee.

60. The third component of the contribution to orderly development of the general criteria rule is subsection (c), the availability and accessibility of human resources required by the proposal, including consumers and related providers. Clearly, the record in this certificate of need proceeding establishes that there will be sufficient availability and accessibility of the consumers for this project. Mr. Sullivan testified at length about the need for this project. Furthermore, by having significantly increased number of child and adolescent beds, the availability and accessibility to child and adolescent consumers of inpatient psychiatric care will be significantly increased by this project, as will the accessibility to dedicated chemical dependency beds at SBHK.

61. With regard to the related providers, Mr. Shaheen's extensive testimony, echoed by that of Mr. Sullivan, concerning the capabilities of Strategic Behavioral Health, LLC to recruit board-certified child and adolescent psychiatrists and other healthcare providers to its hospitals indicate that those human resources will be both available and accessible to this project and to the consumers. Therefore, as this tribunal concludes as a matter of law, that the

application of HSDA general criteria rule 3(c) to CON application CN1312-050 favors the grant of the certificate of need for SBHK's project.

62. The final component of the HSDA general criteria rule under contribution to orderly development is subsection (d) (the quality of the proposed project in relation to applicable governmental professional standards). It is clear that this record establishes, as a matter of law, that SBHK will be able to satisfy this criterion. Strategic Behavioral Health, LLC has developed and operates numerous other successful psychiatric hospital and other inpatient psychiatric provider projects in Nevada, New Mexico, Colorado, Texas and North Carolina. Therefore, it is familiar with the requirements of governmental and professional standards for these projects. There is no significant proof in this record to contradict the conclusion of law that Strategic Behavioral Health, LLC or its affiliate SBHK will be able to satisfy the quality requirements of applicable governmental and professional standards at the 72-bed psychiatric hospital it proposes to develop in Kingsport, Tennessee. Thus, this tribunal concludes, as a matter of law, that the application of HSDA general criteria rule 3(d) to the project at issue is satisfied, and that the certificate of need should be granted to SBHK.

63. In Johnson City, Tennessee, MSHA operates a large multi-specialty hospital known as Johnson City Medical Center. Johnson City Medical Center has a "satellite" hospital, Woodridge Psychiatric Hospital, which is across the street from Johnson City Medical Center. However, the Intervenor in this matter is not Woodridge Psychiatric Hospital or Johnson City Medical Center. Rather, the Intervenor in this matter is Mountain States Health Alliance.

64. The status of Woodridge Psychiatric Hospital as a "satellite" of Johnson City Medical Center has an important legal and factual impact on this matter, especially as to MSHA's projections of the impact of SBHK's psychiatric hospital on any MSHA entities.

Tennessee hospital regulations recognize and permit such satellite hospital designations. Medicare also recognizes satellite hospital status for certain hospital facilities, and it imposes significant requirements that such a hospital must satisfy in order to be considered by Medicare as a "satellite" of another hospital. Under Medicare regulations, "satellite" hospitals have status as being "based" in the main provider; this is also known as being "provider-based."[149] These requirements are found at 42 CFR § 413.65(d), which lists four basic requirements, applicable to Woodridge's situation, that Woodridge must satisfy to maintain its status as a "satellite" of JCMC. These four requirements can be summarized as follows: in order to be considered by Medicare as a satellite of JCMC, Woodridge must: be operated under the same license as JCMC; integrate its clinical services and medical staff with those of JCMC; must evidence "shared income and expenses" with JCMC; and it must hold itself out to the public and payors as being a part of JCMC.[150] As the Findings of Fact made herein demonstrate, WPH satisfies all of these Medicare criteria. Dr. Elliott's testimony demonstrated that WPH and JCMC share medical staff; Mr. Levine's testimony and page 1 of Ex. 83 demonstrate that WPH operates under JCMC's Tennessee hospital license; and the testimony of Ms. Bailey and Dr. Collier established that WPH is a "department" of JCMC. Thus, WPH must also show shared income and expenses with HCMC, so that WPH can, for Medicare purposes, remain a "satellite" of JCMC.

65. By virtue of the impact of Medicare regulations on WPH and JCMC and WPH's status as a department of JCMC, MSHA's projected negative financial impact of SBH-Kingsport's psychiatric hospital on Woodridge by itself, without any proof in this record of SBHK's impact on JCMC, is not probative, as a matter of law, of SBHK's impact on other

[149] 42 C.F.R. § 413.65(d)(1) requirements provide, in part, as follows: (1) " . . . the satellite facility and the main provider are operated under the same license, ..."

[150] With regard to the requirement of WPH holding itself out to the public as being part of JCMC, 42 C.F.R. § 413.65(d)(4) actually states, in part, as follows: "When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly."

licensed hospital providers, regardless of whether such providers are inside or outside SBHK's service area.

66. This case arises under the Tennessee Uniform Administrative Procedures Act, T.C.A. § 4-5-301, *et seq.*, because it is a contested case proceeding. Tennessee cases under the UAPA provide that in administrative proceedings such as this one, the burden of proof ordinarily rests on the one seeking the relief, benefits or privilege. See *Big Fork Mining Co. v. Tennessee Water Quality Control Board*, 620 S.W.2d 515, 520 (Tenn. App. 1981). In *Big Fork*, the court also held that proceedings such as this one are *de novo* hearings; thus, evidence not previously submitted to the Agency can be offered. As a matter of law and fact, SBHK has moved its burden of proof herein, and established as a matter of law and fact that the psychiatric hospital that it proposes to establish in Kingsport, Tennessee as set forth in CON application CN1312-050 satisfies the three statutory criteria of T.C.A. § 68-11-1609(b), generally described as "need, economic feasibility, and contribution to the orderly development of healthcare.

67. The provisions of the Guidelines for Growth, are, by statute (T.C.A. § 68-11-1609(b)), to be used as "guidelines" by the HSDA in CON matters such as this one.

68. The HSDA has the statutory power, pursuant to T.C.A. § 68-11-1609(a), to approve all or part of the CON application presented to it, or to disapprove all or part of the CON application.

Accordingly, **IT IS HEREBY ORDERED THAT** the certificate of need application number CN1312-050 filed by, and owned by, SBH-Kingsport, LLC, for the establishment of a 72-bed free-standing psychiatric hospital and the initiation of inpatient psychiatric services is **APPROVED.** Said psychiatric hospital shall initiate inpatient psychiatric services and shall contain 18 inpatient beds for adult patients, ages 18-64, 16 inpatient beds for geropsychiatric patients over 55 years of age, 28 inpatient beds for child and adolescent patients ages 5-17, and 10 adult chemical dependency beds.

It is so Ordered.

This Initial Order entered and effective this ___ day of _____, 2015.

_____
LEONARD POGUE
ADMINISTRATIVE JUDGE

Filed in the Administrative Procedures Division, Office of the Secretary of State, this the ___ day of _____, 2015.

_____
Director, Administrative Procedures Division

Accordingly, **IT IS HEREBY ORDERED THAT** the certificate of need application number CN1312-050 filed by, and owned by, SBH-Kingsport, LLC, for the establishment of a 72-bed free-standing psychiatric hospital and the initiation of inpatient psychiatric services is **APPROVED IN PART.** Said psychiatric hospital shall initiate inpatient psychiatric services and shall contain 62 beds, configured as follows: 18 inpatient beds for adult patients, ages 18-64, 16 inpatient beds for geropsychiatric patients over 55 years of age, 18 inpatient beds for child and adolescent patients ages 5-17, and 10 adult chemical dependency beds.

It is so Ordered.

This Initial Order entered and effective this ___ day of _____, 2015.

_____
LEONARD POGUE
ADMINISTRATIVE JUDGE

Filed in the Administrative Procedures Division, Office of the Secretary of State, this the ___ day of _____, 2015.

_____
Director, Administrative Procedures Division

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been delivered via email to:

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Brian Jackson, Esq.
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and

Jim Christoffersen, Esq.
General Counsel
Tennessee Health Services and Development Agency
9th Floor, Andrew Jackson Building
Nashville, TN 37243

this 28 day of October, 2015.

William West

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SECRETARY OF STATE

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

APPLICANT'S REPLY BRIEF

The Applicant herein, SBH-Kingsport, LLC ("SBHK" or "SBH"), hereby files its Reply Brief in this matter as set forth below.

ARGUMENT

I. MSHA's Proposed Findings of Fact admit that the HSDA rules define a "service area" as "representing **a reasonable area** in which a healthcare institution intends to provide services and in which **the majority** of its service recipients reside."

MSHA's Proposed Finding 13 admits that the HSDA's own rules define a project's service area as the counties which represent "a reasonable area in which a healthcare institution intends to provide services and in which the majority of its service recipients reside." (Emphasis

added.) MSHA's numeric citation of the applicable HSDA rule in its proposed Finding 13 is incorrect: the rule cited is actually found at Tenn. Comp. R. & Regs. R. 0720-9-.01(23).

Thus, contrary to Dr. Collier's assertions that a "service area" definition by a CON applicant requires identifying the patient origins of 90-95% of the project's anticipated patients, the HSDA requires only that a CON project's service area must only be the source of the majority of the project's anticipated service recipients. Given the population density of Sullivan and Hawkins Counties, it is clear that the majority of SBHK's patients will come from Sullivan and Hawkins Counties in Tennessee, as well as from the three Virginia counties claimed by SBHK as its designated service area.

Dr. Collier's elaborate CON planning process is based on identifying the patient origins of the "vast majority" of a facility's patients. As Dr. Collier testified:

> Collier, TR 699: The service area is "the area that accounts for the vast majority of the patients receiving service at an institution."
>
> Collier, TR 784: "My definition of service area would account for 90 to 95 percent of the patients." (Emphasis added.)

In her definition of service area, Dr. Collier did not account for the HSDA's own rule which actually defines the term "service area":

> Tenn. Comp. R. & Regs. R. 0720-9-.01: DEFINITIONS. The following terms shall have the following meanings.
>
> *****
>
> (23) "Service area" means the county or counties or portions thereof, representing a reasonable area in which a healthcare institution intends to provide services and in which the majority of its service recipients reside." (Emphasis added.)

Dr. Collier's testimony that a service area must be the source of "the vast majority" of the healthcare institution's patients utilizes a descriptive term ("vast") that is not present in the HSDA's own rule. Thus, Dr. Collier's requirement that a service area must be the source of a

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"vast majority" of SBHK's patients, or the source of anything other than "the majority", of a healthcare institution's patients, is inconsistent with the HSDA's rules. Her analysis violates the relevant rule's requirement that the term "service area" "shall have" the meaning set forth by the HSDA itself in Tenn. Comp. R. & Regs. R. 0720-9-.01(23): only "the majority" of the patients for SBHK must come from its designated service area. Tennessee law requires administrative agencies to act consistently with their own regulations. *Jackson Express v. Tenn. Public Service Commission*, 679 S.W.2d 942, 945 (Tenn. 1984). Unlike the HSDA rule provisions that, under its Rule 0720-11-.01, provide "general criteria" upon which the CON application "may be evaluated", the HSDA's rule definition for "service area" is mandatory: the "service area" term "shall have" the meaning set forth in Rule 0720-9-.01(23).

In its proposed conclusion of law number 2, on page 30 of its findings, MSHA recommends that this tribunal adopt "the service area proposed by Dr. Collier as representing a reasonable expectation of where most of SBH's patients will originate." This proposed conclusion is contrary to the HSDA Rule 0720-9-.01(23) which requires that the CON project's service area be defined in part by the area "in which the majority of its service recipients reside." Thus, the proper service area for a CON applicant need not be where "the vast majority" or where "most" of SBH's patients originate, but where "the majority of its service recipients reside." The term "majority" is one of common usage. It is defined at page 1161 of the *Random House Dictionary of the English Language*, 2nd Ed., unabridged, in the first definition thereof as meaning, "the number larger than half the total".

MSHA conclusion of law number 2 also asserts that "the reasonableness of this alternative service area is borne out by the historical experience of Indian Path Pavilion, the most appropriate proxy for the proposed SBH facility." However, MSHA fails to note that Dr.

Collier's own proof, in Map 3 of Ex. 381, demonstrates that the majority (nearly two-thirds) of the Indian Path Pavilion patients were from Hawkins and Sullivan Counties in Tennessee, plus Wise and Scott Counties in Virginia. Therefore, the "historical experience of Indian Path Pavilion" demonstrates that the most appropriate service area for SBHK's proposed psychiatric hospital is comprised primarily of Hawkins and Sullivan Counties in Tennessee and Wise and Scott Counties in Virginia.

The need criterion issue for this tribunal, and for the HSDA, in assessing whether a certificate of need application should be granted is not whether the applicant followed a particular protocol in developing its application, but whether the applicant and its proof in the contested case proceeding have established that there is a need for the project. Furthermore, the actual contact person for the CON applicant is nowhere required to establish that he or she is an expert in health planning. The applicant itself has to demonstrate a need for the project and satisfy the other statutory criteria for the grant of the certificate of need by the HSDA. In this matter, SBHK has done so.

II. Dr. Collier's own report, Ex. 381, asserts that the majority of SBHK's patients will come from its five-county designated service area.

In Ex. 21 to Dr. Collier's expert report (Ex. 381), she projects that, in year 2 of SBHK's operations, SBHK will admit a minimum of 1,056 of its projected 1,859 cases (56.8% of SBHK's projected cases) from SBHK's designated service area, admissions which would otherwise, in the absence of SBHK's establishment, go to WPH (according to Dr. Collier). Dr. Collier thus projects on this basis alone that the majority (56.8%) of SBHK's year 2 cases will come from patients residing in SBHK's designated five-county service area. Thus, Dr. Collier has projected that SBHK's designated service area satisfies this major component of the HSDA's service area

definition requirement; e.g., that the majority of the applicant's patients reside in its claimed service area.

III. As to reasonableness, the HSDA's rule definition of "service area" requires only that it be "a reasonable area."

The other major component of the HSDA's service definition rule is that the "service area" counties represent "a reasonable area in which a healthcare institution intends to provide services. . . .". The HSDA service area definition rule does not require the applicant's designated service area to be "the most reasonable area" or "the only reasonable area" -- it merely mandates that the CON applicant designate "a reasonable area." Clearly, SBHK's designated service area is "a reasonable area" in which it "intends to provide services." This rule is why the HSDA accepted Trustpoint Hospital's two-county service area, as shown by Mr. Sullivan's testimony. TR 322-324. Mr. Sullivan specifically testified, at p. 11 of his expert report (Ex. 80), that SBH's designated five-county service area "is a reasonable basis on which to determine the need for a new behavioral health facility in Kingsport." At trial, Mr. Sullivan testified (TR 378) that "I do believe the service area that SBH has set forth is reasonable."

Dr. Collier's expert report (Ex. 381, p. 7) claims that SBHK's claimed five-county service area is wrongly defined because "a more reasonable likely service area" for SBHK should include "several additional counties." However, Dr. Collier's claimed service area definition requirement of "a more reasonable likely service area" contradicts the specific requirement of HSDA Rule 0720-9-.01(23) that the term "service area" shall have the meaning of "the county or counties, or portions thereof, representing a reasonable area in which a healthcare institution intends to provide services and in which the majority of its service recipients reside." (Emphasis added.)

Dr. Collier admitted at TR 775 that the term "reasonable" permits more than one meaning:

> Q: So from your report, it appears that the service proximity expression, quote, "service proximity," that is in there, you read that as extending service proximity beyond the service area?
> A: I think it could be reasonable to consider beyond the immediate boundaries if it's very proximal.
> Q: But it's also reasonable not to, isn't it?
> A: It doesn't preclude you from that reading.

Thus, that SBHK's designated service area is "a reasonable area" under the HSDA rule's definition of "service area" is not prevented by Dr. Collier's design of a different service area. This is especially true when Dr. Collier herself projects that the majority of SBHK's patients will come from SBHK's designated five-county service area.

IV. MSHA's proposed Findings which attempt to discredit Mr. Sullivan's testimony are flawed.

MSHA's proposed Finding 32 asserts that Mr. Sullivan did not use Indian Path Pavilion as a proxy because he opined that the time period 2007 to 2009 was a different competitive market place than currently exists in 2015. However, though MSHA asserts that Mr. Sullivan "seemed to suggest" that Woodridge was not really an effective competitor during that time period, Mr. Sullivan's testimony at TR 461-462 actually indicates that, while Woodridge "was not doing well financially at the time Mountain States bought it from Frontier Health" (in 2005), Mr. Sullivan emphasizes on page 462 that "Mountain States took it over and made some sort of corporate decision that they were going to concentrate psych services at Woodridge and de-emphasize those services at Kingsport. That's what I know." Thus, Mr. Sullivan's testimony contradicts the version of his testimony that MSHA sets up as a straw horse in its proposed Finding 32. MSHA also criticizes Mr. Sullivan's use of the "data". However, Mr. Sullivan did not have access to THA's data for Indian Path Pavilion. Furthermore, MSHA witness Bailey

testified at TR 564 that, prior to MSHA's purchase of WPH in 2005, WPH did not report its data to the Tennessee Hospital Association. Therefore, even if Mr. Sullivan had had access to THA data, which he did not, it would not have shown any WPH data prior to the time MSHA acquired it in 2005.

MSHA asserts in its proposed Finding 33 that Ms. Bailey and Dr. Jessee "rejected any suggestion that Woodridge was weak or uncompetitive." However, Dr. Jessee did not do so in his testimony. In fact, Dr. Jessee testified that, at TR 655, that Frontier was essentially forced to sell WPH in 2005:

> When that waiver was given up by the state, then it (WPH) had to be attached to an acute care hospital. We could no longer operate it after losing that waiver under what was called the IMD rule; so we had to sell it or turn it into something other than a public provider organization, public psychiatric facility that we had maintained it as. And we did not want to do that, to turn it into a Medicare facility or some other type of facility that could have been operated outside of that particular exclusion; so we felt like we did have to sell it, and ended up making that sale to Mountain States. (Emphasis added.)

Thus, it is clear from Dr. Jessee's testimony that Frontier was, in fact, virtually forced to sell WPH to MSHA, given TennCare's abandonment of the waiver it previously had from the applicability of the IMD rule (which did not permit combined federal and state reimbursement under Medicaid to free-standing psychiatric hospitals with more than 16 beds.[1]) Dr. Jessee thus admitted that Woodridge was not strong enough to compete outside the protection of the IMD rule waiver by TennCare. Thus, if Mr. Sullivan characterized it as "weak or uncompetitive", he had ample justification in this record for doing so.

Also, during the time period from 2007 to 2009 referenced by MSHA in its proposed Findings Nos. 32 and 33, MSHA itself was the owner of Indian Path Pavilion which it had purchased in 2005. Furthermore, as Ex. 246 indicates, Woodridge's psychiatric utilization fell

[1] Mr. Shaheen addressed the "IMD rule" in detail in his testimony, TR 176-179.

from 2,883 admissions in 2006 to 2,548 admissions in 2009, while Indian Path Pavilion's utilization became significantly smaller as MSHA prepared for its closure. Finally, Dr. Collier's proof, at Map 3 of Ex. 381, indicates that an average of only 252 cases per year left Washington County to go to Indian Path Pavilion in Sullivan County during 2007-2009.

In MSHA Finding 34, MSHA criticizes Mr. Sullivan's use of Indian Path Medical Center in Kingsport as a comparable institution for assessing the validity of SBHK's designated service area. This attack ignores MSHA's own characterization of Indian Path Medical Center ("IPMC") in Ex. 211, p. 31, as a "regional referral center." MSHA itself described Indian Path Medical Center in Ex. 211 as providing "regional" services. Therefore, it is entirely proper for Mr. Sullivan to compare IPMC's currently claimed service area to the one he justifies for SBHK. Furthermore, Mr. Sullivan's expert report expressly cited (Ex. 80, p. 11) the prior 2012 Community Health Needs Analysis ("CHNA") for IPMC, which stated that IPMC's service area consisted of Hawkins and Sullivan Counties in Tennessee, and Wise, Scott, Lee and Dickinson Counties in Virginia. Thus, in IPMC's 2012 CHNA, MSHA claimed that Lee County, Virginia was in IPMC's service area, while it excluded Washington County, Tennessee from IPMC's service area. As MSHA's proposed Finding 28 indicates, Washington County, Tennessee is directly adjacent to Sullivan County. Yet MSHA itself excluded Washington County from IPMC's service area, while including Lee County, Virginia in 2012. If IPMC's service area can include Lee County, Virginia, but can exclude Washington County, Tennessee from the service area for a "regional referral center" providing "regional" services, SBHK can properly do the same as a facility located in Kingsport for a service area for its "regional" inpatient psychiatric services.

In its proposed Finding 34, MSHA also mischaracterizes Mr. Sullivan's testimony at TR 441 by stating that "Mr. Sullivan conceded, however, that acute care services are localized in nature and, thus, typically have smaller service areas." This is not what Mr. Sullivan stated at TR 441, lines 13-17. He did not state that acute care services "typically" have smaller service areas. Instead, he was responding to a question concerning "community care hospital beds":

> Q: Community care hospital beds, meaning acute care beds, those are more localized too, aren't they?
> A: Sure. And particularly as it relates to emergency services, you want to make sure that those are readily accessible to the population.

The cross-examination of Mr. Sullivan went on at TR 442 as well, in which he was asked:

> Q: And obviously, it is a higher acuity problem or more complex problem, then those people often get referred to a tertiary care center, right?"
> A: That's true.

Like Indian Path Medical Center, MSHA describes JCMC as a "regional" referral center in Ex. 212, p. 31. It is described as "tertiary" also, but both JCMC and IPMC are described by MSHA itself in Exs. 211 and 212 as being "regional" in their services.

In its proposed Finding 36, MSHA asserts, as a negative feature of SBHK's certificate of need application, that "thousands of people living in Washington County live in closer proximity to the new SBH facility than Woodridge." However, those same "thousands of people living in Washington County" who are in closer proximity to SBH than to WPH are also in closer proximity to Indian Path Medical Center than to JCMC in Johnson City. However, that proximity did not cause Indian Path Medical Center to claim Washington County, Tennessee as part of its service area in Ex. 211, p. 31.

V. SBHK's proof herein has satisfied the HSDA's "orderly development" criterion: as MSHA admits, any "impact on other providers" that should be analyzed is limited to impact on those providers in the service area proposed by the Applicant.

MSHA admits in its proposed Finding 12 that the providers to be reviewed for this "impact" are "other providers in the proposed service area . . .". (Emphasis added.) Mr. Sullivan's report (Ex. 80) and testimony assessed the impact of SBHK's CON project on the only other provider of inpatient psychiatric hospital services in SBHK's proposed service area, the 12-bed unit at Wellmont Bristol Regional Medical Center ("BRMC") in eastern Sullivan County. BRMC did not oppose SBHK's CON application . Mr. Sullivan demonstrated that the majority of BRMC's patients in 2013 came from counties outside SBHK's designated five-county service area. Ex. 80, p. 11; Ex. 232. He opined that BRMC was more oriented toward Virginia than toward Tennessee. Sullivan at TR 318-319.

VI. WPH's high level of patient deferrals demonstrate the need for SBHK's CON project.

MSHA asserts in its proposed Finding 44 that SBH's proof regarding WPH census or deferrals is limited to the "flow sheets" themselves, which, according to MSHA, disclose "that on several days during the year", Woodridge was full and had to defer patients to other facilities. Woodridge's own records show that it has had deferrals on many occasions, not just on "several days during the year." This is especially true for Ex. 238, the WPH flow sheets from January 2015 through June 2015.

As shown by SBHK's proposed Finding 134 (Findings pp. 19-20) and proposed Finding 170 (Findings p. 31), MSHA witness Bailey, also testified (TR 583) that there are frequently difficulties with admitting patients into WPH because of limitations imposed by the types of units that WPH operates and those units' very distinct separate identities: "Now it is not simply I

discharge one, I admit one. If you discharge one on Cedar, you can't admit a person that needs Poplar to Cedar, because the units are very different and have very distinct identities; . . .".

The WPH "flow sheets" that are in this record, particularly those in Ex. 238 (the flow sheets from January 2015 to June 2015), demonstrate this, showing that on many days, there is a large number of potential patients listed in the "name of patient waiting" column, particularly for the months of May and June 2015. Furthermore, in Ex. 221, Mr. Sullivan provided a daily analysis of the flow sheets for the period of time March 2015 to June 2015 shows that WPH's "census" (a term utilized by WPH on the flow sheets themselves) frequently exceeded 90 to 95% occupancy for many days in those months in 2015.

In its proposed Finding 44, MSHA minimizes the impact of its "deferrals" on the potential WPH patients who experience them. MSHA admits that the term "deferral" still means that for patients who are deferred, treatment by and in a psychiatric hospital is delayed. Such delays are clearly not optimal for the patient -- even MSHA itself seeks to diminish such deferrals. This record shows that such deferrals can go on for several days for some patients. Bailey testimony, TR 638-639, and Ex. 46. Ex. 238, for example, in its May 11-12, 2015 entries (MSHA doc. nos. 2023-2034), shows a number of deferred potential patients who have been waiting for several days to gain admission to WPH. There are many other pages in Ex. 238 showing multi-day deferrals for many other potential WPH patients.

The chart of adolescent deferrals on p. 37 of SBHK's proposed Findings of Fact contains a typographical error in the heading of the "annual total" column. The corrected version is set forth below, with notes as to how the "annual total" was derived.

Source: Exhibit	Time Period	Adolescent Deferrals	Reason for Deferral: "No Bed"	Annual Total
Ex. 65	6/13 through 12/13	75	27	
Ex. 65	1/14 through 5/14	43	26	118*
Exs. 239-242	1/15 through 5/15	45	36	108**

* 118 equals the sum of 75 and 43, accounting for 12 months of deferrals.

**108 equals the annualization of the five months of 2015 data (45 deferrals in five months).

VII. The record demonstrates that currently hundreds of patients from SBHK's service area are traveling to Peninsula Hospital in Blount County and elsewhere to obtain inpatient psychiatric hospital care.

This record shows that hundreds of patients from SBHK's proposed service area have been traveling over 100 miles outside SBHK's proposed service area to obtain psychiatric inpatient psychiatric hospital services at Peninsula Hospital (in Blount County) and elsewhere. This fact proven by Dr. Collier's report establishes a need in the service projected by SBHK for more inpatient psychiatric services to be located in the service area itself. Thus, the project described by the SBHK CON application will provide "needed healthcare in the area to be served", thereby satisfying the statutory need criterion of the HSDA's guiding statute. As SBHK's proposed Finding 152, on page 25 of its proposed findings of fact, demonstrates, the record shows that Peninsula Hospital in Blount County is 113 miles from SBHK's proposed site in Kingsport, while Ridgeview in Oak Ridge is 123 miles from SBHK's proposed site in Kingsport. Ex. 9, p. 99.

MSHA's proposed Finding 37 states, "Moreover, SBH's financial and volume projections will require it to capture a significant number of patients from Johnson City." While Dr. Collier's testimony is quoted in support of this, Dr. Collier's own expert report, Ex. 381, sets forth in Ex. 14 thereto that even in Dr. Collier's "alternate service area", in 2013 WPH had a market share of only 57.2% of the patients. Ex. 14 also shows that in 2013, there were 826

patients from the "alternate service area" who were not served by either MSHA or Wellmont facilities. Of these 826 admissions, 495 were served by Peninsula Hospital in northwestern Blount County, south of Knoxville. Therefore, either using a comparative market share approach under Dr. Collier's analysis of WPH's market share in Ex. 14, or utilizing the patient flow beyond Knoxville or beyond the MSHA or Wellmont facilities, there is such a heavy patient flow involved that the MSHA's claim that SBH's volume projections will "require it to capture a significant number of patients from Johnson City" is not credible. Furthermore, there is no proof in this record regarding any patient flow from Johnson City itself. Dr. Collier's data (as to Washington County patients) in this exhibit to her report demonstrate that even if what MSHA's finding asserts is true, it is not at all clear that those patients drawn by SBHK from "Johnson City" or Washington County to SHBK are patients who otherwise would go to Woodridge.

The record in this matter demonstrates that MSHA's proposed Finding 45 contains a number of factual errors. The first error is MSHA's claim that "SBH was simply unable to point to any evidence that a significant number of patients from the service area are unable to access care or are out migrating (leaving the region for treatment.)" MSHA's proof in this record contradicts this proposed finding. For example, Ex. 17 to Dr. Collier's expert report, Ex. 381, specifically states that in 2013, Peninsula Hospital, located in western Blount County, Tennessee (south of Knoxville), received 10% of all the Blue Cross/commercial/managed care patients from the "SBH proposed service area." Similarly, Dr. Collier's Ex. 17 states that Peninsula Hospital received 14.7% of all the TennCare/Medicaid patients from SBH's proposed service area, and received 6.8% of all the Medicare patients from the SBH proposed service area in 2013. Thus, the record in this case proves that there is significant outmigration of patients insured by Medicare, TennCare, or commercial insurance to Peninsula Hospital, in western Blount County,

Tennessee, from the SBHK proposed service area. Therefore, the first sentence of MSHA's proposed finding number 45 is factually incorrect.

The proof from Ex. 17 of Dr. Collier's report, Ex. 381, also contradicts the second sentence in MSHA's proposed Finding 45. This sentence claims that "the small number of patients leaving the region" were receiving psychiatric treatment at Peninsula Hospital and Moccasin Bend in Chattanooga. This statement is incorrect: the record herein demonstrates that the number of patients leaving the region is large, not small. Ex. 13 to Dr. Collier's report indicates that 400 patients left the SBH proposed service area in 2013 for services in hospitals that are not owned by MSHA or Wellmont. These include: Peninsula Hospital, Parkridge Valley Child and Adolescent Campus, Vanderbilt University Hospital and Takoma Regional. Thus, there were 400 such patients who left SBH's proposed service area and went to facilities farther distant than any owned by MSHA or Wellmont. As noted earlier, Peninsula received 296 of such patients from the SBHK service area, or 74% thereof. Furthermore, with regard to patients who left Dr. Collier's "alternate service area", Ex. 17 shows that there were 826 such patients who went to facilities other than those owned by MSHA or Wellmont. Of these, Peninsula received 495, or 60%. Thus, it is erroneous, for MSHA to claim that there was only a "small number of patients leaving the region" to receive services at Peninsula or Moccasin Bend.

MSHA Finding 45 also states that Peninsula Hospital and Moccasin Bend are "both state institutions that specialize in treating chronically and severely indigent patients on a long-term basis." While this comment may be true for Moccasin Bend, which is now the state regional mental health institute serving northeast Tennessee, Peninsula Hospital is not a "state institution". If Peninsula Hospital were a "state institution", it would not, like Woodridge, have a state contract to care for indigent patients. Dr. Collier makes clear in footnote 1 to Ex. 17 in her

expert report that Peninsula is like Woodridge, and has a state contract to care for indigent patients. The state would not have to contract with Peninsula in the way that it does with MSHA if Peninsula were in fact a state institution, which is owned, operated and controlled by the state of Tennessee, as Moccasin Bend is. MHSAS would not have a "state institution" in Blount County after closing down Lakeshore Mental Health Institute in Knoxville in 2012. This claim by MSHA in its Finding 45 is untrue and unsupported by this record.

Thus, virtually all of MSHA's proposed Finding 45 is contradicted by this record. The final assertion of fact by MSHA in its proposed Finding 45 is also false: in this claim, MSHA asserts that "the only patients leaving the region for treatment are patients that SBH cannot treat (chronic long-term patients) or will not treat (indigent patients without the ability to pay)". Contrary to this assertion, the record establishes that many of the patients leaving SBHK's proposed service area to go to Peninsula are commercially insured, or covered by TennCare or Medicare. See Ex. 17 to Dr. Collier's expert report, Ex. 381. Thus, MSHA's proposed Finding 45 is unsupported by this record. Furthermore, even Dr. Collier's report credits SBHK with service of many indigent patients. Ex. 21 to Dr. Collier's report, Ex. 381.

VIII. MSHA has asserted matters in its proposed Findings of Fact that are either not in the record herein or are contradicted thereby.

MSHA proposed Finding 48 contains a statement that is not found anywhere in this record. In MSHA's proposed Finding 48, the third sentence reads as follows:

> The Quillen psychiatric department at East Tennessee State University has accepted responsibility for preforming [*sic*] an analytics-driven mental health assessment that will determine the actual psychiatric needs of northeast Tennessee and southwest Virginia.

While this provision cites two pages of testimony by MSHA CEO, as its source in this record, Allen Levine, nowhere in Mr. Levine's testimony or elsewhere in this record do all the facts

claimed by this sentence appear: in his testimony, Mr. Levine never mentions the "Quillen Psychiatric Department at East Tennessee State University"; he does not mention that any such department "has accepted responsibility" for anything; nor does he mention "the actual psychiatric needs of northeast Tennessee and southwest Virginia". Therefore, this sentence should be stricken from any findings of fact made here -- it simply has not been proven and does not appear anywhere in this record.

In its proposed Finding 41, MSHA erroneously asserts that SBH did not call a single medical provider from the Tri-Cities service area to establish that there are any access issues in the community. To the contrary, SBH called Dr. Harold Elliott, the former director of ETSU's psychiatry residency program, as a witness. He practiced psychiatry in the Johnson City area during the four years he served on the psychiatry faculty at ETSU's medical school. He continued to practice and serve patients in Johnson City and the surrounding area until he left his practice in mid-June 2015. The hearing in this matter came in July 2015; therefore, Dr. Elliott's testimony was based upon very recent experiences in the northeast Tennessee area regarding his views that there are significant needs for additional inpatient psychiatric facilities in northeast Tennessee. In fact, Dr. Elliott confirmed and reaffirmed, in his testimony, the comment he made in his letter of June 24, 2014, to the Executive Director of the HSDA that there was a "huge need for psychiatric services in the Tri-Cities area." He noted further in that letter, Ex. 207, "I have seen no evidence or data that opening a facility in Kingsport will threaten the existence of Woodridge." Therefore, the argument set forth in MSHA's Finding of Fact 41, concerning SBH's medical provider proof are erroneous, as shown by the record citations set forth above.

MSHA's proposed Finding 42 contains the assertion that, pursuant to the grant to MSHA from the Tennessee Department of Mental Health and Substance Abuse Services, MSHA serves

patients formerly sent to Lakeshore, the now-closed state regional mental health institution in Knoxville. Although in its proposed findings MSHA claims that those patients have a higher "acuity", that claim of higher "acuity" is not reflected what this record reveals about the average length of stay at WPH for MSHAS grant patients there. While the 2014 actual average length of stay data for all WPH patients as set forth in MHA's own documents, such as Ex. 253, was 5.74 days, Ex. 254 states that the average length of stay for WPH patients covered by the MHSAS grant was only 4.28 days in June of 2014. Ex. 67 states on its final page that the ALOS for WPH patients covered by the MHSAS grant was 4.26 days in July of 2014. Thus, WPH patients covered by the MHSAS grant have a lower ALOS than the ALOS for all WPH patients. Logically, this ALOS difference indicates that the MHSAS grant-covered patients at WPH are not of "higher acuity" than the average WPH patient. Ms. Bailey also testified at TR 599 that the ALOS at WPH of MHSAS patients there in August 2014 was 4.27 days.

In MSHA proposed Findings 64-66 in which it makes certain claims about the financial impact of SBHK on Woodridge, MSHA fails to account for the impact of the proposed adolescent CSU on the $1.1 billion in annualized revenues that MSHA received in 2014 or in the years thereafter. See Ex. 214 (MSHA experienced $791 million in total revenue, gains and support through the first nine months of FY 2015; annualized, that amount yields approximately $1.1 billion in total revenue, gains and support for MSHA in FY 2015 on an annualized basis.) Mr. Levine testified, at TR 897, that it is his intent, speaking on behalf of MSHA, for the adolescent patient volume at Woodridge to decline due to the projected establishment of the adolescent CSU in Washington County. Mr. Levine also testified at TR 898 that the establishment of the adolescent CSU's operations will have a financial impact on MSHA -- they

will reduce MSHA's revenues. Despite this, Mr. Levine seeks to reduce the volume of inpatient psychiatric admissions at WPH. Levine, at TR 920.

With regard to any asserted SBHK impact on WPH, MSHA fails to address in its proof and in its proposed findings the issue of WPH's legal status of being merely a "department" of Johnson City Medical Center. Ms. Bailey so described WPH at TR 588: WPH "is a department of Johnson City Medical Center." Mr. Sullivan testified at TR 396-397 that WPH is simply a service of Johnson City Medical Center ("JCMC"), and that therefore any analysis of "the impact" of SBHK's CON project on WPH must start with any "impact" on JCMC itself. He testified that JCMC had a bottom line profit of over $30 million in 2013, according to its JAR, and that figure was derived after MSHA's allocation of JCMC funds to MSHA's corporate overhead. JCMC's 2013 JAR, Ex. 83, indicates on page 19 thereof that its total expenses include "system overhead/management fees" of $36,255,432.

MSHA has never addressed or rebutted SBHK's assertions and proof that, because WPH is a satellite of JCMC, WPH and JCMC must evidence shared income and expenses, pursuant to federal Medicare regulations. MSHA has presented no proof whatsoever of any impact of the SBHK CON project on JCMC. Thus, any claim that SBHK's CON project will negatively impact WPH must look at the claimed impact as being on JCMC, not WPH alone. MSHA has admitted in its proposed Finding 12 that the "impact" measurement called for in the CON process is limited to impact on "other providers in the proposed service area." Neither WPH nor JCMC is in SBHK's proposed service area. Thus, even under MSHA's own interpretation of the HSDA CON process, assessment of the impact of SBHK's CON project on WPH is not called for. By failing to produce any proof of the SBHK's CON project on JCMC, MSHA has failed to show any impact of the SBHK CON project on any licensed hospital.

IX. MSHA's Findings concerning a proposed adolescent CSU are speculative, and do not support denial of the SBHK CON application.

Ms. Bailey testified that CSUs currently serve only people over 18. Bailey, TR 616. MSHAS Rule 0940-5-18(.01) specifically limits eligibility for CSU services to patients aged 18 years and older. As of the date of the filing of this brief, there is no indication in the Secretary of State's Administrative Register that MHSAS is undertaking any rulemaking activity to alter this prohibition of CSU services to patients under the age of 18.

Contrary to the implication by MSHA in its proposed Finding 56 that SBH should have considered establishing a "smaller adolescent CSU" to provide an alternative inpatient hospitalization, establishing a CSU could never be an option for SBH. Dr. Trivedi testified that a hospital company like SBH would not be permitted by the Tennessee Department of Mental Health and Substance Abuse Services to operate a CSU. As Trivedi testified at TR 858: "There is no desire in the state to have a hospital be the entity that is also managing the mobile crisis team or the CSU beds . . . ."

Contrary to MSHA's assertion in its proposed Finding 56 that the adolescent CSU will "offer an alternative to inpatient hospitalization and meeting additional demand that may be in the market for adolescent psychiatric services", neither Dr. Collier nor Mr. Sullivan counted the 15-bed adult CSU in Washington County as an inpatient psychiatric alternative in counting the inpatient psychiatric beds in either the SBHK's or the alternative service area. Furthermore, Ms. Bailey testified at TR 616 that the current CSU regulations do not permit patients under 18 to go to a CSU, and she further testified at TR 612 that CSUs and inpatient psychiatric hospital facilities serve different needs.

There is no certainty that any adolescent CSU will be established in northeast Tennessee. Dr. Elliott had heard nothing about it. TR 139. Dr. Trivedi is not involved in its establishment.

TR 860. Mr. Levine is not involved in any CSU activities. TR 896. Ms. Bailey testified that, as of July 29, 2015, there was no letter of intent or completed lease for the adolescent CSU. Dr. Jessee could not specify what any adolescent CSU revenue reimbursement rate would be. TR 672.

X. The record establishes that Strategic Behavioral Health's charity care definitions and budgeting resemble those of MSHA and WPH.

Mr. Shaheen's description of how he defines "uncompensated care" criticized by MSHA in its proposed Finding 60, is very similar to how MSHA's CEO Levine defined "uncompensated care" at TR 922-923:

> Q: What is charity care, in your understanding in Tennessee?
>
> A: Well, that word's used a lot and has different meanings to different people. In my view, when I hear the words "charity care" I'm hearing "uncompensated," people either don't have insurance, people who have insurance but they have capped out on their benefit, people who may be underinsured, in other words they have coverage, but they don't have coverage for that specific service.
>
> So, you know, different -- if you go to five different health systems, you'll get, I think, five different answers for how they account for uncompensated care. So, generally, when I hear "charity," I'm thinking those multiple pots.

In Finding 60 on page 27 of MSHA's proposed findings, MSHA criticizes SBH for its assertedly low (.53% of expenses) cost attributed to charity care. However, when Mr. Levine's testimony is analyzed with regard to the actual cost of charity care provided by MSHA itself, he testified, at TR 925, that the annual cost of charity care for Mountain States was around $20 million. As Ex. 214 indicates, Mountain States had expenses of approximately $770 million through the nine months of FY 2015, ending March 31, 2015. If the level specified in Ex. 214 of MSHA's expenses is annualized, MSHA's total expenses are approximately $1,027 million. (See also Ex. 211, p. 3: MSHA facilities operate "at approximately $1.0 billion in net revenues.") Thus, the $20 million testified to at TR 925 by Mr. Levine of MSHA's total cost of

charity care amounts to only 1.9% of MSHA's total expenses. Furthermore, in MSHA's proposed Finding 61, MSHA argues at length regarding Woodridge's bearing the largest share of indigent psychiatric care in the region. However, as WPH's 2014 Joint Annual Report indicates (Ex. 250, p. 18) the $14.5 million worth of charity care claimed by WPH on its 2014 JAR is the amount of charges, not the amount of costs. As Ex. 252 indicates, as recently as 2011, WPH provided only $85,680 in total charity care charges. Thus, it appears that, given Mr. Levine's testimony at TR 923-925, WPH's claims of over $14 million in charity care on its 2014 JAR include the difference between payments received by MSHA for MHSAS grant payments at WPH and the charges for the services WPH provides to MHSAS grant patients.

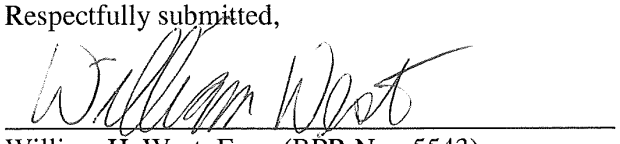
MSHA asserted in its proposed Finding 60 that SBH's proposed budgeted 4.5% of patients as uncompensated care was contradictory to SBH's cost of charity care of .53%. In Ex. 253, Woodridge itself, while budgeting 2.8% of its actual revenue for charity/self pay patients in 2013, actually allocated only .7% of its revenue to charity/self pay patients. Thus, Woodridge itself experiences gaps between what it budgets and what it actually provides with regard to charity/self pay patients in its hospital.

Contrary to the arguments by MSHA in its proposed Conclusion of Law No. 6 concerning SBH's alleged lack of intent to serve indigent patients, Mr. Shaheen testified at length at TR 192-186 that SBHK will take indigent patients, and that SBH strongly desires to contract with MHSAS for a contract similar to Ex. 53 for services to indigent patients. Also, Mr. Shaheen testified that Strategic Behavioral Health hospital facilities serve significant volumes of indigent patients at its facilities in Texas, Nevada and elsewhere.

CONCLUSION

For the reasons set forth in its Proposed Findings of Fact and Conclusions of Law and this Reply Brief, SBHK's CON application number CN1312-050, should be granted by the HSDA. SBHK has moved its burden of proof on all three of the statutory CON criteria of need, economic feasibility, and contribution to the orderly development of healthcare. SBHK's proof has not been rebutted by MSHA. Thus, the HSDA should approve CON application CN1312-050, and issue the requested CON to SBHK.

Respectfully submitted,



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The undersigned hereby certifies that a copy of the foregoing has been delivered via email to:

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this 19th day of November, 2015.

William West

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

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IN THE MATTER OF:	)	
	)	
SBH-KINGSPORT, LLC	)	**Docket No. 25.00-126908J**
	)	
Applicant,	)	
	)	
v.	)	
	)	
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
MOUNTAIN STATES HEALTH ALLIANCE,	)	
	)	
Intervenor.	)	

MOUNTAIN STATE HEALTH ALLIANCE'S REBUTTAL BRIEF

The rules and regulations of the Health Services Development Agency ("HSDA") require that an application identify a reasonable service area – a rational approximation of where a healthcare provider's patients will originate. Tenn. Comp. R. & Regs. R. 0720-9-.01(23). From this service area, the HSDA applies a population based formula and evaluates the negative impact of the project on existing providers. *See State Health Plan*, Psychiatric Inpatient Services Criteria; Tenn. Comp. R. & Regs. R. 0720-11-.01(3).

Both before and after filing its application, SBH determined its service area through the use of a 60-mile concentric circle surrounding its proposed psychiatric hospital. (Shaheen, Vol. 1, pp. 207:2-209:7; 229:23-239:5; Exs. 6, 10). MSHA's health planning expert, Dr. Collier, agreed that this was an appropriate methodology to construct a service area, although in her

opinion a smaller, 35-mile concentric circle, approximating a one-hour drive time, would be more a reasonable service area for SBH's proposed facility. (Collier, Vol. 4, p. 708:19-710:12, Ex. 381, Map 8). Alternatively, Dr. Collier testified that simply adopting the service area of Indian Path Pavilion, the psychiatric hospital across the street from SBH's proposed location that closed a few years ago, would also be reasonable. (Collier, Vol. 4, p. 710:13-712:2, Ex. 381, Map 3). Applying the State Health Plan's bed need formula to either alternative service area, in 2019, there will be a net bed need of approximately 30 total beds according to the State Health Plan's quantitative criteria, fewer than half of the 72 beds proposed by SBH.[1]

In an effort to circumvent the State Health Plan's quantitative criteria, SBH concocted a service area – for CON purposes only – which was obviously designed to generate an artificial "need" for its project. SBH cherry-picked counties to the west and northwest, connected to Kingsport by rural roads and over mountain ranges. SBH hired a litigation expert, Dan Sullivan, to generate rationalizations for this gerrymandered service area. SBH's gamesmanship is designed to circumvent both the spirit and the letter of the HSDA's rules, and should not be countenanced.

Despite Mr. Sullivan's efforts to explain away the inherent inconsistences between SBH's internal analyses and the service area it presented to this Court, SBH has failed to meet its burden in establishing the need for its new Project. When evaluating the "need", the Agency seeks to answer the following health planning questions:

1) Does a particular population have access to a medical service? (R. 0720-11-.01(1)(b))

[1] Using the 35-mile/one hour drive time service area, there will be a net bed need of 29.6 total beds in 2019 according to the State Health Plan's quantitative criteria. (Collier, Vol. 4, p. 710:13-712:2, Ex. 381 at Exhibit 12). Using Indian Path Pavilion's historic service area (which removes the populations Lee, Unicoi, and Russell Counties while also removing the 20 psychiatric beds at Clearview Center) there is a net bed need of 29.3 total beds in 2019. (Ex. 381 at Exhibits 8, 9, 11).

2) Are there existing providers serving this population? (R. 0720-11-.01(1)(c)) and
3) Will the proposed project unnecessarily negatively impact the existing providers? (R. 0720-11-.01(3)(b))

While Mr. Sullivan's presentation was long on national psychiatric statistics and broad generalizations about the condition of Tennessee's psychiatric population, he was never able to point the Court to specific deficiencies in the provision of psychiatric services in the Tri-Cities area. On occasion, Woodridge Psychiatric Hospital is full (and operating at the same occupancy level that is the target of SBH's other facilities). But SBH presented no testimony from any patients, referral sources, or providers currently practicing in the Tri-Cities to establish that there is a service gap that SBH's cookie-cutter 72-bed psychiatric hospital will fill.

To the contrary, through the testimony of Marlene Bailey, Dr. Randy Jessee, and Dr. Harsh Trivedi, MHSA established that Woodridge and other existing providers are meeting the needs of the psychiatric patients in the region. Ms. Bailey discussed the process improvements Woodridge has implemented to boost efficiency, decrease wait time for admission, and improve patient care. Woodridge operates at or around 85% capacity on a routine basis, demonstrating efficient use of its existing resources while maintaining exemplary patient satisfaction scores.

Dr. Jessee, as the vice president of Frontier Health, testified about the wealth of geographically-dispersed outpatient psychiatric services in the region. He also explained how MHSA and Frontier Health are collaborating to construct a 12-bed Crisis Stabilization Unit ("CSU") for adolescents, an innovative service which will help alleviate the need for some patients to be hospitalized.

Dr. Trivedi testified that a healthy mental health system is not achieved simply by building more inpatient beds, but rather by focusing on the creation of the right environment to stimulate growth of all levels of psychiatric care. Dr. Trivedi concluded that SBH's proposed 72

new inpatient beds are duplicative of existing community resources, and that there are more efficient and productive ways to address any needs in the region, such as the construction of the CSU.

Finally, Alan Levine, the CEO of MHSA, testified regarding how Tennessee's nonprofit hospitals, and MHSA in particular, continue to face ongoing economic challenges. MHSA must perform a delicate balancing act to stay financially healthy. SBH's proposed new hospital will primarily serve insured inpatients (i.e., the patients with the most generous reimbursement), leaving uninsured patients and lower-reimbursement services to existing providers, including Woodridge. This is a recipe for financial stress and instability.

In sum, the psychiatric health system in the Tri-Cities is working. A full spectrum of centralized inpatient and geographically dispersed outpatient resources are available and are being utilized. Moreover, the project will do real and lasting harm to a nonprofit system that is providing vital community services. As the HSDA concluded, the CON should be denied.

1. **The Health Planning Experts Agree that a Reasonable Total Service Area Is 90 to 95% of Patients**

The health planning experts in this case agreed that a reasonable total service area of a health care facility is the geographic area from which the facility can expect to receive 90 to 95 percent of its patients. (Sullivan, Vol. 2, p. 444:10-13; Collier, Vol. 4, 699:11-699:19). Inexplicably, SBH misquotes Dr. Collier's testimony in an effort to refute this consensus. In paragraph 129 of its Findings of Fact, SBH asserts that:

> **Collier had testified on direct as follows, at TR 699:**
>
> **Q: . . . When we say service area, what are we describing exactly?**
>
> **A: Well, it's the area that accounts for the vast majority of the patients receiving service of an institution..."**

In fact, Dr. Collier's complete, unedited answer was "Well, it's the area that accounts for the vast majority of the patients receiving service of an institution. **And I would agree, I think Mr. Sullivan said in his deposition and reaffirmed here that it would account for 90-95 percent of your patients."** (Collier, Vol. 4, 699:11-699:19).[2]

To wit, Mr. Sullivan had previously testified as follows:

Q. And I think you've told us that the total service area of a health care facility is where about 90 percent of the patients come from, right?

A. True.

(Sullivan, Vol. 2, p. 444:10-13). Furthermore, Mr. Sullivan conceded that at least 20 percent of SBH's patient volume will likely come from outside its proposed 5-county service area. (Sullivan, Vol. 2, p. 386:6-13). Mr. Sullivan attempted to avoid this admission by dividing SBH's service area into "primary" and "secondary," suggesting that the Court should only consider the "primary" service area. Mr. Sullivan's artificial distinction, however, is nowhere to be found in the rules, regulations, or statutes governing the HSDA. (Sullivan, 444:14-445:4).

Moreover, Mr. Sullivan's proposed distinction asks the Court to dispel with common sense. As discussed *supra*, the "reasonable service area" is the basis for answering the questions "Are there populations in the State in need of a particular service" and "Are there existing providers offering that service to those populations?" Here, there is no dispute that populations in SBH's proposed service area are currently accessing Woodridge and other area providers. In fact, in 2014, 24.9% of patients admitted to Woodridge were from Sullivan County, which represented the second highest volume from any one county. (Collier, Vol. 4, p. 706:3-706:17). Patients residing in other counties claimed as the service area constituted 36% of Woodridge's inpatients. (Collier, Vol. 4, p. 706:3-706:17).

[2] Hours later, in describing the differences between primary and total service area, Dr. Collier testified that the "vast majority" of primary service areas consist of 60-75% of the patient volume. (Collier, Vol. 4, p. 784:25-785:3).

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Any analysis of need and impact of this proposed project necessarily requires inclusion of Washington County and its environs. If the contrived and unreasonable service area is disregarded and an appropriate service area is applied to the project, it is undisputed that there is no need for a new 72-bed psychiatric hospital under the State Health Plan.

2. The Frontier/MHSA Adolescent CSU Will Create Functional Capacity in the Market

In addition to not being warranted by the quantitative criteria, the testimony of community providers showed that Woodridge is already meeting the needs of community, by helping to increase availability of inpatient beds, including the introduction of the joint venture with Frontier Health to establish a CSU for adolescents. SBH again misquotes trial testimony, suggesting that Mrs. Bailey "testified that CSUs and psychiatric hospital service different needs." (SBH Finding of Fact 194, p. 42). Admittedly, all of MHSA's witnesses agreed that the 72-hour CSU is designed to treat specific psychosocial stressors that can be resolved over a shorter period of time. (Trivedi, Vol. 4, p. 846:13-849:9; Jessee, Vol. 4, p. 659:15-665:17; Bailey, Vol. 3, p. 611:23-612:19). But Ms. Bailey also agreed that the CSU would be the equivalent of adding functional bed capacity to the region:

> If you did not have CSUs, many of those people who are going to the CSUs would require hospitalization because something less than a CSU would not be sufficient; so, therefore, there would be more people needing services inpatient going to Woodridge, one of those other hospitals in the area, Peninsula, Moccasin Bend. So the CSUs do prevent hospitalization.

(Bailey Vol. 3, p. 613:23-614:9).

Alternatively, SBH argues that once operational, the CSU will negatively impact MHSA's finances. (SBH Findings of Fact 193, 194). SBH ignores that MHSA will have a financial interest in the CSU through lease payments. But even if it would not receive any revenue, Mr. Levine explained the difference between the CSU and SBH's 72-bed project:

There's a fundamental difference in what we're talking about here.

> There's a difference between a patient not being admitted and us not getting the revenue because there's an alternative service that's a lower cost and more available in the community versus losing the revenue because there's a duplicate program being added. There's just a difference. And so here's my concern. If you have an impact to the contribution margin because an incremental number of children -- or adolescents are not admitted because they went to outpatient treatment, I view that as a good thing. If you have loss of margin at the -- frankly, at the level we're talking about, with duplication of inpatient beds, that contribution margin is going to get worse because the variable cost of what remains is going to go up. You then have to start subsidizing physicians for the lost revenue from the commercial business. And so the magnitude is very different than what we're talking about.

(Levine, Vol. 5, p. 899:4-900:10).

The HSDA's need criterion requires the Court to compare "the proposal to any existing applicable plans." The proposed 12-bed adolescent CSU will be operational in the next few months. (Jessee, Vol. 4, p. 659:15-665:17). To the extent there is need in the community, the CSU is a far more economical and efficient way to create functional bed capacity and will help avoid the necessity of inpatient hospitalization for many patients.

3. **SBH Will Not Treat Patients Currently Out-Migrating From the Region**

In an effort to minimize the adverse impact on MHSA and other existing providers, SBH suggests that it will capture the patients who are out-migrating from the region. (SBH Findings of Fact 152, 163). Not only do these patients represent a very small fraction of the total population SBH intends to treat, but the demographics of these out-migrating patients are not SBH's target market.

Data produced as part of SBH's application showed that only a small number of patients are currently leaving the region for care, demonstrating that the overwhelming majority of patients are receiving the psychiatric help they need in the Tri-Cities. (Ex. 9, p. 12; Sullivan, Vol. 2, p. 465:9-471:22). For those who do leave, almost all are receiving psychiatric treatment

at either Peninsula Hospital outside of Knoxville or Moccasin Bend in Chattanooga, both State-affiliated institutions that specialize in treating chronically and severely sick indigent patients on a long term basis. (Ex. 9, p. 12; Sullivan, Vol. 2, p. 465:9-471:22).

Neither SBH nor Mr. Sullivan ever performed an analysis of these out-migrating patients to determine why they are leaving, nor did they project what percentage, if any, would go to SBH if it opens. (Sullivan, Vol. 2, p. 468:23-469:20). SBH concedes that "state facilities are focused more on the chronic, longer-stay patients." (*Id.* at 470:2-471:2). These patients are typically uninsured, homeless, and have significant mental illness requiring long-term treatment. (*Id.*) SBH has no intention of treating this type of patient. SBH's average length of stay for its adult population is approximately nine days. Furthermore, SBH will target the insured patients with the highest reimbursement; in 2014, SBH only saw 150 indigent patients in all 8 of its hospitals. (Collier, Vol. 4, p. 728:9-731:8).

Even if SBH were to capture 100% of the out-migrating population, those patients would constitute less than 13% of SBH's Year 2 projected census, which was described as "conservative." SBH's remaining patients will come from the patient bases of existing providers, including Woodridge.

4. **Economic Feasibility of a Smaller Project Has Not Been Established**

SBH has submitted two proposed orders for the Court's consideration – the first approves the proposed 72-bed psychiatric hospital and the second approves a previously undescribed 62-bed hospital. The 62-bed proposal is a tacit admission that even using SBH's gerrymandered service area, there is not a need for the 28 new child and adolescent psychiatric beds proposed in the Project. (Collier, Vol. 713:12-715:22). SBH has offered no evidence that a smaller facility would be economically feasible. SBH's pro forma, its financial presentation to its ownership,

and its CON application were all based on constructing a 72-bed facility. Moreover, SBH's business model is predicated on the use it is 72-bed and 92-bed hospital prototypes, which it has used for all of its projects across the country. (Shaheen, Vol. 1, p. 225:14-226:15). No proof was offered at trial that a 62-bed hospital, or any smaller alternative, would succeed. The Court should not award a CON in the absence of any evidence supporting the size facility being sought.

Conclusion

MHSA submits that SBH has failed to meet its burden in establishing that its proposed 72-bed psychiatric hospital is needed, that it is financially feasible, and that it will contribute to the orderly development of healthcare. SBH's request for a Certificate of Need should be denied.

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SBH-KINGSPORT 000456

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Berkowitz, P.C.
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this 19th day of November, 2015.



BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	
SBH-KINGSPORT, LLC	**DOCKET NO: 25.00-126908J**

INITIAL ORDER

This matter came to be heard on July 27-31, 2015, before Leonard Pogue, Administrative Judge, sitting for the Tennessee Health Services and Development Agency (Agency) in Nashville, Tennessee. The Petitioner, Strategic Behavioral Health-Kingsport, LLC (SBHK), is represented by William West and Charles Grant. The Intervenor, Mountain States Health Alliance (MSHA), is represented by Brian Jackson and Travis Swearingen. The Agency was represented by James B. Christoffersen, General Counsel. This matter became ready for consideration on November 19, 2015, upon the parties' submission of proposed findings of fact and conclusions of law and rebuttal/reply briefs.

The subject of this hearing is the appeal filed by SBHK of the denial of a certificate of need (CON) to SBHK by the Agency for the establishment of a 72 bed psychiatric hospital in Kingsport, Tennessee. After consideration of the record in this matter, it is determined that the SBHK CON should be **GRANTED**. This decision is based upon the following findings of fact and conclusions of law.

FINDINGS OF FACT

I. PROCEDURAL BACKGROUND/PARTIES

1. On December 3, 2013, SBHK filed a CON application with the Agency to construct and operate a 72-bed mental health hospital in Kingsport, Tennessee at a cost of approximately $12 million, with the initiation of psychiatric services beginning in November, 2015.

2. On June 25, 2014, the Agency considered the SBHK application. A motion to approve the CON failed by a vote of four in favor of approval and four opposed. SBHK timely perfected its petition for a contested case proceeding on the denial of its CON application. MSHA, which had opposed the SBHK CON application before the Agency, was granted permission to intervene in the contested case.

3. SBH Kingsport is an entity formed by its parent company, Strategic Behavioral Health, LLC (SBH), a privately owned Memphis based psychiatric hospital company, to build and operate the proposed psychiatric hospital. SBH has acquired, developed, and operates eight psychiatric hospitals in North Carolina, Texas, New Mexico, Colorado and Nevada. SBHK will be SBH's first psychiatric hospital in Tennessee.

4. SBHK proposes that its hospital will have the following inpatient psychiatric bed components: 18 adult psychiatric beds, 28 child and adolescent psychiatric beds, 16 gero-psychiatric beds, and 10 chemical dependency beds. SBH has previously developed two facility prototypes, a 72 bed hospital and a 92 bed hospital, for use in its projects across the country.

5. MSHA is a Tennessee non-profit health care system with its principal offices in Johnson City, Tennessee and provides comprehensive medical care in 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. MSHA owns and operates 13 hospitals, including

Johnson City Medical Center (JCMC), a 501 bed regional tertiary referral and Level I trauma center, Indian Path Medical Center (IPMC), a 239 bed hospital in Kingsport, and Niswonger Children's Hospital, a 69 bed children's hospital in Johnson City.

6. MSHA, through JCMS's department known as Woodridge Psychiatric Hospital (WPH), operates an 84 bed psychiatric hospital in Johnson City that has 12 child and adolescent beds, 14 geropsychiatric beds, and 58 adult psychiatric beds. WPH's beds are in five separate buildings. WPH provides chemical dependency services in some of the adult psychiatric beds.

II. SERVICE AREA

A. Project Origins

7. In the summer of 2012, SBH began evaluating 95 potential expansion markets across the United States where the company might want to construct a new psychiatric hospital. One of the 95 potential locations identified by SBH was the "Tri-Cities." The Tri-Cities service market was defined to include both Johnson City and Kingsport. To evaluate these 95 markets for need, SBH identified all psychiatric providers located in a 60-mile radius. WPH was noted as the primary provider in the Tri-Cities area and other providers in the area were identified.

8. To project need, SBH applied a 30 bed per 100,000 population formula to these markets, the same formula dictated by the State Health Plan. SBH concluded that the Tri-Cities region ranked 34th in need for new psychiatric beds and that the area ranked 2nd in the country in terms of SBH's ability to staff the facility. SBH considered other metrics in its evaluation and in the final weighted analysis, the Tri-Cities ranked 15th out of 27 potential locations for a new psychiatric hospital.

9. James Shaheen is the President and founder of SBH. In early September 2013, Mr. Shaheen chose to proceed with the project and designated Michael Garone, SBH's Director

of Development, to take charge of the project. Mr. Garone's expertise is in marketing, not health care.

10. The first area SBH collected information from was Johnson City and SBH submitted an application for economic development incentives from the Johnson City Industrial Bond Board. In early October 2013, Mr. Garone visited the Tri-Cities and met with seven people, six of whom worked in Johnson City. Soon thereafter, SBH decided to place their proposed new hospital in Kingsport instead of Johnson City. Mr. Shaheen attributed the selection of Kingsport to Sullivan County being the most populated county in upper east Tennessee, a factor critical to staffing. Mr. Garone also noted in an email at that time that SBH chose not to be in Johnson City to avoid MSHA contesting the CON application. SBH did not create documents analyzing or setting out the need for a new psychiatric hospital in Kingsport versus the case for need in Johnson City.

B. Proposed Service Area

11. SBHK describes a service area consisting of five counties: Sullivan and Hawkins Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. In this five county service area, there are 12 inpatient psychiatric beds, all for adults, at Bristol Regional Medical Center (BRMC) in Bristol, Tennessee. SBHK did not provide in its application any projections of how many patients would come from any particular county or zip code within its claimed service area and did not perform a written analysis of historical patient patterns. Mr. Shaheen and Mr. Garone were involved in the development of the CON application but SBH did not engage a health planning expert to assist in determining the service area.

12. Several weeks after filing its CON application, SBH executives made an internal presentation to representatives of the company's owner setting forth the financial rationale and

summary for the proposed project. As part of the proposal, SBH identified a catchment area consisting of 25 mile and 50 mile radii around Kingsport to demonstrate where staff and patients would come from. SBH further identified its immediate market as the area within 25 miles of the facility that included, Ridgeview Pavilion with WPH and Magnolia Ridge at or just barely beyond the 25 mile distance. SBH's proposed catchment area used for its internal business analysis is similar to the service area MSHA has argued is appropriate for CON purposes.

13. IPMC has defined its service area (based on MSHA's 2012 Social Responsibility Plan) as Sullivan County and Hawkins County in Tennessee, plus Scott, Lee, Dickenson and Wise Counties in Virginia and in MSHA'S June, 2015 Community Health Needs Assessment IPMC's primary service area was listed as western Sullivan County, Hawkins County, Wise and Scott Counties. JCMC defines its service area as being six counties: Washington, Sullivan, Unicoi, Carter, Greene and Johnson (all Tennessee).

14. In 2013 HealthSouth Rehabilitation Hospital in Kingsport received 91% of its admissions from Sullivan and Hawkins Counties in Tennessee and certain Virginia counties. Wellmont Holston Valley Medical Center (Wellmont Holston) in Kingsport, in 2013, received 86.5 % of its admissions from Sullivan and Hawkins County in Tennessee and Scott, Wise and other counties in Virginia.

15. Daniel J. Sullivan was offered by SBHK as an expert witness in the areas of Tennessee CON issues and health care planning issues. After analyzing the CON application and reviewing various comparable facilities, Mr. Sullivan concluded that SBHK's service area is a reasonable basis on which to determine the need for a new behavioral health facility located in Kingsport.

16. Mr. Sullivan noted that Wellmont Holston received only 5.7% of its patients from Washington County, Tennessee in 2013 despite the fact that it is located in Kingsport. BRMC, the only psychiatric provider in Sullivan County (12 beds), received less than one percent of its psychiatric patients from Washington County and 42.1% of its psychiatric patients were from any of the five counties (including Sullivan County) in SBHK's service area. According to Mr. Sullivan, Indian Path Pavilion, a 61 bed psychiatric hospital formerly located in Kingsport, filed a CON in a project that involved combining IPMC and Indian Path Pavilion hospital licenses and described its primary service area as Hawkins and Sullivan Counties in Tennessee, and Wise, Scott and Lee Counties in Virginia. Mr. Sullivan acknowledged that adult and child/adolescent psychiatric services are more regional in nature.

17. Mr. Sullivan found that, in reviewing and acting upon CON applications, the Agency generally has accepted CON applicants' service area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients. Specifically, the Agency recently approved an application by Trustpoint Hospital in Rutherford County, Tennessee to expand its inpatient psychiatric bed capacity. In its application TrustPoint defined its service area as including only two counties, Rutherford and Bedford, and excluded the contiguous counties of Davidson and Williamson. Both Davidson and Williamson counties have other large and significant hospital providers of inpatient psychiatric services and Trustpoint's application indicated that Davidson County itself was the second largest source of its admissions, yet its defined service area of Bedford and Rutherford Counties was utilized by the Agency in analyzing the need for Trustpoint's additional psychiatric beds. Also, Rolling Hills Hospital, a psychiatric hospital in Williamson County, Tennessee had its CON application

approved with Rutherford and Bedford Counties included as part of Rolling Hills service area. Williamson County is contiguous to both Rutherford County and Davidson County.

18. It was the opinion of Mr. Sullivan that it is there is no reason to believe that a psychiatric hospital in Kingsport would be able to draw a significant number of people from Washington County when Washington County residents already have access to inpatient psychiatric care at WPH. He further testified that in health planning the primary service area is the source of approximately 75% of the patients and that he does not believe that Washington County's patients going to SBHK would be within the 75% of patients in the service area definition for a new hospital in Kingsport. Mr. Sullivan projected that approximately 20% of the patient volume at SBHK would likely come from outside the five county service area.

19. Mr. Sullivan did not analyze discharges from Indian Path Pavilion to see where its patients came. He opined that Indian Path Pavilion and WPH during the 2000s involved a different competitive marketplace than 2015. Specifically, Mr. Sullivan argued that after MSHA took over WPH (2005) a decision was made to expand psych services at WPH and de-emphasize those services at Indian Path Pavilion.

20. MSHA offered the testimony of Dr. Deborah Kolb Collier as an expert witness in the areas of Tennessee CON issues and health care planning/finance. Dr. Collier opined that SBHK gerrymandered its proposed service area to exclude consideration of existing psychiatric beds in the surrounding area. She noted that the SBHK CON application did not explain the quantitative basis for the service area and she was surprised that the service area stretches more than 35 miles northwest into an area of Virginia, while it extends only a few miles to the south, excluding Washington County, Tennessee and its population base.

21. Dr. Collier and Mr. Sullivan believe that in formulating a reasonable service area (if a provider does not already offer services in the area) one looks to identify a surrogate or proxy facility which can be used as a reasonable approximation of the proposed project. Dr. Collier opined that Indian Path Pavilion (open until 2009 and less than a mile from the proposed SBHK facility) was the most reasonable proxy. Dr. Collier analyzed Indian Path's historic patient origin mix to identify its service area. According to Dr. Collier, Washington County was the second highest county of origin for patients at Indian Path, accounting for almost 12% of admissions over its last three years of operation, with Hawkins County also almost at 12%. Scott County was fourth with 5.5 %. More patients originated from Washington County than Scott, Wise and Lee Counties combined. Sullivan and Hawkins Counties, Tennessee, and Wise and Scott Counties, Virginia accounted for 66.4% of Indian Path Pavilion's admissions in the 2007-2009 averaged data.

22. Dr. Collier examined existing patient origin data in determining what she considered a reasonable service area for SBHK's project. She concluded that there is flow of patients between Washington and Sullivan Counties for health services, including psychiatric services. From 2012-2014, 26% of patients admitted to WPH were from Sullivan County, which represented the second highest volume from any one county. Patients residing in other counties in the SBHK proposed service area also utilize WPH. Over a three year period, residents of the SBHK claimed service area constituted 36% of WPH's inpatients. Dr. Collier testified that Washington County is experiencing more growth than Sullivan County, particularly as it relates to the child and adolescent population, and that there is a population on the edge of Washington County that could as quickly access Kingsport as WPH.

23. Dr. Collier believes that SBHK's financial and volume projections will require it to capture patients from Johnson City and that SBHK will market its new facility to a broader service area. She determined that SBHK would need a 75% market share in its proposed service area to meet its projected volume and thinks that is unlikely. Dr. Collier concluded that a service area (11 counties, 6 in Tennessee and 5 in Virginia) that includes Washington County, Tennessee and other counties contiguous to Kingsport is a much more reasonable approximation of where SBHK's patients will likely originate. Two of these Virginia counties in Dr. Collier's alternate service area are not designated by MSHA as being part of IPMC's or JCMC's service areas.

24. Mr. Sullivan disagrees with Dr. Collier's proposed alternate service area definition. Mr. Sullivan opined that the area WPH serves is not relevant to what the service area should be for a hospital located in Kingsport, which is in a different location and situation, not part of a major medical center, and would be facing existing competition. He believes WPH currently has no real competition in terms of another comprehensive psychiatric hospital provider and that a hospital in Kingsport would thus have a significant competitive situation than does WPH. Mr. Sullivan thinks it would be very difficult for any psychiatric hospital in Kingsport to draw a material number of patients out of Washington County. Mr. Sullivan opined that the alternate service area proposed by Dr. Collier shows a need for 30 to 38 beds in that area.

25. Dr. Collier included Russell County and Washington County, Virginia in her alternate service area. Mr. Sullivan has not seen any data that would indicate a provider in Sullivan County would serve a material number of patients from Russell County; Russell County patients traveling to Kingsport would have to pass three psychiatric hospitals. Mr. Sullivan testified that he doubts a significant number of people from Washington County, Virginia would leave to go to a provider located in western Sullivan County, noting that neither Washington

County nor Russell County has been a significant source of patients for the HealthSouth hospital in Kingsport. Concerning Carter County, Tennessee, Mr. Sullivan stated that there is not a significant patient flow from Carter County to Kingsport's hospitals. With regard to patient flow to Kingsport from Unicoi County, patients from Unicoi would have to drive past WPH and go a considerable distance farther to get to SBHK. Mr. Sullivan noted that IPMC's recent Community Health Needs Assessment did not include Russell County or Washington County, Virginia or Carter County, Unicoi County or Greene County in Tennessee as part of its primary service area. Mr. Sullivan concluded that the orientation for the Kingsport area healthcare facilities is to the west and north in terms of where their patients come.

26. Mr. Sullivan did not perform the type of impact analysis that Dr. Collier performed because he did not have access to the proprietary information that had been available to Dr. Collier. With regard to Dr. Collier's use rate analysis, Mr. Sullivan, unlike Dr. Collier, was not able to utilize the Tennessee Hospital Association's (THA) detailed discharge data because only members of THA can have access to them. SBH is not a member of THA because it does not currently operate any hospitals in Tennessee.

III. NEED

27. Under the *Guidelines for Growth* bed need formula, Mr. Sullivan determined a total need of 92 beds in 2015, rising to 93 beds by 2020 for the proposed service area. Since the only inpatient psychiatric provider in the SBHK proposed service area is BRMC with its 12 beds, the net inpatient psychiatric bed need is 81 in 2015 and 82 beds by 2020. After applying the *Guidelines for Growth* inpatient psychiatric bed need formula, Mr. Sullivan opined the 72 beds proposed by SBHK is consistent with the overall net need.

28. Mr. Sullivan also analyzed the bed need for the individual categories of beds at the proposed facility, which include geropsychiatric, children and adolescents, and adult. He determined a need for 44 additional beds for adult inpatient psychiatric patients, which is in excess of SBHK's proposal for an 18 bed adult psychiatric unit and a 10 bed adult chemical dependency unit. No methodology exists for calculating chemical dependency bed need under the *Guidelines for Growth* formula, so Mr. Sullivan included the ten adult chemical dependency beds with the adult psychiatric beds. Mr. Sullivan also analyzed the need for the 65 and older population to determine the geropsychiatric bed need. In his expert opinion there is a need for that too.

29. With regard to the 18 and under age group population's bed need calculation, Mr. Sullivan determined that there was a need for 17 child and adolescent beds in 2015 and 15 such beds in 2019. SBHK is proposing 28 of these beds. Mr. Sullivan noted that while SBHK's proposal for 28 beds is in excess of the bed needs guidelines for this age group, very few inpatient psychiatric beds for this population exist in East Tennessee. Mr. Sullivan expects in-migration from outside the service area for child and adolescent patients to Kingsport, because of the paucity of inpatient psychiatric bed resources available for these patients in the area and, therefore, he felt it was prudent to have additional inpatient psychiatric bed capacity for child and adolescent services.

30. Dr. Collier determined, using her alternative service area, that there will be a net bed need of 30 total beds in 2019. Using Indian Path Pavilion's historic service area (which removes the populations of Lee, Unicoi, and Russell Counties while also removing the 20 psychiatric beds at Clearview Center), Dr. Collier found a net need of 29 total beds in 2019. She acknowledged that if Russell County, Virginia were excluded from her alternate service area,

that the bed need there would increase since Russell County's 20 psychiatric hospital beds would be excluded from the bed need calculations, along with Russell County's population. If Russell County is eliminated, her proposed alternate service area, under the *Guidelines for Growth* formula, would need 51 new psychiatric beds.

31. Dr. Collier found that 400 patients from SBHK's proposed service area went to facilities in Blount County and as far away as Vanderbilt in FY 2013. Of these 400, Peninsula Hospital in Blount County received 296 (74%).

32. Mr. Sullivan testified that Tennessee has seen a dramatic rise over the last 10-15 years in the number of inpatient psychiatric beds which have been closed, particularly as to state beds. The state regional mental health institute, Lakeshore Mental Health Institute, which had previously served eastern Tennessee, closed in 2012, thereby taking 250 licensed inpatient psychiatric hospital beds out of service in eastern Tennessee. The result is that the regional public mental health institute that now serves eastern Tennessee is Moccasin Bend in Chattanooga, which is over 200 miles from the Tri-Cities area. From 2005 to 2010, hospitals in Tennessee closed 462 psychiatric beds. State facilities typically focus on the chronic, longer stay patients who are typically uninsured.

33. Sullivan County is the ninth largest county in Tennessee by population, but it contains only 12 inpatient adult psychiatric hospital beds. Mr. Sullivan opined there is a high need for additional inpatient and outpatient services in SBHK's proposed five-county service area because the population has limited access to inpatient psychiatric services. According to Dr. Collier, the adolescent population of Sullivan and Hawkins Counties will decline from 2014 to 2019, but combined the adolescent population of Wise, Scott and Lee Counties in Virginia will

slightly increase from 2014 to 2019. There are no inpatient psychiatric facilities in Lee County, Virginia, or between Lee County and Kingsport. Population growth in the area is modest.

34. Dr. Collier concluded that compared to the Tennessee average there is higher use of inpatient psychiatric services by Sullivan County residents. In 2013, the state wide use rate was 938.6 per 100,000 population, compared to 1,026.8 for Sullivan County residents and 983.0 in Dr. Collier's alternative service area. Based on her statistical analysis, Dr. Collier believes there is no obvious access problem to psychiatric services in the SBHK proposed service area.

35. Mr. Sullivan opined that SBHK's application is consistent with the *Guidelines for Growth* both in terms of establishing a numerical need for beds, as well as satisfying the more qualitative aspects of its proposal.

36. Admissions at WPH have been growing at an increasing rate since 2011, and patient days are up by almost 32% since 2011. Since 2013, admissions are higher at WPH in FY 2015 by more than 23%, and patient days are higher by 3,936 patient days, or 17.7%. WPH had 89.5% occupancy for the month of May 2015, 89.9% occupancy in November 2014, and an occupancy rate of 88% for July 2015. MSHA CEO Alan Levine testified that his goal is for MSHA to have fewer inpatient psychiatric admissions, yet WPH grew by 15.5% in inpatient admissions from FY 2014 to FY 2015.

37. Marlene Bailey is the current director of behavioral health programs at WPH, where she has worked for the last 26 years. Ms. Bailey explained that when Lakeshore closed in mid-2012 WPH volunteered to take more patients who typically went to Lakeshore. According to Ms. Bailey, WPH required time to adjust not only to an increase in patient census but also an increase in the acuity of the patients who were previously being treated at Lakeshore. This

transition caused occasional operational issues which resulted in lag between patients presenting for psychiatric treatment and admission to WPH and a higher bed census.

38. As of May 31, 2015, admissions at WPH were running more than 1,000 admissions higher than the number of admissions MSHA had budgeted for WPH for the first 11 months of FY 2015. Dr. Collier forecasts WPH's future results from a period of WPH utilization (2010-2013) which was lower than the last half of FY 2014 and all of FY 2015. WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally. If WPH's utilization increases (as measured by patient days) were to continue at the FY 2015 numeric volume of increase, WPH will be close to 100% full in less than two years from FY 2015.

39. WPH's "patient flow sheets," contain patient data described by Ms. Bailey as a worksheet to show the number of beds available and needed at approximately 7:00 a.m. on the day reported. She noted that patient flow sheets are commonly filled out before discharges have been made on a particular day. Ms. Bailey explained that if a patient is listed as "deferred" on a patient flow sheet, it means that WPH cannot take that patient at that particular moment in time; however, deferred patients are sometimes admitted to WPH later on in the day after morning discharges occur. If a bed does not open at WPH, the deferred patient will be transferred to another available bed in the Tri-Cities region for care and while a patient is deferred, the patient continues to receive psychiatric treatment in a hospital setting. Mr. Sullivan testified that not many people are discharged from a psychiatric hospital between midnight and 7:30 in the morning. He believes the patient flow sheets provide a reasonably close count of the number of patients in the hospital on any given day. The census for 22 of 27 days in May 2015 showed that 90% or more of the WPH beds were occupied. Mr. Sullivan found that the highest levels in the four months of patient flow sheets he examined were as follows: on March 30, 2015, there were

82 patients, and 97.6% occupancy, which was repeated on April 26 and April 27 and on May 5, 2015, there was an occupancy rate of 98.8%. According to Mr. Sullivan, any occupancy at WPH of 76 beds or higher would constitute a WPH occupancy level in excess of 90%.

40. Mr. Sullivan reviewed WPH "deferral" data. (Sullivan defined a "deferral" to mean that if a patient was referred for admission to an inpatient psychiatric bed and could not be admitted, but was deferred for any reason; such action would be considered a "deferral." Deferral could mean that the patient was placed on a waiting list for later admission, or it could mean that the patient was referred to a different facility). He concluded that adult deferrals for the period of June 2013 through December 2013 show 365 deferrals and that 242 of those deferrals were for the following reason: "appropriate bed not available."

41. For the period of January through May 2014, there were 107 adult deferrals (70, appropriate bed not available); for the period of January through May, 2015 there were 194 adult deferrals (126, appropriate bed not available). For the period of January through May, 2014 there were 43 adolescent deferrals (26, no bed); for the period of January through May, 2015 there were 45 adolescent deferrals (36, no bed). In the January 2015 through May 2015 time period, 76 of the total of 194 adult deferrals were from Sullivan County, while 17 deferrals were from Hawkins County. January through May, 2015 resulted in an occupancy rate of 86.5% at WPH. The 172 psychiatric beds in the Tri-Cities region operated at 64% occupancy in 2013.

42. While WPH operates at or around 85% capacity on a routine basis, Ms. Bailey feels that WPH is meeting the current needs of patients and providers. Ms. Bailey testified that since WPH implemented its process improvements, WPH's deferrals have been reduced by half from 2013. Further, despite running at 85% capacity, WPH continues to receive outstanding patient satisfaction surveys and has very low restraint rates.

43. Mr. Sullivan testified that Allen Levine, the CEO of MSHA, issued a press release in April 2015, in which Mr. Levine stated: "Northeast Tennessee and southwest Virginia disproportionately suffer from serious health issues," including "addiction and access to mental health services" which need to be addressed. Mr. Levine explained that he has never advocated for more inpatient beds to be built and wants to drive down use rates by ensuring that alternative services are available in the community. MSHA performs annual community health assessments of Sullivan and Washington Counties. According to Mr. Levine, in the course of those community health assessments, no stakeholder has communicated a need for a new 72-bed inpatient hospital.

44. MSHA recently announced a task force to explore expanding treatment options for mental health and addiction. The task force will help identify areas where MHSA can invest in additional psychiatric services.

45. MSHA has entered into a collaborative relationship with Frontier Health to construct a 12 bed Crisis Stabilization Unit (CSU) for adolescents. The CSU has to receive licensing approval and, if approved, was on pace to be operational before the end of 2015. A CSU provides a level of care prior to psychiatric hospitalization and offers treatment geared towards assessment, evaluation, early intervention, and stabilization within a 24-96 hour time period. Some patients in a CSU can have the same or similar level of severity of psychiatric illness as an inpatient unit. This level of care is advantageous for those with specific psychosocial stressors (loss of job or relationship issues) or readily mitigated treatment issues (a patient who is decompensating due to not taking psychotropic medications). Tennessee currently has some adult CSU beds but no pediatric CSU beds have previously been implemented. Ms. Bailey believes that a CSU meets a different need than an inpatient psychiatric hospital and also

opined that without CSUs more individuals would be needing services at WPH or other area hospitals. The adult CSU located in Johnson City (opened in 2009) has not slowed WPH's utilization rates.

46. Dr. Harsh Trivedi serves as the Executive Director and Chief Medical Officer for Vanderbilt Behavioral Health, the Vice Chair for Clinical Affairs at the Vanderbilt Department of Psychiatry and Vanderbilt, and Regional Chief Medical Officer for the Vanderbilt Affiliated Health Network. Dr. Trivedi expressed that he was not a health planning expert or a financial expert. In Dr. Trivedi's opinion modern psychiatric care should focus on providing patient centered treatment at the level of care most appropriate for that patient. He opined that patients do not want to be locked in an institution or deprived of their civil liberties. Dr. Trivedi feels the SBHK would be duplicative and he would prefer to see a greater availability of lower levels of care.

47. Dr. Trivedi opined that the availability of CSU beds can impact the need for inpatient beds for patients of all ages. He believes that if more patients are treated as outpatients or in other treatment settings, then that should alleviate demand for existing licensed beds. Dr. Trivedi thinks that adding a 12 bed CSU for adolescents has the same impact as adding 28 inpatient adolescent beds to the service area. From a health planning perspective, Dr. Collier opined that the appropriate goal is not to build more inpatient psychiatric care but to try to substitute better community distributed services.

48. Mr. Shaheen testified that coverage changes under the federal Affordable Care Act, which became effective in insurance policy renewals after July 2014, have increased insurance coverage for inpatient psychiatric and substance abuse care and that since January

2015, SBH has seen significant increases in patients who have access to mental health and substance abuse care because of the Affordable Care Act insurance requirements.

IV. ECONOMIC FEASIBILITY

49. Mr. Sullivan opined that the SBHK project is economically feasible and that SBH had demonstrated that it had adequate funds to complete the project. He found SBHK's proposed project cost of $12 million was reasonable. He further opined that revenue projections were reasonably developed and that SBHK plans to participate in state and federal programs in terms of reimbursement. Mr. Sullivan believes that SBHK has demonstrated conformity with the state health plan criteria regarding economic feasibility.

50. With regard to any alternatives considered to the project, Mr. Sullivan testified that not building a facility in Kingsport would not be the best alternative, because such inaction would do nothing to address the shortage of inpatient psychiatric services and the lack of access to care that he feels currently exists in the area. He testified that it would be possible to build a facility smaller than 72 beds, but given that the *Guidelines for Growth* formula has identified a need for more than 72 beds and that the SBHK project would be serving a service area population of over 300,000 people, Mr. Sullivan opined that building a smaller facility would not be advantageous. He explained that an advantage of a larger psychiatric hospital facility is that it would enable the hospital to treat different patient segments within the populations it serves - a larger facility would create sufficient space within the hospital to separate children from adolescents. Mr. Sullivan was also of the opinion that having a larger facility gives the hospital a clinical advantage in terms of being able to separate patients into different treatment tracks depending on different diagnoses and patient needs. Lastly, he did not believe there would be an

alternative to the SBHK CON project that was less costly or more effective than this project for many of the same reasons listed above.

51. Mr. Shaheen testified that, after revenues of approximately $105 million in its FY 2014, SBH projected its revenues would be approximately $127 million in its FY 2015. As of July 2015, SBH was on track to achieve that revenue figure of $127 million for 2015 and had $70 million in its line of credit from commercial banks available to fund the project, as well as $25-30 million available in annual cash flow from the company. SBH's CFO, James Cagle, is licensed as a certified public accountant in Tennessee. Mr. Cagle testified that SBH's operating cash flows and credit availability establish that there is a very good likelihood that SBH can economically establish and maintain the SBHK CON project.

52. In Dr. Collier's opinion, SBH has not set forth sufficient evidence that the project is economically feasible as proposed, although she acknowledges that SBH has a sufficient line of credit to complete the project. She feels one cannot assess the economic feasibility of the project because SBHK failed to apply an accurate service area, and therefore, did not consider the appropriate socio-economic demographics and population density for the project, which effects utilization and financial projection. Dr. Collier testified that SBH did not use a distinct utilization projection for this project but based utilization projection on SBH's prior projects. Dr. Collier did not find any indication that SBH investigated other alternatives to its proposed hospital.

V. ORDERLY DEVELOPMENT

53. As to the statutory CON criterion of orderly development of healthcare, Mr. Sullivan opined that the SBHK project would contribute to the orderly development of healthcare. He noted that the CON application indicates the intent of SBHK to become an

integral part of the healthcare delivery system within its service area by reaching out to community based organizations involved in mental health treatment such as schools, law enforcement agencies and other types of outpatient mental health providers, to try to integrate their services. Mr. Sullivan opined that the SBHK project will be an enhancement to the overall delivery of mental health in the service area.

54. Mr. Sullivan testified that the positive effects attributable to competition were a material consideration supporting the grant of a CON for the proposed project and opined that SBHK would provide a competitive alternative to WPH and to MSHA. He feels that the project will attract additional healthcare professionals, specialized psychiatrists and other staff to the area. Mr. Sullivan believes that SBHK would provide services in ways different from MSHA, giving patients increased choices in terms of where they want to go and could potentially stimulate price competition as it relates to contracting with third-party payors in the market. From these standpoints, Mr. Sullivan opined that any duplication that might occur would be necessary duplication. He explained that in health planning, duplication can be either "necessary" duplication or "unnecessary" duplication. "Unnecessary" duplication would occur where there is no need for what is being proposed and the applicant is merely duplicating what another facility already provides; in the case of SBHK, any duplication that might occur would be "necessary" because more inpatient psychiatric beds are needed in the community.

55. With regard to the project's impact on existing area providers, Mr. Sullivan opined that BRMC primarily serves a Virginia focused population so WPH would be the primary facility that would be impacted. Mr. Sullivan's opinion is that the SBHK project will not materially impair MSHA's operation of WPH. According to Mr. Sullivan, MSHA personnel in

April 2014 projected that the impact of SBHK's operation on WPH in the first year to be $30,000 and the second year would be only about $50,000.

56. Mr. Sullivan believes that a factor limiting the impact of the SBHK project on WPH is that WPH is not a distinct hospital; rather, it is a department/service of or satellite hospital of JCMC. On the 2013 Joint Annual Report (JAR) of JCMC to the Tennessee Department of Health, JCMC reports that JCMC owns and operates WPH. The medical staffs of JCMC and WPH are integrated (Dr. Hal Elliott, a former director of the ETSU psychiatry residency program, testified that he was on the medical staff of JCMC while he practiced at WPH). Mr. Sullivan thinks that the more appropriate impact analysis would be to examine the impact of the SBHK project on JCMC or on MSHA. He testified that the 2013 JAR for JCMC indicated that JCMC had a bottom line profit of over $30 million in fiscal year 2013, and that even if the impact of SBHK were as large as was projected by Dr. Collier's projections, JCMC would not experience a significantly detrimental impact from it. Mr. Sullivan opined a new psychiatric hospital would not require JCMC to discontinue any services and that any impact of SBHK on JCMC would be that which results necessarily when a new facility is approved. He further opined that the weight of health planning analysis favors the benefits that accrue to the community from SBHK's project over and above any monetary impact on WPH or JCMC.

57. An analysis performed by Dr. Collier suggests that the presence of SBHK will result in 1,084 lost cases to WPH or a $1.5 million loss net income per year ($1.7 million if there is no indigent care at SBHK) based on the proposed service area. When Dr. Collier assumes patients come from her alternative service area, she shows a loss of $1.6 million ($1.9 million if there is no indigent care at SBHK). Dr. Collier's estimate was based on SBHK's application which projected a Year 2 occupancy rate of 72%. SBHK hopes to operate at 85% by Year 3 or 4.

As to fewer patients recently, WPH had more positive financial results with 3,724 patients in the first 11 months of FY 2014 than it had with 4,320 patients in the first 11 months of FY 2015.

58. Dr. Collier made no analysis of the effects of SBHK's hospital on JCMC. SBHK has not prepared an analysis examining the potential impact of SBHK on any existing provider.

59. Mr. Levine testified that MSHA has a yearly cash flow of $150 million a year with about $70 million representing debt service and $70 million a year in depreciation. In the last six years, MSHA has annually spent $30 million more than its cash flow on capital expenditures and reserving its debt. According to Mr. Levine, MSHA has a BBB-plus bond rating, but MSHA's financial performance metrics are below its bond class median in several respects and MSHA maintains its BBB-plus rating through successful management of its cash flow. If MSHA's bond rating was downgraded, MSHA would be faced with several million dollars per year in additional interest payments.

60. Mr. Levine believes that a loss of a couple of million dollars per year would require an examination of other services to offset the loss of revenue. He feels that a loss of insured patients at WPH may drive up the variable costs of its programs (in part, to help subsidize loss revenue for physicians).

61. Ms. Bailey described WPH as a safety net hospital for psychiatric patients in the region. WPH receives a grant from the State for patients it takes that previously would have been served at Lakeshore. The grant with the State is reviewed annually for renewal and is subject to change and reduction without notice. When WPH sees more indigent patients than are covered by the grant amount (which has occurred every year), WPH must petition the State to cover the remaining costs. SBHK has not had any conversations directly with representatives from the State about caring for the indigent patients formerly seen at Lakeshore. SBHK believes it makes

sense for those patients to continue to be seen at WPH since there is a reimbursement mechanism in place even after SBHK opens.

62. In its application, SBHK projects that 5% of its patient volume will be charity care. In written discovery, SBHK listed 4.5 % of its patients are uncompensated. SBHK's definition of uncompensated care includes bad debt, denials, and administrative adjustments. When an auditor reviewed SBH's 2014 financials, it noted that SBH "maintains records to identify and monitor the level of charity care it provides" and that "[t]hese records include the amount of charges foregone for services and supplies furnished under its charity care policy." Dr. Collier testified that she did not see in documents produced by SBHK any precise breakdown of charity patients. According to the auditor's report, $491,000 of SBH's total expenses of $92 million in 2014 was attributed to charity care. Extrapolating this expense ratio, Dr. Collier estimates that SBH saw 150 indigent patients in all 8 of its hospitals in the country in 2014.

63. The treatment staff at SBHK will include licensed physicians who will be board certified or board eligible in adult or child and adolescent psychiatry. Medical surgical nurses will be on staff to serve on the geriatric units. Behavioral health therapy will be delivered by masters level therapists, and some who are license eligible, as well as case managers. While SBH does not employ physicians, its facilities utilize the open medical staff model, as will SBHK. Mr. Shaheen testified that SBH is able to recruit new physicians into the community as well as to permit established physicians in the community to be on its medical staff. Mr. Shaheen stated that while there is a shortage of child and adolescent psychiatrists in the Tri-Cities the revenues SBH generates enables it to recruit board certified child and adolescent psychiatrists to the communities in which its facilities are located.

64. At all SBH facilities, except those in North Carolina, SBH offers outpatient services as well as inpatient services. It also offers partial hospitalization programs. In outpatient programs at SBH facilities, it is not necessary for a participant to have been an inpatient in any SBH hospital prior to utilizing the programs. SBH asks its physicians to participate in outpatient therapy and shares its therapists with the community. SBH takes both voluntary and involuntary patients.

CONCLUSIONS OF LAW

1. The Administrative Law Judge sits without the Agency in this de novo hearing pursuant to Tenn. Code Ann. § 68-11-1610.

2. The party petitioning for the hearing bears the burden of proof to establish, by a preponderance of the evidence, that the CON should be granted or denied. Tenn. Comp. R. & Regs. Rule No. 0720-13-.01(3). SBH has the burden of proof to establish that the SBH CON should be granted.

3. Pursuant to T.C.A. § 68-11-1609(a), the Agency shall approve part or all of the CON application or disapprove part or all of the CON application.

4. Tenn. Code Ann. § 68-11-1609(b) provides:

> No certificate of need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care facilities or services. In making such determinations, the agency shall use as guidelines the goals, objectives, criteria and standards in the state health plan. Until the state health plan is approved and adopted, the agency shall use as guidelines the current criteria and standards adopted by the state health planning and advisory board, and any changes implemented by the planning division pursuant to § 68-11-1625. Additional criteria for review of applications shall also be prescribed by rules of the agency....

Therefore, the CON can be approved only if it satisfies the three criteria set forth above.

5. Pursuant to T.C.A. § 68-11-1609(b) the Agency should use "*Tennessee's Health: Guidelines for Growth,*" 2000 edition (*Guidelines*) as guidelines until such time as a comprehensive state health plan is prepared. The *Guidelines* sets forth a specific methodology for determining need for many types of health care services, including inpatient psychiatric hospital services. The applicable Guidelines for Growth section provides as follows (2000 edition) as to "Psychiatric Inpatient Services:"

A. Need

1. The population-based estimate of the total need for psychiatric inpatient services is 30 beds per 100,000 general population (using population estimates prepared by the Department of Health and applying the data in Joint Annual Reports).

2. For adult programs, the age group of 18 years and older should be used in calculating the estimated total number of beds needed.

3. For child inpatient under age 13 and if adolescent program the age group of 13-17 should be used.

4. These estimates for total need should be adjusted by the existing staffed beds operating in the area as counted by the Department of Health in the Joint Annual Report.

B. Service Area

1. The geographic service area should be reasonable and based on an optimal balance between population density and service proximity or the Community Service Agency.

2. The relationship of the socio-demographics of the service area, and the projected population to receive services, should be considered. The proposal's sensitivity to and responsiveness to the special needs of the service area should be considered including accessibility to consumers, particularly women, racial and ethnic minorities, low income groups, and those needing services involuntarily.

C. Relationship to Existing Applicable Plans

1. The proposal's relationship to policy as formulated in state, city, county, and/or regional plans and other documents should be a significant consideration.
2. The proposal's relationship to underserved geographic areas and underserved population groups as identified in state, city, county and/or regional plans and other documents should be a significant consideration

3. The impact of the proposal on similar services supported by state appropriations should be assessed and considered.

4. The proposal's relationship to whether or not the facility takes voluntary and/or involuntary admissions, and whether the facility serves acute and/or long-term patients, should be assessed and considered.

5. The degree of projected financial participation in the Medicare and TennCare programs should be considered.

D. Relationship to Existing Similar Services in the Area

1. The area's trends in occupancy and utilization of similar services should be considered.

2. Accessibility to specific special needs groups should be an important factor.

E. Feasibility

The ability of the applicant to meet Tennessee Department of Mental Health licensure requirements (related to personnel and staffing for psychiatric inpatient facilities) should be considered.

6. Rule 0720-11-.01 of the Rules of the Tennessee Health Services and Development

Agency sets forth additional criteria for review of CON applications as adopted by the Agency:

GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

(a) The relationship of the proposal to any existing applicable plans;

(b) The population served by the proposal;

(c) The existing or certified services or institutions in the area;

(d) The reasonableness of the service area;

(e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;

(f) Comparison of utilization/occupancy trends and services offered by other area providers;

(g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(3) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition;

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers;

(d) The quality of the proposed project in relation to applicable governmental or professional standards.

7. Rule 0720-11-.01(23) of the Rules of the Tennessee Health Services and Development Agency provides that "'Service area' means the county or counties, or portions thereof, representing a reasonable area in which a health care institution intends to provide services and in which the majority of its service recipients reside."

NEED

8. SBH was initially drawn to the Kingsport area by doing a national evaluation of psychiatric bed need. MSHA questions the process SBH used in formulating its SBHK CON request. However, the need criterion of the Agency in weighing a CON does not prescribe a certain protocol to be followed in developing an application. The applicant must demonstrate a need for the project and satisfy the other statutory criteria for the grant of the CON by the Agency.

9. The designated service area should be reasonable. Including Washington County, Tennessee and other nearby counties in the proposed SBHK service area may arguably create a more reasonable service area than that proposed. Yet, the rules of the Agency specifically

provide that "service area" means the counties representing a reasonable area in which the services are provided and in which the majority of its service recipients reside.

10. The two health care planning experts in this matter, both deemed credible, differ as to whether the SBHK proposed service area is reasonable. They examined the region's past and current health care providers' service areas in support of their respective positions. Similar to SBHKs designated services area, several medical facilities in Kingsport and Sullivan County (including MSHA's IPMC) have service areas that consist of Sullivan and Hawkins Counties and a few counties in Virginia, while excluding Washington County, Tennessee. The Agency has accepted CON applicants' service area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients.

11. The prior psychiatric hospital in Kingsport, Indian Path Pavilion, drew just 12% of admissions over its last three-years of operation (2007-09) from Washington County. From 2012-2014, 26% of patients admitted to WPH were from Sullivan County. In 2013, both Wellmont Holston in Kingsport and BRMC had very few patients from Washington County and four of the five counties in the proposed area accounted for approximately 66% of Indian Path Pavilion's admissions from 2007-2009. Mr. Sullivan projected that approximately 20% of the patient volume at SBHK would likely come from outside the five-county service area.

12. Not including a contiguous county (Washington, Tennessee) where some patients may originate does not make the service area unreasonable. SBHK has established that its designated service area is reasonable.

13. A 72 bed facility for the proposed service area meets the *Guidelines for Growth* bed need formula. Applying Indian Path Pavilion's service area the need is 29 beds in 2019;

using Dr. Collier's alternative service area the need is 30, though eliminating one county in Virginia (Russell) increases the need to 51.

14. Admissions and patient days at WPH have been growing steadily since 2011 with a considerably higher number of admissions than budgeted for fiscal year 2015 (as of May 31, 2015). Occupancy at WPH in 2015 (January-May) has been between 82-89%. There were days in 2014 and 2015 (January-May) when WPH had in excess of 90% occupancy and deferrals because a bed was not available for both adults and adolescents.

15. Population growth is not spurring the need for more beds; nonetheless, Sullivan County is the ninth largest county in Tennessee by population, but it contains only 12 inpatient adult psychiatric hospital beds. Hundreds of patients from SBHK's proposed service area have been traveling over 100 miles outside SBHK's proposed service area to obtain psychiatric inpatient psychiatric hospital services at Peninsula Hospital (Blount County) and elsewhere. The presence of SBHK could eliminate some of this out of service area inpatient psychiatric patient flow.

16. MSHA is actively working to provide mental health services to the region. It is assisting with treating patients who previously went to Lakeshore and is collaborating on a CSU project. A CSU should decrease the need for inpatient psychiatric beds. However, as evidenced by the Johnson City adult CSU not curtailing WPH's utilization rate, a CSU in of itself does not alleviate the total need for inpatient beds for some CSU patients and non-CSU patients.

17. When all of need criterion are considered, SBHK has established, by a preponderance of the evidence, that SBHK is necessary to provide needed health care to the proposed service area.

ECONOMIC FACTORS

18. SBH has adequate funds through its cash flow and line of credit to complete the project and the projected project costs are reasonable. Mr. Sullivan found the revenue projections also to be reasonable and SBHK will participate in Medicare and Medicaid. Dr. Collier's criticisms of the economic feasibility of the project are primarily based on her opinion that the proposed service area is inappropriate.

19. As to alternatives to the project, Mr. Sullivan did acknowledge that it would be possible to build a facility smaller than 72 beds. However, he felt the need for a 72 bed facility exists under the *Guidelines* formula and that there are advantages to a larger facility in terms of spacing and separating age groups.

20. The *Guidelines* address feasibility in terms of the ability of the applicant to meet Tennessee Department of Mental Health licensure requirements related to personnel and staffing for psychiatric inpatient facilities. SBH has retained and recruited the requisite personnel at its other facilities and should be able to draw upon its resources to do the same at SBHK.

21. When all of these factors are considered, SBHK has established by a preponderance of the evidence, that SBHK can be economically accomplished and maintained.

ORDERLY DEVELOPMENT

22. SBHK proposes to provide 5% indigent or charity care, take Medicaid/Medicare patients, accept involuntary patient commitments and participate in the TennCare program. SBH has been able to attract medical professionals to staff its other facilities and there was no indication it could not do so for SBHK. The area should benefit from the addition of healthcare professionals.

23. The only provider of inpatient beds in the proposed service area, BRMC, has only 12 beds which generally service an adult population; SBHK would provide additional beds for this population as well as for children and adolescents. The presence of SBHK should enhance the overall delivery of mental care in the area.

24. WPH would be the facility most impacted by SBHK. WPH is safety-net hospital for psychiatric patients in the region and plays a vital role in the area serving TennCare, Medicaid and patients formerly seen at Lakeshore. Dr. Collier estimates a possible loss of $1.5 million per year to WPH if SBHK is built, though WPH did have more positive financial results with 3,724 patients in the first 11 months of FY 2014 than it had with 4,320 patients in the first 11 months of FY 2015. The impact of SBHK on WPH is limited by the fact WPH is a satellite or department of JCMC and consideration should be given to SBHK's impact on JCMC and MSHA. No expert analysis was done regarding the effect of SBHK on JCMC or MSHA. JCMC had profits of over $30 million in fiscal year 2013 and MSHA is financially operationally healthy. Any adverse impacts on WPH/JCMC/MSHA by the approval of SBHK are outweighed by the benefits that accrue to the community from SBHK and the provision of the additional inpatient psychiatric beds that SBHK brings.

25. When all of these factors are considered, SBHK has established, by a preponderance of the evidence, that SBHK will contribute to the orderly development of adequate and effective health care facilities and care.

CONCLUSION

SBH-Kingsport having established by a preponderance of the evidence that the application for a Certificate of Need for a 72 bed psychiatric hospital in Kingsport, Tennessee meets the statutory and regulatory criteria, it is hereby **ORDERED** that the Certificate of Need filed for SBH-Kingsport be **GRANTED.**

It is further **ORDERED,** pursuant to Tennessee Code Annotated § 68-11-1610(i), that all of the costs of this contested case proceeding are assessed to and shall be paid by MSHA.

This Initial Order entered this 8th day of February, 2016.

Leonard Pogue
Administrative Judge

Filed in the Administrative Procedures Division, Office of the Secretary of State, this 8th day of February, 2016.

J. Richard Collier, Director
Administrative Procedures Division

BEFORE THE COMMISSIONER OF THE TENNESSEE DEPARTMENT OF HEALTH

IN THE MATTER OF:

SBH-Kingsport, LLC **DOCKET NO.: 25.00-126908J**

NOTICE

ATTACHED IS AN INITIAL ORDER RENDERED BY AN ADMINISTRATIVE JUDGE WITH THE ADMINISTRATIVE PROCEDURES DIVISION.

THE INITIAL ORDER IS NOT A FINAL ORDER BUT SHALL BECOME A FINAL ORDER UNLESS:

1. THE ENROLLEE FILES A WRITTEN APPEAL, OR EITHER PARTY FILES A PETITION FOR RECONSIDERATION WITH THE ADMINISTRATIVE PROCEDURES DIVISION NO LATER THAN **February 23, 2016.**

YOU MUST FILE THE APPEAL, PETITION FOR RECONSIDERATION WITH THE ADMINISTRATIVE PROCEDURES DIVISION. THE ADDRESS OF THE ADMINISTRATIVE PROCEDURES DIVISION IS:

SECRETARY OF STATE
ADMINISTRATIVE PROCEDURES DIVISION
WILLIAM R. SNODGRASS TOWER
312 ROSA PARKS AVENUE, 8th FLOOR
NASHVILLE, TENNESSEE 37243-1102

IF YOU HAVE ANY FURTHER QUESTIONS, PLEASE CALL THE ADMINISTRATIVE PROCEDURES DIVISION, **615/741-7008 OR 741-5042, FAX 615/741-4472.** PLEASE CONSULT APPENDIX A AFFIXED TO THE INITIAL ORDER FOR NOTICE OF APPEAL PROCEDURES.

APPENDIX A TO INITIAL ORDER
NOTICE OF APPEAL PROCEDURES

Review of Initial Order

This Initial Order shall become a Final Order (reviewable as set forth below) fifteen (15) days after the entry date of this Initial Order, unless either or both of the following actions are taken:

(1) A party files a petition for appeal to the agency, stating the basis of the appeal, or the agency on its own motion gives written notice of its intention to review the Initial Order, within fifteen (15) days after the entry date of the Initial Order. If either of these actions occurs, there is no Final Order until review by the agency and entry of a new Final Order or adoption and entry of the Initial Order, in whole or in part, as the Final Order. A petition for appeal to the agency must be filed within the proper time period with the Administrative Procedures Division of the Office of the Secretary of State, 8th Floor, William R. Snodgrass Tower, 312 Rosa L. Parks Avenue, Nashville, Tennessee, 37243. (Telephone No. (615) 741-7008). See Tennessee Code Annotated, Section (T.C.A. §) 4-5-315, on review of initial orders by the agency.

(2) A party files a petition for reconsideration of this Initial Order, stating the specific reasons why the Initial Order was in error within fifteen (15) days after the entry date of the Initial Order. This petition must be filed with the Administrative Procedures Division at the above address. A petition for reconsideration is deemed denied if no action is taken within twenty (20) days of filing. A new fifteen (15) day period for the filing of an appeal to the agency (as set forth in paragraph (1) above) starts to run from the entry date of an order disposing of a petition for reconsideration, or from the twentieth day after filing of the petition, if no order is issued. See T.C.A. §4-5-317 on petitions for reconsideration.

A party may petition the agency for a stay of the Initial Order within seven (7) days after the entry date of the order. See T.C.A. §4-5-316.

Review of Final Order

Within fifteen (15) days after the Initial Order becomes a Final Order, a party may file a petition for reconsideration of the Final Order, in which petitioner shall state the specific reasons why the Initial Order was in error. If no action is taken within twenty (20) days of filing of the petition, it is deemed denied. See T.C.A. §4-5-317 on petitions for reconsideration.

A party may petition the agency for a stay of the Final Order within seven (7) days after the entry date of the order. See T.C.A. §4-5-316.

YOU WILL NOT RECEIVE FURTHER NOTICE OF THE INITIAL ORDER BECOMING A FINAL ORDER

A person who is aggrieved by a final decision in a contested case may seek judicial review of the Final Order by filing a petition for review in a Chancery Court having jurisdiction (generally, Davidson County Chancery Court) within sixty (60) days after the entry date of a Final Order or, if a petition for reconsideration is granted, within sixty (60) days of the entry date of the Final Order disposing of the petition. (However, the filing of a petition for reconsideration does not itself act to extend the sixty day period, if the petition is not granted.) A reviewing court also may order a stay of the Final Order upon appropriate terms. See T.C.A. §4-5-322 and §4-5-317.

BEFORE THE TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

IN THE MATTER OF:	
SBH-KINGSPORT, LLC VS. HEALTH SERVICES AND DEVELOPMENT	**DOCKET NO: 25.00-126908J**

NOTICE OF APPEAL OF THE INITIAL ORDER

An Appeal of the Initial Order was filed on **February 23, 2016.**

The Initial Order DID NOT BECOME FINAL and record of the case will be transmitted to the agency for review and a Final Order pursuant to T.C.A. §4-5-315.

J. Richard Collier

J. Richard Collier, Director
Administrative Procedures Division

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of this Notice of Appeal has been served upon counsel for all interested parties by delivering same to their offices or by placing a true and correct copy of same in the United States mail, postage prepaid.

This the 25th day of February 2016.

By: Nina Parham
Administrative Procedures Division

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

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IN THE MATTER OF:	)	
	)	**Docket No. 25.00-126908J**
SBH-KINGSPORT, LLC	)	
	)	**CON no. CN1312-050**
Applicant.	)	

MOUNTAIN STATES HEALTH ALLIANCE'S PETITION FOR APPEAL OF ADMINSTRATIVE JUDGE'S INITIAL ORDER

Pursuant to Tenn. Code Ann. §§ 4-5-315 and 68-11-1610, Respondent Mountain States Health Alliance ("MHSA") respectfully requests that the Health Services and Development Agency review and reverse the Initial Order entered in this proceeding on February 8, 2016. The Administrative Law Judge overturned the action of this Agency and granted a Certificate of Need ("CON") to SBH-Kingsport, LLC. The Initial Order is contrary to this Agency's rules and regulations and is inconsistent with the State Health Plan.

CASE OVERVIEW

1. MHSA is a non-profit health care system with its principal offices in Johnson City. MSHA provides comprehensive medical care to 29 counties in Tennessee, Virginia, Kentucky, and North Carolina. MSHA owns and operates 13 hospitals, including Johnson City Medical Center, a 501-bed regional tertiary referral and Level I trauma center, Indian Path Medical Center, a 239-bed hospital in Kingsport, and Niswonger Children's Hospital, a 69-bed children's hospital in Johnson City that is one of only six St. Jude Affiliate Clinics and serves more than 200,000 children in the area. As one of the largest TennCare providers in the State, MSHA plays an essential role in supporting the TennCare program. In Fiscal Year 2014, MSHA provided more than $40 million in unreimbursed care to Medicaid and TennCare patients, and

more than $20 million in charity care, as well as subsidized health care and community health improvement services totaling approximately $90 million.

2. MSHA's hospitals also include Woodridge Psychiatric Hospital ("Woodridge"), an 84-bed facility in Johnson City that treats more than 4,000 inpatients a year. When Lakeshore Mental Health Institute, the public psychiatric hospital for East Tennessee, closed in mid-2012, Woodridge volunteered to become the primary provider for psychiatric patients who were historically cared for in state psychiatric hospitals. Woodridge has served more than 3,000 such patients since that time. MHSA also promotes intensive outpatient mental health programs in outlying communities so patients can avoid the expense and inconvenience of inpatient care.

3. Strategic Behavioral Health ("SBH") is a privately-owned, for-profit company that develops, owns and operates psychiatric hospitals. SBH currently operates eight facilities in Nevada, New Mexico, North Carolina, and Texas. SBH served only 150 charity patients in all 8 of its hospitals in 2014. SBH does not currently own or operate any hospitals in Tennessee.

4. On December 13, 2013, SBH filed an application for a CON to build a new, freestanding 72-bed psychiatric hospital in Kingsport. As discovered during the contested case proceeding, this project was not conceived to address any community healthcare need, but was conceived solely to further the financial objectives of SBH, who decided to pursue the project mainly because of cheap building and labor costs in the Tri-Cities. SBH initially planned to locate its new hospital in Johnson City, but moved the location to Kingsport in an effort to avoid opposition to its CON, not for any legitimate health planning reason. Moreover, SBH's plan to build 72-bed facility is not based on any analysis supporting a need for 72 beds, but is based solely on SBH's 72-bed architectural plan "template" that it builds throughout the country.

5. The Agency considered the SBH application at its regular meeting on June 25, 2014. MHSA opposed the application. At the hearing, MHSA explained that SBH's project is duplicative and will not offer any services not already available in the Tri-Cities area. MHSA also pointed to SBH's lack of commitment to care for uninsured patients, including public statements by SBH officials that indigent patients could continue to be seen at Woodridge, to establish that SBH's project is focused on serving well-insured and affluent patients with significant adverse consequences to Woodridge.

6. After presentations from both parties, and comments from the Tennessee Department of Mental Health, which did not support the project, the Agency denied the application by a 4-4 vote. SBH subsequently filed its Petition for Contested Case pursuant to Tenn. Code Ann. §§ 68-11-1601, *et seq.*

7. The contested case hearing was held on July 27-31, 2015, before Leonard Pogue, Administrative Law Judge (the "ALJ"), sitting for the Agency. On February 8, 2016, the ALJ entered an Initial Order reversing the Agency's decision and granting a CON to SBH.

REASONS TO ACCEPT REVIEW

The Agency should exercise its authority under Tenn. Code Ann. §§ 4-5-315 and 68-11-1610 to review and reverse the ALJ's Initial Order and deny the CON to SBH. The following reasons support review:

1. Proof in the contested case established that SBH intentionally gerrymandered its proposed service area to exclude consideration of existing psychiatric beds in the adjacent county thereby artificially creating the appearance of quantitative need under the State Health Plan criteria. SBH's unrealistic service area excludes Washington County, which has 150,000 residents and is directly contiguous to Sullivan County. On the other hand, the service area

includes Lee County, Virginia, which is two counties away, separated from Kingsport by a large mountain range, and has only 25,000 residents. In other words, the proposed service area stretches more than 35 miles northwest, deep into an area of Virginia that is mountainous and sparsely populated, while it extends only a few miles to the south, excluding Washington County. SBH manipulated the State Health Plan's need formula by creating a service area that excluded consideration of existing psychiatric resources, primarily Woodridge, the largest provider in the region. If the contrived and unreasonable service area is disregarded and an appropriate service area is applied to the project, it is undisputed that there is no need for a new 72-bed psychiatric hospital under the State Health Plan.

2. While the ALJ acknowledged that a service area that includes Washington County might be more reasonable than the service area in the application, the ALJ noted that the Agency's Rules and Regulations are silent as to how an applicant should determine its service area. In effect, the ALJ concluded that an applicant can simply pick and choose counties it wishes to claim as a service area even if the underlying reason for doing so is to avoid the State Health Plan criteria. The ALJ's Initial Order contradicts the Agency's Rules, the Agency's long-standing practices, and the purpose and intent of the State Health Plan.

3. The ALJ's Initial Order incorrectly addresses the consequences of the project to the existing health care system. The ALJ found that Woodridge is the safety-net hospital for psychiatric patients in the region and plays a vital role in servicing TennCare, Medicare and patients formerly seen at Lakeshore. The ALJ also found that SBH's project would result in a potential annual loss of $1.5 million by Woodridge. The ALJ concluded, however, that this negative impact on the health care system, including the safety net provider of inpatient psychiatric care in Northeast Tennessee, was not sufficient to justify denial of the application.

This conclusion is contrary to the plain meaning and intent of the Agency's Rules and the policies underlying the CON process.

CONCLUSION

For the foregoing reasons, MHSA respectfully requests that the Agency accept review of the ALJ's Initial Order dated February 8, 2016, and that the Agency place this matter on the agenda to be considered at its earliest opportunity.

Respectfully Submitted,

Dan H. Elrod (BPR No. 003871)
G. Brian Jackson (BPR No. 015497)
Travis B. Swearingen (BPR No. 025717)
Butler Snow LLP
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700

Counsel for Mountain States Health Alliance

SBH-KINGSPORT 000498

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been served by U.S. Mail, postage prepaid, to the following:

James B. Christoffersen
Tennessee Health Services &
Development Agency
500 Deaderick Street, 9th Floor
Nashville, TN 37243

William H. West
Charles Grant
Baker Donelson Bearman Caldwell &
Berkowitz, P.C.
211 Commerce Street, Suite 800
Nashville, Tennessee 37201

this 22nd day of February, 2016.



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BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	**Docket No. 25.00-126908J**
SBH-KINGSPORT, LLC	)	**CON No. CN1312-050**
	)	
Applicant.		

SBH-KINGSPORT, LLC'S BRIEF URGING THE HSDA TO DECLINE TO HEAR MSHA'S APPEAL OF THE INITIAL ORDER HEREIN

SBH-Kingsport, LLC, the CON Applicant which filed certificate of need application number CN1312-050 to establish a new, 72-bed psychiatric hospital in Kingsport, Sullivan County, Tennessee, hereby files this brief to urge the HSDA to decline to hear the appeal, filed by Mountain States Health Alliance ("MSHA"), of the Initial Order issued by the Administrative Judge in this contested case matter. SBH-Kingsport, LLC ("SBHK"), the CON Applicant herein, files this brief pursuant to T.C.A. § 68-11-1610(e) and HSDA Rule 0720-13-.03(1).

BACKGROUND

On February 8, 2016, the Administrative Judge filed his Initial Order in the contested case proceeding on CON application number CN1312-050. CON application CN1312-050 had originally been denied by HSDA at its June 2014 meeting by a tie vote of four members in favor of granting the CON to four members opposed. SBHK appealed this denial. The appeal hearing took five days, from July 27 to July 31, 2015, and generated a substantial record of testimony transcripts and exhibits in evidence.

In the Initial Order in this proceeding, which is the subject of the petition for appeal filed by MSHA on February 23, 2016, the Administrative Judge, Judge Pogue, concluded, after having heard the witnesses at the contested case hearing testify in person and after considering

the record in this matter, that: "After consideration of the record in this matter, it is determined that the SBHK CON should be granted."[1] He made this ruling based upon the Findings of Fact and Conclusions of Law he reached and set forth in his Initial Order.

ARGUMENT

The HSDA's contested case proceedings are held, by law, pursuant to the Tennessee Uniform Administrative Procedures Act. This law requires, at T.C.A. § 4-5-315(c), that in a petition for appeal of an Initial Order, "the petition for appeal shall state its basis." The HSDA is empowered by T.C.A. § 68-11-1610(e) to "decline to hear any appeal." MSHA's petition for appeal essentially makes three arguments as the basis for its appeal of Judge Pogue's Initial Order herein. SBHK asserts that none of MSHA's bases for appeal justify an appeal, and that therefore the HSDA should decline to hear any appeal in this matter.

The bases for MSHA's appeal are set forth in pages 3 through 5 of its petition, in which MSHA asserts three reasons why it believes that the HSDA should accept its appeal of the Administrative Judge's Initial Order herein. As argued below, none of the arguments MSHA makes in its appeal petition justify a decision by the HSDA to accept the appeal petition. Judge Pogue made the correct decision in his Initial Order. His decision is amply justified by his Findings of Fact and Conclusions of Law set forth in the Initial Order. A decision by the HSDA to refuse to accept the appeal will result in Judge Pogue's Initial Order becoming the Final Order in this matter. Any subsequent appeal by MSHA would be to the Chancery Court of Davidson County.

I.

The first basis for MSHA's appeal petition asserts that the service area claimed by SBHK in its CON application (Sullivan and Hawkins Counties in Tennessee, plus Scott, Wise and Lee

[1] Initial Order, page 1.

SBH-KINGSPORT 000501

Counties in Virginia) is a "contrived and unreasonable service area". One of the main reasons why MSHA asserts that the service area claimed by SBHK is "unreasonable" is because it "excludes Washington County" in Tennessee.[2]

While MSHA argues that SBHK's claimed service area is "unreasonable", Judge Pogue expressly concluded on page 28 of the Initial Order as a matter of law that the HSDA's regulations require that "the designated service area should be reasonable." Judge Pogue analyzed the proof on this issue at length in his Initial Order. He then found and concluded that SBHK's proposed service area for its Kingsport hospital "is reasonable."[3] He held further, in Conclusion of Law No. 9 in the Initial Order, that: "the rules of the Agency specifically provide that 'service area' means the counties representing a reasonable area in which the services are provided and in which the majority of its service recipients reside." (Emphasis added.) See HSDA Rule 0720-9-.01(23). (The text of this HSDA rule is set forth more fully in the Initial Order at Conclusion of Law No. 7, on page 28 of the Order.)

As noted in the Initial Order, and as required by the HSDA rule cited above, the service area designated by an applicant in its CON application must represent "a reasonable area" in which the institution intends to provide services and in which the majority of its service recipients reside. The HSDA's service area definition rule does not require that the proposed service area be "the most reasonable" service area possible or that it must exclude the capability of any other party to design a different, alternative "reasonable" service area.[4]

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[2] Appeal petition, page 3.
[3] Initial Order, page 29 (Conclusion of Law No. 12).
[4] In Finding of Fact No. 30, on page 12 of the Initial Order, Judge Pogue found that Dr. Collier's proposed alternative service area for this project would itself have a need for 51 psychiatric hospital beds (if Russell County, Virginia were excluded; residents of that county would have to pass three other psychiatric hospitals to get to SBHK). Judge Pogue found that there was a net inpatient psychiatric bed need of 81 to 82 beds in SBHK's five-county service area, based upon the 30 beds per 100,000 population need standard in the *Guidelines for Growth*. (Finding of Fact No. 27, page 10: "Since the only psychiatric provider in the SBHK proposed service area is BRMC with its 12 beds, the net inpatient psychiatric bed need is 81 in 2015 and 82 beds by 2020.")

The full text of the HSDA's rule defining service area must be examined in evaluating this basis for MSHA's appeal petition. This provision is found in the HSDA's "Definitions" rule, HSDA Rule 0720-9-.01, of which subsection (23), cited earlier herein, is a subsection. The entire text of the HSDA rule defining the term "service area" is set forth immediately below (a copy of the complete HSDA rule from the Secretary of State's website is attached hereto as Exhibit A to this brief):

> Tenn. Comp. R. & Regs. R. 0720-9-.01: DEFINITIONS. The following terms shall have the following meanings.
>
> *******
>
> (23) "Service Area" means the county or counties or portions thereof, representing a reasonable area in which a healthcare institution intends to provide services and in which the majority of its service recipients reside. (Emphasis added.)

The HSDA's own rules require that the "service area" claimed for CON applications to be defined as set forth in this rule. Other HSDA rules, such as those cited by Judge Pogue at pp. 26-27, contain provisions that state that CON applications "may be evaluated" on the basis of listed criteria set forth in those rules. The use in those rules of the verb "may be" instead of "shall" indicate that such criteria are not required to be considered. However, the use of the verb "shall" in the HSDA's service area definition rule mandates the use of its express terms in defining the CON project's service area: the service area must be "a reasonable area in which a healthcare institution intends to provide services and in which a majority of its service recipients reside."

The Tennessee Supreme Court has held that administrative agencies must act consistently with their own rules. *Jackson Express v. Tenn. Public Service Commission*, 679 S.W.2d 942, 945 (Tenn. 1984). Judge Pogue's Initial Order is consistent with the rules of the HSDA.

MSHA does not assert that the majority of SBHK's service recipients for its psychiatric hospital in Kingsport, once developed, will not come from the five-county service area SBHK

has claimed in its CON application. Rather, MSHA's attack on the Initial Order's approval of SBHK's proposed service area focuses on whether Judge Pogue correctly construed what the term "reasonable" means in CON application service area determinations.

The HSDA's definition by rule of what defines a "service area" does not look to or require a particular process to be followed for designating such a service area, other than that the service area must be "reasonable" and that a majority of the service recipients for the healthcare institution must come from the service area it designates. In the Initial Order, Judge Pogue cites and specifically applies the HSDA's service area designation rule. In the Initial Order, Judge Pogue analyzed the service areas, past and present, of hospital facilities located in Kingsport and elsewhere in Sullivan County as part of the his assessment of whether SBHK's proposed service area is reasonable.

For example, Judge Pogue held, in Conclusion 10 on page 29, that:

> Similar to SBHK's designated service area, several medical facilities in Kingsport and Sullivan County (including MSHA's IPMC)* have service areas that consist of Sullivan and Hawkins County and a few counties in Virginia, while excluding Washington County, Tennessee. The agency has accepted CON applicants' service area definitions even when the proposed service area excludes contiguous counties from which an applicant might draw patients.

In Conclusion 11 on page 29 of the Order Judge Pogue concluded as follows:

> The prior psychiatric hospital in Kingsport, Indian Path Pavilion, drew just 12% of admissions over its last three years of operation (2007-09) from Washington County. . . . In 2013, both Wellmont Holston in Kingsport and BRMC had very few patients from Washington County and four of the five counties in the proposed service area accounted for approximately 66% of Indian Path Pavilion's admissions from 2007-2009. Mr. Sullivan projected that approximately 20% of the patient volume at SBHK would likely come from outside the five-county service area.

Based on these facts, in the Initial Order Judge Pogue went on to conclude, at Conclusion 12 on page 29, as follows:

*"IPMC" means MSHA's acute care hospital facility, Indian Path Medical Center, located in Kingsport in Sullivan County.

> Not including a contiguous county (Washington, Tennessee) where some patients may originate does not make the service area unreasonable. SBHK has established that its designated service area is reasonable.

Earlier in the Order's Findings of Fact, Judge Pogue made numerous Findings of Fact which support his Conclusions of Law that the service area proposed by SBHK is reasonable as required by the HSDA rule. For example, in Finding of Fact No. 16 on page 6 of the Initial Order, the Judge stated:

> According to Mr. Sullivan, Indian Path Pavilion, a 61-bed psychiatric hospital formerly located in Kingsport, filed a CON for a project that involved combining IPMC and Indian Path Pavilion hospital licenses and described its primary service area as Hawkins and Sullivan Counties in Tennessee and Wise, Scott and Lee Counties in Virginia.

Earlier, in Finding No. 13 on page 5 of the Initial Order, Judge Pogue made the following factual finding:

> IPMC has defined its service area (based on MSHA's 2012 Social Responsibility Plan) as Sullivan and Hawkins County, Tennessee plus Scott, Lee, Dickenson and Wise Counties in Virginia and in MSHA's June 2015 Community Health Needs Assessment, IPMC's primary service area was listed as western Sullivan County, Hawkins County, Wise and Scott Counties.

Thus, it is clear that Indian Path Medical Center ("IPMC"), an acute care hospital owned by MSHA and located in Kingsport in Sullivan County, has itself excluded Washington County from its own service area as early as 2012, and repeated such exclusion in June 2015, shortly before the contested case hearing herein.

In Finding of Fact No. 14 on page 5 of the Initial Order, Judge Pogue made the following Finding:

> In 2013 HealthSouth Rehabilitation Hospital in Kingsport received 91% of its admissions from Sullivan and Hawkins County, Tennessee and certain Virginia counties. Wellmont Holston Valley Medical Center (Wellmont Holston) in Kingsport, in 2013, received 86.5% of its admissions from Sullivan and Hawkins County in Tennessee and Scott, Wise and other counties in Virginia.

Judge Pogue found as facts that Indian Path Medical Center in Kingsport, Wellmont Holston Valley Medical Center in Kingsport, and HealthSouth Rehabilitation Hospital in Kingsport all draw the majority of their patients from groups of counties which do not include Washington County, Tennessee. IPMC, owned by MSHA, has specifically and repeatedly excluded Washington County, Tennessee from its primary service area even though it is located in Kingsport, in western Sullivan County, Tennessee. Furthermore, Judge Pogue expressly found that IPMC has recently claimed (as noted above) to serve Lee County, Virginia, as part of its service area, while simultaneously excluding Washington County, Tennessee from its service area even though Washington County, Tennessee is contiguous to Sullivan County, Tennessee. Therefore, MSHA's own hospital facility and other hospital facilities located in Kingsport have identified Lee County, Virginia as being in their service area, while excluding Washington County, Tennessee from their service area. It is therefore fully "reasonable" for SBH-Kingsport to include Lee County, Virginia in its service area while excluding Washington County, Tennessee from its service area.

The Findings listed above support the Initial Order's Conclusion of Law that SBHK established that its service area was reasonable. If it is reasonable for Indian Path Medical Center to include Lee County, Virginia in its service area while excluding Washington County, Tennessee, that fact constitutes an admission by MSHA that the process of including Lee County, Virginia in IPMC's service area while excluding Washington County, Tennessee from its service area is "reasonable" for hospital facilities based in Kingsport in western Sullivan County, Tennessee. If MSHA has defined its Kingsport hospital facility's service area in such a fashion, it is certainly "reasonable" for SBHK to do so also. The service areas of other hospitals in Kingsport and Sullivan County were also proven in this record not to include Washington County, Tennessee.

II.

The second basis for appeal set forth by MSHA in its Petition for Appeal is set forth on page 4 of its Petition and is comprised of the following statements by MSHA:

> While the ALJ acknowledged that a service area that includes Washington County might be more reasonable than the service area in the application, the ALJ noted that the agency's rules and regulations are silent as to how an applicant should determine its service area. In effect, the ALJ concluded that an applicant can simply pick and choose counties it wishes to claim as a service area even if the underlying reason for doing so is to avoid the State Health Plan criteria. The ALJ's Initial Order contradicts the agency's rules, the agency's long-standing practices, and the purpose and intent of the State Health Plan.

This purported basis for appeal contains material misstatements about what the Initial Order actually states. The first one is its assertion that "the ALJ noted that the agency's rules and regulations are silent as to how an applicant should determine its service area." The ALJ made no such notation, Finding or Conclusion in the Initial Order. The contents of the Initial Order directly contradict this assertion. The Initial Order simply does not contain any statement that " the agency's rules and regulations are silent as to how an applicant should determine its service area."

For example, Conclusion of Law No. 9 on pages 9-10 of the Initial Order expressly states:

> The designated service area should be reasonable. Including Washington County, Tennessee and other nearby counties in the proposed SBHK service area may arguably create a more reasonable service area than that proposed. Yet, the rules of the Agency specifically provide that "service area" means the counties representing a reasonable area in which the services are provided and which the majority of its service recipients reside. (Emphasis added.)

In Conclusion of Law number 9 of the Initial Order, the underlying statements set forth above are virtually a direct quote of the HSDA's service area definition rule, rule 0720-9-.01(23) of the rules of the HSDA. The language of the rule itself is set forth by the Initial Order in Conclusion of Law number 7 on page 28. Thus, the Initial Order directly cites the contents of

the agency's own mandatory rule on an applicant's determination of its service area, and specifically applies it to the CON application at issue.

In the Initial Order, Judge Pogue goes on in Conclusion of Law 10 to point out that the health planning experts in this case, Mr. Sullivan for SBHK and Dr. Collier for MSHA, are both credible health planning experts. However, they differ in describing the reasonableness of the SBHK proposed service area: Mr. Sullivan finds it reasonable, while Dr. Collier does not. The ALJ notes in Conclusion 10 that both experts "examined the region's past and current healthcare providers' service areas in support of their respective positions." The Initial Order points out, at Conclusions of Law 10 and 11 (page 29) that several medical facilities in Kingsport in Sullivan County, including Indian Path Medical Center, now owned by MSHA and located in Kingsport, have service areas that consist of Sullivan and Hawkins Counties plus a few counties in Virginia, while excluding Washington County, Tennessee from the service area. The Initial Order concludes in Conclusion number 10 (page 29) as follows: "The Agency has accepted CON applicants' service area definitions even when the proposed service area excludes contiguous counties from which an applicant might draw patients." As noted above, in Conclusion number 11 the Initial Order then reviews the experience of the prior psychiatric hospital in Kingsport, Indian Path Pavilion, over the last three years of its operation (2007-2009), particularly as to the share of its patients that came from Washington County, Tennessee.

Thereafter, in Conclusion of Law number 12, on page 29, the ALJ concluded specifically as follows:

> Not including a contiguous county (Washington, Tennessee) where some patients may originate does not make the service area unreasonable. SBHK has established that its designated service area is reasonable.

Clearly, in Conclusion 12, the ALJ, through the Initial Order, is directly applying the HSDA's own mandatory rule defining what a service area is to the facts of this certificate of need

application. In the Initial Order, the ALJ never finds or "notes" that the agency's rules and regulations are "silent as to how an applicant should determine its service area." Instead, in the Initial Order Judge Pogue directly applies the actual service area definition rule of the HSDA to the facts of the SBHK CON application and the record of the contested case proceeding, and in doing so specifically determines that the service area proposed by SBHK is reasonable even though it does not include a certain county contiguous to it. Therefore, contrary to MSHA's assertions in its appeal petition, there is no basis in this Initial Order to claim that the ALJ had concluded that the agency's rules and regulations are silent as to how an applicant should determine its service area. Such an assertion is false; it is contradicted by the text of the Initial Order itself.

Contrary to the Petition for Appeal, there is no basis in the Initial Order itself to conclude that an applicant can simply pick and choose counties it wishes to claim for a service area. The ALJ has made it clear in his Initial Order that the designation of service area must comply with the rules of the HSDA, which require the service area to represent a reasonable area in which the services are provided and in which the majority of its service recipients reside. Thus, the second sentence in MSHA's appeal petition's basis number 2 simply is not supported by the contents of the Initial Order itself; instead, it is contradicted by those contents.

There is similarly no support in the Initial Order itself for the assertion in MSHA's appeal petition's basis for appeal number 2 that: "The ALJ's Initial Order contradicts the Agency's rules, the Agency's long-standing practices, and the purpose and intent of the State Health Plan."

To the contrary, as noted above, the Initial Order clearly and directly applies the rules of the HSDA to the CON application at issue, CN1312-050. Furthermore, the Initial Order directly cites and applies the long-standing practice of the HSDA in "accepting CON applicants' service

area definitions, even when the proposed service area excludes contiguous counties from which an applicant might draw patients." See Conclusion of Law No. 10, at p. 29 of the Order.

In the ALJ's Findings of Fact and Conclusions of Law, Judge Pogue also directly cites and utilizes the applicable provisions of the *Guidelines for Growth*. Therefore, the claimed basis for appeal number 2 in MSHA's appeal petition is contrary to the actual text of the Initial Order. Judge Pogue's Initial Order does not contradict the Agency's rules, the Agency's long-standing practices, or the purpose and intent of the State Health Plan. To the contrary, Judge Pogue clearly cites and utilizes all three of these provisions in his Initial Order to reach his Findings of Fact and Conclusions of Law. Thus, MSHA's appeal petition's asserted basis for appeal number 2 constitutes no reason for the HSDA to accept this appeal -- the appeal petition is factually and legally inaccurate when examined in light of the actual text and contents of the Initial Order. Therefore, the appeal petition should be declined by the HSDA.

III.

The final basis MSHA cites for its appeal is contained in paragraph number 3 beginning on page 4 of its appeal petition, which begins: "The ALJ's Initial Order incorrectly addresses the consequences of the project to the existing healthcare system."

In its support of this assertion, at pages 4-5 of the appeal petition, MSHA fails to challenge or assert as error a core Conclusion of Law and Finding of Fact in the Initial Order: MSHA's psychiatric hospital, Woodridge Psychiatric Hospital, is a department of the Johnson City Medical Center, a much larger and very profitable hospital institution owned and operated by MSHA. Judge Pogue concluded, in Conclusion of Law No. 24 on page 32 of the Initial Order that "The impact of SBHK on WPH is limited by the fact WPH is a satellite or department of JCMC . . .". In its appeal petition, MSHA does not challenge this Conclusion of Law (in Conclusion of Law number 24) in the Initial Order, nor does it contradict in any manner

whatsoever or assert as error the Findings of Fact which support this Conclusion of Law, such as Findings number 56 on page 21 of the Initial Order and Finding number 58 on page 22 of the Initial Order:

> Finding 56: "On the 2013 Joint Annual Report (JAR) of JCMC to the Tennessee Department of Health, JCMC reports that JCMC owns and operates WPH. The medical staffs of JCMC and WPH are integrated . . ."
>
> Finding 58: "Dr. Collier made no analysis of the effects of SBHK's hospital on JCMC."

The MSHA appeal petition's asserted basis for appeal no. 3 also contains a factual error. The third sentence in basis number 3 on page 4 of the MSHA appeal petition states as follows: "The ALJ also found that SBH's project would result in a potential annual loss of $1.5 million by Woodridge."

There is no such Finding in the Initial Order. In Finding No. 57 on page 21 of the Initial Order, Judge Pogue notes "an analysis performed by Dr. Collier suggests that the presence of SBHK will result in 1,084 lost cases to WPH or a $1.5 million loss net income per year ($1.7 million if there is no indigent care at SBHK) based on the proposed service area." (Emphasis added.) In partial contradiction of Dr. Collier's analysis, Judge Pogue then specifically finds as a fact, on page 22 of the Initial Order, the following: "As to fewer patients recently, WPH had more positive financial results with 3,724 patients in the first 11 months of FY2014 than it had with 4,320 in the first 11 months of FY2015."

In Conclusion 24 on page 32 of the Initial Order, Judge Pogue reviews these Findings and makes the following Conclusion of Law:

> Dr. Collier estimates a possible loss of $1.5 million per year to WPH if SBHK is built, though WPH did have more positive financial results with 3,724 patients in the first 11 months of FY2014 than it had with 4,320 in the first 11 months of FY2015. The impact of SBHK on WPH is limited by the fact that WPH is a satellite or department of JCMC and consideration should be given to SBHK's impact on JCMC and MSHA. No expert analysis was done regarding the effect

> of SBHK on JCMC or MSHA. JCMC had profits of over $30 million in fiscal year 2013 and MSHA is financially operationally healthy. Any adverse impacts on WPH/JCMC/MSHA by the approval of SBHK are outweighed by the benefits that accrue to the community by SBHK and the provision of the additional inpatient psychiatric beds that SBHK brings.

Nowhere in the Initial Order did Judge Pogue "find" as a fact that SBHK's project would result in a potential annual loss of $1.5 million by Woodridge. Instead Judge Pogue found that Dr. Collier made such estimates, but he did not find that that such an impact would in fact occur or that it would form a factual basis for any conclusion of law.

MSHA never claims in its appeal petition that WPH is not a department of JCMC; nor does MSHA ever assert in its appeal petition that the ALJ's conclusion that WPH was a department of JCMC is erroneous. Simply put, MSHA does not challenge the Initial Order's Findings of Fact and Conclusions of Law that WPH is a department of JCMC. Therefore, as Judge Pogue did, the HSDA should accept as a fact that WPH is merely a department of JCMC. MSHA articulates no basis whatsoever in its appeal petition for appealing the Initial Order's Conclusion of Law that WPH is a department of the Johnson City Medical Center, a large and profitable MSHA hospital. Similarly, MSHA does not assert in its appeal petition that the ALJ erred in concluding that JCMC had over $30 million in profit in fiscal year 2013 and that MSHA is "financially operationally healthy".

Given the appeal petition's failures to make any challenge to those Conclusions of Law by the ALJ in the Initial Order, or even to assert that they are erroneous, the appeal petition's basis for appeal number 3 simply fails to identify any mistake or error in the Initial Order or elsewhere that would justify the HSDA's hearing the appeal of MSHA in this matter by granting the appeal petition. If WPH is a department of JCMC, a Conclusion not challenged by MSHA's appeal petition, then MSHA's claims of the CON project's impact on WPH focus on the wrong facility: MSHA should have focused on the CON project's impact on JCMC (which includes its

department, WPH). Instead, MSHA and its expert totally failed to conduct this analysis. There is no dispute that this failure occurred.

IV.

In his Initial Order, Judge Pogue carefully laid out the HSDA rules applicable in this case and then expressly applied them in the Order.

For example, he held in Conclusion of Law No. 2 on page 24 that the party which asked for the contested case hearing (SBH-Kingsport, LLC in this case) "bears the burden of proof to establish, by a preponderance of the evidence, that the CON should be granted or denied." This is a direct quote by Judge Pogue of the HSDA's rule governing appeals (Rule 0720-13-.01(3)) which states, in relevant part: "The Petitioner shall have the burden of proving, by a preponderance of the evidence, that a certificate of need should be granted or should be denied."

The Tennessee Supreme Court has defined the term "preponderance of evidence" in the 2005 case of *Teter v. Republic Parking System*, 181 S.W.3d 330, 341 (Tenn. 2005), as follows:

> Generally, in civil cases, facts are proved by a mere preponderance of the evidence. (Citations omitted.) The preponderance of the evidence standard requires that the truth of the facts asserted be more probable than not, whereas the clear and convincing evidence standard requires that the truth be highly probable. "Clear and convincing evidence means evidence in which there is no serious or substantial doubt about the correctness of the conclusions drawn from the evidence." (Emphasis added, citation omitted.)

Under the "preponderance of the evidence" standard applicable by law and HSDA rule to this civil matter, the existence of any doubt about the correctness of conclusions draw from the evidence, does not cause the conclusions reached by the judge in this case to be wrong or reversible. Judge Pogue's statements citing Dr. Collier's impact statement or that another service area definition might have included Washington County, Tennessee merely articulate some possible potential for doubt about the correctness of his decision. However, those doubts (if they

exist), by law, do not mean that Judge Pogue's Initial Order is not supported by the preponderance of the evidence and is therefore correct.

In his Initial Order, Judge Pogue emphasized a great deal of record proof in this case that supports his conclusion that a preponderance of the evidence in this case supports the grant of the CON to SBHK. These include, but are not limited to, the following:

Finding 28, p. 14:

> "WPH is currently running in calendar 2015 between 85.2% and 89.5% occupancy generally. If WPH's utilization increases (as measured by patient days) were to continue at the FY 2015 numeric volume of increase, WPH will be close to 100% full in less than two years from FY 2015."

Finding 39, pp. 14-15:

> "The census for 22 of 27 days in May 2015 showed that 90% or more of the WPH beds were occupied. On May 5, 2015, there was an occupancy rate of 98.8%."

Finding 31, p. 12:

> "Dr. Collier found that 400 patients from SBHK's proposed service area went to facilities in Blount County and as far away as Vanderbilt in FY 2013. Of these 400 patients, Peninsula Hospital in Blount County received 296 (74%)."

Finding 41, p. 15:

> WPH records show that hundreds of potential patients were deferred at WPH in years 2014-2015 because WPH did not have appropriate beds available.

Finding 36 on p. 13:

- WPH patient days are up 32% since 2011.
- Since 2013, by 2015 patient days at WPH increased by 17.7%, while admissions increased more than 23%.
- "WPH had 89.5% occupancy for the month of May 2015, 89.9% occupancy in November 2014, and an occupancy rate of 88% for July 2015.".

Clearly, in light of these and other facts set forth in the Initial Order, Judge Pogue's determination that "the SBHK CON should be GRANTED" is well justified. Thus, MSHA's appeal petition should be declined by the HSDA.

CONCLUSION

The Findings and Conclusions reached by Judge Pogue in his Initial Order demonstrate that the CON criteria of need, economic feasibility, and contribution to the orderly development of healthcare are satisfied by the project set forth by SBHK in CON application CN1312-050, and are established to be proven by the preponderance of the evidence in the record in this case. Since MSHA has failed in its appeal petition to cite any legally effective basis to justify granting its appeal of the Initial Order entered in this matter by the Administrative Judge, SBHK respectfully asserts that the HSDA should decline to hear the appeal sought by MSHA. The Initial Order should, by operation of law, become the Agency's Final Order in this matter. Counsel for SBHK will appear at the appropriate HSDA meeting to articulate this position in oral argument before the Agency.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been delivered via email to:

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this 29 day of March, 2016.

William West

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RULES
OF
HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-9
DEFINITIONS

TABLE OF CONTENTS

0720-9-.01 Definitions

0720-9-.01 DEFINITIONS. The following terms shall have the following meanings.

(1) "Adult psychiatric" means inpatient mental health services provided to patients 18 years of age and over.

(2) "Agency" means the Tennessee Health Services and Development Agency.

(3) "Ambulatory surgical treatment center" means any institution, place or building devoted primarily to the performance of surgical procedures on an outpatient basis.

(4) "Capital expenditure" in relation to a proposed establishment of, modification, renovation, or addition to a health care institution, means an expenditure by or on behalf of a health care institution which, under generally accepted accounting principals, is not properly chargeable as an expense of operation and maintenance. Any series of expenditures, each less than the threshold, but which when taken together are in excess of the threshold, directed toward the accomplishment of a single goal or project, requires a certificate of need. Any series of related expenditures made over a twelve (12) month period will be presumed to be a single project.

(a) Establishment, modifications, additions, or renovations. In calculating the capital expenditure for establishment, modifications, additions, or renovations, "capital expenditure" is the amount per construction bid or total amount of invoices for the single project excluding major medical equipment.

(b) Equipment. The cost of major medical equipment over the monetary threshold of T.C.A. § 68-11-1607 is not considered when determining the amount of capital expenditures for determining whether the monetary threshold of T.C.A. § 68-11-1607 is met for an establishment, modification, addition, or renovation. The cost of all other equipment, whether fixed or moveable, is considered. The cost of major medical equipment is considered in calculating the amount of the examination fee. The cost for such fixed and moveable equipment includes, but is not necessarily limited to, taxes, government fees, assessments, and any other fees, assessments or charges directly associated with the acquisition of the equipment.

(c) Lease, loan, or gift. In calculating the value of a lease, loan, or gift, the "cost" is the fair market value of the above-described expenditures. In the case of a lease, the cost is the fair market value of the lease or the total amount of the lease payment, whichever is greater.

(5) "Certification period" means the period of time beginning on the date of issuance of a certificate of need and ending on the expiration date of a certificate of need, as established by statute, rule, or order of The Agency.

(6) "Change of location" means a change of the specific location of an existing institution, facility, service, or piece of major medical equipment, in part or in its entirety. The following activities involving a home care organization are a change of location of a health care institution, and require a certificate of need:

Exhibit A

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(a) The addition of one or more counties to the licensed service-area of a home care organization;

(b) The change of location of a parent office to a different county.

(7) "Child and adolescent psychiatric" means inpatient mental health services provided to patients under 18 years of age.

(8) "Executive director" means the chief administrative officer of The Agency and the appointing authority, exercising general supervision over all persons employed by The Agency, as defined in T.C.A. § 68-11-1606.

(9) "Expiration date" is the date upon which a certificate of need expires and becomes null and void. The expiration date may be established by statute, by rule, or by order of The Agency.

(10) "Home health service" is as defined in T.C.A. Title 68, Chapter 11, Part 2.

(11) "Hospital" is as defined in T.C.A. Title 68, Chapter 11, Part 2.

(12) "Long-term categories" includes nursing home services, regardless of the length of stay, and any other health service which is intended or reasonably expected to result in an average length of stay of 21 days or longer.

(13) "Major medical equipment" - "Cost."

(a) As used in T.C.A. §§ 68-11-1602 and 68-11-1607, "major medical equipment" means any single item of equipment or a series of components with related functions, within the definition and cost threshold set forth at the referenced statutes, and which costs more than the amounts determined under T.C.A. § 68-11-1607.

(b) The cost of major medical equipment includes all costs, expenditures, charges, fees and assessments which are reasonably necessary to put the equipment into use for the purposes for which the equipment was intended. Such costs specifically include, but are not necessarily limited to, the following:

1. maintenance agreements, covering the expected useful life of the equipment;

2. federal, state, and local taxes and other government assessments; and

3. installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding.

(c) Any individual components or a piece of medical equipment with related functions, which are purchased over a 12 month period shall be considered toward the cost of the piece of major medical equipment.

(d) If the acquisition is by lease, the cost is either the fair market value of the equipment, or the total amount of the lease payments, whichever is greater

(14) "Mental health hospital" means a public or private hospital or facility or part of a hospital or facility equipped to provide inpatient care and treatment for persons with mental illness or serious emotional disturbance, as licensed by the Department of Mental Health and Developmental Disabilities.

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(Rule 0720-9-.01, continued)

(15) "Mental retardation institutional habilitation facility" means a facility which offers on a regular basis health related services to individuals with mental retardation who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but, because of physical or mental condition require residential care and services (more than room and board) and involves health related care under the supervision of a physician. Such a facility also offers an intensive program of habilitative services, as licensed by the Department of Mental Health and Developmental Disabilities.

(16) "Neonatal intensive care unit" means a special care unit staffed and equipped to provide professional intensive treatment for the care of newborns with severe or complicated illnesses and/or high-risk newborn infants, staffed by a neonatolgist and specialized nurses and in which bassinets are used as licensed beds.

(17) "Not directly related to patient care" may include the following types of single, isolated expenditures:

(a) Telephone systems;

(b) Non-clinical data processing systems;

(c) Heating and/or air conditioning systems;

(d) Energy conservation devices;

(e) Parking facilities;

(f) Roof repairs;

(g) Medical office buildings;

(h) Warehouses; and

(i) Cafeterias.

(18) "Nursing home" is as defined in T.C.A. Title 68. Chapter 11, Part 2.

(19) "Outpatient diagnostic center" is as defined in T.C.A. Title 68, Chapter 11, Part 2.

(20) "Person" where the context requires, may refer to any natural person, legal entity, facility, or institution, as defined in T.C.A. § 68-11-1602.

(21) "Recuperation center" is as defined in T.C.A. Title 68, Chapter 11, Part 2.

(22) "Residential hospice" is as defined in T.C.A. Title 68. Chapter 11, Part 2.

(23) "Service area" means the county or counties, or portions thereof, representing a reasonable area in which a health care institution intends to provide services and in which the majority of its service recipients reside.

(24) "Substantive amendment" as used in T.C.A. § 68-11-1607 means any amendment which has the effect of increasing the number of beds, square footage, cost, or other elements which are reasonably considered in the discretion of The Agency to be integral components of the application. A reduction of the above referenced components may be considered a substantive amendment if the amendment and supporting documentation are not received by the staff and Agency in a timely manner, necessary to allow The Agency to make an informed decision. Nothing in this rule shall be interpreted as limiting The Agency's authority to approve or deny all or part of any given application.

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(Rule 0720-9-.01, continued)

Authority: *T.C.A. §§ 4-5-202 and 68-11-1605.* ***Administrative History:*** *Original rule filed August 31, 2005; effective November 14, 2005.*

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APR 15 '13 2:02

BEFORE THE TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY
Nashville, Tennessee

IN THE MATTER OF:	)	
	)	**Docket No. 25.00-126908J**
SBH-KINGSPORT, LLC	)	
	)	**CON no. CN1312-050**
Applicant.	)	

MOUNTAIN STATES HEALTH ALLIANCE'S REPLY IN SUPPORT OF ITS PETITION FOR APPEAL

The applicant, SBH-Kingsport, LLC, crafted a service area in its application to create the perception of need for its proposed 72-bed psychiatric hospital when no actual need exists. Specifically, SBH excluded Washington County – the adjacent county of 125,000 people home to the 84-bed Woodridge Psychiatric Hospital, the primary provider of psychiatric services in the Tri-Cities. SBH did not perform any health planning analysis to justify this exclusion. Instead, SBH's service area was designed to manipulate the application of the State Health Plan's bed need formula and to avoid Certificate of Need opposition from Woodridge's parent company, Mountain States Health Alliance ("MHSA"). Excluding Washington County from the service area meant that Woodridge was simply ignored in evaluating the need for a new psychiatric hospital in Kingsport, even though the two facilities would be in adjacent counties, only 24 miles apart. If the contrived service area is disregarded and a more reasonable service area is applied to the project, it is undisputed that there is no need for a new 72-bed psychiatric hospital under the State Health Plan.

Indeed, even as SBH claimed a service area excluding Washington County in its application, discovery in the contested case revealed that, for internal financial purposes, SBH continues to believe that it will capture significant market share from all of its surrounding areas, including Washington County. Although the Administrative Judge recognized that SBH

manipulated its service area, he incorrectly concluded that the Health Services and Development Agency's criteria do not establish a method or protocol by which an applicant must establish its proposed service area. By this rationale, an applicant's actual plans about where its patients will originate are irrelevant, no matter how inconsistent they may be with the application. Allowing the Initial Order to stand will establish dangerous precedent that undermines the CON process by sanctioning the use of unrealistic service areas.

The proof at trial also showed that MHSA is a cornerstone of the TennCare program in Northeast Tennessee, and it provides hundreds of millions of dollars in charity and uncompensated care. Woodridge is the safety-net psychiatric provider for its region, serving thousands of patients without resources who were formerly treated at the State mental health hospital. The proof further showed that SBH provides virtually no charity care at its existing hospitals and that SBH's focus will be on capturing the insured patient population while the indigent population would continue to be seen at Woodridge. MHSA's health planning expert concluded that the proposed project would have a significant negative financial impact on Woodridge. The CEO of MHSA testified that the SBH facility would impair Woodridge's ability to continue to offer a full array of psychiatric services to its community. Despite the economic damage the project would cause to Woodridge, the Administrative Judge concluded that the impact on Woodridge was insufficient to warrant denial of the application, because the MHSA system as a whole is financially stable. This conclusion is contrary to Agency's policy and practice of considering the consequences of a project in the context of the entire health care system, including safety-net providers.

The Agency retains the authority to review the findings of fact and conclusions of law made by an Administrative Judge sitting on its behalf. This project offers only duplicative

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services to an area already sufficiently served and will do real and lasting harm to a nonprofit hospital that is providing essential community services. The Agency should review the Initial Order to determine whether its conclusions are consistent with the Agency's policies and objectives.

ARGUMENT

I. SBH'S CLAIM THAT JOHNSON CITY IS NOT IN THE SERVICE AREA OF A KINGSPORT PSYCHIATRIC HOSPITAL IS UNREASONABLE ON ITS FACE AND THE EVIDENCE SHOWED THAT THE CLAIMED SERVICE AREA WAS ADOPTED SOLELY TO IMPROVE THE CHANCES OF CON APPROVAL.

The State Health Plan includes a population-based need formula for psychiatric services of 30 psychiatric beds per 100,000 population. The calculated need is then compared with existing staffed beds to determine whether there is any shortage of beds in an area. In performing this analysis, the selection of the service area is critical—both in order to ascertain the appropriate population for the need calculation and to identify the number of existing beds.

Typically, CON applicants present health planning assumptions in an application; a good faith service area is projected, divided into county units or zip codes, demonstrating the size of the market, the projected market share, and patient volumes that the applicant expects to receive from each area. The Agency and the Agency's staff expect these assumptions to be bona fide and not concocted simply to drive a numerical result that circumvents the State Health Plan's bed need formula.

In this case, discovery into SBH's internal application process revealed that SBH's service area development was anything but genuine. SBH knew that if it included Washington County and its 84-bed psychiatric hospital in its service area, then it could never justify a new 72-bed psychiatric hospital in adjacent Kingsport. In order to circumvent the State Health Plan's quantitative criteria, SBH devised a service area – for CON purposes only – to generate an

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artificial "need" for its project. SBH creatively included counties to the west and northwest, connected to Kingsport by rural roads and over mountain ranges, that have no existing psychiatric providers. SBH's approach circumvents the spirit and the letter of the HSDA's rules and undermines the CON process. Specifically, the proof at trial showed:

- SBH chose the Tri-Cities as a potential location for a new psychiatric hospital, not because of any documented need for additional psychiatric services, but because of costs – the Tri-Cities had available staffing and staff wages and building costs are relatively low. (Initial Order, p. 4, ¶ 10).

- SBH initially planned on placing its facility in Johnson City. (Initial Order, p. 4, ¶ 10). SBH applied for economic development incentives from the Johnson City Industrial Bond Board. (*Id.*) SBH representatives met with seven psychiatric stakeholders prior to filing, six of whom were in Johnson City. (*Id.*)

- Approximately one month before the application was filed, however, SBH executives reversed course and decided to locate the proposed new hospital in Kingsport instead of Johnson City. (Initial Order, p. 4, ¶ 10). SBH did not create a single document setting out the health planning rationale for a new psychiatric hospital in Kingsport versus the case for need in Johnson City. (*Id.*) Instead, internal SBH documents established that the change in location was made simply to avoid MHSA contesting the CON application. (*Id.*)

- SBH filed its application for a CON in December 2013, less than 60 days after the company first visited the Tri-Cities. Despite the geographic proximity and historical ties between Johnson City and Kingsport, SBH's proposed service area excluded Johnson City and Washington County and instead claimed a number of rural Virginia counties to the Northwest of the Tri-Cities. Only by ignoring Washington County and Woodridge's 84 beds could SBH successfully derive a need for its proposed 72-bed facility under the State Health Plan's quantitative criteria.

- SBH did not provide in its application any projections of how many patients would come from any particular county or zip code. (Initial Order, p. 4, ¶ 11). SBH performed no analysis of historical patient patterns to determine probable patient origins. (*Id.*) SBH never performed a written analysis of where patients in its proposed service area are currently receiving their psychiatric care. (*Id.*) No health planning analysis of any sort was done to support SBH's service area.

- At the same time that SBH was presenting a service area to the Agency that excluded Washington County, SBH's internal financial projections – setting forth the financial rationale and anticipated return on investment for the proposed

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project – identified a service area that included Johnson City and Washington County. (Initial Order, pp. 4-5, ¶ 12).

- SBH's proposed catchment area for its internal business analysis is similar to the service area MSHA argued at trial is appropriate for CON purposes. (Initial Order, p. 5, ¶ 12). Contrarily, SBH executives never used the application's proposed service area as a basis for evaluating the financial return on investment for the project.

SBH does not dispute that this "process" occurred - SBH's brief focuses only on the post hoc rationales presented by SBH's litigation-retained health planner as to why excluding Washington County was reasonable.

Despite the blatant conflict between what SBH viewed as its service area internally and the service area declared in the application, the Administrative Judge found that an applicant can devise its service area however it chooses:

> MSHA questions the process SBH used in formulating its SBHK CON request. However, the need criterion of the Agency in weighing a CON does not prescribe a certain protocol to be followed in developing an application. The applicant must demonstrate a need for a project and satisfy the other statutory criteria for the grant of the CON by the Agency.

(Initial Order, p. 28, ¶ 8). The Administrative Judge held that the Agency's rules and regulations do not establish a method for deriving a service area and that so long as the quantitative need criteria are met, the underlying rationale for the service area should not be considered.

Any evaluation of the need for new psychiatric resources in the Tri-Cities must include consideration of the 84-bed Woodridge Hospital in Johnson City, which is the primary psychiatric provider for every county in SBH's proposed service area. The Administrative Judge erred in disregarding these existing community assets, especially in light of the uncontroverted evidence that those resources were excluded by SBH solely to increase the chances of CON approval. The Agency should review the Initial Order to evaluate SBH's process for defining its service area and the reasonableness of such service area.

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II. SBH Failed To Offer Specific Evidence Establishing Any Difficulties Accessing Mental Health Services In The Tri-Cities

Even if the Agency accepts the proposed service area as reasonable, SBH provided no evidence at trial that there is an actual need for additional psychiatric services in the Tri-Cities, let alone a new 72-bed hospital. The 172 psychiatric beds in the Tri-Cities operated at 64% occupancy in 2013, demonstrating that capacity exists in the community. (Initial Order, p. 15, ¶ 42). SBH did not call as a witness a single patient or medical provider practicing in the Tri-Cities to testify that there are any access issues. Similarly, SBH provided no evidence that a significant number of patients from its service area are out-migrating (leaving the region for treatment).

Unlike SBH, MHSA called two clinical providers to discuss available resources in the area – Marlene Bailey, the Director of Behavioral Health Programs at Woodridge, and Dr. Randall Jessee, the Senior Vice President of Specialty Services at Frontier Health, the leading outpatient psychiatric service provider in Upper East Tennessee and Southwest Virginia. (Initial Order, p. 15, ¶ 42). Ms. Bailey testified that Woodridge is meeting the current needs of patients and providers in the region, that Woodridge has implemented numerous process improvements to increase efficiencies, and that its deferral rates have been reduced by half in the last two years. (*Id.*) Moreover, Woodridge continues to excel in quality control measures including outstanding patient satisfaction surveys and very low restraint rates. (*Id.*)

Dr. Jesse spoke at length about the various outpatient psychiatric and outreach services that Frontier has developed across the Tri-Cities. Dr. Jesse also testified regarding Frontier's construction of a 12-bed Crisis Stabilization Unit ("CSU") for adolescents in collaboration with MHSA. (Initial Order, p. 16, ¶ 45). A CSU is a non-hospital facility offering 24-hour, 7-days a week, intensive behavioral health treatment geared towards assessment, evaluation, early

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intervention, and stabilization within a 72 hour time period. (*Id.*) While patients in a CSU can have the same or similar level of severity of psychiatric illness as an inpatient unit, care provided in a CSU setting tends to be less costly than an inpatient stay both in daily cost as well as overall cost due to shorter length of stay. (*Id.*) Both Dr. Jessee and Dr. Harsh Trivedi, the Chief Medical Officer of Vanderbilt Behavioral Health, described how the CSU will help alleviate any periodic capacity constraints in the Tri-Cities once it opens. (Initial Order, p. 17, ¶¶ 46, 47).

The focus of the Initial Order is whether the Applicant meets the quantitative criteria of the State Health Plan formula. The Initial Order does not engage the evidence regarding the existing mental health resources in the Tri-Cities, or the utter lack of testimony from patients or providers having difficulty accessing care. Similarly, the Initial Order fails to evaluate the impact the creation of the CSU will have on inpatient demand.

SBH failed to demonstrate a lack of access to psychiatric services in the region justifying the creation of a new 72-bed psychiatric hospital. The evidence demonstrated that Woodridge has taken and continues to take steps to provide additional community resources to increase availability of inpatient beds, including the joint venture with Frontier Health to establish a CSU for children and adolescents. SBH's proposed Project will simply duplicate existing psychiatric services and will harm existing health care providers.

III. The Economic Impact On Woodridge Is Contrary to the Orderly Development of Health Care

Woodridge serves a critical role as a safety-net hospital for psychiatric patients in the Tri-Cities. In 2012, the State closed the Lakeshore Mental Health Institute, the public mental health hospital for East Tennessee. Woodridge volunteered to accept those patients who would have otherwise been treated at Lakeshore and since 2012, Woodridge has provided care for over 3,000 chronically mentally ill and uninsured patients. (Initial Order, p. 13, ¶ 31).

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SBH has no intention to serve these indigent patients. SBH has had no conversations with representatives from the State about caring for the indigent patients formerly served at Lakeshore. (Initial Order, pp. 22-23, ¶ 61.) SBH executives admitted that, in SBH's opinion, these indigent patients should continue to be served at Woodridge (*Id.*) Moreover, while SBH claimed in its application that it would admit 70 charity care patients annually, even these minimal projections were proven at trial to be inflated. (Initial Order, p. 23, ¶ 62). Based on audited financials produced in discovery, SBH admitted only 150 indigent patients in all 8 of its existing hospitals in 2014, slightly more than one half of one percent (.053%) of its total patient population. (*Id.*)

Given SBH's location in the middle of Woodridge's service area, it is undeniable that many if not most of the patients admitted to SBH would be patients that otherwise would have been treated at Woodridge. Because of SBH's goal in securing only the best paying patients, MHSA's health planning expert conservatively estimated that Woodridge would lose between $1.51 and $1.92 million in net income each year. (Initial Order, p. 21, ¶ 57).

SBH offered no analysis to contradict these projections. Instead, SBH simply argued that Woodridge was one part of Johnson City Medical Center ("JCMC") and that because JCMC is financially stable, the loss of a few million dollars to Woodridge could be absorbed. SBH is licensed as a department of JCMC for administrative convenience. But Woodridge files its own Joint Annual Report, has its own profit and loss statement, and, most importantly, for the last few years has operated at marginal profitability. It is inconsistent with the purposes of the CON process to conclude that it is acceptable for a safety-net facility to be forced into a chronic loss position.

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Alan Levine, MHSA's CEO testified at length regarding the financial challenges facing his health system. (Initial Order, p. 22, ¶¶ 59, 60). While operationally healthy, MHSA is burdened by substantial debt and faces formidable challenges. (*Id.*) The loss of at least $1.51 to 1.91 million in contribution margin per year would represent a major challenge to the ability of Woodridge to support the full range of its current services, especially in today's environment of federal and state budgetary pressures to reduce/control health care payments. (*Id.*) An impact of this magnitude would cause serious financial stress on Woodridge and could result in the elimination or reduction of needed services or investment. (*Id.*)

The CON process is not designed to insulate healthcare providers from competition. The Agency, however, has sought to protect the safety-net providers of Tennessee – those institutions that provide the necessary community healthcare services regardless of the patients' ability to pay – from duplicative projects designed only to cherry-pick the well-insured patients. The Initial Order is contrary to the Agency's policy objectives and there is a compelling reason for the Agency to exercise its discretion to review the Initial Order.

CONCLUSION

For the foregoing reasons, MHSA respectfully requests that the Agency accept review of the Administrative Judge's Initial Order dated February 8, 2016.

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Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing has been served by U.S. Mail, postage prepaid, to the following:

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